Difference and distinction? Non-migrant and migrant networks

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Abstract

In recent years the role of social networks, and of social capital, in shaping migrants' lived experiences and particularly, their employment opportunity has increasingly come to be recognised. However, very little of this research has adopted a relational understanding of the migrant experience, taking the influence of non-migrants' own networks on migrants as an important factor in influencing their labour market outcomes. This paper critiques the alterity and marginality automatically ascribed to migrants that is implicit in existing ways of thinking about migrant networks. The paper draws on oral history interviews with geriatricians who played an important role in the establishment of the discipline during the second half of the twentieth century to explore the importance and power of non-migrant networks in influencing migrant labour market opportunities in the UK medical labour market.

Keywords

South Asian doctors

Migrant networks

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Introduction

There has been longstanding interest in migrants' social networks and their role in migrants' labour market outcomes, especially access to jobs, career mobility and social mobility in countries of destination (Bonacich, 1973; Boyd, 1989; Poros, 2001). For Bourdieu (1986) the ways in which these networks of relations provide potential and actual resources, including access to jobs suggests that they are a form of social capital. Migrants were often seen to have attenuated networks and relatively impoverished social capital (Portes, 1995) until the richness of the networks that extend across transnational social fields was recognised (Kelly and Lusis, 2006; Ryan et al., 2008).

Yet, despite the diverse range of studies thus far conducted on migration, social networks and social capital, most studies focus either on shared ethnicity (ethnic ties) or on the experience of migration (migrant ties) as the basis for networking (Anthias, 2007). Ethnicity and migration provide the implicit or explicit boundaries for defining meaningful networks within the labour market. Underlying the treatment of the two forms of networks (migrant and ethnic) is a notion of migrant as 'other', as distinctive, as someone who shares little with non-migrants[1] and as enclosed within migrant experiences. Thus, in most empirical research on migrants' labour market prospects, it is only migrants who are put under the spotlight. Non-migrant networks, their ability to reproduce privilege, and how migrants fit into and rework such networks often escape

attention. Besides, migrant networks also seem to be enclosed within a particular temporal framework, delineated by the migration event. Pre-migration networks only come into view as they become mobilised into a form of social capital by migrants. The networks that prevent migrants from capitalising on their skills in the countries of origin, the dark side of social capital (Portes, 1998) prior to migration are also neglected.

In this paper we aim to address these gaps through an exploration of social networks and social capital as they influenced migrant South Asian[2] geriatricians in the UK in the period from the1960s to 1980s. We suggest that the social networks of non-migrants both in countries of origin and destination can be crucial to shaping migration. In locating our study in a skilled sector of the labour market we also expand the current literature, which has largely focused either on entrepreneurship or on lesser skilled sectors of the labour market.

The paper draws on two data sets of oral history interviews[3]: those conducted by Margot Jefferys and colleagues with pioneers who established geriatrics as a medical specialty in the UK in the second half of the twentieth century and those conducted in 2008-2009 with overseas-trained South Asian doctors who joined geriatrics in the last 40 years[4]. Geriatrics offers us a lens through which to explore networks 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. It also has a relatively high proportion of South Asian doctors.[5]

The rest of the paper is divided into four sections. The first section discusses some of the literature on social networks, social capital and migration and identifies several lacunae in the existing literature. The second section provides details of the projects this paper draws on. The third section discusses some of the complexities of networks as they pertain to migrant doctors focusing on how migrants were differentially excluded and incorporated into non-migrants' networks both in countries of origin and destination. The last section provides a conclusion.

Social networks, social capital and labour markets

Social networks have been used as an analytical frame for understanding migration for some time. By emphasising the role of agency and aspects of the social which condition agency during the migration process (Boyd, 1989) network analysis partially overturns the unhelpful distinction between agency and structure. Within the labour market context professional networks and alumni associations are seen to provide leverage to new migrants entering the labour market (Harvey, 2008; Shih, 2006), becoming a form of 'migrant institution' providing a sustained structure of support for migrants.

