Peopling Skilled International Migration: Indian Doctors in the UK

Vaughan Robinson* and Malcolm Carey*

ABSTRACT

This article uses a case-study approach in relation to the migration of Indian doctors to the UK in order to illustrate the complexity and multi-levelled nature of explanations for international migration.

It argues that whereas, at the level of discursive consciousness, the movement of Indian doctors to the UK appears an economically driven and shaped phenomenon akin to other examples of highly skilled international migration, when the practical consciousness of participants is investigated through qualitative methods, the migration can also be seen as a cultural and social phenomenon.

Although migrants move to "better themselves", they also make choices based on factors such as the kind of novels they read as children or "taken for granted" familial obligations rooted in the everyday life of their culture.

INTRODUCTION

This article focuses on an important component of skilled international migration from less developed countries to the UK: medical personnel from the Asian subcontinent. A case study approach is used to demonstrate and support some of the arguments presented by Halfacree and Boyle (1993), and to respond to some of the criticisms which White and Jackson (1995) made of contemporary population geography, including work on migration. White and Jackson's central argument was that geographers have ignored theoretical developments since the 1970s, cutting themselves off from new thinking on social theory, preferring instead to continue working within a behaviouralist paradigm employing positivist methods. As a result, population geographers have

* Migration Unit, Department of Geography, University of Wales, Swansea, UK.

Published by Blackwell Publishers Ltd.,
108 Cowley Road, Oxford OX4 1JF, UK, and
350 Main Street, Malden, MA 02148, USA.

International Migration Vol. 38 (1) 2000
ISSN 0020-7985

focused upon observable and measurable "events" such as the act of migration for which they have sought explanations in "causes" that are rooted in the immediate locality and which precede the event. By taking such a perspective, researchers have implied that individuals are at the mercy of circumstances rather than being able to shape them. One of the key research tasks has therefore been to seek correlations between measurable (often economic) causes and events. Jackson and White suggested ways in which population geography could escape this cul-de-sac, including the use of Social Construction Theory to investigate how social categories were created in preference to accepting categories which are implicit in most of the numerical data sets we employ. They championed the use of qualitative rather than quantitative research methods, suggesting that the former were more appropriate for understanding complex or multi-layered processes (thereby echoing Findlay and Graham's (1991) earlier call for multi-method research). They also suggested that researchers need to look beyond the immediate causes of an event by putting that event into a wider political, economic and social context, and therefore seeing it as part of a process.

Although their critique was trenchant and wide-ranging, several of White and Jackson's recommendations built upon prior realization by others of the need for change within population geography. In particular, their plea for the use of biographical methods in order fully to contextualize "events" echoed prior work by Halfacree and Boyle (1993). Their critique of migration research concluded with a plea that migrants should not be viewed as what Thrift (1986) termed "cognitive drones" who respond to simple external stimuli, but as people who cannot and should not be artificially disconnected from the place- and time-specific social and cultural systems within which they are imbedded. In addition, and following Giddens (1984), they proposed that attempts to gain a fuller understanding of migration (or any other act of human agency) would need to be pursued at two different levels of consciousness: "practical" and "discursive". Discursive consciousness refers to what "actors are able to say, or to give verbal expression to, about social conditions, including especially the conditions of their own actions" (Giddens, 1984: 374). Practical consciousness is "what actors know (believe) about social conditions, including especially conditions of their own action, but cannot express discursively; no bar of repression, however, protects practical consciousness as is the case with the unconscious" (Giddens, 1984: 374). Thus, whilst people may verbalize their decisions and rationalize their behaviour at the level of discursive consciousness (e.g., "I migrated to take up a better job"), their actions also need to be understood at the level of practical consciousness; with individuals perhaps not articulating, but recognizing, that they migrated, for example, because of a cultural expectation that they provide their daughter with a dowry, the size of which could not be earned locally. Halfacree and Boyle (1993) claim that such a consciousness is rooted in the "hurly burly" of everyday life, where behaviours and expectations are taken for granted and depend on a stock of knowledge

which has accrued over time, and where agency is temporally, socially and culturally imbedded. "The decision to migrate is not made whilst placing in suspension the rest of one's life", rather "a specific migration exists as a part of our past, our present and our future; as part of our biography" (Halfacree and Boyle, 1993: 337). They therefore proposed that future research into migration needed to use a biographical approach in order to access this practical consciousness.

The research reported in this article also embraces the structurationist perspective of Giddens (1984) as applied to migration by Goss and Lindquist (1995). Giddens argued that the relationship between structure and agency is by no means unidirectional and that structures do not simply constrain what agents can achieve. Rather there is a "duality of structure", with human agency and structure interacting recursively so that structures are (re)produced by human agency and human agency is tempered by norms and expectations. Goss and Lindquist (1995) concurred with this view and criticized existing functionalist and structuralist research into migration as having ignored the duality of structure, preferring instead to reduce labour migration to the response of individuals to discrepancies in wage rates.

> Migration is therefore reduced to the circulation of labour power and the social, cultural, political and institutional dimensions of the phenomenon are subordinated to an economic logic (Goss and Lindquist, 1995: 317).

They then used the case-study of migration from the Philippines to demonstrate how

> overseas labour migration is the outcome of a complex combination of individual actions and social structures. The model of international migration that we have presented seeks to capture this complexity by theorizing migration as the result of knowledgeable individuals undertaking strategic action within institutions – specifically the institutions of migration which operate according to recognizable rules and which distribute resources accordingly (p.344).

