

Oral history voicing differences: South Asian doctors and migration narratives

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Abstract:

Oral history's narration of its origins as a method lies in a commitment to challenge, reveal and give voice to those who are disempowered, misrepresented or simply missed out of official, documentary and dominant accounts of the past. People who are marginalised through discriminations based in race and ethnicity, reasons of class and status, gender, age or simply because they have moved location have been at the centre of oral history's achievements. The case of doctors from the Indian sub-continent who travelled to the UK during the twentieth century and who found employment in those parts of the National Health Service where UK graduate doctors were unwilling to work presents us an opportunity to give these assumptions a different twist. In this article we link the memories of a group of South Asian overseas doctors, working in an elite profession with a distinctly non elite group of patients (older, unwell and predominantly working class) to an earlier set of archived interviews with the founders of the geriatric specialty. Used separately and then together, our analysis of these two sets of interviews identifies muted voices, generates recognition and acknowledges ways of understanding and using the polyphony of difference. From this, we argue that the value of re-using archived oral history data lies in the possibility this brings for multiple interpretations of both old and new data and with this new ways of hearing and listening to voices in interviews.

Introduction

Voice is at the heart of oral history as process and product. The conditions under which the past is uttered, heard and reproduced determines what is available to be included, understood and interpreted and what may disrupt existing and dominant accounts of the past. Oral historians engage and prompt voices with the aim of

encouraging and drawing out memory or leaning back when performance takes over and the voice commands its audience. In this article we explore the contribution of the idea of the multidimensional nature of voice in an oral history project. Since the 1970s, oral historians have been interested to engage, record and preserve voices of those who have not previously been heard, or have been excluded from dominant narratives because of their class, status, ethnicity, gender or age. In developing our case study, drawn from interviews with doctors from the Indian sub continent who travelled to work in the UK's National Health Service during the second half of the twentieth century, we deliberately set out to complicate ideas of voice. Our approach involved articulating these South Asian voices with the voices of UK born doctors similarly working with older patients and developing the geriatric specialty and interviewed some years earlier. Both sets of interviewees reflect on their work in an elite profession but with a distinctly non elite group of patients: older, unwell and working class. They discuss the setting up of geriatrics as a profession and their own role and sometimes, that of the other group within this process. Working with a dialogue between these voices we suggest that listening and hearing may be changed as questions are raised as to how we can hear in their voices the weighting of issues such as elite status, migration history, ethnicity, racialisation and voice in two overlapping sets of voices. In the sections below we discuss how voices may be muted, recognised and represented and how they may sometimes dissonant. We conclude with an exploration of polyphony and the multiplicity of meanings in a heard and interpreted utterance. We begin with a brief overview of voice in the oral history literature.

Oral History and Voice

Paul Thompson in his *Voice of the Past* (2000) argues that researchers and society, until recently, neglected evidence about the past when spoken directly from memories of experience. Drawing on an interdisciplinary partnership between the methods and theorising of sociology and history, oral history emerged as a definable approach to investigation, rapidly acquiring a following and a literature of its own (See for example Passerini, 1979; Lummis, 1987; Frisch, 1990; Portelli, 1991; Ritchie, 2003, 2011; Yow, 2005; Perks & Thomson, 2006; Abrams, 2010). Foregrounding witness and direct testimony meant seeking out interviewees whose voices had not, until then, been heard much in accounts of social and historical change. They might have been

represented through the work of others but were rarely given the opportunity to speak for themselves. From the start, oral history sought to do more than simply rebalance this hegemony, practitioners saw their role as bringing new knowledge to challenge and change understanding of the past, bringing in dissonant and contesting accounts from women, children, migrants, workers. These were voices which had rarely been given space, let alone credibility. In such ways, the past takes on new and often more recognisable dimensions when farm and factory workers (Ewart Evans, 1970; Hareven, 1993; Menon & Adarkar, 2004), working class children (Roberts, 1995), artisans (Bertaux & Bertaux-Wiame, 1981), women (Passerini, 1979; Gluck & Patai, 1991), victims of oppression and political change (Butalia, 1998; Adler et al, 2009) as well as activists (Portelli, 1991; Reed & Brandow, 1996) are heard and recognised for their uniqueness and their eloquence. As Portelli argues, oral history's role was to "amplify" those voices by "taking them *outside* (his emphasis) to break their sense of isolation and powerlessness by allowing their discourse to reach other people and communities" (Portelli 1997: 69).