The centrality of networks to the well-being of migrants has meant that the effective potential of migrant ties to promote social and economic advancement have also been widely investigated and theorized, the latter largely through the lens of social capital. Social capital involves the 'social networks and the associated norms of reciprocity and trustworthiness' (Putnam, 2007: 137) that people accumulate and convert to other forms of capital or which are sustained by cultural forms and representations. These networks

may involve 'strong ties' marked by emotional intensity, intimacy and reciprocity within socially bounded groups with strongly overlapping network membership as well as 'weak ties' that members have with those from other social groups (Granovetter, 1973). Drawing on the experiences of professional, technical and managerial workers, Granovetter argued that human capital was not wholly adequate in understanding labour market experiences. He suggested that weak and strong ties, that vary with ethnicity, skills and structure and sector of the labour market too play a role (Harvey, 2008). The forms of capital that these different ties offer also vary between 'bonding capital', engagements that 'brings together people who are like one another in important respects (ethnicity, age, gender, social class, and so on)' (Putnam and Goss, 2002: 11), and 'bridging capital' which, on the other hand, 'bring together people who are unlike one another' (Putnam and Goss, 2002: 11).

Empirical research has shown that the relationship between networks as a form of capital and migrants' experiences is particularly complex. For instance, the power differentials between those who have achieved some stability and upward mobility after migration and those who have not can mean that the former act as bridging agents for others within their bonding group (Williams and Baláž, 2008). Similarly class and gender hierarchies also influence the nature of both bonding and bridging capital (Anthias, 2007; Ryan et al., 2008). Finally, those who offer bridging capital (such as recruitment agents) may not only offer informational and instrumental support but also provide emotional support, characteristic of bonding networks (Elrick and Lewandowska, 2008).

As we see above, a large number of studies have been conducted on migrant social networks, providing empirical nuance and theoretical advancement to notions of social capital. Yet, the methodological starting point - a focus on migrants and their networks – has also had an unfortunate side effect: migrants and their experiences come across as distinctive and different from non-migrants with either migration or ethnicity seen as offering the cementing glue to the networks that migrants form. Critiquing this tendency, Kelly and Lusis (2006) suggest that migrants, who form part of a transnational space, not only bring and convert social capital accrued in their countries of origin, but also continue to accrue social capital in both countries of origin and destination because of the ongoing nature of the network relations they maintain. Kelly and Lusis, thus, expand the spatial basis for networking. However, as their interest lies in the effectiveness of pre-migration networks in the post-migration context, they fail to see ways in which the limits to social capital that migrants possess in the pre-migration scenario can itself spur migration. The blocks to networking and the limits to social capital seem to follow migration, never to precede it. However, migrants do not have unlimited social capital prior to migration – there too they are embedded in social fields with their own boundaries, limits and ensuing struggles over inclusion and exclusion. Migration may, for some, provide opportunities to mobilise one's social capital in ways not available in origin countries.

Although Kelly and Lusis (2006) draw on Bourdieu's notion of habitus for their theorisations, they pay little attention to the conceptual base behind Bourdieu's use of habitus, the social reproduction of privilege. For Bourdieu, the purpose of theorising forms of capital was, in large part, to trace the ways in which privilege (especially that of class

position) is sustained and often enclosed amongst those within particular social strata. However, migration theorists rarely look at the shared habitus that migrants and non-migrants occupy or how elite practices influence migrants as they focus almost exclusively on migrants as a distinctive category. In as much as enclosure is also the modality in which migrants are studied, the two literatures reflect each other – that on migrants focusing on migrant or ethnic networks, which are usually seen through the lenses of alterity, if not marginality, and that on elite networks focusing on those who have class privilege, reproducing their privileges through mobilising different forms of capital. Very rarely do the two intersect, or elite networks have migrant participants (but see Beaverstock, 2002).