As examples of the duality of structure, and the intertwining of the social and the economic, they point to the pivotal role of patrons, private recruiters and returned migrants who control knowledge of migration opportunities and selectively disburse this through their social networks in such a way that these networks become migrant networks and eventually migrant institutions. They conclude that individual interests and actions are not determined by institutions, but individuals draw selectively on institutional rules and resources in pursuit of their interests and inevitably reproduce the social system.

The first section of the article outlines the economic and legal structures which stimulated and shaped the migration of Indian doctors to the UK. By stressing the economic, this section emphasizes the commonalities that exist between the

migrations of Indian doctors and other highly skilled migrants into and out of Britain. The second section describes the migration that resulted, its scale, importance and characteristics. The third attempts to understand the human agency which creates the migration by reporting conventional research at the level of discursive consciousness and biographical research at the level of practical consciousness. The central contention is that migration of any group, including Indian doctors, is complex and can be fully understood only through research on different levels. It argues that at the level of discursive consciousness the movement of Indian doctors to the UK appears to be an economically driven and shaped phenomenon akin to other examples of highly skilled international migration. However, when the practical consciousness of participants is investigated through qualitative methods, the migration can also be seen as a cultural and social phenomenon rooted in Indian society and which therefore has strong parallels with the prior migration of Indian peasants to the UK. This section also illustrates the duality of structure by demonstrating how structures shape agency and how, in turn, agency can create new migration structures.

STRUCTURES OF MIGRATION FOR OVERSEAS AND INDIAN DOCTORS IN THE UK

Immigrant doctors played on important role in the creation and growth of Britain's National Health Service (NHS). The inability of Britain's medical schools to satisfy rising demand for trainee doctors, and the emigration of many of their qualified colleagues to the old Commonwealth in the immediate post-war years (Fortney, 1970), meant that the NHS had to turn initially to Europe and later to the new Commonwealth for additional manpower. However, as public and political opinion turned against unregulated labour migration from the Caribbean and the Asian subcontinent, politicians and civil servants had to be increasingly ingenious at manipulating and recasting immigration legislation so as to allow continued movement of doctors to the UK from these sources. Gish (1971) argues that the immigration Acts of the 1960s and early 1970s were purposely designed to allow the recruitment of new Commonwealth doctors, whilst excluding the majority of other potential migrants from the new Commonwealth and Pakistan (NCWP). He notes that between 1966 and 1968, 40 per cent of all vouchers issued to NCWP professionals went to doctors. Overseas doctors and dentists were even exempted from the provisions of the Immigration Act of 1971, which further tightened restrictions on other occupational groups seeking entry from the NCWP. By 1971 Gish (1971: 52) was able to declare that "... the National Health Service simply could not function without the overseas doctors ...".

However, once the recommendations of the 1968 Todd Report had been implemented, Britain enjoyed a growing domestic supply of medical manpower more commensurate with the slowing demands of the NHS. Since that time,

progressively tighter controls have been introduced on the immigration of Commonwealth doctors in order to match supply and reduced demand. First, fears that British policy towards immigrant doctors had perhaps been too generous led in 1975 to the creation of the Temporary Registration and Assessment Board, which sought to quality-assure the medical and linguistic abilities of doctors entering the UK. Second, in 1979 this was replaced by the permanent Professional and Linguistic Assessment Board (PLAB), which doctors had to satisfy before being granted temporary registration. Third, in April 1985, the government introduced new Immigration Rules which allowed non-EEC doctors and dentists to remain in Britain for postgraduate training for a maximum four years, and denied them the opportunity of then transferring to work permit status. The principal effect of this was "to end the special exemption from the immigration rules which gave overseas doctors and dentists unrestricted right of entry and employment in this country" (Anwar and Ali, 1987: 9). In practice, however, some switching from training to training-grade employment continued to be tolerated, allowing selected doctors to remain in the UK for considerably longer than four years. However, on the 1st January 1994, this possibility was finally removed so that trainees cannot now stop in the UK beyond a fifth year.

The key structures shaping the migration of Indian doctors to the UK have therefore been the historically variable demand for their labour within the National Health Service, differentials in the remuneration of doctors in India and the UK, and legal structures which have selectively regulated immigration from certain countries, implicit within which is racial exclusionism.

THE MIGRATION OF INDIAN DOCTORS TO THE UK

Despite careful attempts by successive governments to regulate the immigration of NCWP doctors, this group has remained important to the NHS. Smith (1980) showed that 38 per cent of doctors working within hospitals in the late 1970s and 20 per cent of GPs were born overseas. Anwar and Ali (1987) showed that in 1981 about one-half of Registrars and Senior House Officers in England and Wales were from overseas and within particular specialties the figure was as high as 84 per cent. Beishon et al., (1995) provide recent figures on nurses in the NHS. The Department of Health estimated that by the mid-1980s between 1,500 and 2,000 overseas doctors were entering the UK each year (see Seccombe et al., 1993 for information on the migration of nurses). Table 1 (page 106), which contains comparable data for late 1995, indicates that persons born outside the EC now comprise 32 per cent of all hospital staff, the percentage varying from 18 of all House Officers to 68 of Associate Specialists. While the proportion of Registrars and Senior House Officers born outside the EC (40 per cent) has declined since 1981, it nevertheless remains significant.

