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THESIS TITLE

THE MIGRATION AND RACIALISATION OF DOCTORS FROM THE INDIAN SUBCONTINENT

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SUMMARY

This research identifies and examines the circumstances and processes surrounding the migration and racialisation of doctors from the Indian subcontinent to Britain. Theoretically the research will critically evaluate several current debates within sociology and reconstructs a different set of criteria to that which has until recently governed investigations into racism.

The research argues that the concept of 'race' is an ideological construction with no analytical role to play in the investigation of racism and discrimination. The real object of analysis is the development and reproduction of racism as an ideology within specific historical and material conjunctures determined by the uneven development of capitalism. Within this context a full explanation of the migration and racialisation of doctors from the Indian subcontinent requires not only an examination of the post-war era, but also an investigation of the origins of that migration and racialisation during the pre-1945 period when India was the subject of British rule.

A great deal of contemporary research on migration and racism, has tended to concentrate on unskilled and semi-skilled migrant labour. This study will focus on the neglected area of the 'professions', through an investigation of doctors from the Indian subcontinent and their relationship with the British 'professional' occupation of medicine. Through the exegesis and critique of the 'sociology of professions', the research will demonstrate that doctors from the Indian subcontinent represent a racialised fraction of the new middle class.

The main question surrounding the analysis of the relationship between Indian doctors and the British 'professional' occupation of medicine as 'gatekeepers' of the occupation, will focus on the relationship between professionalism and racism. The research will contend that the content of professionalism does not merely define certain occupations as 'professions', but more importantly, professionalism like racism is an ideology. Professionalism not only operates to justify and legitimate the supposed special status of medicine, but it also reinforces racist exclusionary practices in a 'sanitised' form within the occupation.

This provides the research with the rare opportunity of analysing the nature and content of two ideologies operating within the same arena: the relationship between racism and professionalism. This will illustrate that the racism which black migrant 'professional' labour is subject to, does not only operate in a functional way for capitalism in providing labour for the less desirable specialisms of medicine, but also operates through the mediation of the occupation of medicine to help reproduce the 'professional status' of the occupation.

LIST OF ABBREVIATIONS

AIMC	All India Medical Council
BMA	British Medical Association
BMJ	British Medical Journal
CRE	Commission for Racial Equality
DHSS	Department of Health and Social Security
EEC	European Economic Community
EIC	East India Company
GMC	General Medical Council
IMD	Indian Medical Department
IMS	Indian Medical Service
NEC	National Executive Council
NHS	National Health Service
ODA	Overseas Doctors Association
PLAB	Professional and Linguistic Assessment Board
PSI	Policy Studies Institute
RHAs	Regional Health Authorities
RAMC	Royal Army Medical Corps (India)
TRAB	Temporary Registration Assessment Board

C H A P T E R I:

I N T R O D U C T I O N

This research is offered as a contribution and stimulus to the recent embryonic debates within sociology concerning racism and the 'professions'. [CRE: 1987a; 1987b] It focuses on racism within the 'professional' occupation of medicine by identifying and examining the circumstances and processes surrounding the migration and racialisation of doctors from the Indian subcontinent. Migrant doctors from the Indian subcontinent were chosen as the doctor group to be investigated, because they have historically been shown to be the largest grouping of black migrant doctors working in the National Health Service.

The way in which this question arose and has been constructed, implies a different starting point of analysis from that which usually governs research into racism and the 'profession' of medicine. This is a result of moving beyond the confines imposed by the sociology of 'race relations', and utilising an alternative conceptualisation of racism and discrimination.

Preliminary research in this area had indicated to me, that there was a gap in the literature on racism and the 'professional' occupation of medicine. In the past the

focus has been on identifying whether and to what degree, black migrant doctors working in Britain are the object of racist discrimination. [CRC: 1976; Smith: 1980; Anwar and Ali: 1987] These 'snap-shot' studies tell us that black migrant doctors are discriminated against, but provide little detail on how the racism they face occurs. A 'problem' is identified, but its origins and reproduction are largely left unexplored.

This failure to take account of the historical context of racism and black doctor migration, is, I want to argue, primarily the result of these research studies operating within what has been termed a 'race relations' perspective. Essentially the sociology of 'race relations' remains within the 'mythology of race'. What I mean by this, is that until very recently sociology has accepted the view that certain social relations, which are set within a framework which divides the the worlds population into distinct 'races' and ranks them hierarchically, result in racism and discrimination. The supposed existence of distinct 'races', the relations between these 'races', and the racism and discrimination which derive from these 'race relations', become the objects of analysis for this perspective. The fact that people believe that the worlds population can be divided into distinct 'races' which are then

ranked hierarchically, is the starting point of analysis for the sociology of 'race relations'.

This research, however, argues that there is a fundamental flaw with the approach of the sociology of 'race relations'. There is no scientific evidence to support the belief that the world's population can be divided into distinct 'races'. Neither the pseudo-science of the nineteenth century, nor contemporary genetics provides a scientific basis for 'race categorisation'. Consequently, the concept of 'race' and its derivative, 'race relations', have no analytical value. They should not be used as the starting point of analysis.

This leaves us with three questions which need to be addressed. First, if the concept of 'race' and its derived problematic, 'race relations', do not actually exist, then what do these phenomena which people continue to believe in, represent. Second, if racism and discrimination do not derive from relations between the supposed distinct 'races', how do we explain the existence of racism and discrimination. Third, what should be the starting point of sociological analysis,

given the fact that the concept of 'race' has no objective reality.

The first question is resolved when we recognise that the concept of 'race' and the 'race relations' problematic, merely represent ideas. They are the ideas through which we as people come to make sense of and understand the world in which we participate. In this sense, 'race' represents a social construction. It is the social significance attributed to certain characteristics, such as skin colour, which structure the social relations between social groups, rather than their supposed actual existence as distinct 'races'.

The second question, concerning the manner in which we explain the existence of racism and discrimination, is derived from the resolution of the first. The social construction of 'race' implies a historical and social process of 'race-making', or racialisation. Racialisation refers to the political and ideological process whereby the idea of 'race' is historically created and reproduced. It is this historical, political and ideological process of racialisation which creates and reproduces racism as an ideology and discrimination as its practice.

The third question, relating to the appropriate starting point of analysis, is resolved as a consequence of conceptualising the creation and reproduction of the ideology of racism, as an integral constituent of the racialisation process. When we recognise that racism occurs as a result of a historical process, we also recognise that in order to fully understand how it operates within the material world at any given point in time, we have to trace the basis of its historical development. The starting point of analysis should be concerned with how people historically have come to believe that 'races' exist and how that belief is continually reproduced.

The analysis of racism and discrimination, therefore, is an historical project. It requires an exploration of the circumstances and processes surrounding its creation and reproduction. In relation to this research, therefore, we can only begin to fully understand the specific form of occupational racism and discrimination faced by black migrant doctors from the Indian subcontinent, by both tracing its origins within Britain's colonial rule in India, and its subsequent reproduction in the post-1945 period.

Even given this alternative historical conceptualisation of racism, a complete understanding of the circumstances and processes involved in the racialisation of black migrant doctors from the Indian subcontinent, is not possible without taking into account the impact of professionalism upon that process. I will argue that professionalism like racism, is an ideology. As an ideology it operates to justify and legitimate the special status accorded the occupation of medicine.

More importantly, however, it will be argued that professionalism as an ideology can operate to reinforce racist exclusionary practices, by obscuring their racist content within the politically neutral language of professionalism. The occupation has historically legitimated increased controls on black migrant doctors from the Indian subcontinent by containing the debate within the issue of 'professional' standards.

The main conclusion to be drawn from this, is that during its racialisation of black migrant doctors from the Indian subcontinent, the occupations claims to 'professional' status were reinforced. Throughout the history of this racialisation process, which will be shown to span the period from British colonial rule in

India through the agency of the Indian Medical Service to its continued reproduction in the post-1945 era of doctor migration to Britain, the British 'professional' occupation of medicine used 'professional' criteria to problematise black migrant doctors. In doing this, the occupation was able to present itself as defenders of 'professional' medical standards. Consequently, in the process of racialising black migrant doctors, it also reproduced and reinforced the ideology which allowed the occupation to be successful in its racialisation of black migrant doctors in the first place.

The issue of ideological articulation between racism and professionalism provides the research with the rare opportunity to investigate the nature, content, and the relationship between two distinct ideologies operating within the same social and political arena. The alternative historical conceptualisation of racism referred to earlier, enables the research to move beyond the static, 'snap-shot' research which is usually undertaken concerning the 'problem' of migrant doctors working in Britain. In addition, by focussing on the 'professional' occupation of medicine, the research contributes to the comparatively small amount of investigative work done in relation to black 'professionals' in contemporary Britain. Research on

racism has traditionally concentrated on the situation of the black working class in Britain.

The presentation of the research which follows is divided into five chapters covering Chapter II to Chapter VII. Chapter II presents a brief outline of the historical context of doctor migration from the Indian subcontinent to Britain. Chapter III is divided into two distinct parts. The first part elaborates the central theoretical concepts which will be used to analyse the historical evidence in Chapters IV, V and VI. The second part provides an outline of the methods used. Chapter IV is also divided into two parts. The first part outlines the historical roots of British racism, while the second part connects this to the specific relationship between British and Indian doctors during Britain's colonial rule of India. Chapters V and VI provide a detailed historical account of the the creation and reproduction of British racism and the racialisation of black migrant doctors during the post-1945 period. Chapter V covers the period between 1945 and 1974, and Chapter VI 1974 to 1990 (with a summary of the whole period). Chapter VII presents the conclusions drawn from the preceding analysis, and offers some thoughts on the implications for the future.

CHAPTER II:

DOCTOR MIGRATION TO BRITAIN: A HISTORICAL OVERVIEW

INTRODUCTION

This chapter will provide a brief outline of the historical context of doctor migration from the Indian subcontinent to Britain. This will be done by reference to the available statistical evidence on doctor migration to Britain, the influence of both the 'professional' occupation of medicine and the British State on those migration flows, and an examination of recent research into the position of migrant doctors working in Britain. First, the reasons behind the migration of doctors to Britain will be identified.

BRITAIN'S DEMAND FOR MIGRANT DOCTORS

The demand for migrant doctors in Britain is usually linked to the creation of the NHS in 1946 and the expansion of health provision associated with this. Some of the first labour recruitment drives were initiated by the administrators of the NHS. In 1941 'aliens' were recruited as nurses, and in 1948 selection committees were set up in sixteen UK colonies to recruit nurses and midwives. [Doyal: 1980]

This specific demand for labour in the NHS, coincided with general labour shortages in the UK economy after the Second World War. Britain was utilising labour from the European Volunteer Force and ex-service personnel from the New Commonwealth. Indeed, as early as 1947, a Government Economic Review recognised that migrant labour was the only substantial additional source of labour power available to Britain. [Unit for Manpower Studies: 1976]

Other political policy decisions, historic colonial links, and individual motivations, combined to encourage migrant doctors to come to Britain to train and work. In the Policy Studies Institute (PSI) research on migrant doctors in the NHS, Smith suggests that poor medical labour power planning in Britain, was one factor in the demand for migrant doctors. [Smith: 1980] The Willink Committee of 1957, greatly underestimated Britain's future doctor labour power requirements. These low estimates then served as the foundation for planning the output of British medical schools for the following fifteen years. Consequently, the NHS could not be provided with sufficient number of British medical graduates to meet its service needs.

In relation to doctor migration from the Indian subcontinent, Smith further suggests that migration from this area developed naturally from ex-colonial links. The hospital services in India (and the other areas of the subcontinent where Britain governed), were established by the British administration in a similar form to that operating in Britain, and medical training and practice were carried out in English. The independent government in India subsequently extended the pattern of the medical system, based on the British model. [Smith: 1980]

Historically, Indian medical graduates had come to Britain to gain postgraduate qualifications and to qualify for entrance into the Indian Medical Service. This will be referred to in greater detail in Chapter IV. The colonial connection between Britain and India, therefore, had resulted in the exchange of doctors for many years prior to the post-1945 medical labour needs of the NHS.

The circumstances which motivated New Commonwealth doctors to migrate to Britain, were not solely related to the relative earning levels. Research by both the PSI and the Commission for Racial Equality (CRE)

provides us with more specific reasons why doctors migrated to Britain from the New Commonwealth. Both studies show that migrant doctors come to Britain primarily to obtain further qualifications and experience. [Smith: 1980; Anwar & Ali: 1987]

It should be remembered, however, that economic demands for labour, political policy decisions, historic colonial links and individual motivations, occur within certain structural determinants. The migration of New Commonwealth labour to Britain needs, therefore, to be analysed within the context of the uneven development of capitalism internationally. [Phizacklea: 1984; Miles: 1990] In general terms, economic stagnation in the New Commonwealth, combined with population growth, led to increasing unemployment and greater competition for the jobs that were available. [Layton-Henry: 1984] Britain on the other hand, was experiencing large scale economic expansion as a result of post-war reconstruction. In the specific case of migrant doctors, it was the lack of postgraduate medical training in the Indian subcontinent and its availability in Britain, combined with the shortage of qualified doctors in a rapidly expanding NHS, which facilitated the movement of medical labour power.

STATISTICAL DATA ON MIGRATION FLOWS

Detailed historical statistical information concerning migration to Britain from the Commonwealth is scarce. This is especially true in relation to migrant doctors. Immigration statistics rarely contain data providing a breakdown by occupation, and labour statistics collected by the Department of Health and Social Security (DHSS) do not distinguish between the various country's of birth. At best, DHSS data only indicates the historically increasing reliance on migrant doctors by the NHS.

The only official data collected prior to the 1962 Commonwealth Immigrants Act, concerns the migration flows in and out of Britain by sea, contained in the Central Statistical Office Annual Abstract of Statistics. The Home Office from 1955 onwards maintained incomplete estimates of migration flows between Britain and the New Commonwealth and Pakistan, in its Control of Immigration Statistics. In addition, the International Passenger Survey (IPS), undertaken by the Office of Population Censuses and Surveys (OPCS), carries out a sample survey of migration flows at seaports and airports. The IPS, however, includes all migrants whereas immigration statistics are confined to

those migrants who are the subject of immigration control, and therefore, the two sets of data are not comparable. [Gordon: 1988]

Since 1962, the Home Office has attempted to be more systematic with its Control of Immigration Statistics, by publishing annual statistics of people entering Britain who are subject to immigration control. Except for a short period between 1968 and 1971, however, there is an absence of any really detailed information concerning the occupation (intended or otherwise) of migrants. Table 1 reproduces these data in relation to doctor migration into Britain. It is reasonably clear from Table 1, that New Commonwealth doctors constitute a substantial majority of the total migrant doctors entering Britain to practice medicine over the period identified, between 1962 and 1971.

The only other source of official data on doctor migration is provided by the DHSS Annual Digest of Health Statistics series, which was begun in 1969, although in relation to doctors the data itself begins a little earlier. Unfortunately, as with so many official statistics, the criteria on which the data is collated has changed several times. For both hospital doctors

Table 1
Number of Category B Voucher Doctors Arriving Between 1968 and 1971 [1]

	1968		1969		1970		1971	
	No.	%	No.	%	No.	%	No.	%
NEW COMMONWEALTH								
India	782	77	735	74	211	52	193	49
Pakistan	176	17	184	18	47	12	48	12
Ceylon	27	3	14	1	27	7	33	8
Total	985	98	933	94	285	71	274	69
OLD COMMONWEALTH								
Australia	7	1	19	2	59	15	57	14
Canada	1	*	3	*	0	0	2	1
New Zealand	8	1	22	2	27	7	31	8
Total	16	2	44	4	86	21	90	23
OTHERS	9	1	19	2	32	8	32	8
TOTAL	1010		996		403		395	
DOCTORS AS A % OF TOTAL VOUCHERS ISSUED	45		57		26		24	

[1] From June 1st 1971 doctors no longer required employment vouchers to practice in Britain, but were admitted with Entry Certificates only.

Note: Total and sub-total percentage columns may not add-up correctly due to rounding.
* = too small a number to register as a percentage.

SOURCE: Compiled from Home Office: Control of Immigration Statistics (Annually: 1968-71)

and general practitioners, the geographical coverage has changed from England and Wales (up to 1972) to England only from 1972 onwards. In addition, the classification by grade of hospital doctors had changed at least twice (although this is not significant for our present purposes).

For our purposes, however, the major drawback with this data, is its failure to categorise migrant doctors by country of birth and/or country of first qualification. For hospital doctors, the series classifies doctors by place of birth with two categories: 'UK and Irish Republic' and 'Elsewhere'. For general practitioners, there are three place of birth categories: 'Great Britain', 'Other UK and Irish' and ' Elsewhere' (as well as classification by sex). This data is presented in Tables 2a-2d and Tables 3a-3d.

The only significant information the above tables illustrate, is how heavily the NHS relies on migrant doctors to meet its demand for doctors, and therefore, ensure its service provision. For example, over the time periods identified, migrant doctors have consistently represented over one-third of all hospital doctors working in the NHS, except for a slight decline

Table 2a
Hospital Doctors; Analysis By Place Of Birth (ENGLAND & WALES 1967-1971)

	1967		1968		1969		1970		1971	
	No.	%	No.	%	No.	%	No.	%	No.	%
ALL STAFF										
All Places of Birth	22547	100.0	23376	100.0	24131	100.0	24775	100.0	25669	100.0
UK / Irish Republic	15417	68.4	15770	67.5	16076	66.6	16558	66.8	17282	67.3
Elsewhere	7130	31.6	7606	32.5	8055	33.4	8217	33.2	8387	32.7

Table 2b
Hospital Doctors; Analysis By Place Of Birth (ENGLAND 1969-1973)

	1969		1970		1971		1972		1973	
	No.	%	No.	%	No.	%	No.	%	No.	%
ALL STAFF										
All Places of Birth	22855	100.0	23478	100.0	24353	100.0	25469	100.0	26752	100.0
UK / Irish Republic	15295	66.9	15745	67.1	16447	67.5	16938	66.5	17475	65.3
Elsewhere	7560	33.1	7733	32.9	7906	32.5	8531	33.5	9277	34.7

Table 2c
Hospital Doctors; Analysis By Place Of Birth (ENGLAND 1974-1978)

	1974		1975		1976		1977		1978	
	No.	%	No.	%	No.	%	No.	%	No.	%
ALL STAFF										
All Places of Birth	27576	100,0	28922	100,0	29719	100,0	30520	100,0	31515	100,0
UK / Irish Republic	17949	65,1	18755	64,8	19433	65,4	20236	66,3	20984	66,6
Elsewhere	9627	34,9	10167	35,2	10286	34,6	10284	33,7	10531	33,4

Table 2d
Hospital Doctors; Analysis By Place Of Birth (ENGLAND 1979-1984)

	1979		1980		1981		1982		1983		1984	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
ALL STAFF												
All Places of Birth	32607	100,0	33475	100,0	34218	100,0	34585	100,0	35238	100,0	35338	100,0
UK / Irish Republic	21856	67,0	22715	67,9	23472	68,6	24025	69,5	24994	70,9	25243	71,4
Elsewhere	10751	33,0	10760	32,1	10746	31,4	10560	30,5	10244	29,1	10095	28,6

Source: Compiled from DHSS Digest of Health Statistics (Annually; 1967-84)

Table 3a

General Medical Practitioners; Unrestricted Principals; Analysis By Place Of Birth (ENGLAND & WALES 1965-1971)

	1965		1969		1970		1971	
	No.	%	No.	%	No.	%	No.	%
All Places of Birth	20014	100,0	20133	100,0	21357	100,0	20633	100,0
UK / Irish Republic	17759	88,7	17440	86,7	17471	85,8	17558	85,1
Elsewhere	2255	11,3	2693	13,4	2886	14,2	3075	14,9

Table 3b

General Medical Practitioners; Unrestricted Principals; Analysis By Place Of Birth (ENGLAND 1968-1974)

	1968		1970		1971		1972		1973		1974	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All Places of Birth	18732	100,0	19099	100,0	19374	100,0	19775	100,0	19997	100,0	20219	100,0
UK / Irish Republic	16301	87,0	16332	85,5	16426	84,8	16618	84,0	16647	83,2	16654	82,4
Elsewhere	2431	13,0	2767	14,5	2948	15,2	3157	16,0	3350	16,8	3565	17,6

Table 3c

General Medical Practitioners: Unrestricted Principals: Analysis By Place Of Birth (ENGLAND 1975-1980)

	1975		1976		1977		1978		1979		1980	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All Places of Birth	20377	100,0	20551	100,0	20796	100,0	21040	100,0	21357	100,0	21812	100,0
UK / Irish Republic	16641	81,7	16647	81,0	16706	80,3	16994	79,8	16871	79,0	17075	78,3
Elsewhere	3736	18,3	3904	19,0	4090	19,7	4256	20,2	4486	21,0	4737	21,7

Table 3d

General Medical Practitioners: Unrestricted Principals: Analysis By Place Of Birth (ENGLAND 1981-1986)

	1981		1982		1983		1984		1985		1986	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All Places of Birth	22304	100,0	22786	100,0	23254	100,0	23640	100,0	24035	100,0	24460	100,0
UK / Irish Republic	17326	77,7	17627	77,3	17963	77,2	18241	77,1	18539	77,1	18854	77,1
Elsewhere	4978	22,3	5159	22,6	5291	22,7	5399	22,8	5496	22,9	5606	22,9

Source: Compiled from DHSS: Digest of Health Statistics (Annually; 1965-1986)

in 1983 and 1984. Migrant doctors working as general practitioners (GPs) have nearly doubled as a proportion of the total of GPs working in the NHS over the same period.

The decline in the proportion of migrant doctors working in the hospital sector in the years 1983 and 1984, is due to the British medical professions successful campaign to place greater controls on the entry of migrant doctors generally, and black migrant doctors in particular. This decline in the proportion of migrant doctors working in the NHS will probably extend into the migrant doctor GP population, and will continue for both groups of doctors in the future.

Smith identifies a 'time lag' between migrant doctors working as hospital doctors and moving into general practice, as a result of difficulties in obtaining specialist and consultant hospital work of their choice. [Smith: 1980] Consequently, there will be a 'time lag' between a proportional decline in the migrant hospital doctor population, and its corresponding reflection in the migrant GP population. The decline for both groups of doctors will continue as new immigration regulations place increased restrictions on their entry into the UK.

CONTROLS ON MIGRANT DOCTORS

The influence of the State on the migration of doctors from the Indian subcontinent has taken two main forms. On the one hand, it has implemented a series of laws to restrict immigration to Britain since 1962, which as we shall see had both a direct and indirect impact on both immigration and racialisation of Indian doctors. On the other, it has instigated various committees and reports examining migrant doctors working in Britain. The influence of the 'professional' occupation of medicine operates through its various occupational organisations, such as the British Medical Association (BMA) and the Royal Colleges. The occupation has the power to influence government committees in all matters concerned with health, and makes its opinion known to the general public through the media.

Official and 'professional' concern over the standards of migrant doctors working in Britain appears to have surfaced in the early 1960's. This concern focused upon their clinical competence and ability to speak English. Gish indicates that as early as 1962, the quality of postgraduate training and the experience gained in Britain by migrant doctors was identified as below that

which was deemed sufficient to guarantee safe medical practice. [Gish: 1969]

As a result of this concern, the Porritt Report of 1963, which investigated medical aid to 'developing' countries, suggested that a voluntary assessment scheme should be instigated for migrant doctors working in Britain. This assessment would involve a clinical attachment for a period of two months before a recommendation for appointment to a permanent post could take place. The underlying principle at this time was that migrant doctors were not receiving the necessary training and experience which would be of use to them on their return to their country of origin. [Gish: 1969]

This theme of assessment for migrant doctors on entry into Britain to work, was continued in 1969 when the then head of the DHSS, Richard Crossman, suggested that compulsory assessment was now necessary for migrant doctors who wished to work in British hospitals. [Gish: 1969] The emphasis had changed from assessment for the benefit of the doctor to assessment for the benefit of the British hospital service.

Assessment through clinical attachment, however, did little to assuage concern over the competence of migrant doctors. Throughout the early 1970's, clinical competence and ability to speak English remained as the central debate concerning migrant doctors in the NHS. This period culminated with the Merrison Report in 1975, which investigated the regulation of the medical profession. Using evidence from the Royal Colleges concerning the relatively poor pass rates of doctors from the Indian subcontinent compared to their white overseas counterparts, the report came to the *"inescapable conclusion"* that:

> *... there are substantial numbers of overseas doctors whose skill and the care they offer to patients fall below that generally acceptable in this country.* (1)

Following the publication of the Merrison Report, the General Medical Council (GMC) acted on the supposed substandard competence of many migrant doctors. Immediately prior to the publication of the Merrison Report, eighty six overseas medical schools were recognised by the GMC for the purposes of full registration, with fifty five of these located in India. Following publication of the Report, the GMC withdrew recognition for full registration from all Indian colleges because the council was not satisfied as to the

standard of the qualifications granted. [Anwar & Ali: 1987]

The GMC, however, did recognise these qualifications for the purposes of temporary registration. At the same time, the GMC initiated the Temporary Registration Assessment Board to test migrant doctors who were eligible for temporary registration in medical and linguistic ability. In January 1976, temporary registration was also made conditional upon the completion of one years interneeship in a hospital before coming to Britain. [Anwar & Ali: 1987]

The GMC at this time granted three kinds of registration: provisional, temporary and full. Full registration means that there are no limitations on the practising doctor. In order for a migrant doctor to be recognised by the GMC for full registration, the primary medical qualification and practical experience obtained (which should be of a broadly similar nature to that undertaken by a British qualified doctor during the first pre-registration year as a resident House Officer in a hospital) should meet the approved standard. [Smith: 1980]

Provisional registration is the kind normally held by British qualified doctors during their first year of practice after obtaining their Bachelor of Medicine or equivalent. Following this first year as House Officer in a hospital, they are usually eligible for full registration. Most migrant doctors do not apply for provisional registration, because usually they undertake their first year of practical experience in the country of first qualification. [Smith; 1980]

Temporary registration places certain restrictions upon doctors. They have to work in a specified post for a specified period, and registration is tied to that post. This means that a migrant doctor has to be accepted for the post prior to applying for temporary registration. The registration lasts for twelve months only, and the doctor has to re-apply at the end of this period. Finally, temporary registration is confined to hospital posts and is not available for general practice. [Smith; 1980]

Clearly the ending of reciprocity arrangements with India and other New Commonwealth countries by the GMC in 1975, indicated that what were once recognised qualifications for the purposes of full registration to

practice in Britain, were now deemed unsatisfactory. In addition, those doctors who entered the UK with these qualifications, were now subject to increased controls on their occupational activities and training while on temporary registration.

Two further changes occurred in the 1970's. First, in 1976, as a consequence of Britain joining the European Economic Community (EEC), new EEC medical directives allowed free movement of doctors within the community to those who were nationals of EEC countries and held basic qualifications obtained within the community. Under these regulations, however, British nationals whose basic medical qualifications were obtained outside of the EEC, such as migrant doctors from India, would be denied this free movement within the EEC. [CRC: 1976] Second, the 1978 Medical Act replaced temporary registration with limited registration. Migrant doctors who were eligible for limited registration would only be able to qualify for full registration after being in Britain for five years. [cited in Anwar & Ali: 1987]

The British 'medical professions' campaign to place increasing restrictions on the entry and activities of black migrant doctors, also influenced the British

state's stance on immigration regulations. Initially, however, New Commonwealth migrant doctors were largely exempt from the increasing constraints immigration legislation imposed on other New Commonwealth migrants attempting to enter Britain.

Historically, it had been a custom and practice of the British Empire that all its citizens were equal subjects under the Crown. This principle was enshrined in the the 1948 British Nationality Act. The Act gave all citizens of the UK and its Colonies, and independent Commonwealth countries, equal citizenship rights. All British subjects, therefore, had a right to enter and settle in the UK without restriction. [Handsworth Law Centre: 1980]

The 1962 Commonwealth Immigrants Act for the first time placed restrictions on Commonwealth citizens entering Britain. The Act, therefore, extended the statutory control of immigration from 'aliens' only, to include British subjects. From 1962 onwards, all Commonwealth citizens (ie. all British subjects and British Protected Persons, except those born in UK and those UK citizens who held a British Passport), who wished to enter Britain to work and settle had to possess an employment

voucher, issued by the Ministry of Labour. Migrants from the Republic of Ireland were exempted from these provisions. [Evans: 1983] This demonstrates the extent to which the British State wanted to exclude black migrants specifically, and continue to encourage 'white' migration from Eire.

Ministry of Labour employment vouchers could be obtained under three categories: 1) category A vouchers were for applications by employers in the UK who had a specific job to offer which could not be filled by indigenous labour; 2) category B vouchers were for applications by those with specific skills and qualifications which were in short supply in the UK (although with no specific job to go to on arrival). Doctors and dentists were among those occupations specified under this category; 3) category C vouchers were for applications by those who were unskilled and without a pre-arranged job to go to on arrival. [Evans: 1983]

In the first year of the 1962 Act a total of 400 employment vouchers per week (ie. almost 21,000 per annum) was set to be issued. As early as 1965, however, with the publication of a White Paper on Commonwealth Immigration, category C vouchers were discontinued, and

the total vouchers issued was to be reduced to an effective 7,500 per year for categories A and B. [Gish: 1968] Gish suggests that this measure had the effect of reducing the inflow of Commonwealth migrant voucher holders by two-thirds, [Gish: 1968: p32] although it is clear that those migrants who continued to be eligible for category A and B vouchers remained a priority for the British economy: doctors and dentists included.

The next major immigration legislation to effect migrant doctors, came with the 1971 Immigration Act. The general principal of the Act was to introduce the notion of patrial. Broadly speaking, a patrial is someone who is either: 1) a citizen of the UK and Colonies who was born, registered or naturalised in the UK and Islands, or had a parent or grandparent which meet these criteria, or had been resident in the UK for at least five years; or 2) a citizen of a Commonwealth country and had a parent born in the UK and Islands and was a citizen of UK and Colonies, or is/had been married to a man with patrial status. From January 1973 onwards, all Commonwealth citizens who were not categorised as partials would be in the same position as 'aliens' for purposes of entry and settlement in the United Kingdom. [Evans: 1983]

The 1971 Act abolished the employment voucher system and it was now necessary for all nationals outside the EEC to have a work permit. The permit normally lasted for 12 months and restricted the holder to a particular job with a specific employer who had applied for it. Migrant doctors were exempted from the work permit system, and only required an entry certificate in order for them to take up medical posts in the UK. [Evans: 1983, Handsworth Law Centre: 1980]

This largely laissez-faire attitude to the entry of migrant doctors remained without significant change until new immigration rules were introduced in April 1985. These new rules in combination with the advent of limited registration, effectively removed the special exemptions which had previously governed the entry of migrant doctors and dentists into Britain to train and work. Under these new regulations, migrant doctors had to undertake medical and language assessment examinations on entry to the UK as visitors. If they passed the test, then they were eligible to apply for limited registration and could request the Home Office to allow them to remain in Britain with a permit-free status for the purpose of undertaking postgraduate training in a hospital for up to four years. [Anwar & Ali: 1987] All other migrant doctors seeking to work in

Britain would be subject to the same work permit restrictions as all other migrant labour entering Britain.

RESEARCH DATA ON MIGRANT DOCTORS

'Professional' and political concern over migrant doctors working in the NHS, prompted three research initiatives in the late 1970's and early 1980's. [CRC: 1976; Smith: 1980; Anwar & Ali: 1987] These studies, either rely on aggregate national data similar to that presented above, or on sample surveys which represent little more than a 'snap shot' picture of migrant doctors, or a combination of the two. The authors concur that a detailed historical overview of doctor migration is difficult, if not impracticable, due to the lack of historical data. Consequently, while these studies do not contribute significantly to a historical understanding of doctor migration, they do provide additional information on the position of migrant doctors working in Britain.

The three studies illustrate that Britain relies heavily on the labour of migrant doctors generally, and doctors from the Indian subcontinent in particular. One-quarter

of all doctors working in the NHS are migrant doctors: about one-fifth of GPs and about one-third of hospital doctors, with the majority originating in the Indian subcontinent.

All three studies also conclude that black migrant doctors are a disadvantaged grouping within the occupational structure of medicine. The evidence of the research indicates that migrant doctors from the New Commonwealth are: 1) over-represented in the lower hospital grades and under-represented in the higher hospital grades; 2) over-represented in the less popular hospital specialties and under-represented in the more popular hospital specialties; 3) generally only reach higher hospital grades in those specialties which are less popular; and 4) under-represented in the teaching districts. [CRC: 1976; Smith: 1980; Anwar & Ali: 1987]

The under-representation of black migrant doctors in teaching hospitals is significant because migrant doctors come to the UK primarily to gain more experience and qualifications. Teaching hospital districts are generally regarded as offering a wider range of training opportunities than non-teaching ones, and in the case of

London teaching hospitals their workloads are generally lighter.

The study for the Commission for Racial Equality by Anwar and Ali (1987), provides the clearest evidence that the disadvantaged position of black migrant doctors is due to racist discrimination. The primary objective of the research was to compare the position of white and black British-trained doctors with similar qualifications.

Although the numbers of British trained black doctors was relatively small and the findings concerning them could only be regarded as indicative rather than conclusive, the report argued that in relation to the main segregation patterns, black British-trained doctors were located in very similar positions to their black overseas-trained colleagues. [Anwar & Ali: 1987] This suggests that country of birth and first qualification are less significant factors in recruitment and career progress, than one's supposed 'racial' classification.

SUMMARY

This chapter has attempted to provide a brief outline of the historical context of doctor migration from the Indian subcontinent. It has been shown that this migration has occurred within the parameters set by the uneven development of capitalism internationally. India's inability to develop its British based system of medical care in terms of postgraduate medical training, and Britain's need for qualified doctors in an expanding NHS, provided the basis for this migration.

Britain's NHS also benefited economically from this arrangement. By encouraging the migration of already qualified doctors from the Indian subcontinent, doctors who had been trained in the 'British way', Britain did not have to fund their initial training. The costs of producing this qualified migrant labour had been born by India.

Comprehensive historical data on this transfer of medical labour, is scarce. Only in recent years have the DHSS and Home Office collected and published anything approaching effective records. Despite this, no information is provided in relation to a detailed

breakdown of country of origin or first qualification. At best, the data only indicates how heavily the NHS has relied on migrant doctors to meet its service needs.

The degree to which the NHS has relied on migrant doctors is, however, likely to be less in future years. Both the British 'professional' occupation of medicine and the State have operated to restrict the entry and the activities of black migrant doctors in particular. The 'profession' actively sought to question the competence and standards of black migrant doctors, and as a result was able to impose increasing restrictions on their entry in terms of assessment procedures, reform of registration requirements and withdrawal of reciprocity in the recognition of qualifications.

The British State supported these changes within the 'professional' occupation of medicine, and importantly gave official recognition to the 'problem' of black migrant doctors through the Merrison Report. In addition, it subsequently removed the exemptions black migrant doctors had historically received in relation to immigration regulations.

The supposed 'problem' of black migrant doctors, also gave rise to a number of research projects which investigated their situation in Britain. This research data consistently identified the fact that black migrant doctors in particular were located in a disadvantaged position within the 'professional' occupation of medicine. They were over-represented in the lower hospital grades, the less popular specialties and the non-teaching districts, and under-represented in the higher hospital grades, the more popular specialties and the teaching districts. They tended to reach the higher hospital grades only in those specialties which were less popular.

Evidence from the CRE, which compared the position of white British trained doctors and black British trained doctors, illustrated that black British trained doctors were located in very similar positions to their overseas trained colleagues. This clearly indicates that it is not necessarily the doctors country of birth or first qualification which mitigates against career progress in the NHS, but rather it is the doctors supposed 'racial origin' which largely determines their disadvantaged position in the medical occupational structure.

The above historical overview of doctor migration to Britain, has indicated that processes have operated to first, encourage the migration of doctors from the Indian subcontinent to Britain, and then second, to produce various mechanisms of restrictive controls on that migration movement. The complex detail of those processes is the subject matter of Chapters, IV, V and VI. These chapters will investigate how the ideologies of racism and nationalism, and professionalism, have operated as mechanisms of inclusion/exclusion and justified discrimination and disadvantage in the 'professional' occupation of medicine. Before moving on to this historical investigation, however, the main theoretical concepts of analysis will be elaborated, and the research method will be outlined.

REFERENCES

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CHAPTER III :

THEORY AND METHOD

INTRODUCTION

This chapter is divided into two distinct sections. The second section will outline the methods used. The first section will elaborate the central theoretical concepts which will be used to analyse the historical and empirical evidence presented in Chapters IV, V, VI. It will be shown that sociology's traditional conceptualisation of 'race' and 'profession' are inadequate.

It will be argued in respect of the concept of 'race', that sociology has traditionally tended to give analytical importance to the concept which is not deserved. Although people act as though distinct 'races' exist, it is not appropriate to take these directly experienced social phenomena as the starting point of analysis. To do so, disconnects these phenomena from the material conditions of their existence and reproduction.

It will be argued that 'races' do not really exist, and therefore, should not be given undue importance by making them the starting point of sociological analysis. Rather, the belief in the existence of distinct 'races'

is the outcome of historical, political and ideological processes. It is these processes which should be the starting point of analysis.

With respect to the concept of 'profession', it will be argued that certain occupations, such as medicine, should not be defined as a 'profession' as a result of some supposed unique characteristic associated with the occupation, such as occupational autonomy. Rather, certain occupations can be defined as a 'profession' by virtue of their political power to be successful historically in having their claims to 'professional status' accepted as legitimate.

My contention is that first, racism and professionalism should be regarded as ideologies. Ideologies that justify and legitimate the categorisation process which identifies people as distinct 'races' and certain occupations as 'professions', and as a consequence of this categorisation process, operate as mechanisms of inclusion/exclusion. Second, that these processes of categorisation should be conceptualised as racialisation and professionalisation respectively. In combination, these political and ideological relations present otherwise common class interests as appearing to be

fractured. Third, that as ideologies which operate as mechanisms of inclusion/exclusion, racism and professionalism are able to articulate with each other. I will begin by outlining my definition of ideology.

THEORY – THE CENTRAL ANALYTICAL CONCEPTS: IDEOLOGY, RACISM AND RACIALISATION, AND PROFESSIONALISM

Ideology

A Marxist conceptualisation of ideology argues that ideology has its origins in the way class society organises human productive practice. It is through human productive practice, by creating and reproducing themselves and society, that humans come to know and understand the social reality of which they are a part. In these terms, the ideas which allow humans to make sense of their existence, are grounded in the material and social reality of that existence. Within capitalist class society, however, the underlying material conditions of human existence, which determine the class-based nature and form of capitalist society, are not directly accessible to human consciousness. This is due to the relational character of capitalist social reality. [Larrain: 1979, 1983]

Marx characterised this aspect of capitalist society by the distinction between essence and appearance (or phenomenal form). Appearances are the phenomena of the external, social world, and are the representations of social reality which become internalised as people's lived experiences of that world. Phenomenal forms are the obvious, directly experienced forms of social reality. They constitute the surface appearance of the way in which capitalist society is organised, and manifest themselves as universal, natural and inevitable. Essence, on the other hand, are those underlying relations which provide the conditions for the existence of the phenomenal forms. The essential relations explain the form and content which the phenomenal form takes. [Geras in Blackburn (ed): 1972; Larrain: 1979]

It is the class-based nature of capitalist society which constitutes the essence of that society. These essential relations give rise to and explain the form and content of the phenomenal forms which manifest themselves. It is these phenomenal forms which people experience directly and make sense of in order to understand their role and place in society.

If the phenomenal forms of capitalist social reality is the basis of human consciousness, then the ideas with which humans make sense of that reality will fail to grasp it completely in its totality. Human consciousness will not penetrate to, or be able to comprehend, the underlying essential structures which give rise to the phenomenal forms. Human consciousness under these conditions, therefore, operates to misrepresent and distort human understanding of the material and social world. This is the basis of ideology.

Ideology comes into existence, therefore, as a consequence of the transformation of essential relations into their phenomenal manifestations. This transformation is referred to as the process of reification. Reification can be understood as the process which gives the phenomenal form of reality an independent existence which it does not actually have. [Larrain: 1979] By operating in this manner, the essential relations which give rise to the phenomenal form, become obscured and appear to play little or no part in human experience and understanding. Under these circumstances, the class-based nature of capitalist society is largely hidden from human experience. The social relations which are directly experienced, are perceived as natural, universal and inevitable. They appear to be

disconnected from their origin in essential relations: essential relations which are the outcome of a specific set of class-based relations of exploitation. [Geras in Blackburn (ed): 1971]

Reification presents the phenomenal form of capitalist social reality as the outcome of natural and universal processes which are independent of human thought and actions. The fact that capitalist society is the result of a specific way of organising social relations is obscured, as is the recognition that other forms of organising society are possible which do not create a class society based on exploitation.

Ideology, therefore, can be conceptualised as the projection into consciousness of the experienced, external, phenomenal world, and is the mechanism through which humans make sense of and participate in that world. The experienced world, however, is a distorted phenomenal representation of underlying and largely hidden essential structures. Consequently, ideological consciousness becomes a distorted representation of social reality, which obscures the nature and content of the essential relations, and operates to justify and legitimate the existing social structure.

In conceptualising ideology in this way, the phenomenal form should not be regarded merely as illusory. Both appearances and essence are real, because reality is the unity of essence and appearance. [Larrain: 1979] The relationship between essence and appearance should not be regarded as an external causal one, ie. that the essence causes, deterministically, the phenomenal forms. The relationship is more appropriately conceptualised as one of internal entailment, where the phenomenal form embodies incomplete, but practically adequate, representations of the essence. [Sayer: 1979] In other words, the correspondence between essence and appearance cannot be regarded as one of total continuity.

There are at least two consequences for ideology in relation to this lack of continuity between essence and appearance. First, because ideology arises out of the relationship between essence and appearance which is not causal and deterministic, it can generate effects within capitalist society of its own accord, although always within the parameters set by the capitalist mode of production. This possibility will become clearer in the next part of this chapter, when racism is examined.

Second, discontinuity can arise where ideology may itself contain contradictory notions, and therefore, will be unable to adequately make sense of the material world for humans. In this sense, ideology is continually negotiated anew in relation to the partial experience humans have of their material conditions of existence. This allows the possibility of creative and alternative forms of theory and practice emerging.

The notion of creative alternative forms of ideological thought and practice has been taken up by Paul Willis. [Willis in Barton & Walker (eds): 1983] He conceptualises this process as one of cultural production. Willis defines cultural production as:

> ... *the active, collective use and exploration of received symbolic, ideological and cultural resources to explore, make sense of and positively respond to 'inherited' structural and material conditions of existence.* (1)

Willis is arguing that while individuals are born into a given, already existing social structure with its own ideological and cultural symbols and resources, these mechanisms of making sense of the world may not be totally appropriate in terms of explaining the individuals actual material and social existence. Consequently, in order to make 'better' sense of their

participation in the social world, individuals constantly respond in an active and creative way to the given ideological and cultural symbols and resources. As a result, revised and 'new' forms of ideological and cultural images and resources are generated.

