

# Asian doctors in the NHS: service and betrayal

Aneez Esmail

## INTRODUCTION

Current estimates suggest that almost one-third of doctors practising in the NHS are from overseas and that the vast majority of these overseas doctors are from the Indian subcontinent.<sup>1</sup> This of course is a surprising statistic because within the general population ethnic minorities represent only about 8% of the population of the UK.<sup>2</sup>

Why are so many doctors from the Indian subcontinent practising in the UK? Why do they come here and what has been their experience 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.

The purpose of this paper is to make an attempt at understanding the contribution of Asian doctors to the development of the NHS, and more generally, to British medicine.

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. Following the publication of the *NHS Plan*,<sup>3</sup> the NHS has undergone a period of massive expansion not dissimilar to that which took place in the 1960s. 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 General Medical Council (GMC)<sup>4</sup> — 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 from non-European Union (EU) countries to practise in the UK. The migration dynamics are also changing with many EU-trained doctors taking the place of doctors from the subcontinent. The continuing dependence of the NHS on non-British trained doctors will continue for the foreseeable future and this new generation of migrant doctors from the EU may encounter similar problems to

those experienced by the Asian doctors that are the subject of this paper.

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 that led to the development of racism within the profession.

## EMPIRE AND BRITAIN IN INDIA

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

Britain's relationship with India is complex. It spans over 400 years and, as in many other aspects of Indian life, the development of the medical profession in India was intimately influenced and controlled by Britain.

An important analysis and description of early colonial rule and the influence of western medical practice is provided by Gorman<sup>5</sup> and Jeffery.<sup>6</sup> Both authors described the early development of the Indian Medical Service (IMS).

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 GMC. At the time there were many schools training Indian doctors, but only as licentiates.

*A Esmail, PhD, MRCP, FRCP, MFPHM, professor of general practice, School of Primary Care, University of Manchester, Manchester. This text is based on the William Pickles Lecture delivered on 10 April 2005.*

### Address for correspondence

Professor Aneez Esmail, School of Primary Care University of Manchester, Rusholme Health Centre, Walmer Street, Manchester, M14 5NP.  
E-mail: aneez.esmail@manchester.ac.uk

**Submitted:** 8 February 2007; **Editor's response:** 8 March 2007; **final acceptance:** 8 June 2007.

©British Journal of General Practice 2007; 57: 827–831.

The future of medical education in India was always highly contested and exemplified by the Orientalist–Anglicist controversy that raged in the early part of the 19th century.<sup>5</sup> The Orientalists maintained that indigenous culture should remain intact with European concepts being gradually assimilated. 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.

In relation to medical education, the Anglicist viewpoint prevailed and, through pressure applied by the IMS, indigenous courses for the training of Indian doctors were abolished. Within a short space of time, several medical colleges, modelled along western pedagogic styles, were established. The staff of all these colleges were appointed from the IMS and their methods of instruction were virtually indistinguishable from those practised in England and Scotland.

Indian degrees were recognised in 1892 by the GMC and this recognition persisted until 1975, with a short interlude in the mid-1930s 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.<sup>7</sup> By the time that India achieved independence in 1947, 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 Indian doctors who collaborated with colonial rule were the ones that stepped into power after 1947 and their socialisation into the model of western medical practice meant that the development of medical practice in India did not follow the pattern that was being advocated for many developing countries at the time. For example, there was a view that medical services in developing countries should integrate indigenous practice with western medicine and they should not be over reliant on medically trained professionals, relying instead on assistants and health workers who did not have to undertake a fully fledged medical training. The emigration of Indian doctors, the failure to produce a coherent medical policy, and 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.

## 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-1800s 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 young people 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.

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 1000 Asian doctors throughout Britain, 200 of them in London alone and most of them GPs.<sup>8</sup>

The best historical record of the early pioneers is contained in Rosina Visram’s excellent book on Asians in Britain.<sup>8</sup> 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 that 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 that still exists today.<sup>9</sup> It is also true that many doctors were also probably influenced by the Ghandian philosophy of service to the benefit of humanity without personal rewards. This is perhaps why many doctors also ended up in deprived areas and became involved in local politics.