The few studies that do bring together the experiences of migrants and non-migrants typically lay the two side-by-side, comparing the experiences of these two groups and establishing the privilege that non-migrants have in the labour market. For instance, Behtoui (2008) compares labour market opportunities of migrants and non-migrant workers in the regulated sectors of the Swedish labour market. However, he too largely treats the two groups, migrants and non-migrants as separate entities, rather than looking at them relationally, and specifically at how relations among non-migrants may shape labour market opportunities for migrants.

A more relational understanding of migrant and non-migrant networks is offered through the notion of bridging ties which transcend migrant or ethnic groups (Putnam, 2007). However, here it is migrants and their agency that has been central to the analysis – the practices of trust and reciprocity, the advantages of being known by or knowing someone

with symbolic capital, such as a 'great name' (Bourdieu, 1986) amongst non-migrants evades analysis. Moreover, the basis for drawing the boundaries between bonding groups and bridging groups too can often be essentialist, drawing on aspects of identity, such as ethnicity, ignoring the ways in which identities through which capital is accrued can be dynamic and change during and after the migration process (Ryan et al., 2008). Besides, the boundaries between bonding and bridging groups can also be also contested, blurred, contingent and contextual.

The blurred and overlapping nature of networks has often been missed in migration research because starting with migrants and their networks has led to a failure to fully consider other networks that impinge on migrants but of which they may only be at the edges. Even where cultural capital, institutionalised through accreditation is transferred after migration, lack of access to adequate social capital may limit migrants' access to the labour market. In particular, the weak ties that migrants may form with non-migrants may be influenced by the networking practices and strong ties among non-migrants.[6] Alejandro Portes (1998) recognises this dark side of social capital in his analysis emphasising the forms of closure that those outside these networks face. Migrants' ability to convert social networks into social capital is limited by the social capital that non-migrants possess. They may participate in non-migrant elite networks but the ability to convert this participation into economic capital, through jobs is often limited by the processes of closure that Bourdieu (1986) writes about. However, closure is not always complete. The contextual nature of capital means that there may be openings, both because of changing structures of the labour market and because of a shared investment in some form of

cultural capital, embodied and institutionalised as skills and qualifications. This leads to some fluidity in the boundaries of eliteness but also undermines the fixity of migrants in their migrant identities. Both classed and migrant identities are de-essentialised, not only by showing their internal heterogeneity, as in most of the current literature, (Anthias, 2007; Salaff and Greve, 2003) but also by showing their dynamicity and fluidity.

In sum, network analysis, and its theoretical lens of social capital, plays a profound role in migration research. Much of this research has explored networks in relation to notions of social capital and labour market outcomes but underlying most discussions of migrant social networks is a sense that they are distinctive and separate. They become an object of study, leaving little room for exploring how these networks relate to and are formed alongside the networks of non-migrants.

Our research

In this paper we explore networks and social capital as they relate to South Asian geriatricians in the UK. We focus on how migrants are positioned within overlapping migrant and non-migrant professional networks and the effects of these network engagements in shaping labour market outcomes amongst a group of highly skilled migrants.

Migrant doctors were, since the inception of the National Health Service, seen as an integral, 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 race and by 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 (Department of Health, 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; Essed, 1991). It is in this context that geriatric medicine became a refuge for overseas qualified doctors who found they were unable to make progress in their preferred specialties (Goldacre et al., 2004).

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).

Migrant doctors working in the geriatric specialty typify an example of operating within a secondary medical labour market, despite their skills. Geriatrics, thus offers us an ideal point to explore ethnic clustering amongst skilled migrants and the way in which this emerges because of the operation of networks – both migrant and non-migrant.