For example, black people have generated for themselves positive 'race identities' as a challenge to the given content of racist categorisations. This, however, while performing a subjective role, appears to have done little to undermine the 'mythology of race'. This is probably not surprising, given that positive 'race identities' continue to reproduce the belief in the existence of distinct 'races', and therefore, this positive conceptualisation itself continues to obscure the historical and political process of racist categorisation on the basis of skin colour. This process of 'race-making' will be examined next, and the conceptualisation of ideology elaborated above will be used in relation to racism.

Racism and 'Race-Making': The Mythology of 'Race'

The aim of this section is to reveal the ideological basis and content of racism, and thereby re-construct a

more appropriate theoretical framework within which to understand the production and reproduction of racism. This will be partly achieved by critically referring to some of the main arguments which underpin how sociology has traditionally analysed 'race' and racism. It is not my intention, however, to investigate the whole substantial literature which is associated with the sociology of 'race relations'. This tradition contains Weberian, Functionalist and so-called Marxist interpretations of the 'race relations' problematic. (2) A systematic exegesis and critique of this literature has been undertaken by others. (3) I will then go on to outline in some detail my preferred neo-Marxist approach, which while defining racism as an ideology, grounds its production and reproduction within capitalist relations of production.

The Sociology of 'Race Relations'

The colonial and post-1945 history of British racism, as we shall see in the Chapters IV, V and VI, has been produced and reproduced within the language of the concept 'race'. Black people have historically been perceived as fundamentally different and inferior to white people, by virtue of the biological difference of skin colour. Other social and cultural characteristics

have then been attributed to this apparent basic difference.

Sociology too, has historically recognised certain forms of social interaction as being structured by beliefs about the existence of distinct 'races'. The concept of 'race' can be defined as a classification based on the belief that the perceived difference which distinguishes the specified group is immutable and fixed in nature. [Kahn in Husband (ed): 1982] This process of 'race identification' usually takes the form of biological categorisation by phenotype and/or genotype. The biological groups identified are then structured hierarchically and typically attributed with fixed cultural characteristics. [Miles in Husband (ed): 1982] The analysis of social relations categorised in this way, has given rise to the sociology of 'race relations'. Racism and discrimination are perceived as the primary and 'natural' outcome of relations between the distinct 'races'.

The sociology of 'race relations' characterises 'race' and its derivatives, racism and the 'race relations' problematic, as real social categories. They are presented as referring to real social and political

phenomena which have determinant effects in the material world. 'Race', 'race relations' and racism become the objects of descriptive and explanatory importance: they become the objects of analysis. To focus exclusively on 'race' and its derivatives in this way, however, implies that black people are in opposition to, or outside of, other locations in the social structure, such as class. In these terms, 'race' and class are given equivalence as analytical concepts within the sociology of 'race relations'. This has led some Marxists [eg. Sivanandan: 1982] and others, to grapple with the apparent problem of the relationship between 'race' and class in sociological theory. [Miles: 1982; April 1984] It will be argued below, that this so-called 'problematic is itself the consequence of racialised thinking.

In utilising the concept of 'race' in this way, it appears as though it is the facticity of black people, of itself, which generates racism organised around colour, and as a consequence leads to discrimination. Skin colour becomes the biological referent through which 'race identification' takes place. The belief in the existence of distinct 'races' is the mechanism through which relations of superiority and inferiority can and are reproduced. This in turn informs the practices guiding social interaction between the 'races'

and produces unequal outcomes. The disadvantaged position of black people is explained primarily as a consequence of them belonging to a distinct and inferior 'race', a categorisation which is presented as a 'natural' phenomenon.

The sociology of 'race relations' has generally remained within the discourse of 'race'. It has tended to analyse what is believed to be, ie. that 'races' exist, and has uncritically accepted this perspective as the correct starting point of analysis. This has remained the case despite writers such as Rex, recognising that the concept 'race' is socially constructed and not an appropriate basis for sub-dividing the worlds population into discrete groups. [Rex: 1970] In this way, although studies in the field of 'race relations' have done a great deal to reveal the endemic nature of racism in British society, by remaining within the 'race' paradigm, the sociology of 'race relations' has tended to continue to reproduce the mythology of 'race'. We have to look beyond the sociology of 'race relations' towards a political economy of racism in order to de-mythologise the concept of 'race'.

A Political Economy of Racism

A political economy perspective on racism is provided by Robert Miles in his book, Racism and Migrant Labour (1982). Miles argues that the biological arguments for the existence of 'races' are without scientific and objective foundation, and that variability in phenotype and genotype prevent a division of the world's populations into discrete and permanent 'races' which can be structured hierarchically. Put simply, there is no scientific basis for the concept of 'race'. The pseudo-science of the nineteenth century nor twentieth century genetics, provide any evidence for the existence of 'races'. Consequently, the concept of 'race' and its derivative 'race relations', have no analytical value, and the apparent 'problem' of the dichotomy between 'race' and class dissolves.

Miles goes on to argue that the continued adherence to the concept of 'race' and the 'race relations' problematic in academic discourse, is due to the reification of the concepts. As we saw earlier in the discussion of ideology, reification is the process by which the relational character of capitalist social reality is misrepresented. By reifying its conceptualisations the sociology of 'race relations' is

only addressing the apparent or phenomenal aspects of the social world, and by giving them a determinate status equivalent to that of the essential relations which are the basis of their origin, the phenomenal categories of 'race' and 'race relations' become incorrectly perceived as the real and active subjects of analysis.

By conceptualising social reality in terms of the distinction between phenomenal forms and essential relations, Miles can recognise that people do conceive of 'races' and also that some social relations are described as 'race relations'. The concept of 'race', however, has no objective reality, and therefore, the notion of 'race' and the 'race relations' problematic merely represent ideas. They are the ideas through which humans make sense of some of the social relations they experience. The concept of 'race' is a <u>social construction</u>. It is the social significance attributed to biological difference, such as skin colour, which generates the view that there are differential social relations defined in terms of 'race'. It is this <u>social significance</u> which structures social interaction, rather than the mere facticity of biological difference, such as skin colour. [Miles: 1982] Signification, therefore, is:

> *... a central moment in the process of representation, that is, the process of depicting the social world and social processes, of creating a sense of how things 'really are'.* (4)

The idea of 'race' is, therefore, the result of a process of signification whereby certain phenotypical characteristics are attributed with meaning and are then used to organise human populations into distinct groups defined as 'races'. Groups categorised in this way are also usually attributed with certain cultural characteristics. The result is that these groups are then perceived as embodying a specific set of biological and cultural attributes. This process of 'race-making', whereby the application of the 'race' label to groups distinguished by certain signified phenotypical and cultural characteristics, represents an aspect of the social construction of reality. 'Races' are socially imagined rather than biological realities. [Miles: 1989]

The process of 'race-making', where the idea of 'race' is socially constructed and reproduced, is conceptualised as the process of racialisation. Racialisation can be defined as:

> *... the political process by which attributes, such as colour, country of origin, language, religion, values and beliefs are defined as constituting discrete organising principles of*

> *human consciousness and conduct. These attributes are thus used to categorise people into groups, and such groups are defined as 'races'. Racialisation ossifies historically specific cultural responses into unchanging and unchangeable elements of human identity. An individuals 'racial' characteristics then assume the burden of explaining their behaviour and attitudes. Racialisation puts the concept of 'race' into everyday discourse; 'race-ism' is the ideological form of this process.* (5)

Racialisation is the real social process, whereby the 'race' label is socially constructed and applied in the social world, and its application produces specific effects of itself through racism. [Miles: 1982]

The conceptualisation of the 'race-making' process as one of racialisation means that racism and discrimination derive from racialisation and not from the 'presence of races'. In these terms, Miles defines racism as an ideology, and distinguishes racism as an ideology from discrimination as the practice. [Miles: 1982] He defines the concept of racism as referring to:

> *... those negative beliefs held by one group which identify and set apart another by attributing significance to some biological or other 'inherent' characteristic(s) which it is said to possess, and which deterministically associate that characteristic(s) with some other (negatively evaluated) feature(s) or action(s). The possession of these supposed characteristics may be used to justify the denial of the group equal access to material and other resources and/or political rights.* (6)

Racism defined in these terms operates as an ideology of inclusion for the group performing the signifying, and

as an ideology of exclusion from the group being signified. [Miles: 1989]

If we utilise the concept of ideology elaborated earlier, we can see that racism as ideology is not imposed upon people in order to produce a conscious falsification of social reality. It has its own conditions of existence and reproduction, although these are set within the constraints of the material basis of social life. Capitalist production relations are the terrain upon which racism (and other ideologies) are generated and reproduced, although not deterministically. In these terms, ideology is not fixed and given, but is actively produced and reproduced through the lived experience of humans. Their content and object are, therefore, the subject of change. As a consequence of this, ideology can have specific structural effects upon capitalist production relations.

The political process of racialisation is similarly produced and reproduced within the context of the capitalist mode of production. The mode of production determines the nature and form of the class structure. The process of racialisation, therefore, occurs within the parameters set by the capitalist mode of production,

including the relative positions of classes. Yet, because ideological and political processes can have specific structural effects upon capitalist relations, racialisation can precipitate specific conjunctures within the economic, political and ideological relations of the social formation. [Miles: 1982]

As a consequence of this, racialisation results in the fractionalisation of classes. In other words, in so far as people act upon racialised world views; that is, where discriminatory practices produce patterns of segregation organised around colour which result in differential material rewards, then in this sense, one's fundamental class interests appear to be 'fractured'. Racialisation is one means by which persons are allocated to specific positions within the structure of class relations. [Miles: 1982] Miles, himself, puts it in the following way:

> *The articulation of racism, and the development of practices in accordance with this ideology, is but one means by which persons are so allocated and reproduced within a social formation, not simply as a class, but always as a class fraction. In the historical instance of labour migration from the New Commonwealth to Britain since 1945, the political and the ideological have had determinate effects, simultaneously with the economic, in creating and reproducing a racialised fraction of the working class (and other classes).* (7)

The racialisation of people and groups, by definition entails the racialisation of the processes which they participate in, and thereby, the structures and institutional arrangements that ensue. Miles argues that institutional racism should refer to two sets of circumstances. First, where exclusionary practices originate from a racist discourse, but may no longer be overtly justified by that discourse. For example, although British immigration legislation does not employ an explicitly racist discourse, the debate was conducted within a racist discourse at the time. [Miles: 1989]

The second case of institutional racism refers to those circumstances where an overtly racist discourse has been altered to remove its explicit racist content, but other words are then used which embody the original racist meaning. For example, British immigration legislation refers to controlling the entry of 'immigrants' in order to promote good 'race relations'. 'Immigrant' became/ remains a euphemism for 'coloured' or 'black' migrants, so that controlling the entry of 'immigrants' was understood to apply principally to 'black' migrants. [Miles: 1989]

We shall see below, that this second from of institutionalised racism did occur in relation to black migrant doctors. In the mid-1970's, the occupation of medicine constantly referred to doctors with a lack of competence in English as a 'problem' for service provision for the NHS. Lack of competence in English was understood to refer primarily to black migrant doctors. Consequently, the formal testing procedure introduced at this time for all newly arriving migrant doctors, was also understood to apply principally to black migrant doctors.

By conceptualising racism as an ideology, and recognising the belief in the existence of distinct 'races' is socially constructed through the 'race-making' process of racialisation, it has been possible to move beyond the limitations of the 'race relations' discourse. Black people do not constitute a distinct 'race', but are located as a racialised class fraction, where racism becomes the justificatory mechanism through which this allocation is produced and reproduced. The ideology of racism, therefore, operates as a mechanism of exclusion/inclusion.

Racism is not the only ideology which operates as a mechanism of exclusion/inclusion. If two or more ideologies operate in this way, there is the possibility that the ideologies will combine and interact with each other in various ways to facilitate exclusionary/ inclusionary outcomes. Miles suggests that this process of ideological articulation is evident in the relationship between racism and nationalism. Miles: 1987; 1989] This is the subject of the next section.

Nationalism will also be shown to be an important factor in the post-war racialisation process. For example, in the general political arena Powell used a nationalist discourse to justify his position on immigration and repatriation. From the late 1960's onwards, the occupation of medicine used the language of nationality to identify black migrant doctors as a 'problem'.

In addition, the process of ideological articulation is a significant process in relation to the racialisation of migrant doctors. It will be argued below, that professionalism is most appropriately conceptualised as an ideology which operates as a mechanism of inclusion/exclusion, and that as an ideology it operates in combination with racism and nationalism to racialise

migrant doctors within the occupation of medicine. This articulation will be confirmed when the historical and empirical record is examined in Chapters IV, V and VI.

Ideological Articulation

Miles argues that the ideology of nationalism operates to justify and legitimate the belief that the world's population can be naturally divided into distinct 'nations' on the basis of cultural difference, usually identified by language. Nationalism justifies this notion by asserting that the 'nation' defined in this way represents the ideal location for the continued reproduction of the collective self-determination of a people within recognised geographical boundaries, which embodies the 'national' character and identity of that people. [Miles: 1987, 1989]

As with the idea of 'race', the idea of 'nation' represents a social construction and a reification of concepts. Cultural differences only have social effects when social significance is attached to that difference. It is the process of attribution of significance which is the active element in the process of categorisation, rather than the fact of cultural difference in itself.

The idea of 'nation' is reified because it is presented as the appropriate object of analysis with an existence which is independent of the material conditions of its origin and reproduction. The real object of analysis should be those processes which came together historically to put the idea of 'nation' into social discourse and then continued to reproduce it in its varying forms. The content of nationalism is the ideological aspect of this process, which operates to legitimate and justify the continued use of the idea of 'nation'. [Miles: 1987; 1989]

The idea of 'nation', like that of 'race', is a category of exclusion/inclusion, where the boundary of categorisation in the case of 'nation' is cultural rather than biological. The potential for the interlinking of the two ideas is clear, when it is remembered that the idea of 'race' asserted that the biological criteria that supposedly defined a distinct 'race', also determined the cultural characteristics attributed to that group. With the idea of 'nation' defined in terms of a cultural collectivity, then it is possible that 'nation' could refer to a biologically grounded grouping sharing similar cultural characteristics. In these terms, 'nation' becomes the location for a particular 'race': an articulation where

'race' is 'nation'. This proposition is verified by the recognition that the ideas of 'race' and 'nation' underwent a similar process of theorisation during the late eighteenth and nineteenth centuries. [Miles: 1987; 1989]

The correspondence between the idea of 'race' and the idea of 'nation' clearly have implications for the manner in which the discourse surrounding black migration to Britain in the post-1945 period was conducted. On the one hand, a conception of English/Britishness based on the ideas of 'nation' and 'race', would provide a definition of self and belonging, as well as a definition of other and outsider. Black migrants from the New Commonwealth would thus be signified as a threat, an intrusion or a dislocation of the imagined community that constitutes that Englishness/Britishness. On the other hand, with the idea of 'nation' grounded in the idea of 'race', then the use of a nationalist arguments to either justify increased immigration controls on black migrants, or increased controls on the entry of Indian migrant doctors, would by definition contain 'hidden' references to a discourse of 'race.

The relationship between racism and nationalism is clearly very close, even symbiotic. The next section will explore the notion of professionalism, and it will be argued that professionalism is also an ideology which operates as a mechanism of inclusion/exclusion. Consequently, because the three distinct ideologies share the common characteristic of being mechanisms of inclusion/exclusion, professionalism could articulate with racism and nationalism in the racialisation of migrant doctors. The examination of the historical and empirical record in Chapters IV, V and VI will confirm this. The relationship between professionalism on the one hand, and racism and nationalism on the other, however, is not symbiotic, as is the case between racism and nationalism.

Professionalism as Ideology

Introduction

Sociology's response to the issue of the 'professions' and professionalism, has traditionally operated on the basis that one or more of the supposedly unique characteristics associated with certain occupations defines it as a 'profession'. I want to suggest, by a critical analysis of a selection of the sociological

material, that criteria such as occupational autonomy, are an inadequate basis for defining an occupation as a 'profession'. Rather, it is the power an occupation is able to exert, to both successfully claim 'professional status' and have that claim legitimated, which operates to define an occupation as a 'profession'.

It will also be argued that a successful claim to 'professional status' and its legitimation, is the result of the process of professionalisation. Professionalisation is the process whereby certain occupations such as medicine, have historically produced and reproduced an ideology of professionalism to justify and legitimate their supposedly special status, their high material rewards in society, and sustained their mechanisms of inclusion/exclusion to the occupation. The first task, however, is to briefly outline how sociology has traditionally analysed the concept of professionalism.

Sociology and Professionalism

A review of some of the pertinent sociological literature relating to professionalism, tends to fall into two broad perspectives. (8) On the one hand we

have the traditional or orthodox view of sociology, which is represented by the 'trait' and 'functionalist' approaches. On the other, are more recent alternative conceptualisation provided by Freidson's neo-Weberian approach, and Johnson's neo-Marxism.

The 'trait' and 'functionalist' approaches, have utilised the concept of professionalism to refer to a set of supposedly essential elements which serve to distinguish 'professional' occupations from other forms of occupation. For example, the key characteristics which would define the occupation of medicine as a 'profession' would include the notion of a skill base that requires a long period of specialised education, a comprehensive system of testing the standard of those acquired skills, self regulation through autonomous organisations, an adherence to a code of ethics which governs the practice of the specialised skills, and a service ethic which is oriented to the community interest rather than the self-interest of the 'professional'. These characteristics are then said to explain both the status and high income afforded the occupation. [Johnson: 1972]

The 'trait' approach, is an atheoretical attempt to provide a model or 'ideal type' of 'profession'. A simple listing of attributes which are viewed as essentially 'professional', and which constitute a 'checklist' against which to measure an occupations 'professional' status. The 'functionalist' approach attempts to be more analytical. The characteristics identified are supposed to illustrate the functionally positive contribution the 'professions' make to the maintenance of society. [Johnson: 1972] The occupation of medicine, for example, is functionally significant because many of its activities involve the reproduction of society's members, which is an essential requirement for the maintenance of society. [Johnson: 1976] This functional significance is presented as the basis of professional power. [Johnson: 1972]

An alternative explanation is provided by Johnson and Freidson, although from different theoretical perspectives. [Johnson: 1972; Freidson in Halmos (ed): 1973] They argue that orthodox sociology's conceptualisation of professionalism does not really provide the basis for a definition of 'professional' occupations. For them, professionalism does not correspond to the supposed nature and content of the work undertaken by 'professional' occupations. Rather,

professionalism refers to a specific form of occupational control: autonomous control of the occupations activities by the occupation itself. [Wilding: 1982]

Freidson argues from a neo-Weberian perspective, that professionalism is most appropriately understood in relation to the increasing significance of science and technology in a 'post-industrial' world, where the dominant class will increasingly be constituted by 'professionals' and 'technologists'. Freidson suggests that the 'professional' occupations represent a unique form of organised work, which is due to a dual and mutually reinforcing tendency inherent in knowledge-based labour. Not only does this type of labour tend towards the establishment of stable occupations, but also the complexity and esoteric nature of its content renders it resistant to processes of routinisation and fragmentation. [Freidson in Halmos (ed): 1973]

This inherent resistance to routinisation and fragmentation provides an effective barrier to intervention in the organisation of 'professional' occupations from external agencies, such as management or the State. In these terms knowledge and technique

are perceived as having their own internal logic, which not only determines the emergence of specialised functions, but also their resistance to other forms of authority. The authority structures of post-industrial society, therefore, are characterised by conditions which enable the emergence and future dominance of knowledge-based occupational groups - a 'professional class' of technocrat's. [Freidson in Halmos (ed): 1973]

Freidson's argument asserts that it is the complex and esoteric nature of expert knowledge that provide the conditions under which an occupation is able to secure for itself, autonomy and monopoly over its practice. Expert or 'scientific' knowledge becomes the basis for both 'professional' power and the status and high rewards offered to these occupations in society. [Freidson in Halmos (ed): 1973; Johnson in Scase (ed): 1977] For Freidson, professionalism as a form of autonomous occupational control, is determined by the complexity and esoteric nature of 'scientific' knowledge associated with the nature and content of the work done by 'professional' occupations.

For example, the medical 'profession' would derive its high status and material rewards from the complex and

esoteric nature of the occupations knowledge base. Its complexity arises from its reliance on a variety of natural sciences, such as biology and anatomy. Its esoteric or mysterious nature would derive from the occupation dealing with life and death situations. It is this dual quality of medicine's knowledge base which ensures the activities of the occupation are best left to the occupation itself to manage and regulate. Other agents, such as NHS managers or the relevant State authority, would not have the appropriate knowledge to judge whether an occupation's activities were appropriate to any given medical or clinical situation.

Johnson, arguing from a neo-Marxist position, suggests that professionalism is in reality a strategy. A strategy by which an occupation aims to achieve for itself those characteristics which appear appropriate in defining it as a 'professional' occupation, and thereby, secure its autonomy and monopoly over practice. [Johnson: 1972] The strategy of professionalism is only effective when the core work activities of the occupation fulfil the global functions of capital in terms of surveillance and control. [Johnson in Scase (ed): 1977] For example, the 'profession' of medicine only came into existence when ideological processes, such as claims to competency and expertise based on

scientific rationalism, effective self-regulation and control and, service ethic, and political processes, such as State sanctioning of occupational autonomy and monopoly of practice, which in combination operate to sustain occupational autonomy, are consistent with the requirements of capital and the specific function of medicine's role in the reproduction of labour power.

In these terms, professionalism as a strategy is also a professional ideology, whose component characteristics operate to justify occupational power, privilege and status. In addition, professionalism as a form of institutionalised occupational control, represents for Johnson a process which *"is integral to the class structuration"* of the medical 'profession' as part of the new middle class. [Johnson in Scase (ed): 1977; p106] For Johnson then, professionalism is a strategy, an ideology, and as a form of occupational control operates as a mechanism for intra-class structuration.

All the four approaches outlined above define certain occupations as 'professions' in relation to one or more supposed unique criteria, which are associated with the activities of the occupation. I want to suggest, by a critical analysis of the four approaches, that an

occupation may only be defined as a 'profession', if historically, it had the political power to succeed in its claim to 'professional status'. The criteria which are supposed to define an occupation as a 'profession' such as occupational autonomy, therefore, represent the ideology of professionalism rather than the basis of definition. To create and sustain these claims to 'professional status', occupations such as medicine have produced and reproduced an ideology of professionalism, which operates to justify and legitimate their supposedly special status, their high material rewards in society, and their mechanisms of inclusion/exclusion to the occupation.

A Critique and Re-Construction

The key concept in understanding how these four approaches misrepresent the true nature of 'professions' is that of reification. We earlier defined reification as the process which misinterprets the relational character of capitalist society, whereby, the phenomenal representations of social reality appear to have an existence independent of the essential relations which are the basis of their existence. All four approaches reify the concepts they utilise, giving them a determinate, analytical status which is invalid. In

addition, Johnson is guilty of conceptual imprecision/slippage, especially in relation to professionalism.

Both the 'trait' and 'functionalist' approaches uncritically accept everyday images and representations of 'professional' occupations, and use these formulations as the basis of their analysis. Reification occurs because both approaches fail to take account of the process of professionalisation. Professionalisation refers to the historical process through which an occupation, such as medicine, was able to successfully make a case to be categorised as a 'profession'.

The professionalisation of the occupation of medicine, occurred mainly during the nineteenth century when Britain was undergoing massive structural changes brought about by the rapid development of capitalism. (9) These changes provided the necessary conditions for a transition in the mechanism of control governing the occupation of medicine. Client control through patronage was replaced with occupational control. The occupational community itself, through its autonomous 'professional' associations and its monopoly

over medical practice, gained control of the occupation, and was able to define both client needs and the manner in which they were serviced. Both occupational autonomy and monopoly of practice were sanctioned by the State as a result of a successful campaign by the occupation of medicine to claim 'professional status'. [Johnson in Hurd (ed): 1973]

Both the 'trait' and 'functionalist' approaches are essentially ahistorical formulations. They refer to sets of attributes that are fixed in time, and make no reference to changing forms of occupational control that occupations necessarily undergo during the process of professionalisation and their transformation into 'professions'.

The 'functionalist' approach is also ahistorical as a consequence of it being derived from a structural functionalist theory of society: where social differentiation and the corresponding system of rewards are functionally related to a graduated hierarchy of skills. This is supposed to ensure that the required skills are available in the correct location to fulfil society's needs and solve its problems. History, however, indicates that any given structure of rewards

is the consequence of the power of various social groupings to secure their claims and create their own systems of legitimation. [Johnson: 1972] This is exactly what the process of professionalisation illustrates.

The 'trait' and 'functionalist' approaches disconnect their categorisation from the historical and material conditions which give rise to them. It is the social significance attributed to characteristics such as specialised knowledge and occupational autonomy by these two approaches, that is the active element in categorisation, rather than the nature and content of these characteristics themselves.

Freidson is not only guilty of reification but in the process of this reification, his analysis also contradicts itself. Freidson asserts that professionalism should refer to a specific form of occupational control, where the occupation itself controls all aspects of the occupation's activities, rather than to the supposed nature and content of the work undertaken by 'professional' occupations. Simultaneously, however, he argues that it is the complex and esoteric nature of

specialised knowledge which determines a successful occupational claim to autonomy and monopoly of practice.

If it were possible to sustain the claim that specialised knowledge of an occupation had an existence independent of the nature and content of the work activities of that occupation, then Freidson's analysis would not be ambiguous. It is, however, not possible to sustain this dualism. The work activities of an occupation are the practical outcome of the application of the occupation's specialised knowledge within the work context. The actual work performed, and the specialised knowledge which frames and informs those work activities, are mutually inclusive of each other.

Freidson's use of the notion of specialised knowledge is also implicated in the reification of concepts in his approach. Freidson is unequivocal in his assertion that the 'scientific knowledge' associated with an occupation, is the basis of the 'professional' power that an occupation can exert. This is an inversion and distortion of the relationship between knowledge and technique, and power. This results in a form of technical determinism where knowledge and technique on the one hand, determines relations of power on the

other. My sense is that a more adequate conceptualisation of the relationship between technique and power is to be found within the Marxian concept mode of production. This concept distinguishes between the forces of production and the relations of production, with the latter being determinant. Thus,

> ... *within any given mode of production, such as capitalism, technology is developed and applied in a form consistent with the dominant relations of production.* (10)

The relations of production in the capitalist mode of production are ones of exploitation and therefore are antagonistic. This is the structural basis of social power. These power relations, grounded in the capitalist mode of production, determine how the continuous revolution in the technical means of production are applied. [Johnson: 1976] In these terms, the relationship between knowledge and technique, and power are reversed. The Marxian perspective, therefore, has the capacity to,

> ... *generate a theoretical view which comprehends power as integral to the organisation of work rather than the effect of technical causes.* (11)

Within this framework, 'professional' power or occupational authority is determined by the occupations location within the social relations of production, ie. its class location in the Marxist sense, rather than on

the esoteric and complex content of the occupations base of knowledge and technique.

In a similar manner to that identified with the 'trait' and 'functionalist' approaches, Freidson's inversion of the relationship between knowledge and technique, and power, disconnects specialised knowledge from the material conditions which create, reproduce and apply that knowledge in the real world. Freidson's conceptualisation of professionalism, which is determined by the complex and esoteric nature of the specialised knowledge which informs an occupations work activities, is unable to recognise that it is the power of the occupation to successfully claim 'professional status' which defines the occupation as a 'profession', and not the esoteric nature of specialised knowledge. It is the social significance he attributes to specialised knowledge that is the active element in the process of categorising an occupation as 'profession', rather than the nature and content of that knowledge.

Johnson's approach is limited by his imprecise use of the concept professionalism, in which he defines it in several different ways. This is in part due to his reification of his conceptualisation of 'profession',

where he defines 'profession' in relation to the autonomy of an occupation. This reification is itself the result of conflating the distinction between the political-legal process of professionalisation and its ideological form: professionalism, and referring to both entities as the 'strategy of professionalism'.

Johnson is correct to claim that professionalism should be regarded as an ideology, and that its content includes claims to competency and expertise based on scientific rationalism, effective self-regulation and control, and a service ethic. In this way, the ideology of professionalism can operate to justify the occupation's autonomy and monopoly of practice, as well as legitimating the occupation's power, high status and material rewards.

By not analytically distinguishing between the political-legal process of professionalisation and professionalism as its ideological component, however, Johnson fails to recognise that the capacity of an occupation to claim 'professional status' is dependent upon its ability to exert its political power to that end. It is the power of an occupation to successfully claim 'professional status' which is the significant

moment in defining an occupation as a 'profession', and not merely the fact that an occupation is perceived as autonomous.

Johnson, by defining 'professions' in the way that he does, gives occupational autonomy an analytical role that is not justified. Occupational claims to autonomy is an important justificatory component of the professionalisation process by which an occupation aims to be categorised as a 'profession'. Indeed, in the case of the 'professional' occupation of medicine, occupational autonomy was sanctioned by the State. Johnson, however, gives occupational autonomy a determinate status, which denies and simultaneously obscures the role of occupational power in securing 'professional status' for an occupation.

By addressing the inconsistencies in Johnson's approach, along with the above critical analysis of the other three approaches, we can now reconstruct a more appropriate conceptualisation of the concepts professionalism and professionalisation. Professionalism should refer to the ideology which operates to justify and legitimate those characteristics which are supposed to constitute certain occupations, such as medicine, as

'professions'. The actual process of categorising certain occupations as 'professions' is the result of the political process of professionalisation. Professionalisation should refer to the political process by which attributes such as specialised knowledge and expertise, self regulation through autonomous organisation, and the ethic of service, become defined as principles by which occupations who exhibit these characteristics are categorised as 'professions'. The process of professionalisation represents the political process through which an occupation has been able to exercise its power to successfully claim 'professional status'. Professionalism is the ideological form which justifies and legitimates this process.

Having reconstructed a more adequate concept of professionalism and professionalisation, the next task is to contextualise this theorisation within the capitalist mode of production. The object of this is to illustrate the structural effects of the professionalisation process and the operation of professionalism as an ideology.

The political process of professionalisation, and the ideology of professionalism are produced and reproduced within the capitalist mode of production. The mode of production determines the nature and form of the class structure. Therefore, the process of professionalisation occurs within the parameters set by the capitalist mode of production, including the relative positions of classes. Yet, because ideological and political processes can have specific structural effects upon capitalist relations, professionalisation can precipitate specific conjunctures within the economic, political and ideological relations of the social formation.

As a consequence of this, professionalisation results in the fractionalisation of classes. In other words, in so far as people act upon professionalised world views; that is, where certain practices of inclusion/exclusion produce occupational categorisations supposedly organised around the notion of specialised knowledge and occupational autonomy which result in differential rewards, then in this sense, one's fundamental class interests appear to be 'fractured'. Professionalisation is one means by which persons are allocated to specific positions within the structure of class relations.

The actual class location of 'professional' occupations, has been the subject of a great deal of debate in recent years. It is not my intention to enter into this debate. (12) Wright, in a recent collection of essays on contemporary class structure comments in relation to conceptualising the 'professions' as part of the class structure:

> *In many ways, experts and professionals of various sorts, ... constitute the category which has caused me (and others) the most persistent difficulty in formulating a coherent Marxist class structure concept. (13)*

To attempt to address this 'problematic' in any fruitful way, is far beyond the remit of the present project. For our purposes it is sufficient to suggest, that the occupation of medicine is located as part of the new middle class. Consequently, the professionalisation process operates to locate persons to specific positions within the new middle class, as a professionalised class fraction.

By conceptualising professionalism as an ideology, and recognising that the content of this ideology comes into existence to justify and legitimate an occupation's claim to 'professional status' through the process of professionalisation, it has been possible to move beyond

the limitations of the sociology of 'professions'. People working in certain occupations are not organised within the social formation as a distinct 'professional' class, but are located as a professionalised class fraction, where professionalism becomes the justificatory mechanism through which this allocation is produced and reproduced. The ideology of professionalism, therefore, operates as a mechanism of exclusion/inclusion.

In conclusion the above analysis has argued that 'professional' occupations exist and operate in the real world by virtue of their power to successfully claim 'professional status', rather than as a result of some unique criteria such as occupational autonomy which is supposed to set them apart from other 'non-professional' occupations. I have argued that if we are to retain the concept of 'profession', then what defines a 'profession' is an occupation's power to have its claims to 'professional status' accepted as legitimate.

It has also been argued that a successful claim to 'professional status' is the result of the political-legal process of professionalisation. For example, in the case of the 'professional' occupation of medicine,

the occupation has historically been able to utilise criteria such as specialised knowledge, examination of entrants, a code of ethics, self-regulation through autonomous organisation and the ethic of service, to create and sustain its 'professional status.' Added legitimacy was provided for the occupation through the State providing a legal basis for monopoly of practice and sanctioning occupational autonomy for the occupation. These criteria, however, are not an appropriate basis by which to define an occupation as a 'profession'. Rather, they represent the content of the ideology of professionalism, which operates as a mechanism of justification and legitimation to the occupations claims of 'professional status'.

Sociology has traditionally relied on one or more of these criteria of professionalism, to explain why certain occupations may be defined as 'professions'. In doing so it has been quilty of reifying its concepts. It is not the actual content and nature of criteria such as occupational autonomy which forms the basis of categorisation, but rather the social significance that is attributed to such criteria that operates as the principle of definition. The real basis of categorisation should be the power an occupation is able

to exert in order to make a claim to 'professional status' successful.

Summary

The arguments presented above have demonstrated that sociology's traditional conceptualisations of 'race' and 'professions' is inadequate. By reifying both concepts, the discourse that ensues remains within phenomenal relations, failing to take adequate account of the material conditions of existence and reproduction of these forms. The alternative conceptualisation, allows us to recognise that the belief that distinct 'races' exist and that certain occupations can be defined as 'professions', is the outcome of historical, political and ideological processes within the capitalist mode of production. These processes have been conceptualised as racialisation and professionalisation, and racism and professionalism have been defined as ideologies.

Racialisation is the historical and political process by which 'race' categories are socially created and reproduced. Racism is the ideological form of this process. Racism as ideology sustains the belief that people can be categorised and ranked on the basis of

biological criteria, to which other cultural characteristics are attributed. Consequently racism operates to justify and legitimate differential treatment and outcomes for those groups. As an ideology, racism operates as a mechanism for group inclusion/exclusion. Discrimination is the practice associated with the ideology of racism.

The effect of these political and ideological processes is to make it appear as though common class interests are fractured by organising human actions in such a way that discriminatory practices produce patterns of segregation organised around skin colour, which denies access to material resources. That is, the creation of a space for the establishment and reproduction of groups of people who are located disadvantageously within classes. In this sense, black doctors can be conceptualised as a racialised class fraction.

Professionalisation is conceptualised as an historical and political process by which certain occupations become categorised as 'professions'. Professionalism as ideology sustains the belief that certain occupations can be categorised as uniquely different by reference to claims of scientific expertise, occupational autonomy

and service ethic. As a result, professionalism operates to justify and legitimate differential access to material rewards and power by the various occupations. As an ideology, professionalism, like racism therefore, operates as a mechanism for inclusion/exclusion to an occupation. The power to control the entry requirements of the occupation is the practice of the ideology of professionalism.

The effect of these political and ideological processes, is once again to make it appear as though common class interests are fractured. By organising occupational activities in such a way as to strictly control access to that occupation, ensures that access to material resources by that occupation is privileged in relation to other 'non-professional' occupations. That is, the creation and reproduction of a space in which certain groups of people are located advantageously within classes. In this sense, the occupation of medicine can be conceptualised as a professionalised class fraction.

Black migrant doctors are subject to both sets of processes. They are simultaneously a professionalised class fraction, and a racialised class fraction. The relationship between racism/nationalism and profession-

alism would appear to be a contradictory one. Racism contains a negative connotation, in the sense that it denies access to material rewards and structures of power in society to those subject to its operation. Professionalism on the other hand, has a positive connotation, in that it facilitates access to material rewards and structures of power for those who benefit from its operation. The concrete outcome of this relationship between the operation of the ideologies of racism, nationalism and professionalism cannot be specified theoretically.

The discussion relating to the ideology of nationalism, where people appear to divided into 'national' groups on the basis of common cultural attributed, illustrated in respect of racism, that ideologies can articulate with each other. The ideologies of racism, nationalism, and professionalism, all operate as mechanisms of inclusion/exclusion. The precise nature of this articulation: between racism and nationalism, and these two and professionalism, will become apparent when they are applied to the historical record relating to the racialisation of British politics and the British medical profession, which follows in the next four chapters

METHOD

The primary objective of the research is to identify, record and explain the process of racialisation that doctors from the Indian subcontinent have undergone as a consequence of their migration to Britain to train and work. There would be two aspects to this process of racialisation. On the one hand, would be the racialisation of migrant doctors within the occupation of medicine. This would focus on the response of white, British-trained doctors to their Indian qualified counterparts. This 'occupational racialisation', however, would take place within a broader political context, which identified black migration into Britain as a 'problem'.

The scope of these two main themes - the general and the specific aspects of the racialisation process, was initially determined by a review of the existing research on migrant or 'overseas' doctors. It was apparent that although there was little concrete statistical data on this migration, doctors from India were travelling to Britain to train and work during Britain's colonial rule of India. The research, therefore, had to extend its coverage beyond the

contemporary period of migration since 1945, to colonial rule in India in the nineteenth century.

The project relied on documentary evidence as its source material. For the general racialisation of British politics, secondary sources were used. It was decided that this area had already been very well documented, both in terms of the historical legacy of British colonialism, and the more recent discoveries from the Public Records Office, concerning the covert political creation and reproduction of a 'race/immigration problem' in Britain between 1945 and the late 1950's. The investigation of primary sources would be confined to the historical record relating to the 'occupational racialisation' process.

The 're-construction' of this historical record, relied on three primary sources. The two main sources were the general medical journals of the occupation: The British Medical Journal (BMJ) and the Lancet. The third source was the Annual Reports and Minutes of the General Medical Council (GMC) - the regulatory body of the occupation. All three series of publications covered both the the post-1945 period of doctor migration into Britain, and the era of British colonial rule in India.

British colonial rule in India was significant, because the British introduced the western style of medicine into the country and established a medical system based on the one operating in Britain. Consequently, the first Indian doctors to practice western style medicine in India, gained their qualifications through a transplanted British system. British colonial rule in India with a British type of medical system, therefore, formed the context within which relations between British and Indian doctors first occurred.

The medical journals provide useful information on the attitude of white, British-trained doctors towards their Indian counterparts, especially through their editorials and other special articles. Both journals also report regularly on the debates and decisions of the GMC. In addition, the BMJ provides regular accounts of the British Medical Associations (BMA) Annual Representative Meetings, which recount the policy decisions of the Association. These primary sources of historical data will be supplemented by evidence drawn from the various State sponsored reports, such as Committees of Inquiry and Royal Commissions, which are concerned with migrant doctors.

It was hoped that two other sources of information would make a useful contribution to the research. Given the value of the data drawn from the Public Records Office in relation to the covert political agenda on 'race and immigration' mentioned above, it was hoped that the records would prove equally valuable in relation to doctor migration. This was not the case for two reasons. First, it is extremely difficult to identify data on specific narrow subjects from within the very broad categories used to collate the records held. The process involved tends to be a time consuming 'hit and miss' affair. Second, the significant time period in relation to post-1945 'occupational racialisation' is between 1960 and 1975. Confidential Government documents for this period, currently remain closed under the 'thirty-year rule'

It was also hoped that the Overseas Doctors Association would provide a useful input into the research. The Association, however, operates a policy of confidentiality on information regarding migrant doctors. The views and policy recommendations of the Association can only be identified through its contributions to various official reports.

An alternative approach to this research may have been to undertake interviews with doctors from the Indian subcontinent working in Britain. This, however, would only have repeated other empirical studies such as that by Smith, which have provided useful information on the subjective experiences and expectations of migrant doctors working in Britain. [Smith: 1980] I do not wish to imply that the experiences of black migrant doctors working in Britain are not important, but my objective is of a different nature. I wanted to investigate how the racism and discrimination black migrant doctors have faced came about, and the role the 'professional' occupation of medicine has played in the racialisation process. Interviews with black migrant doctors would not provide the information necessary to achieve this aim. Consequently, the historical record which frames the migration of black doctors to Britain, is the main object of investigation and analysis.

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CHAPTER IV:

THE ROOTS OF BRITISH RACISM AND THE RACIALISATION OF INDIAN DOCTORS IN COLONIAL INDIA

INTRODUCTION

This chapter has two main objectives. First, it will outline the historical roots of British racism. It will be shown that Britain's involvement in the slave trade, the use of slave labour in the plantation economy of the West Indies, and the subsequent expansion of Empire, required a justificatory racist discourse in order to legitimate these activities. This discourse operated to obscure the wholesale exploitation of black people throughout the British Empire, and secure the economic development of British capitalism.

Second, the chapter will explore the specific relationship between British and Indian doctors during Britain's colonial rule of India. It will be shown that the racist discourse outlined in the first part, was reproduced by the British 'professional' occupation of medicine, in combination with the ideologies of professionalism and nationalism, to secure the domination of British doctors in the Indian Medical Service (IMS), and the consequent subordination of Indian doctors within the service. The ideologies of racism, professionalism and nationalism articulated with each other to produce and reproduce Indian doctors as a racialised fraction of medicine within the IMS.

THE ROOTS OF BRITISH RACISM

The language of 'race' has a long history, which is strategically linked to British involvement in the slave trade and the use of black labour in the West Indies, and to Britain's role at the centre of Empire. British history generally is a history of colonial expansion and domination, and more specifically, it is a history of exploitation of black people throughout the world. Racism developed as a mechanism through which this exploitation and domination could be justified and legitimated. Britain's colonial legacy contains within it the roots of British racism.