Oral history's popularity and now general recognition¹ across the world means that there are now many hundreds of thousands of voices, recorded, archived and published in a variety of forms: books, websites, radio, television and film. Voice has thus become an uncontested contributor and companion to almost any investigation into past experience and events. And yet the story of the amplification of voice is not quite so straightforwardly simple as oral historians also show. Thompson sets out the conditions under which voice is produced in the oral history interview when he writes: "The constructing and telling of both collective and individual memory of the past is an active social process, which demands both skill and art, learning from others, and imaginative powers" (Thompson 2000: 163). Portelli is more explicit about the process of creation of the material that oral historians work with, emphasising that it is produced when: "...voices go through some kind of machine" so that it becomes evident that what has been spoken may be repeated and told again before unknown audiences (1997: 13). He also points out that recording 'voice' means that it "...rides time rather than resisting it; orality is free to improvise, to converse, to interact loosely on the spot, reacting to the immediate situation" (1997: 185). It is that potential malleability which interested us in our investigation. Even so, while oral historians celebrate the qualities of voice it is the case that most

interpretation and analysis comes via the compression of its translation from a physical act into its representation in the form of a transcript. They also recognise the difficulties of full expression of ‘prosody’, the ‘intonation and stress’ which “separates a real human voice from a synthesised one” and which helps us to understand as listeners what meaning is being communicated (Karpf 2006: 33) and to voice as a performative act in the elicitation of memory (Abrams 2010: 137).

However, a specific issue which arises in the case of oral histories undertaken with different groups is when the voices do not harmonise and present different views of similar situations. How do we make sense of the voices of different individuals who are not speaking in unison? What questions of ‘truth’ arise? Whose voices do we listen to and how? Much has been learned from discussions of differing and conflicting memories and the roles which these play in constructing myths, replaying actions and attributing responsibility. Striking examples from Italy and Greece, where partisan history during World War Two has left legacies which disturb and deconstruct consensus, provide a recognisable focus (Portelli, 2003; Danforth & van Boeschoten, 2012). However, where investigations centre on relationships and personal histories and where privilege and difference complicate oral history’s more usual commitment to listening to voices on the margins, there is less of a literature to draw on.

The re-use of archived interviews and research data has taken a number of forms. Some projects have replicated earlier research often going back to original data with the aim of repeating the project, keeping as closely as possible to the earlier study. So for example Johnson et al (2010) sought to replicate Peter Townsend’s ‘Last Refuge’ study, using similar research instruments to investigate life in care homes for older people, sixty years after his original study (Townsend 1962). With replication it is possible to take a longitudinal view of variables which may or may not contribute to change, noting the effects of time in relation to the research design and the consequent findings. In effect replication produces two separate studies, comparatively linked by topic and methods but always with the possibility of producing new ideas and new data.

A second type of secondary analysis is reanalysis. Studies which reanalyse, work with deposited data, applying new questions with the aim of generating new evidence from that data. April Gallwey (2013) in her investigation of single motherhood in England between 1945 and 1990 used archived oral history interviews rather than generating new interviews of her own. She argues that the archived interviews meant that she was able to sidestep issues of sensitivity around recruiting interviewees for a topic involving single parenthood or divorce. She searched a number of collections before settling on the 6079 life history interviews in the British Library's Millennium Memory Bank. These were generated in 1997-2000 through a partnership between the British Library and BBC Local Radio stations. From this data set and others she constructed a sample of fifty interviews, geographically and socially representative of women born between 1910 and 1971. Her experience led her to conclude that "...oral history has much to offer multiple users for the purposes of constructing broad social histories, after the recorder has been switched off and the interviews stored away" (Gallwey 2013: 48).