While overseas doctors in the UK originate from a variety of countries, Table 2 (page 106) shows that the proportion of doctors in Great Britain from the Asian subcontinent increased steadily between 1966 and 1980. By 1980 they formed 12 per cent of all doctors in Britain and 14 per cent of doctors working within NHS hospitals. This supports Gish's (1971: 39) observation that "Britain's great source of medical gain, ...was the Indian subcontinent from where almost twice as many doctors are known to have come to Britain than had left." Table 3 (page 107) indicates that despite tightening restrictions on entry, doctors of Indian ethnicity comprise the largest group of non-white doctors, representing about ten per cent of the stock in England and Wales in late 1995.

UNDERSTANDING HUMAN AGENCY

It is argued above that human agency needed to be understood on two different levels of consciousness – discursive consciousness and practical consciousness – and that study of these required different research methods.

The level of discursive consciousness

Discursive consciousness is most often studied through the collection of "facts" obtained through the medium of a questionnaire in which people are asked their reasons for doing particular things. Despite the importance of overseas doctors to the NHS, there have been only three such studies on their migration and position within the British medical sector. Only some of the material from these studies can be disaggregated by country of origin. The Community Relations Council's (1976) study was based upon a review of published and unpublished reports. Smith's (1980) Policy Studies Institute report was based upon interviews conducted between September 1977 and February 1988 with a matched national sample of 1,981 respondents, of which 337 were from the Asian subcontinent. Anwar and Ali's (1987) study on behalf of the Commission for Racial Equality relied upon a sample of 244 ethnic doctors, of which 57 per cent were born in India. Their interviews during 1980 and 1981 were confined to two Regional Health Authorities (North Western and Merseyside). These reports, though somewhat dated, nevertheless provide facts about the nature, characteristics and causes of migration.

The findings of this earlier research can be summarized to show how the nature of migration has been characterized in the past. Smith (1980) describes the migration succinctly:

> Most of these doctors had their basic training and obtained their basic qualifications in the country of origin, but came to the UK to complete their training and with the intention of returning to the country of origin after a few years. ... Of all

> adult migrants, 85 per cent said they had come chiefly to further their medical training or careers, but there are some significant differences between groups. Doctors from the Asian subcontinent and from Arab countries are the most likely to have migrated for career or training purposes (91 per cent and 90 per cent respectively) ... (Smith, 1980: 36).

Anwar and Ali's study showed that the predominant reason given for migration was to gain further qualifications (60 per cent), acquire a Fellowship (18 per cent) or to gain experience (12 per cent). The same authors also found that 51 per cent of respondents claimed that the UK had better facilities for doctors than their home country, but 82 per cent intended returning to their home country after achieving self-defined goals. Most of the doctors were aged between 25 and 30 years on arrival in the UK, with two-thirds of having being under 30 on arrival in Britain. About one-half were married. Over one-third of those remaining in the UK eventually reached Consultant grade, and 36 per cent expressed the view that their careers had lived up to their hopes "very well".

The migration of Indian doctors to the UK has traditionally been deemed as an economically motivated phenomenon in which migrants are skills providers, not people. Indian doctors in the UK are considered classic skilled international migrants. Authors characterize their migration as being planned, externally regulated, and determined by the needs of a specialized labour market. The young, well-educated and ambitious migrants move purposively for career advancement, looking only towards short-term placement geared to specific occupational targets. In short, they are rational, successful and pro-active individuals making planned and considered moves for positive reasons and to take advantage of defined opportunities found in the UK.

The level of practical consciousness

At this level, the migration of Indian doctors is seen as a socially, culturally and historically imbedded phenomenon. The central argument of this article is that although discrepancies in wage levels and training opportunities are undoubtedly important for the migration of Indian doctors to the UK, this is only part of a more complex explanation. In order to gain a richer and fuller understanding of this particular migration it is necessary to contextualize it socially, culturally and historically. This can be achieved only through biographical methods which shed light on the practical consciousness of participants.

We considered that the practical consciousness of Indian doctors could not be probed effectively through conventional interviews and formal questionnaires, and so rejected the idea of surveying a large and statistically representative sample of respondents. We opted for a qualitative methodology in which in-depth discussions were held over a six months period with a small number of respondents who were prepared to discuss their experiences in a reflective and

introspective manner. We sought the permission of a medium-sized District General Hospital (2,500 employees) to interview Indian doctors on their staff. Of the 131 junior doctors and 47 consultants employed by the hospital, 30 junior doctors and seven consultants were from overseas. Of these, 12 were migrants of Indian ethnicity, including two consultants. After contacting the 12 potential respondents and explaining the purpose of our research and how we felt they might be able to inform and enlighten us, nine were selected from the 12 for further discussions. Each was then interviewed in English on three occasions: first to acquire factual information; second to understand the meaning of this factual material at the level of discursive consciousness; and third to explore the "taken for granted" practical consciousness underlying action. Each doctor was interviewed for about three hours in total which we felt was the maximum we could ask of respondents working between 80 and 120 hours per week.