The Origins of Plantocracy Racism

British racism emerged in its first 'systematic' form with the development of the slave trade. This plantocracy racism provided a justification for the enslavement of black people in the New World. Plantocracy racism itself, however, was a development of earlier myths and legend concerning the differences within the human population, which was deeply embedded in the consciousness of white Europeans. [Fryer: 1984]

Even before the first expeditionary contact with Africans in 1550, when English merchant explorers traded with the natives of Africa, the terms black and white were already loaded with emotional meaning. The word black was associated with things being soiled, dirty or foul; with death, wickedness and things sinister; a symbol of the devil: baseness, evil, danger and repulsion. The word white, on the other hand, was associated with purity, virginity and virtue; beauty and Godliness. [Jordan in Husband (ed): 1982]

It is not surprising, therefore, that skin colour should be the main focus of comment by travel writers of the time, when one of the fairest skinned peoples came face-to-face with one of the darkest. The fact that Africans were described as 'black' was an exaggeration which signified the impact of differing skin colour upon the perceptions of the white European observer. The black African appeared to be the 'perverse negative' of the white Briton. [Jordan in Husband (ed): 1982]

The African was also identified as heathen. The English reaction to heathenism was not so much in terms of it being a specific defect of the African native, but it had more to do with an inability not to live a civilised

life. English Christianity was closely linked to English nationality, and to be an English Christian meant more than merely subscribing to a set of religious doctrines. It was a quality inherent in the individual and the society from which that individual came. To say Africans were Godless and lawless, was tantamount to saying they were not English. [Jordan in Husband (ed): 1982] The Bible also provided a justification for explaining human differentiation. The Old Testament identified blackness as being synonymous with sin, where God curses Ham for looking on his father's nakedness by turning his skin black. [Fryer: 1984]

Africans were also equated with beasts. It was an unfortunate coincidence that at the same time that the English first came into contact with Africans, they were also introduced to the apes of the African continent. Ancient literature had often indicated the existence of ape-like humans. Apes were described as lustful, devil-like and evil, and some commentators even suggested that Africans were direct descendants of the ape. Speculation about the relationship between beast like humans (the African) and human like beasts (the ape) were widespread. The apparent similarity between the two, at least in English perceptions, led to the conclusion that Africans and apes inter-bred. A belief

in the supposed potent sexuality of Africans was well established prior to first contact with the African continent. [Jordan in Husband (ed): 1982]

These early beliefs about black peoples, were already well established in the perceptions of white Britons by the time the plantation economy in the West Indies, which was based on the labour of black slaves from Africa, was established. The array of images, themes and mythology concerning Africans, could be taken up and reproduced to justify the slave trade. The need to justify the use of slave labour in the West Indies and the more general trade in slaves Britain was involved with, became increasingly necessary as humanist activists began to assert pressure for the abolition of the slave trade and slavery in the late eighteenth century. [Walvin in Husband (ed): 1982; [Fryer: 1984]

Plantocracy Racism

The need to justify the use of slave labour is apparent when it is realised how important the slave trade was to the economic development of Britain. Slavery was a triangular trade. British manufactured goods were exchanged for slaves on the African coast. The African

slaves were then transported across the Atlantic ocean and sold for the sugar produced on the West Indian islands. This sugar, and other goods, were then shipped back to Britain to be sold. British manufactured goods were then bought, and the whole cycle began afresh. The trading cycle was particularly profitable because on each leg of the journey the ships were always carrying a cargo of one sort or another. [Williams: 1964; Fryer: 1984; 1989]

The British economy benefited in a number of ways from the slave trade. Industrial capitalists who produced the manufactured goods in Britain which were both traded for the slaves and exported to the plantations for consumption by white estate owners, profited from the new market in Africa and the West Indies. Textiles, guns, wrought iron, brass and copper products, flint, pewter, cutlery, gunpowder, bullets, tallow, tobacco, glass beads, toys, malt spirits and beer, all found a new outlet in Africa, allowing a wide variety of British industries to expand, develop and prosper. [Williams: 1964; Fryer: 1984; 1989]

The English owners of the plantation estates profited from the sale of sugar produced from slave labour, and

the merchant capitalists who shipped the slaves to the West Indies also prospered. This wealth was subsequently used to purchase either luxury goods or became investment capital in British industry. The iron and coal industries of south Wales, the slate industry in north Wales, the Yorkshire iron industry, the Great Western and Liverpool and Manchester Railways, were all initially funded in full or in part out of the profits from the slave trade. Finally, the early history and development of the British banking system and insurance industries had close links with the triangular trade. [Williams: 1964; Fryer: 1984; 1989]

It was not surprising then, that West Indian planters in particular, and others more generally, would perceive it to be in their interests to use whatever means were necessary to legitimate the slave trade and the use of black slave labour. The pro-slavery lobby were eager to demonstrate that black African slaves were little more than animals, and that slavery was operating as a humanising mechanism, which was actually of benefit to the slave. [Williams: 1964; Fryer: 1989]

The notion that British involvement in the slave trade represented a civilising mission, is clearly expressed

in a passage from a pro-slavery pamphlet by Jamaican planter John Gardner Kemeys in 1789:

> *Many of the negroes imported from Africa partake of the brute creation; not long since a cargo of them arrived in Jamaica, whose hands had little or no ball to the thumbs, whose nails were more of the claw kind than otherwise, and their want of intellectual faculties was very apparent. Every planter knows that there are negroes, who ... cannot be humanised as others are, that they will remain, with respect to their understanding, but a few degrees removed from the ouran-outang [ie. the chimpanzee and gorilla]; and from which many negroes may be supposed, without any very improbable conjecture to be the offspring ... The Colonists of the West-Indies are instrumental in humanising the descendants of the offspring of even brutes ... to the honour of the human species, and to the glory of the divine being ...* (1)

Such openly racist propaganda in Britain towards the end of the eighteenth century, was possible due largely to the works of three 'eminent' thinkers of the century: Sir William Petty, John Locke and David Hume. Sir William Petty is often regarded as the founder of modern Political Economy. In an essay of 1677 entitled *The Scale of Creatures*, he argued that Europeans differed from Africans in almost all respects: skin colour, hair type, various aspects of body shape, skull shape, behaviour and intellectual capacity. For Petty, the African was inferior to the European in all these aspects. [Fryer: 1984]

John Locke, a liberal philosopher and contemporary of Petty was able to reconcile his theory of the inalienable rights of man (sic) with a defence of slavery. In addition, in a paper of 1690 entitled *Essay Concerning Human Understanding*, he contributed to the belief that Africans were an inferior 'race' of humans by outlining the foundation for a possible racist theory of intellectual gradation. [Fryer: 1984]

The third 'eminent' thinker of the eighteenth century, the philosopher David Hume, was openly racist. In a footnote added to his essay entitled *Of National Characters* in 1748 he commented:

> *I am apt suspect that negroes, and in general all the other species of men (for their are four or five different kinds) to be naturally inferior to whites. There never was a civilised nation of any other complexion than white, nor even any individual eminent either in action or speculation. No ingenious manufacture amongst them, no arts, no sciences ... Such a uniform and constant difference could not happen, in so many countries and ages, if nature had not made an original distinction betwixt these breeds of men.* (2)

The supposed authoritative nature of the texts of these three well respected intellectuals laid the foundation for many more racist outpourings in the years that followed. Two volumes of the twenty-three volume work

the *Universal History* (1736-1956) contains page after page of vitriolic abuse of Africans. Various Greek and Roman authors are cited describing Africans as deceitful, inhuman, cowardly, treacherous, savage, cruel, incestuous, lazy and treacherous, amongst others. [cited in Fryer: 1984; p153] William Knox, a racist pamphleteer from 1768 onwards, who had first hand experience of slavery having been provost-marshal of Georgia between 1757 and 1761, was convinced that blacks were intellectually inferior to whites, were incapable of education and had no emotional feelings. [Fryer: 1984]

Probably the most influential and widely read of the propagandists of plantocracy racism was Edward Long, the son of a Jamaican planter. In a pamphlet of 1772, having described black people in Britain as a *"disolute, idle, profligate crew"*, he went on to defend the purity of the 'white English race' in the following way:

> *The lower class of women in England, are remarkably fond of the blacks, for reasons too brutal to mention; they would connect themselves with horses and asses if the laws permitted them. By these ladies they generally have a numerous brood. Thus, in the course of a few generations more, the English blood will become so contaminated with this mixture ... this alloy may spread so extensively, as even to reach the middle, and then the higher orders of the people.* (3)

Probably Long's most infamous work is his three volume *History of Jamaica* (1774), which contains lengthy sections detailing the innate inferiority of black people. This text has come to be recognised as the classical expression of eighteenth century English plantocracy racism. For example:

> *When we reflect on ... their dissimilarity to the rest of mankind, must we not conclude, that they are a different species of the same genus? ... Nor do [orang-utans] seem at all inferior in the intellectual faculties to many of the Negroe race; with some of whom, it is credible that they have the most intimate connexion and consanguinity. The amorous intercourse between them may be frequent ... and it is certain that both races agree perfectly well in lasciviousness of disposition.* (4)

In this short passage, Long crystallises the central beliefs white Europeans had about black people: their supposed distinctiveness as a separate and inferior 'race'; their inhumanity and beast-like behaviour; their lack of intellect and prodigious sexuality. The manner in which Long wrote enabled him to claim scientific rigour for his assertions, and in this sense he can be recognised as the first pseudo-scientific racist: it was his writings which bridged the gap between the self-interested racism of the plantation system and the so-called scientific racism of the nineteenth century. [Fryer: 1984]

Pseudo-Scientific Racism

Plantocracy racism had ensured that racist ideas had taken a firm hold in Britain by the 1770's. The British slave trade ended in 1807, however, and slavery was terminated in 1833. The new basis for the development of pseudo-scientific racism was the expansion of the British Empire. Edward Long's *History of Jamaica* operated as one of the linking mechanisms between the two forms of racism. His arguments depicting the inherent inferiority of black people, were widely read and accepted by scientists of his own time and for a further forty years after his death in 1813. Plantocracy racism was being reproduced and refined in a more supposedly scientific form in order to justify the expanding British Empire. [Fryer: 1984]

Empire, like the slave trade and the use of black slave labour in the sugar plantations of the British West Indies, was crucial to the economic development of Britain. British colonial rule was primarily a mechanism for providing British capitalism with cheap raw materials, land and labour. In the various colonies, minerals were dug by low-paid black workers in British owned mines, and crops were produced either by poorly-paid black workers on British owned plantations

or by peasants whose crops were bought by British monopoly enterprises who could dictate the lowest possible price. Black labour created profits for British enterprise by producing sugar and bananas in Jamaica, tea and rubber in Ceylon, cocoa on the Gold Coast, groundnuts in Gambia, cloves in Zanzibar, and sisal and coffee in Tanganyika. Besides this direct exploitation of black labour in the colonies, British traders were also able to generate profits from their investments in mines and plantations, from selling goods manufactured in Britain in the closed and protected markets of the colonies, and through shipping, banking and other services which ensured the system was maintained. [Fryer: 1989]

In short, British capitalism was able to profit enormously from its exploitation of black people in the colonies. While British capitalists grew rich, the majority of black people in the Empire suffered from chronic poverty and hunger, disease, atrocious housing, illiteracy and tyranny. Conditions which were a direct result of the colonial economic system. [Fryer: 1989] If we take the example of India, it will be possible to illustrate how this enrichment of Britain at the expense of the impoverishment of a colony under British rule took place.

The East India Company (EIC), founded in 1600, established British rule in India with its first base in Surat in 1619. Initially, the trading merchants of the EIC traded <u>with</u> India, exchanging silver for the goods produced in India. Britain obtained the necessary silver through its trade in slaves with Spanish America. By 1687, the EIC had moved its headquarters to Bombay and more than one hundred British resident agents were operating in India. [Desai: 1976; Fryer: 1989]

British military victory at Plassey in 1757 by Clive, ensured that Britain had control over a great deal of the country. The EIC began the exploitation of the India shortly afterwards. The company replaced the traditional form of taxation with a system which introduced a fixed tax irrespective of productivity. In a poor year Indian farmers were forced to borrow money at high interest rates from British money lenders to pay their taxes. The taxation system not only reduced the living standards of Indian farm workers, but also undermined their agricultural economy and political structure based on self-governing villages. British monopoly control of productive activity in the country allowed exploitation to become endemic, with resistance or inability to meet obligations imposed by the EIC brutally repressed. [Desai: 1976] Between 1757 and 1815

estimates suggest that Britain drained between £500 million and £1,000 million from the Indian economy. [Fryer: 1989]

Monopoly control of the Indian economy by Britain, through the EIC, led to the de-industrialisation of the country. Prior to British exploitation, India's economy in agriculture and manufacturing was reasonably advanced. India produced cotton, silk and woollen products, was involved in shipbuilding and metal mining and manufacture, and had an effective export capacity. Under British rule, however, this indigenous development ceased. India became an agricultural colony of British capitalism, forced to export raw cotton, wool, jute, oilseed, dyes and hides to Britain. British tariff controls ensured that any exports to other destinations was severely restricted. At the same time, India became a new market for the continued expansion of British manufactured goods. Previously the country had been a substantial exporter of textiles, but under British rule India became an importer of textile goods. [Desai: 1976]

The EIC handed over its rights of trade in India to the British Crown in 1858, following the first national uprising against British rule by the Indian population.

By this time, however, Britain had already found a new use for Indian labour. The abolition of slavery throughout the Empire in 1834 resulted in the freed slaves leaving the plantations in the West Indies in large numbers. The plantation estates were desperately in need of cheap labour, and from 1838 to 1917 about half a million poor Indian workers left the poverty and harshness of British rule in India in order to go to the West Indies as indentured labour, in the hope of a better life. [Tinker: 1974; Fryer: 1989]

Indenture, however, proved to be little more than serfdom. Recruiting agents on behalf of the planters in the British West Indies would tour India encouraging labourers to sign-up and migrate. Indian men were contracted for five years, and women for three. They were held criminally liable, with draconian penalties, for even the smallest breaches of contract. In addition, most Indian workers arrived in the plantations with little idea of their conditions of work. Labourer's could not withdraw from their contracts under any circumstances, they could not move freely between one estate and another in order to sell their labour power, nor could they leave their own estates without a pass. The labour of indentured migrant Indians (the 'coolie' system) saved the sugar economy of the British

West Indies, enabling them to continue making a contribution to British wealth. [Tinker: 1974; Fryer: 1989]

The situation in India was repeated in one form or another, throughout the British Empire: Africa, South Africa, Tasmania, Australia, New Zealand, Malaya, Fiji and Mauritius. British colonial rule meant the enrichment of the British economy through subjugation and exploitation of the black populations of the various countries which constituted the Empire. [Fryer: 1989] 'Scientific racism', which aimed to provide a scientific basis to the notion that black people belonged to an inferior 'race', crated the necessary justification and legitimisation for British rule and control of black people and their lands.

The early forms of pseudo-scientific racism by authors like Long, was nourished by various aspects of the developing biological sciences of the late eighteenth and nineteenth centuries. Swedish botanist Car Linne (generally known as Linnaeus), who laid the foundations for the modern classification of plants and animals, categorised Africans and Europeans in the following way in 1792:

> *H. Europaei. Of fair complexion, sanguine temperament, and brawny form ... Of gentle manners, acute in judgement, of quick invention, and governed by fixed laws ..*
> *H Afri. Of black complexion, phlegmatic temperament, and relaxed fibre ... Of crafty, indolent, and careless disposition, and are governed in their actions by caprice. - Anoint the skin with grease.* (5)

The so-called science of craniology was also used as a basis of human differentiation. The originator of the study of human skulls, Johann Friedrich Blumenbach, a German professor of medicine, identified five varieties of humans. The word 'Caucasian' to describe white humans, comes from his studies of skulls. One skull from the Caucasus in Russia led Blumenbach to suppose that Europeans originated in that region. He preferred the 'Caucasian' type of skull to those of the 'Mongolian' or 'Ethiopian' type, which he asserted were furthest removed from the 'Caucasian' form. Blumenbach's method of studying skulls relied on him placing the skull between his feet and then examining them from above to determine their shape and which category they belonged to. [Fryer: 1984] Blumenbach's method was clearly a subjective approach, which had little connection with the objective criteria of analysis and measurement usually associated with scientific investigation.

A variation of craniology, phrenology, asserted that it was possible to determine human character from skull shape. Phrenologist believed that there was a direct correlation between skull shape on the one hand, and the different human groups and their level of civilisation on the other. They asserted that the skulls of black people were very similar to that of monkeys, and consequently were inferior to the highly developed skull of the white European. [Fryer: 1984]

A further variation on the study of skulls, was the measurement of 'facial angle', devised by Dutch anatomist Peiter Cramer. Cramer's technique measured the extent to which the jaw jutted out from the rest of the skull. He supposed that a wider angle proved a higher forehead and therefore indicated a bigger brain and greater intellect. Cramer concluded from his studies that the angle grew wider as one moved from apes to Africans, then to Indians and finally to Europeans. Cramer's technique, 'proved' therefore, that Europeans had the bigger brain capacity and greater intellect. [Fryer: 1984]

By the beginning of the nineteenth century, then, the so-called 'sciences' of the time had propagated the view

that the human population could be sub-divided into a number of distinct 'races', which could be graded hierarchically. Pseudo-scientific racism supported the view that the white 'race' was biologically superior to the black 'races', and therefore, was destined to rule over them. [Fryer: 1984]

In the middle of the nineteenth century Social Darwinism arrived to add its weight to the claims of 'scientific racism'. Darwin's theory of evolution, published in 1859, proved conclusively that white Europeans were related to Africans and that all humans were in turn related to Apes. While it had already been argued by some, (eg. noted author Thomas Carlyle in 1853) that white European society represented the culmination of the human evolutionary process, it was not until the sociologist Herbert Spencer applied Darwin's ideas to human societies and ethics, coining the phrase 'survival of the fittest', that writers began to draw racist conclusions from the Darwin's 'natural law of evolution'. [Fryer: 1984]

Sir Francis Galton, Darwin's cousin and founder of 'eugenics', (6) believed that human evolution had left the black 'races' two grades lower intellectually than

the white 'races'. He also claimed that his findings were supported by the statistical techniques he had used. Karl Pearson, a pupil of Galton and a professor at London University and fellow of the Royal Society, argued that the black 'races' were of *"poor stock"*, and he went on to declare:

> *History shows ... one way, and one way only, in which a high state of civilisation has been produced, namely, the struggle of race with race, and the survival of the physically and mentally fitter race ...*
>
> *This dependence of progress on the survival of the fitter race ... gives the struggle for existence its redeeming features.* (7)

This was how Darwin's theory of evolution had been distorted to authenticate racist theory and justify British colonial rule. At its most extreme form, evolutionist racism was not shy about advocating the extinction of supposed inferior black 'races' to make space for the supposed superior 'white races'. Deplorably, the extinction of black people was not confined to theory. British rule in Tasmania, which began in 1803, resulted in the extinction of the black population (estimated at some 4,000 at its largest) within seventy-five years. [Fryer: 1989]

This extreme form of pseudo-scientific racism was exemplified by the work of the Scottish medical practitioner and anatomist, Dr Robert Knox. In April 1855, the Lancet published an article by Knox, which outlined his views on 'race' categorisation. [Lancet, 1, 7-4-1855; pp357-60] For Knox, the human family had a common origin, but was divided into distinct 'races'. The races of humankind, could be identified by scientifically determined anatomical differences. The minutiae of anatomical difference, however, was not sufficient by itself to allow the categorisation of 'races'. Knox was adamant that:

> *... the presence of the exterior is necessary, and the most important.* (8)

In an approving retrospective review article of Knox's *The Races of Man*, the Lancet reproduced his ideas to explain 'racial conflict' as a natural phenomenon. [Lancet, 2, 2-12-1865; pp626-7] The article comments:

> *Amongst the more important of the principles enunciated by the once great anatomical teacher was the doctrine that human character, individual and national, is traceable solely to the nature of the race to which the individual or nation belongs ...* (9)

The article cited Knox's belief that 'race' is what *"stamps the man"* (sic). (10) Consequently, human

literature, science and art, the very signifiers of human civilisation, depended on 'race'. Conflict between the 'races', therefore, was inevitable and natural, and merely another form of Darwin's natural selection. Knox is further reported as suggesting that only one 'race: black or white, would be master of the world. Consequently, because the 'white race' was superior in all respects, it was legitimate that white Europeans should take up arms in order to defend and extend their colonial Empires.

Knox not only contributed to the production and reproduction of pseudo-scientific racism, but his views also demonstrate how ideological articulation between racism and nationalism occurred. Knox argued that historical analysis demonstrated that each 'race' was engaged in a struggle to form its own laws, literature, and language, that is it own civilisation, in accordance with its biological characteristics. In addition, because these cultural phenomena were biologically determined they could not be socially transmitted. [Miles: 1987] As Knox commented:

> *The fact, the simple fact, remains just as it was: men are of different races. Now, the object of these lectures is to show that in human history race is everything.*
>
> *The results of the physical and mental qualities of a race are naturally manifested in its*

> *civilisation, for every race has its form of civilisation.* (11)

Knox is clearly arguing that each 'race' requires its own territory within which its distinctive capacity for 'civilisation' could be realised. For Knox, then, 'nation' is grounded in the concept of 'race'. The determining character of 'race' shapes all aspects of culture to such an extent that the category of 'nation' dissolves into that of 'race. The articulation and interdependence of the categories 'race' and 'nation' was, for Knox, hierarchical and biologically dominated.

By the beginning of the second half of the nineteenth century, pseudo-scientific racism had enabled British rule over its Empire to go largely unquestioned in Britain itself. The white British as the superior 'race' was biologically best suited to instil the benefits of civilisation upon the inferior black 'races' over which it ruled. That this perspective was taken for granted in Britain, is summed up by the Colonial Secretary Sir Edward Bulwer Lytton, who told MPs in 1858 that it was in the nations common interest to:

> *... fulfil the mission of the Anglo-Saxon race, in spreading intelligence, freedom, and the Christian faith wherever Providence gives us the dominion of the soil.* (12)

Racism was now, in nineteenth century Britain, permeating all aspects of life. Historiography, children's literature and popular literature, all operated in their own ways to reproduce the mythology of 'race'.

The youth of Britain was taught a version of history which glorified Britain's leading role in Empire, and portrayed black people as inherently inferior. For example, James Anthony Froude, Regius Professor of Modern History at Oxford, wrote in *The English in the West Indies* (1888):

> *The poor black was a faithful servant as long as he was a slave. As a freeman he is conscious of his inferiority at the bottom of his heart, and would attach himself to a rational white employer with at least as much fidelity as a spaniel. Like the spaniel, too, if he is denied the chance of developing under guidance the better qualities which are in him, he will drift back into a mangy cur ...*
>
> *We have a population to deal with, the enormous majority of whom are of an inferior race ... Give them independence, and in a few generations they will peel off such civilisation as they have learnt as easily and as willingly as their coats and trousers.* (13)

British school children were also subject to a racist version of history. Cassell's *Class History of England* (1884) commented:

> *[In the British Empire] we are face to face with barbarous peoples, whom it is profitless to conquer, yet amongst whom it is difficult otherwise to enforce peace and order ... [This difficulty] meets every nation which goes forth to carry civilisation to uncivilised peoples.* (14)

and *School History of England* (1911) by C L R Fletcher and Rudyard Kipling, describes black inhabitants of the West Indies as:

> *... lazy, vicious and incapable of any serious improvement, or of work except under compulsion. In such a climate a few bananas will sustain the life of a negro quite sufficiently; why should he work to get more than this? He is quite happy and quite useless, and spends any extra wages which he may earn upon finery.* (15)

Some of these students then went on to reproduce British history distorted by racism for the next generation, and into the twentieth century.

The British 'professional occupation of medicine, through the occupations journals were also involved in reproducing pseudo-scientific racism into the twentieth century. The Lancet, in 1906, in an article entitled, *Racial Peculiarities of the Negro Brain* [Lancet, 2, 10-11-1906; pp1314-5] reported that it had now been proven beyond all doubt that the 'negro' was of smaller stature and weight, with less skull capacity and a smaller brain, than the 'caucasian'. The article suggested that these phenotypical differences between 'negro' and

'caucasian' by which 'races' are characterised, was largely due to this difference in brain size.

As a consequence of this assertion, the article defined the 'caucasian' as:

> *... subjective, dominant and masterful, full of determination, will power, self-control, with a high development of the ethical and aesthetic faculties. He is a great reasoner ...* (16)

The article, then presented the 'negro' as the direct opposite of the 'caucasian':

> *The negro is affectionate, very emotional, sensual, and under excitement passionate. He has love of ostentation, of outward show, of approbation, love of music and singing, and undeveloped artistic power and taste, for he makes a good artisan. He has instability of character, lack of self-control (especially in sexual relationships), and a certain peculiar bumptiousness caused by too high an appreciation of himself and his surroundings. He is meek and submissive but prone to become violent when any sudden danger appears. His body senses, smell and sight are usually well developed.* (17)

The journal was clearly reproducing racism as ideology. It first defined the main difference between the white and black 'races' by reference to phenotypical characteristics, and then explained the distinction in terms of brain size. Having defined the two 'races' in this manner, the article then goes on to attach a range of cultural attributes to the two basic somatic groups

identified. This corresponds almost exactly to the definition of racism as ideology identified earlier in Chapter II.

Summary and Conclusions

The above outline of the historical roots of British racism, illustrate how racism as an ideology had its origins in Britain's colonial connections: initially through the slave trade and then in relation to the expansion of Empire. These two aspects of Britain's colonial history, formed the material basis for the generation and reproduction of racism. Plantocracy racism emerged to justify and legitimate the economic exploitation of black slave labour and participation in the slave trade. Pseudo-scientific racism of the nineteenth century reproduced and modified plantocracy racism in order to justify and legitimate colonial expansion and the exploitation of black people, their lands and resources, throughout the British Empire. Both the slave trade and Empire were crucial to Britain's development as a capitalist society.

These two forms of racism were the outcome of much earlier perceptions about the 'other'. The British

already had a language and set of images to make sense to the distinction between black and white. Black was ascribed negative evaluated characteristics, and white carried with it positive meanings. It was not surprising, therefore, that when the white British came into contact with the black African, skin colour should become a primary signifier of the differences between the two peoples.

Plantocracy racism operated within this process of signification to describe black people as animals with a potent sexuality. They were said to be generally inferior and specifically intellectually inferior to white people. Slavery was touted as a humanising and civilising force on black people. With respect to pseudo-scientific racism, the desire was to demonstrate that the process of signification had a scientific basis. Biology, anatomy, craniology, phrenology, the bastardisation of Darwin's notion of 'natural selection', were each used as evidence to support the belief that black people were of a different and inferior 'race' to white people, while at the same time emphasising the superiority of the English race and claiming it was a moral obligation for Britain to bring civilisation, christianity and the law to black 'races'.

The transition from plantocracy racism to pseudo-scientific racism raises an interesting question in relation to whether at any historically specific point in time we are observing and analysing a single manifestation of racism, or a number of distinct varieties of racism. Plantocracy racism was concerned primarily with the African as a slave, and although popular consciousness did and continues to distinguish between black people of African descent from those of Asian origin, this subtle distinction is not readily apparent within plantocracy racism.

It was shown, however, that pseudo-scientific racism did posit this distinction by identifying Indian or Asian people as a biologically distinct 'race', located 'between' the African and European 'races'. [see p128] However, it is again unclear whether Africans and Asians were the object of distinct variations of pseudo-scientific racism. The available literature focuses almost exclusively on racism in relation to the African or black people generally.

It will also be shown in the next section of this Chapter, which investigates the Indian Medical Service operating in colonial India, that the 'professional'

occupation of medicine reproduced this general form of racism. There is no evidence to suggest that the occupation undertook a specific re-formulation of this racist discourse which related to black people generally, in order to racialise Indian doctors seeking to enter and work in the IMS.

This issue does suggest, however, that the actual content of any historically specific form of racism could itself be constituted by more than one concrete form of racism. Because black people are themselves a heterogeneous grouping, they may be subject to a variety of actual racisms. Indeed, it will be shown in Chapter VI, that from 1974 onwards, migrants from the West Indies and India were subjected to distinct forms of racism. The 'race/immigration' issue of post-1945 Britain continued to be reproduced in respect of the continued migration of dependants from the Indian subcontinent. For the migrant, now obviously settler West Indian population, however, the racist discourse was re-formulated because continued migration from the West Indies had largely halted. The 'immigration' of West Indians was no longer the issue. The re-formulated racist discourse focused on the 'problem' of the 'second generation' West Indian population. West Indian youth

were being politically criminalised as the 'enemy within'.

With pseudo-scientific racism relying so heavily on the biological and 'natural' sciences, it is not surprising that doctors were involved in sustaining the mythology of 'race'. Craniology was founded by a German professor of medicine, and Dr Robert Knox exemplified the most aggressive form of 'scientific racism'. A discourse which was highly regarded by the medical journals at the time. In addition, Knox's writings also illustrated the articulation of nationalism with racism, where he grounded his idea of 'nation' within his conceptualisation of 'race'.

By the second half of the nineteenth century, the efficacy of 'scientific racism' as a satisfactory mechanism of explanation of Britain's colonial relations, had resulted in the idea of 'race' becoming a largely unquestioned common sense notion. Racist ideas were part of British historiography, and children's and popular literature. By the first-quarter of the twentieth century ,the British 'professional' occupation of medicine was continuing to reproduce the idea of 'race', by giving credibility to the belief in the

natural and inherent biological differences between 'races', and linking this biological differentiation to cultural variation.

Plantocracy and pseudo-scientific racism formed one part of the ideological terrain upon which British colonial rule in India occurred. The effects of racism as ideology during this period are the subject of the next chapter. It will be argued that the ideology of racism operated to shape the relationship between the British 'professional' occupation of medicine in colonial India and Indian doctors. A process which was to have a legacy in relation to the post-1945 migration of Indian doctors to Britain.

THE RACIALISATION OF DOCTORS IN COLONIAL INDIA

Introduction

The objective of this section is to outline and analyse the process of racialisation that doctors from the Indian subcontinent have faced, in terms of their relations with the British 'professional' occupation of medicine. It will be shown that Indian doctors were subject to unequal treatment in relation to entry into

and terms of conditions of employment in the IMS, when compared to their British counterparts.

This will be followed by an exploration of the justificatory arguments used by the British 'professional' occupation of medicine, to create and sustain their dominance within the IMS, and the subordination of Indian doctors. Before presenting any detailed outline of the racialisation of doctors in colonial India, however, a brief description of the Indian Medical Service will be provided, in order to set this early phase of the racialisation process in context.

British Medicine and the Indian Medical Service

The creation of the IMS by the British ruling administration in colonial India, which was based largely on the system of medical education and service provision operating in Britain at the time, had its origins in the operation of the East Indian Company (EIC). The first British medical officers arrived in India on the original three ships sent out by the East India Company in 1600, when trading relations were first established with India. These were then succeeded by other fleet surgeons and medics who remained in India to

serve in the company settlements. [BMJ, 1, 31-5-1924; pp970-1] The first surgeon general of the East Indian Company was John Woodall, who was appointed in 1612. [Lancet, 2, 30-8-1947; p319]

Although the Indian Medical Service was not formally established until 1897, [BMJ, 1, 31-5-1924; pp970-1] the first 'native' Indian medical students emerged under the control and supervision of the surgeons of the East India Company. Initially these students were taken on as apprentices in dispensing, with instruction in chemistry, anatomy and pharmacology. As the benefits from this system were recognised by the Company, all the major subjects of the medical curricula were subsequently included in the training programme. [BMJ, 1, 15-3-1930; pp508-11]

The Indian government in colonial India began to involve itself in the organisation of medical education with the establishment of medical colleges at Calcutta and Madras in 1835. This was supplemented in 1845 with the opening of Grant Medical College in Bombay, a medical college at Lahore in 1860, and Lucknow Medical College in 1911. By 1925 there were ten university medical colleges in colonial India. [BMJ, 2, 14-9-1946; pp369-72] In the

early days many medical colleges in colonial India granted their own diplomas, but affiliation to the newly developing universities provided a guarantee of educational standards. [BMJ, 2, 14-9-1946; pp369-72] All of these colleges were to quickly become government institutions working in close relationship with the IMS. [BMJ, 15-3-1930; pp508-11]

There was no coordinating body to register or maintain medical education standards, such as the GMC in Britain. Medical education was largely controlled by high ranking medical officers of the IMS. [BMJ, 2, 14-9-1946; pp369-72] All the professors working in the medical colleges were initially part-time Presidency officers of British origin. Entrance to the IMS as a medical officer was gained only by passing an examination in London. All candidates for the service, Indian and British, had to be holders of British qualifications. [BMJ, 1, 15-3-1930; pp508-11] This requirement ensured, in the early years of the IMS at least, that the main medical teaching posts in colonial India were held by white British-trained medical officers.

The IMS was both a military and civil operation. Although it main medical work was military, a number of

appointments were reserved for civil duties. These civil appointments were always subject to recall for military purposes. A doctor had to spend the first two-to-five years in the service providing for the medical needs of the army in colonial India, before becoming eligible for transfer to civil employ. The 'elite' jobs in the reserved civil medical posts were the civil surgeoncies. These included specialist appointments at teaching hospitals and the most prestigious research jobs. [BMJ, 2, 9-10-1937; pp222-32. Lancet, 1, 8-3-1913; pp707-9]

The IMS was supplemented by two other military branches of medical provision: the Royal Army Medical Corps of India (RAMC) and the Indian Medical Department (IMD). The RAMC was concerned mainly with medical care of British troops and their families, and had little to do with the civil population of India. The IMD supplied the subordinate military medical personnel for the armed forces in India. It comprised two divisions. On the one hand, were the military assistant surgeons who serviced British troops in India. They were mostly Anglo-Indians, and underwent training in medical colleges funded by the government of India. On the other hand, were the sub-assistant surgeons who served Indian troops. They were trained in medical schools,

attached to Indian Station hospitals and served under IMS officers. Both assistant surgeons and sub-assistant surgeons could be selected for civil appointments. [BMJ, 2, 9-10-1937; pp222-32. Lancet, 1, 8-3-1913; pp707-9]

From 1919 onwards, much of the control of medical provision in India was regionalised under Provincial Medical Services. From this date onwards medical administration, hospitals, dispensaries, asylums, medial education, public health, sanitation, health statistics, and the regulation of medical qualifications and standards all came under the control of the various provincial administrations. [BMJ, 2, 9-10-1937; pp222-32]

The civil medical head of each province was a surgeon-general, who also acted as the chief administrative officer of the province. Each province recruited its own medical personnel, with the exception of those IMS officers who were eligible for civil employ, who were appointed. As a result, one-fifth of all civil surgeoncies were allocated to IMS medical officers. The duties of civil surgeons varied with the locality, but typically they were responsible for the medical administration of the district and all government

hospitals. They also acted as medico-legal advisers to the government, and provided medical care for government officers and their families. They were assisted by a number of assistant and sub-assistant surgeons. [BMJ, 2, 9-10-1937; pp222-32. Lancet, 1, 8-3-1913; pp707-9]

Typically, a district hospital in each province had 100 beds with one civil surgeon, one assistant surgeon and one sub-assistant surgeon. Smaller hospitals were supervised by assistant surgeons, and even smaller rural hospitals would be run by sub-assistant surgeons. Both, however, remained under the overall control of the civil surgeon of the region. [BMJ, 2, 9-10-1937; pp222-32]

Graduates of recognised Indian universities, after competitive examination, were selected as civil assistant surgeons. They were employed as lecturers, professors, assistant-professors in medical schools, demonstrators in medical colleges, house surgeons and physicians in large hospitals. Licentiates of Indian medical schools were selected as civil sub-assistant surgeons. They were located in many and varied occupations covering all the medical posts of subordinate status. Assistant surgeons could be promoted to become civil surgeons and sub-assistant

surgeons could progress to assistant surgeon, but only after many years experience. [BMJ, 2, 9-10-1937; pp222-32]

We have already seen above, that many matters dealing with medicine in India had been transferred to the regional authorities at the end of the First World War. Regulation of medicine was attempted between 1912 and 1936, when most of the provinces in India had established Provincial Medical Councils, although these were solely concerned with medical education in the specific region. [BMJ, 2, 14-9-1946; pp369-72] This, however, lead to problems of effective coordination, because each province had a large degree of independence in relation to how it operated with other provinces and with respect to the central government. [BMJ, 1, 15-3-1930; pp508-11]

The solution to this problem, was the establishment of an All India Medical Council (AIMC) to oversee medical education and standards, in February 1934. The Council was established to ensure the maintenance of a uniform minimum standard of medical education for the whole of British India, and to establish reciprocity with

appropriate countries and institutions. [BMJ, 2, 14-9-1946; pp369-72]

Other features of the AIMC's activities included its active support in encouraging the upgrading of medical schools to medical colleges (and the abolition of medical schools that could not efficiently be upgraded), as well as supervising the establishment of new medical colleges during post-war re-construction. In addition it had been encouraging licentiates to undertake extra tuition in order to gain medical degrees. At the outset, the AIMC recognised all British qualifications, and following negotiations with the GMC, the Council agreed to recognise all medical qualifications granted by British Indian Universities recognised by AIMC. [BMJ, 2, 14-9-1946; pp369-72]

The creation of the AIMC was preceded by a long drawn out dispute over British recognition of Indian qualifications. It also corresponded with a substantial decrease in the proportion of European teachers in the older colleges. For example, in the two new colleges affiliated to the universities of Calcutta and Bombay respectively during this period, the professorial staff

included no British doctors. [BMJ, 1, 15-3-1930; pp508-11]

This 'Indianisation' of western medicine in colonial India was progressing quickly, especially with the prospect of Indian independence on the political horizon. In addition the independent medical profession in India was growing rapidly in the first thirty years of the twentieth century, especially in the larger towns of colonial India. Most of them were graduates and a number had come to the UK to gain postgraduate qualifications. Some of them acted as honorary officers in government medical schools and colleges and private hospitals. The less qualified licentiate had converged on the towns, operating privately alongside graduates. [BMJ, 2, 9-10-1937; pp222-32. Lancet, 1, 8-3-1913; pp707-9]

This was the position prior to Indian Independence in 1947. The IMS ceased to exist at midnight on Thursday, August 14, 1947, with Indian independence. At the birth of India as an independent 'nation-state', the country was left with ten medical colleges training students for university medical degrees, and seventeen medical schools for licentiate education (most of which were

rapidly being raised to the status of colleges with University affiliation). [BMJ, 2, 23-8-1947; pp300-1]

The British Medical Journal's leading article at the time commented:

> *What of the legacy that the IMS bequeaths to India and Pakistan? In the first place it has two lineal descendants - the Provincial Medical Services, in most provinces highly efficient, and the young and vigorous Indian Army Medical Corps. In addition, it leaves behind a highly organised and independent medical profession of some 50,000 medical practitioners, of which the vast majority were directly taught by officers of the Service, and the remainder by teachers who had received their own professional education from that source. The creation and development of this independent profession has been, and is, a source of legitimate pride and pleasure to the whole Service; and the professional and ethical standards set by the IMS will provide its successors - in the public services and in the independent profession alike - with an inspiring tradition and a yardstick by which their success or failure will be measured.* (18)

While this self-congratulation by the British 'professional' occupation of medicine may in part be justified, it will be demonstrated below, that the British occupation was able to ensure Indian doctors became/remained a racialised fraction of medical practice in colonial India. The occupation drew on a racist discourse to both secure for itself the 'best' posts in the IMS, while simultaneously relegating Indian

doctors to a largely subordinate and supportive role within the service.

Occupational Exclusion and Control in the IMS

There were a number of clearly defined constraints on Indian doctors joining the IMS, and progressing within the service in a similar way to their British counterparts. Although technically, the IMS as whole was open to all doctors whose qualifications were recognised by the GMC to compete for entry, the requirement that 'native' Indian doctors must take their entry examination in England obviously placed severe constraints on the number who could afford to take up this offer. [Lancet, 1, 30-5-1908; p1598: Lancet, 2, 19-12-1908; p1859]

The terms and conditions of employment on entering the IMS were also different for Indian and British doctors. Recruitment to the IMS for British doctors provided a permanent post, with the first three years of service representing a probationary period. The longer they worked as an officer in the service so their retirement gratuity increased proportionally. [BMJ, 2, 9-10-1937; pp222-32] Before April 1937 Indian doctors entered the

IMS on a temporary basis. Commissions were renewable year-on-year. and it would take up to five years before an Indian doctor became eligible for permanent appointment. In addition, retirement with gratuity was limited to Indian officers completing six years service from the date of permanent appointment. [BMJ, 2, 9-10-1937; pp222-32]

After April 1937, the rules governing admission to the IMS for Indian doctors were revised. A short-service commission lasting for five years was introduced. These officers were then asked on conclusion of their short-service commission whether they wished to be considered for a permanent appointment. It was estimated at the time that only seventy per cent of those whose stated preference was to be considered for a permanent position, would be accepted. The remainder would be retired with a small gratuity. While this system may appear more adequate for those who failed to be selected for a permanent position in the IMS, those who were successful under the new system lost the right to any retirement gratuity after six years service (ie. after one years service with a permanent commission). [BMJ, 2, 9-10-1937; pp222-32] Under either system, Indian doctors did not enter the service on the same basis as their British counterparts.

In relation to rates of pay, both Indian and British doctors in the IMS were paid the same basic rates. British doctors, however, also received an overseas allowance which Indian doctors were not eligible for. The difference in gross pay was further widened in 1937, when basic pay was reduced while the overseas allowance was increased. [BMJ, 2, 9-10-1937; pp222-3]

Other privileges of being an officer in the IMS were not equally shared between Indian and British doctors. A limited number of posts such as civil surgeoncies, teaching, research and public health, were reserved for officers of IMS in civil employ. The number of civil posts reserved for Indian IMS officers was significantly less than the number reserved for British IMS officers, and no specialist posts in the principal teaching centres were reserved for Indian officers of the service. In addition, Indian doctors in the independent private sector were excluded completely from these reserved posts. This effectively denied this section of Indian doctors any contact with specialist medicine or innovative techniques. [BMJ, 2, 9-10-1937; pp222-32]

The requirement to take entry examinations in England, the differing criteria governing the appointment to

permanent posts and pension entitlements, restricted entry to the most prestigious civil posts, and the differing pay structure, illustrates how the British 'professional' occupation of medicine in colonial India was able to control and exclude Indian doctors in the IMS. The justificatory arguments which legitimated this 'second-class' status of Indian doctors practising in colonial India, were conducted through the language of the ideologies of racism and nationalism, and professionalism. This justificatory discourse was most vividly expressed in relation to the debate concerning the increasing use of 'native' Indian doctors in the IMS, that is, the Indianisation of the IMS.

From the beginning of the twentieth century, the British 'professional' occupation of medicine believed that their position in the IMS was increasingly under attack because of the expansion in the number of 'native' Indian doctors entering the service. This was of particular concern to the occupation, as medical work in the colonial territories generally, and the IMS in particular, carried with it high status and material rewards for white British trained doctors.

A leading article in the BMJ of 1909 identifies the existence of a secret dispatch by the Secretary of State to the Government of India (Lord Marley) (19) stating that there was to be no further increase in the IMS, and that its civil side would be increasingly recruited from 'native' Indian doctors qualified in Indian universities. [BMJ, 1, 15-5-1909; pp1203-4] The idea was that 'native' Indian doctors should be encouraged to establish themselves in private practice in the cities, towns and villages of India and be available and willing to undertake government work within the IMS when necessary. [BMJ, 2, 24-7-1909; pp223-4] They would be required to undertake competitive examinations in Calcutta, rather than by examination in London which was currently the practise. [Lancet, 1, 16-3-1901; pp818-9]

The BMJ warned that such a move would reduce the attractiveness of the IMS generally to British graduates, resulting in a substantial decline in their willingness to apply to join the service. [BMJ, 1, 15-5-1909; pp1203-4] The fear of the occupation was that a change in policy like that suggested by Lord Marley would operate to replace the British civil officer of the IMS. [BMJ, 2, 24-7-1909; pp223-4] The Lancet went even further, when its 'Special Correspondent' on India commented:

> *... it is ... absurd to compare an Indian degree and education with those obtained in the British Islands. The feeling in the service is that there are too many natives in it already, so that any further concessions in this direction would be undoubtedly unpopular.* (20)

The British 'professional' occupation of medicine, through the Lancet, is using the language and imagery of professionalism to justify its position against the trend towards the increasing number of Indian doctors entering the IMS. Although the medical education system in colonial India was based on the one operating in the UK, the Lancet is clearly implying that the high medical education standards existing in Britain which allow the occupation to claim that medicine is based on highly specialised scientific knowledge, and therefore operates to safeguard the health interests of the population, is not reproduced in Indian medical colleges. Consequently, the clinical standards of Indian graduates is presented as insufficient to warrant their wholesale entry into the IMS.