Our project involved what we describe as parallelising with an initial oral history data set. 'Parallelising' involves complementing a secondary data set with new primary data. As we describe below the two data sets are complementary and overlapping in key aspects, but separated in time and with different researcher interests and research contexts. The re-use of archived interviews from an already completed project lead to the generation of new questions, new data and opportunities to reconceptualise the voices we were able to hear. However, it also led to multiple voices reflecting on similar times, raising questions about how we analyse these dissonant voices. Using two datasets involved more than simply increasing the number of voices, or adding opposing perspectives; rather it led us to contemplate on how to reconcile these different voices. But before that we describe our project in a little more detail.

Muted voices

The project developed serendipitously following a visit to a set of interviews conducted by a team led by Professor Margot Jefferys with the pioneers of geriatrics in the UK ²(henceforth Jefferys interviews), The Jefferys data set comprises 72 interviews, including eight women, which Jefferys and colleagues carried out in 1990-91 with the founders of the geriatric specialty. Between them they cover the history of

developments in the health care of older people in the UK from the late 1930s to the end of the 1980s. Geriatrics was known as the ‘Cinderella’ specialty in the early days of the NHS. Care of older people with chronic conditions was little more than tending and took place in the back wards of large municipal hospitals, ex Poor Law infirmaries and cottage hospitals. Patients might go for years without seeing a doctor and were often confined to bed permanently. The founders of the geriatric specialty attempted to change this situation, in part as a more humane approach to medical care and treatment in late life in hospitals inherited by the new National Health Service (established 1948) but also in response to a demand to find ways to release hospital beds for use by other patients (Bornat et al 2011; Bridgen 2001; Denham 2004). Checking the interviews for details of the careers of these early geriatricians it soon became obvious from passing comments that there was another group of doctors, whose presence was evident in the accounts of the pioneer geriatricians but whose contribution appear to have gone unremarked in any account of the development of the specialty. Thus for example:

...I am very fond of Indians and Pakistanis, I like them very much, get on very well with them...(goes on to talk about types of geriatricians) ...then there's the third group who I really don't have an awful lot of time for. I am sorry to say most of them are Asians, who came into geriatrics because there was nothing else they could get a consultant job in, other than psychiatry. Some of these are very good, but a lot of them are third-rate. Some of the Pakistani senior registrars we had really weren't very good. One had to have unpleasant fights to get them consultant jobs, and I felt it was the right thing to do. But going up to Bristol and sitting on interview panels for senior registrar with a Professor of Medicine and other people there, you'd interview some pathetic Indian senior registrar, like one of ours, and the other chaps would all say ‘Oh well, I wouldn't appoint him. I wouldn't dream of appointing him. I suppose he's good enough for geriatrics.’ That's exactly what was said, and I would say well look, he is good. I know he's not as good as you'd like, but we're appointing a job in Bradford where (a) there are a lot of Asians there, but (b) if we don't appoint him they won't get a geriatrician in Bradford. And it's all very well saying if we wait we'll get a splendid Guy's graduate who is a different

colour and who's first class, because we won't. You either appoint this chap or you have nobody at Bradford....'³

Such remarks made apparently in passing were present amongst the accounts which Jefferys and her colleagues collected, suggesting that the contribution of this new group of doctors to the development was scarcely credited. Such restricted perspectives are perhaps not so surprising given the times that they were recalling when those very same pioneer geriatricians were expressing concern about the recruitment situation in what can only be viewed as prejudiced language:

...the present pattern of education of medical students, nurses and other health personnel in Britain does not reflect the needs of this high risk group...so that elderly people have grave difficulties in attaining the Health Care appropriate to their needs...there has been a considerable expansion of Consultant posts in Geriatric Medicine throughout the country...this expansion in England and Wales has been achieved to a large extent by the appointment of Overseas Graduates, mostly from the Indian Sub-Continent. In 1974 to 1975, 67% of new appointees to Consultant posts in Geriatric Medicine were born overseas compared with 22% in all other specialties combined. This concentration of Overseas Graduates in what remains a low status specialty is undesirable on many grounds and for the future it is not clear that plans for future expansion cannot be based on the assumption that the supply of such Graduates will continue'.⁴

Hearing these and similar generally unsolicited comments led to a new way of listening to the Jefferys' interviews as we recognised the historical context they were recalling was the late 1960s and 1980s, a period where as well as anxieties about health provision for the older generation and the management and future of the NHS there was also a highly politicised environment where issues of migration and race were openly and often crudely debated with new legislation restricting migrant movement enacted through the Commonwealth Immigrants Act (1968) and the Immigration Act (1972). Although overseas trained doctors have played a crucial part in the NHS their presence was rarely acknowledged beyond the crude contours of brain drain (Raghuram 2009). Listening to the archived interviews with this in mind we were changing the listening voices and revisiting speaking voices. But, serendipitously finding evidence of the presence of another group of doctors amongst

the geriatricians showed us that there were a group of doctors' whose own histories, and contributions to the development of the geriatric specialty were muted, being only indirectly voiced through the recollections of others. Amongst the Jefferys' interviewees there was only one South Asian and he was quite clear about why he and other South Asian colleagues were working with frail older patients:

And they didn't want this crummy thing, to go and work with old people. And so, even though they wanted to learn the latest medicine, they had to come in and try and make up for it by working hard. And quite a few people did. So this is the background to the fact that a lot of them came into geriatrics. At one time the junior posts were flooded with people from the Indian subcontinent....And the local boys wouldn't touch it with a barge pole. So, in effect, geriatrics owes its origin and its beginning to the pioneers who had the vision and the junior doctors from the Indian subcontinent - as simple as that - who had come - they didn't want to come and do geriatrics because there was no need for geriatrics back in India, but they wanted to do medicine. And they found medicine, but they suffered from the same disability which continued for a long time - no opportunity for doing the other medicine, acute medicine, and opportunity for training. This is what they wanted.⁵

Visiting the Jefferys collection had revealed another set of experiences, embedded in the original set, not the focus of that original study which had been to identify the careers of geriatricians identified as 'pioneers' in the specialty's 'Hall of Fame'. It seemed that these other disembodied and shadowed voices had no presence in their own right. Finding a way to hear their accounts and to *represent* these voices became a new research goal.

Voice as recognition and representation

In response to the muted voices we identified in the Jefferys interviews above, a new set of interviews was conducted with South Asian geriatricians (henceforth SAG interviews).⁶ The South Asian geriatricians project produced interviews with 60 South Asian overseas-trained doctors and was recruited through networks of overseas doctors (British Association of Physicians of Indian Origin for example), the British Geriatrics Society and through snowballing. These interviews cover the period from 1950 to 2000.

Our approach was similar to Jefferys: we used an interview schedule which incorporated a life history approach, asking participants to talk about their life from childhood through to the time of the interviews. All the interviews have been transcribed and deposited in the British Library where they sit alongside the Jefferys interviews.⁷ The SAG interviewees were mainly clustered in North Wales, South Wales, Manchester and northern fringe of London, in the main mapping onto the centres where geriatric medicine had been first developed. They include 38 doctors born in India, 8 each in Bangladesh and Sri Lanka, 5 in Pakistan and 1 in Burma, ranging in age between 40 and 91, of whom five were women, arriving in the UK from the early 1950s onwards⁸. Almost all of our interviewees worked as consultants and some also held academic posts such as that of professors.