The material provided by respondents was not only of value for its intensity and depth and for the insight shown by respondents, but also because it provided us with the biographical context within which the migration decision was set. For example, the respondents not only discussed the attitudes of family and friends, but also how their upbringing had shaped the decision to emigrate. By the third interview, we were able to explore such topics as racial prejudice and discrimination which would have been very difficult in a more conventional quantitative survey. However, we cannot (and do not wish to) make any claims for the representativeness of the views expressed by respondents, since the findings are not judged against the traditional positivist yardsticks of replicability and representativeness. Rather, we follow Winchester (1996) and also Findlay and Li (1997: 38) who, in advocating autobiographical methods in migration research, suggest that "the validity of qualitative methods ... rests on the ability to illuminate the structures and mechanisms which underpin observable behaviour". We also acknowledge with Findlay and Li (1997) the danger that qualitative methods can reify a small number of ideas selected by the researcher from the interview transcripts. We deliberately adopted an inductivist approach to the early phase of data collection, and only after we had acquired the transcripts and immersed ourselves in them did we conclude that four issues (*Izzet*, colonial ties, traditions of migration, and racism) shed new light on previous assumptions.

Illuminating concepts

Robinson (1986) shows that four elements have been important in explaining the nature, form and meaning of the parallel migration of Indian peasants to factories in Britain during the post-war era. But because of the way geographical literature is dichotomized into skilled and unskilled migration, the four elements have not been brought to bear on the migration of highly-skilled Indians. These elements are:

Colonial and post colonial ties between Britain and India. The historic ties which Britain formed with her erstwhile India colony have been of enduring significance. They opened channels of communication in both directions, provided awareness of opportunities in the UK for Indians able to migrate (Rose, 1966), established a dependency between India and the metropolitan power, established a racialized social hierarchy (Robinson, 1986: 53-55), and transformed the aspirations of many Indians (Robinson, 1986: 110-111). In short, Empire provided ideological linkages of the type which Sassen (1988) regards as essential for converting potential migration into actuality.

The tradition of migration from India to Britain. The recent movement of Indian doctors to Britain has to be seen as part of a wider and continuing migration established during British colonial rule in India (Visram, 1986). The migration involved groups as disparate as students, princes, nannies, seamen, military personnel, rural peasants, brides, academics, performers and international entrepreneurs and traders. Despite the differing characteristics of participants, migration has been bound together by certain continuities such as the presence of a migration ideology which links India with Britain and which vests in the UK certain characteristics (for example access to opportunity) and engenders certain emotions, including respect for the country's achievements and standards.

The notion of Izzet. Central to an understanding of migration from the Asian subcontinent is the linkage between spatial and social mobility, and the concept of *Izzet* (Robinson, 1986: 69-70). While *Izzet* can be likened to status, it is a far more complex concept that involves not only material belongings and social standing but also intangibles such as honour, integrity, bearing, and "correct" behaviour. It is also a shared label which applies to all members of the extended family, not to any one individual, and it is both fragile and subject to constant assessment and re-assessment in the light of new behaviour. *Izzet* can be acquired through migration in two ways: first by the acquisition of material wealth which can be used to buy status (through ownership of land, accessing political influence, investment of remittances in conspicuous community projects or the payment of larger dowries which ensure "better" marriages for daughters). Second, via the far less tangible route of acquiring status and gravitas often associated with the well-travelled, the worldly-wise, the qualified and the experienced. To have been abroad is to have achieved and experienced. *Izzet* is also important because its maintenance in Indian societies is not only dependent on what is acquired, but also upon codes of behaviour. *Izzet* can be enhanced or diminished by how an individual receives and treats others. How young people respect and care for elders is important. So too is helping the needy, whether they be fellow villagers, family members or individuals from the same regional-linguistic community. Social networks thus become support networks and migration networks, in which earlier migrants are obliged to assist those seeking to migrate later. Information, advice and

finance flow through the transnational network, and the movement of people from one country to another is lubricated by assistance both to negotiate immigration procedures and to find accommodation and employment upon arrival. The spread of Indians into what is now an international diaspora provides one of the best examples of the power of chain migration (see Clarke et al. (1990) for details of the Indian diaspora and Cohen (1997) on the contemporary reformulation of the concept of diaspora). Chain migration and diasporic relations also have an important bearing upon the maintenance of value systems. The continual cycling of migrants between the "home" and diasporic societies serves to maintain and reinforce social control and value systems. Information about an individual migrant's overseas success (or lack of it) will be channelled back to the sending society long after they may have decided to settle in the diaspora on a permanent basis, and it will continue to have a bearing upon the *Izzet* of their family there. Permanently settled migrants will therefore have to live within a value system which on one level is still grounded in the sending society (India), on another is grounded in the diasporic satellite (the Anglo-Asian populations), and on a third reflects in some measure life in a new society (Britain).