Four years later in 1905, however, the Lancet appeared to be less harsh about the abilities of 'native' Indian doctors. In a leading article on the IMS, the journal recognised that India was increasingly producing its own

qualified doctors capable of undertaking most of the duties of British commissioned officers of the IMS:

> *It is not logical ... that we should spare no pains to educate the Indian and, at the same time, should refuse him forever the opportunities of a free exercise of the talents that we have enabled him to cultivate.* (21)

In recognising the increasing employment of 'native' Indian doctors in more responsible and highly placed posts, however, the Lancet article goes on to warn:

> *... we must not ignore the influence which the difference of race introduced into it - not merely those of a physical nature but racial distinctions of character, religion, education and methods of thought which ... tend to keep the European and the native races of India more or less apart.* (22)

The article then asserts that these fundamental differences between the European and Indian 'race' result in different standards of ethical conduct. Further, it is suggested that the evidence for this is provided by the preference of 'native' Indians themselves to be treated by a white commissioned officer of the IMS. [Lancet, 1, 18-2-1905; pp441-2] From this line of argument, the article then goes on to suggest that it is perfectly *"natural"* for Europeans in power in India to wish to continue to be treated by their *"own countrymen"*. The article states:

> *... it goes without saying that Europeans serving in India will always prefer medical men of their own race.* (23)

The final argument of this leading article in the Lancet of 1905, introduces one further inability that Indian doctors are supposed to display. The article reports that Indian doctors are not as capable as their British counterparts to deal with administrative duties. While 'native' Indian doctors, qualified through the British medical system in India, are perfectly capable of taking medical charge of the smaller districts in India, so long as British rule in India lasts. It is suggested that British medical officers would be required for the larger stations and more important appointments for some time to come. [Lancet, 1, 18-2-1905; pp442]

It is very clear that the Lancet is using the discourse of 'race' to justify the continued subordination of 'native' Indian doctors through their exclusion from the the more powerful, prestigious and highly rewarded posts in the IMS, and of course by definition, to ensure white British trained doctors alone are eligible for these positions. The article makes it clear that the different biological characteristics of Indian doctors are perceived as determining their cultural,

psychological and ethical attributes and organisational or administrative abilities. The implication is that in all these respects Indian doctors are inferior to their British counterparts, solely because of supposed inherent 'racial' differences.

The expressed desire that British officers and their families serving in colonial India would prefer to be treated by their 'own countrymen', is in itself, of course, not racist. Only when it is articulated in relation to justifying some form of exclusionary/inclusionary practice, is it racist. The expression of preference involves a process of ranking doctors according to their supposed suitability as medical practitioners: in this case, a process which operates to exclude Indian doctors. By suggesting that preference is 'only natural', the journal is justifying this process of exclusion as non-racist. The criteria by which this process of ranking takes place, however, is clearly racist. As the article goes on to argue, Indian doctors because of their supposed 'racial' characteristics are inferior in every way, compared to their British counterparts.

The Lancet was once again facing two ways at once in respect of opening-up the IMS to 'native' Indian doctors in 1909. In a leading article of that year the Lancet states that, *"properly qualified candidates ... from the excellent [Indian] Medical Colleges"* should have existing appointments thrown open to them. The article goes on:

> *As to the intellectual and professional ability, both of the native Indian - whether Bengali, Parse, Sikh or Mohammedan, or Madrassi, and the Eurasian, there can be no doubt. Their mental acuteness is equal to their industry and power of application. They pass excellent examinations, they lay in a large stock of knowledge, and they devote themselves with zeal to their profession.* (24)

The sting in the tale comes later in the article when the leader comments:

> *[S]peaking in general terms ... it cannot be said that, as years go on, they increase in scientific knowledge or professional skill, or in the wisdom that comes from a gradual ripening of the intellectual faculties, reinforced by practical experience.*
>
> *[A]s a general rule, though the Indian, as a student, meets on equal terms, and frequently excels, his British fellow, the mature middle-aged Indian practitioner stands in quite a different comparative relation with the European-born medical man of similar age and experience. There is undoubtedly precocity of development in the Eastern compared with the Western races: as far as concerns the particular class of men that enters the medical profession in India, the brilliant promise of youth and early manhood is not as a rule fulfilled: there is a want of the power of initiative, a*

> *disinclination to take responsibility, a tendency to run in a groove ...* (25)

The Lancet suggests that the solution to this apparent maturity problem of the 'native' Indian doctor is the civilising influence of European education and communication with Europeans, because only then will:

> *... the Indian-born [doctor] ... progress, and approximate the European characteristics.* (26)

It is this slow, gradual improvement through the civilising influence of the European, which leads the author of the article to contend that there should be increasing employment of 'native'-born medical men in India, but suggests that it should be:

> *... slow and deliberate, the fitness of the native-born for his increased responsibilities being measured, not by the examination success of the youthful student, but by the gradual evolution of character in the mature practitioner.* (27)

This suggested restricted intellectual development in mature Indian doctors is presented as the result of 'racial' difference. The argument is slightly more subtle, however, than earlier presentations by the Lancet. The journal no longer suggests that medical education in India is of a lower standard than that in the UK. The 'problem' is one of an inherent lack of

initiative and responsibility in the Indian doctor. This subtle change of emphasis is not surprising given that medical education in India had been created and was operating on similar lines to the British system. Consequently, to criticise the basic clinical competence of Indian doctors would by implication be undermining British medical educational standards. If British medical education could be criticised in this way, then the so-called scientific basis of professionalism would also be undermined. In this way, this change of emphasis, while remaining within a racist discourse, operated to safeguard the ideology of professionalism.

Racism and nationalism are used to justify the argument in the article that the 'problem' of maturity would be resolved by allowing the 'civilising' influence of British culture and practices to be absorbed by the Indian doctor. No longer is it sufficient for the Indian doctor to be qualified by virtue of a British inspired medical education system in colonial India, but it also now requires the uncritical absorption of British 'ways of doing things' in order for Indian doctors to be fit to work in the IMS.

The BMJ continued these themes into the second decade of the twentieth century. The journal supported the continued examination in the UK of 'native' Indian doctors who wished to enter the IMS. The journal justified this in the following terms:

> *... can it be doubted that in the interests of the Empire that it is a good thing ...*
>
> *... can it be disputed that it is a good thing that they should have seen something of English life and conditions, and have been compelled to realise by residence that, after all, England is not the decadent Power which so many Indian seditionists love to picture it?* (28)

The BMJ's 'special correspondent' in India argued that opening up civil posts to 'native' Indian medical practitioners could have disadvantageous outcomes for the progress of Indian medicine. The prospect of impending changes had already meant the IMS had lost a considerable amount of its attractiveness. In the past the IMS had attracted the best quality British doctors, who passed on the best traditions of European practice, research and teaching. The reduction in number of these gifted practitioners, argued the correspondent, would lead to a lack of progress for medicine in India. [BMJ, 1, 16-4-1910; p963]

The BMJ also reported on the BMA's suggestions as to why the IMS had become less attractive to British doctors. The increasing numbers of 'native' Indian doctors, trained in British colleges based in India, had slowly taken over most of the available private practice. Traditionally, private practice had been a worthwhile supplement to the income of British doctors working for the IMS. Many now had only government service in the IMS to supply their income. The Association disparagingly commented:

> *... the teacher has been largely replaced by his pupil in this lucrative field, and ... it will go on increasing in the future.* (29)

This situation was then further compounded by the government in colonial India actively restricting IMS officers from undertaking private practice, in order to encourage 'native' Indian doctors to take up private practice so that they could be available for secondment to the IMS when required. Finally increased workloads and increasing costs of living, had made medical practice in colonial India less attractive to British doctors. [BMJ, 1, 7-2-1914; pp57-63]

The journal then goes on to report the BMA's case for the continued dominance of British doctors in the IMS, and the need to maintain its attractiveness to British doctors by keeping the 'native' Indian doctor in their

subordinate place. On the clinical competence of the 'native' Indian doctor, the BMA commented:

> *Those who know the Indian most intimately, and who admire most intelligently his many excellent qualities as a professional man, cannot blind themselves to the fact that his standards are still far from being those of his British Brother.* (30)

Medical standards could only be maintained and improved if the pace of change were slow and controlled:

> *We must move to our goal with the 'ordered action' of our race. The time is not yet ripe for any wide or sudden change in past policy if the medical education of the rising generation [in India] ... is not to suffer ...* (31)

The BMA continued to stand by the assertion that Indian doctors should be examined in the UK for entry into the IMS, because it allows the aspirant Indian IMS officer to become familiar with:

> *... English ways, manners, and customs to enable them to live without mutual discomfort in the society of British officers and of other Europeans of the same class.* (32)

and it allows them:

> *... to become acquainted with the methods of sanitation, the modes of living, hospital treatment and duty, and the other features of medical practice which are so widely different in Europe and in India.* (33)

For this reason, The BMA suggested that Indian practitioners who wish to serve in IMS should have three

years medical experience in the UK. This would also guarantee the highest standard of medical education possible:

> *As Europe is the home of Western medicine, the whole tone and atmosphere of a British medical school is better, higher, and more stimulating than that of the Indian medical college.* (34)

The journal reports that the BMA concluded:

> *If the Indian medical practitioner of today were of the same mental and moral fibre as his teacher, the European Indian Medical Service officer would speedily be swept away by a force which would prove irresistible.*
>
> *[T]he position of Englishmen, and still more of Englishwomen and children, in India must not be forgotten when the subject of the provision of medical aid for the country is being handled.*
>
> *[F]or many long years India will need the best men the profession at home can supply to foster and to care for its still immature profession. High standards of work and morals must be set before the Indian student ... [and] can only be set by men whose enthusiastic devotion to duty, and understating obedience to a high code of probity and honour are the inheritance of long generations of thought and training.* (35)

To restrict the supply of such men would, the Association argued:

> *... result ... [in] a widespread deterioration in the morale, the training, and the efficiency of the medical profession of India.* (36)

The BMJ is using a similar justificatory discourse, centred on the ideologies of professionalism and

nationalism, both of which are expressed within an assumption of 'race' difference, as that used by the Lancet. The BMA continues to criticise the 'professional standards' of Indian doctors, arguing they are far below the standards acceptable in Britain. Consequently, Indian doctors should continue to be examined for entrance to the IMS in England, where they can absorb English culture and Western medical ideas and practice where they originated.

The BMA continually presents the British 'professional' occupation of medicine as the guardians and standard bearers of what is regarded as good medical practice in colonial India. Any reduction in the numbers of British doctors working in the IMS as a result of continuing Indianisation of the service, in order to make room for Indian doctors, would result in a reversion back to less ethical and less scientific methods of operation. It is argued that the Indian doctor is not yet ready to take on the awesome responsibilities the IMS would demand of them. Only with the careful guidance and example of the best of British medical practitioners, can the Indian doctor hope to become proficient.

The above debate concerning the changing role of the IMS in India, seems to have come to a head with the publication of the Lee Commission in 1924. (37) The Commission recommended that the IMS should become a military only service, by incorporation with the Royal Army Medical Corps of India. The RAMC would operate to service the needs of British and Indian troops in India. As a result of this, a new civil medical service in India would be established, which would be administered by the various provincial governments. Recruitment to the new civil medical service would be by competitive examination in England and India. However, a minimum number of posts would be reserved for British medical officers in order that they could supplement the military service when necessary, and meet the clinical needs of British officers and their families. [BMJ, 1, 31-5-1924; pp978-9. Lancet, 1, 31-5-1924; p114]

The publication of this report appears to have made the British 'professional' occupation of medicine realise that the IMS was going to change, and the medical needs of the population of colonial India would be increasingly met by 'native' Indian doctors. The Lancet commented that the Indianisation of the medical service in India, *"it is recognised, must be a long and steady*

process." (38) The main question for the Journal now was not:

> *... how many Indians should be admitted into the service, but what is the minimum number of Englishmen which must still be recruited.* (39)

The BMJ, however, were less accepting. In a leading article in December 1924, the journal argued that the potential for greater State interference in medical matters with the provincialisation of civil medical services in India would effectively make it less attractive in terms of recruiting more and better British doctors to serve in India. [BMJ, 2, 13-12-1924; p1123.]

In 1927, the BMJ published an article by Sir Norman Walker, a senior officer in the IMS, which argued that since medical education had been transferred to the responsibility of provincial governments in India, the number of British medically qualified teachers had declined markedly. Walker went on to suggest that this situation had been compounded by several other circumstances. First, since 1922 the number of medical colleges in India had doubled. This, coupled with no coordinating authority, such as the GMC in Britain,

meant that medical educational standards could vary considerably throughout India. Third, the standard of Indian secondary education did not compare with that in the UK. Walker cites the fact that no British university accepts the matriculation examinations of any Indian university as the same as its own, as evidence of this disparity. [BMJ, 2, 20-8-1927; pp312-13]

It appears that the BMJ was prepared once again to use the supposedly poor clinical and education standards of Indian doctors as an argument against their access to the IMS. In addition, the less attractiveness of the IMS had resulted in fewer British doctors working in the service. Consequently, the journal argues that the situation had deteriorated to the point that British medical expertise was no longer in a position to safeguard the standards of medical education in colonial India. Once again recourse to the ideology of professionalism in the form of maintaining medical standards, is used to justify continued British control of the IMS.

This, however, seems to have been the last faltering attempts by the British 'professional' occupation of medicine to safeguard its interests in colonial India.

The recommendations of the Lee Commission had set the agenda for changes in the IMS. In addition, as a consequence of a long running dispute between the GMC and the Indian universities concerning training in midwifery in colonial India, which was resolved by the late 1920's, the All-India Medical Council was established in February 1934.

The function of the new Council was to secure a uniform minimum standard for the qualifications of Indian universities and to arrange reciprocity schemes with the medical authorities of other countries. Unlike the British GMC, however, it would be a Council of medical education only, and would not be a registering authority. The main task of the Council would be to endeavour to guarantee the *"sufficiency"* of Indian medical degrees. [BMJ, 2, 11-11-1933; pp876-7]

The significance of this development was that the GMC in Britain, for the first time, could judge accurately, on the basis of the information provided by the inspectors of the All-India Medical Council, whether the qualifications granted by the various medical colleges in India were of sufficient standard to allow the holders to be registered to practice in the UK. Prior

to this, the information on which the GMC based its decisions concerning recognition of qualifications came directly from the Indian universities themselves. [Minutes of the GMC, Vol LVIII, 1920; pp27-36] Consequently, from the mid-1930's onwards, Indian medical qualifications had gained a new status: a status which was on a par with British medical qualifications and formally sanctioned by the GMC.

Two other factors were important in convincing the British 'professional' occupation of medicine that their continued influence over the IMS was increasingly tenuous. One factor was the increasing agitation within India for the creation of an independent 'nation-state'. The second factor was the impending outbreak of the Second World War. The need to provide extra medical personnel to serve the needs of the British Empire at war, resulted in a breakdown of some of the inequalities existing between British and Indian doctors.

The Second World War and the Rise of Nazism

With increasing demand on British civilian doctors for war work, in January 1941 the GMC under Defence Regulations temporarily allowed overseas doctors to be

included on the Medical Register. This meant that doctors qualified to practice in any part of the British Empire could be selected for a medical commission in the British armed forces, or employment in hospitals, institutions or service in the UK other than attendance in patients own homes. Doctors from India, therefore, who may have been working and training in Britain could now work for the British military on similar terms and conditions to their British counterparts. [BMJ, 1, 18-1-1941; pp93]

In the spring of 1943, the Indian Army Medical Corps was established, on the recommendation of the Soutter Mission. The IAMC was to include both Indian graduates and licentiates. Regular and commissioned officers of the IMS would be seconded to it, and the new Corps would receive by transfer the whole existing personnel of the Indian Medical Department and Indian Hospital Corps. [BMJ, 1, 8-5-1943; pp575-6. Lancet, 1, 17-4-1943; p502]

The 12,000 graduates of the Indian medical universities would easily be assimilated into the new Corps. They would have passed through a full medical curriculum and gained qualifications which were registrable in the UK. As the BMJ at the time commented:

> *... [m]any of them have attained distinction and are capable of specialised work of a high order.* (40)

The 35,000 licentiates, who had previously been the subject of derisory comment concerning their varied and sub-standard clinical abilities, were now seen as fit to for *"full medical responsibility"*, because:

> *... their training, which twenty years ago was very poor indeed, has been improved, and many of them are skilled doctors who compete successfully in civil life with the university graduates.* (41)

It would seem that any previous caution expressed by the British 'professional' occupation of medicine concerning the standard of Indian doctors, especially licentiates whose qualifications were not previously recognised by the GMC, could now be dismissed as demand for doctors increased due to the requirements of war. Indeed, as the BMJ commented, for the first time:

> *... <u>every</u> doctor who has qualified to practise in India will be given the opportunity to rise to any position in the corps which his abilities justify.* (42)

The material circumstances of war had rendered the ideologies of racism and nationalism, and

professionalism, which had previously been used to justify the exclusion of Indian doctors from their legitimate place alongside British doctors in the IMS, redundant for the present. It was not until the outbreak of the Second World War that Indian doctors were effectively on an equal footing, in respect of recognition and registration, with their British counterparts.

This change in attitude by the British 'professional' occupation of medicine, was also apparent in relation to their contribution to the reproduction of the 'race' concept. The spectre of Nazism in Europe witnessed a challenging of the notion of purity of 'race' within the medical journals. The conception of the Aryan 'race' was presented as ideological (being largely based on cultural traits) with no anthropological basis. The superiority of the 'white race', and its destiny to rule others was vigorously criticised, and the common sense use of 'race' to justify and rationalise various political and national activities was condemned.

For example, the Lancet in January 1938 reported on the Seventeenth International Anthropological Congress in Bucharest, where Eugene Pittard from the University of

Geneva gave an address which demonstrated that the theory about the purity of certain 'races' was untenable. [Lancet, 1, 8-1-1938; pp104.] Pittard argued that a powerful European 'nation' was being misled by its leaders. The German people were being told that they belonged to a 'pure race' with a great mission. Pittard suggested that the concept of an 'Aryan race' was ideological, because it had no anthropological basis. The belief in such a concept, that nations can be divided into 'select' and 'first rate' groups, only led to the encouragement of 'racial hatred'. Pittard observed:

> *... the white peoples are not of a higher order and are by no means necessarily called to rule and to boast of the achievements of their civilisation. Innumerable proud civilisations have disappeared one after the other.* (43)

In a similar vein, the BMJ reported that Julian Huxley presented a lecture at the Royal Institute, in which he argued that there was no 'Aryan race', since the term Aryan referred to differences of language and national culture rather than genetic differentiation. The article concluded:

> *Today there existed no important human group which could properly be called a race and the term not only had no useful application, but actually led to confusion, both scientific and political. Hence Mr Julian Huxley held it desirable on every ground to abandon it altogether as applied to existing conditions.*

> *To define race in man scientifically was impossible, since the implications of the term did not conform with reality. [T]he word race had been widely used in a pseudo-scientific way to justify and rationalise political and national activities.* (44)

SUMMARY AND CONCLUSIONS

This chapter has outlined the origins of British racism, and then detailed how the development of this ideology has operated in relation to the relationship between British and Indian doctors within the IMS in colonial India. Although British racism only became an effective social force in relation to Britain's involvement in the slave trade and subsequent colonial expansion, this racism was the outcome of earlier ideas, myths and legend concerning human differentiation.

Britain already made use of a discourse which distinguished between black and white. White was positively evaluated, while black was associated with negative attributes. Consequently, when the first contacts with the people of Africa were made in the mid-sixteenth century, the terms black and white already embodied specific and diametrically opposed meanings. It was not surprising, therefore, that skin colour

should become a primary signifier of the difference between the white European and the black African.

These early ideas, images and myths, were taken up and reproduced to justify British involvement in the slave trade and the plantation economy in the West Indies. The slave trade and the plantation economy based on slave labour, was crucial to Britain's capitalist development. It was vital, therefore, that a justificatory ideology be created, which would legitimate these activities. This became especially important when the anti-slavery lobby became increasingly vocal.

Plantocracy racism attempted to justify the slave trade and the use of slave labour by identifying the African slave as a heathen savage, who would benefit from the civilising influence of the British imposed plantation economy in the West Indies. Eminent intellectuals of the time, such as Lock and Hume, provided credibility to the explicit racist pamphleteering of the pro-slavery lobby, by arguing that the African was in all respects inferior to the European.

Plantocracy racism lost its practical adequacy with the with the abolition of the slave trade and slavery in the first half of the nineteenth century. Britain's continued colonial expansion, however, required another form of justificatory ideology. Plantocracy racism was reproduced and refined into a more supposedly scientific form in order to justify the expanding British Empire. Empire was also crucial to Britain's capitalist development. The exploitation of black peoples under British colonial rule ensured that British capital was enriched and the colonies suffered chronic poverty, hunger, disease and foreign domination.

Pseudo-scientific racism utilised the developing natural sciences to provide a more supposed scientific basis to the notion that the human population could be divided into distinct 'races' and ranked hierarchically. Biology, anatomy, craniology, phrenology, and the distortion of Darwin's concept of 'natural selection', were all drawn upon to give an objective foundation to the idea of 'race'.

With pseudo-scientific racism relying so heavily on the biological and natural sciences, it was not surprising that eminent doctors at the time would be involved in

creating and reproducing this form of racism. Knox was probably the most vociferous in this respect. In addition, his work on 'race' and 'race conflict', illustrated the articulation between the ideologies of racism and nationalism. For Knox, 'nation' was grounded in his conceptualisation of 'race': where 'national character' and culture were determined by the biological characteristics of the 'race' that constituted that 'nation'.

By the late nineteenth and early twentieth centuries, pseudo-scientific racism, had ensured that the idea of 'race' was generally accepted as a basis for the differentiation of the world's population. Racist ideas had become part of British historiography, and children's and popular literature, and was being reproduced through the education system. The British 'professional' occupation of medicine was also implicated in this process. Through its journals the occupation was actively reproducing racism as ideology. Black and white people were distinguished by their somatic differences, then a range of cultural characteristics were attributed to the identified somatic groups.

Plantocracy racism, and then pseudo-scientific racism, were one part of the ideological terrain within which British colonial rule and expansion occurred. Britain's period of colonial rule in India was not exempt from this. These forms of racism as ideology operated to influence the relationship between British and Indian doctors in colonial India. It allowed the British occupation of medicine to create and maintain a dominant position within the IMS, by justifying the subordinate role of Indian doctors.

There were several forms of inequalities apparent within the IMS. While technically the IMS was open to competitive entry by all doctors who had qualifications recognised by the British GMC, Indian doctors were expected to travel to the UK to take the entry exam in order to practice in the IMS in their own country. Once accepted into the IMS, British and Indian doctors were treated differently. British doctors had permanent posts which carried an incremental pension gratuity on retirement. Indian doctors, however, were given temporary posts for the first five years, and then if they were selected for a permanent position they were denied a pensionable gratuity.

In terms of remuneration, both sets of doctors received the same basic pay. British doctors, however, also had an overseas allowance. From 1937, basic pay was cut and overseas allowances were increased, so that the differential was increased further. Finally, the number of prestigious reserved civil posts for Indian officers of the IMS was significantly less than that for British officers. In combination, such mechanisms ensured that British trained doctors were able to maintain a dominant position in the IMS over their Indian trained counterparts.

The British 'professional' occupation of medicine utilised a number of justificatory arguments to sustain this dominance of British doctors in the IMS. This discourse was most clearly expressed in relation to the occupations reaction to the increasing 'Indianisation' of the IMS. This strategy appears to have been developed in order to defend the high status and material rewards which were available to British doctors who were prepared to work in colonial India.

The core argument presented by the British 'professional' occupation of medicine in defence of its interests focused on the assertion that increasing

numbers of Indian doctors entering the IMS would not only make it more difficult to recruit the best British doctors to the service, but this situation would also undermine the standards of medicine in India as the influence of the British example was not actively and continually reinforced by a strong British presence.

These arguments were often explained in terms of the supposed fundamental differences between the two 'races'. It was argued that the difference in medical educational standards, in ethical standards, in human development tendencies and in different capacities to govern medical districts, were determined by inherent biological and cultural characteristics which were associated with the two distinct 'races'. The implication was that 'racial' differences were a barrier to achieving an adequate level of 'professionalism'.

It should be recognised, however, that some of these arguments were 'double edged'. For example the occupation found it increasingly difficult to simply suggest that the qualities of Indian doctors were substandard, because many of them were trained in India by the best British doctors of the time within institutional arrangements and educational forms copied

directly from the British system. To have taken this line of argument would by implication have undermined the system which produced the supposedly superior British trained doctor.

Consequently, while young Indian medical graduates could be recognised as equal to or even excelling the standards of their British counterparts, it was simultaneously asserted that this precocity went unfulfilled in the mature middle-aged Indian through lack of continued application. A 'problem' which was the result of 'racial' difference.

The proposed solution to this supposed inadequacy of Indian doctors, was that they should be made to absorb English culture. It was no longer sufficient that they should be educated in medicine through a British type of medical education system, it was now necessary for them to be 'civilised' by English culture directly. Racism and nationalism, and professionalism, were in combination being used to maintain the subordinate role of Indian doctors in the IMS.

Towards the end of the 1920's and early 1930's, it was increasingly realised by the British 'professional' occupation of medicine, that the trend towards 'Indianisation' combined with moves towards Indian independence, was making their position increasingly untenable. With this recognition came a change of emphasis in the debate. The occupation now decided that any changes in the IMS should be slow and controlled in order to ensure that high 'professional' standards would always be maintained, while the Indian doctor was 'made fit' to work in and run the IMS.

Interestingly, this later stage of the debate, implies that the supposed differences of 'race' could be overcome given the appropriate example of how things should be done (that is the 'British way'). This in itself undermines the notion of 'race' as a categorisation based on fixed biological and cultural characteristics. Consequently, even during the application of the discourse of 'race' to justify the arguments defending British occupational control of medicine in India, the actual changing material conditions were themselves evidence of the falsity of the concept of 'race'.

The question of medical standards in India seemed to have been resolved in 1934, with the establishment of the All India Medical Council. This allowed the GMC in Britain to judge the quality of medical education in India and subsequently recognise many qualifications for the purposes of registration to practice in Britain. Many Indian medical qualifications were now on an equal footing with those awarded by British medical colleges.

Although the Indianisation of the IMS, the prospect of Indian independence and the creation of the AIMC was the basis of a change of emphasis in the debate, it was only with the advent of World War Two and the spectre of Nazism, that the relationship between British and Indian doctors became one of more or less equality. Indian doctors, whether graduates or licentiates, were welcomed as equal partners in meeting the medical needs of the British war effort.

Racism, nationalism and professionalism were now redundant ideologies, because the need to recruit doctors for the war effort took precedence over the occupations desire to maintain a racialised fraction in a subordinate position, and thereby, secure their own dominant role. This was also reflected in medical

journals of the period, where the occupation was now using its influence to undermine the use of racism and nationalism to justify and rationalise fascist political objectives.

This first period in the relationship between the British 'professional' occupation of medicine and Indian doctors was brought to its conclusion with Indian Independence in 1947. With independence came the formal disbanding of the IMS, on August 14, 1947, ending an association which had lasted over 330 years. As we shall see below, however, Indian doctors and the newly established British NHS would continue that association, but on slightly different terms.

Nazism had changed the nature of the debate on 'race'. Explicit racism would from now on be extremely difficult to justify. This, however, would not prevent newly arriving doctors from the Indian subcontinent, who were encouraged to migrate to staff the expanding NHS, from being subject to the process of racialisation. The discourse was less overtly racist, with a reliance on the ideology of nationalism to mask the racist content of the debate. The post-1945 migration and

racialisation of doctors from the Indian subcontinent, is the subject of the following two chapters.

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(6) 'Eugenics: the study of *all influences that improve the inborn qualities of a race; also with those that develop them to the utmost advantage.* Cited in Lancet, 1, 14-5-1904; p1363.

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(9) Lancet, 2, 2-12-1865; p626.

(10) Lancet, 2, 2-12-1865; p626.

(11) cited in Miles: Recent Marxist Theories of Nationalism and the Issue of Racism, *British Journal of Sociology*, Vol. 38, No. 1, 1987; p30

(12) cited in Fryer: 1984; p182.

(13) cited in Fryer: 1989; p74.

(14) cited in Fryer: 1989; p78.

(15) cited in Fryer: 1989; pp78-9.

(16) Lancet, 2, 10-11-1906; p1314.

(17) Lancet, 2, 10-11-1906; pp1314-5

(18) BMJ, 2, 23-8-1947; p301.

(19) The Lancet does appear to have identified this trend much earlier, around 1901. So while the dates identified are nine years apart, the two journals are discussing the same set of circumstances.

(20) Lancet, 1, 16-3-1901; p819

(21) Lancet, 1, 18-2-1905; pp441

(22) Lancet, 1, 18-2-1905; pp441

(23) Lancet, 1, 18-2-1905; pp442

(24) Lancet, 1, 29-5-1909; p1537.

(25) Lancet, 1, 29-5-1909; p1537.

(26) Lancet, 1, 29-5-1909; p1537.

(27) Lancet, 1, 29-5-1909; p1537.

(28) BMJ, 1, 29-1-1910; p271

(29) BMJ, 1, 7-2-1914; p62

(30) BMJ, 1, 7-2-1914; p57

(31) BMJ, 1, 7-2-1914; p58

(32) BMJ, 1, 7-2-1914; p58

(33) BMJ, 1, 7-2-1914; pp58-59

(34) BMJ, 1, 7-2-1914; p59

(35) BMJ, 1, 7-2-1914; p62

(36) BMJ, 1, 7-2-1914; p62

(37) cited in Lancet, 1, 31-5-1924; p114

(38) Lancet, 1, 31-5-1924; p114

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(40) BMJ, 1, 8-5-1943; pp575

(41) BMJ, 1, 8-5-1943; pp575

(42) BMJ, 1, 8-5-1943; pp575 (my emphasis)

(43) Lancet, 1, 8-1-1938; pp104.

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CHAPTER V:

POST-1945 BRITISH RACISM AND THE RACIALISATION OF MIGRANT INDIAN DOCTORS: 1945-1974

INTRODUCTION

This and the next chapter will provide a detailed historical account of the creation and reproduction of British racism and the racialisation of black migrant doctors, during the post-1945 period. Chapter V will describe how the 'race/immigration' issue was constructed in such a way as to present the black presence in Britain as a 'problem'. It will also be demonstrated how racism came to be institutionalised within the practice of the State by 1971.

Chapter V will also illustrate how within this broader political context, the occupation of medicine came to regard black migrant doctors as a 'problem', after initially actively encouraging them to come to Britain to train and work. The occupation began to problematise black migrant doctors from the late 1960's onwards, as competition for scarce, good training posts in the hospital sector began to increase.

Chapter VI will describe how British racism continued to be reproduced by the State, through its labelling of British black youth as the 'enemy within' during the 1970's and reproducing the 'race/immigration' issue in

relation to new Asian migration and the entry of Indian dependants. It will then go on to detail how the State reproduced racism through the debate on 'nationality' in the 1980's.

It will also be demonstrated in Chapter VI, how the occupation of medicine was able to racialise black migrant doctors, by having its campaign to discredit their competence supported and given legitimacy by the State sponsored Merrison Report of 1975. It will be shown how the occupation were then able to persuade the government that black migrant doctors should no longer have exemptions under immigration legislation, but should be subject to the same regulations and restrictions as all other New Commonwealth migrants.

THE POLITICAL CREATION OF A 'RACE/IMMIGRATION PROBLEM' AND DOCTOR MIGRATION FROM INDIA: 1945-62

Introduction

Between 1945 and 1962, both Labour and Conservative government's were involved in secret discussions to

introduce immigration control legislation. With the help of a public campaign by some right-wing Tory MPs, the creation of a 'race/immigration problem' in post-1945 Britain culminated in the introduction of the Commonwealth Immigrants Act of 1962.

The official public stance of the State during this period, however, endorsed the 'open door' policy of the 1948 Nationality Act, which provided free movement and residence rights within the Commonwealth. On the basis of this policy, the British 'professional' occupation of medicine actively encouraged the migration of doctors from the Indian subcontinent to fill the vacancies in an expanding NHS.

On the whole during this period, Indian migrant doctors were welcomed into Britain and recognised for the valuable role they performed in meeting the service needs of the NHS. At the time of the introduction of the 1962 Commonwealth Immigrants Act, however, the British 'professional' occupation of medicine were beginning to question the quality of these doctors.

The Post-War Labour Government 1945-51

Post-war economic reconstruction had left Britain with acute labour shortages in agriculture, coal-mining, textiles, clothing and the foundry industries. A Cabinet Manpower Working Party reported in November 1945 that there would be an estimated labour shortage of 940,000 by June 1946, and that this would rise to 1,346,000 by the end of 1946. [Joshi & Carter; 1984]

The demand for labour beyond that which could be supplied internally, led to a number of private and State recruitment initiatives. Consequently, between 1946 and 1950, 77,000 displaced persons from Eastern Europe were brought to Britain under the European Volunteer Worker scheme, and a further 88,000 members of the Polish Armed Forces who did not wish to return to Poland after the war were encouraged to settle in Britain to work. [Miles & Phizacklea; 1984] In addition, there were an estimated 30,000-40,000 Irish migrant workers entering Britain annually at this time. [Joshi & Carter; 1984]

This predominantly white European migration to Britain was supplemented from 1948 onwards with the arrival of

black migrants from the New Commonwealth. The beginnings of this post-war labour migration from the New Commonwealth is usually identified with the arrival in Britain of the 492 West Indians on the *Empire Windrush* in 1948. [Layton-Henry; 1984]

It has previously been argued in Chapter II above, that New commonwealth migration into Britain was structurally determined by the uneven development of capitalism. Within this, specific policy decisions on recruitment of migrant labour by the British State, historical colonial links, and individual motivation, all combined to encourage workers from the New Commonwealth, including doctors from India, to migrate to Britain.

The type of people this migrant labour should be, however, had already been the focus of considerable debate, with much of this debate being held in secret discussions within the Cabinet. The first public expression came through the Royal Commission on Population, published in 1949. The Commission had the task of providing the basis for a planned expansion of the economy. The Commission's report suggested that 140,000 migrant workers would be needed immediately to meet the labour shortages Britain was then experiencing.

In addition, considerable resources would have to be deployed in housing, the social services and industrial training provision in order to service this migrant labour. [Royal Commission on Population: 1949]

On the preferred type of migrant labour, the Commission commented:

> *Immigration on a large scale into a fully established society like ours would only be welcomed without reserve if the immigrants were of good human stock and were not prevented by their religion or race from intermarrying with the host population and becoming merged in it.* (1)

The implication is clear: Britain's acute labour shortages should not be met by encouraging the entry of black migrants from the New Commonwealth. The issue of 'race/immigration' was already being presented as a 'problem'

This conclusion by the Commission is not surprising when it is realised that the Labour government had already been very concerned about potential black migration to Britain. Two days after the arrival of the *Empire Windrush*, eleven Labour MPs sent a letter to Prime Minister Clement Attlee urging the introduction of immigration controls, commenting:

> *An influx of coloured people domiciled here is likely to impair the harmony, strength and*

> *cohesion of our public and social life and to cause discord and unhappiness among all concerned.* (2)

Even earlier, in March 1948, correspondence between senior civil servants concerning the use of surplus colonial labour power indicates that the use of black migrant labour was perceived as problematical. On the one hand, there was the perceived difficulties of their assimilation as UK citizens with permanent settlement rights, and on the other, was the question of their physical and mental suitability for the types of work available in Britain, as well as acceptance by the Trade Unions. [Joshi & Carter; 1984]

In the October of 1948, following representations from various Colonial governments, the Labour government established an Interdepartmental Working Party to:

> *... inquire into the possibilities of employing in the United Kingdom surplus manpower of certain colonial territories in order to assist the manpower situation in this country and to relieve unemployment in those colonial territories.* (3)

The Working Party appeared to prefer European migrant labour. Unlike New Commonwealth migrants who as British

citizens were not bound by restrictions governing their entry or length of stay, European migrant workers were subject to strict controls. They were assigned to a particular job, could not change their jobs without permission, were required to belong to the relevant Trade Union, could not be promoted over British workers, would be the first to be made redundant, and could be deported if they became unemployed, injured or disabled. These were one set of reasons why the Working Party recommended to the Cabinet that no organised large scale migration of New Commonwealth labour should be contemplated. [Layton-Henry; 1984]

Indian Migrant Doctors and the 'Problem' of New Commonwealth Migration

Doctor migration from the Indian subcontinent during these early years of post 1945-Britain, however, seems to have been less of a political 'problem'. In relation to the covert 'race/immigration' agenda, the debate was primarily associated with semi- and unskilled working class migrants from the New Commonwealth. For example, a memorandum by the Secretary of State for Commonwealth Relations in September 1955, reported that recent increases in working class Indian migration to Britain was:

> *... a new development, and unless it is checked, it would become a menace.* (4)

The relatively small number of 'professional' migrants from India, appears not to have presented the same 'problem' for the British State.

In relation to official state policy on migration generally, and doctor migration in particular, the government were advocating the 'open door' policy enshrined in the 1948 Nationality Act which allowed free movement and residence within the Commonwealth to all its citizens. In the case of migrant Indian doctors, this policy was reflected in the findings of the 1944 interdepartmental Goodenough Committee, which had investigated the organisation of medical schools, with special reference to clinical teaching and medical research. [Goodenough Committee: 1944]

With respect to migrant doctors, the Committee concluded that those doctors who were suitably qualified, especially those from the Commonwealth and Empire, should be made welcome and their suitability to study in Britain should be judged by the same criteria as British born doctors.

The Committee, however, did comment that the primary obligation of British medical schools should be to British born medical students, and that it was preferable if migrant doctors should have gained their primary medical qualifications in their country of origin. Given this proviso, the Committee regarded postgraduate training of migrant doctors as a from of aid to less developed Commonwealth countries. In addition, the Committee recommended that British medical schools should continue to make staff available to develop medical schools in the colonies. [Goodenough Committee: 1944]

Labour's Covert Agenda Continues

The continued migration of working class New Commonwealth migrants to Britain remained a pressing concern to the post-war Labour government. A further interdepartmental meeting was held at the Home Office in February 1949. This meeting recommended to the Cabinet the introduction of a series of ad hoc administrative measures designed to discourage the entry of black migrants. These measures were to include instructions to Colonial governments to make it clear to intending migrants that employment and accommodation were difficult to obtain in Britain, that identified

'undesirable' New Commonwealth migrants would not be issued with passports, that there would be a clampdown on stowaways, and that immigration controls at UK ports of entry would be tightened by requiring all arrivals to prove British nationality. [Layton-Henry; 1984]

In West Africa, for example, this demand for proof of British nationality was effected by the modification of British Travel Certificates used in the area. This document had previously identified the holder as a British subject for the purpose of travelling between French and British Colonial territories along the West African coast, and also, therefore, provided a legal means of entry into Britain. The new form of document had no citizen status on it, and consequently, those arriving in the UK with this document could be deported as aliens, although it would be known that the holder was a legitimate British subject. [Carter, Harris & Joshi; 1987]

Other control measures included placing migrants from the West Indies who were bound for Britain at the back of the queue on shipping lists. In India and Pakistan, passports were withheld unless migrants could prove that they could establish themselves in the UK without

recourse to public funds. These covert, and sometimes illegal, ad hoc administrative measures to discourage black migrants from entering Britain, were continued by the Conservative government of 1951-55. [Carter, Harris & Joshi; 1987]

The Labour government, however, remained concerned at continued migration from the New Commonwealth, and in June 1950 the Cabinet ordered a further confidential review of the means by which immigration into Britain from British Colonial Territories might be checked. The Review Committee noted that since 1945 5,000 black migrants had entered Britain, and went on to concentrate on the illegal (ie. stowaways) and threatening (ie. 'invasion' and 'swamping' of British society) aspects of this migration. [Joshi & Carter; 1984]

Three potential forms of control of black migration were identified. First, to extend the law covering alien entry to British overseas subjects. This was rejected on the grounds that it would be extremely difficult to justify the exemption of white migrants from the Irish Republic. Second, the deportation of British subjects who had abused National Assistance, were convicted of serious criminal offences or involved in industrial

unrest. Third, to tighten the measures concerning stowaways, although this would only deal with part of the 'problem'. [Joshi & Carter; 1984]

The Review Committee recognised that all three proposals would cause embarrassment to the government which introduced them. Britain was the 'Mother Country' of the Commonwealth and freedom of entry to the UK was one of the principal benefits of British subject status. The 'open-door' policy enshrined in the 1948 Nationality Act made it extremely difficult to introduce restrictions which were designed to specifically control Black British Subjects. The Review Committee concluded, that due to the controversial nature of control measures for New Commonwealth migrants, no restrictions should be introduced while the numbers entering the UK were so small. The Committee did add, however, that if New Commonwealth migration increased, than control legislation would be essential. [Joshi & Carter; 1984]

The Conservative Government: 1951-56

The post-war Labour government had clearly identified an apparent 'race/immigration' issue concerning black migrant labour from the New Commonwealth. When the

Conservatives came to office in 1951, they were also concerned about the 'problem' of 'race' and 'immigration'. It was noted above that the Conservative government, like the Labour government before it, continued to utilise a series of ad hoc administrative procedures to discourage black migrants from entering Britain.

