Ethnic clustering among South Asian geriatricians in the UK – an oral history study

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What is already known:

1 Overseas qualified doctors have always made up at least a third of the NHS medical workforce

2 Geriatric (or Old Age) medicine has been one of the least popular clinical specialties

3 Occupational clustering tends to be seen as a feature associated with less skilled migrants.

What this paper adds:

1 The combined effects of fluctuating labour scarcity in sectors of the medical labour market, discrimination against outsiders and level of skill led to a clustering of skilled migrants in geriatrics

2 Clustering in the geriatric specialty followed advice from more senior doctors who acted as patrons

3 Ethnic clustering was compounded by geography and type of hospital as opportunities for employment and progression tended to occur mainly outside London and the South East of England and away from teaching hospitals

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Abstract

The literature on ethnic occupational clustering and its impacts is large. However it mostly focuses on the lesser skilled sectors of the labour market or on entrepreneurship. In parallel, the extensive literature on employment of skilled migrants has focused on expanding diversity in the workforce, and on issues of representation of migrants and minorities. This article takes a fresh look at skill, ethnicity and migration recognising the clustering that also occurs in parts of the skilled sectors of the labour market. Using the example of South Asian doctors in a poorly valued specialty - geriatrics (now more often known as old age medicine) - the article suggests that over-representation and clustering can be processes for career advancement amongst health professionals. Drawing on oral history interviews conducted with South Asian trained geriatricians and drawing on an earlier collection of interviews with UK born and trained pioneers of geriatrics, the article explores the experience of clustering, especially as it occurred from the late 1960s through to the 1980s, a period when there was rapid growth both in the discipline and in the numbers of overseas trained doctors in the specialty. The article demonstrates how the double experience of marginality, as members of a minority ethnic group and as doctors working in geriatric medicine, created a professional niche with opportunities for career development. It concludes by suggesting that dependence on migrant workers and a lack of regard for the care and cure of older people continue to be important challenges for the health and social care sectors, and that a look at past experiences can alert us to the problems and prospects that clustering affords the workforce in these sectors today.

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Overseas qualified doctors have, since the inception of the National Health Service, been an integral part of the health service with 37% of the doctors on the GMC register in 2008 having qualified outside the UK (Catto, 2008), particularly in South Asia. Yet, despite some recognition of the significance of South Asian doctors in the provision of health in the UK, there has been little research on their clustering within specific parts of the health service (but see Esmail, 2007). This echoes the wider literature on ethnic clusters, which has tended to focus on clustering as a function of lower skills, and ignored the nature and extent of ethnic clustering that operates within skilled sectors of the labour market. In this article we show how ethnicity and skill work together, under certain conditions, resulting in clustering in areas of employment traditionally associated with high status. With regard to the health services, concern has tended to highlight the importance of a diverse workforce with appropriate representation from ethnic minority groups (Notter, 2006). However, ethnic clustering too can be a marker of discriminatory practices and lack of access to equal opportunities. Under-representation in some areas can be accompanied by over-representation in others, a pattern that is also prevalent in skilled sectors of the labour market. In this paper we analyse participants' narratives and policy documents on the process of ethnic clustering within the geriatric specialty within the NHS and the factors that led to it from the late 1960s. Using evidence from oral history interviews, we explore some of the ways in which this clustering was experienced as discrimination based on nationality, race and country of qualification. We also

highlight some of the intersecting forms of ethnic clustering based on professional hierarchy (specialty), geography, type of hospital and client group that influenced geriatricians between the 1960s and 1980s. We show how some of these issues seem to continue into the 1990s and beyond and raise some questions about what this means for the future.

The paper draws on two data sets. The first is a set of oral-history interviews conducted by Professor Margot Jefferys with pioneers who established geriatrics as a medical specialty in the UK in the post-war period.[ii] These pioneers were identified by their peers in the British Geriatrics Society (BGS). Jefferys' sample largely consists of those selected for the BGS 'Hall of Fame' of members who played a significant role in developing the care of older people in the second half of the twentieth century. This Hall of Fame was established by the then president Bobby Irving around 1989. Although several interviewees mention the significance of overseas-trained South Asian doctors in building the specialty, the Jefferys data set includes only one interview with a South Asian.

