

William Pickles Lecture

Asian Doctors in the NHS: Service and Betrayal

Introduction

Current estimates suggest that nearly one third of doctors practicing in the NHS are from overseas and that the vast majority of these overseas doctors are from the Indian sub continent. This of course is a surprising statistic because within the general population ethnic minorities represent only about 8% of the population of the UK.

Why are so many doctors from the Indian sub continent practicing in the UK? Why do they come here and what has their experience been of working in the NHS? Although they are such a significant and visible part of the NHS, it is surprising how little we know about this group.

As an observer of the celebrations surrounding the 50th Anniversary of the NHS in 1997, I noted that in all the speeches and in all the self congratulations and the analysis, hardly any mention was made of the contribution of Asian doctors. It was almost as if they had been airbrushed out of the picture.

Even within the medical profession there seems little acknowledgement of the contributions of this group of doctors. Donald Irvine in his book 'The Doctor's Tale' describes his presence at a meeting of senior leaders of the profession called by the BMA in the mid 1990's when doctors were going through one of their periodic bouts of naval gazing and worrying about the future of medicine. He commented on how unrepresentative they were of the profession – not a single woman or ethnic minority doctor graced the high table. It is hardly surprising to me that nothing ever came of their deliberations.

So the purpose of this paper is to make an attempt at understanding the contribution of Asian doctors to the development of the National Health Service and more generally to British Medicine.

A materialist view of history suggests that studying the past can help us understand the present. So understanding the contribution of Asian doctors is more than a sterile historical exercise.

Understanding what happened in the past is important because it should inform current changes that are taking place, especially in relation to the medical workforce and one would hope, avoid the mistakes of the past. The NHS has undergone a period of massive expansion not dissimilar to that which took place in the 60's. The policy initiatives being developed now bear a striking resemblance

to what was being proposed then, most notably the huge dependence that has been placed on the expansion of the medical workforce through the active recruitment of overseas qualified doctors. And not surprisingly we are encountering the same problems again – overseas qualified doctors now constitute nearly 60% of new registrations with the GMC – and the medical press is full of stories about the plight of these doctors. Recent changes to the immigration rules once again complete the repetition of history, as the over expansion of the workforce results in a curtailment of the rights of overseas qualified doctors to practice in the UK.

Looking at the history of the contribution of Asian doctors is also important because it gives us insight into the darker side of medicine, the role of racism within the profession. Much of the research in this area has been about describing what happens and has focused on a description of the discrimination that many overseas doctors face. There is surprisingly little written about the causes of racism and the historical antecedents which led to the development of racism within the profession.

Documenting the history of Asian doctors in the NHS is also important because the narrative is about discovering and celebrating the contribution of Asian doctors to the NHS. It also puts into context the way we are treated, the racism that we face and the struggle that we are involved in for equality and human rights. Stuart Hall the eminent British sociologist described this as the creation of 'identity'.

'Identities are about questions of using the resources of history, language and culture in the process of becoming rather than being; not 'who we are' or 'where we came from', so much as what we might become, how we have been represented and how that bears on how we might represent ourselves'.

Empire and Britain in India

Understanding how and why so many doctors from the Indian sub continent work in the NHS cannot be separated from the relationship that Britain had with India.

Britain's relationship with India is complex, long and profound and as in many other aspects of Indian life the development of the medical profession in India was intimately influenced and controlled by Britain.

Britain's links with India go back to 1600 when the East India Company was chartered by Queen Elizabeth I as a joint stock company. Queen Victoria became the Queen Empress in 1858. The relationship with Britain therefore spans nearly 400 years.

An important analysis and description of early colonial rule and the influence of western medical practice is provided by Gorman and Jeffery. Both authors described the early development of the Indian Medical Service (IMS).

The East India Company established the IMS as early as 1764 to look after Europeans in British India. IMS Officers headed military and civilian hospitals in Bombay, Calcutta and Madras and also accompanied the Company's ships and army. The need to provide expert apothecaries, compounders and dressers as assistants in different hospitals prompted the earliest official involvement in medical education in India. These subordinate assistants would help European doctors and surgeons look after the health of European civilians and military employees and also helped reduce the Company's financial burdens by limiting the appointment of European doctors. Initially only open to Europeans, Indians were allowed to enter the IMS in 1855 although the requisite was that they still had to sit exams based in London and had to be registered with the General Medical Council (GMC). At the time there were many schools training Indian doctors but only as licentiates.