Methods

The paper draws on secondary analysis of interviews conducted by a team led by Professor Margot Jefferys with the pioneers of geriatrics in the UK and a new dataset of interviews with South Asian geriatricians, who also entered this profession and played a central part in its development. The first data set (MJ) comprises the 72 interviews which Jefferys and colleagues carried out in 1990-91 with the founders of the geriatric specialty. Between them they cover the history of developments in the health care of older people from the late 1930s to the end of the 1980s. The second data set (SAG) consists of oral history interviews with 60 South Asian overseas-trained doctors who have been recruited through networks of overseas doctors (British Association of Physicians of Indian Origin for example), the British Geriatrics Society and through snowballing. These interviews cover the period from 1950 to 2000. The two datasets thus reflect slightly different, albeit overlapping, periods in the history of geriatrics - the emergence of the discipline in some centres and the adoption and adaptation of practices as they radiated out from these centres across the country. Hence, the South Asians operated in a framework where there was some national infrastructure for advancing geriatrics but faced similar issues to those interviewed by Jeffreys as up to the mid 1980s both were operating in areas that had very little local infrastructure and accorded geriatrics with little status. Both sets of

interviewees developed services and progressed their careers in the context of fluctuations in the supply of and demand for geriatric doctors. However, the SAG interviewees also encountered the effects of changing immigration regulations and of living in a Britain where the meaning of race was changing, issues which influenced the habitus within which social networks operated.

The interview schedule uses a life history approach, asking participants to talk about their life from childhood through to the present. All the interviews have been transcribed and will be deposited in the British Library (unless specified otherwise by participants) where they will sit alongside the Jefferys interviews.[7]

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 early 1950s onwards. Almost all of our interviewees work(ed) as consultants and some also held academic posts such as that of professors. We primarily focus on the period between the late 1960s and late 80s, a period where the issues of the time often 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, the early years saw a rapid increase in the number of geriatricians, especially those who qualified overseas - by 1974 at least a third of consultant geriatricians had trained overseas (BGS, 1975).[8]

The choice of oral history as a method in migration studies is well-attested. It offers the possibility of locating the migration experience within the longer trajectory of a life history, contextualising migration as one of many events that shapes individual lives. It is produced in a dialogue which encourages narration and reflection and thus provides evidence of subjective lived experiences (Thompson, 2000; Perks & Thomson, 2006). Comparing two different datasets has produced its own richness, undermining the alterity that is ascribed to migrant networks but also exposing the partial fluidity of the boundaries of elite networks.

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

Social capital – pre-migrant, migrant and non-migrant

In this section we explore three specific aspects of social capital – those that migrants possessed prior to migration; those that they invoke post migration; and how these are related to non-migrants' social capital. Thus, we first explore the limits to social capital faced by migrants in origin countries. Social exclusion, or the dark side of social capital, is, we suggest, not new to migrants. Secondly, we highlight the transnationality of some networks, how it is the structural temporariness that is inherent to the medical labour

market, which allows migrants to capitalise on some social networks that originated within their countries of origin. These migrant networks provide first entry to the labour market. We suggest, thirdly, that there are opportunities but also limits to the convertibility of such social networks into social capital at least in part, due to the strength and significance of non-migrants' social capital. The embodiment of social capital in particular individuals who were at the centre of intersecting networks of power relations within the discipline, meant that many migrants too benefited from non-migrants' social capital, at least within geriatrics, a medical specialty that faced severe labour shortages.

Pre-migrant capital

Ryan et al. (2008) rightly argue that the dynamicity and the changing nature of the social networks that migrants use have rarely been recognised. Their research on Polish migrants to the UK shows some of the complexity of migrant social capital in the post-migration scenario. However, they begin with the migration event, focusing on arrival as the moment when migrants become discursively relevant. In our research we found that migration was in fact, often spurred by people's ability to activate particular connections while being unable to mobilise others. Within the context of regional, class and caste politics which shaped South Asian medical labour markets, some doctors did not have the embodied cultural capital accrued through belonging to particular regions or castes, and thus found it difficult to obtain jobs in South Asia. Moreover, this was a form of cultural capital that they could not acquire through education or qualifications.