In this paper we use the term overseas doctors for most of the paper, in line with the early use of this term to cover medical migrants. More recently they have come to be called International Medical Graduates or IMGs. In this research project they were all ethnically Asian. It is worth noting that for most of the period about which our interviewees were speaking, data on ethnicity and on country of qualification was not routinely collected. Moreover, even now the types of data collected vary across the nations so UK wide comparisons are impossible to draw up. For most of the period that we discuss, country

of initial qualification was the major marker of distinction although this distinction was then racialised, as through the use of the term 'brown-skinned specialty'. More recently the number of doctors who are born and educated in the UK but are South Asian in ethnicity is increasing so the match between race and 'overseas qualified' has become diluted.

The second data-set of interviews, conducted with South Asian trained doctors who joined geriatrics in the last 40 years, complements the Jefferys data set. The interviews were conducted in 2008-2009 as part of an ongoing ESRC funded project[i] exploring South Asian geriatricians' contribution to the National Health Service (UK). The two sets of interviews together cover a time period of medical practice from before World War Two up to the first decade of the twenty-first century. Geriatrics (now known as Old Age Medicine) offers us an interesting site to explore the processes and experiences of ethnic clustering in a highly skilled sector of the labour market. It also raises an interesting paradox because although geriatricians are highly-skilled and relatively well-paid, geriatrics is seen as a marginalized area of medicine within the spectrum of medical specialties. Similar patterns are observable in other specialisms such as psychiatry and general practice.

Ethnic clustering

In the context of wider literature of labour market integration, labour market clustering into niche occupations has gained considerable attention. Clustering is seen as the effect of social networks that channel migrants into specific parts of the labour market and is

seen to have mixed effects on migrants (Bonacich, 1973; Waldinger, 1996). Economists, in particular, have conducted large multivariate studies on occupational clustering.

For some, clustering can be seen as a manifestation of labour market discrimination, whereby migrants find jobs in the few sectors of the labour market that are open to them. This form of clustering was explained in the 1970s through a Marxist analysis of labour market segmentation into a primary market with better wages and a secondary market with temporary labour on lower paid wages that migrants largely populated (see Colic-Peisjer, 2006 for a discussion). Subsequently race was seen as working alongside class to segment labour (Reid and Rubin 2003) so that it is the fertile intersection of race and class that keeps migrants within limited sectors of the secondary labour market. This structural analysis has been added to and refined in subsequent years.

For others, clustering is about people's agency within the context of labour market discrimination. Clustering may be seen as an effect of how people negotiate networks (Elliott and Lindley, 2006) or of the social capital that migrants possess, whereby some migrants are able to network in order to get access to particular kinds of jobs (Schrover et al., 2007). These studies increasingly differentiate between immigrant clustering, where all immigrants cluster, and ethnic clusters, where people from one ethnic group employ others from the same ethnic group.

Despite these variations, certain common features of existing research on clustering are identifiable. For instance, because of the interest in clustering as a marker of

disadvantage, most of the literature on labour market clustering focuses on entrepreneurship or on employment in lesser skilled sectors of the labour market such as domestic work (Kloosterman and Rath, 2003). It also tends to look at ethnicisation as a process 'whereby an association develops between a certain economic sector and an ethnic group.' (Schrover et al., 2007: 535). There is little in the literature on ethnic clustering as a process that marks migrants in skilled sectors of employment. Yet as we will show below, ethnic clustering may also operate amongst highly skilled migrants.

Clustering may also be analysed as a mark of relative failure within the labour market. As a result, social networks that lead to clustering are usually seen as disadvantageous both to labour market integration and to social mobility (Smith et al., 2006). However, the terms and basis of social mobility and labour market integration are often not interrogated. As a result, the nature of networks, the form of clustering and the shifting status of a labour market niche within narratives of success may be ignored. For instance, is ethnic clustering amongst highly skilled migrants still a form of relative disadvantage or can it allow some forms of career progression? Moreover, how is the labour market experienced and narrated by those who work in these niches? These are some of the questions that remain unanswered in the large literature on ethnic clustering.

In this paper we explore the processes that led to ethnic clustering amongst a group of highly skilled migrant workers. We explore how an ethnic niche was constructed within geriatric medicine in a particular time period – late 1960s to 1980s – a period of growth both in geriatrics and in recruitment of overseas qualified doctors in the NHS. We also

explore the complex multi-dimensionality of ethnic clustering and suggest the need to undertake further research into the implications of such clustering for understanding the diversity of health care in the UK.