British style medical education began in Calcutta in 1822. Medical teaching was imparted in the vernacular, texts on anatomy; medicine and surgery were translated from European languages for the benefit of the students. In general, the medical education provided by the Colonial state at this stage involved parallel instruction in western and indigenous medical systems. Translation of western medical texts was encouraged and though dissection was not performed, clinical experience was a must.

Successful Indian doctors were absorbed into Government jobs. However the future path of medical education was highly contested and exemplified by the Orientalist-, Anglicist controversy which raged in the early part of the 19th Century. All participants in the debate agreed that the certain sections of the Indian population would benefit from the introduction of European science and literature. The Orientalists maintained that indigenous culture should remain intact with European concepts being gradually assimilated. The medium of instruction should be in India's classical languages. Anglicists argued that the heritage of India was not worthy of consideration and that its culture should be replaced by western culture transmitted by the English language.

The Anglicist viewpoint prevailed and in the field of medicine, pressure applied by the IMS, resulted in the abolition of indigenous courses for the training of Indian doctors. Within a short space of time, several medical colleges, modelled along western pedagogic styles were established. Calcutta Medical College, established in 1835 was the first western style medical college. It was shortly followed by the establishment of colleges in Madras, Bombay and Lahore. The staff of all these colleges were appointed from the IMS and their methods of instruction were virtually indistinguishable from those practiced in England and Scotland.

Shortly after completing the first medical course following the founding of the Calcutta Medical College, four Indian students were sent to University College London to train as doctors. They all passed with flying colours, obtaining silver and gold medals from the college. The significance of this was that it showed that Indians could master science and medicine on a level with Europeans. When they returned to India, they became role models and set the stage for a flood of Indian students to study medicine in England.

Indian degrees were recognised in 1892 by the GMC and this recognition persisted until 1975 with a short interlude in the mid 30's when there was a dispute between the GMC and the Government of India about the quality of Indian medical education.

Towards the end of the 19th and the beginning of the 20th century, the IMS like other parts of the Government of India was forced to include many more Indians in positions of influence and leadership. There were problems from an old guard within the IMS who were concerned about the possibility of Indian doctors supervising European doctors, but on the whole many Indian doctors were successfully integrated into the IMS albeit in the more junior positions.

However concerns about the standards of Indian medical education began to surface in early 1900's mainly related to then lack of midwifery teaching in the curriculum. So although there was a considerable debate in the early part of the 20th Century about the way medicine should be developed within India, the IMS, supported by the British Medical Association (BMA) and the GMC, insisted that in order for standards to be maintained, medical education, the continued exclusion of Ayurveda medicine and the appointment of Professorships in Indian Medical Schools should be maintained under the control of the IMS.

The net result of these developments was that by 1939 the prevailing orthodoxy was that only one type of medical education was relevant to Indian conditions - namely as close an approximation as possible to medical education in Britain. In effect the patterns of medical education and training were geared towards meeting the needs of the GMC and the IMS. Standards were set to ensure

that Indian trained doctors were able to work in Britain. The current orthodoxy however, is that medical standards should be specific to the context in which they are used. Medical services in developing countries for example should integrate indigenous practice with western medicine and that crucial members of the health team are those below the fully fledged doctor. This is the pattern that is adopted very widely in many developing countries. But the actions of the GMC and the IMS backed by the BMA frustrated such moves in India. The Indian doctors who collaborated with Colonial rule were the ones that stepped into power after 1947. By then their socialisation into the model of western medicine was complete. This combined with emigration, the failure to produce a coherent medical policy, the absence of public health medicine and health facilities in rural areas, meant that Indian degrees were quite suitable for working in England but probably totally irrelevant for working to the benefit of the vast majority of the Indian population.

This short look at history aims to make the point that although it was not by design, Indian medical education became ideally suited to meet the needs of the NHS. When the NHS was created in 1948, there was already a supply of doctors willing and able to migrate. They had been trained in an education system which was closely modelled on that which was already operating in the United Kingdom.