The Jefferys and the SAG datasets reflect slightly different, albeit overlapping, periods in the history of geriatrics, the emergence of the discipline in some centres and the adoption and adaptation of practices as they radiated out from these centres across the country. As geriatricians, South Asian doctors operated in a framework where there was some national commitment to develop services for older patients and were facing similar issues to those interviewed by Jeffreys. Up to the mid 1980s both were operating in areas that had very little local infrastructure and accorded the geriatric specialty and its patients with low status. Both sets of interviewees developed services and progressed their careers in the context of fluctuations in the supply of and demand for geriatricians. However, the SAG interviewees also encountered the effects of changing immigration regulations and of living in a Britain where the meaning of race was changing, issues which influenced the habitus within which social networks, recruitment practices and career progression operated (Bornat et al 2009; Raghuram et al 2010; Smith 1980).

To become a geriatrician was rarely the first choice of doctors in either group, as we learned from both sets of interviews. Being ‘local’ could be an important deciding factor for getting access to one of the more attractive specialties, but local had more elaborated meanings for the South Asian doctors, which could be spelled out bluntly as more than one of the SAG interviewees remembered:

So you're going for a job to Leeds for cardiology?' I said 'yes I am thinking about it' ... And he said 'I'll show you something then' So there was a job in Newcastle coming up applying for cardiology consultant job, you see. And he showed me the applicants you see, because he was on the interview panel for that consultancy. So guy from Edinburgh, a guy from Cambridge, a guy from Oxford, one guy coming from Canada, one coming from New Zealand, one coming from London from Brompton. And he said 'Have a look at their names as well. They are all local graduates' so he said 'Where do you fit in there? Do you think you have any chance there?' [laughing] So I said 'Probably not' so he said 'Well my advice to you, forget about it because you could be wasting for time by doing cardiology⁹.

The project allowed the voices of the South Asian geriatricians referred to, but rarely heard, in the Jefferys interviews to be recorded and made available for public record. The aim was to let the South Asian geriatricians tell their own story of career choice, discovery of a new specialty with its own opportunities for professional development and commitment to a health service which offered free treatment irrespective of age and income. Both sets of interviews together also narrated the story of the making of a marginalised part of the health service. Separately, the voices recorded in the interviews with the South Asian geriatricians mean that they are not only present as doctors in their own right but claiming recognition for their role:

I think the geriatric medicine again would not have evolved without the contribution of South Asian doctors and majority of them of Indian origin and the Pakistani and the Sri Lankan and Bangladeshi doctors come proportionality with their own contribution. ... and the South Asian doctors who contributed to the development of the service and without them I don't think the service would have developed actually to the current stage. And when it has come full circle actually and the British graduates now are going to this specialty as a matter of choice, ok, to contribute and so it is the contribution of the South Asian doctors which made it possible'¹⁰.

When given the opportunity the South Asian geriatricians clearly voiced their presence in the history of geriatrics. They saw their role as crucial for addressing a concern of that period but also of altering the landscape of geriatrics in the UK for future generations of doctors.

Dissonant voices

So far we have considered the two sets of interviews separately, for what they each say and do not say about a particular group of migrant doctors working in the UK National Health Service. In this section we consider ways in which by juxtaposing these voices we are able to question set scripts, identifying dissonance as this emerges through comparison. A common theme amongst the Jefferys interviews, as our earlier excerpt from Dr Morton illustrates is that not only did the South Asian doctors face various forms of prejudice and discrimination as they sought permanent jobs within the National Health Service, but that this could operate through informal networks of information and judgement exercised by non-migrant doctors. These controlled access to training posts and could thus determine job mobility and promotion prospects. The SAG doctors' testimony elaborates on this, often identifying personal and professional judgements which they felt unable to challenge or contest. Thus for example:

Unfortunately it was not easy to get a new job in the general medicine. They were very clear about it, especially for foreign doctors. You had to compete with the local boys when you go for interview. There was a job coming up at that time in Newcastle. I would have been interested. I was interested but it was not readvertised when I was there it was advertised when I left it. I think it was deliberate ¹¹.