Even those who had connections were sometimes reluctant to capitalise on it to get the more desirable posts in their home countries, in this case in the capital city:

> J021: And the other reason is I may be able to, using my social connection, I may be able to use, you know, able to manipulate where I've been placed which I feel is very unethical to do because that means, you know, somebody else will be going to that, you know, far away. So I think, so I thought I'd better do something else. So I went to do a sale job plus the manager for a trading company relating to medical products…(*SAG, Male consultant, born 1968, arrived UK 1996*)

Thus, doctors often faced difficulties in mobilising social capital to acquire jobs appropriate to their skills and aspirations. On the other hand, medical training in the UK, and membership of prestigious UK Royal Colleges (MRCP etc) were seen as forms of institutionalised cultural capital that the doctors could acquire. These doctors felt drawn to the UK because they were already part of a socio-cognitive community for whom some markers of participation in the UK labour market (medical training and qualifications awarded by the Royal Colleges) were central to notions of career progression (Bornat et al, 2009). Moreover, the doctors' mobility was already embedded in a network of professional development as all but one of our interviewees stated that their lecturers in medical school had undergone some form of training in the UK. These medical professionals, therefore, felt that they shared the frameworks of a common institutionalised cultural capital but also social networks with doctors in the UK.

However, migrants found that even where their qualifications were accredited, they needed to access social capital in countries of destination as we see below.

Networks post-migration

While participation in the socio-cognitive networks of the profession shaped and directed migration trajectories, once in the UK very few doctors were able to make their networks of professional connections count in the UK labour market:

> P021 … And I sent job applications with my reference from consultant and so on and didn't work at all, you know, when I first came. I sent lots of applications with copies of my glowing reference from my consultant in Sri Lanka, didn't help at all. (*SAG*, *Consultant, male, born 1944, arrived in UK 1968*)

It appears that letters of reference written by doctors who had trained in the UK but had returned to South Asia were not considered sufficient. The cultural capital that accreditation offered was not adequate – the migrants were unable to convert their networks into social capital.

However, the transnational social capital of family members, but, more commonly, members of the college alumni, was adequate for short term locum posts (covering for absent doctors) and clinical attachments. They vouched for the person to their colleagues and seniors but it is the structure of the medical labour market - abundant availability of

short term, temporary, posts – which allowed these networks to be effective. This structural temporariness of the labour market provided leverage for social networks to operate. As one doctor said the hospital authorities would not advertise for such locum posts but would use references from existing staff: '"My God we want a locum doctor. Do you say that's a nice Sri Lankan doctor and he says he's good, we can take his word for it" and they appointed.' (P021 *SAG*, *Consultant, male, born 1944, arrived in UK 1968*)

Previous experience with graduates of a particular medical school provided assurance about the skills and qualifications of others from that school. It provided some measure of the trust and certainty automatically given to UK trained graduates, enabling migrants to get a toe-hold in the labour market. However, migrants were rarely able to dispense jobs to other migrants themselves; rather it was through introducing alumni to their usually white consultant that these very junior posts were filled.

Migrant and non migrant networks

Access to these very junior early posts allowed migrant doctors to establish relationships with more senior colleagues such as consultants (and registrars)[9] which would prove critical for their career progression in the UK. They provided the possibility for obtaining formal and informal recommendations which could be used to seek more secure jobs. However, placement in more permanent posts and desirable specialties was largely influenced by other forms of networks, especially the patronage networks which operated in favour of non-migrants. It worked alongside

race and country of qualification to ensure that South Asians who came to the UK were steered towards the less desirable specialties such as geriatrics. Barriers rooted in racist attitudes and discriminatory practice foreclosed both career development and satisfaction for overseas doctors, who were clearly not 'local'. A frequent comment was that in the mid-70s the Consultants would say "I have shortlisted, this is my shortlist. I have included all those that I could – the names I could pronounce and spell" *(*SAG*,* L022, Professor, male, born 1945, arrived in UK 1973). Stories of these barriers to entry in more desirable specialties were echoed by almost all our interviewees.