Early pioneers

What of the doctors that came to Britain to study and to work during this early period? Any reading of the literature about Britain in India and the relationship that Indians had with Britain will show the high esteem that Britain was held in. Coming to Britain in the mid 1800's was like a badge of honour. It is still cited today as something worth doing. A visit to Britain formed part of the future plans of ambitious children and youth of those days and a man who returned from abroad commanded considerable distinction in society in India. It is no coincidence that some of the great leaders of the Indian Nationalist Movement including Ghandi and Nehru were educated in England. The flow of students who came to England to study, with medicine and law being the two most popular subjects, gradually increased. There were only about 160 Indian students studying in England in 1887 but by 1945 estimates suggested that there were anything between 1500 to 2000 students *pgs 85-88*. In early 1900 there were nearly 700 students studying in England and because there was concern about the involvement of these students in anti-British activity, a committee of enquiry was set up in 1903 with the aim of establishing a hostel for the supervision of Indian students. In the evidence presented at the enquiry, Indian students were described as "raw youth" lacking in "self control", unable to withstand the pressure of British cities. It was suggested that they easily succumbed to the temptations of London life and found the attractions of a London brothel and intercourse with white women almost irresistible *pg 89*. It is interesting to see how these

concerns about sex and mixing with white women are still a feature of the present day stigmatisation of Indian doctors who are brought before the GMC.

Although the greatest immigration of Asian doctors occurred after the creation of the NHS in 1948, it is worth highlighting very briefly the period before the creation of the NHS and the contributions that some Asian doctors made to British medicine. One historian has estimated that by 1945 there were 'no less' than 1,000 Asian doctors throughout Britain, 200 of them in London alone and most of them general practitioners *pg 281*.

The best historical record of the early pioneers is contained in Rosina Visram's excellent book on Asians in Britain. Visram documents how many doctors, some who came as already qualified from India and some who trained here were active in the anti-Colonial movement. Repeating a pattern which is still present today, they ended up working in the poor areas of Britain. Perhaps it is a bias of historical records which has highlighted contributions of doctors who worked in deprived areas and made a significant contribution through their involvement in local politics. However, it is also likely that many avenues were closed to these doctors because posts in the financially lucrative areas were almost certainly taken up by white doctors. This is a pattern which still exists today. It is also true that many doctors were also probably influenced by the Gandhian philosophy of service to the benefit of humanity without personal rewards. This is perhaps why many of them also ended up in deprived areas and became involved in local politics. There are many GP's included in this group. Dr Baldev Kaushal (1906-92) who worked in Bethnal Green and was awarded an MBE in 1945 for his gallant conduct during the blitz over East London. Dr. Jainti Saggar (1898-1954) was the only Indian doctor in Dundee in the 1920's and was one of the longest serving members of Dundee Town Council. Dundonian's esteem for Saggar is so great that 20 years after his death, in the 1970's, a street was named Saggar Street by Dundee Corporation and in 1974 a public library was opened in memory of him and his brother. There was the Boomla medical 'dynasty' which practiced in Plumstead from 1928 and endured for nearly 60 years. One of the grandsons of this dynasty, Kambiz Boomla is currently working as a GP in East London and is still active in local politics. Dr. Sukhsagar Datta (1890-1967) worked in Bristol and was active in the British Labour Party and the anti-Colonial movement. He was famous for seconding the resolution which was passed at the Labour Conference in 1945, calling for the withdrawal of Britain from India. Dr. Dharam Sheel Chowdhary (1902-59) practiced as general practitioner in Laindon for over a quarter of a century and was hugely popular with his patients. It was said that at his death patients paid their last homage by standing perfectly still on the pavement and that no one had ever seen a church so full. Chowdhary County Primary School built in 1966, seven years after his death was named after him by popular demand. Dr. Harbans Gulati (1896-1967) the pioneer of the 'meals on wheels' service worked as a GP in the working class district of Battersea for over 40 years. He

resigned from the Conservative Party in 1947 on principal over its hostility to the creation of the NHS *pgs 281-288*.

But there are two doctors that are worth highlighting in this period of the early pioneers. The first was Frederick Akbar Mohamed who was only 35 when he died in 1884 and is only now being recognised because of his contribution towards the understanding of hypertension, a topic of immense importance in General Practice. It was Akbar who first described the concept of essential hypertension as we understand it today. He was the first person to recognise that it was a primary condition and provided the first clear description of it. He described the history of the progression of the disease and showed how young people with high blood pressure showed little signs of illness but that with age it could prove fatal. He even described its aetiology as being a combination of genetic and environmental factors. He was also instrumental in developing the Collective Investigation Record which was a printed questionnaire survey sent to doctors throughout the country asking them to describe aspects of diseases that presented to them in order to build up a record of clinical, hereditary and anthropological features of disease. It was a brilliant concept way ahead of its time. It is of interest that the concepts and ideas which we take for granted today in the form of cohort studies were formulated by an Indian doctor as long ago as 1880. Will Pickles would have been proud of him and would have found many similarities in the approach to the epidemiology of disease. There are two things that I find interesting about Akbar. The first is that his contribution was never recognised even though he lectured widely. He is listed on *Munk's Roll* for the period 1826-1925, among the 864 members of the Fellows of the Royal College of Physicians, but he was never recognised for his contribution during his life. The other interesting thing is that his family changed their name to Deane and one of them in fact became a doctor *pgs 77-79*. Was it because he was an Indian that he wasn't recognised?