Racism in the Health Service. Despite the weight of evidence which demonstrates racism in other walks of life (Brown, 1984; Jones, 1993 and Modood et al., 1998), racism within the health service has only recently been officially recognized in the UK. It first reached public attention in November 1986 when a London teaching hospital was found to be selecting its students by using a computer programme designed to mimic previous decision-making by senior staff. The programme had an in-built weighting mechanism that automatically gave precedence to men and caucasians. The subsequent investigation by the Commission for Racial Equality (1987) led to the issuing of a non-discrimination notice. Further evidence of discrimination was provided in 1993 when two doctors published an article in the *British Medical Journal* demonstrating, through the use of a form of situational actor testing, that Asian doctors applying for jobs were half as likely to be shortlisted as were comparably qualified white applicants (Esmail and Everington, 1993). Racial differences have also been shown in the likelihood of complaints against doctors reaching the General Medical Council's Professional Conduct Committee (BBC TV, 1997). Racism has several impacts. First, Anwar and Ali's (1987) study showed that overseas doctors had been less successful in penetrating the upper grades of occupational structure than their white counterparts, and their levels of job satisfaction were approximately half that of their white colleagues. Second, Indian doctors who had come to the UK to gain additional training also found it very difficult to put their training programmes together or gain training posts. Beishon et al. (1995) note that this also applies to ethnic minority nurses. Third, racism has led to particular concentrations of overseas doctors in specialties that are unpopular amongst white doctors, for example, geriatrics and psychiatry. Akinsaya (1988) demonstrated that there were concentrations of ethnic minority nurses

in the same specialties. Fourth, overseas doctors not only had to be content with less popular specialties, they also had to accept placements in less popular geographical locations in the UK. Anwar and Ali (1987: 66) quote a white doctor as saying, "The teaching hospitals are staffed by white British graduates and the peripheral hospitals are staffed by coloured doctors". Robinson (1988) has also commented upon the concentration of Indian doctors in some of the least attractive parts of the UK. This should be contrasted with case studies of skilled transients (e.g., Findlay et al., 1996) which note their overwhelming concentration in global cities.

FINDINGS

Reasons for migration. Although our respondents were highly skilled international migrants, they gave two parallel sets of reasons for their migration. First, and presumably at the discursive level of consciousness, they described how they had moved in search of further qualifications and greater occupational experience. Three careerist reasons were cited: they sought better quality and more varied training to allow more rapid career progression, one doctor saying, "There was really only one reason why I moved to Britain. I just thought I'll do more training and in the long run it will help me"; they wished to acquire British postgraduate qualifications, Dr C saying that "in order to get out of hard-going hospital work in India I realized that I needed a postgraduate qualification"; and they wished to have access to the latest ideas and methods, Dr D saying, "I now have access to some highly advanced medical equipment and procedures".

However, our attempts to penetrate beneath the level of discursive consciousness suggested that there were more varied reasons for migration, some of which were not economic in nature. A number of respondents told us they saw migration as a form of "escape" (an emotion rarely associated with skilled international migrants), escape from the daily grind and bureaucracy of work in under-staffed and under-resourced public hospitals in India. Dr B, a 47 year old from Bangalore, stated that a critical factor in his decision was an unpleasant two years spent working as a doctor in Bangalore City: "I didn't really enjoy the experience at all. My time spent at medical school was wonderful, but once I transferred to full-time work in one of the public hospitals, things became much harder." Oommen (1989) provides corroborating evidence of the difficulties experienced by doctors in India. Another respondent (Dr E, a 45 year old from Assam) described his desire to make a fresh start: "I had worked in India for six years and was fed up. I was therefore very keen at the time to get away from all the negative aspects." He wanted to work in an environment where he could benefit his patients more. "In many Indian hospitals you often have to wait a long time before getting to see patients and you sometimes have to go through quite a lengthy procedure."

Two other respondents told us that their migration had been driven, in part, by the taken for granted duty of sons to uphold family *Izzet*. One said that "In India it is the duty of the eldest son to look after his parents. The main reason I came here is to support my parents." Dr A said, "I also assumed during my time in Britain I would be able to earn, and save, some money" for when he returned to India. He felt this to be important not only because it allowed him to secure his own future, but also to support his parents in old age. Migration to the UK and the acquisition of British qualifications was seen as a key to fulfilling this obligation, and also ensuring that the family did not suffer the loss of *Izzet* associated with falling on hard times.

Clearly, decisions to migrate were not driven only by career aspirations, but also by non-economic factors such as a sense of adventure, duty and curiosity.

Reasons for migrating to the UK. When researched biographically, respondents revealed a set of reasons for migrating to the UK which were more taken for granted than instrumental. Colonial links figured strongly in these accounts. For instance, Dr H described how he was educated in English and he remembered reading lots of Enid Blyton books as a child, which presented Britain as almost heaven on earth, a comment that succinctly demonstrates the powerful emotional legacy of colonialism and colonial relations. Dr B noted that his father's cotton business had always traded with Lancashire, and that his father had therefore both encouraged him to select the UK as his destination and had been proud when he had done so. Having a son as a doctor in the UK would enhance the family's *Izzet* considerably. Another doctor told us that his father was a police officer during the Raj and encouraged him to come to Britain because of his respect for the British. However, the legacy of colonial relations was not just personal and emotional, but also institutional. This became clear when respondents indicated why they had chosen to migrate to the UK. Whilst for some Britain had not been the preferred destination, others had never considered alternatives because of the enduring nature of previous colonial links. We were told how the Indian health service was modelled on the British NHS and how British medical practice was held up as an ideal in Indian medical schools. One of our respondents noted how his tutors at medical school continually extolled the virtues of the NHS and that to acquire British experience and qualifications would be highly beneficial. Others commented that they looked naturally to the NHS for models of good practice.