Our research

Migrant doctors were an essential but devalued, part of the health workforce. They were necessary for its operation, providing a mobile army of labour in the lower rungs of the medical hierarchy but were systematically disadvantaged in terms of access to jobs, career mobility, the places where they found employment and the specialties they could occupy (Kyriakides and Virdee, 2003). These doctors were ethnically marked both through their race and through their countries of qualification (Anwar and Ali, 1987; Coker, 2001; Robinson and Carey, 2000). The fact that in 2003 only 17 per cent of South-Asian doctors were consultants compared with 42 per cent of white doctors (Decker, 2001: 34; Goldacre et al., 2004) provides some evidence that migrant doctors from South-Asia found their careers limited by the institutionally racist and hierarchical nature of the NHS (Esmail & Carnall, 1997; Hutton, 2001).

Since its inception, geriatric medicine has been a 'Cinderella specialty' (Smith, 1980; Jefferys, 2000; Thane, 2002), treating one of the least regarded groups of patients: frail older people (Evans, 1997). As such, geriatrics became a field where South Asians could find jobs so that 23 per cent of consultant geriatricians appointed between 1964 and 1991 were non-white and had trained outside the UK, compared to only three percent in General Medicine and nine per cent of all consultants in the NHS. Between 1992 and

2001, 21 per cent of all geriatric consultants appointed were non-white and had trained outside the UK, compared to 14 per cent of all consultants in the NHS and 10 percent in General medicine (Goldacre et al., 2004; Table 1).

Migrant doctors working in the geriatric specialty are an example of a group operating within a secondary medical labour market, despite their skills. By looking at the complexities of the formation of skilled labour markets, we can also see that narrations of career success and of career mobility cannot be treated as given for skilled migrants. Geriatrics, thus offers us an ideal point to explore ethnic clustering amongst skilled migrants. The period we are discussing is also interesting as the concerns then resonated with many today: anxieties about an ageing population (RCP 1968); a highly politicised environment around issues of migration and race as evidenced by the Commonwealth Immigrants Act (1968) and the Immigration Act (1972); and concerns over the management and future of the NHS (HMSO 1979). However, this was also a period when there was rapid increase in the number of geriatricians, especially those who qualified overseas, as Table 2 shows.

It is worth noting that the early 1970s were a period of greater acceptance of geriatrics and a relative improvement in its status. The role of geriatrics as a discipline had already been lauded by the Ministry in its publication *Care of the elderly* (MoH, 1965). In 1972/73 a standing committee on geriatric medicine was set up in the Royal College of Physicians and in 1973 for the first time a geriatrician, Dr. John Wedgwood, was appointed an examiner for MRCP exams. In 1984 40% of all patients in hospital were

over 65 so the centrality of care for older people within the NHS became cemented (Denham, 2004). Moreover, it was recognised that one-third of all doctors had to look after older patients. As a result, although geriatrics had low status, it also came to be increasingly recognised as playing a crucial role in the NHS, just as the immigrant status of many people who populated it became marked and problematic in the early 1970s.

Tables 1 and 2 here

Methods

The paper draws on a secondary analysis of interviews conducted by Professor Margot Jefferys with the pioneers of geriatrics in the UK and with a new dataset of interviews with South Asian geriatricians, who also entered this profession and played a central part in its development (Bornat, 2003). The first data set comprises the 72 interviews which Jefferys and colleagues carried out in 1990-91 with the founders of the specialty of geriatric medicine. Between them they cover the history of developments in the health care of older people from the late 1930s to the end of the 1970s. This was a period of profound change in health policy in the UK. The interviews open up a fascinating picture of class and privilege in the medical profession while at the same time revealing attitudes and practice in the care of the most marginal of all patient groups, frail older people. The second data set generated in this project consists of oral history interviews with 60 South Asian overseas-trained doctors.

The decision to use oral history as a method was felt to be appropriate for several reasons. In both cases, our own and Jefferys', the aim was to retrieve eye-witness testimony to changes in an area of medical practice which had consistently been marginalised within the medical hierarchy and which had, in consequence, enjoyed little attention from researchers. In recording the experience of those older doctors who are ethnically marked we also aimed to capture accounts of professional lives and working conditions which might otherwise be lost to public record given their marginal and uncelebrated status within histories of the NHS (Smith, 1980 and Rivett. 1998 are exceptions). We were also conscious of oral history's tendency, given its origins, to focus on those lower in social and professional hierarchies. In seeking accounts from those who might be described as elite we were taking oral history as a method into relatively uncharted territory (Bornat et al, 2009).