The other doctor who was an outstanding early pioneer was Dr. Chuni Lal Katial (1898-1978) who died in 1978 and was Britain's first Asian Mayor and the driving force behind the creation of Finsbury Health Centre. Finsbury was an industrial borough described as 100% working class and suffered from overcrowding and poor housing. Medical facilities were fragmented and inaccessible and spread over the borough in a maze of dispensaries, voluntary hospitals, private contracts, clubs and clinics. However in 1931 the Labour council drew up what became known as the Finsbury Plan, a comprehensive programme for health and housing with a new health centre at its heart. The plan appears to have been dropped until it was revived in 1935 by Katial when he became Chairman of the Public Health Committee. It was Katial who commissioned Bertold Lubetkin as the architect for the Finsbury Health Centre which opened in 1938. Not only was it revolutionary architecturally but it introduced a new concept in medicine, a centralised health service. There was a TB clinic, a foot clinic, a dental surgery, a woman's clinic, a solarium as well as disinfectant rooms

and a mortuary. Administrative offices, case records and statistics were all under one roof. According to Lubetkin's biographer, Finsbury Health Centre marked a conspicuous advance in social policy and administrative co-ordination. It anticipated the NHS reforms by over ten years *pgs 286-288*.

The creation of the NHS and medical migration

The creation of the NHS coincided with the beginning of a wave of immigration from the Commonwealth and Colonies. As the increase in immigration continued – the newly formed public services did not only need doctors, but required nurses, cleaners, porters and other support staff. And with the influx of immigrants came the call for immigration controls. Again the modern parallels are interesting. However even though political agitation for the introduction of immigration controls had begun to gather momentum in the 60's, an exception was always made for well qualified migrants to bypass immigration controls. Recent changes to the immigration controls for medical staff represent an interesting departure from previous policy initiatives with doctors for the first time being subject to similar immigration controls to the rest of the population.

Since its creation in 1948 the British National Health Service has become an enduring and endearing symbol of British welfare capitalism and it was an important part of the post war consensus. Asian doctors have been described as saviours of this great institution on many occasions but sadly, have also been stigmatised as pariah's .

There is little information on the number of overseas qualified doctors working in the NHS at its inception but there is a consensus that there were about 3000 doctors working in the NHS in the 1950's.

Many historians of the NHS have described its creation as a compromise between the demands for a universal system of health coverage counter balanced against the demands of a relatively autonomous medical profession which was keen to preserve its elite status. So although it may seem natural now, the relationship between Consultants and General Practitioners, the hierarchy of Consultants within the hospital service and crucially its dependence on junior staff, came about as a result of this compromise. This more than anything else created the dependency on migrant labour that has become a feature of the NHS.

Although it was clear from outset that the NHS could not be entirely staffed by British qualified doctors, the views of the medical establishment can be summarised as one of antagonism to migrant doctors. The BMA was keen to pursue a policy which would severely restrict the rights of foreign medical students to practice in Britain, but it was clear that the needs of the NHS had to take

precedence and throughout the 1960's the Ministry of Health worked very closely with the Ministry of Labour to maintain the flow of overseas doctors at a level necessary to ensure the smooth running of the NHS.

There was already an official acknowledgement of the roles that these overseas doctors were playing. In a debate in the House of Lords in 1961, Lord Cohen of Birkenhead commented on the fact that

"The Health Service would have collapsed if it had not been for the enormous influx from junior doctors from such countries as India and Pakistan". (Lord Cohen of Birkenhead cited in pg 289

Lord Taylor of Harlow in the same debate said

"They are here to provide pairs of hands in the rottenest, worst hospitals in the country because there is nobody else to do it". (see pg 289.

In an article in the Lancet of 1964 (*cited in pg 289*) it was pointed out that the total output of British medical schools over two years would be required in order to replace the 3,500 foreign doctors in Britain at that time.