Mechanisms of migration. As noted above, the British Government restricted the intake of Indian doctors through general immigration law and eligibility criteria specific to the medical profession. Recent arrivals have had to circumvent these barriers. Our respondents told us how social networks became migration networks and how earlier migrants used their knowledge and resources to circumvent or nullify the effect of these barriers on later migrants. Central to this was chain migration built on the historic links which existed between the

subcontinent and the UK, and dependent upon mutual support rooted in non-economic networks. Dr C told us how he had corresponded over a three years period with friends from medical school who were in the UK. Their generally positive feedback had been instrumental in his own migration decision. Dr F noted that: "In order to step into Britain, you really need to know somebody working here (from India) first. I don't think I would have been able to move here without knowing Dr MB. It would have been too much trouble, and I would not have had the money. The cost of the flight and the PLAB fees (etc) is so expensive, and you don't get many pounds to the rupee." Dr A described how a friend in Bradford had paid his air fare and PLAB fees and had given him accommodation and food during his first few months in the UK. Dr A had then done the same for two other Indian doctors. Dr C was given two and a half month's accommodation by a doctor friend whilst he sought work. Highly skilled migration was thus not just prompted by social and economic imperatives, but was also operationalized through non-economic networks and facilitated by socially and culturally derived obligations. This lends support to Goss and Lindquist's view that social networks, migration networks and migration institutions are closely intertwined.

Future plans and racism. When asked to reflect on their careers and future plans, respondents revealed little concern for what might be termed conventional career advancement. While all the pre-1985 arrivals had abandoned plans to return to India, this was not because of satisfaction with career progress in the UK to date or prospects for further advancement. Indeed, most were somewhat gloomy about the likelihood of rapid promotion in Britain. Dr B described how after twenty years in the NHS he was still only a Senior House Officer, but despite this he and his family were "very happy" in Britain and settled for good. He "cherished" the security he was able to provide his family. Dr E said, "I feel more secure and settled here. My family are happy and my children are getting a good education. In short, things are made easier here." Career rewards were thus being sacrificed for other less tangible rewards. Because the 1985 ruling limits the period a non-EC doctor can stay in the UK, recent arrivals had different future plans than their predecessors. All but one female doctor who had married a British man, were committed to returning home. While many shared Dr F's view that "India is my country. My country needs my services", those who intended returning to India said that working in the public sector or hospitals was not for them. They intended establishing a private practice as specialists in major cities such as Hyderabad or Madras.

A central factor which shaped the experiences and plans of all respondents was racism in the UK, including within the medical system. Dr B said, "Nearly all the staff look down upon you. They don't usually express their feelings, however, because then you can take legal action." Dr H said, "Overseas doctors have to be so much better and work much harder than a 'local' in order to achieve the same results." Dr C said, "It might be a comment you overhear or

just the general attitude towards you from some staff. Whatever, it does appear that overseas doctors are looked down upon in general." And Dr D argued that "overseas trained doctors do not receive equal treatment in general and there is a clear bias towards indigenous graduates." Dr F simply said it was "common knowledge" in the NHS that foreign doctors were discriminated against. And Dr A noted that "overseas doctors do seem to get the worst jobs." These responses suggest an exploitative relationship between the employer (the NHS) and the migrant rather than the symbiotic relationship which is often thought to characterize the highly skilled international migrant and the TNC, although it should be noted that the employers may well have had a different perspective as might UK-born medical staff.

The cohort of doctors who had migrated recently also considered that they were being "used" by the NHS. In view of the high daily workload that they were expected to carry in the NHS, most thought that four years was insufficient time to also acquire the postgraduate qualifications which had been a prime motive for migration. Dr F said, "I do not think that four years is enough time to either complete my training or acquire my postgraduate qualifications. Six years would be a more realistic period of stay."

Indian doctors migrating to the UK have commonalities both with other highly skilled international migrants and with other (unskilled) Indian migrants to the UK. At the level of discursive consciousness, our respondents appear an archetypal example of skilled international migrants with participants seeking career progression and material rewards. Further investigation at the level of practical consciousness revealed the migration to be more chaotic and to draw its inspirations from everyday life: colonial legacies, the desire for adventure, the wish to enhance the *Izzet* of the family, and racism. It could be understood only with reference to the participants' past and their chosen life trajectory. Doctors came to the UK for personal and family, as well as professional, reasons and some were escaping negative factors. They were using social networks to operationalize their migrations and to challenge immigration restrictions, and they were incurring and disbursing material obligations along the way. Some had not made a "rational" choice to come to Britain because it offered the greatest opportunity to achieve their objectives; rather they had veered towards the UK because of past colonial linkages and images of the NHS and Britain acquired during their education in India. Early arrivals soon shed their "myth of return" and become permanent settlers (often for reasons which had little to do with their careers or material wealth), but neither they nor the post-1985 arrivals were enjoying the fruits of their skills through rapid social mobility, job satisfaction or residence in global cities. Rather, they were being used as "cheap labour" (Dr F's term), or professional guestworkers by the NHS in those grades, specialties and localities which were unattractive to white doctors (c.f. Akinsaya, 1988 on overseas nurses in the UK and Bernstein and Shuval, 1995, on Russian doctors in Israel). Underpinning and operationalizing

this unequal treatment was racism. Indian doctors acquiesce to this treatment only because it provides an escape from the even more arduous alternative of working in an Indian public hospital, and because it provides an opportunity, albeit one which might remain unrealized.