There are many GPs included in this group. Dr Baldev Kaushal (1906–1992), who worked in Bethnal Green, 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 1920s and was one of the longest serving members of Dundee Town Council. Twenty years after his death, in the 1970s, a street was named Saggar Street by the Dundee Corporation and in 1974 a public library was opened in memory of him and his brother. There was the Boomla medical 'dynasty' that practised 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 (1902–1959), practised as a GP in Laindon for over a quarter of a century and was hugely popular with his patients. Chowdhary County Primary School built in 1966, 7 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.<sup>8</sup>

But there are two doctors that are worth highlighting in this period of the early pioneers.

### **Frederick Akbar Mohamed**

Frederick Akbar Mohamed, who was only 35 years old when he died in 1884, is only now recognised for his contribution to the understanding of essential hypertension. He was instrumental in developing the collective investigation record. This 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 is of interest that the concepts and ideas that we take for granted today in the form of cohort studies, many of which are dependent on GP records, were formulated by an Indian doctor as long ago as 1880.

### **Chuni Lal Katial**

Dr Chuni Lal Katial (1898–1978), who died in 1978, was Britain's first Asian Mayor and the driving force behind the creation of Finsbury Health Centre.

As Chairman of the Public Health Committee of Finsbury Council in 1935, Katial revived the Finsbury Plan, a comprehensive programme for health and housing with a new health centre at its heart. He commissioned Bertold Lubetkin as the architect for the Finsbury Health Centre, which

opened in 1938. The centre was not only revolutionary architecturally, but it introduced a new concept in medicine, a centralised health service. According to Lubetkin's biographer, Finsbury Health Centre marked a conspicuous advance in social policy and administrative coordination. It anticipated the NHS reforms by over 10 years.<sup>8</sup>

## **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. The influx of immigrants also coincided with demands for immigration controls. However, even though political agitation for the introduction of immigration controls had begun to gather momentum in the 1960s, 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.<sup>10</sup>

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 1950s. Many historians of the NHS have described its creation as a compromise between the demands for a universal system of health coverage counterbalanced against the demands of a relatively autonomous medical profession, which was keen to preserve its elite status. So although the relationship between consultants and GPs may seem natural now, 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 the 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 British Medical Association (BMA) was keen to pursue a policy that would severely restrict the rights of foreign medical students to practise in Britain, but it was clear that the needs of the NHS had to take precedence. Throughout the 1960s 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.'*<sup>11</sup>

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.'*

So although there was acknowledgment that the NHS could not function without them, there was also a deep antipathy to this group of doctors from within the medical profession. A hand search of the correspondence columns of the *British Medical Journal (BMJ)* between 1961 to 1975 gives an interesting insight into the extent of this antipathy.<sup>12-14</sup> 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 as Minister of Health in 1963 who oversaw the first expansion of the NHS and was an architect of the policy of recruiting doctors from the Indian subcontinent. 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 in that the huge investment in the NHS following the publication of the *NHS Plan* in 2000 required a significant increase in the recruitment of overseas doctors.<sup>3</sup>

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, many overseas qualified doctors had a personal desire to come to England to improve themselves, to work in the great institution of the NHS, and to pick up skills that 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. Even to this day the premium of British experience continues to play well particularly in the private medical market in India. But what was clear from the outset was that both the jobs 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. For example, research published in the late 1990s showed very clearly that in general practice there was a clear distribution of overseas qualified doctors in certain parts of the country.<sup>9</sup> This problem is now becoming 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, or the ability to earn more — a perception of the best and worst places to practise family medicine.

Work by David Smith published in 1987, in the first major study of overseas doctors, showed very clearly that about one-third of doctors arriving in the UK during the 1970s achieved their ambitions and went back to the Indian subcontinent but the vast majority did not. The reasons for this are complex but they include doctors 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 these doctors became the indentured labourers of the NHS.