So although there was acknowledgment that the NHS could not function without them, there was also a deep antipathy to this group of doctors. A hand search of the correspondence columns of the British Medical Journal between 1961 to 1975 gives an interesting insight into the extent of this antipathy. Much of it would have been considered offensive and racist if it was published today. In virtually every issue there were letters from doctors complaining of the standards of overseas qualified doctors, covered in polite code and hidden under discussions about difficulties in understanding intonations of Indian speech, their language problems, their standard of education and the impact that this was having on the health care of the population.

Ironically it was Enoch Powell in 1963 as Minister of Health who oversaw the first expansion of the Health Service and was an architect of the policy of recruiting doctors from the Indian sub continent. It was probably his own spell in the army in India that influenced his views about the roles that Indian doctors could play in fulfilling the dire labour shortages in the NHS. The modern parallel is very interesting. An interview by the Prime Minister Tony Blair in 2003 made it clear that once again the expansion of the Health Service would depend on international recruitment.

"More staff are being trained and recruited within Britain, but that takes time, so we are now working with other nations to welcome well qualified health professionals from other countries to work in the NHS whether it be for a short stay or an extended period".

(Cited in pg 299)

Although it is useful to understand immigration from the point of view of the state, it is also important to acknowledge that much like the late 19th and early 20th Century, because of the links that have already been described, there was amongst many overseas qualified doctors a personal desire to come to England to improve themselves, to work in the great institution of the NHS and to pick up skills which they would then take home. Many of course chose to immigrate permanently but the most common reason for coming was to obtain skills and then go back. The premium of British experience even to this day continues to play well particularly in the private medical market in India. But what was clear from the outset was that the jobs available and the experience available to this influx of immigrant doctors were going to be severely restricted.

Asian doctors as indentured labourers

One of the features of medical migration was the way that Asian doctors ended up working in the Cinderella services of the NHS. Research published in the late 1990's showed very clearly for example that in general practice there was a clear distribution of overseas qualified doctors in certain parts of the country, a problem which is now becoming so acute because as this generation of doctors retires, there is considerable concern and anxiety as to who will fill their places. Why this distribution? Is it anything to do with the opportunities for care, the ability to earn more – a perception of the best and worst places to practice family medicine?

Work by David Smith published in 1980 in the first major study of overseas doctors showed very clearly that about a third of doctors arriving during the 1970's achieved their ambitions and went back but the vast majority did not. The reasons for this are complex but they include not achieving their educational, training or career objectives, some because they liked it here and some because they got married or their family circumstances changed. In my view they became the indentured labourers of the NHS.

The concept of indentured labourer has never been applied to such highly skilled professionals such as doctors but it has been a significant part of emigration from India for over a hundred years. With the end of slavery it was clear that there was still a need for labour in the Colonies of Britain and hundreds of thousands of Indian workers were recruited to work in the sugar plantations of the West Indies and on the railways in the African Colonies. The reason that there are so many Indians in the West Indies, in South East Asia and in East and Southern Africa is because of this indentured labour. Workers were willingly recruited in India with the offer of work, accommodation, food, safe

passage and yet when they arrived they found they were paid such poor wages that they could never afford to pay back the money they borrowed to get there in the first place.

Whilst this is not strictly true of Indian doctors there are similarities with the indentured labourers of the early part of the 20th Century. Like their forbearers, Asian doctors were tied into the system of the NHS. They left India with the specific aim of obtaining further medical qualifications – to complete a stage in their medical training and careers. As Smith showed so clearly in his survey, over half the migrant doctors were disappointed with their experience of working and studying in this country. So the Asian doctors ended up being tied to the UK and the NHS because returning without fulfilling your aspirations was not an option. You always hoped that you would break out of the cycle but in the end you don't but you stay on and make the most of it. You were indentured to the system.

So although the vast majority of doctors came here wanting to work in teaching hospitals, developing skills in specialities like medicine and surgery, options to work in these areas were not available. What the NHS wanted was not only physicians and surgeons but geriatricians, psychiatrists, people working in mental health rehabilitation and of course in general practice. Smith showed that nearly two thirds of doctors ended up in careers which were not their first choice. This of course can have significant implications because the impact of having to work in an area which you never intended to can be quite demoralising. This is not to say that the vast majority of people did not end up giving their all to their new chosen specialities, but we have to recognise the impact that this may have had on them as individuals.