CONCLUSION

Interviews with a small number of Indian doctors have shown that their migration to the UK was a multi-layered and highly complex phenomenon. Though skilled migration, in some respects it bears closer comparison with the migration of Indian peasants to the UK, since both migrations are embedded within the same colonial legacies, similar prior histories of migration and a common cultural drive for *Izzet*. Even though Indian doctors are highly skilled and relatively well-rewarded, their migration is still rooted in everyday Indian life.

Our interviews suggest the need for reconsideration of four significant issues within the study of skilled international migration. First, its study by geographers could usefully be broadened from the present focus on high-flying employees of TNCs and contract employees recruited by head-hunters. Second, perhaps the current dichotomy in the migration literature between "highly skilled" and the "unskilled" is, in many ways, artificial and unhelpful, giving undue salience to a single characteristic of the individual. Third, we need to move well beyond functionalist theory and neo-classical economics and see highly skilled labour not only as a factor of production flowing across transnational space and "subordinated to an economic logic" (Goss and Lindquist, 1995: 317), but also as people living within a social, cultural and historical context. By peopling skilled international migration we might better understand such migrations and also recognize that highly skilled migration is internally differentiated on criteria other than skills or qualifications (e.g., gender and ethnicity). The peopling of highly skilled migration would also allow us to identify commonalities often shared by highly skilled and unskilled migrants moving between the same source and destination. The parallels between skilled Indian doctors and unskilled Indian labourers are clear to see. In both cases, migration to the UK is shaped by colonial links, is driven – amongst other things – by the search for family *Izzet*, generates a myth of return, is operationalized through chain migration based upon village or regional social networks, and creates a population fraction which – because of racism – occupies an outsider role in society and economy. Fourth, following from the previous point, we suggest that there is a need to unpack the term "skilled international migration" or replace it with a typology (beyond that proposed by Gould, 1988) of the different forms of migration undertaken by persons with skills to sell, however these may be defined.

REFERENCES

Akinsaya, J.
1988 "Ethnic minority nurses, midwives and health visitors: what role for them in the NHS?", *New Community,* 14: 444-50.

Anwar, M., and A. Ali
1987 *Overseas Doctors: Experience and Expectations*, Commission for Racial Equality, London.

BBC Television
1997 *An Unhealthy Practice: East*, June, BBC TV, London.

Beishon, S., S. Virdee, and A. Hagell
1995 *Nursing in a Multi-ethnic NHS*, Policy Studies Institute, London.

Bernstein, J., and J. Shuval
1995 "Occupational continuity among immigrant physicians from the FSU in Israel", *International Migration,* 33: 3-31.

Brown, C.
1984 *Black and White Britain*, Heinemann, London.

Clarke, C., C. Peach, and S. Vertovec
1990 *South Asians Overseas: Migration and Ethnicity*, Cambridge University Press, Cambridge.

Cohen, R.
1997 *Global Diasporas: An Introduction*, UCL Press, London.

Commission for Racial Equality
1987 *Medical School Admissions: Report of a Formal Investigation into St Georges's Hospital Medical School*, CRE, London.

Community Relations Council
1976 *Doctors from Overseas: A Case for Consultation*, CRC, London.

Esmail, A., and S. Everington
1993 "Racial discrimination against doctors from ethnic minorities", *British Medical Journal,* 306: 691-692.

Findlay, A., and E. Graham
1991 "The challenge facing population geography", *Progress in Human Geography*, 15: 149-162.

Findlay, A., and F. Li
1997 "An autobiographical approach to understanding migration", *Area,* 29: 34-44.

Findlay, A., F. Li, A. Jowett, M. Brown, and R. Skeldon
1996 "Skilled international migration and the global city: a study of expatriates in Hong Kong, *Transactions, Institute of British Geographers,* 21: 49-61.

Fortney, J.
1970 "International migration of professionals", *Population Studies,* 24: 217-235.

Giddens, A.
1984 *The Constitution of Society*, Polity Press, Cambridge.

Gish, O.
1971 *Doctor Migration and World Health*, Occasional Papers on Social Administration, Bell, London.

Goss, J., and B. Lindquist
1995 "Conceptualizing international labour migration: a structuration perspective", *International Migration Review,* 29: 317-351.

Gould, W.
1988 "Skilled international labour migration: an introduction", *Geoforum*, 19: 381-385.
Halfacree, K., and P. Boyle
1993 "The challenge facing migration research: the case for a biographical approach", *Progress in Human Geography*, 17: 333-348.
Jones, T.
1993 *Britain's Ethnic Minorities*, Policy Studies Institute, London.
Modood, T., R. Berthoud, T. Lackey, T. Nuzroo, P. Smith, S. Virdee, and S. Beishon
1998 *Ethnic Minorities in Britain: Diversity and Disadvantage*, Policy Studies Institute, London.
Oommen, T.
1989 "India: brain drain or the migration of talent?", *International Migration*, 27: 411-425.
Robinson, V.
1986 *Transients, Settlers and Refugees: Asians in Britain*, Clarendon, Oxford.
1988 "The new Indian middle class in Britain", *Ethnic and Racial Studies*, 4: 456-473.
Rose, E.J.B.
1966 *Colour and Citizenship*, Institute of Race Relations, Oxford University Press, Oxford.
Sassen, S.
1988 *The Mobility of Labour and Capital: A Study in International Investment and Labour Flow*, Cambridge University Press, Cambridge.
Seccombe, I., J. Buchan, and J. Ball
1993 "Nurse mobility in Europe: implications for the UK", *International Migration*, 31: 125-149.
Smith, D.
1980 *Overseas Doctors in the National Health Service*, Policy Studies Institute, London.
Thrift, N.
1986 "Little games and big stories", in K. Hoggart and E. Kofman (Eds), *Politics,Geography and Social Stratification*, Croom Helm, London.
Visram, R.
1986 *Ayahs, Lascars and Princes: Indians in Britain, 1700-1947*, Pluto Press, London.
Winchester, H.
1996 "Interviews and questionnaires as mixed methods to analyse changes in the life-course", in J. McKendrick (Ed.), *Multi-Method Research in Population Geography*, Population Geography Research Group of the Institute of British Geographers, Manchester.
White, P., and P. Jackson
1995 "Re-theorising population geography", *International Journal of Population Geography*, 1: 111-124.