The concept of indentured labourer has never been applied to such highly-skilled professionals as doctors but it has been a significant part of emigration from India for over 100 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.

While 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 forebears,

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.<sup>12</sup> So the Asian doctors ended up being tied to the UK and the NHS, because returning without fulfilling your aspirations was not an option. They always hoped that they would break out of the cycle but in the end they did not but stayed on and made the most of it. They 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 that were not their first choice.<sup>12</sup> 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.

## 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 who in his 'Rivers of blood' speech,<sup>13</sup> gave respectability to the prejudices of many. The shock of the speech was the apocalyptic language and naked demagoguery coming from the lips of this austere intellectual.

Of course Powell was responding to what he would have claimed were his constituents' fears. Although he is frequently cited as the *bete noire* of the political establishment, comments by Margaret Thatcher in 1978 when she referred to this country being 'swamped by a people of a different culture' could be construed as equally offensive.<sup>11</sup>

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 *BMJ* at that time were filled with articles complaining about the standards of overseas qualified doctors and much of the concern centred around the issue of communication.<sup>12-14</sup> Smith's survey showed that about 17% of overseas qualified doctors coming to Britain in the early 1970s had problems with communication, as assessed by an objective test that he had designed, but the vast majority did not.<sup>12</sup> And what is more, once they had been here for more than 3 years, these problems disappeared. Interestingly, Smith found no problems with language among GPs.<sup>12</sup> 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 GPs 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.

## SAVIOURS AND PARIAHS

The rise of racism in the UK conflicted with the needs of the NHS which still required the migrant doctor. Alternately described as either saviour or pariah — it was as pariah that the Asian doctor was frequently perceived by the medical profession.<sup>11</sup> (Interestingly the term pariah is derived from the description of low caste Hindus).

In 1972 the GMC, in response to external pressures about standards of overseas qualified doctors, withdrew recognition from all medical school and colleges from the New Commonwealth with a few exceptions. The Merrison committee in 1975 gave official 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 practises in ...'*<sup>14</sup>

In a letter to the *BMJ* in 1975, Dr Roy, a GP from Essex gave an interesting perspective on the shortcomings of the report.<sup>15</sup> 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.

### **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 *BMJ* in the 1960s 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 among a very small minority of doctors. Yet the extension of this problem to cover all doctors, irrespective of their ability and knowledge, seems so widespread 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 1970s for GPs 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 1960s 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 senior house officer jobs.<sup>16</sup> I then went on to show how this situation still persisted in 1997.<sup>17</sup> 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.<sup>18</sup>

### **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 GMC. It provides an interesting insight into how racism operates in terms of who has complaints lodged against them and how those complaints are assessed.<sup>19</sup>

Reviewing all cases brought before the Professional Conduct Committee (PCC) of the GMC between 1982 and 1991, I was able to show that ethnic minority doctors were six times more likely to be brought before the PCC when compared with their white colleagues.<sup>19</sup> I noted that in the 10 years of cases that I examined, ethnic minority doctors were nearly 12 times more likely to be brought before the PCC and charged with indecent behaviour when compared with white doctors who were more likely to be charged with having improper relationships. In my view this is a telling statistic. Is it the case that white doctors were incapable of indecent behaviour or perhaps the ethnic minority doctor was incapable of having an improper relationship without the inclusion of indecent behaviour being part of that relationship? The data suggests that if such relationships did exist, then 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.<sup>19</sup> Ethnic minority doctors were nine times more likely to be charged with this offence compared with white doctors, suggesting that this was a phenomenon exclusively related to the clinical practice of ethnic minority doctors. Finally, I showed that ethnic minority doctors were over 30 times more likely to be charged with 'improper demand for fees'. Can we believe that the charge of improper demand for fees is the prerogative of only ethnic minority doctors, or are people more ready to make this specific complaint against ethnic minority doctors than white doctors?