However, similar networks operated within geriatrics too, glimpses of which can be seen in the Jefferys interviews. A large number of the interviewees talk about how they had known each other. For example John Brocklehurst the first Professor of Geriatric Medicine in England at Withington Hospital, Manchester describes getting his first house job:

> JB: And this was my ... well, in fact he died between taking me on and my getting there, and when I started, his successor, Stanley Alstead, had just been appointed as professor, so really it was Stanley Alstead who was the influential person in my life. Interestingly, there were two house physicians and the other one was Bernard Isaacs (second English professor of geriatrics) who was in my year and whom in fact I had known from school days.
>
> And at that time the sub-chief, as he was called, was Ferguson Anderson and (first UK professor of Geriatrics) …

(*MJ*, *Brocklehurst, born 1924; joint author of a key text book in geriatric medicine, first published in 1973, now in its fifth edition*)

Here, the 'names' of several key figures in the development of geriatrics are invoked, indicating a form of social capital that migrant doctors had little access to. Similarly, one of the ex-presidents of the British Geriatric Society, Philip Arnold, speaks of his relationship with Lord Amulree (one of the founders of the British Geriatric Society and its president for 25 years):

JB: Lord Amulree was interested in this idea and with his continued advice and support I put in for this. And I would again, perhaps, refer to the fact that over the time I knew him there, and indeed subsequently, I found he was an extremely good friend and considerate and supportive of those who were working for him. (*MJ*, *born 1920*)

The casual invocation of these 'names', which are clearly recognizable in any history of the discipline suggests the existence of networks, which were clearly supportive of those who worked for them. As Hey (2005: 868) suggests in the case of middle class sociality: 'They too need to 'bond', not in the enclosures of the ghetto, but for some, in the compulsory sociability of the instrumental network.' These forms of sociality and the importance of contacts for accessing jobs and in facilitating career growth, and eventually in the making of the discipline, were clear in the Jefferys interviews:

MJ: Was it an important and an interesting job?

JB: Oh, it was great, yes. I mean it was .. . there was only one consultant, called Philip Arnold, who was the Secretary of the British Geriatrics Society at that stage, who had been one of Lord Amulree' s protégés, and I was there as the assistant (*MJ*, *John Brocklehurst*).

However, these networks were not wholly exclusionary. Migrants could also sometimes access these networks, especially, in the less desirable geriatric specialty. For instance, once in post the migrant junior doctors engaged with their consultants' patronage networks and were expected to demonstrate attributes deemed by the consultant to prove their potential as physicians in order to progress. Patronage was not regarded as synonymous with ascription but was seen as overlain by meritocratic principles. The attributes which were likely to lead to upward progress reportedly included hard work, clinical skills, interpersonal skills and communication skills, as one of our interviewees reminisces about his experience in the early 1980s:

L025 In that post I spent most of the time in the ward looking after the patients. Being totally committed to the patients and teaching ….And so one day one of the consultants turned up at about six thirty, seven in the evening and he saw me still doing the round and said "What are you doing there?" "I'm finishing my patients. Still there are two more left" He said "You are too dedicated" he said, and the next year recommended me for a senior

registrarship post to the professor. (*SAG*, *Consultant, male, born 1946, arrived in UK 1976*)

This extension of networks to particular migrant doctors can also be sensed in the interviews conducted with the pioneers of geriatrics:

EM: And the fourth is Dr S, who is a very dear friend of mine - Indian doctor, who was our senior registrar for years and who again I had to wangle into the job here because he went up again and again for appointment. Not a good interviewer, not a very forceful personality - brilliant academically. I'm not sure that he's all that good a doctor, but in theory he's marvellous. Anyway, he couldn't get a job and he applied for my job when I retired and I recommended him. He didn't get it. So they re-advertised, and I and Doug had to pull all sorts of strings in a way to get him appointed. (*MJ*, *Eric Morton, born 1919*)

Support given to junior doctors by consultants included advice on career development, formal and informal references on which to build their reputation and access to job opportunities through the professional networks inhabited by the consultant, both within their hospital and without. Some of these practices, whereby consultants would promote the interests of their juniors would today contravene diversity legislation. Talking about the mid 1970s one of our interviewees relates:

L022 After working there for a month the day before the interview for the permanent job he said to me just casually, he said "I'll see you tomorrow at the interview" and I said "I'm sorry Sir I haven't applied, or what interview?" and he said "Haven't you applied for the substantive job?" and I said "No. I was waiting for you to tell me that I should apply" because that had been my experience in (hospital) you see. And he said "Oh no, no, why haven't you applied. Hold on a minute" And he rang the medical personnel and he said "Include Dr N. I've got his application, I'll bring it tomorrow, include Dr N in there for the interview" and that's how I got the Registrar job in general medicine. (laughs) So it was – had I applied simply I suspect he would have looked at either the name or the whatever criteria they applied and probably I wouldn't have been shortlisted. (*SAG*, *Professor, male, born 1945, arrived in UK 1973*)

Whilst our informants emphasized the meritocratic underpinnings of the operation of patronage within consultants' networks it should be noted that they have all been able to navigate this system with a degree of success and that many are now at the apex of their own patronage networks. However, there were limits to which these networks could be capitalised on and the non-migrant network continued to define boundaries:

LO35: We used to joke that go to the annual general meeting of BGS it's like Indian Medical Association really. It is still like that you know. South Asian doctors have run the NHS really isn't it? If you take general practice or, I mean, like our hospital here, probably thirty per cent are South Asian.

> NHS was about thirty/thirty five per cent South Asian. So there's a massive contribution really…The only South Asian doctor was Dr Banerjee who was the chairman of the BGS and then there's a couple of doctors in Wales, Dr Sastry and Dr Bhowmick. They are the ones who are quite high up at the College level or at the national level and all that, you know, but very few... But it doesn't represent thirty per cent of the population of South Asian doctors really. (*SAG*, *Consultant, male, arrived in UK 1972*)

The mixture of formal and informal procedures, and spoken and tacit understandings, structured by power inequalities between patrons and their clients could potentially disadvantage some candidates. For example, not maintaining a close relationship with their consultant could have harmful effects on career mobility. Some informants suggested that references could be withheld or written references would contain codes encouraging members of the panel to discuss the applicant over the telephone. And because it was either not regulated or regulated by normative rather than procedural forms of accountability and operated in the context of power imbalances it left space for malpractice (direct discrimination) and could reinforce marginalisation (institutional discrimination).

The nature, role and power of networks changed considerably over time. They appeared to have played a different, perhaps a greater, and certainly more visible, role in the earlier periods of our study than they do more recently. At least four types of changes are important. First, Race Relations Legislation has altered the parameters of discrimination.

Secondly, over time, the structuring of career progression and the overt markers of achievement and career progress have also solidified so that discriminatory recruitment based on ethnicity is harder to justify. Thirdly, these processes are largely structured by competition for posts which goes through peaks and troughs, depending on the size of the UK medical graduate cohort. The role of networks too alters with these changes. Fourthly, the status of geriatrics as a discipline and its desirability for non-migrant doctors has also changed, becoming more competitive, although even today geriatrics retains a strongly clustered South Asian workforce.

Conclusions

In line with the dominant literature our research suggests that transnational social networks were clearly important for the geographical and career mobility of South Asian doctors who came to the UK (Harvey 2008; Smith and Nicolson, 2007; Williams and Baláž, 2008). Much of this literature, however, suggests that migrants tend to be channelled and contained almost exclusively within migrant networks, whether they are intra-ethnic or inter-ethnic. Our research extends the boundaries of analysis of migrant social capital, and suggests the importance of approaching migrant social capital from the perspectives of pre-migrant and non-migrant populations too. Reflections on pre-migrant experiences suggest that the failure to capitalise on social networks in countries of origin can spur migration. However, the importance of social cognitive professional networks and alumni provided alternatives that our doctors then capitalised on. This ability to use transnational social capital was, however, only made possible by structural temporariness, which has been a central feature of the UK's medical labour market.