The project was submitted for ethical review and approved by the Open University's Human Participants and Materials Ethics Committee and by a committee of the NHS National Research Ethics Service. The research was conducted in line with the ethical recommendations of the UK Data Archive. Ethical and copyright issues relating to the rights and perspectives of the interviewees were taken into account in the training of the research team members. Members of the research team attended an oral history training day, run by the Oral History Society, at which issues of confidentiality, disclosure, copyright and consent were addressed. Before each interview the interviewee's rights under copyright law and the aims and objectives of the project were explained. Following the interview, participants were invited to sign a consent form which enabled them to stipulate the conditions under which their words would be quoted in publications and

their interview would be archived.

Our target of 60 interviews was designed to comprise forty retired, semi-employed doctors who had arrived in the UK in 1976 or earlier. We expected many of them to have worked with the Jefferys pioneers. As a control, we also aimed to interview twenty serving doctors, younger in age and with a more recent experience of geriatric medicine. The size of the sample was designed to match the Jefferys' data set and to enable a broad enough reach with which to capture the diversity of the South Asian experience. The initial pool of potential informants consisted of 28 south Asian geriatricians who responded to an invitation letter sent by the British Geriatrics Society (BGS) in 2003. Of this group 12 responded positively and a total of 10 were interviewed. This was followed up by an advertisement in the BGS newsletter to which one person responded and was interviewed. A follow up mailshot to BGS retired members yielded a further six interviewees. One informant was recruited after seeing correspondence relating to him in the National Archives; another one was the only South Asian Jefferys informant. An additional 33 informants were identified from contacts generated in previous interviews of whom 10 were interviewed. The bulk of the potential informants (110) was identified by snowballing from the above sources and of these 25 were interviewed. This was supplemented by purposive searches of internet sources such as hospital websites and doctors directories for particular categories of geriatricians (women and Staff and Associate Specialists) which yielded 18 potential informants of whom 6 were interviewed. Our interviewees include doctors trained in India, Bangladesh, Sri Lanka, Pakistan and Burma, ranging in age between 40 and 91 and arriving in the UK from the

late 1940s onwards. All except two of our interviewees serve or served as consultants and some also held senior academic posts.

As shown above most of the informants (41 per cent) and over half of the retired informants were recruited through 'snowball' sampling. We are aware that this approach is likely to have replicated a bias in our sample towards relatively successful geriatricians. Of course such a bias is an inherent aspect of not being able to access a doubly invisible group (retired and unsuccessful) and also illustrates a contradiction between making a public record of achievement of South Asian Geriatricians and recruiting a representative sample of geriatricians. However, diversity of experience was revealed in the interviews, in their early lives, migration decisions, experiences of networking and progression within the medical hierarchy, as well as the geography of employment opportunities. At the same time, patterns and regularities in the accounts were clearly evident both within our data set and between ours and the Jefferys recordings.

The interview schedule used a life history approach (Thompson, 2000), asking participants to talk about their childhood, upbringing, education at school and college and subsequent training and careers in their home countries and after arrival in the UK. The doctors were asked about their reasons for migration to UK, arrival and subsequent career progression in the UK with a focus on opportunities, barriers and sources of support. All the interviews have been transcribed and will be deposited in the British Library where they will sit alongside the Jefferys collection. [ii]

The choice of oral history as a method in migration studies is well-attested. Both as an approach and as a source of evidence, interviewing leads to rich and more greatly nuanced theorising as well as adding directly to knowledge of particular migrant experiences (Thomson, 1999). In this paper it provides personal accounts of the experience of clustering in a skilled sector of the labour market.

The oral history interviews are supplemented by archival research. The archives of the Department of Health, the British Geriatric Society, British Medical Association, Wellcome Institute, the Royal College of Physicians, the Royal Society of Medicine and the papers of organisations such as the Overseas Doctors Association have all been consulted to provide an understanding of official narratives and policy discourses related to the issues facing doctors working in the specialty in the second half of the twentieth century.

Clustering – geriatrics as a discipline

For almost all the informants geriatrics was not their first choice of specialty; rather their entry to the specialty was a result of an interplay between the failure of their UK based networks to facilitate entry into the specialty they hoped to enter during their time in the NHS and the support given by their network in finding alternative channels of career advancement. Many of those interviewed reported that their networks were not able to overcome barriers to entry into high status specialties even in times of relative labour shortage. After repeated failure to secure a post as a consultant or specialist registrar in

their chosen specialty the informants who subsequently became consultants (46/48) were advised by their patrons that as overseas trained doctors the most direct route to becoming a consultant was to become a geriatrician.