By the early 1950's some government departments were supporting the introduction of control legislation because these ad hoc measures had failed to halt increasing migration into Britain from the New Commonwealth. For example, the Welfare Department of the Colonial Office in September 1955, reported that:

> *... it would be far better to have an openly avowed policy of restricted immigration than fall back on rather devious devices.* (5)

The Conservative government realised, however, that it had to build a strong case to justify immigration controls which were primarily aimed at Black British Subjects. At a confidential meeting at the Colonial Office in April 1954, Conservative Ministers realised that this would require the collection of information on Britain's black migrant population by various government departments. This would involve gathering details about

unemployment levels, claims on National Assistance, numbers entering and resident, housing conditions, health and criminality. [Carter, Harris & Joshi; 1987]

It was hoped that this data would establish the 'fact' that migration of black labour posed grave problems for social, economic and political stability. Consequently, the Ministry of Labour, the National Assistance Board, the Welfare Department of the Colonial Office, the Commonwealth Relations office, the Department of Health, Housing and Transport, and various voluntary organisations were instructed to carry out surveys of Britain's black population. [Carter, Harris & Joshi; 1987]

The results of the various surveys were collected and passed on to the Working Party concerned with employment of New Commonwealth labour in Britain, which had been established in December 1953. In each instance, evidence for a 'strong case' which would facilitate the introduction of immigration controls was not proven. The comments by the Working Party in relation to employment, housing and criminality are interesting in terms of how they produce and reproduce stereotypical

images of black people in Britain. [Carter, Harris & Joshi; 1987]

On employment the Working Party commented that the evidence suggested that black migrant men generally lacked stamina and were physically unsuited for certain types of labour: especially winter outdoor work and work in hot conditions underground. Black migrant women were characterised as being slow mentally, with the speed of factory work totally beyond their capabilities. [Carter, Harris & Joshi; 1987]

The Working party went on to conclude that these characteristics were the reason for relatively high black unemployment, and therefore, relatively more black migrants were dependent upon National Assistance. This assumption that black unemployed workers would automatically be entitled to National Assistance, however, fails to take into account that arrivals of less than one years residence would not qualify for benefit. [Carter, Harris & Joshi; 1987]

In relation to housing, a Cabinet statement prepared from the Working Party's findings, asserted that black

migrants were competing with white people for housing which was in very short supply. This in turn, had the consequence of causing serious problems for local authorities, both in terms of allocating resources for new housing and in relation to providing accommodation for black migrants in preference to long-term white residents. [Carter, Harris & Joshi; 1987]

This statement on housing assumes that black and white people were competing for the same housing resources. Black migrants, however, would not be considered for council housing until they had met the qualification requirements. In addition, the housing shortage was not the result of black migration to Britain, but was largely due to government housing policy. Macmillan, the then Minister of Housing had cut council house building from 235,000 units in 1953 to 160,000 in 1954. [Carter, Harris & Joshi; 1987]

On criminality of the black population, the Working Party commented that certain police areas had reported that there were large numbers of black men living off the immoral earnings of white women, and that reported levels of crime involving the black population was considerably below the actual level. The association

between black men and white women was presented as a threat to the sanctity of white womanhood (and by implication, the patriarchal structure on which it rested). [Layton-Henry; 1987]

In each area of political concern, however, there was little concrete evidence to support the belief that Britain's black population was causing severe social problems. The failure of the Conservative government to produce a 'strong case' for the introduction of immigration controls, did not prevent the Cabinet from establishing a Interdepartmental Working Party in May 1954 to examine what form such control might take. [Carter, Harris & Joshi; 1987] The objectives of the Working Party were explained by Cabinet Secretary Norman Brook in a briefing to the Prime Minister:

> *Its purpose should be, not to find a solution (for it is evident what form control must be), but to enlist a sufficient body of public support for the legislation that would be needed.* (6)

The Working party recommended that controls on entry to the UK should not apply to self-governing countries or citizens of the Irish Republic, but should apply to citizens of the UK and Colonies who did not 'belong' to Britain. Those who 'belonged' to the UK were defined as

one who was born or had been born of parents who at the time of the birth were normally resident in the Britain, or who had ordinarily been resident in the UK for more than seven years and had not since been continuously resident in any other part of the Commonwealth, or were naturalised in Britain, or were a wife or child of any of the above categories. [Layton-Henry; 1987] Clearly, immigration controls on the basis of 'belonging' to the UK as defined above, would in the vast majority of cases only apply to black migrants seeking entry into Britain.

The Working Party went on to recommend a set of essential measures for immigration officers to apply to any British subject who was liable to control on arrival in the UK. The immigration officer could refuse entry unless the migrant had approved employment, was a genuine visitor, or had proof that recourse to public funds would not be necessary. In addition, the immigration officer should have the absolute right to refuse entry to migrants who had a criminal record, were certified unfit, or were stowaways or seamen deserters. [Layton-Henry; 1987]

The Working Party's recommendations were recognised by the Cabinet as being very difficult to reconcile with

Britain's leading role as head of the Commonwealth. The racist measures would be offensive to the Colonial Territories, liberal opinion in Britain and throughout the Commonwealth as a whole. They may have even broken international declarations Britain had supported. As a result, the government decided not to act on the Working Party's recommendations. [Layton-Henry; 1987]

Occupational Support for Doctor Migration to Britain

While the covert attempt by the 1951 Conservative government to build a strong case in order to justify immigration controls was in progress, the British 'professional' occupation of medicine were operating within the official 'open-door' policy by actively encouraging doctor migration from India. The substantial contribution made by Indian doctors in providing extra medical personnel to serve the needs of the British Empire during the Second World War, had resulted in the establishment of good relations between the British 'professional' occupation of medicine and Indian doctors. These good relations were acted upon during the 1950's. Shortages of junior hospital doctors in a rapidly expanding NHS witnessed the British occupations active encouragement of the migration of

Indian medical graduates to Britain to fill these vacancies.

As early as 1952, only a few years since the establishment of the NHS, the BMJ reported that the Consultants and Specialists Committee of the BMA was advocating that it might be possible to fill certain hospital staffing vacancies which had remained vacant for some time, with doctors from India. [BMJ, 1, 21-6-1952; p321] The Committee suggested that this might be done through the Indian Medical Association nominating suitable candidates from India.

The Lancet was also supportive of the occupations policy of encouraging migrant doctors to come to the UK for postgraduate training. The journal commented:

> *Many young doctors come from other parts of the Commonwealth to work in our hospitals and to take our examinations.*
>
> *It is good to know that ... our postgraduate qualifications are so highly regarded.* (7)

In the same article of 1952, however, the journal did express concern over the unorganised manner in which migrant doctors entered Britain.

Throughout the 1950's the GMC was continually adding qualifications from newly established Indian medical colleges for the purposes of registration in the UK. The BMJ reports that between June 1954 and June 1956, the Council added the qualifications from eleven new Indian medical colleges to its list for purposes of registration to practice in Britain. [BMJ, 1, 5-6-1954; p294: 1, 4-6-1955; p267: 1, 9-6-1956; p344]

This continued expansion of recognition by the GMC of Indian medical qualifications, was due not only to the recommendations made by the Indian Medical Council, but also to the fact that British methods of medical teaching continued to predominate in India. Not only were British medical textbooks used in the universities in India, but also, English was the preferred language of instruction. The educated generation in India at that time thought and spoke in English. [Lancet, 2, 13-9-1958; pp574-77]

The number of medical colleges in India was increasing rapidly at this time. An 'original article' in the BMJ observed that in 1947 there were only seventeen medical colleges in India, but by 1957 there were forty two. Admissions of medical students had increased from 2,500

in 1950, to 3,500 in 1955. The Indian government projected that over the five years from 1955 to 1960, 2,500 Indian doctors per annum would graduate. To facilitate this continued expansion, the Indian government planned to build more new medical schools, and expand, improve and upgrade its older ones. The author of the BMJ article concluded by asserting that these new medical colleges would undoubtedly be of excellent quality, and would easily match the standards of the older colleges. [BMJ, 2, 7-9-1957; pp537-9]

The public policy of the government's response to doctor migration from India, was expressed in the committee of inquiry to consider the future number of doctors and the appropriate intake of medical schools, which was established in February 1955 and chaired by Sir H Willink. [Willink Committee; 1957] With respect to migrant doctors, the Committee were interested in their contribution to the doctor population in terms of how this might effect long-term medical labour power planning.

The Committee undertook a random sample of doctors from the Medical Directory of 1953 and 1955, and analysed this sample by place of residence and country of first

qualification in order to determine how many migrant doctors were currently practising in Britain. They discovered that about 12 per cent of the sample had received most or all of their training overseas - a similar proportion to that indicated by the Goodenough Committee of 1943. [Willink Committee; 1957] The migrant doctor population had remained at a relatively static and low level for over a decade.

The Committee reported that the current stock of mainly resident migrant doctors had entered and settled in Britain mostly during and immediately after the war. Since 1950, the numbers entering Britain had been very small, and they had come to Britain primarily for postgraduate studies before returning to their country of origin. Those migrant doctors who were settling in Britain during the 1950's were almost exclusively from Northern Ireland, Eire and the Commonwealth. Estimates commissioned by the Committee indicated that a total of some 170 doctors from these three locations, would be expected to arrive and settle in Britain to practice per annum over the next seven or eight years. [Willink Committee; 1957]

In terms of future numbers of doctors available to practise in Britain, however, the Committee suggested that even with this intake of migrant doctors, Britain was a net exporter of doctors at around 200 per annum. The Committee did believe, however, that this position would be alleviated as there would be less opportunity in the future for British doctors to find posts abroad as these countries expand their own output of doctors, and increases in British medical school output would cause a decrease in migration to Britain from overseas. [Willink Committee; 1957]

The report of the Willink Committee gives us a valuable insight into why doctor migration from Indian was not perceived as a 'problem' by the State, in the same way as other New Commonwealth migration was. First, doctor migration was recognised as temporary for the purposes of gaining experience and postgraduate training in Britain. Second, the numbers entering Britain at this time were few, and had remained at this low level for over a decade. Third, the Willink Committee concluded that demand for qualified doctors in Britain would be met in the future by the increased output of British medical schools.

We shall see below, however, that the assessment of the future level of medical labour power to meet the needs of the NHS proved be a serious underestimate of the actual future demand. Expansion of the NHS and a failure to match the output of British medical schools to this expansion, resulted in a substantial increase in the number of migrant doctors coming to Britain to train and work. As competition between white British trained doctors and migrant doctors from India for the available posts increased and the career prospects of British graduates were perceived as under threat from this increased competition in the late-1960's, the British 'professional' occupation of medicine sought to racialise migrant Indian doctors and reproduce a racist ideology under the guise of 'professional' criteria.

The Conservative Campaign for Immigration Controls Continues

Neither the failure to build a strong case to justify immigration controls, nor the concrete reality of severe labour shortages in areas such as the NHS, operated to prevent the Conservative Home Secretary from preparing a Draft Bill on immigration control in November 1954. Cabinet discussions of the Draft Bill had to await the parliamentary session of October 1955. Similar

objections to those which had been directed at the Working Party's recommendations of May 1954 were once again raised in Cabinet. In addition, at a Cabinet meeting of November 1955, it was recognised that while the House of Commons was moving towards support for immigration controls, the country at large had not yet been prepared for such a move. [Carter, Harris & Joshi; 1987]

This Cabinet meeting, also for the first time, recognised how important black migrant labour from the New Commonwealth was as a cheap source of labour power to the UK economy. [Carter, Harris & Joshi; 1987] The 'racial' threat to the 'British way of life', however, remained paramount, as one member of the meeting commented:

> *The problem of colonial immigration has not yet aroused public anxiety ... [But] if immigration from the colonies, and, for that matter, from India and Pakistan, were allowed to continue unchecked, there is a real danger that over the years there would be a significant change in the racial character of the English people.* (8)

The government decided to reserve judgement on the Draft Bill, and in November 1955, Prime Minister Eden declared in a House of Commons reply to Cyril Osborne's initiation of a debate on controlling New Commonwealth

entry, that the Conservative government had no intention of introducing legislation. [Carter, Harris & Joshi; 1987] Eden, however, did not let the matter rest there. Later in the month, he appointed a Committee of Ministers to consider what form legislation should take. [Layton-Henry; 1984]

The Committee circulated its report to the Cabinet in June 1956, and it was discussed in Cabinet in the July. The Committee had noted the rise in black migration to Britain from 3,000 in 1953, to 10,000 in 1954, and 35,000 in 1955, but also recognised that this had presented few problems. Most had found employment with little difficulty. The black population were generally law-abiding and little intolerance had been shown towards them by white Britons. The Committee believed that problems were only likely to emerge if economic recession occurred. [Layton-Henry; 1987]

On balance, the Committee were against the introduction of immigration controls at the present time, although they did recommend that the situation should be kept under review, preferably on an annual basis. The Cabinet accepted the report of the Committee of Ministers and took no action. [Layton-Henry; 1987]

The continued inability of government's to produce a 'strong case' for the introduction of immigration control legislation, did not remove the 'race/immigration' issue from the political agenda. From 1956 until the introduction of Commonwealth Immigrants Act of 1962, the issue moved from the hidden political agenda to the public domain.

The Political Campaign for Immigration Control Goes Public

The 'race/immigration' issue was clearly a matter of concern for the post-1945 Labour and Conservative governments, although much of the debate had been conducted secretly within Cabinet. During the second half of the 1950's and the early 1960's, however, Conservative backbencher's in particular brought the issue into the public arena. Two of the most vocal in the mid-1950's were Cyril Osborne (Louth) and Norman Pannell (Liverpool, Kirkdale). Throughout this period in a series of debates in the House of Commons, they continually sought to make the link between New Commonwealth migrants and crime and disease. Calls for controls were not confined to Conservative MPs. Labour's John Hynd (Sheffield, Attercliffe) argued for controls on entry because 'coloured immigration' was

causing problems in employment and housing. [Miles & Phizacklea; 1984]

The Labour party attempted to keep the racist views of its right-wing MPs out of the public arena. Official party policy defined the 'problem' as one of racist discrimination, and opposed restrictions on the entry of New Commonwealth citizens. The party also advocated the provision of resources to aid the process of assimilation. Some on the Labour backbench highlighted these other problems in the debates on 'race/immigration' issues. [Miles & Phizacklea; 1984]

The Labour MP for South-West Islington, Albert Evans, stressed the contribution West Indian's were making to the economy, and suggested that the arrival of Black British Subjects was highlighting the already existing chronic housing situation. Eric Fletcher (East Islington) argued that competition for scarce housing resources was one factor in the cause of racism. [Miles & Phizacklea; 1984] Migrants often had no choice but to move into inner-city areas which were already in decline, as the more affluent white population moved out into the suburbs. Those white people who were left in the inner-city areas came to associate the falling

status of the areas with the arrival of black residents. [Rex and Tomlinson: 1979]

Support for immigration controls within the Conservative parliamentary party, was also extended to the activities of party members outside parliament. At their 1955 party conference there were resolutions on legislation to make Commonwealth citizens subject to the same entry requirements as aliens, and there were repeated calls that New Commonwealth migrants should undergo health checks. [Miles & Phizacklea; 1984] The official public Conservative party line, however, was a continued commitment to the principles of Commonwealth citizenship and an 'open door' policy allowing the free movement of all Commonwealth citizens. [Layton-Henry; 1984]

The Trade Union movement was more in tune with the Conservative party, than with Labour. The major unions, such as National Union of Railwaymen and the Transport and General Workers Union supported the introduction of immigration controls. The General Council of the TUC also advocated controls, but not on the basis of colour. [Miles & Phizacklea; 1984]

Historically the Trade Union movement had been hostile towards migrant labour, calling for controls on Jewish migration at the turn of the century, and demanding (and obtaining) strict controls over the utilisation of labour provided by the European Volunteer Worker scheme. The movement feared that migrant workers would form a pool of cheap labour which unintentionally would operate to undermine wage levels and working conditions for the majority and mainly white labour force. [Patterson: 1969]

The event which brought the issue of 'race/immigration' most sharply into the public consciousness, was the civil disturbances of 1958, first in Nottingham in August then in London's Notting Hill in September. Essentially, the disturbances involved attacks by white Britons on West Indian people and their property. [Miles & Phizacklea; 1984]

In Nottingham, the disturbances lasted for several days with crowds of between 1,500 and 4,000 reported on the streets of the city. In Notting Hill, crowds varying between 200 and 700 were reported and 140 people were arrested over a four day period. The Prime Minister of Jamaica, Norman Manley, and the Deputy-Chief Minister of

the West Indian Federation, Carl Lacorbiniere, flew to London for consultations and tours of the areas involved. [Layton-Henry; 1984]

The reaction of politicians and the media resulted in the disturbances being labelled as 'race riots'. On August 27, the *Times* reported that Labour and Conservative MPs in Nottingham were advocating immigration controls. Subsequent reports in the press consistently referred to the incidents as a 'race/ immigration problem', a 'race riot', a 'colour problem'. These labels operated to obscure the racist basis of the attacks by white's upon West Indian's and their property. [Miles & Phizacklea; 1984]

The official Labour party response was to denounce the incidents as the outcome of hooliganism, and outline appropriate legislation to curb racist discrimination. Some individual members of the party, however, supported their Nottingham colleagues with calls for immigration controls. Labour MP for Kensington North, George Rogers argued that black migrants were overcrowding housing needed by white Britons, and supported calls for immigration controls. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

Once again, the TUC was out of step with the official policy of its political wing. The disturbances of 1958 occurred during the TUC annual conference of that year. In its annual report, the General Council called for controls on immigration and the introduction of health checks for New Commonwealth migrants wishing to enter the UK. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

In Parliament, Osborne and Lindsay (Conservative, Solihull) suggested 'coloured immigration' was the main problem behind the disturbances. The issue, they argued, was whether Britain wished to become a 'multi-racial' society: a matter which effected the future of the British 'race and breed'. At the Conservative party conference in 1958, conference passed a resolution supporting the introduction of immigration controls. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

By explaining the disturbances of 1958 within the 'race/immigration' framework, commentators on the incidents had been able to argue that their origin was natural rather than social, where culture and social behaviour was the result of 'racial characteristics'. The West Indian presence in Britain was identified as the 'problem'. It followed from this, that the solution

was to stop further entry in to Britain. The Conservative government of the day, however, decided to take no action for the present. [Miles & Phizacklea; 1984]

The disturbances of 1958, also allowed a small group of overt racist MPs, inside and outside parliament, to advance their views on the national political stage. This was centred in the Midlands in the late 1950's and early 1960's. The Conservative election victory of 1959 had resulted in the election to parliament of a number of racist Conservative MPs in the Midlands. This increased the size of right-wing Conservative MPs in the party, and provided the opportunity for a more organised campaign in support of immigration controls. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

Conservative MP Harold Gurden (Selly Oak), organised a series of meetings in late 1960 and early 1961 where backbench MPs could discuss immigration controls, and which provided a forum from which to lobby the Home Secretary. During this period the Birmingham Immigration Control Association (BICA) was formed. This was a small but very active group which organised protest meetings, the distribution of leaflets, the

collection of petitions and sent letters to the local press, in order to promote their views concerning the introduction of immigration legislation. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

In February 1961, Osborne introduced a Private Members Bill concerned with the introduction of immigration legislation. The Bill was worded to include all migrants to Britain, but Osborne identified his racist credentials when the *Daily Mail* reported him as saying he wanted Britain to 'remain white'. In the debate on the Bill in the House of Commons, Osborne and Pannell emphasised that the differences in culture, values and beliefs between black and white people could lead to conflict. [Miles & Phizacklea; 1984]

The Joint Under-Secretary of State for the Home Department, David Renton, presented the Conservative governments official position in response to Osborne's Bill. He stressed the principle of maintaining the unrestricted right of entry to Britain of all British subjects. For the first time publicly, however, Renton's additional comments reflected a shift in official Conservative government thinking. He pointed out that the government was monitoring the situation,

and that the government agreed with the Bill's supporters that migrants were exacerbating existing social problems. [Miles & Phizacklea; 1984]

National, regional and local press interest in the 'race/immigration' issue over the preceding decade, had ensured that the public would have a perspective on the matter. This combined with the recognition that immigration into Britain from the New Commonwealth and Pakistan was increasing sharply, had shaped public opinion to the extent that in 1961 a Gallop Poll indicated that 73% of the population favoured immigration controls. [Miles & Phizacklea; 1984] The Conservative's desire to build a case in favour of immigration controls had been finally realised, and the 1962 Commonwealth Immigrants Act was introduced.

To briefly recap on the details of the Act which were more fully outlined in Chapter II. The 1962 Act, for the first time, placed restrictions on Commonwealth citizens wishing to enter Britain. From this date all Commonwealth citizens who wished to enter Britain to work and settle had to first of all possess the relevant employment voucher. The number of employment vouchers available in any one year was limited by the Ministry of

Labour, in order to match the supply and demand for labour in Britain.

This desire to match demand to supply, appeared to be the rational and non-racist basis of the Act. In reality, however, the Act was introduced primarily to curb the entry of Black British Subjects into Britain for the purposes of employment and settlement. The threat of its introduction actually precipitated a massive increase in entrants from the New Commonwealth immediately prior to its arrival on the statute book, [See Table 4], whereas previously migration to Britain had actually been closely matched to the demand for labour in the economy. [Miles & Phizacklea; 1984]

If the Act had genuinely been intended to match the supply and demand for labour, and facilitate the integration of those black migrants already settled in Britain, then controls would have been supplemented by a substantial increase in the resources available for housing, education and the industrial training of migrant labour. Finally, its racist content was revealed by the fact that the Act did not apply to migrant labour from the Irish Republic, even though they were not British citizens and the numbers entering the

Table 4

Estimated Net Immigration from the New Commonwealth 1953-1962

	West Indies	India	Pakistan	Others	Total
1953	2,000				2,000
1954	11,000				11,000
1955	27,500	5,800	1,850	7,500	42,650
1956	29,800	5,600	2,050	9,350	46,800
1957	23,000	6,600	5,200	7,600	42,400
1958	15,000	6,200	4,700	3,950	29,850
1959	16,400	2,950	850	1,400	21,600
1960	49,650	5,900	2,500	-350	57,700
1961	66,300	23,750	25,100	21,250	136,400
1962*	31,800	19,050	25,080	18,970	94,900

* first six months up to introduction of first controls

Source: cited in Layton-Henry; 1984: p23.

UK stood at between 60,000 and 70,000 per year at this time. The Act was attempting to ensure that the migrant labour entering the UK, which the British economy needed, was of the 'right stock': namely, <u>white</u>. [Miles & Phizacklea; 1984]

The Labour party opposed the Act on both political and economic grounds. Politically, the party argued the legislation was anti-Commonwealth and anti-colour, and defended the unrestricted free entry of Commonwealth citizens into Britain. In economic terms, Labour argued the legislation was not needed because up to 1959 New Commonwealth migration had been controlled by the supply and demand of the labour market. [Layton-Henry; 1984] In addition, Labour suggested that the legislation made no attempt to address the economic and social problems which had been associated with too high a level of black migration. [Miles & Phizacklea; 1984]

The Labour leader, Gaitskell used the issue to unify the party, which had been riven by internal conflict over the preceding months. His speeches in the debates on the Bill focused on the non-inclusion of migrants from the Irish Republic. Gaitskell was supported by a very powerful summary of Labour's position by Patrick Gordon-

Walker, and between them they were able to cause considerable embarrassment to the government over the racist content of the legislation. The new Act became law on July 1, 1962. [Miles & Phizacklea; 1984]

The opposition of Labour to the 1962 Act obscures some of the the issues that both major political parties held in common on the matter. First, both parties agreed that New Commonwealth migrants belonged to a distinct 'race', and that this fact produced problems of relations between the 'black' and 'white' 'races'. Second, although Labour opposed the specific measures adopted in the Act, they were not opposed in principle to immigration controls of some form. [Miles & Phizacklea; 1984]

Continued Support for Doctor Migration to Britain

The political debate which had resulted in the introduction of the 1962 Commonwealth Immigrants Act, failed to deter the British 'professional' occupation of medicine from continuing to encourage doctors from India to come to Britain to train and work. It was shown earlier in Chapter II, that black migrant doctors from New Commonwealth countries had exemptions under British

immigration regulations until the mid-1980's. It was at this time coincidentally, however, that the occupation began to question the quality of those migrant doctors.

In early 1962 the BMJ was eloquent in its praise of migrant Indian doctors, claiming that:

> *... we welcome [them] into our midst and are grateful for what they have done to keep the hospital service going.* (9)

Doctors from the Indian subcontinent were perceived as being a useful source of medical labour power for the areas of shortage in the NHS. In the same article the BMJ argued:

> *The fact that these have won their places in competition with native British graduates is surely a tribute to their merit and expression of the confidence their British selectors have in them. There must be few if any doctors in Britain who have anything but the warmest regard for the doctors who come here from the great subcontinent of India. One of the happiest experiences of British doctors since India became independent has been the increasing contact with their Indian colleagues, accompanied by a respect and friendliness which we know to be mutual.* (10)

The Lancet even went so far as to suggest that perhaps the NHS was not making full use of some of the more senior Indian doctors who come to Britain. The journal commented:

> *There is sometimes a regrettable tendency to treat senior Indians as though they were*

> *juniors: they can teach much wherever they go ...* (11)

The Lancet was not, however, averse to indicating its racist predilections at this time. The journal contributed to the argument prevalent in the wider political debate concerning the health of New Commonwealth migrants.

Following the introduction of the Commonwealth Immigrants Bill, the journal identifies in a leading article of 1962 entitled The Immigrant, 'black' immigration as one cause of the transmission of infectious disease, especially tuberculosis, and supports the BMA's call for compulsory X-ray examination of entrants. [Lancet, 1, 21-4-1962; p843]

While the article recognises the important contribution black migrants were making to the UK economy, especially in the less skilled area of public sector jobs, it is suggested they had tended to create a greater demand upon the social services. Contributing to the rhetoric of the 'race relations' discourse at the time, the article suggests that if migration into Britain were restricted and the burden on the social services consequently lessened, then these resources could be

used to ensure those migrants that were settled in the UK could be fully integrated into British society.

Although the occupation was more than happy to support the continued entrance of migrant doctors into Britain to work in the NHS, one problem was identified with respect to migrant doctors working in the UK at this time. Concern was expressed about the standard of postgraduate training being offered in many of the poorly equipped hospitals of the NHS to migrant doctors. This was a situation which applied to all doctors working in the UK, but it seems to have been addressed by the occupation in Britain, primarily in terms of the problems it created for migrant doctors. [BMJ, 1, 24-2-1962; pp539-40] The Lancet commented that many migrant and British trained doctors were in posts which were:

> *... remote from the larger centres; with much work and little supervision; with little access to libraries, and little time to use them; and with few opportunities to attend meetings, or even discuss their patients with colleagues.* (12)

Given this state of affairs, it not surprising that the Lancet in 1963 should comment that migrant doctors:

> *... often have difficulty in coping with the responsibilities that are suddenly thrust upon them.* (13)

In this article, however, the Lancet argues that it is not the poor training facilities offered to many migrant doctors which cause these 'coping difficulties'. The main reason why many of the 3,000-4,000 overseas graduates who were employed in junior hospital posts in the NHS, and were usually located in the less well equipped hospitals with heavy workloads and little supervised training, is the result of the poor capabilities of migrant doctors themselves. The article suggests that the undergraduate training of many migrant doctors was not be up to standard of British graduates, that they were unfamiliar with workings of NHS, and their command of English was often inadequate. [Lancet, 1, 23-2-1963; p430]

Poor training opportunities for migrant doctors in Britain did not rest easily with the occupations expressed view that postgraduate medical training in the UK for migrant doctors was an effective form of overseas development aid. In a leading article in October 1965, the BMJ commented in relation to Indian medical graduates working in Britain:

> *We are fortunate to have them and grateful for their service, but they come because they need training which they cannot get at home, Their effective postgraduate training ... represents one of the greatest contributions Britain can make in the whole field of medical aid.* (14)

The occupations solution to the problem of poor training was to support the recommendation of the Porritt Report of 1962 which advocated the introduction of a two month clinical attachment scheme in selected regional or teaching hospitals for migrant doctors, before they took up full-time posts in the NHS. The stated objective was to provide a better training structure and maximise postgraduate opportunities for migrant doctors practising in Britain. [BMJ, 2, 3-11-1962; pp1174-5]

The Porritt Report was concerned with the training of migrant doctors in Britain, with respect to the development of health care systems in the poorer 'developing' countries of the Commonwealth. Gish suggests that the report was the first official expression of the need for some sort of assessment scheme for migrant doctors training in Britain. The concern expressed by the working party about the standards of training and practical experience migrant doctors were receiving in Britain, was presented in terms of its value as a form of overseas aid to the 'developing countries' of the Commonwealth, rather than in relation to the competence and usefulness of migrant doctors to the British NHS. [Gish: 1969]

The British 'professional' occupation of medicine appears to have begun to face two ways at once in respect of migrant doctors from India during the early 1960's. On the one hand, it recognised the important role Indian migrant doctors were performing in the NHS. On the other, however, it had begun to question the 'professional quality' of those same doctors. Although the new immigration legislation provided certain exemptions to migrant doctors wishing to train and work in Britain in order to meet the continued increasing demand for medical labour power in the NHS, the dualistic position by the occupation represents the beginnings of an occupational campaign to place increased controls on black migrant doctors.

There seems to be a lack of connection between the more general racialisation of all black migrants by the State, and the response of the British 'professional' occupation of medicine towards the specific instance of black doctor migration to Britain. This can in part be explained by the fact that until the mid- to late-1950's the political debate on the 'race/immigration' issue was undertaken largely behind the closed doors of Cabinet. Outwardly, both post-war government's were endorsing an open-door policy to migrants from the New Commonwealth. Not surprisingly, therefore, the 'professional'

occupation of medicine in Britain was operating within this framework: actively encouraging the arrival of graduate doctors from India, to work in the NHS and settle in Britain.

These good relations between British and Indian doctors, however, did not endure far beyond the introduction of the 1962 Commonwealth Immigrants Act. It will be shown below, that during the period between 1962 and 1974, when racism was politically institutionalised in British society through the activities of the State, the British 'professional' occupation of medicine reproduced the content of this racist ideology through the ideology of professionalism, to present black migrant doctors as a 'problem' for the quality of medical provision in the British NHS.

THE INSTITUTIONALISATION OF BRITISH RACISM AND THE CREATION OF BLACK MIGRANT DOCTORS AS A 'PROBLEM': 1962-1974

Introduction

Between 1962 and 1974, successive government's operated to institutionalise racism in the practice of the State.

The political right kept the 'race/immigration' issue central to the political agenda through its campaigns surrounding the arrival of Kenyan and Ugandan Asians. The Labour government during this period, appeased the racist beliefs of both the political right and the electorate by operating a dualist policy which combined legislation to aid the integration of Britain's black population with stricter immigration controls. The end result was the extension and rationalisation of immigration legislation by the Conservative government in 1971.

The 'professional' occupation of medicine during this period were engaged in a concerted effort to racialise black migrant doctors working and training in Britain. The occupation campaigned to introduce testing of newly arriving black migrant doctors, and by influencing the GMC, restricted reciprocity arrangements with overseas medical institutions and revised registration regulations for migrant doctors.

The 1964 General Election

The Conservative government had hoped that the 1962 Commonwealth Immigrants Act would have resulted in the

end of the 'race/immigration' debate. The right-wing of the party, however, believed that the 'white English race' continued to be 'under threat' from black migration to Britain. The Act had effectively encouraged those black migrants already working in the UK to settle permanently and raise their families (the numbers of dependants entering Britain was on the increase), because of the potential difficulty of being able to return if they left. Consequently, the political right realised that there would be the emergence of a new generation of black people who would be born in Britain. This was one of the principle reasons why the political right continued its campaign. [Miles & Phizacklea; 1984]

The Labour party, also, could not ignore the 'race/immigration' issue. Although the party was victorious in the 1964 general election, it was also deeply shocked by the defeat of Patrick Gordon-Walker in the Smethwick constituency. Gordon-Walker had been elected MP for Smethwick, Birmingham in 1950, and was subsequently made Secretary of State for Commonwealth Relations in the Labour government. It was Gordon-Walker who had brilliantly summarised Labour's opposition to the 1962 Commonwealth Immigrants Act in

November 1961. The speech, however, caused considerable hostility within the constituency. [Foot: 1965]

The 'race/immigration' issue had already been the focus of media and political debate in the Smethwick area. The local press in 1960 had carried a series of racist letters, and the activities of the local branch of BICA had resulted in the introduction of a 'colour bar' at the largest youth club in the area. Mr Finney, the chair of the Smethwick branch of BICA, joined the Conservative party and was a successful candidate in the municipal elections. Finney then went on to campaign on an anti-immigration platform with Peter Griffiths, the newly selected prospective Conservative parliamentary candidate in the 1964 general election. Griffiths defeated Gordon-Walker with a swing of 7.2% to the Conservative's in the seat, against a 3.5% swing to Labour nationally. [Foot: 1965]

Labour also did poorly in the other areas of New Commonwealth migration settlement. For example, it lost the Birmingham seat of Perry Bar and Fenner Brockway's seat in Eaton (Slough), both of which the party expected to win. Although the Smethwick result was untypical of the 1964 general election, it did illustrate that the

'race/immigration' issue could be used by unscrupulous politicians for electoral purposes. [Layton-Henry; 1984]

The Labour Government: 1964-70

Labour's majority in the 1964 general election was five seats. This very small majority and the discomfort of the Smethwick result, meant that the new Labour government had little confidence with which to positively address the 'race/immigration' issue. [Layton-Henry; 1984] One of Labour's first government decisions was whether to renew the 1962 Act. They did so in November 1964, but they also promised to hold discussions with Commonwealth government's on the issue of immigration, thereby, holding out the prospect of removing the racist basis of the Act. [Miles & Phizacklea; 1984]

The Labour government's policy on the 'race/immigration' issue was to build a bi-partisan consensus with the Conservative party, in order to remove the debate from the political agenda so that any immanent general election could be fought on more traditional lines. Gaitskell's previous outright opposition to racist immigration controls was modified in the light of the

Smethwick result and the recognition that this opposition could damage Labour's electoral chances. This retreat from principle was further enhanced by the defeat of Gordon-Walker in a 'safe seat' at Leyton in a by-election in January 1965. [Layton-Henry; 1984]

The change in Labour policy was given official expression by Home Secretary Soskice, who announced in February 1965, that following evidence suggesting apparent widespread illegal immigration under the 1962 Act, deportation regulations and entry requirements for dependants would be tightened. [Layton-Henry; 1984, Miles & Phizacklea; 1984] In March 1965, the new Labour leader, Harold Wilson, announced measures which would provide some 'balance' in Labour's new policy. [Layton-Henry; 1984]

Following a series of Cabinet meetings, Wilson announced the appointment of a Minister (Maurice Foley) to encourage integration and better community relations, to introduce legislation to outlaw racist discrimination, to review the administrative machinery concerned with illegal immigration, and to establish a commission of inquiry to discuss the problems associated with immigration control with the relevant Commonwealth

countries. This final measure, under the directorship of Lord Mountbatten, returned from its mission completely empty handed, with Pakistan not even allowing the members of the commission to enter the country. [Layton-Henry; 1984]

Labour's appeasement of the racist basis of immigration control, however, did produce its desired effect: the establishment of a bi-partisan consensus on the 'race/immigration' issue. In a major debate in the House of Commons in March 1965, there was widespread cross-bench support for a dual policy of strict immigration controls and positive measures to assist with the integration of black migrants already settled and working in Britain. [Layton-Henry; 1984]

The first result of this new consensus on the 'race/immigration' issue was the introduction of a Race Relations Bill by Labour in April 1965. The Bill made racist discrimination illegal in specified public places (although employment and housing were consciously excluded from this clause by the government), and introduced the category of incitement to 'racial hatred' as a criminal offence. The exclusion of employment and housing as areas to be covered by the legislation,

appears to have been largely the result of pressure from the Trade Union movement. The TUC had suggested that the case for discrimination in employment had not been proven, and to outlaw racism in this area would only produce a privileged minority within the labour force which would generate tension with the white majority. The TUC and the CBI had collaborated to oppose the 1965 Bill. The Bill became law in November 1965. [Miles & Phizacklea; 1984]

The enactment of the 1965 Race Relations Bill, was preceded by the publication of a White Paper on black migration to Britain in August 1965 by the Labour government. The White Paper argued that the majority of new immigration was increasingly from the New Commonwealth, ie. 'black' migration, and this was especially the case in relation to the number of dependants then currently entering Britain, (although this assertion totally ignored the continued high levels of migration from the Irish Republic). The document recommended that category C employment vouchers should be discontinued and reductions be made in the other categories. Powers of deportation would be strengthened and health checks on arrival in the UK would be introduced. In addition, the authority of immigration officers would be extended in order that where necessary

Commonwealth migrants would be required to register with the police. [Miles & Phizacklea; 1984]

The White Paper was the first public official endorsement that immigration led to a 'race relations' problem, with the cause of the 'problem' identified as the presence of the migrant. [Miles & Phizacklea; 1984] Indeed, the racist content of the White Paper and its recognition of political expediency, was identified by Richard Crossman in his diaries:

> *This has been one of the most difficult and unpleasant jobs the government has had to do. We have become illiberal and lowered the quotas at a time when we have an acute shortage of labour. No wonder all the weekend liberal papers have been bitterly attacking us. Nevertheless I am convinced that if we hadn't done this we would have been faced with certain electoral defeat in the West Midlands and South East. Politically fear of immigration is the most powerful undertow today.* (15)

The debate in the House of Commons in November 1965 over the White Paper was bitter and protracted. On the left of the Labour party, there were attacks on the document for its racist content. Forty-one Labour MPs signed an appeal to have the White Paper withdrawn. From the right of the Conservative party there was support for

tighter controls and calls for the repatriation of black migrants. [Layton-Henry; 1984]

The position of the Labour government, however, illustrates that there was very little difference between the two major political parties. Both agreed that the number of black migrant workers entering Britain should be strictly controlled. The difference between them focused on the actual numbers which should be allowed in. Public opinion was firmly in favour of the measures proposed in the White Paper. Eighty-eight percent of the population were reported to support the proposals. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

The complete institutionalisation of racism had to wait a little longer, however. This was partly due to the appointment of Roy Jenkins in December 1965 as Home Secretary. Jenkins wanted to be remembered as a liberal and reforming Home Secretary, and wished to move the debate on the 'race/immigration' issue away form controls towards integration and assimilation of the black population. He knew, however, that his plans could not be put into operation until after the 1966

general election, when hopefully, Labour would have an effective working majority. [Rose et al: 1969]

The Labour party duly won the 1966 general election, with a majority of 100 seats. The strong stand by the Labour party with its 1965 White Paper, and Heath's refusal to allow Conservative candidates to exploit the 'race/immigration' issue, meant that the issue did not dominate the election. In fact, Labour was able to regain the seats it had lost on the 'race/immigration' issue, in 1964. Jenkins was retained as Home Secretary in the Labour administration, and began to implement his new policies immediately. [Layton-Henry; 1984]

One of his first acts as Home Secretary was to press the Race Relations Board (established under the 1965 Race Relations Act) and the National Committee for Commonwealth Immigrants (NCCI), to commission research into the levels of racist discrimination in Britain. The first fruits of this initiative were published by the Political and Economic Planning group (PEP) in April 1967. The report found that levels of racist discrimination faced by black migrants was substantially higher than had previously been thought. In addition, the Street Report on the use of anti-discrimination

legislation reported in October of the same year, recommending that legal sanctions should replace conciliation as the only effective means of discouraging discrimination. [Rose et al: 1969]

Jenkins used this evidence to persuade the Cabinet that stronger measures were needed to combat racist discrimination. Consequently, in May 1967, he announced the government's intention to introduce a new and more effective Race Relations Bill. The Labour government at this time, however, was becoming increasingly unpopular. In April 1967, the party lost control of the Greater London Council, and did badly in the local government elections in May. In terms of the 'race/immigration' issue, widespread media coverage of illegal Asian immigrants entering Britain in south-east England, and the arrival of Asian refugees from Kenya, had the result of undermining Jenkins' attempt to shift the 'race/immigration' debate away from controls towards integration. [Rose et al: 1969]

The arrival of Asian refugees from Kenya in 1967 provided the opportunity for right-wing Conservative MPs to begin the process of undermining the bi-partisan consensus between the two major parties. As holders of

UK passports the Kenyan Asians were entitled to enter Britain without immigration control. [Miles & Phizacklea; 1984] Enoch Powell commented that half a million people, claiming British citizenship, could be allowed to enter the country because of a loophole in the 1962 legislation. The media supported Powell by reporting the incident with headlines that defined the migration as an 'uncontrolled flood' and a 'deluge of immigrants'. There was no comment on the entrants of Irish migrants or the legal entitlement of Kenyan Asians to enter Britain. [Foot: 1969] The Labour government's response to these events was the publication of a new Commonwealth Immigrants Bill.

Migrant Doctors and the Clinical Attachment Scheme

The British 'professional' occupation of medicine at this time was intent on increasing the restrictions faced by black migrant doctors coming to train and work in the NHS. Following the recommendations of the Porritt Report in 1962, the occupation was successful in its campaign for the introduction of a voluntary clinical attachment scheme by the Department of Health in July 1966. [Gish: 1969]

The new scheme was intended to apply to all independent migrant doctors seeking appointment as house officers or senior house officers in the UK. They would have to complete a period of supervised clinical attachment not exceeding one month before they could take a permanent post. The scheme would not apply to sponsored migrant doctors or those being offered work at registrar or higher grade, as these were deemed to be of sufficient standard not to require this introductory training. [BMJ, 3, 2-9-1967; p126]

The BMJ reported on the concern expressed by the Medical Director of the BMA's Commonwealth and International Medical Advisory Bureaux (Dr Pallister) about the proposed introduction of this new scheme. [BMJ, 3, 2-9-1967; p126] The Director commented that the new scheme would add to migrant doctor's anxiety. They already faced substantial delays in entering the UK under the regulations of the Commonwealth Immigrants Act. Pallister questioned why it was necessary for migrant doctors who had already fulfilled GMC requirements for registration be asked to undergo further assessment.

There appears to be a question mark over the intention behind this new scheme. The stated aim was to provide a

more structured introduction to postgraduate training in Britain for migrant doctors, in order that they would gain as much as possible from their time in the NHS. This introductory and assessment period, however, would appear to be unnecessary given the already strict regulations and recognition procedures imposed by the GMC on migrant doctors seeking registration to practice in Britain.

This is especially the case since only two years earlier, a delegation from the GMC had spent six weeks in India in the middle of 1965, at the invitation of the Central Minister of Health (Dr Suskila Nayor) and the President of Indian Medical Council (Dr C S Patel). The delegation visited fifteen of the forty-five medical colleges operating in India at the time, and reported that they were impressed with activities of the IMC. The medical standard in these institutions were of an appropriate level to justify the GMC's Executive Committee in taking a *"liberal view"* over the recognition of Indian Medical Colleges. (16) It seems clear from this that the GMC were more than satisfied with the standards of migrant doctors coming to Britain.

The occupation, however, after a period of relative harmony, remained dissatisfied with the standard of migrant doctors. In 1966, the BMA proposed the establishment of an examination in English language for overseas graduates before they began independent medical practice in UK, [BMJ, 1, 26-2-1966; p45] and as we have seen above, the Lancet, three years earlier in 1963, had expressed doubts about the clinical competence and language ability of some migrant doctors.

The defence of 'professional' standards is clearly implicated in the occupations justification for the added assessment procedures migrant doctors would face under the provisions of the voluntary clinical attachment scheme. It seems then, that the first moves to increase restrictions governing the entrance of migrant doctors to Britain were taken under the guise of promoting a more structured and better postgraduate training for them through a clinical attachment scheme.

A one-month clinical attachment scheme would not provide any substantial or coherent form of training for migrant doctors. It would at best only contribute to a process of familiarisation with the workings of the NHS for newly arriving migrant doctors. If the occupation had

really wanted to address the issue of postgraduate doctor training in Britain, it could have put its considerable political influence behind the introduction of a systematic and comprehensive training programme for all junior hospital doctors. Such a measure would have ensured that all junior hospital doctors, whether British or overseas qualified, would meet the required standard of clinical competency to practice in the UK.

The occupation's campaign in support of the clinical attachment scheme, however, was merely the precursor to a more concerted effort to discredit black migrant doctors working in the NHS during the late 1960's and early 1970's. Repeatedly, the occupation questioned the 'professional' standards of these doctors during this period.