Retaining a strongly pyramidal career hierarchy required mobility among the lower cadres of medical professionals which was then provided by and hence, a dependence on migrants. Moving beyond the lower rungs therefore required forms of social capital that were in practice, exclusionary. The embodiment of social capital in particular individuals, who became key brokers in labour market networks, meant that contact with these individuals became essential for entry to more permanent jobs. This form of social capital was central to recruitment in medicine and probably acted to close off opportunities for career progression in the more desirable medical specialties. Yet, at least in geriatrics, a specialty often facing severe labour shortages, these non-migrant networks were not wholly closed. In this paper, we saw some ways in which migrants were influenced by the social networks of non-migrants, how they were sometimes excluded from them, and sometimes inserted themselves into the networks but only in very particular ways.

Conceptually our paper highlights the problems of analysing both migrants and elites as separate bounded groups whose primary loyalty is towards the social reproduction of their own groups. It questions the clear divide that often exists between the analysis of migrants and non-migrants' experiences, arguing that difference and distinction are not complete but are contextual. While migration may be the most definitive aspect influencing the labour market outcomes of migrants, their lives are also deeply influenced by the regulations, practices and networks of non-migrants. The network practices of non-migrants, therefore, require as much attention as those of migrants, and should all be analysed as occupying the same habitus and occurring relationally. Key figures emerge in the discipline networking with whom provides opportunities for migrants and non-

migrants although not to the same extent. Migrants' cultural capital, education and skills can only become validated through the social capital they generate through relations with non-migrants. These networks shape the contexts in which migrants attempt to convert their pre-migration capital in the post-migration context, limiting but not foreclosing opportunities for migrants. By analysing these networks through the lens of habitus (Bourdieu, 1986) the co-presence and the relationality of migrant and non-migrant networks and of cultural and social capital may be better understood. It poses challenging questions regarding the reproduction of privilege both in the pre-migration and post-migration scenario.

Methodologically, this paper has provided a longitudinal view of the continuing importance of certain kinds of networking within medicine. The simultaneous use of two different sets of oral history interviews, drawn from non-migrants and migrants, each talking about their own networks, as well as that of others, reinforces the need to ensure that migrant voices are studied alongside those of the non-migrants who play significant roles in shaping migrant work experiences. The strong sense of temporality that our interviewees offer also advances existing literature as the notion of temporality is extended beyond the migrant's life span (Ryan et al.,2008) to include the changing nature of the labour market.

In policy terms, within the medical profession there is an acceptance that patronage and sponsorship have over a long period of time played a pivotal role in doctors' career

progression in the NHS. For example a survey undertaken by the BMA in 2003 concluded that in

> "this environment of artificial competition, where only 'outstanding' candidates have any chance of progress, is a breeding ground for prejudice. Opaque selection criteria means that patronage of the 'golden boy', rather than competency, governs progression." (Cooke et al 2003, 11)

However as we have illustrated the relationship between merit and patronage within these networks is far more complex, involving both processes of inclusion and exclusion for migrants. Clearly the power of these networks to shape the labour market and to affect recruitment and diversity policies have caught the attention of policy-makers but are yet to be transferred and translated into the literature on migrant networks and social capital. This paper offers a first step towards this.

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[1] The term non-migrant is used as a heuristic device to differentiate them from the mostly white 'British' doctors who were interviewed by Jeffreys.

[2] 'South Asian doctors' here means doctors who obtained their first medical qualification in South Asia.

[3] For analyses of the discursive quality of oral history material see Perks & Thomson (2006) and of comparing datasets see Bornat et al (2008).

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

[5] Similar patterns can be seen in psychiatry and general practice.

[6] Race as embodied cultural capital, was critical because reliance on references from doctors in New Zealand and Canada did not disadvantage migrants from there (Smith, 1980). However, UK born Asian doctors too were not excluded in the same way as migrant doctors.

[7] 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. SAG interviews have stipulations for access and have been anonymised.

[8] Through the early 1970s the status of geriatrics improved. For instance, in 1972/73 a standing committee on geriatric medicine was set up in the Royal College of Physicians and in 1973 the first 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.

[9] Medical graduates' early training followed this path: house officer, senior house officer, registrars. The latter two posts were heavily populated by migrant doctors. Migrants found it difficult to move from registrar posts to senior registrars, a post which was seen as preparatory to a consultant post.