> L040: So I actually, I applied for the job for cardiology…the reference came to Dr Mitra you see – and he said to me "Oh you applied for this job?" I said "Yeah" "So you're going for a job to Leeds for cardiology?" I said "yes I am thinking about it" …And he said "I'll show you something then" So there was a job in Newcastle coming up applying for cardiology consultant job, you see. And he showed me the applicants you see, because he was on the interview panel for that consultancy. So guy from Edinburgh, a guy from Cambridge, a guy from Oxford, one guy coming from Canada, one coming from New Zealand, one coming from London from Brompton. And he said "Have a look at their names as well. They are all local graduates" so he said "Where do you fit in there? Do you think you have any chance there?" (laughs) So I said "Probably not" so he said "Well my advice to you, forget about it because you could be wasting your time by doing cardiology" *(L040 Male Consultant, born 1947, arrived in UK 1973)*

This repeated pattern of pressure on overseas doctors to enter geriatrics rather than their chosen specialty can be seen as reinforcing their marginalization from the mainstream labour market as whilst their patrons highlighted the realities of discrimination against

foreigners in the networks in which they, of course, played a critical part they apparently did little to challenge the discriminatory practices within their networks.

But interestingly, they were also remarked upon in the interviews Jefferys conducted:

> One of the problems has been that staffing of geriatric departments hasn't always been easy, we have had to appoint quite a lot of doctors from the Indian sub-continent to be registrars and even senior registrars, so for quite a period the only applicants for consultant jobs were in fact not British citizens trained by British methods. They had been to respectable geriatric departments and learnt the trade but when they got appointed to x, y, z, they had Indian or Pakistani names or whatever else. And it tended to get known as the sort of, you know, dark-skinned specialty. *(John Agate, Jefferys interview 1991, male consultant, born 1919)*

Those interviewed were of course aware that geriatrics had a low status:

> L034: In medicine geriatric medicine was the most unglamorous. People who can't get in(to) any other specialty will try geriatric medicine. This will come every time you talk to one of us. And that becomes a subject of pain for rest of the life for these people, do you see what I mean….If your colleague has gone into say rheumatology or cardiology somehow they squeezed in and they say "What do you do?" "Geriatric medicine" the

conversation stops almost because you have that in the lower unglamorous, you are a failed physician. (*L034, Male professor, born 1940, arrived in UK1969*)

However patrons could also offer advice on the basis of their analysis of gaps in the labour market and future developments within medicine. Sometimes this might be more than simply verbal:

L037: Now that was a time I started seriously thinking about my future. Especially in 1971 after 1971 events in Bangladesh. And I wanted to do general medicine. My mentor, Dr Kenneth Chalmers, he was a Scottish Chest Physician. He was a very kind hearted man. He gave me a lot of advices and encouragements and discouragements about everything and one thing he said "Your best bet would be not to compete for general medicine because you will find it very difficult. A. you are slightly older than other competitors, and b. there is still a lot of discrimination against Asian doctors in such posts. So you either consider to be a general practitioner or a dermatologist or a geriatrician to remain in the general medical field you see, and take your pick of these three" And he even arranged to the local general practice to take me as their partner, you understand. (*L037, Male consultant, born 1935, arrived in UK 1967*)

Furthermore, our interviewees suggest that clustering was multidimensional. For instance, South Asian geriatricians appear to cluster in hospitals with fewer facilities and areas that UK qualified graduates avoided:

> L022: First of all in the initial days they filled the jobs when nobody else would take it. And they tried to copy the best leaders. And implement changes in their own patch like the best leaders had done. So there were geriatricians in hospitals where facilities were so poor I probably wouldn't work in those even today. And so that's one of the things that they went to the areas where local doctors didn't go. And they filled those jobs where local doctors weren't interested. It wasn't that the local doctors didn't get those jobs. They weren't interested in those jobs. *(L022, male consultant, born 1945, arrived in UK 1973)*

Overseas qualified doctors found it easier to get posts in provincial district general hospitals, rather than in major metropolises or teaching hospitals.