The 1968 Commonwealth Immigrants Act

Much of the substance of the Labour government's Commonwealth Immigrants Bill of February 1968 was taken from Osborne's 1965 Private Members Bill. This was the first action of the new Home Secretary, James Callaghan, who had replaced Jenkins in November 1967. The Act removed the right of free entry to Britain to all UK

passport holders who did not have a parent or grandparent born in the Britain. This provision would clearly apply most often only to black migrants, and was therefore, even more overtly racist than its predecessor. The Act became law in March 1968. [Layton-Henry; 1984]

The debates in the House of Commons on the second and third readings of the Bill, illustrate how the language associated with the 'race/immigration' notion had come to dominate the definition of the issue. Labour and Conservative MPs spoke of 'racial purity', 'racial tension', 'coloured immigration', 'alien cultures', 'racial prejudice' and 'natural instinct'. Only thirty nine MPs voted against the Bill, and the legislation went one step further in institutionalising racism in the practice of the State. [Miles & Phizacklea; 1984]

The passage of the new Race Relations Bill followed soon after the introduction of the new Immigration Act. The political environment could not have been more unhelpful. Powell and his colleagues, encouraged by their success in the debates on the Kenyan Asian situation, began to campaign against the introduction of new 'race relations' legislation. Two days before the

introduction of the Bill in the House of Commons, Powell made his infamous 'rivers of blood' speech in Birmingham, where he commented on the 'madness' of Britain allowing in 50,000 dependants annually of migrants already settled in the UK. His speech received massive publicity and a great deal of public support. He became the figurehead for the expression of ant-immigration resentment in Britain. Support for Powell from within the Conservative Shadow Cabinet, however, was in very short supply. Indeed, Heath sacked him from the Shadow Cabinet shortly afterwards. [Schoen: 1977]

The Labour government were absolutely furious with Powell. The Birmingham speech had effectively ended the bi-partisan consensus on the 'race/immigration' issue. Labour vigorously pushed through the new legislation with few amendments. The Bill became law in November 1968. [Layton-Henry; 1984]

Enoch Powell's influence on the 'race/immigration' issue, following the arrival of East African Asians and his Birmingham speech, was considerable. In a Gallop Poll of May 1968, 74% of those polled agreed with Powell's views on black migration, and 24% preferred him as leader of the Conservative party. This suggests that

his views were an important factor in the Conservative electoral victory in the 1970 general election. [Miles & Phizacklea; 1984]

Powell did not use the term 'race' or 'coloured immigrants', but subsumed these notions within the concepts of 'Britishness' and 'nationhood'. By doing this, he was able to both appeal to and legitimate the experiences and fears of the white British population. He was totally against the Race Relations Act. He argued that it was a specifically one-sided piece of legislation which effectively made white British people the persecuted population. For Powell, racist discrimination was the prerogative and legitimate behaviour of every free and private individual: the State could not legislate to control the feelings of private individuals in their relations with others. [Miles & Phizacklea; 1984]

The Conservative party in opposition during 1964-70, had to some degree followed Powell's campaign, by steadily becoming more racist. The leader of the party, Ted Heath, in a speech in New York in September 1968, had called for a reduction of the numbers of New Commonwealth migrants entering Britain and financial

assistance for those wishing to return to their country of origin. This move by Heath, allowed Powell in October 1968, to advocate the establishment of a Ministry of Repatriation. In January 1969, Heath demanded that Labour stop all immigration into Britain. [Miles & Phizacklea; 1984]

Although the campaign led by Powell in the 1960's had dissolved the bi-partisan consensus between the two major parties, and contributed to the rightward shift in immigration policy, by the time of the 1970 general election his influence had been circumscribed. He was increasingly at variance with the Conservative leadership over issues other than 'race/immigration' issue. For example, he was totally opposed to Britain's entry to the EEC. Consequently, his position with the party became increasingly marginalised and tenuous. [Layton-Henry; 1984]

Powell's intervention in the 'race/immigration' debate of the late 1960's, disseminated with equal passion by the mass media, however, created a high public profile for the issue. While this political debate was in full flow, the British 'professional' occupation of medicine

were engaged in the process of constructing a case to discredit 'black' migrant doctors working and training in Britain.

This campaign by the occupation, as we shall see below, reflected a central theme of the more general political debate on the 'race/immigration' issue. For example, Powell's evocation of the 'numbers game' through the notion of an 'immigration invasion', was reproduced within medicine by the occupation. Certain sections of the BMA were becoming concerned about the increased competition for scarce junior hospital doctor posts. They believed this was being caused by too many black migrant doctors freely entering the UK to work and train within the NHS. As a result, the occupation wanted measures introduced which would act as a disincentive to potential migrant doctors. In this way, the number of black migrant doctors entering Britain would be restricted, reducing the competition in the hospital sector and ensuring that the best junior hospital posts went to white, British trained doctors.

Building the Case for Greater Control of Black Migrant Doctors

The late 1960's saw increasing concern by the British 'professional' occupation of medicine over the expansion in the numbers of migrant doctors entering the UK to train and practice. The BMJ reports that the BMA's Hospital Junior Staffs Group Council believed that migrant doctors were spoiling the career prospects of British graduates, by swelling the numbers competing for junior training posts in the NHS. [BMJ, 4, 19-10-1968; pp17-18]

Migrant doctors generally, and 'black' migrant doctors in particular were being constructed as a 'problem' for the NHS by the occupation. This problematisation of black migrant doctors is clearly expressed in a leading article in the BMJ of March 1969. [BMJ, 1, 22-3-1969; pp729-30] The article reviews the apparent problems associated with migrant doctors seeking work in Britain, especially those from the New Commonwealth.

The article suggested that for many years the UK had relied on migrant doctors to staff its junior posts. This had typically meant that about forty per cent of

junior hospital posts had been occupied by migrant doctors. While jobs were fairly easy to come by there was little problem. The article, however, argues this had changed in recent years as it had become increasingly difficult for migrant doctors to get appointments.

The article suggests that there were several reasons for this change. First, stricter immigration policy in the USA had meant one avenue of migration for migrant and British doctors had been restricted. Second, in the UK, the output from British medical schools had been increasing, while simultaneously the overall numbers of migrant doctors coming to the UK (especially from the Middle East) had also increased. As a result, doctors from the New Commonwealth had supposedly been finding the competition for good training posts / career posts increasing sharply.

The article goes on to suggest that the major 'problem' concerns those migrant doctors, especially from Indian and Pakistan, who come to Britain on category 'B' immigration vouchers which allows permanent residence in the UK. The journal feels that these vouchers:

> *...seem to have been freely available to any doctor from any Commonwealth country.* (17)

Consequently, many migrant doctors often arrived in the UK without the necessary experience required. They, therefore, had to compete directly with British trained doctors for a limited number of approved pre-registration posts.

The article further argues that there was little coordinated support for migrant doctors on their arrival in Britain, and the one-month voluntary clinical attachment scheme had been too short for adequate assessment of their abilities. In addition, good postgraduate hospital training posts, which provided good prospects for advancement, were generally in short supply, and the Royal Colleges had recently tightened up the regulations for postgraduate examinations.

The journal felt that competition from migrant doctors for the restricted number of postgraduate training posts was unfair on British trained doctors. The article asserts:

> *No society in the world would give the best jobs for unknown foreigners while good native applicants came forward: hence very few unsponsored overseas graduates get the sort of jobs they would like.* (18)

The article then goes on to justify why migrant doctors from the New Commonwealth tend to be disproportionately concentrated in the less popular specialities which are located away from the teaching hospitals. First, the article suggests that most junior hospital posts are in fact located in the regional hospitals which are not connected with the teaching areas. Consequently, these jobs by their very nature, contain little of postgraduate training value. Second, the more unpopular specialties are more likely to be filled with applicants who are least equipped to compete for the better posts.

The journal is clearly attempting to argue that migrant doctors are not the victims of racism. Neither can they be exploited, the article suggests, if they voluntarily come to Britain and earn more than if they stayed in their countries of origin. The article contends that postgraduate students from overseas are always welcome in the UK, but:

> *... the existing situation - a rising pool of unemployed overseas doctors and a widening gulf between jobs which are worth while and those that can be filled from the unemployed - should not be allowed to deteriorate. A consultant in a northern mill-town is often faced with the choice of no houseman or one with no previous experience in Britain and with a poor command of English. Should he take on such a candidate, hoping to find a keen useful pair of hands while he learns English? Whose responsibility is it if a tragedy occurs because of misunderstanding or failure in communications?* (19)

The journal reports that the BMA proposed three steps to resolve the current problem's associated with migrant doctors at this time. First, no migrant doctors should be allowed into Britain unless their qualifications allow them to be fully registered by the GMC either temporarily or permanently. The only exemption to this would be approved postgraduate students. Second, some form of screening to test knowledge of English and medicine, similar to the American ECFMG examination, should be required for all migrant doctors. (20) Finally, appointment committees should refuse to appoint unsuitable applicants to posts in the NHS, even if this means a hospital or a department would have to be closed down for a while.

The Lancet made its contribution to this debate by identifying an apparent decline in the standards of recent arrivals of doctors from overseas. [Lancet, 1, 1-3-1969; pp452-3] The article reports that as sending countries had begun to recognise that their doctors often receive little training and heavy workloads in Britain, and that in any case British postgraduate diplomas are of little value when they return, sending countries have introduced measures to ensure that their more able graduates remain at home (21). Consequently, Britain is now receiving migrant doctors which:

> *academically, intellectually, and linguistically, are less gifted than their predecessors.* (22)

For these reasons the journal insists that the need to fill vacant junior hospital posts with migrant doctors should not be undertaken at the expense of maintaining medical standards.

The article believes that the clinical attachment scheme was the ideal introduction and orientation structure for migrant doctors, but suggests that difficulties encountered with such schemes means:

> *... it is clear that many candidates would have been well advised to stay at home in the first place.* (23)

While the journal believes the clinical attachment scheme should remain voluntary, it also urges the GMC to revise its reciprocity arrangements in the light of overseas medical schools modifying their courses to meet local needs rather then European requirements. The journal also supported the recommendation of the Royal Commission on Medical Education (Todd Report: 1968) that the appointment of overseas candidates should be restricted to those with postgraduate experience in their own countries.

The Todd Report was a Royal Commission established to review medical education at both undergraduate and postgraduate levels. Advances in medical knowledge and increasing specialisation had led to concern over whether full registration to practise after graduation and only one years pre-registration experience was now appropriate.

In relation to migrant doctors, the report recommended that those migrant doctors who come to Britain for postgraduate training should have similar opportunities to those of British graduates provided their existing training was equivalent to that which British doctors had received. To facilitate this, the report recommended that a number of approved posts in excess of those needed to fill expected career consultant posts in Britain should be set aside for them.

The Commission, however, were concerned about the heavy reliance by the NHS on migrant doctors:

> *... the current excessive reliance on the services provided by young doctors from overseas was bad for them and their countries, and was tending to distort the staffing pattern of British hospitals.* (24)

The Commission, however, recognised that without their services many of the smaller hospitals throughout the

country would have great difficulty in providing adequate hospital provision.

The Commission concluded that the pool of available talent in Britain was sufficient for future demand for doctors, provided medical school output was expanded and especially if the Commissions recommendations for an improved career structure were implemented. Within this context, however, the report recognised that the training of migrant doctors from less 'developed' countries was a significant source of overseas aid to 'developing' countries, even though the evidence suggested that migrant doctors tended to have great difficulty in obtaining the kind of training post they needed, and posts in university teaching hospitals were extremely hard to obtain. In addition, the Commission also recognised that some migrant doctors had difficulty with the English language, and as a consequence recommended that all migrant doctors with this problem should have access to courses to improve their language competence.

It seems clear that following the British 'professional' occupation of medicines arguments that migrant doctors should be subject to extra assessment with the clinical

attachment scheme in the early 1960'S, the last quarter of that decade saw the occupation continue to campaign to create a strong case to justify increased restrictions on black migrant doctors in particular. The principal justificatory argument for the occupations position rested on the apparent problems British graduates were having in competing with black migrant doctors for scarce junior hospital posts. This was cited as unfair: that 'unknown foreigners' should be given equal or preferential treatment over 'good native doctors', through apparently unrestricted provision of category 'B' immigration vouchers to doctors from the New Commonwealth.

By collectively labelling black migrant doctors as 'foreigners', the occupation were categorising them as 'non-British outsiders' who did not legitimately deserve to be treated on equal terms with 'good' British citizens. Indeed, in referring to the free availability of employment vouchers, the occupation was implying that tighter regulations governing there issuance would in itself operate to exclude these undesirable outsiders. This is particularly ironic as most migrant doctors from the New Commonwealth at this time would hold British citizenship.

The problem of increased competition for increasingly scarce training posts, is presented as the result of too many non-British doctors entering the NHS. Black migrant doctors are identified as the 'problem', although in terms of national origin rather than of explicit 'racial' criteria. The occupation is reproducing a version of popular nationalist discourse associated with politicians like Powell, to identify black migrant doctors as a problematical, culturally (and, therefore, 'racially') distinct group of medical practitioners in the NHS.

The supposed 'unfair competition' from 'foreigners' is the real material origin of the occupations concern, and is the basis on which the occupation wishes to impose greater controls on black migrant doctors. It is the self-interest of the occupation, in terms of securing good career prospects for white British-trained doctors, that is perceived as being under threat from the increasing numbers of black migrant doctors entering Britain. Once again, the occupation is reproducing a version of the popular discourse relating to 'immigration', by referring to the 'numbers game'. 'Scare stories' about 'swamping' and 'invasion' have always been part of the media's response to migration into Britain.

The real concern over competition for jobs, however, is justified by the occupation by reference to the ideology of professionalism. The occupation argues that it is a concern with the defence of 'professional' medical standards, rather than occupational self-interest in terms of competition from 'outsiders' for scarce hospital training posts, which determines its desire to see black migrant doctors tested prior to employment in the NHS. The issue, therefore, is associated with the clinical standards generally, and competence in English specifically, of black migrant doctors. The real issue of occupational self-interest, is distorted and obscured by 'problematising' the role of black migrant doctors working in the NHS.

To reiterate, if the real concern of the occupation had been the poor 'professional' standard of black migrant doctors, then rather than 'problematising' this group of doctors and campaigning to have them subjected to an assessment and screening procedure, the occupation could have used its considerable political influence to secure the introduction of a systematic and comprehensive training programme for all junior hospital doctors. This would have ensured that all junior hospital doctors, whether British or overseas trained, could meet the 'professional' standards required to practice in the

UK. The occupation, however, were more concerned with placing increased restrictions on black migrant doctors in order to reduce the competition for scarce junior hospital doctor training posts and secure them for white, British trained doctors.

The occupation's increasing support for greater control over black migrant doctors seemed to challenge the role of the GMC in regulating the occupation. In December 1968, a leading article in the BMJ was asserting that the pass rates for graduates of Indian medical colleges compared favourably with graduates in Western countries. The journal was able to make such an assertion because the Institute of Manpower Research and National Institute of Health Administration and Education in India, had recently published a report on India medical manpower providing comprehensive details about medical colleges in India.[BMJ, 4, 21-12-1968; p722]

The occupation's proposal for additional assessment of migrant doctors on arrival in Britain, especially in relation to competence in English, was also put in perspective by the Minister of State, Richard Crossman, in March 1969. The Minister had commented that he recognised that there was some concern over the lack of

communication skills of a minority of migrant doctors. The Minister added, however, that as the GMC approved medical schools in Commonwealth and Foreign countries only where English was the medium of instruction, there were no plans at present to introduce further assessment in this area. [BMJ, 1, 15-3-1969; p725]

It would appear that the occupation was in reality less concerned about the actual 'professional' competence of black migrant doctors, and more concerned about creating appropriate exclusionary practices to reduce competition for its white British trained colleagues. In addition the actual activities of the occupation in relation to migrant doctors, was in marked contrast to their supposed public policy on racism. In a leading article in response to the infamous speeches of Enoch Powell in the late 1960's the journal commented:

> *... the subject of his speech, race relations, is something that concerns the medical profession, the humane nature of medicine and its international connexions make it stand as plainly opposed as could be to racial prejudice and conflict.*
>
> *The public face of medicine in Britain has always been firmly set against any kind of discrimination.* (25)

The journal goes on to suggest that complaints of racism in its correspondence columns are rare. Even when such issues are raised, the journal contends that notions of 'colour' or 'race' are not the main concern. Rather, such issues are deemed to be the result of a natural British *"social reserve"* towards the *"foreigner"*. (26) The article concludes:

> *This country owes a debt to the hosts of doctors and nurses, many of them coloured, who have come here for training or to find a permanent home. To these colleagues, our fellow physicians and surgeons, we owe an obligation of working in complete harmony.* (27)

Even where it is publicly declaring its opposition to racism and discrimination, the occupation utilises the ideology of nationalism to justify its position. The journal suggests that poor relations which might occur between black migrant doctors and white British doctors is due to the British national characteristic of 'social reserve' towards non-British nationalities. This supposed character trait, however, can itself be the basis of exclusionary practices. This 'social reserve' may inform decisions concerning recruitment and promotion. Preference will be given to those doctors identified as belonging to the same 'national group', while those identified as outsiders or foreigners, will be more likely to be excluded.

The occupation continued its active support for the introduction of a compulsory clinical attachment scheme. The BMJ reported that at the Annual Representative Meeting of the BMA in Aberdeen in 1969, the following resolution was passed:

> *... the General Medical Council should accept responsibility for the selection of overseas doctors, based on their original qualifications, comprehension of English, and basic medical knowledge, and selection should be made under properly supervised conditions.*
>
> *The GMC should advise the Government Department responsible for issuing work permits (which were at present apparently freely available) to issue them only to doctors able to pass a screening test of English and those who could produce a registrable medical qualification.* (28)

In the August of 1969 the Lancet reported on the intended introduction of a compulsory clinical attachment scheme and restrictions on the number of migrant doctors entering the UK. [Lancet, 2, 2-8-1969; p257] The Secretary of State for Health, Richard Crossman, estimated that that for the next two or three years Britain would continue to require around 700 migrant doctors per annum. Subsequent to this, however, expansion of UK medical school output should mean decreasing dependence on migrant doctors. Consequently, the Secretary of State for Employment and Productivity would limit the number of migrant doctors entering on

category B vouchers to some 1,000 per annum for that period (the same as the previous year).

The new compulsory clinical attachment scheme, to be introduced in October 1969, would assess both the clinical and language competence of migrant doctors. After consultation with Commonwealth governments, the occupation of medicine and others, the Secretary of State decided to make assessment by attachment to a hospital under consultant supervision compulsory before an migrant doctor could enter hospital employment.

Migrant doctors who would be required to be assessed would have to spend up to a month in an approved hospital unit, they would have no clinical responsibility and their activities would be limited to history taking, examination of selected patients, and the performance of certain procedures under supervision. The doctor would have access to local and national postgraduate institutions, would be paid at half the salary of a first house officer appointment, and would be provided with free accommodation. At the end of the attachment period the consultant would state on a certificate the sort of post the attached doctor would be most suited to, bearing in mind both clinical

competence and command of English. [Lancet, 2, 29-11-1969; p1206]

Several groups of migrant doctors would be exempt from clinical attachment. Those exempted would include: sponsored doctors; doctors accepted for posts at registrar or above; doctors who had attended postgraduate training in the UK for three months or more and attained a certificate of competence in English from the course tutor; doctors who could prove, via a testimonial by a known referee, that they were suitable to begin full-time work without acclimatisation period. The BMA intended to monitor the new assessment scheme in order to identify the number who failed to gain certificates. [BMJ, 2, 18-4-1970; p70]

The first phase in the racialisation of black migrant doctors by the occupation had been achieved through the introduction of the compulsory clinical attachment scheme. It replaced the earlier voluntary scheme, which had proved ineffective because so few migrant doctors had made use of it. Now all newly arriving migrant doctors, except those exempted, would be required to undertake the scheme prior to full-time appointment in the NHS.

The Conservatives Return to Government: 1970-74

The 'race/immigration' issue was not generally exploited in the general election of 1970, however, Powell's rise to prominence resulted in the media regarding him as a 'one-man-party', with his election address being treated as a manifesto in its own right. The Conservative's unexpectedly won the election with a comfortable overall majority of forty-three, and research on the voting patterns in the election has shown that Powell's campaign contributed significantly to Conservative victories in the West Midlands area. [Layton-Henry; 1984]

One of the early tasks of the new Conservative administration was to replace the existing immigration legislation with the 1971 Commonwealth Immigrants Act, which came into force in January 1973. The Act was a comprehensive rationalisation and extension of the racist legislation of the 1960's. It based immigration controls around the single distinction between patrial and non-patrial. Essentially this meant that the previous distinction between aliens and Commonwealth citizens no longer existed. Consequently, patrials: those who were born, adopted, naturalised or registered in the UK, or one of whose parents or grandparents held

British citizenship, were free to enter and settle in the UK. Non-patrials on the other hand, had to obtain permission to enter and settle in Britain by applying for a work permit which provided a specific job, with a particular employer for a specific length of time. [Miles & Phizacklea; 1984]

The Act aimed to overcome fears about black migration into Britain, and hopefully for the Conservative government finally diffuse the 'race/immigration' issue once and for all. It extended the right to enter and settle in the UK to more people, but defined those eligible in such a way as to ensure they were of the 'right stock', that is, mainly white. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

The 'race/immigration' issue did not disappear, however, due to the expulsion of Asians from Uganda in 1972. That potentially 50,000 Ugandan Asians with British passports could gain entry to the UK was greeted with horror by the media and some politicians. The Conservative government, however, recognised its responsibility to the refugees, and accepted 27,000, with the remainder going to other countries following

substantial representation from the British government. [Layton-Henry; 1984]

Powell and other right-wing MPs saw this as an opportunity to challenge the Conservative leadership. At the 1972 Conservative party conference Powell and his supporters submitted a resolution calling for the end to all immigration, the instigation of voluntary repatriation, and the acceptance of a statement proclaiming that Britain was not responsible for the Ugandan Asians. An alternative anti-Powellite resolution presented by the Youth movement of the party which supported the government's acceptance of the Ugandan Asians, however, won the vote on the day. [Layton-Henry; 1984]

The Labour party had opposed the new legislation, arguing it was racist and would have the effect of making 'race relations' in Britain potentially worse. Labour party policy in opposition was based on the belief that immigration controls could be made non-racist if they were based upon a major review of British citizenship laws. The party's own legacy of racist immigration controls while in office in the 1960's, however, made this proposal less than credible. The

prospect of new Nationality legislation, was however, now firmly on the political agenda, and would be the focus of much political debate over the next few years. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

The Occupation and Doctors from the EEC

The British 'professional' occupation of medicine at this time were becoming increasingly concerned about Britain joining the EEC. The GMC was prompted to formulate a recommendation concerning free movement of doctors in Europe on Britain's entry into the Common Market. The Council proposed that:

> *... the General Medical Council be asked to safeguard the high standards of British medicine by making it compulsory for doctors wishing to practise medicine in this country, and who do not hold a British medical qualification, to sit an entrance examination.* (29)

It appeared that the BMA was being even handed in relation to migrant doctors from the Commonwealth and Europe, at least for the present.

Concern about unrestricted entry into Britain by European doctors once Britain joined the EEC was expressed as early as 1962. [BMJ, 2, 4-8-1962; pp86-7] The occupation were issuing warnings about the need to

safeguard the existing standards of qualifications to practise medicine in Britain. The article in the BMJ went on to argue that:

> *The Association must direct its attention to making sure that the profession's ethical, academic, and economic standards are maintained if the decision was to join.* (30)

The occupation were deeply concerned that if unrestricted entry of European doctors into Britain were allowed, then this might create a doctor surplus in all areas of the occupation. In 1972, the BMJ reported that the BMA supported the view of the Permanent Standing Committee of Doctors on the EEC that migrant doctors should undergo a period of adaptation of up to six months. The Association suggested this would include a type of assessment similar to the clinical attachment scheme which other overseas doctors were to undergo. [BMJ, 2, 13-5-1972; p110]

The perceived potential 'threat' of unlimited numbers of European doctors arriving in Britain on the UK's entry into the EEC provided an extra dimension to the occupation's campaign for increased control of migrant doctors. As with black migrant doctors, the occupation justified its position on European doctors in terms of defending 'professional' standards and thereby securing

the populations confidence in medical practice in the NHS.

By the early 1970's, however, the informal assessment of European and other migrant doctors within the new clinical attachment scheme was insufficient to satisfy the occupation. The call now was for a more formal, separate assessment of clinical and linguistic standards through a ECFMG type examination. This, however, seemed more symbolic than practically effective, as this American form of examination did not assess English or the application of clinical knowledge in the clinical context. The occupation wanted to be seen to be safeguarding professional standards through a more formal, yet probably less effective, gatekeeping mechanism.

The regulating body of the occupation, the GMC, was not excluded from the debate concerning the increased control of black migrant doctors working and training in Britain. The Council felt that the time was propitious to redefine the parameters of the registration regulations governing the medical practice of all migrant doctors in Britain during the first half of the

1970's. Doctors from the Indian subcontinent were given special attention.

The Early 1970's: The Role of the GMC

The debates within the British 'professional' occupation of medicine detailed above, concerning the desire to restrict migrant doctors generally, and black migrant doctors in particular, formed the background to the implementation of a review on registration regulations by the GMC. The BMJ presented a detailed summary of the GMC's Interim Report of this review in March 1972. [BMJ, 1, 11-3-1972; pp67-8]

In May 1970 the GMC established a Special Committee to examine the registration of migrant doctors. Its terms of reference were:

> *To review the present arrangements for the registration in this country of doctors who have qualified overseas, with a view of determining whether those arrangements are satisfactory, and, insofar as they are unsatisfactory, to make recommendations for changes in them.* (31)

A general invitation to participate was made in the medical press, and specific invitations were issued to the Health Departments, the Foreign and Commonwealth

Office's, the Royal Colleges, the BMA and the British Postgraduate Medical Federation.

The Report gives six reasons why the review was instigated. First, public allegations had been made concerning the 'professional' and/or linguistic competence of individual doctors qualified overseas, although evidence to support such allegations had been scarce. Second, expansion of medical education throughout the world had made it increasingly difficult for the GMC to satisfy itself that standards of medical education were being maintained for purposes of recognition by the Council.

Third, the Medical Acts did not allow testing of linguistic capacity for registration purposes (although with temporary registration the GMC had discretionary powers to take account of reports of linguistic competence). Fourth, extensions of temporary registration due to job changes were causing difficulty because of a lag between application and renewal. It was possible that some doctors were practising without being registered.

Fifth, the present system was identified as operating to hinder unduly the registration of eminent and highly qualified doctors from countries with whom no reciprocal arrangements applied, especially doctors from the USA. Finally, there was no existing provision for some migrant doctors who had given satisfactory service in a succession of appointments in UK, to transfer from temporary registration without undergoing qualifying exams in medicine, surgery and midwifery for a registrable primary qualification.

The Report then goes on to outline the ~~the~~ three kinds of registration which were then currently open to migrant doctors. Provisional and full registration for migrant doctors was exactly the same as when applied to a UK qualified doctor. Full registration entitled a doctor to engage in any form of 'professional' employment. Provisional registration limited a doctor's practice to any hospital which was approved for the purpose of pre-registration house officer service. Provisional registration did not need to be renewed on change of post and had no time limit.

A doctor who had obtained qualifications overseas was entitled to either form of registration without further

examination (or language test) in the UK, provided the qualifications were recognised for that purpose by the GMC. For full registration the doctor must also satisfy the GMC that she/he had completed a house officer year or acquired equivalent experience. The only other major condition in the granting of full or provisional registration to migrant doctors was the requirement that the doctors must have gained their first medical qualification in a country with whom Britain had reciprocity arrangements.

The basis of GMC recognition rested on the requirement that the qualification:

> ... *furnishes a sufficient guarantee of the possession of the requisite knowledge and skill for the efficient practise of medicine, surgery and midwifery.* (32)

The Council at the time (1972) recognised for the purposes of registration the qualifications of seventy-six overseas universities and other bodies.

The third form of registration, temporary registration, applied to migrant doctors only in respect of employment in a hospital or institution approved by the GMC for that purpose. Any post or grade could qualify for the purposes of temporary registration, but it had to be

approved for that purpose by the GMC. Temporary registration had to be renewed on change of employment or the extension of an existing post. In practice the Council had full discretionary powers over temporary registration.

Previously temporary registration could only be granted to a migrant doctor who was in the UK temporarily. Provisions under the 1969 Medical Act removed this restriction, and thereafter, it was possible for migrant doctors to make a permanent hospital career on the basis of temporary registration alone. To be eligible for temporary registration the doctor must have been selected for an approved post and hold a qualification recognised by GMC for the purposes of temporary registration. Unlike full and provisional registration, however, the country of qualification need not have reciprocal arrangements with UK.

The GMC felt that because those holding temporary registration could only work in the hospital service and that work was supervised, it was able to recognise qualifications for temporary registration whose standards were not as well known to the Council as those for the other two types of registration. In addition,

through its discretionary powers, the Council was able to take account of professional experience and linguistic competence of an applicant prior to registration, even though this responsibility lay primarily with the employing authority.

One of the problems identified with the existing arrangements was that they did not allow highly-qualified doctors qualified in non-reciprocating countries (such as the USA) to proceed directly to full registration on entering the UK. Migrant doctors in this position were required to take a qualifying examination in the UK in order to obtain a recognised registrable primary qualification. Medical organisations, however, required only the taking of the exam without having to undergo the whole course.

The Review Committee were reported as acknowledging that evidence from the Department of Health showed that only a very small number of migrant doctors assessed under the clinical attachment scheme were regarded as unsatisfactory. The majority of this small number had difficulty only with the English language and their clinical ability was satisfactory. The Committee stated that it had:

> *... received no documented evidence of specific cases of alleged clinical incompetence ...* (33)

and concluded:

> *... that very few overseas doctors had been granted registration whose professional knowledge had been seriously deficient.* (34)

Despite this, the Review Committee were concerned that there was evidence that some migrant doctors had difficulty adjusting to the habits and attitudes of patient care in UK. Although this was not deemed to be serious at present, expansion of overseas medical schools and the replacement of English as the first language of instruction in medicine with national languages could, it was argued, pose problems in the future.

On the basis of this review, the Committee made three recommendations. First, full registration without further examination should be retained, and should be confined to doctors with qualifications and experience recognised by GMC. However, the Committee stated that:

> *It is expected that only a small number of overseas qualifications would in future be recognised for this purpose, as compared with the recent situation.* (35)

Second, temporary registration should be superseded by a more flexible system of limited registration. The Committee felt that temporary registration had outlived its purpose. It was established in 1947 to cater for a small number of visiting foreign doctors. Currently, At any one time 2,550 migrant doctors were practising in the UK on temporary registration. Under limited registration the GMC would take into account not only the standard of migrant doctors primary qualification, but also any higher qualifications gained in UK, and the doctors performance in an ECFMG type of examination or their performance in an improved clinical attachment scheme.

Third, the review recommended the creation of a flexible procedure to allow certain other doctors to proceed to full registration. The majority of migrant doctors would have completed satisfactory service, which had been supervised and assessed while on limited registration. A small number (ie. exceptionally) would be granted full registration immediately. These would include distinguished migrant doctors who did not hold qualifications normally recognised by the GMC for that purpose, but whose standards were proven. If the proposals of the Interim Report were accepted, then new legislation would be required to implement them.

Shortly after the publication of the GMC review, and despite finding little evidence to support a case which suggested that a significant number of migrant doctors had difficulty with English, the GMC produced a memorandum concerning the Council's intention to create a formal scheme to test the ability of migrant doctors to understand and express themselves in English, and their ability to practice medicine in the UK. [Lancet, 2, 15-9-1973; p630] When introduced these new arrangements would apply to migrant doctors seeking temporary registration (and the forthcoming limited registration). In addition, the Lancet also reported that the GMC declared its wish to discontinue reciprocity as a condition for recognition of overseas medical qualifications for the purposes of full registration in the UK, and to shorten the list of recognised qualifications.

It is clear that the GMC had taken on board the criticisms and proposed solutions to the 'problems' associated with migrant doctors, that the occupation had been articulating since the early 1960's. Despite the Council finding that there was no substance to allegations of incompetence by migrant doctors working in the NHS, and that only a very small number of migrant doctors had been registered to practice in the UK who

were not of a sufficient standard, the Council accepted in principle the notion of formally testing the clinical competence and linguistic knowledge of migrant doctors. In addition, in the following September (1973), the Council decided that testing should be introduced in the near future, and that reciprocity arrangements which had previously recognised overseas medical qualifications for the purposes of full registration, would be discontinued.

The claims by the occupation in Britain that migrant doctors generally, and black migrant doctors in particular, were below the standard required for safe practice in the NHS, were legitimated by these proposed changes of the GMC. These recommendations of the regulatory body of the occupation would be the basis on which to institutionalise a range of discriminatory practices which would operate to control and exclude black migrant doctors, and thereby, would associate them with the stigma of a second class status. The implication was that NHS patients would be better served by white, British trained doctors.

The review of doctor registration regulations by the GMC, once again reflected the central theme of the

broader political debate of the late 1960's and early 1970's, which focused on the need to restrict the numbers of New Commonwealth migrants who were eligible to enter and settle in the UK. The Council accepted the occupations claim that the continued high numbers of black migrant doctors entering the UK to work and train, was creating increased competition for scarce junior hospital doctor training posts. The Council recognised that the continued expansion of overseas medical schools, and the attendant potential for large numbers of recently qualified migrant doctors seeking entry into the UK to train and work, would create severe problems for the occupation. 'Problems' not only in terms of the stated concern relating to the difficulty of monitoring the quality of these newly arriving migrant doctors, but also in terms of their effect on the job prospects of white, British trained doctors.

The proposed solution by the Council was to strengthen the assessment procedures for migrant doctors, and make it a condition of the proposed new limited registration. This measure combined with the ending of reciprocity arrangements, would mean that migrant doctors from the Indian subcontinent would face increased restrictions on their attempts to enter Britain to train and work in the NHS.

The statistical evidence suggests that these measures were effective in stabilising the proportion of migrant doctors entering the UK at around thirty per cent. (See Tables 2a-2d) This in effect was a relative decline, because as the Council stated in its review, the potential numbers of migrant doctors who might have considered migrating to Britain was set to increase substantially, especially from the Indian subcontinent. The issue of 'numbers' was influencing not only the general political agenda, but also that of the 'professional' occupation of medicine

In addition, it should no be forgotten that the Council, like the occupation generally, made no commitment to address the issue of the supposed substandard quality of migrant doctors by recommending the introduction of a comprehensive and systematic training programme for all junior hospital doctors. The Council merely reproduced the claims of the occupation and legitimated its position in this respect, by strengthening the assessment procedure for migrant doctors and making it a condition of limited registration. The objective was to make it increasingly difficult for black migrant doctors to enter the UK to train and work, rather than ensuring that all junior hospital doctors received the kind of

structured postgraduate training a complex and modern medical system required.

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(16) BMJ, 1, 5-6-1965; p243.

(17) BMJ, 1, 22-3-1969; p729.

(18) BMJ, 1, 22-3-1969; pp729-30.

(19) BMJ, 1, 22-3-1969; p730.

(20) The American Educational Council for Foreign Medical Graduates (ECFMG), is a 'professional' test which migrant doctors have to pass before practising in the USA. The test relies on the factual recall of textbook information. It does

not test the candidates competence of written or verbal English, nor does it test the doctors ability to apply their 'professional' knowledge in the clinical context. [Minutes of the GMC, Vol CXI, 1974: Appendix VII, May 1975]

(21) The BMJ reported in August 1965 that the Indian government were taking steps to discourage their young doctors from coming to the UK for postgraduate training, as this was causing a shortage of the most able doctors in India. The Indian government would henceforth withdraw passports of doctors if they had been qualified for less than seven years or had been qualified at least three years but had achieved at least sixty per cent marks in the subject in which they wished to specialise. [BMJ, Vol 2, 1965, August 7; p112]

(22) Lancet, 1, 1-3-1969; p453.

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(35) BMJ, 1, 11-3-1972; p68.

CHAPTER VI:

POST-1945 BRITISH RACISM AND THE RACIALISATION OF MIGRANT INDIAN DOCTORS: 1974-1990 - AND SUMMARY

THE CONTINUED REPRODUCTION OF BRITISH RACISM AND THE RACIALISATION OF MIGRANT INDIAN DOCTORS: 1974-1979

Introduction

Between the introduction of the 1971 Commonwealth Immigrants Act and the Conservative electoral victory in 1979, the British 'professional' occupation of medicine succeeded in its campaign to discredit black migrant doctors. The publication of the Merrison Report in 1975, gave an authoritative legitimacy to the belief that migrant doctors generally, and black migrant doctors in particular, were below an acceptable standard.

The British State during this period, created a distinct strand of racism to operate alongside the 'race/immigration' issue. The issue of 'immigration' became less salient in relation to West Indian migration as regulatory legislation had its effect in reducing the numbers of West Indian migrants entering Britain. The issue of racism came to predominate, through its contribution to the notion of the 'enemy within'. The idea of the 'enemy within' was reproduced through the ideology of 'black criminality'. The 'race immigration'

issue, however, did not disappear. Continued Asian migration into Britain during the second half of the 1970's, in terms of both expulsions from Africa and entry of dependants of those already settled in the UK, ensured that the issue of 'immigration' controls on new entrants would remain on the political agenda.

The Labour government were attempting to ameliorate institutionalised racism with the 1976 Race Relations Act and its involvement in in the anti-racism campaign of the political left, however, it remained an advocate of strict immigration controls. The political effectiveness of the National Front and the subsequent rightward shift of the Conservative party under the leadership of Thatcher, was operating to change the political climate for the 1980's.

Political Concerns after the 1971 Act

The 1971 Commonwealth Immigrants Act rationalised and extended the scope of immigration controls. In addition, the Act represented the complete institutionalisation of racism in the practice of the State. The racist content of immigration controls was clearly expressed by a Home Office legal representative

contesting the legality of the Commission for Racial Equality to carry out a formal investigation into the activities of the Immigration Office in 1980:

> *The whole of immigration control is based upon discrimination. It is of the essence of the Immigration Act that people will be discriminated against on the grounds of race or nationality and it is the function of certain officials to ensure that discrimination is effective.* (1)

The passage of the 1971 Act should have meant that the majority of New Commonwealth primary migration would be halted, and that the main migration in the future would be dependants of black migrants already settled in Britain. Consequently, it was hoped that the Act would remove the 'race/immigration' issue from the political agenda. Racism and the 'race/immigration' issue, however, was not confined to the margins of political debate.

We have already seen that the arrival of expelled Asians from Uganda in 1972, ensured that the 'immigration' issue remained on the political agenda. Alongside this, a new form of racism was reproduced in relation to the supposed criminality of West Indian youths. This issue focused on the 'crime' of 'mugging', and the way the police used the 'sus' laws. This continued throughout

the 1970's and into the early 1980's. [see Hall et al: 1978]

The political and public concern over supposed black criminality, however, was not matched by concern with increasing violent racist attacks on members of the black community. A Home Office inquiry into the issue found that Asians and other black people were were fifty times and thirty six times more likely, respectively, to be the victims of racist attacks than white people. The Committee also noted that the police tended to be reluctant to take action concerning racist attacks on black people because they viewed such attacks as being offset by the 'anti-social' behaviour of the black population. [Hall et al: 1978]

Throughout the 1970's the emphasis concerning street crime was to link it to the activities of black youths generally and in particular to West Indian youths. The fact that black people were considerably more likely to be the victims of violent crime than their white counterparts, was largely ignored. This criminalisation of black youths was actively encouraged by the police and brought into the public arena by the media. The link between one's colour or 'race' and violent street crime

was to emerge again with the 'riots' in England in 1981 and 1982.

The Labour Government: 1974-79

Victory by Labour in the 1974 general election, saw the party continue with its dual policy of tight immigration controls to keep black migrants out, and measures to combat racism. The government decided not to repeal the 1971 Commonwealth Immigrants Act, but aimed to review Nationality law in order to locate immigration legislation within a framework which would allow entry to Britain on the basis of citizenship rather than patriality. The main proposal was to recommend two forms of British nationality: UK citizenship for those who had close ties (or 'belonged') to Britain; and, British Overseas citizenship for those who were citizens of the Colonies. Ultimately, however, the government was only able to publish a discussion document in April 1976, before the 1979 general election. [Layton-Henry; 1984]

While it was in office, the Labour government did introduce some reforms associated with immigration (Roy Jenkins was again Home Secretary). It increased the

number of staff dealing with dependants entry certificates in order to reduce the ever increasing waiting lists. In August 1974, under a set of new Immigration Rules, the government restored the right of entry to husbands and fiances of women living in the UK (a right previously removed by a Labour government). Most importantly, it introduced a new and considerably strengthened Race Relations Act in 1976, which established the Commission for Racial Equality. [Miles & Phizacklea; 1984]

Simultaneously, however, Labour also introduced a number of measures under various Immigration Rules which continued the theme of control. In March 1977, measures were introduced to control alleged marriages of convenience. In the same month, Jenkins was forced to respond to a debate in the House of Commons in which Powell and others had requested he comment on the continued growth in immigration. Jenkins replied by saying he recognised that it was in the interests of those migrants already settled in Britain, that the number of new arrivals should be strictly controlled. In January 1979, gynaecological virginity examinations were instigated for migrant women who were intending to marry their fiances once arrived in the UK. Those that failed the test, could be deemed illegal immigrants,

because it was believed a fiance in an arranged marriage, was by definition a virgin. An immediate outcry emerged around this practice and it was discontinued in the February. [Layton-Henry; 1984]

Essentially, the 1974 Labour government had not challenged the 'race/immigration' issue which framed the political agenda, but had continued to reinforce it. The issue returned to the centre of the public and political arena in May 1976 with the arrival of 250 Asian UK passport holders expelled from Malawi. Although this number of entrants could easily be admitted within the annual voucher quota of 5,000 available to Asian UK passport holders, the media once again expressed its fears over a new 'tidal wave' of migration. [Miles & Phizacklea; 1984]

The arrival of the Malawi Asians coincided with a debate in the House of Commons, initiated by Jonathan Aitken the Conservative MP for East Thanet, who expressed concern about emigration from Britain and continued New Commonwealth 'immigration' and its effect on 'race relations'. He also suggested that there was evidence of abuse of the welfare system by migrants and large scale illegal immigration taking place. Aitken's motion

was supported by Bob Mellish (Labour, Bermondsay) and Powell. Powell went on to suggest, with little evidence to support his allegations, that the increasing numbers of black Commonwealth people in Britain, was leading to a breakdown in law and order because of their criminal tendencies. [Miles & Phizacklea; 1984]

The Labour government consistently defended the notion of a 'multi-cultural' Britain, with Home Secretary Roy Jenkins pointedly commenting that strict immigration controls would be maintained. Widespread reporting of the debate by the media, especially the interventions by Powell, however, were the backdrop to a series of disturbances and racist attacks on Asians in London's Southall area at the time, which included the murder of one Asian. This led to a reaction by the Asian community in the form of organised demonstrations against racist attacks. [Miles & Phizacklea; 1984]

Not all of Labour's supporters were constrained by the 'race/immigration' issue which framed the debate concerning New Commonwealth migration. A number of left-wing MPs continued to view, and argue for, racism as the real problem. The Labour party, as opposed to the Labour government, committed itself to a campaign

against racism and fascist violence in June 1976. This was largely the outcome of the increased electoral legitimacy and success of the National Front. The TUC followed this initiative by the party, when at its 1976 annual conference it established a Race Relations Advisory Committee. [Miles & Phizacklea; 1984]

In the September of 1976, a Labour party/TUC joint campaign against racism was launched. One of the campaign's major aims was to educate Labour party members and trade unionists on the evils of racism and the implications for the labour movement of neo-fascist policies of the extreme right. Labour local authorities were advised not to allow racist organisations to use their council buildings for meetings, and Labour MPs were invited to speak at anti-racist meetings and demonstrations. This initiative culminated in a demonstration in London which numbered 30,000 people in the autumn of 1976. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

In the same month, September 1976, the Labour party conference passed a resolution to repeal the 1968 and 1971 Immigration Acts. Then in the following year in December of 1977, the Labour party established an

all-party Joint Committee Against Racialism, and launched a national campaign against racism in April 1988. This response by the labour movement to racism, was partly the outcome of the activities of broad-based organisations like the Anti-Nazi League. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

While this movement against racism was significant in attempting to shift the ideological and political emphasis, its long-term effect was minimal. The Labour Movement was more concerned about the electoral appeal of the National Front than racism itself. During this period, as identified above, Labour was busy strengthening immigration controls, and the Conservative party was moving further to the right under the leadership of Margaret Thatcher. [Miles & Phizacklea; 1984]

Neo-Fascist political parties such as the National Front were prominent during the mid-1970's. Before examining the activities of the 'professional' occupation of medicine during this period, therefore, the next section will briefly explore the role of neo-fascism in the politics of post-war British racism.