TABLE 1

REGION OF BIRTH OF NHS HOSPITAL STAFF IN ENGLAND AND WALES, OCTOBER 1995

	Place of birth (percentage)				
	UK	Eire	Other EC	Elsewhere	Number
Consultant	74.3	1.9	1.1	22.7	19,454
Staff grade	28.3	0.8	2.5	67.3	1,920
Associate specialist	30.3	0.3	1.2	68.1	1,151
Senior registrar	67.7	4.1	2.9	25.3	4,448
Registrar	49.8	1.5	3.5	45.2	6,931
Senior house officer	53.4	0.7	8.3	37.5	13,874
House officer	71.6	0.4	9.7	18.2	3,392
Other staff	61.5	0.0	0.0	38.5	13
Hospital practitioner	71.0	0.5	0.4	28.0	764
Clinical assistant	64.6	0.7	1.6	33.0	6,836
All staff	62.3	1.4	3.8	32.4	58,783

Note: Some percentages do not total to 100 because of rounding.

Source: Unpublished statistics supplied by NHS Executive.

TABLE 2

BIRTHPLACE COMPOSITION OF THE STOCK OF DOCTORS IN GREAT BRITAIN TO 1980

	Percentage		
	1966	1971	1980
UK and Eire	78	79	69
Other European	4	2	3
Old Commonwealth	4	3	3
Asian subcontinent	9	11	17
Arab countries	1	1	3
African countries	1	1	1
Far East	2	1	2
Others	1	2	2

Source: 1966 figures calculated from data in Gish (1971). Figures represent entire national stock; 1971 figures from CRC (1976). Figures represent entire national stock; 1980 figures from Smith (1980). Figures represent a national sample.

TABLE 3

ETHNIC ORIGIN OF HOSPITAL MEDICAL STAFF, ENGLAND AND WALES, OCTOBER 1995

Ethnic Origin	Per cent of all staff
White	63.1
Black-Caribbean	0.8
Black-African	2.2
Black-other	0.8
Indian	10.0
Pakistani	2.0
Bangladeshi	0.4
Chinese	1.1
Other	7.4
Not known	12.0

Notes: Percentages may not total to 100 because of rounding.
Includes following grades: Consultant; Staff; Associate Specialist; Senior Registrar; Registrar; Senior House Officer; House Officer; Hospital Practitioner and Clinical Assistant.

Source: Unpublished NHS Executive statistics.

MIGRATION INTERNATIONALE DE MAIN-D'OEUVRE QUALIFIÉE: LES MÉDECINS INDIENS AU ROYAUME-UNI

Cet article adopte l'approche d'une étude de cas face à la migration des médecins indiens au Royaume-Uni pour illustrer la complexité des facteurs pouvant expliquer la migration internationale.

Selon les auteurs, si, au niveau de la conscience discursive, la migration des médecins indiens vers le Royaume-Uni apparaît comme un phénomène à motivations économiques analogue à d'autres types de migrations internationales de main-d'œuvre très qualifiée, cette migration peut également apparaître comme un phénomène culturel et social si l'on examine la conscience pratique des participants par des méthodes qualitatives.

Si les migrants se déplacent pour "s'épanouir", il font également des choix qui s'appuient sur différents facteurs tels que le type de romans qu'ils ont lus dans l'enfance ou les obligations familiales "prises pour argent comptant", enracinées dans la vie quotidienne de leur culture.

MIGRACIÓN INTERNACIONAL DE PERSONAS COMPETENTES: MÉDICOS INDIOS EN EL REINO UNIDO

Este artículo utiliza una perspectiva de estudio por casos con relación a la migración de médicos indios al Reino Unido a fin de ilustrar la complejidad y la naturaleza múltiple de las explicaciones de la migración internacional.

En él se expone que a pesar de que en la conciencia discursiva el movimiento de médicos indios hacia el Reino Unido parece ser un fenómeno conformado y guiado por cuestiones económicas, como en otros casos de migración internacional altamente competente donde la conciencia práctica de los participantes se investiga a través de métodos cualitativos, la migración también puede considerarse como un fenómeno cultural y social.

Si bien los migrantes se desplazan porque aspiran a "mejorarse a sí mismos" también efectúan elecciones basadas en factores tales como el tipo de novelas que leían cuando eran niños o las obligaciones familiares "de por vida" ancladas en la vida cotidiana de su cultura.