> LH: And why do you think there's so many South Asian doctors went into geriatrics?
>
> L039: I think, yes it should be, it should be, one should recognise it actually, that that was a specialty where the local graduates were not attracted to at that time because it was not very attractive to go to. So it was easier to get probably to become a consultant actually, yes. But then places like King's College or Greenwich, not easy, it was not easy there, ok. So in provincial

hospitals it was probably easier. *(L039, male consultant, born 1939, arrived in UK 1965*)

The doctors were advised not to apply for jobs in the southern parts of the UK where competition from UK graduates was high:

L044:   And by chance there were a lot of jobs on the Southampton and Bath and, you know, Portsmouth area and I would go there and there would literally be one that is hell of a good candidate. So, you know, be careful. They didn't want me really. So ultimately one consultant told me "You will not get on in the South. Don't even think about it. I feel sorry for you"

LH: Right, so what was it about the south that …?

L044:   They wanted people from, you know, indigenous population here. They didn't want people like me. Sad but true. *(L044, consultant, male consultant, born 1952, arrived in UK 1978)*

Instead they found opportunities in the more remote parts of the country, a pattern that continued into the 1990s as we see below:

L026:   After I passed my PLAB in July I came to Wrexham to stay with my friend and then I started to apply and there was no job and then one of my

friend who used to work in Oswestry … cos Wrexham had a rotation which was shared through Oswestry and he knew one of the person who's duty start on the 3rd of August has stroked out. So the post was vacant and it was so small a place, there wasn't any … they are used to employing overseas graduates. All the three SHO posts is always employed by overseas graduates because none of the British graduate would want to come and work there because it was so remote. Unless they are in a rotation and compelled to come. So they knew that there was no place they were going to get a British graduate. *(L026, male consultant, born 1966, arrived in UK 1995)*

Ethnic clustering was thus layered with geographical clustering, with South Asian geriatricians being pushed into the more remote areas and in areas with a poorer client base. They were largely excluded from the metropolises and the big teaching hospitals.

However, there is more than one way of viewing this particular aspect of clustering which occurred in geriatrics as the clustering was not only a result of discrimination but was also a result of recognition of opportunity. A shortage in a particular area of medicine or locality was also a gap that could be filled and for many informants provided opportunities for career progression. Talking about the late 1970s one of our interviewees said:

L025: I knew that I will never get a job in general medicine, it is highly competitive and the preference is given to the local population. I didn't

feel bitter about it because I've experienced that before in another country. (laughs) So I didn't' feel bitter about it. I said "Whatever the job I get I'll take geriatric medicine and then see how it is" Within six months I cleared the membership, part of it at least. *(L025, consultant, male, born 1946, arrived in UK 1976)*

This ability to recognise and make space for personal career development also continued into the late 1990s, the period to which the interviewee below refers:

L023: Because my consultant, who was exactly like me, I know him now, he was a trained cardiologist and then there were openings in geriatrics so he quickly moved into that area and he said "Look if you want to go through the fast track up then this is a less crowded road. You could do geriatrics and you could do cardiology and you could, it would be a good way up rather than waiting in the queue" *(L023, Professor, male, born 1958 arrived in UK 1996)*

Table 3 here

Most of those interviewed came to the UK with a particular specialty in mind such as cardiology, gastroenterology, neurology or general medicine. They were quickly disabused of their ambitions and found a new chosen career in geriatrics. This movement across disciplines brought benefits in terms of training and progression. However, the changing nature of geriatrics in the 1970s and 80s, particularly the emergence of sub-

specialities, meant that many were able to maintain a specialist interest, while some went on to specialize within geriatrics. While the broad scope of geriatrics marked it as a non-specialty in the eyes of some doctors, for others it offers an opportunity to gain experience of a wide range of acute and longer-term conditions and to work with other professionals, social workers, occupational therapists and nurses in less hierarchized working arrangements. And for those interested in developing a research base, there was some possibility of developing specialisms such as treatment of stroke, Parkinsonism and other conditions more typical of late life. Once inside the specialty, these more successful geriatricians describe careers which have brought research-based as well as material rewards although these opportunities were sometimes limited by their location outside the teaching hospitals where funding and time for such work was concentrated.