Neo-Fascism and the Politics of Post-War Racism

It was not until the arrival of Ugandan Asians in 1972 that the National Front began to gain political ground. Prior to this, organisations such as the National Labour Party and the White Defence League had been active in the Nottingham and London disturbances of 1958. The aims of these type of organisation were not only to secure a 'white man's Britain', but also the establishment of an authoritarian State similar to the German Nazi model. [Benewick: 1972]

The political ideology of neo-fascist organisations went beyond notions of 'race' and 'nation', and was based on a more general fascist ideology. The ideology was founded on the fiction of a world Jewish conspiracy, which argued that Jewish conspirators in collusion with the British government were promoting immigration from the New Commonwealth in order to facilitate 'race mixing' and the biological degeneration of the superior 'white race'. [Miles & Phizacklea; 1984]

The National Front, created by A K Chesterton in 1967, emerged from the incorporation of the League of Empire Loyalists, the British National Party and the Racial

Preservation Society, following the very poor showing of the various extreme right parties in the 1966 general election. The new party's stated aim was to provide a new arena for far-right activism outside the Conservative party. The party declared its commitment to parliamentary democracy, and its nationalist policies included opposition to Britain's entry to the EEC, the reconstruction of the British Empire, strengthening of law and order, and compulsory repatriation of all coloured immigrants. Their political aims are very similar to those of the Conservative party, with both parties emphasising patriotism, anti-communism, tough law and order policies and opposition to New Commonwealth immigration. [Benewick: 1972; Fielding: 1981]

As proof of its apparent commitment to parliamentary democracy, the party fielded 10 candidates in the 1970 general election, but achieved little success gaining only 3.6 percent of the vote overall. The National Front leadership decided to infiltrate the Conservative party's Monday Club, following its poor showing in the 1970 election. The aim was to be able to present the National Front as a legitimate and respectable right-wing party. The Monday club was a political forum for radical right-wing Conservative's who were concerned

about the decline of the Empire and the level of black 'immigration' to Britain. In 1972, the Club claimed to have a membership of 2,000 Conservative party members and thirty four Conservative MPs. [Walker: 1977]

It was not until the arrival of Ugandan Asians in 1972, with the party picketing Heathrow Airport and the subsequent publicity of the event, that the National Front began to gain popular support. In the following year, 1973, the party claimed 14,000 members, with thirty two branches and eighty groups. In the West Bromwich by-election of May 1973, the National Front candidate polled 12.4 percent of the vote, and this was the only time a National Front candidate did not lose their deposit. This success was followed in the June, with ten of the forty-seven National Front candidates in the local district elections achieving between ten and twenty-six percent of the vote. [Walker: 1977; Fielding: 1981]

In the two general elections of 1974 (one in February and the second in October), the National Front fielded fifty four and ninety four candidates respectively, but only managed to average 3.2 percent of the vote in the first and 3.1 percent in the second. The party did,

however, gain substantial media coverage. This media interest in the National Front intensified in the June of 1974, when the party held a demonstration in London. The police defended the party's right to a public march, and protected it from a left-wing counter-demonstration. Inevitably, disturbances broke out as the anti-fascist demonstrators clashed with the police protecting the National Front march, and one demonstrator was killed. [Walker: 1977; Fielding: 1981]

This increased media interest in the activities of the National Front, combined with the arrival of Ugandan Asians in 1972 and Malawi Asians in 1976, contributed to a new 'moral panic' concerning the 'race/immigration' issue. The party were quick to capitalise upon this position. In the local elections of 1976 and 1977, they achieved over ten percent of the vote in twenty five districts and over twenty percent in two districts. [Taylor: 1982]

The major political parties were beginning to be concerned about the political legitimacy of the National Front. For the Labour party in particular, it was clear that recent election results indicated that working class voters were being drawn to the National Front, and

that this was now the case not only in London and some parts of the Midlands, but also in the Labour heartlands of the north. Labour despatched the national agent of the party on a tour of the northern constituencies, while at the same time, the NEC and the TUC embarked upon an education programme within the labour movement to combat racism and illustrate to the movements activists how National Front policies were anti-working class. [Walker: 1977]

The National Front continued to demonstrate and hold meetings in those areas where black people were concentrated, and the police continued to defend the party's right to conduct public marches. This had the consequence of provoking conflict with the anti-fascist groups who responded with counter-demonstrations. [Miles & Phizacklea; 1984] For example, civil disorder was the outcome of marches and counter demonstrations during August 1977 in Lewisham and Birmingham (Ladywood constituency), with Socialist Workers Party members clashing with police who were protecting the right of the National Front to march. The press, in reporting these incidents were almost unanimous in blaming the political left-wing for the violence which took place. [Taylor: 1982]

The 1979 general election was the significant moment in the history of the National Front. The party was able to proudly contest 303 seats, after pooling all its resources. The result, however, was a complete reversal of previous trends. All the candidates lost their deposits, and the party only achieved 1.3 percent of the vote. Even in the party's strongholds of the East End of London and the West Midlands, the party only averaged 5.2 and 2.5 percent of the vote, respectively. The immediate outcome for the party, following this disaster and the huge cost it entailed, was internal conflict and the fracturing of the party into several small new organisations. [Taylor: 1982]

The apparent commitment by the National Front to parliamentary democracy, did not prevent the party or other neo-fascist organisations from involvement in political violence. The 1960's saw the emergence of 'Paki-bashing'. These were spasmodic and unprovoked attacks on Asians by groups of young white youths, with some incidents leading to the death of the Asian victim. This phenomenon reached its height in 1969-1970, which coincided with Enoch Powell's racist and inflammatory speeches. [Layton-Henry; 1984]

In September 1974 about fifty National Front supporters disrupted a speech by the Home Secretary at Chichester Cathedral, forcing its abandonment. In November 1975, a group of National Front supporters broke up a meeting by the National Council for Civil Liberties at Manchester University, with many of those attending requiring medical aid following the disruption. In February 1978, two members of the National Front were convicted of conspiring to cause the physical harassment of Asians. In the late 1970's, there were two court cases against National Front members charged with the possession of bomb making equipment. [Miles & Phizacklea; 1984]

The rise and fall of support for neo-fascist organisations coincides with the degree to which the major political parties were committed to controls on immigration. The breakthrough made by the National Front coincided with the Conservative government's agreement to allow Ugandan Asians into Britain, despite the government's commitment to tougher controls. The decline of the National Front following its disastrous showing in the 1979 election, coincided with a marked move rightward by the Conservative party in the mid- to late 1970's, which allowed the Conservative party to take the political initiative on the 'race/immigration' issue away from the National Front. Neo-fascist

activity became severely limited where the State was already practising and legitimating racism. Similarly, it is not surprising that the period of greatest neo-fascist advance (1974-79) coincided with a weak minority Labour government and a Conservative party undergoing an ideological shift toward the right. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

The Case for Greater Control Over Migrant Doctors Appears Proven

The mid-1970's saw the British 'professional' occupation of medicine engaged in probably the most significant debate in the racialisation of black migrant doctors. The event was the establishment of the Merrison Committee in November 1972, which inquired into the changes needed in the regulation of the occupation. The Committee published its findings in April 1975. [Merrison Report: 1975]

The inquiry was commissioned in order to alleviate further disruption within the profession caused by the GMC's intention to replace the once only registration fee with an annual charge. The report provided the opportunity to assess the existing registration system.

Of the reports reviewed so far, the Merrison Report is the only one to examine the position of migrant doctors in a distinct separate section within the report. This reflected the growing recognition that there were certain supposed specific problems associated with migrant doctors practising in the NHS.

The Committee recognised that the level of care offered by the NHS would have been extremely difficult to maintain without the crucial contribution made by migrant doctors. Estimates from the Health Departments suggested that in order to maintain the development of the NHS, it would be necessary to admit between 2,500 and 3,000 migrant doctors annually (although the numbers required in the future may decline), due to the inability of British medical schools to provide enough graduates to meet demand, and the fact that many migrant doctors left the NHS each year to return to their countries of origin.

Evidence presented to the Committee by two Royal Colleges, however, indicated doubts about their competence. Data from the Royal College of Psychiatrists on pass rates for membership showed that black migrant doctors had a pass rate thirty four per

cent lower than British and 'white' migrant doctors. Consolidated statistics from the Royal College of General Practitioners for the period between spring 1972 and autumn 1974 illustrated that migrant doctors had only a twenty one per cent pass rate, whereas British trained doctors had a pass rate of eighty two per cent.

In addition the Committee was aware of the so-called widespread conviction within the occupation, which was often expressed through the correspondence columns of medical journals, that the standards of migrant doctors practising in Britain was below that of their British trained counterparts. This was compounded by the view that migrant doctors often had difficulty with the English language, which caused problems with fellow medical staff as well as in relations with patients.

The Committee indicated that they believed that these circumstances explained why migrant doctors were concentrated in the lower grades and unpopular specialties, and under-represented in the higher grades and more popular specialties of medicine. The Committee came to the *"inescapable conclusion"* that:

> *... there are substantial numbers of overseas doctors whose skill and the care they offer to patients fall below that generally acceptable in this country, and it is at least possible that*

> *there are some who should not have been registered.* (2)

The causes of this unsatisfactory situation were attributed by the Committee to the willingness of the GMC to allow its duty as the protector of medical standards to be compromised by the labour power requirements of the NHS. Consequently, the Committee recommended that the GMC should ensure that migrant doctors had:

> ... *reached a standard of competence which is at least equivalent to that of the minimum required for the registration of a doctor trained in the United Kingdom.* (3)

The Committee also recommended that the degree of discretionary control exercised by the GMC over migrant doctors practising in this country should be extended through the introduction of limited registration

The findings published in the Merrison Report in April 1975, were the result of a protracted campaign by the occupation to gain legitimacy for their claim that black migrant doctors were substandard. The BMJ reported on the BMA's evidence to the Merrison Committee on the registration of migrant doctors in June 1973. [BMJ, 2, 30-6-1973; pp159-68] The Association's main recommendation was that 'foreign' medical graduates applying

to enter Britain to work should sit an ECFMG type examination before being granted any form of registration in the UK. In addition, the Association welcomed the GMC's recommendations in its Interim Report, to abolish temporary registration.

In the following August of 1973, the BMA presented further supplementary evidence to the Merrison Commission. [BMJ, 3, 18-8-1973; pp28-30] The Association recommended that all migrant doctors should be required to pass a written and clinical examination of the same standard as a UK graduate prior to any form of registration to practice in Britain. They should be tested on their knowledge of medicine, English, and workings of the NHS. In addition, the BMA proposed that all migrant doctors should be required to undertake a period of defined work in a hospital for a specified period to gain more experience prior to full registration.

The Association went on to propose that the pre-registration assessment should be in two parts depending on the intention of the migrant doctor. Initially, the doctor should be tested to ascertain whether she/he was qualified to practise as a doctor in training. That is,

as a doctor in the hospital service under supervision, for a specified period, in specified posts and for a declared purpose. Following this, the doctor would then be assessed by examination for suitability as a fully registered practitioner, should the doctor wish to remain in the UK and was eligible to do so.

The BMA argued that the only exception to these regulations would be eminent and distinguished migrant doctors recommended by a Royal College or a specialist faculty. Doctors accepted under these circumstances would be granted limited registration for a specified period. If this group of doctors wished to remain in Britain permanently, then they would have to submit themselves for examination by an appropriate licensing body. Finally, the Association recommended that if these proposals were adopted, then the Association would further recommend that reciprocity should be abandoned, and therefore, there would no longer be an automatic recognition by the GMC of primary qualifications obtained overseas.

While the BMJ was reporting on the proposals the BMA were putting before the Merrison Committee, the Lancet was continuing the campaign to discredit the

'professional' abilities of migrant doctors. In a leading article in December 1973, the journal commented upon the problems associated with Britain's (and other European countries) dependence on migrant doctors. [Lancet, 2, 15-12-1973; pp1367-8] The article suggests that European countries should aim at self-sufficiency in the number of doctors each country requires, in order to prevent the continued migration of migrant doctors from hard pressed 'under-developed' countries. The article argues that more than ever, postgraduate training of migrant doctors in Europe was increasingly recognised as being unsuitable for the medical needs of 'developing' countries. The benefits of this 'training' largely accrue to the receiving countries.

In the case of Britain, the article goes on to note that sixteen per cent of GP's, thirteen per cent of consultants, twenty-five per cent of senior registrars, fifty-five per cent of registrars, sixty-one per cent of senior house-officers, and sixteen per cent of house officers then working in the NHS, received their undergraduate training outside the UK and Eire, mainly in the Indian subcontinent. The article warned:

> *... in some specialties (notably geriatrics and psychiatry) the dependence is fast becoming total; and patients in these unfavoured areas deserve, and may soon begin to demand, something different.* (4)

The article suggests that one of the reasons for this continued dependence on black migrant doctors is the failure of the UK medical school system to meet the recommendations on graduate expansion recommended by the Todd Report (1968). The article estimates that for the years between 1975 and 1979 3,000 fewer British trained doctors than the number recommended would graduate. Medicine is identified as the only university course of study in Britain to have an imposed ceiling on entry numbers.

In the August of 1974, the Lancet once again comments on the quality of migrant doctors in a leading article. [Lancet, 2, 10-8-1974; pp328-9] The article suggests that there was a dualism surrounding doctor migration. On the one hand, with migration from 'underdeveloped' countries to 'developed' countries meant that the poorer countries were providing aid to the richer countries in the form of qualified medical staff. On the other hand, wealthier countries were not, and because of migration did not need to, meeting their own targets to secure self-sufficiency in doctors. So long as this is the case, the article suggests, the medical staffing problems of the 'developing' world can:

> *... only be helped by imposing harsh restrictions at one or both ends of the brain drain.* (5)

The article goes on to imply that now is the time for Britain to impose greater controls on the numbers of migrant doctors entering Britain. Concern about the movement of qualified doctors from the poorer to the 'developed' nations was compounded in the UK by worries over the quality of overseas medical graduates. This concern was not restricted to only their clinical or 'professional' competence, but also extended to their command of English and their comprehension of the NHS system. The article suggests that these reasons could be the basis on which the government is forced to address the goal of doctor self-sufficiency more energetically.

In relation to concern over competence, the article cited recent newspaper headlines in the *Daily Mail*, which reported that foreign doctors were a *"... lethal threat to hospitals ..."* (6) This perspective is given further credence in the article, by reference to a survey of consultants, who expressed concern about not only the quantity but also the quality of their junior staff. The article goes on to argue that English is no longer the universal language of Commonwealth medical schools, and even when it is, the language of the lecture theatre is not appropriate to the communication between doctor and patient.

The editorial arguments of the Lancet at this time were not confined to migrant doctors from the New Commonwealth. In a leading article in 1975, the journal extends its concern about 'professional quality' to doctors from Europe. [Lancet, 1, Pt 1, 23-2-1975; pp438-9] The article argues that Britain's relationship with the Commonwealth and its doctors, is markedly different to that which has come to exist between Britain and Europe with Britain's entry into the Common Market. Historically, the GMC had determined who is/is not entitled to practise medicine in the UK. Britain's historical colonial linkages with the Commonwealth had meant that Commonwealth countries shared a common history, language and medical knowledge with Britain.

This had generated a rough parity between many Commonwealth primary medical qualifications and the standards of British medical schools. The GMC had regulated this relationship through the principle of reciprocity and regulations concerning registration. The article suggests, however, that with free movement of doctors between member states of the EEC, the GMC's future role is less than clear. While reciprocity within Europe is guaranteed through the Medical Directives, the article questions the quality and

quantity of both undergraduate and postgraduate training on the continent.

It is quite clear that the occupation did its utmost to influence the Merrison Committee to support the campaign for greater controls on migrant doctors. The BMA in its evidence to the Committee were not slow in utilising the suggestions made earlier in the GMC review of registration regulations, to maintain its arguments concerning greater control over migrant doctors. The Association recommended the introduction of formal testing and the abandonment of reciprocity arrangements.

While the Merrison Committee was deliberating, the Lancet continued its campaign to problematise the position of black migrant doctors working in the NHS. The journal suggested that white British patients would not continue to be satisfied with being treated by supposedly substandard doctors from the Indian subcontinent. The defence of 'professional standards' and the security of safe medical practice for NHS patients, is used to legitimate the journals position. The articles in the Lancet use the language of exclusion and control, although coded in terms of concern for the medical needs of developing countries, to justify both

controls on the numbers of migrant doctors entering the UK (identified as mainly from the Indian Subcontinent), and a large expansion of places for the training of British medical students. By making use of the issue of 'national interests', the occupation is reproducing ideas of nationalism to justify its position.

Finally, the journal turns its attention to European doctors. It is ironic that the article should use the example of the parity between British and Commonwealth medical systems as a justification for imposing controls on the entry of EEC doctors. [Lancet, 1, Pt 1, 23-2-1975; pp438-9] For the past ten years the occupation in Britain had been campaigning to build a strong case to support the argument that many black migrant doctors were substandard, both clinically and in terms of their competence in English. Yet the occupation was prepared to use the example of the system that had supposedly produced these substandard black migrant doctors, to argue that European doctors who had not passed through such a system, were also substandard. This mutually contradictory line of argument, clearly indicates that the occupation defines 'good doctors' as white, British-trained, and all other qualified practitioners as 'less good' or 'bad doctors'. It would appear that occupational self-interest is the primary motive behind

the occupations position towards all non-British doctors.

The publication of the Merrison Report, and the debate within the occupation during the Committee's deliberations, resulted in the introduction of a preregistration test beginning in June 1975. In December 1974, the BMJ reported that the object was to provide some means of testing the linguistic ability and 'professional knowledge' and competence of migrant doctors applying for temporary registration, as an interim measure until new legislation was formulated following the publication of Merrison Committee. [BMJ, 4, 7-12-1974; pp606-7]

The article goes on to report that the GMC proposed two separate but complementary elements to testing to achieve this objective. On the one hand would be formal testing. Those migrant doctors applying for temporary registration would be referred by the GMC to one of three non-university examining bodies. The formal test would comprise an assessment of spoken English, 'professional knowledge', and written English. The standard of 'professional competence' applied to this test would be equivalent to that normally attested by

the granting of full registration to newly qualified British Doctors. To complement the formal testing, a revised clinical attachment scheme would be introduced. The assessment of the migrant doctor would be done by one or more consultant assessors through a structured reporting procedure. [BMJ, 4, 7-10-1974; pp606-7]

The test was to be supervised by the GMC's Temporary Registration Assessment Board (TRAB), and would comprise four parts. Examiners would test the understanding of spoken English, factual knowledge of medicine by multiple-choice questions, and the understanding of written English, as well as the ability to write it intelligibly in a clinical context. In addition, there would be a 'viva' on both language ability and 'professional competence'. [Lancet, 1, Pt 1, 15-3-1975; p645] All applicants would be required to take all four parts, and testing would take place in London, Edinburgh and Glasgow. [BMJ, 1, 8-3-1975, ; p588]

Exemptions from the TRAB test would include those doctors who already held temporary registration by 1 June (unless their performance had been adversely reported on), and certain individuals, especially those undergoing organised training. In line with this new

testing procedure, the GMC had also decided that from January 1, 1976, it would no longer grant temporary registration to any doctor who had not prior to arrival in UK completed the equivalent of one years approved internship. [BMJ, 1, 8-3-1975; p588]

The introduction of the TRAB tests were meant to provide an interim form of assessment until the recommendation of the Merrison Report could be implemented. The creation of these tests, however, already indicated that the occupation had in large measure been successful in building a case for the implementation of restrictive practices in relation to migrant doctors. The TRAB test represents the embodiment of this successful campaign by the occupation. The publication of the Merrison Report and its findings in respect of black migrant doctors provided official support for the occupations cause.

In a leading article in April 1975, the BMJ describes the findings of the Merrison Commission as a "good report". [BMJ, 2, 26-4-1975; pp155-6] The Journal argued that the report provides the basis on which to halt the decline in standards within the NHS because:

> *For the first time an authoritative body has had the courage to state that the NHS has been kept going by employing overseas doctors "whose skill*

> *and the care they offer to patients fall below that generally acceptable in this country".* (7)

Of the many aspects the Merrison Committee covered in its report, the BMJ article focuses almost entirely on that section dealing with migrant doctors. It cites the finding in the report that the performance of black migrant doctors in postgraduate exams was substantially below that of white British doctors. The article goes on to suggest that the new TRAB tests introduced by the GMC would overcome the problems associated with the employment of substandard migrant doctors. The article warns, however, that:

> *... if they are to be of any value the tests must exclude those whose English comprehension or medical competence is below the minimum required of a British medical graduate.* (8)

The journal also suggests that while recognising the undoubted good work many migrant doctors have done in the NHS over the years:

> *... their willingness to work in substandard hospitals has propped up the NHS for too long.* (9)

The Lancet, on the other hand, was less overtly approving about the reports findings, merely commenting that:

> *Reciprocity of registration with overseas medical schools, other than those of the EEC, is*

> *to be brought to a timely end, and overseas graduates will obtain UK registration on the strength of their individual ability.* (10)

The publication of the Merrison Report in 1975, gave a great deal of authority and legitimacy to the occupation's long campaign to present black migrant doctors as a 'problem' that could only be resolved by imposing strict controls on their activities. The occupation had finally succeeded in creating a second class status for black migrant doctors.

The Late 1970's: Migrant Doctors Post-Merrison

One result of the publication of the Merrison Report was that TRAB testing was incorporated into the 1978 Medical Act. The BMJ reported that under the Act migrant doctors would have to satisfy the GMC that they had the necessary knowledge of English in order to apply for full or provisional registration in the UK. Consequently, unless exempted, migrant doctors would have to pass the TRAB test before they were eligible to be registered to practice in the UK. [BMJ, 1, 12-8-1978; p516] The examination was subsequently known as the Professional and Linguistic Assessment Board test (PLAB).

The following categories of doctors would be exempted: those who had already passed the language component of the test for temporary registration; doctors who had undertaken full-time medical work for not less than one year in the UK; doctors who had obtained registrable primary or additional qualifications granted in the UK; and, graduates of overseas universities whose degrees were recognised by GMC for purposes of full or provisional registration. [BMJ, 1, 12-8-1978; p516]

In addition, the GMC announced that from February 15 1979, temporary registration would be replaced with limited registration. [BMJ, 1, 12-8-1978; p516] Limited registration would apply to migrant doctors who held a recognised qualification and had completed at least twelve months internship or equivalent, and had passed or been exempted from the PLAB test. This new form of registration could not last for more than five years and confined a doctor to particular specified jobs, although they could later apply for full registration when eligible. [BMJ, 282, 28-3-1981; pp1045-7]

Reciprocity of recognition of qualifications in relation to full registration would from now on be valuable in allowing the relevant migrant doctors to be exempt from

these new regulations on testing. From May 1975, graduates from Indian medical colleges, however, would no longer be afforded this right. An article in the Lancet reported that India at the time had over one hundred medical schools, which between them produced 11,000 doctors in 1974. Before the second world war, the GMC with the cooperation of the Indian Medical Council was able to assess and supervise the qualifications of Indian doctors wishing to come to work in Britain with relative ease. At that time, there were far fewer medical schools in India. [Lancet, 1, Pt 2: 31-5-1975; p1255]

The article goes on, however, to suggest that the GMC had found it increasingly difficult to oversee all medical courses in the Asian Commonwealth. In 1974 only fifty five Indian medical degrees were recognised for the purposes of full registration. In addition, the BMJ suggested that this problem of assessment of Indian medical qualifications was now compounded by the apparent problem of some Indian doctor's failure to meet the necessary standards in relation to competence in the English language.

Consequently, in May 1975, reciprocity with India was to be withdrawn. From this date onwards, all qualifying Indian doctors would have to apply for temporary registration and pass the two-day TRAB test before being allowed to practice in the UK. [Lancet, 1, Pt 2: 31-5-1975; p1255] Those qualifications previously recognised for full registration would continue to be recognised for temporary registration. Indian doctors would still be able to take further exams in the UK and apply where appropriate for full registration. [BMJ, 2, 31-5-1975; p512]

The BMJ reports that the GMC perceived its role in this matter as one of :

> *... properly exercising its function of safeguarding by registration the public of this country.* (11)

The GMC goes on to observe that its decision:

> *... does not imply any deep anxiety within the Council about the standard of practice of Indian doctors in this country. The great majority of them have given and are giving excellent service, which the Council is glad to acknowledge.* (12)

The long historical connection between British and Indian medicine was finally broken with the decision to discontinue reciprocity. The qualifications of doctors from India were no longer to be given equal status to British qualifications.

European doctors wishing to enter Britain to practise under the forthcoming medical directives of Europe were also to be subject to a modified TRAB test. In April 1977, the BMJ reported on a statement by the Secretary of State for Health. [BMJ, 1, 16-4-1977; p1037] David Ennals stated that all appropriately qualified EEC doctors wishing to enter Britain would be given immediate registration on arrival in the UK, although this would be restricted initially to six months, unless the doctor satisfied the GMC that she/he had the necessary expertise in English. If after six months the doctor failed to prove proficiency in English, then registration would lapse.

The article reported that to achieve the assessment of the linguistic ability of doctors qualified in Europe, the government would require them to take a modified TRAB test. This was to be introduced despite the fact that the free movement directive forbade testing of clinical competence because mutual recognition of qualifications already existed under the directive.

On the surface, this proposal appears to place European and other migrant doctors in a similar situation in relation to pre-assessment prior to registration to

practise in the NHS. In November 1980, however, the BMJ reported on differing criteria governing the assessment and registration of the two groups of doctors. [BMJ, 281, 29-11-1980; p1508] On the one hand, doctors who were nationals of EEC countries or the Irish Republic were required to satisfy a requirement as to their knowledge of English within 6 months of registration in UK. That is, they were registered first and then assessed later. On the other hand, all other migrant doctors had to satisfy the above requirement in order to be registered. They had to be assessed and pass the TRAB test prior to registration.

It was during this period after the publication of the Merrison Report, that the BMA suddenly began to actively support migrant doctors in their attempts to overcome some of the difficulties they faced. In October 1975, the BMJ reported on a meeting which took place between representatives of the Overseas Doctors Association (ODA) (13) and the BMA, and officials of the DHSS, to discuss the effect of EEC medical directives on doctors of British citizenship who obtained their qualifications outside UK. [BMJ, 4, 25-10-1975; p242]

The BMA and ODA urged the British government to seek fresh discussions on the special position of migrant doctors in the UK. Under the medical directives, migrant doctors working in Britain, who obtained their first medical degree in their country of origin, were not allowed free entry into the countries of the EEC to practise medicine like their British trained colleagues were.

In February 1979, the BMJ once again reported that the BMA was using its influence on this matter. [BMJ, 1, 10-2-1979; p432] On the 24 January 1979, the BMA Council accepted the following recommendation by its Committee on the EEC:

> *That a renewed approach now be made to the Secretary of State for Social Services with a view to securing an amendment to the Medical Directives which would allow those UK nationals with third country qualifications who are fully registered with GMC automatic right of free movement within the EEC.* (14)

The BMA were even willing to go further, and be more active on behalf of migrant doctors beyond merely supporting their claims to fair treatment under the regulations of Britain's membership of the EEC. The BMJ reports in July 1976, that at the Associations Annual

Representative Meeting of that year, the Association passed the following resolution:

> *That this meeting requests Council, in consultation with the Overseas Doctors Association, to seek arrangements which will help those doctors who come to the United Kingdom for training to obtain the experience and training they desire before they take the TRAB test, provided all UK graduates are offered no less favourable facilities in getting their training.* (15)

This sudden turn-around in the policy of the BMA would at first seem difficult to explain. After many year's involvement in the campaign to create a strong case for increased controls on migrant doctors, the BMA was now using its considerable influence to defend the interests of migrant doctors. The Association, however, clearly expressed the reason for this change of policy in its Annual Report of the Council in May 1976. The new approach was instigated to encourage increased membership of the Association, at a time when the organisations numbers were in decline. [BMJ, 1, 1-5-1976; p1095]

The pragmatic basis of this support for migrant doctors is given further credence, when it is realised that the Association knew that migrant doctors would be excluded from the provisions of the EEC medical directives as

early as December 1962, [BMJ, 2, 29-12-1962; p236] and as we shall see below, the campaign for greater control of migrant doctors did not cease during the 1980's.

The change in direction by the occupation towards migrant doctors, is in part reflected in the findings of the Royal Commission on the NHS in 1979. The inquiry was intended to be the first complete review of the NHS since the Guillebaud Committee of 1956, covering England, Scotland, Wales and Northern Ireland. It identified about 18,000 migrant doctors working in the NHS, about half of them from the Indian sub-continent and another quarter from other Commonwealth countries. They constituted one-third of all doctors employed in the NHS, although their turnover was relatively high with 3,500 to 4,000 entering the NHS annually and about 3,000 leaving. The Commission, however, expected the expansion of British medical schools in the early 1980's would result in less demand for migrant doctors in the future. [Royal Commission: 1979]

The Commission did not question the obvious high value of their contribution to the NHS, but were concerned that this reliance by the NHS on migrant doctors was not healthy for poor New Commonwealth countries, whose

scarce doctor resources were being trained in skills more appropriate to developed industrial societies. The Commission also recognised that migrant doctors tended to compete less successfully than British trained doctors for the available posts. Consequently, migrant doctors were often found in the unpopular specialties and the lower grades. The Overseas Doctors Association reported to the Commission that migrant doctors receive very little training in district hospitals which are isolated from the high quality teaching hospitals, and therefore, it is not surprising that their performance in 'professional' examinations is so relatively poor.

The Commission recognised that training was generally inadequate for graduate doctors, but that this was not confined to migrant doctors. They recommended that training conditions for all doctors needed to be improved, with closer links between peripheral and teaching hospitals, and the upgrading of training posts. The Commission believed that migrant doctors should compete for posts and that it was in the interests of patients that the GMC should ensure they have adequate clinical skills and competence in English through the registration arrangements. The Commission recommended that Health Departments should consider the establishment of special training centres for migrant

doctors, independently funded and outside the NHS structure.

The mid-1970's, first with the publication of the GMC Review of registration regulations, and then the publication of the Merrison Report, was a significant turning point in the occupation's campaign to 'problematise' the position of black migrant doctors in the NHS. The campaign was organised around the issue of testing: the formal assessment of both clinical knowledge and competence in English. The discourse which accompanied the campaign used a variety of arguments based on the ideologies of professionalism and nationalism, in order to justify the introduction of this testing procedure.

A formal examination which assesses a doctor's clinical abilities and knowledge of the English language need not of course be racist in origin or content. What must be remembered, however, is that this assessment procedure was created for, and directed particularly toward, newly arriving black migrant doctors from the New Commonwealth. The test would be little more than a formality for newly arriving white doctors from the Old

Commonwealth, because this group of doctors use English as their first language.

For black migrant doctors from the Indian subcontinent, however, even if much of their undergraduate medical education had been conducted in English, English would not have been their first language. Consequently, the PLAB test would represent a real obstacle which had to be overcome in order for these doctors to be eligible to practice medicine in the UK. An examination like the PLAB test would provide an effective gatekeeping mechanism, operating to discourage some black migrant doctors from even attempting to apply to come to Britain to train and work.

One of the justificatory arguments for the introduction of the PLAB test, was in addition, flawed. It had often been cited by the occupation that one of the difficulties black migrant doctors faced was in understanding and expressing colloquial English. Difficulties over colloquial English, however, is a justification for all qualified doctors working in the Britain to take the test. Colloquial English is by definition, identified with a specific location in Britain. As a result, white British trained doctors

from Scotland for instance, would have difficulty initially in understanding the local colloquialisms of the North of England, the Midlands, the South or Wales. While it could be argued that because English is their first language, and they would therefore assimilate colloquialisms more rapidly than doctors whose first language was not English, the potential for misunderstanding, and wrong diagnosis and treatment, would remain a real possibility. The supposed 'problem' of language difficulties, however, was constructed specifically around black migrant doctors by the occupation.

It should be recognised that some doctors from the Indian subcontinent would indeed have problems with English. Both in terms of understanding their patients and in being understood themselves. Evidence from the PSI research of 1980, however, suggests this affected only a small minority of black migrant doctors. [Smith: 1980] Smith found that about two-thirds of black migrant doctors tested in competence in English from his sample, had no significant linguistic handicap. Of the one-third who displayed some difficulty, only thirteen per cent of this group had 'very poor' English. The evidence from Smith's research indicates that difficulty with the English language is only a problem for a

minority of black migrant doctors. The important point, however, is that the PLAB test was designed specifically as a control and exclusionary measure for newly arriving black migrant doctors.

The discourse which surrounded its introduction did not rely on an overtly racist content. The idea of 'race' had been replaced by a notion of 'nationality'. Language as the primary cultural indicator of 'national origin' served to signify black migrant doctors as the group of practitioners to which this issue applied. Black migrant doctors were the 'non-white', 'non-British', 'foreign' doctors whose clinical competence was alleged to be substandard. The discourse no longer required an explicit racist content in order to identify this group of doctors. The occupation's constant references to a lack of competence in English was used to carry the original racist meaning. Lack of competence in English was understood to refer primarily to black migrant doctors, so that controlling the entry of migrant doctors was understood to apply principally to black migrant doctors. The content of professionalism: safeguarding clinical standards in order to guarantee safe service provision, was then used to justify the practice of testing as a mechanism of exclusion and control.

It will be shown below, that the issue of 'nationality' was to become the central focus of debate within the general political arena during the late 1970's and the early 1980's. The issue of 'race/immigration' was to become subsumed within a discourse of 'nationality'. The debate centred on who 'belonged to Britain' in terms of common cultural characteristics, and who did not.

POLITICAL DEVELOPMENTS SINCE 1979 AND THE CONTINUED RACIALISATION OF BLACK MIGRANT DOCTORS: 1979-1990

Introduction

The years between 1979 and 1990 witnessed a Conservative government which had moved markedly to the political right under the leadership of Thatcher. This resulted in further restrictions on immigration regulations and the introduction of new nationality legislation. The British 'professional' occupation of medicine during this period were able to persuade the Conservative administration that migrant doctors from the New Commonwealth should no longer benefit from their privileged status in respect of immigration legislation. From 1985 onwards, all migrant doctors (excluding doctors from Europe), were subject to the same

immigration regulations as other migrants from the New Commonwealth

The 1979 General Election

The Labour party's manifesto for the 1979 election contained little on the 'race/immigration' issue, although it did commit the party to further legislation to protect black people from racism and discrimination. Labour wished to promote equality of opportunity for black migrants through the good practice of the public sector, which would be expected to take a lead in implementing equal opportunity policies. [Layton-Henry; 1984] Victory by the Conservative's in the election, however, meant that Labour were unable to implement their proposals.

The Conservative s in Government: 1979 Onwards

Prior to the Conservative electoral victory of 1979, the party leadership was already producing details of its tougher line on the 'race/immigration' issue. In March 1977, Mrs Thatcher made a statement indicating that the Conservative s would aim to eliminate immigration into Britain completely. In the October of the same year,

the party's annual conference declared its intention to strengthen controls on the entry of dependants of New Commonwealth migrants. In the January of 1978 it was reported in the press that Keith Speed, the Junior Opposition Spokesperson on Home Affairs, was preparing a report for the Shadow Cabinet on ways of limiting immigration still further. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

In the same month, January 1978, Thatcher made her 'swamping' speech in a television interview, aiming to convince the electorate that she and the Conservative party were responsive to their apparent fears. The comments made by Thatcher in the interview seemed to connect with the feelings of the British public, because the Conservative's moved into a nine point lead in the opinion polls after running neck-and-neck with Labour. The exploitation of the 'race/immigration' issue had allowed the Conservative's to regain the political initiative, at a time when Labour appeared to be consolidating its position. [Layton-Henry; 1984]

In the April of 1978, the Conservative party formally announced its intention to introduce new nationality legislation which would provide the necessary controls

on dependants, and husbands and fiances. This policy, and a series of tough proposals on immigration, were to be included in the 1979 election manifesto. They intended to strictly control the right of settlement to those who entered Britain on a temporary basis, to remove the existing concessions governing the entry of husbands and fiances, strengthen the controls on the issuing of work permits, introduce a register for all wives and dependants entitled to enter for settlement under the 1971 Act, take firm action against illegal immigrants and overstayers, and to provide assistance to those migrants who wished to return to their country of birth. [Layton-Henry; 1984,]

The 'race/immigration' issue , however, was not itself a major influence in the result of the 1979 election, although it was very clear where the Conservative party stood on the issue. This was reflected in the party performing particularly well in those seats where the National Front had been active and successful. In contrast to the national swing toward the Conservative's which won them the election, in those seats with a high black migrant population the number of black people voting Labour increased substantially. [Layton-Henry; 1984]

The Conservative victory in the 1979 general election, brought with it new Immigration Rules towards the end of the year, which put into effect the election pledge for tighter controls on dependants and husbands and fiances of New Commonwealth migrants already settled in Britain. This intention, however, was not without its difficulties. The promise to reduce the number of male fiances and husbands of migrants settled in Britain entering the country, could not be achieved easily without impinging upon the rights of white British women who were engaged or married to foreign nationals and who may have wished to return to the UK with their partners at some future date. Consequently, the government came under increasing pressure from backbench MPs and British wives' organisations in the UK and abroad. This pressure was effective in changing the content of the proposed Immigration Rules. When new rules were announced in February 1980, the right of entry of male fiances and husbands was allowed, providing their wives or fiancees were born or had a parent born in Britain and the primary aim of the marriage was not for settlement purposes. [Layton-Henry; 1984]

Following the introduction of these new Immigration Rules, in July 1980, the government kept its manifesto promise of new nationality legislation, with the

publication of a White Paper on British Nationality Law, and then a Draft Bill in January 1981. The Bill aimed to rationalise the law on nationality in order to bring the definition of citizenship into line with the system of immigration control based on patriality. The 1962 and 1968 Immigration Acts had created two classes of UK citizenship depending upon one's skin colour. The new Nationality Act would remove citizen status from those already in a second class position. The Labour opposition argued against the Bill's enactment, promising to repeal it as soon as the party regained office. [Miles & Phizacklea; 1984]

The Draft Bill proposed three categories of citizenship. First, British citizenship, which would apply to those who had a close personal connection with the UK through a parent or grandparent born, adopted, naturalised or registered as a British citizen, or through permanent settlement in the UK. Second, citizenship of British Dependent Territories. This would apply to those who had citizenship through their own birth, a parent or grandparent's birth, naturalisation or registration in an existing dependency or associated state. Third, British Overseas Citizenship. A residual category, with few rights. It was to be applicable to those in the UK and

Colonies who did not qualify for the other two categories. [Layton-Henry; 1984]

Most of the debate surrounding the new Bill focused on representation from MPs on behalf of dependencies like Gibraltar, Hong Kong and the Falkland Isles, whose white residents wished to qualify for full citizenship under the new legislation. Even with amendments following the second reading, designed to secure the status of white British citizens born and settled in dependent territories, there remained widespread opposition from legal groups, black organisations, church leaders and civil rights groups. [Layton-Henry; 1984]

For some on the right of the Conservative party, the new immigration rules and legislation on nationality were insufficient. Harvey Proctor (MP for Basildon) had already called for repatriation for those New Commonwealth migrants who wished to return to their country of birth, and Tony Marlow (MP for North Northampton) had suggested that racism was a natural, human instinct, and therefore, immigration controls could not be racist. During 1981, Powell added his voice to right-wing pressure, by once again calling for repatriation, and the re-established Monday Club within

the Conservative party established an Immigration and Repatriation Policy Committee under the direction of Proctor. In its October report of 1981, this Committee called for the repatriation of New Commonwealth migrants at the rate of 100,000 per annum. Proctor went further, by suggesting the government should create a Ministry of Overseas Resettlement and abolish the Commission for Racial Equality. [Miles & Phizacklea; 1984]

Following the controversy surrounding the passage of the Nationality law, there was concern over the proposed new Immigration Rules in 1982. These were re-drafted in order to meet the recommendations of the European Court of Human Rights which had investigated the racist and sexist content of the 1968 Immigration Act. The government had intended to amend its restrictions on the entry of foreign-born husbands and fiances, in order to comply with the Court's findings. In the October, however, the news of the amendments were leaked by the right-wing press and fifty Conservative backbench MPs tabled a motion against the new amendments, arguing they would result in an increase in New Commonwealth migration and further abuse of the arranged marriage system. [Miles & Phizacklea; 1984]

A combination of Labour opposition, abstentions and opposition from Conservative backbench, resulted in the new amendments being defeated in the House of Commons. New Immigration Rules were then put before the House in February 1982, and because the proposed regulations were shown to result in an application refusal rate of 51% in the Indian subcontinent, the fears of the right-wing were assuaged, and the new rules were passed. [Miles & Phizacklea; 1984]

In the first three years of this first Conservative administration under the leadership of Thatcher, civil disorder at home and conflict with Argentina over the sovereignty of the Falkland Isles abroad, provided the backdrop to much of their efforts on the 'race/immigration' issue. Relations between the police and the black community, and the supposed tendency of black youths to be disproportionately involved in street crime, were a constant theme in these early years of the Thatcher government. [Layton-Henry; 1984]

During the 1979 election itself, the death of Blair Peach during an anti-racist demonstration, brought into question the activities of the Special Patrol Group in London. This was followed in April 1980 with

disturbances in the St Paul's area of Bristol after a police raid on a cafe frequented by young blacks. Then in February 1981, thirteen black people were killed in a fire at Deptford. When police could not find a cause for the fire, the black community in the area accused them of not taking racist attacks seriously enough. [Layton-Henry; 1984]

The increasing evidence of racist attacks on the black population, forced the Home Office to conduct an inquiry into such incidents in 1980-81. For example, in February 1981, the Joint Committee Against Racialism, presented the Home Secretary with detailed evidence of over 1,000 racist attacks on black people. The Home Office report, published in November 1981, confirmed that the number of racist attacks were increasing rapidly and were widespread. [Layton-Henry; 1984]

The report concluded that neo-fascist propaganda was a significant factor in encouraging racist attacks, but refused to confirm that the attacks themselves were the outcome of the organised activities of neo-fascist groups. Court proceedings in 1980-81, however, indicated that neo-fascist organisations were involved in organised violence against black people. The court

proceedings led to the conviction of fourteen and thirty-eight members of neo-fascist groups for violent attacks on West Indian and Asian people and possession of bomb-making equipment. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

Exactly a year after the Deptford fire, serious anti-police 'riots' broke out in Brixton in April and Toxteth in July, 1981. In these two disturbances, many people were injured and a great deal of property was destroyed. The government's immediate response was to condemn the criminal activity of young people and urge a stronger law and order approach from the police. The more liberal opinion in society explained the disturbances in terms of unemployment, material deprivation, police harassment and racism. The right-wing of political opinion, however, suggested that the pervasive criminality of the ethnic minorities were to blame. [Kettle & Hodge: 1982]

The report of the Committee of Inquiry into the Brixton disturbance, chaired by Lord Scarman, however, tended to support the views of liberal opinion. The report argued that the 'riots' were principally the result of an outburst of anger and resentment by young blacks against

the police. The report went on to criticise the police for their hard policing methods in the area, and the racist attitudes and actions of some of the forces officers. Comments were also made in the report concerning the black community's lack of faith in the police complaints procedure. [Miles & Phizacklea; 1984]

The Scarman Report recommended that in order to overcome the possibility of having racist police officers in the force, police recruitment, training, supervision and policing methods should be reformed, and more black officers should be recruited. Probably the most contentious recommendation concerned the idea that proven racist behaviour in a police officer should be made a specific sackable offence within the police disciplinary code. Finally, the report recommended that an independent element should be introduced into the complaints procedure covering police conduct. [Layton-Henry; 1984]

The Police Federation were initially positively disposed towards the Scarman Report. They were, however, vehemently opposed to the recommendation that racist behaviour in the force should be made a specific sackable offence. The police defended their policing

policy in inner-city areas with relatively large black populations, and were supported in their claims by the media. Throughout February and March of 1982, British newspapers carried a series of stories detailing a supposed increase in 'mugging', and suggested that the conclusions of the Scarman Report should be reconsidered, arguing that the problem was one of 'black crime' rather than police harassment. In March 1982, the Metropolitan police released statistics on robbery and other violent theft crimes to a select number of journalists. These statistics identified the perpetrators by appearance. The newspapers subsequently reported these figures by linking the rise in 'mugging' with the criminal activities of black youths. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

This action by the Metropolitan police was itself racist. Reported crime figures are notoriously misleading. More importantly, however, those crimes which come under the label of 'mugging' (which were 31% of the total of violent theft crimes) accounted for only 0.9% of total crime in London at this time. In addition, when the Metropolitan force were pressed for more information, the data showed that 18% of 'mugging' victims were black, Arab or Chinese and that for the year 1979-80 there were more black victims of recorded

robbery, assault or other violent offences, than the total number of 'mugging' incidents. Finally, details of the appearance of the offender in relation to other categories of crime which are often significantly more important in relation to the total crime level, were not provided. The Metropolitan police were clearly attempting to construct a 'race'/crime connection, and undermine the findings and recommendations of the Scarman Report. [Layton-Henry; 1984, Miles & Phizacklea; 1984]

Civil disorder on the streets of England in 1981 and 1982, was accompanied by armed conflict with Argentina in the South Atlantic in 1982. The war provided an appropriate opportunity for Thatcher to focus attention upon British 'national identity'. She had commented at the conclusion of the fighting that Britain had risen to the occasion and that the spirit of Empire and British 'national identity' which this entailed had not been lost. For the Conservative government of the 1980's, British 'national identity' was clearly associated with colonial exploitation of Empire. Those who were the subject of this colonial exploitation, therefore, were by definition excluded from belonging to a British 'national identity'. The inhabitants of the Falkland

Islands, however, were British by virtue of their language, customs and 'race'. [Miles & Phizacklea; 1984]

The 1980's: The Racialisation of Black Migrant Doctors Continues

During the 'Thatcher years', not surprisingly, the British 'professional' occupation of medicine felt able to continue its racialisation of black migrant doctors. Once again, the occupations policy was one of campaigning for increased control measures on the entry of black migrant doctors. It was only when these measures had been agreed to, that the occupation began to debate and support the introduction of a systematic and comprehensive programme of postgraduate training for all junior hospital doctors.