The rise of discrimination

One cannot explain the problems that Asian doctors had without considering the context of racism in society at that time. The discrimination that has been well documented in the NHS did not just appear and although doctors are reluctant to admit it, they reflect the values and prejudices of society just like any other professional group. Ironically it was Powell, the architect of the mass migration into the NHS again who ignited the touch paper with his famous "Rivers of blood" speech.

Of course Powell was responding to what he would have claimed are his constituents' fears and although he is frequently cited as the *bete noir* of the political establishment, comments by Margaret Thatcher in 1978 could be construed as equally offensive:

She said:

'If we went on as we are, then by the end of the century, there would be 4 million people of the New Commonwealth and Pakistan here.... I think it means that people are rather afraid that this country might be rather swamped by a people of a different culture....' (cited in pg 295)

The current debate on asylum and immigration in the national media is a continuing reminder of the influence of how issues such as race can influence the political discourse in areas such as medical migration and Asian doctors.

As pointed out earlier, the correspondence columns in the British Medical Journal at that time were filled with articles complaining about the standards of overseas qualified doctors and much of the concern centred on the issue of communication. Smith's survey showed that about 17% of overseas qualified doctors coming to Britain in the early 70's did have problems with communication as assessed by an objective test that he had designed, but the vast majority did not. And what is more, once they had been here for more than three years, these problems disappeared. Interestingly he found no problems with language amongst general practitioners. However, the myth of language problems became part of the normal discourse when overseas doctors were being discussed and it was used to justify their failure to progress in their careers, fail their exams and deliver a poor standard of care to their patients. The point about this sort of racism is that eventually all doctors from overseas are stigmatised – fiction becomes fact.

The irony of course is that most general practitioners know that communication is not just about language and intonations and not knowing the right words. It is as much an issue about class and culture and recognising that perhaps the greatest barrier of communication is the culture of biomedicine rather than the culture of your spoken language.

The saviour pariah construct

The rise of racism in the country, with the call for immigration controls conflicted with the needs of the NHS which still required the migrant doctor who was described as a saviour of the service but was also sometimes seen as a pariah.

In 1972 the GMC in response to pressure about standards withdrew recognition from all medical school and colleges from the New Commonwealth with a few exceptions.

The Merrison committee in 1975 gave sanction to this policy and in the view of many overseas doctors, institutionalised the view of overseas doctors as pariah.

The Merrison committee stated that in relation to standards:

“it was obviously a matter of concern to the public who may be treated by overseas doctors, to members of the medical profession whose successful practice will often depend on colleagues’ competence, and to overseas practitioners’ themselves whose effectiveness as doctors may be reduced by doubts about the value of their qualifications....”

“...even when his professional knowledge and skill is sufficient, an overseas doctor may lack understanding of patients and grasp of language, attitudes, values and conventions of the community to which he practices in....”

In a letter to the BMJ in 1975, Dr Roy, a GP from Essex gave an interesting perspective on the shortcoming of the report . He argued that the methods of assessment and its conclusions were open to serious objections on several grounds; there was not a single member from an ethnic minority group on the committee, none of the members of the committee had any experience of working with overseas doctors either in Britain or abroad, not a single organisation representing overseas doctors was asked to give evidence, the evidence considered was mainly subjective and anecdotal and the views of consumers and patients were never sought. Even the views of organisations that had most experience of working with overseas doctors were never considered.

Every country must ensure their standards need to be maintained and many use a test whereby they can satisfy themselves that doctors wanting to come and practice in the country are of the requisite standard. The problem arises when having passed that barrier, discrimination continues. If a standard has been set and once that standard has been achieved, why should people still attempt to define difference?

Current discrimination in the medical profession

In my view, the medical profession cannot consider itself as being immune from what is going on in society around it. Part of the problem has been that it has failed to acknowledge this and therefore somehow thinks that as a profession it is above discrimination.

My review of the correspondence columns in the British Medical Journal in the 60’s gives a very interesting insight into the view of many white doctors about Asian doctors. As I have already pointed out, there is a problem in terms of language but only amongst a very small minority of doctors. Yet the extension of this problem to cover all doctors irrespective of their ability and

knowledge seems so wide spread that the perception that ethnic minority doctors were discriminated against in job interviews for example is almost certainly the reality.