And yet there were rare, though different, experiences. One in particular stands out because the person key to the appointment process turns out not to have a UK background himself:

So after that I was called for interview in Belfast, Professor Bull, I was very lucky because there were local candidates at that time. Belfast graduates and there was one girl who was particular annoyed and very angry that I was selected and not her. But Bull was a south African chap, a white south African an English speaking one not African. And he was taunted by all the colleagues there as Mr United Nations because he didn't care, he just would select whom he thought was the best candidate ¹².

Perhaps it sometimes took an outsider from apartheid South African in this case, ‘Dr Bull’, with different experiences of division and discrimination to set aside the informal networks which typically informed recruitment practices in the medical provision. Certainly, amongst the SAG some interviewees expressed anger and regret as they recalled their professional standing being questioned and threatened and, given the tone of the recollections of the doctors interviewed by Margot Jefferys, their reactions were not unreasonable.

By juxtaposing the two sets of interviews we do occasionally hear accounts which challenge assumptions and which provide opportunities for a more in-depth interpretation of the voices we hear. Such is the case of interviews with Dr John Brocklehurst. We hear him first when interviewed by Margot Jefferys:

All the junior staff I had were trained in India or Pakistan. Many of them had come over; they were junior, their knowledge of medicine was very limited in relation to British medicine, many of them had language problems and so it was a matter of educating them too. And, on the whole, they were very nice people who were keen to learn but it did mean that it was a constant... when you: had an English person. English-trained doctor life became much simpler I must say.

Yes, because of the deficits both due to cultural differences

Yes, and particularly in professional knowledge and the way in which they would go about writing up cases and all the rest of it. So it was a matter of teaching Asian doctors most of the time, and many of them went on, I mean most of these doctors stayed in this country, many went into general practice, quite a few went into geriatrics in fact as the time went by.

What were the most difficult things? Was it to get them to see problems as broadly as you wished them to?

Yes, I think to take an overall view of a case and not get involved in one diagnostic aspect because old people do suffer from various things and they all contribute to their problems. And to have a sort of ordered writing up of the cases and to be able to tell you exactly what was happening the next day or the next week. These were all difficulties¹³.

It is worth noting that this extract comes from a longer conversation with Jefferys, whom all her interviewees knew and treated as an insider. Both Margot Jefferys and John Brocklehurst were academics, with well known publishing records. The impression gained is that the exchanges were very much conversational but what emerges from the language used is a shared understanding of migrant doctors as problematic. The exchanges must be understood within the context of the Jefferys project, the relationship between the interlocutor and the interviewee and the socio-political context of the time (Bornat et al. 2009). If we had only this exchange to go on we might form the impression that John Brocklehurst's record was indistinguishable from others amongst the founding geriatricians. However, the interviews for the SAG project suggest other interpretations. Several describe him in glowing terms, not only because of his leadership qualities, expressed as 'visionary' and 'right thinking' but also for his contribution to the literature of geriatric medicine and the development of the specialty. In this they were not alone as we can see from an obituary (Playfer 2013). However, in one account we hear the description of a senior doctor who was ready to support talent and reward hard work without discrimination:

He was a very kind man. If you wanted anything he will say 'Why don't you see me in my office?' And he will talk to you very patiently, advising you 'Is there anything I can do about you. Do you need some help?' Just like your parents. Oh yes. I wish there were more people like Professor Brocklehurst ...

...So what I was wondering is why it is that there were a lot of South Asian doctors who became geriatricians in that area?

Well I have to say this. He liked people from overseas very much. There were people, how I should put it? They may not, couldn't care less. ... Not everybody likes foreign doctors. Professor Brocklehurst was one who liked foreign doctors very much along with doctors from this country of course. You know. Because he had a knack of knowing that who needs extra help, you know. Yes.

And do you think that overseas doctors need extra help?