Following the publication of this research, the

GMC subsequently commissioned Isobelle Allen from the Policy Studies Institute (PSI) to carry out a thorough review of all the GMC functions, including the handling of complaints. In a series of reports spanning nearly 10 years, the entire fitness-to-practise functions of the GMC were subject to intense scrutiny.<sup>20</sup> Professor Allens' reports provided useful background information for the detailed review by Dame Janet Smith in the Shipman Inquiry. Dame Janet summarised the significance of Isobelle Allens' findings in her fifth report:

*'Thus in three studies conducted over a period of 9 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.'*<sup>21</sup>

The point that I would make is that in much the same way that the Merrison Committee stigmatised the Asian doctors, so the GMC, perhaps inadvertently in procedures related to its complaints process, also stigmatised overseas qualified doctors. They were once again the pariah's of the medical profession.

## **DISCRIMINATION AND BRITISH-TRAINED ASIAN DOCTORS**

I have also published research which shows that ethnic minority doctors are significantly disadvantaged and face discrimination in the allocation of distinction awards (now known as clinical excellence awards). My research showed that white doctors are nearly three times more likely to receive awards than ethnic minority doctors.<sup>22</sup> I have also published research which shows that ethnic minority doctors are less likely to receive discretionary awards.<sup>23</sup> These findings are important because they show that even at the level of

remuneration, ethnic minority doctors are significantly disadvantaged when compared with white doctors. Since the publication of this work, the national body charged with responsibility for the allocation and monitoring of these awards has made significant progress in reducing inequalities in the allocation of clinical excellence awards but significant disparities still exist.

The explanations given to me from the highest level 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. I am told that the problem only exists with overseas qualified doctors and we all know about this group of doctors — language problems, poor standards, and flaky degrees! So again, the media perceptions of this group of doctors are used by the medical profession to justify why some doctors are paid more than others.

This is a relatively new development in the justification of discrimination within the profession because, of course, if you look at our medical schools now nearly one-third of graduates are from ethnic minorities. It is much more difficult to justify discrimination against this group, so already ethnic minority doctors are being classified as those who have qualified here and those who have qualified abroad.

The problem of course is that these are very subtle differences and my own experience shows that the crudest level of discrimination occurs with things like name and colour of skin and is not refined enough to distinguish between where you qualify from.

The end result of this discrimination which has stigmatised these Asian doctors is that while they possessed the skills relevant to the British economy and the NHS, their status as pariahs determined their lived experience. Essentially, they occupy the lower-grade positions in the most unpopular specialties with a high propensity for long hours and shift work, from which promotion is restricted and 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. While 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.<sup>12</sup>

Smith also concluded that migrant doctors were more likely than British doctors to become GPs against their inclination, and more likely to be practising in a speciality 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 postgraduate 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.<sup>12</sup> 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 scheme, for example, and I certainly remember the difficulty of getting into vocational training schemes that were centred around teaching hospitals.

## THE FUTURE

While the NHS is often described as a uniquely British institution, the role that immigrants played in its creation should not be overlooked. While I have talked exclusively about the contribution of Asian doctors, it is important to acknowledge the contribution of other groups of immigrants — Scottish and Irish doctors who traditionally filled gaps in general practice in our large industrial cities. There is also the more recent contribution of Jewish doctors — many of whom have significant memories of the same sort of discrimination that I have described in relation to Asian doctors. All of these groups have played an important role in the development of the NHS and it is appropriate that their contribution is not overlooked. 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, and to the elderly, will be duly acknowledged. This essay is a contribution to an understanding of that history.