Much to my surprise I found that it was common place in the BMJ in the 1970's for General Practitioners to state in adverts that only British Graduates need apply for vacant posts. This practice was only stopped in 1976 because it was deemed illegal following the introduction of the Race Relations Act. The irony is not lost on me because when I look at pictures from the 60's which describe the discrimination faced by immigrants, some of the pictures show signs for accommodation to let saying "No Blacks, no Irish, no Gypsies". Within the medical profession itself, we had our own version of that sign, "Only white graduates need apply for these particular jobs".

In research published in 1993 I have shown that British qualified ethnic minorities with the same qualifications as their white colleagues were half as likely to be short-listed for a SHO jobs. I then went on to show how this situation still persisted in 1997 . I was also able to show that ethnic minority applicants to medical schools were less likely to get a place even though they had the same qualifications as white colleagues. More importantly there was a huge difference in the success rate for ethnic minority applicants between the different medical schools.

The GMC and discrimination.

The most interesting work that I was involved with and which probably had the most far reaching consequences was the work that I did in relation to the General Medical Council. It gives interesting insights into how racism operates in terms of who has complaints lodged against them and how those complaints are assessed .

Reviewing all cases brought before the Professional Conduct Committee (PCC) of the GMC between 1982-1991, I was able to show that ethnic minority doctors were six times more likely to be brought before the PCC when compared to their white colleagues . Earlier in the talk I commented on the fact that as early as 1900 there were concerns about the behaviour of Indian students especially in their relationships with white women. In my own research concerning discrimination with the GMC, I was interested to note that in the ten years of cases that I examined, ethnic minority doctors were far more likely to be brought before the PCC and charged with indecent behaviour when compared to white doctors who were more likely to be charged with having improper relationships. The obvious implication of these findings is that ethnic minority doctors were incapable of having improper relationships with white women. If ever such relationships did exist they were classified as sexual misdemeanours. I also showed that another category of charge 'disregard for responsibility to patients' was a phenomenon restricted exclusively to ethnic minority

doctors, suggesting that this was a phenomenon exclusively related to the clinical practice of ethnic minority doctors.

The GMC subsequently commissioned Isobelle Allen from the Policy Studies Institute (PSI) to carry out a thorough review of all the GMC functions. In a series of reports spanning nearly ten years, the entire fitness to practise functions of the GMC were subject to intense scrutiny. Professor Allen's reports provided useful background information for the detailed review by Dame Janet Smith in the Shipman Inquiry. Dame Janet summarised the significance of Isobelle Allen's findings in her 5th report.

'Thus in three studies conducted over a period of nine years, the PSI found unexplained differences in the treatment by the GMC of overseas qualifiers as compared with UK qualifiers; the overseas qualifiers were more severely dealt with. This may or may not indicate that there is racial bias within the GMC. The importance of these findings from the Inquiry's point of view, is that procedures are lacking in transparency. It ought to be possible to refute a suggestion of bias if it can be demonstrated that decisions are taken according to objective criteria and by the consistent application of established standards. Professor Allen has repeatedly advised the GMC that it will be unable to refute the allegations of racial bias unless and until it develops objective standards and criteria. It seems to me that, without such standards and criteria, the GMC will be unable to satisfy the public that it is complying with its duty to protect patients.'

(The Shipman Inquiry. Fifth Report. Volume 2. 15.60).

Justification of discrimination and British trained Asian doctors

I have also shown that ethnic minority doctors are also significantly disadvantaged and face discrimination in the allocation of discretionary points and distinction awards – white doctors are nearly three times more likely to receive awards than ethnic minority doctors – and this can result in a substantial pay differential for many doctors .. Academic general practitioners have only recently become eligible for these awards so the way that awards are allocated is going to be important for many general practitioners.

A common explanation given for this discrepancy in the allocation of discretionary points and awards is that it is not really discrimination because British trained ethnic minorities are no longer disadvantaged in the allocation of these awards. The problem only exists with overseas qualified doctors. Media perceptions of this group of doctors are then used by the medical profession to justify why some doctors are paid more than others – language problems and poor standards.

This is a relatively new development in the justification of discrimination within the profession because it seeks to separate ethnic minorities on the basis of their country of qualification. Nearly one third of graduates from British medical schools are from ethnic minorities and it is much more difficult to justify discrimination against this group. The problem of course is that these are very subtle differences and my own experience shows that the crudest level of discrimination occurs by things like name and colour of skin and is not refined enough to distinguish between where you qualify from.