By extra help I meant extra fillip, to proceed, you know. For example, if he knew that Dr Chaudhuri was a very good doctor he will say 'Could I help you? Do you want to go to Canada? Somebody rang me from Canada'. Because people will ring him from Canada, from USA, from Australia. 'Have you got any boy, because somebody want to go on holiday for one year or something?' 'Oh yes' So he will ask Dr Chaudhuri 'Will you go?' So similarly, he asked me 'What are your plans?' I said 'I want to visit USA, learn and give lectures and see what is the set up there, how it differs from England'. 'Oh alright, go' and he helped me. But it was not universal. Like anything else it can't be universal. He will know immediately and will ask direct question with the people who could be helped. So that was his beauty, yes, yeah.¹⁴

In this narrative what is striking is not just the dissonance between the voices of the professor and the migrant South Asian doctors who worked with him but that unusually the voices which had been marginalised were supportive of and had benefited from someone in power in the geriatric specialty. In thinking about attitudes towards Indians whose voice should we believe, the rather critical voice of Professor Brocklehurst, when interviewed in 1991, or the voices of the doctors who believed that their career had hugely benefited from his interventions on their behalf?

Polyphony in and of the voices

One way to resolve the dilemma expressed through the apparent contrasts in the voices was to realise the limitations of regarding analysis as simply a summary of the similarities and differences between them. Instead, we found that it is more helpful to think about these voices as part of a polyphony. Each account is partial and it is through the living encounter through the parallelising each with the other that sense can be made of what cultural differences and voice might mean. Recognising polyphony in dialogue as a way of analysing different voices means recognising the multiplicity of viewpoints, the partiality of each viewpoint and the imaginative creativity needed to make sense of these multiple voices (Baxter 2011). Hence, polyphony, for us, became not noise of many, but an articulated sense-making arising from and only through the different viewpoints that these different voices offer.

We found that we were able to shift our hearing and listening in a ways that amplified and also changed the voices in the two sets of interviews. We could hear two sets of subjective utterances, each in and of the transcribed voices. Brocklehurst was both subject and object in the two interviews, he spoke and was spoken of. Similarly, the South Asian doctor who as a member of a collective was described as problematic re-presents this labelling through his own account. Being able to parallelise these two interviews, and others, helps the listener to shift beyond simply contrasting. They are in dialogue in a new time context and with new audiences: "... an utterance spoken in the past can become part of some superaddressee's dialogue with its emergent meanings. In other words, meanings are not fixed" (Baxter 2011: 31). Added to the polyphony produced by the dialogue which we have introduced is the polyphony within each individual voice. John Brocklehurst spoke with the authority of a leading member of the geriatric specialty, when interviewed by Margot Jefferys and as a teacher and physician looking back on success, late in life, but at a time when changes were being introduced into the National Health Service which were to profoundly affect geriatric medicine (Howse 2007; Pollock 2006). His voice is inflected and multiplied by these different perspectives and by the context in which he is being asked to remember. The South Asian doctor who esteemed Brocklehurst as a mentor and sponsor also speaks with more than one voice, recalling his early years as a junior doctor, from the context of successful achievement of consultant status, though, as with so many others who came to the UK in these decades, not in the specialty to which he had at first aspired. He thus speaks as a member of an elite, though one marginalised by ethnicity and by the specialism in which he has succeeded. The picture is thus complicated, but also enriched.

Almost twenty years after his first interview, Brocklehurst was interviewed again, for the SAG project. Again he was asked about the contribution of South Asian doctors to the specialty. His response is measured, giving migrant doctors there due, while also recognising the obstacles and set backs which some had experienced. The polyphony within his voice is perhaps a response to changing perspectives derived from changes in audience, now including qualified and senior doctors who had first arrived from the sub continent several decades earlier:

Well it's been significant in as much as it's been an essential contribution. Because it was very large numbers wasn't it? Very large numbers. Without

those very large numbers it er, one can't speculate how, the service could have developed otherwise. Erm, geriatrics was good because they were on the whole enthusiastic young people coming in, and to, the ones who then went on to become consultants, the majority of them I think fitted in well, not all of them. But the majority did.