However, this clustering also raised alarm. For instance, the minutes of a 'special meeting' of senior officers of the DHSS and RMOs at the Nuffield Provincial Hospitals Trust, 5 June 1975 record the following statement:

> 'At the present time 30% of consultant posts in the specialty were occupied by UK graduates, and the position was likely to deteriorate further during the next few years when a large number of UK born consultants would be retiring... it was apparent that Geriatrics was in imminent danger of becoming an "overseas" specialty. Such a state was in his opinion unfair and unacceptable to the senior citizens of our society. There was an urgent need to decide what should be the fate of the specialty of Geriatrics' (DHSS, 1975)

Clustering was seen to have a negative effect not only on the patients but on the future of the specialty too. The uncertainty over staffing that dependence on medical migrants created was noted by this Professor of Geriatric Medicine in a letter to the Royal Commission on the NHS:

> … This concentration of Overseas Graduates in what remains a low status specialty is undesirable on many grounds and for the future it is not clear that plans for future expansion cannot be based on the assumption that the supply of such Graduates will continue'. *(letter dated 13.12.76 from Professor Ferguson Anderson -the first British Professor of Geriatric Medicine- BGS archives)*

They sought diversity in the labour force, but interestingly, their notion of diversity was a shift away from the ethnic clustering which they noted. Moreover, ethnicity of the doctors was seen as an indicator of the discrimination that older people faced and it is precisely by removing that dependence on South Asians that equality towards older people was sought.

Conclusion

Today, the issue of care of older people has resurfaced as a major political agenda item (Caldwell et al., 2008; Department of Health 2009). These concerns are, however, not new. They echo, for instance, those raised in the Royal Commission's report on the NHS in 1979:

> 'The demographic change which will be the greatest single influence on the shape of the NHS for the rest of this century is the growing number of old people and

particularly those over 75. This will increase the need for long-term care' (Royal

Commission, 1979) *reprinted in BMJ 28.7.1979, p.287).*

Comparing the two data sets, our own and Jefferys', illustrates much that is similar in

terms of career progression and the development of the specialty. For both groups of

doctors, non standard career histories led to opportunity for progression within a

marginalised specialty. However, as we have shown here the formal and informal

mechanics of progression, as described by the South Asian doctors, expose the linkages

between skill, ethnicity and marginalization and present a perspective on clustering

which, we argue, has not so far been given sufficient attention within the literature.

Although the profession was aware of the extent to which the development of geriatric

medicine came largely as a result of the marginalisation of the specialty rather than active

choice on the part of those employed as geriatricians there have been few attempts so far

to explore the experiences of geriatricians or to trace the complexities of opportunity and

constraint that this placed on individual doctors, resulting in a clustering. The academic

literature, has on the other hand, explored the experiences of clustering although these

accounts have been limited to those of lesser skilled and entrepreneurial sectors of the

labour market. This article's focus on the experiences of this group of marginalized elites

in the British medical labour market, thus, contributes to both literatures providing a

personal account of the process and experience of clustering in a skilled specialty.

The status of geriatrics as a discipline, involved in the cure of those who face health

problems in later life, has much to tell us about care provision. The care and the cure of

older people share a status based on the marginalisation of older people and dependence on migrant labour. Issues of racism and ageism come together to present challenges but also opportunities for migrant workers (Raghuram et al., forthcoming). We would argue that despite the extant critique of clustering and its causes, there are also some positive side effects for both geriatricians and older people. There is a perversity in the situation as regards the relation between older people and South Asians because as one informant remarked 'Without racism there would be no discipline of geriatrics' (personal communication, *L035 Male Consultant in Geriatric Medicine arrived in UK 1975).*

So what lessons can be learnt from the historical experience of clustering in geriatrics? The existence and nature of clustering in the medical labour market has not received the attention it deserves. The medical profession, Department of Health administrators and policy makers need to be aware of the issues that clustering raises, and the impact this may have both on the medical specialists and on patients. The Department of Health as well as the BMA (2005) increasingly recognises the need to provide appropriate environments for doctors to practise their skills both in order that doctors fulfil their potential but also to ensure that patients get the best possible treatment. This paper has provided some empirical evidence that suggests the complexity of the discriminatory processes that are limiting such efforts, some of which are, perhaps, still occurring in the NHS.

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

[ii] The Jefferys interviews are catalogued in the British Library Sound Archive with the collection title, 'Oral History of Geriatrics as a Medical Specialty' at http://www.bl.uk/catalogues/sound.html. Accessed 26.11.08 They are open access and hence details of the interviewees have been presented in this paper. However, interviews with the South Asian geriatricians have not yet been archived and have stipulations for access. Hence, they have been anonymised.