## REFERENCES

1. The Information Centre. NHS hospital and community staff (HCHS): Medical and Dental England: 1995–2005. [http://www.ic.nhs.uk/webfiles/publications/nhsstaff/NHSStaffMedDentalDetailedResultsTables240406\\_XLS.xls](http://www.ic.nhs.uk/webfiles/publications/nhsstaff/NHSStaffMedDentalDetailedResultsTables240406_XLS.xls) (accessed 10 Sep 2007).
2. National Statistics. Population size. <http://www.statistics.gov.uk/cci/nugget.asp?id=455> (accessed 10 Sep 2007).
3. Department of Health. *The NHS Plan: a plan for investment, a plan for reform*. London: The Stationery Office, 2000.
4. General Medical Council. GMC News. [http://www.gmc-uk.org/publications/gmc\\_today/gmc\\_news\\_archive/gmcnews2.pdf](http://www.gmc-uk.org/publications/gmc_today/gmc_news_archive/gmcnews2.pdf) (accessed 10 Sep 2007).
5. Gorman M. Introduction of western science into colonial India: role of the Calcutta Medical College. *Proc Am Philos Soc* 1988; **132**(3): 276–298.
6. Jeffery R. Recognizing India's doctors: the institutionalization of medical dependency, 1918–1939. *Mod Asian Stud* 1979; **13**(2): 301–326.
7. Global Security. Military: Army Medical Corps. <http://www.globalsecurity.org/military/world/india/amc.htm> (accessed 10 Sep 2007).
8. Visram R. *Asians in Britain 400 years of history*. London: Pluto Press, 2002.
9. Taylor DJ, Esmail A. Retrospective analysis of census data on general practitioners who qualified in South Asia: who will replace them as they retire? *BMJ* 1999; **318**(7179): 306–310.
10. Curtis P. Migrants ruling leaves trainee doctors jobless: change in law hits 15 000 overseas medics; BMA in urgent talks to help excluded candidates. *Guardian* 2006; Apr 18. <http://www.guardian.co.uk/immigration/story/0,,1755743,00.html> (accessed 2 Aug 2007).
11. Kyriakides C, Virdee S. Migrant labour, racism and the British National Health Service. *Ethn Health* 2003; **8**(4): 283–305.
12. Smith D. *Overseas doctors in the National Health Service*. London: Policy Studies Institute, 1980.
13. Powell E. 'Like the Roman, I see the River Tiber foaming with much blood' [speech]. 20 April 1968. [http://news.bbc.co.uk/onthisday/hi/dates/stories/april/20/newsid\\_2489000/2489357.stm](http://news.bbc.co.uk/onthisday/hi/dates/stories/april/20/newsid_2489000/2489357.stm) (accessed 20 Aug 2007).
14. AW Merrison. *Report of the Committee of Inquiry into the Regulation of the Medical Profession* [Merrison Report]. Cmnd 6018. London: HM Stationery Office, 1975.
15. Roy S. Merrison Report and overseas doctors [letter]. *Br Med J* 1975; **4**(5996): 579–580.
16. Esmail A, Everington S. Racial discrimination against doctors from ethnic minorities. *BMJ* 1993; **306**(6879): 691–692.
17. Esmail A, Everington S. Asian doctors are still being discriminated against [letter]. *BMJ* 1997; **314**: 1619.
18. Esmail A, Nelson P, Everington S. Ethnic differences in applications to United Kingdom medical schools between 1990–1992. *New Community* 1996; **22**(3): 495–506.
19. Esmail A, Everington S. General Medical Council. Complaints may reflect racism. *BMJ* 1994; **308**(6940): 1374.
20. Allen I, Perkins E, Witherspoon S. *The handling of complaints against doctors. Report by the Policy Studies Institute for the Racial Equality Group of the General Medical Council*. London: Policy Studies Institute, 1996.
21. Smith J. *Fifth Report. Safeguarding patients: lessons from the past — proposals for the future*. Cm 6394. London: The Stationery Office, 2004.
22. Esmail A, Everington S, Doyle H. Racial discrimination in the allocation of distinction awards? Analysis of list of award holders by type of award, speciality and region. *BMJ* 1998; **316**(7126): 193–195.
23. Esmail A, Abel P, Everington S. Discrimination in the discretionary points award scheme: comparison of white with non-white consultants and men with women. *BMJ* 2003; **326**(7391): 687–688.