If they didn't fit in well what's your reason for saying that?

Well, they didn't get on with their colleagues, in the, I don't mean in teaching hospitals so much as in hospitals throughout the more remote towns and so on. They didn't always get on with their colleagues who may well have, many of them had er, a erm, unfortunate view about them. And I'm not just thinking about geriatrics, people from other specialties, because people from other specialities didn't really have a very bright view of about British doctors in geriatrics either.

Clearly, the context of this interview, the year, the nature of the project, the relationship with the interviewee had all changed since he was last interviewed. But equally, the speaking voice too cannot be considered as stable and coherent. Rather, the voice of the speaker is dynamic and can have multiple meanings. These complexities do not diminish questions of truth claims or make them irrelevant; rather they point to the dynamicity of these claims based on the context of the interview but also on an ever-changing present.

Conclusions

Hearing the voices arising from these two sets of interviews, separated in time and context but brought into a parallel configuration has presented an opportunity for multiple readings. On their own, each makes points which mark similarity and yet difference in terms of their career patterns as emerging geriatricians. From each we also learn about the other in ways that present experiences of relations of disadvantage and inequality. Given that one project emerged from the reading of another, it is not surprising to find voices speaking as if occupying the same territory. While they cannot merge, bringing them together in the way that we have presented here, has enabled more voices to be heard and for how we hear those voices to be changed, expressing different qualities and yielding different interpretations. Reading transcripts and listening to the voices from the earlier project helped us to recognise

muted voices and led us to use voice as a way of getting recognition. However, these voices were neither mimetic nor necessarily oppositional. Instead, by juxtaposing the similarities and differences of different voices and between one voice over a period of time, we show the impossibility of necessarily reconciling these voices to provide a single meaning. Instead we argue for the possibilities of multiple meanings that hearing different voices over time can open up.

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¹ In the UK, the Heritage Lottery Fund alone, has given £80 million to projects with an oral history focus since 1998,

² The Jefferys interviews are catalogued in the British Library Sound Archive with the collection title, 'Oral History of Geriatrics as a Medical Specialty' at <http://www.bl.uk/catalogues/sound.html>. Accessed 26.11.08. These interviews are open access and hence details of the interviewees have been presented in this paper.

³ Dr Eric Morton, born UK 1919, Jefferys collection, BL catalogue C512/4/01-02, consultant physician in geriatric medicine.

⁴ 'Professors of Geriatric Medicine' to the Royal Commission on the NHS, letter dated 13.12.76 from Professor Ferguson Anderson, BGS archives.

⁵ Dr Mohan Kataria Singh, born India 1917, Jefferys collection, BL catalogue C512/50/01, consultant physician in geriatric medicine.

⁶ 'Overseas-trained South Asian doctors and the development of geriatric medicine', ESRC grant reference number: RES-062-23-0514.

⁷ SAG interviews have stipulations for access and have, therefore, been anonymised.

⁸ Several of the SAG interviewees were born before 1947. They are, therefore, 'marked up' as Indian.

⁹ SAG interviewee, man, born 1947, India, arrived UK 1973, BL catalogue C1356/04, consultant physician in geriatric medicine.

¹⁰ SAG interviewee, man, born India 1939, arrived UK 1965, BL catalogue C1356/03, consultant physician in geriatric medicine.

¹¹ SAG interviewee, man, born India 1932, arrived UK 1963, BL catalogue C1356/02, locum consultant physician in geriatric medicine.

¹² SAG interviewee, man, born India 1935, arrived UK 1965, BL catalogue C1356/57, consultant physician in geriatric medicine.

¹³ Professor John Brocklehurst interviewed by Margot Jefferys, 05.09.1991, Jefferys collection, BL catalogue C512/32/01-2, consultant physician in geriatric medicine.

¹⁴ SAG interviewee, man, born 1936 India, arrived UK 1969, BL catalogue C1356/20. retired consultant physician in Department of Medicine for the Elderly.