What **is** surprising is that the issues surrounding the standards and language of overseas doctors are still very prominent in the political discourse that goes on today. Liam Fox's who was Vice Chairman of the Conservative Party and a general practitioner said that

"Many of the doctors who came from abroad do not have the requisite English language skills to work in Britain, their English language skills are not up to scratch and patients are suffering as a result".

Cited in

Once again overseas doctors are pariah's and responsible for the suffering of patients.

The end result of this discrimination which has stigmatised overseas doctors is that whilst these Asian doctors possess the skills relevant to the British economy and the NHS, casting them as pariah's creates a justification for discrimination. It justifies the structural factors which relegates Asian doctors to occupying the lower grade positions in the most unpopular specialities with a high propensity for long hours and shift work from which promotion is restricted and therefore pay and conditions are similarly affected.

Over 20 years ago Smith in his study of overseas doctors concluded that migrant doctors constituted a floating population integral to the running of the NHS. Whilst migrant doctors have played a key role in the maintenance of the NHS, discrimination has sustained a racially stratified system in favour of British doctors .

Smith also concluded that migrant doctors were more likely than British doctors to become GP's against their inclination and more likely to be practicing in a specialty that was not their first choice. They were also more likely than British doctors to feel that they had progressed more slowly in terms of post graduate training and experience. Smith concluded, as I have intimated earlier, that it wasn't language barriers that prevented progress but specific processes within the profession that functioned as barriers to the career development of migrant doctors. These included the policy of

rotating posts at teaching hospitals. This may also apply to vocational training schemes. Smith suggested that working at a teaching hospital helped in the fostering of vital informal networks which could greatly influence a young doctor's entry into the key areas of many specialties. Having trained outside of Britain, migrant doctors were more likely not to have cultivated a reputation in a British teaching hospital from which rotational opportunities tended to arise. There is absolutely no doubt that there was a pecking order within the vocational training schemes for general practice. I certainly remember the difficulty of getting into vocational training schemes which were centred around teaching hospitals.

The future

Although Asian doctors constitute nearly one third of general practitioners working in the NHS, few have progressed into the echelons of power and influence in organisations such as the Royal College of General Practitioners (RCGP). Why are so few Asian doctors involved in the college? Why are proportionately more Asian GPs not members of the college? The stigmatising of single handed doctors of whom a very significant minority are Asian doctors by some general practitioners and commentators has in my view, undertones of racism. Similar undertones exist in relation to the issue of standards. It is constantly being pointed out by policy makers and commentators that there is a rump of general practitioners who aren't quite up to scratch, who aren't of the right standard in order to become members of the RCGP. I am sure that if the College did a survey to find out which general practitioners were not members, they would find that a significant proportion were overseas qualified. The question you then need to ask is why? What was it about the structures and processes that effectively disadvantaged this large group of doctors?

There are historical lessons the College can learn from and they can take the lead in integrating the large number of Asian general practitioners and other overseas qualified GPs into their organisation. Acknowledging the impact of racism and the important role that Asian GPs have played in the development of the specialty is a beginning. Provided that revalidation becomes the robust form of licensing that Dame Janet Smith argued for in her final report of the Shipman Inquiry, then surely there must be a case for doctors who are licensed as fit to practice and who meet a clearly defined standard for becoming members of the College of General Practitioners.

What is changing now however is the fact that my generation is not prepared to accept discriminatory practices. My generation is being incorporated into the main stream in the sense that we are offered consolation by the fact that because we are British graduates, discrimination is no longer an issue for us. It's these others, these non British trained doctors that are the real problem.

In Sociologists jargon, we will be accepted into a pluralist multi-cultural framework but my overseas colleagues will be still be the subject of discriminatory processes.

Perhaps the contribution of Asian doctors to the modern day NHS will not be fully realised until the history of the present generation is recorded. There is an urgent need – perhaps using the techniques of oral historians- to get the stories of the present group of doctors who are nearing retirement into the record. The Royal College of General Practitioners and probably the British Geriatric Society and the Royal College of Psychiatrists have an important role to play in ensuring that the contribution of overseas doctors to the development of their specialism is properly documented and acknowledged.

My hope is that when the continuing history of the development of general practice in this country is written the contribution of the whole cohort of doctors, a large proportion of whom were Asian doctors, who worked in the deprived areas of our cities, administering health care to the most deprived sections of our society, to the vulnerable, to the elderly will be duly acknowledged. Perhaps the hope is that their children will have a more positive experience than they were allowed to have.