The different criteria governing the registration of doctors from Europe was widened further in 1980. The BMJ reported in September 1980 that doctors from the EEC would in the future be exempt from the GMC's language test. [BMJ, 281, 13-9-1980; p760] The European Commission had notified the British government in 1979, that language testing for EEC doctors was contrary to the Medical Directives under Community law. In future,

EEC doctors would have to show the NHS employing authorities at the time of interview, that they had sufficient knowledge of English for the work they intended to do. The new arrangements would come into effect in 1981. The existing regulations in relation to the PLAB test were to remain in force for all other migrant doctors prior to registration in the UK. The journal reports that the BMA expressed its regret at the decision.

On this issue the Lancet reported that the ODA were very dissatisfied with this new measure. [Lancet, 2, 13-8-1980; p598-9] The ODA wanted all foreign doctors to be exempted from the tests. The Association were considering taking the DHSS to the Commission for Racial Equality and even the European Court of Justice. The President of the ODA at the time (Dr S C Bhattacharaya) commented:

> *... it is beginning to look as if the government is using racialistic criteria here ...* (16)

He went on to say:

> *We are now being isolated as the only people who have to take this language test.* (17)

In the following month the BMJ reported that the Pakistani Doctors (Overseas) Association was also taking

action on this issue. [BMJ, 281, 18-10-1980; p1086] The Association had written to the Secretary of State for Health (Dr Gerard Vaughan) to protest at the government's decision to discontinue language testing for EEC doctors. They described the decision as discriminatory. In addition, the Association had asked the government to challenge the European Commission's decision to exclude those doctors registered to practise in UK with third country qualifications from practising in the EEC.

In the March and April of 1981, the assistant editor of the BMJ, Richard Smith, presented a series of three articles on migrant doctors and the NHS in the journal. [BMJ, 282, 1981: 28-3; pp1045-7, 4-4; pp1133-4, 11-4; pp1214-15] The articles rely heavily for data on the PSI study of 1977, (Smith; 1980) which Smith describes as the most comprehensive examination of migrant doctors undertaken to date. Smith argues that without migrant qualified doctors the NHS would not have been able to have grown as fast as it had, nor would it have been able to do the work that it does today. He goes on to suggest that the problems of migrant doctors are the problems of the whole profession:

> *As a vulnerable group, they have always experienced the worst aspects of manpower, training, and career problems. But their problems today are likely to be those of other*

> *groups - particularly women doctors - of tomorrow.* (18)

The author is critical of the ODA's objection to the exemption and the automatic exclusion of migrant qualified doctors from practising in the EEC even if they have full registration in UK. He suggests that these objections by the ODA are "*... more symbolic than practical.*" (19) Smith contends that there must be few migrant doctors who wish to practise in EEC countries. He supports sponsored doctors exemption from the tests, however, arguing that they are carefully vetted, both in terms of their English and clinical competence. Smith suggests that:

> *... on the whole, sponsored doctors are the most able overseas doctors.* (20)

Smith asserts that none of the organisations which represent doctors in the UK, including the ODA, is opposed to PLAB in principle, although there are some objections to some aspects of the test. For example, he suggests that the criticism that the test of English demands too high a level of knowledge of colloquial English, is unfounded. Smith observes:

> *... the arguments against colloquial English are hard to sustain: patients do not speak like the*

> *actors on Linguaphone records and must be understood when using their own vernacular.* (21)

In the second of his articles, Smith recognises that the NHS has historically needed overseas doctors badly, and that their migration to work in Britain has been largely unplanned. Their place in the system has helped fill the gaps created by poor medical labour power planning and allowed the pyramidal career structure to be retained, where there are two juniors to every one consultant. While many had found the training they sought, others had drifted into unsuitable jobs in peripheral hospitals and received little useful training.

Smith concludes that the available data supports the view that:

> *... overseas doctors are doing mostly junior hospital jobs in peripheral hospitals in unpopular specialties. They are supporting the pyramidal structure of the hospital health service (which has roughly one consultant to two juniors) by doing the junior jobs and disappearing, allowing their British colleagues to take the consultant jobs. This might seem a satisfactory position for the health authorities as it allows the perpetuation of a relatively cheap hospital service in which most of the work is done by junior doctors.* (22)

In the third of his articles, Smith explores migrant doctors future training and employment in Britain. He suggests that migrant doctors have been finding it increasingly difficult to find good training posts in Britain, as UK medical schools have increased their output. Smith reiterates his view that the problems of migrant doctors are the problems of the whole occupation: finding good training posts and career jobs has always been an obstacle course, even for home graduates. He argues that the PSI recommendation to increase the number of consultant posts and ensure all training posts are brought within an organised training scheme, is idealistic.

While it is necessary to improve the organisation of training for all doctors practising in the UK, Smith believes the most appropriate solution to the problems faced by migrant doctors in an increasingly competitive medical labour market, is to match the number of migrant doctors entering the UK to the number of training posts available, while ensuring that there are jobs available for every expensively trained UK graduate. Smith observes:

> *It is reasonable that priority in job allocation should go to British graduates, but for some time yet there are likely to be extra junior jobs available for overseas graduates seeking*

> *postgraduate training. The numbers will have to be controlled, however ...* (23)

Smith proposes three measures to achieve controlled entry of migrant doctors. First, he recommends the provision of better information to make clear to migrant doctors thinking of coming to UK what conditions are really like. Smith believes this is likely to discourage unsponsored migrant doctors applying to enter the UK. Second, doctor immigration should be linked to jobs, so that only those doctors with guaranteed jobs would be allowed a prolonged stay in UK. Third, the PLAB test should be made more difficult, or the number of exemptions should be reduced.

Smith seems to believe that these restrictions, combined with the establishment of a centralised training organisation to coordinate, supervise and assess postgraduate training schemes, would allow all graduates, British and overseas, to compete on equal terms for the quality training posts available. Smith recommends that it should be made clear to new arrivals that they are unlikely to be able to stay permanently in Britain, especially as the output of UK medical schools approaches the number of career posts available.

Consequently, their stay in the UK should be limited to a maximum of five years. Those migrant doctors who were already consultants or principals in general practice would be welcome to stay in the UK, and Smith recognises their contribution as invaluable.

Smith concludes:

> *The problem of overseas doctors cannot be settled in isolation from the problems of all doctors in Britain. This large group of doctors has rendered valuable service to British medicine by doing much of the the NHS service work - particularly in undesirable areas and specialties - and has saved the profession, the universities, and the Government form the full consequences of inept or absent manpower planning. Overseas doctors - many of whom justifiably feel that they have been misled and used - have provided a conveniently large expansion joint in the bridge between the service needs of the NHS and the training requirements of home-produced graduates.*
>
> *A comprehensive effort to plan the admission, training, and employment of overseas doctors would benefit not only overseas doctors themselves but also the NHS. If the present muddle continues both will suffer and tensions will increase.* (24)

Smith's review of the position of migrant doctors is one of the few attempts by the medical journals to coherently assess the problems faced by migrant doctors. Smith's arguments, however, are based on a desire to defend the interest of British graduates, rather than

ease the disadvantaged position migrant doctors find themselves in. This can be clearly seen in his recommendation to strengthen the PLAB test. It was argued earlier, that the PLAB test has less to do with ensuring a sufficient level of clinical skill and competence in English, but rather, is more concerned with providing a gatekeeping mechanism to discourage black migrant doctors from coming to the UK in the first place.

It should not be denied that Smith is correct in his recommendation that postgraduate training for all graduates in the NHS, British and overseas, should be more structured and planned. However, given the suggested racist origins of PLAB testing, and the fact that earlier attempts to structure and plan postgraduate training had more to do with placing unjustified controls on newly arriving doctors from overseas, rather than securing high quality training for them, Smith does not provide any arguments to suggest that any new system will treat migrant doctors more equitably.

Smith's recommendation that the PLAB should be revised was clearly supported within the occupation. In the June of 1981, the BMJ reported on the GMC's decision to

alter the regulations concerning the PLAB test. [BMJ, 282, 13-6-1981; p1992] From January 1982, only sponsored migrant doctors would be exempt from the PLAB test. These sponsored doctors would have to be sponsored by one of the following organisations: a UK University; The British Council; The Association of Commonwealth Universities; Department of Health on behalf of WHO; a Royal College or faculty. The doctor should have been accepted before arrival at a UK hospital at the level of registrar or above (or university lecturer, clinical assistant, or substantive appointment at senior house officer), and have been certified by their sponsoring body on the basis of their competence in English and clinical ability as capable of being appointed at registrar or above in their chosen specialty.

The article reports that the GMC wanted to ensure that the majority of doctors who apply for limited registration should have demonstrated by passing the PLAB test:

> ... *that they have reached a standard of competence at which they may safely be employed at senior house officer level in the hospital service in the United Kingdom.* (25)

The aim of the Council was to encourage the expansion of sponsorship schemes in order to move to a position where, eventually, most overseas qualified doctors seeking limited registration in the UK would be sponsored for approved programmes. In addition, in order to ensure the quality of postgraduate training available to migrant doctors, from January 1983, the GMC would only grant limited registration for hospital posts which had been approved by one of the Royal Colleges or faculties as providing education and training of an acceptable standard.

The 1980's saw continued support for migrant doctors by the BMA. The BMJ in July 1981 reported on resolutions passed by the Associations Annual Representative Meeting of that year. [BMJ, 283, 18-7-1981; pp251] The first resolution referred to the need to address the problems faced by resident migrant doctors. This motion was made in response to the fact that some migrant doctors who had been resident in the UK for some time, were having to work in specialties which are not their first choice, and in unpopular specialties with little supervised training.

The second resolution was also set within the context of defending the interests of migrant doctors. It referred to the need to introduce regulations to control the number of migrant doctors entering the UK and to restrict the period during which they could remain. The proposer of this motion argued that it was *"immoral"* to allow doctors to come to Britain and not provide them with adequate training. Consequently, in order to provide properly organised training programmes it would be necessary to regulate the numbers of migrant doctors entering UK. The aim was to match the number of programmed training posts and the numbers of migrant doctors coming to the UK for training.

The occupation, however, were clearly not unanimous about its policy towards migrant doctors. The same article in the BMJ quotes the comments from a delegate of the HJSC who was concerned at the prospect of positive discrimination:

> *I can tell you candidly that many who have been here for a long time are not of high calibre; they do not have the qualifications, they have had poor training, and it is not easy to fit them into a career post. I hope this Representative Body is not asking us to exercise positive discrimination in favour of weak candidates when there are many people, highly qualified and well trained, who are finding it difficult to get jobs.* (26)

The BMA remained committed to supporting the ODA in its efforts to gain equal treatment in relation to the EEC. In September 1981, the BMJ reported that the BMA and the ODA had once again met the Minister of Health (Dr Gerard Vaughn). [BMJ, 283, 26-9-1981; p871] The aim of the meeting was to urge the Secretary of State to;

> *... end the discrimination that prevents overseas doctors who are UK nationals from practising freely throughout the EEC.* (27)

The BMA's policy on this issue was cited in the article as follows:

> *... all citizens of the United Kingdom who are fully registered with the General Medical Council should be entitled to practise freely within the countries of the European Community.* (28)

The poor quality of postgraduate medical education in Britain, was part of the remit of The Fourth Report by the Social Services Committee on Medical Education. [Short Report: 1982] The Committee recognised that poor training of graduate doctors was disproportionately felt by women and migrant doctors, and had the add-on effect of producing poor career outcomes for these two groups in particular. Migrant doctors were concentrated in the unpopular specialties such as geriatrics, psychiatry and mental handicap, and suggested that this was particularly unfortunate because these specialties required good knowledge of English and

a clear understanding of cultural norms, which seemed to be a problem for some migrant doctors.

Once again the Committee recognised that the NHS relied heavily upon the contribution made by migrant doctors, and that they are often unable to compete on equal terms with their British trained counterparts in terms of the type of training and medical posts they seek. The Committee recommended the sponsoring of migrant doctors, to ensure that they receive high quality postgraduate training and experience while in Britain. In addition, they recommended that the Royal Colleges should endeavour to advise and support migrant doctors in their objective of achieving 'professional qualifications'.

The call for improved training programmes for migrant doctors, did not prevent the occupation from seeking further controls on the number of newly arriving migrant doctors. In February 1984, the BMJ reported that the Secretary of the BMA (Dr John Harvard) had written to the Home Secretary (Leon Britton) suggesting that work permits for a defined period should be introduced for medical graduates of overseas countries other than EEC. [BMJ, 288, 11-2-1984; p506] The communique recognised that postgraduate training in Britain is

often haphazard and unstructured. As a result migrant doctors often do not receive the training they had hoped for. This situation was said to be aggravated by the unbalanced medical career structure which requires a high number of junior hospital doctors to meet service needs, and the small number of consultant posts.

The Secretary of the BMA is reported to have gone on to inform the Home Secretary, that the occupation was currently discussing proposals to ensure in advance both the quality of training which migrant doctors would receive in Britain, and the suitability of the candidates to undertake it. The Association believed that a necessary prerequisite for this initiative would be that training programmes should be confined to a specified period, which would prevent migrant doctors in training to drift into a series of service jobs with little training content. Consequently, the Association recommended that medical graduates from overseas should be required to obtain a work permit of specified duration, in the same way all other non-EEC graduates in other disciplines coming to work in the United Kingdom are required to.

It took less than a year for the occupations recommendations to be implemented by the Conservative government of the day. In August 1985, the BMJ reported on new rules concerning the employment of migrant doctors. [BMJ, 291, 17-8-1985; p494] From April 1 1985, new immigration rules would apply to migrant doctors (excluding EEC nationals). Migrant doctors who were seeking postgraduate training in the UK would be admitted for that purpose for up to four years. To obtain permit free training status for this period, they must prove to the immigration authorities that their training would be in or attached to a hospital, that they are registered or eligible to be registered with the GMC, and that they intended to to leave the UK on completion of training. All other migrant doctors coming to Britain for training (excluding EEC nationals) would be subject to work permit restrictions. The remainder of migrant doctors who come to Britain for employment without training would also be subject to work permit provisions under British immigration legislation, and their prospective employers would have to apply for work permits prior to their arrival.

The article reported that migrant doctors who wished to work in general practice as a GP principle or in private practice would have to meet self-employment immigration

regulations. They would have to show there was a need for the services they intend to provide, and be able to invest £150,000 of their own money in the practice. In addition, the doctor would have to show that they would be creating new full-time employment for people already here and that they would be working full-time themselves. Overseas graduates of UK medical schools would normally be able to apply for a twelve month extension if they wished to undertake a one-year pre-registration year in an approved hospital. It was envisaged that there would be only two exemptions from these new regulations. First, distinguished visiting doctors who wished to come to UK for research, teaching, or clinical practice would not need a work permit. Second, doctors on formal exchange visits would normally be exempt.

In an article earlier in 1985, the BMJ suggested that these measures were to be implemented in order to prevent the over-supply of migrant doctors and dentists. [BMJ, 290, 6-4-1985; p1087] The continued expansion of British medical school output in the late-1960's had now resulted in the virtual self-sufficient supply of doctors and dentists.

In this same article, the BMA was reported as welcoming the Conservative government's decision to bring migrant doctors into line with other groups for purposes of immigration control. The Association believed that in the past uncontrolled immigration had prevented the effective alignment between supply of UK doctors and the demand for them, and could have led to unemployment of UK graduates. The Association were also pleased that bona-fide postgraduate training was now being pursued.

The occupation's successful campaign to have migrant doctors included within the same immigration regulations as all other migrants to the UK, reflected the broader political agenda of the Conservative government to make it extremely difficult for migrants and their dependants to enter and settle in Britain. The occupation now had in place the control measures it required to limit the number of black migrant doctors entering the UK, and ensure that there were sufficient junior hospital training posts for white, British trained doctors.

To reiterate, it was only when this measure had been agreed, that the occupation finally accepted that postgraduate medical training in the UK needed to be reformed and expanded. Now that the 'problem' of black

migrant doctors appeared to be largely resolved, the occupation was willing to consider the introduction of a comprehensive and systematic training programme for postgraduate junior hospital doctors.

Three years later, the occupation had to defend itself against charges of racism and discrimination at one of its medical schools. The Commission for Racial Equality reported in 1988, that St George's Hospital Medical School at the University of London, had been found guilty of discrimination on the basis of 'race' and sex in its admissions procedure. [CRE: 1988]

The Medical School had been using a computer program since 1982, to select candidates for interview which gave differential and less favourable weightings to women and black applicants. If an applicant was either designated as 'non-caucasian or 'female', a negative weighting was ascribed to those candidates, with the result that they were significantly less likely to be selected for an interview. If the applicant was both a woman and black, then she would be doubly disadvantaged. [CRE: 1988]

The Commission found that the evidence clearly indicated that some of those who had been deprived of an interview because of the weighting procedure, would have been selected for an interview if the weighting had not been applied. The report estimated that about sixty black and/or women applicants per annum had been denied an interview because of this procedure at the Medical School. [CRE: 1988]

The Commission also found that this situation had occurred prior to the introduction of the computer program. The program had faithfully reproduced the earlier selection for interview procedure, which was undertaken by a two or three members of the academic staff. [CRE: 1988]

The BMJ responded to the findings of the Commission's report in March 1988, and suggested that:

> *... this is a sad finding ... for the whole profession.* (29)

The Leader went on to comment:

> *... discriminating against all those who have foreign names or black faces is an inefficient way of excluding those with a poor command of English. If the Professional and Linguistic Assessment Board examination is not sufficiently helpful better ways of testing language must be devised and more facilities provided to help those who need to improve.* (30)

The discrimination women faced in seeking entry into St George's Hospital Medical School, is particularly ironic, given the evidence presented by the Department of Health in 1991, that women have a lower failure rate through medical school than men. This finding was part of a report by a Joint Working Party into the careers of women doctors. [Department of Health: 1988]

Part of the report assessed whether men and women progressed within the medical career structure of the NHS at the same rate. This was done by comparing the actual progress of women doctors with what might be expected had man and women doctors progressed at the same rate after their registrable qualification. The report concluded:

> *(1) Women progress more quickly through the earlier stages of their careers, up to Senior House Officer level;*
> *(2) This trend is reversed at registrar level and beyond, with women progressing less quickly than men. The trend becomes most marked at consultant level;*
> *(3) Women doctors are consistently under-represented at registrar level and above. The under-representation of women in these grades is statistically significant. Women remain over-represented at the lower grades;*
> *(4) The trends described ... are consistent over the whole 23 year period covered by this survey.* (31)

It seems that black migrant doctors are not the only doctor group working in the NHS who are marginalised within the 'professional' occupation of medicine.

By the mid-1980's, the occupation's racialisation of black migrant doctors was complete. Migrant doctors (excluding nationals of the EEC) were from this date subject to the same immigration controls as other migrants seeking work in the UK. As in the past, the occupation justified this change in terms of providing a more structured and planned postgraduate training programme for migrant doctors working in Britain. The real objective was to make it extremely difficult for any qualified doctors from the New Commonwealth to enter the UK, and thereby, protect the career prospects of white British graduates.

Even when the occupation was charged directly with racist discrimination, it could only tamely suggest that racism was not an efficient means for excluding black medical students. The occupation's suggestion that if the PLAB test was not effective, then other means of testing English and better facilities to help doctors who need support, is particularly ironic. Systematic measures to assist black migrant doctors to come to terms with working in a foreign country, within a strange medical system, have throughout the history of black doctor migration to Britain been conspicuous by there absence. The occupation preferred to racialise

these invaluable black migrant doctors, and subject them to systematic control and exclusion.

SUMMARY

Post-war reconstruction in Britain had left the country with acute labour shortages in all the major sectors of the economy. The State quickly realised that this situation could only be overcome in the short-term by the use of migrant labour. Displaced Europeans, ex-Polish armed forces personnel and migrants from Ireland were utilised to help overcome the initial labour shortages.

New Commonwealth migration to Britain, however, had been identified as a 'problem' by the first post-war Labour government very early in its administration, despite the desperate shortage of labour faced by the British economy during post-war reconstruction. Both privately within Cabinet and publicly through various published reports, the 'problems' were identified as including both the difficulty of assimilation in terms of their differing culture and the potential conflict this may produce, and the difficulty of assimilating black migrant workers as UK citizens with permanent settlement

rights. This was in contrast to the use of European migrant labour which could be closely controlled and even expelled if necessary. Black migrant labour was perceived as unsuitable for the types of work required in terms of their skills and adaptability to different more disciplined labour processes. In addition there would be the problem of acceptance by the Trade Union movement.

The continued arrival of black migrant workers from the New Commonwealth, resulted in the Labour government introducing a set of ad hoc administrative measures in order to attempt to check the flow. By 1950, the government were considering the possibility of introducing immigration control measures. They were not implemented, however, primarily due to the fact that any such controls could not be introduced without the government being criticised as racist. Not only would immigration controls designed specifically to limit the entry of Black British Subjects undermine the 'open door' policy enshrined in the 1948 Nationality Act and Britain's role as leader of the Commonwealth, but it could not be justified in relation to the large scale and largely unrestricted migration of white labour from the Irish Republic.

This covert political debate appears, however, to have been primarily concerned with semi- and unskilled migrant labour from the New Commonwealth. Doctor migration from the Indian subcontinent did not present a 'problem' for the State. Indeed, migrant doctors were encouraged to come to Britain to train and work, as part of Britain's policy of aid to 'developing' New Commonwealth countries.

The Conservative government of 1951 were less concerned morally about introducing racist immigration control legislation, but did recognise the need to build a 'strong case' in order to justify such action. To this end, the government utilised the considerable resources of the various government departments to try to prove that black migrants were physically weak, mentally slow, without discipline in their attitude to work, were the cause of the chronic post-war housing shortage and overcrowding, and were responsible for a disproportionate amount of street crime.

The government, however, were unable to sustain their strong case for the introduction of immigration controls. There was very little evidence to justify the allegation that Britain's black population were causing

problems for social, economic and political stability. The inability to build a 'strong case', however, did not prevent the government from continually assessing, within Cabinet, the possibility of introducing immigration controls.

While the State was engaged in a covert operation to build a strong case to justify the introduction of immigration controls, the British 'professional' occupation of medicine were continuing to respond to the official public policy of the State, which allowed unfettered movement within the Commonwealth, by actively encouraging doctor migration from India.

The good relations between the occupation in Britain and Indian doctors which had been generated as a result of the medical needs of the Second World War, continued into the early 1960's. During the 1950's, with shortages of junior hospital doctors in a rapidly expanding NHS, the occupation in Britain actively encouraged migration of Indian medical graduates to fill these vacancies. In response to this demand for medical labour power, throughout the 1950's the GMC continually added qualifications from newly established Indian

medical colleges for the purposes of registration to practice in the UK.

The findings of the 1957 Willink Committee, which was established to determine future medical labour power needs in Britain, provided an insight into why doctor migration was not perceived as a 'problem' at this time. The Committee identified black migrant doctors as a transient population, who mainly came to Britain to gain postgraduate qualifications and further experience, before returning to their country's of origin. In addition, the numbers working in Britain at any one time over the previous decade had been very small and relatively static.

These two facts, combined with the belief that the output of British medical schools would meet the future medical labour power demands of the expanding NHS, indicated Britain would not be subject to large numbers of black migrant doctors entering the country in the future. The medical labour power predictions of the Committee, however, grossly underestimated the number of doctors the NHS would require. The output of British medical schools could not match demand, and the numbers

of migrant doctors arriving from the New commonwealth increased substantially during the 1960's.

Continued severe labour shortages generally, did not prevent the incumbent Conservative government from continuing its campaign to justify the introduction of immigration controls. The government's objective was given substantial impetus when the debate on the 'race/immigration' issue moved into the public arena, led by the Conservative MP Cyril Osborne.

The political objective of the public campaign, was to link New Commonwealth migration to Britain with disease and crime. Conservative party members outside parliament began to campaign at the annual party conference for the introduction of health checks for black migrants on arrival in the UK, and also to ensure that they were subject to the same entry restrictions as other 'aliens' wishing to enter Britain.

This public campaign supporting the introduction of immigration control was given added weight with the civil disturbances in Nottingham and London's Notting Hill in the autumn of 1958. The 'problem' of the

'race/immigration' issue was brought into sharp focus in the public's consciousness with these incidents and the media's reporting of them as 'race riots'. The 'problem' was identified as the black presence in Britain. The solution, therefore, was to stop further entry into Britain of black migrants from the New Commonwealth.

The civil disorder of 1958 allowed a small group of racist Conservative MPs and other Tory politicians at the local level, to organise a more coherent campaign in support of immigration controls. The Birmingham based BICA was established at this time. This active group organised protest meetings, distributed leaflets and lobbied the local press, in order to promote support for the introduction of immigration controls.

These events, framed within the 'race/immigration' problematic, and the continued arrival of black migrants from the New Commonwealth, had shaped public opinion in such a way, that by 1961 an opinion poll reported that almost three-quarters of the population supported the introduction of immigration controls. The Conservative government's desire to build a strong case in favour of controls had been realised, and in 1962, the

Commonwealth Immigrants Act was placed on the statute book. The fact that migration from the Irish Republic was not to be included under the new Act, illustrated clearly the racist basis of the new legislation. The Act was intended primarily to control the entry of black migrants.

The laissez-faire attitude afforded migrant doctors within the provisions of the 1962 Commonwealth Immigrants Act, enabled the British 'professional' occupation of medicine to continue to encourage doctor migration from India. Encouragement for migrant doctors coming to Britain continued into the early 1960's. There was expressed concern, however, about the standard of postgraduate training being offered in Britain. While this situation applied to all doctors, it seems to have been addressed primarily in terms of the problems it created for migrant doctors. The occupation explained this in relation to the belief that postgraduate training in the UK should operate as a form of overseas development aid.

The Lancet, however, was not averse to indicating its racist predilections at this time. When 'race' was politicised in the early 1960's, and concern was

expressed about the level of migration from the New Commonwealth, the journal was not slow in asserting that 'black' migrants were the cause of the transmission of infectious diseases such as TB, and placed a greater burden on the social services.

In the late 1950's and early 1960's the occupation were beginning to adopt a dual response to migrant doctors. The important role Indian doctors were performing in an expanding NHS was recognised. The quality of those doctors, however, had begun to be increasingly brought into question. The fact that they were often located away from the teaching centres and in poorly supervised junior posts with heavy workloads, was perceived as being the result of Indian migrant doctors failing to match the 'professional' standards of their British trained counterparts. The possible introduction of a voluntary clinical attachment scheme was presented as the solution to assessing the quality of newly arriving black migrant doctors.

The immediate impact of the 1962 Act was to encourage an increase in migration from the New Commonwealth in order avoid the new controls. Following the Act, the majority of New Commonwealth migrants would be dependants of

those already settled in the UK. The political right, therefore, believed that the battle to save the 'white, British way of life' was not yet over. This period saw the rise of Powellism.

The weak minority Labour government of 1964, was not in a position to deal with the 'race/immigration' issue in any systematic way. The result at Smethwick in the election meant that Labour wished to remove the 'race/immigration' issue from the political agenda and prevent it being used by unscrupulous politicians. It achieved this aim by creating a bi-partisan consensus with the Conservative opposition on the issue, through a dual policy of strong immigration controls on the one hand, and measures to stop racist discrimination and aid integration on the other.

The first results of this dual policy was the introduction of the 1965 Race Relations Act, which aimed to make racist discrimination in certain public places illegal. This was immediately followed by the publication of a White Paper on New Commonwealth migration, which outlined further control measures. This was the first official recognition that Britain had

a 'race relations' problem, with the 'problem' identified as the presence of black migrants in the UK.

During this first half of the 1960's the British 'professional' occupation of medicine were campaigning to increase controls on black migrant doctors through the clinical attachment scheme. The clinical attachment scheme was initially on a voluntary basis, but was later made compulsory. It did seem however, that the introduction of the scheme was less to do with securing adequate medical standards, and more to do with providing a mechanism through which to gain greater control over black migrant doctors training and working in Britain. GMC regulations governing migrant doctors who wished to register to practice in Britain were already strict, and the Council had no reason to question the quality of medical graduates from India.

The second half of the 1960's saw the Labour government continuing with its dualist policy in order to secure the reproduction of the bi-partisan consensus on the 'race/immigration' issue. This appeared to be working effectively, until that is, the arrival in Britain of Kenyan Asians in 1967. Enoch Powell began a campaign, supported by the popular press, to undermine the

political consensus and create a moral panic over the potential number of Kenyan refugees which might enter the UK.

The Labour government responded to the situation with the publication of a new Commonwealth Immigrants Bill in 1968, which removed the right of free entry to Britain to all UK passport holders who did not have a parent or grandparent born in Britain. The legislation was clearly aimed to prevent the black UK passport holders (who would be in the majority of the total number holding UK passports) from gaining access to enter Britain, and therefore, preventing another situation similar to the Kenyan Asian incident.

The debates in the House of Commons during the passage of the 1968 immigration legislation illustrated clearly how the language of the 'race/immigration' issue had come to dominate the discussions. Members of both major parties spoke of 'racial purity', 'racial tension', 'coloured immigration', 'alien cultures', 'racial prejudice' and 'natural instinct'.

The new control legislation was followed by the passage of a new Race Relations Act in 1968. It was during this time that Powell made his infamous 'rivers of blood' speech, which effectively ended the bi-partisan consensus on the 'race/immigration' issue, and Labour vigorously pushed through the legislation with little amendment. Even though Heath sacked Powell from the Shadow Cabinet following the speech, the Conservative party by this time had itself moved further to the political right on the 'race/immigration' issue, calling for even stronger controls and financial assistance to those black migrants who wished to return to their country of birth.

Meanwhile the British 'professional' occupation of medicines campaign to build a strong case for greater control of black migrant doctors was increasingly vocal. Migrant doctors generally, and black migrant doctors in particular, were being constructed as a 'problem' by the occupation. Migrant doctors were said to be damaging the career prospects of British trained graduates through unnecessary competition for junior hospital training posts. The occupation argued that migrant Indian doctors in particular, were too easily able to obtain the necessary employment vouchers to come to Britain to train and work. It was also suggested by the

occupation that the fact that many migrant doctors were in unsuitable posts within the NHS was primarily due to their lack of ability.

The occupation advocated the introduction of the American type ECFMG examination, or a compulsory clinical attachment scheme, and a substantial revision of the reciprocity arrangements which were operating with overseas medical institutions. It was particularly ironic that the justification for the introduction of an ECFMG type examination was based on the need to test migrant doctors in both competence in English and 'professional' knowledge. This test does not assess competence in English nor does it test the doctors ability to apply their 'professional' knowledge in a clinical context.

The inconsistencies in the occupations arguments concerning the supposed 'problem' of migrant doctors and the GMC's satisfaction with the quality of Indian medical graduates, it is clear that the occupation was less concerned about the actual 'professional competence' of black migrant doctors, and was attempting to create exclusionary practices in order to reduce the competition faced by white British trained doctors.

The ideologies of nationalism and professionalism were used respectively to identify black migrant doctors as the 'problem', and justify increased control measures to safeguard medical standards. By labelling them as 'foreigners', the occupation was reproducing the more nationalist discourse of Powellism. The defence of clinical standards by recourse to the ideology of professionalism, operated to distort and obscure the real concern of the occupation: its self-interest in protecting the jobs prospects of white British trained doctors. The end result of this period of debate within the occupation, was the introduction of a compulsory clinical attachment scheme.

The Conservative party returned to office with its victory in the 1970 general election. One of the new administration's first tasks was not merely to renew current immigration control legislation, but to completely rationalise and extend the racist control legislation of the 1960's. This was achieved with the 1971 Commonwealth Immigrants Act. The distinction between patrial and non-patrial of the 1971 legislation ensured that those who were given free entry to Britain were of the 'right stock', ie. white, while those who were non-patrials (ie. black) had to obtain permission to enter Britain by applying for a work permit which was

strictly regulated. The institutionalisation of racism in the practice of the State, had finally been realised.

The 'race/immigration' issue was not, however, taken off the political agenda with the introduction of the 1971 Act. The arrival of 27,000 Asians from Uganda in 1972, ensured that Powell and his colleagues, supported by the mass media, were able to take the political high ground.

During this period, the British 'professional' occupation of medicine had momentarily switched its attention to the prospect of doctor migration from Britain's impending addition to the EEC. Once again the motive for agitation by the occupation was concern over competition for jobs which could have occurred with unrestricted entry of European doctors. The occupation justified its position in terms of its desire to safeguard medical standards, the same argument it was using to justify increased controls on black migrant doctors.

The GMC, at the beginning of the the 1970's, had also changed its position as a result of the concerted campaign of the occupation. The Council's review of the

registration procedures relating to migrant doctors at this time, despite no evidence to support allegations of incompetence on the part of migrant doctors working in Britain, did propose changes in the registration regulations. In addition, the Council was now prepared to support the occupation's view that reciprocity as a condition for recognition of overseas medical qualifications for the purposes of registration to practise in Britain would be severely restricted. The GMC, as the regulatory body of the 'professional' occupation of medicine, had effectively legitimated the occupation's claim that the quality of migrant doctors generally, and black migrant doctors in particular, were suspect.

The mid-1970's was probably the most significant period in the post-1945 racialisation of black migrant doctors, with the publication of the Merrison Report. The occupation's submissions to the Committee emphasised the poor quality of black migrant doctors and the supposed public concern about this, and advocated testing of competence in English and 'professional knowledge'. These arguments were also extended to doctor migration from Europe with Britain's entry into the EEC. The campaign by the occupation against black migrant doctors had been so influential, that testing through TRAB was

introduced prior to the publication of the Merrison Report.

When the Merrison Report was published, the findings of the Committee came out heavily in favour of the occupation's position. As a result, the report gave official legitimacy to the belief that migrant doctors in general, and black migrant doctors in particular, were below the standards necessary to practise competently in Britain. It was argued that it was this low level of 'professional standards' which ensured that black migrant doctors were concentrated in the lower grades and unpopular specialties, and under-represented in the higher grades and more popular specialties of medicine.

Testing of migrant doctors was subsequently made a provision of the 1978 Medical Act. This was supplemented with the introduction of limited registration with its attendant restrictions. These measures, combined with the earlier announcement that reciprocity arrangements were to be severely restricted, meant that migrant doctors were faced with a series of obstacles excluding them from equal treatment with their British trained counterparts.

The findings of the Merrison Report gave authority and legitimacy to the occupation's allegation that black migrant doctors were a 'problem'. The debate within the occupation relied on the ideology of professionalism, through the defence of 'professional standards' and the security of safe medical practise, to justify its position in relation to the introduction of a formal testing procedure.

Ironically, only a few years after the publication of the Merrison Report, the occupation suddenly began to defend the interests of migrant doctors. The BMA in association with the ODA made representations to the government in relation to the fact that British doctors working in Britain whose first qualification was obtained outside the EEC, were not free to practice within the EEC, as all other EEC doctors were. This support from the BMA, however, was less to do with supporting equal treatment for both Commonwealth and European migrant doctors, and more to do with a decline in the membership of the BMA.

The main issue for the occupation during this period was testing: the formal assessment of both the clinical knowledge and competence in English of black migrant

doctors. Once again the discourse used by the occupation to identify the group of doctors to be tested and justify the introduction of the testing procedure, relied on the ideologies of nationalism and professionalism respectively.

The occupation's constant references to lack of competence in English, served to signify black migrant doctors as the group to whom the issue of testing was to apply. Language as the primary cultural indicator of 'national origin' became the basis of group categorisation. The discourse no longer required an explicit racist content, although the issue of language carried the original racist meaning. Lack of competence in English was understood to refer primarily to black migrant doctors, and it was this group of doctors that had to be controlled through a testing procedure. The ideology of professionalism was then used to justify this position. The safeguarding of clinical standards and thereby securing safe medical provision, was presented by the occupation as the rationale behind the principle of testing migrant doctors. Occupational self-interest, however, through a desire to secure the job prospects of white, British trained doctors, was the real, material basis of the occupation's actions.

The debates surrounding the deliberations of the Merrison Committee, and the implications of its publication, took place during the implementation of the 1971 Commonwealth Immigration Act and the Labour government of 1974. The Conservative government had hoped that the 1971 legislation would diffuse the 'race/immigration' issue, but the passage of the Act led to a bifurcation of the political racist discourse. The 'race/immigration' issue remained politically viable due to the arrival of expelled Asians from Uganda in 1972, and the continued entry into Britain of Asian dependants from the Indian subcontinent. Alongside the 'immigration' issue, a racist discourse developed which was aimed primarily at West Indian youths born in Britain. This involved criminalising young West Indians and creating the idea of them as an 'enemy within'.

The media, however, were not predisposed to draw the public's attention to the steadily increasing incidence of violent racist attacks against black people during this period. It was not widely reported that members of the black community were more likely to be the victims of violent crime than their white counterparts.

The 'race/immigration' issue re-emerged in 1976, with the arrival of Asian UK passport holders expelled from Malawi. The media were not slow in reporting the advent of another 'tidal wave' of immigration, even though the 250 involved could easily be accommodated within existing quotas.

The Labour government of 1974 introduced the 1976 Race Relations Act, which considerably strengthened the existing legislation, and established the Commission for Racial Equality. The Labour movement as a whole was involved in anti-racist measures and campaigns during the second half of the 1970's. The political climate, however, was changing. The Conservative party under Thatcher was moving to the right, and her 'swamping' speech on national television in 1978 regained the political initiative for the Conservatives.

The Conservative electoral victory in 1979, brought with it not only tougher immigration regulations, but also the introduction of a new Nationality Act. The Act aimed to bring the definition of citizenship into line with the system of immigration controls based on patriality. In essence, this meant that non-patrials (ie. black migrants from the New Commonwealth) who were

already second class citizens, would have their citizen status removed if they did not 'belong' to the UK through a parent or grandparent born, adopted, naturalised or registered as a British citizen, or through permanent settlement in the UK.

The 1981 Nationality Act was the last major new legislation introduced, although subsequent amendments to the Immigration Rules have tended to increase controls on the entry of migrants from the New Commonwealth to the UK, whilst ensuring that White British Subjects are constrained as little as possible.

Civil disorder on the inner-city streets of Britain kept the 'race' high on the political agenda of the early 1980's. The anti-police 'riots' in Brixton and Toxteth during 1982, were condemned as the outcome of the criminal activity of young black people, by the government. A tougher 'law and order' approach from the police was called for. The Conservative government were once again reproducing the idea of the 'enemy within' in relation to the supposed activities of young black Britain's.

The Scarman Report on the disturbances, however, provided evidence of other causes. The report argued that the 'riots' were the outcome of legitimate grievances by young black people about the hard policing methods used in the areas concerned. The racist attitudes of some police officers was also criticised. The Report recommended that proof of racist behaviour by individual officers should be a sackable offence.

This recommendation of the Scarman Report was vehemently opposed by the Police Federation. To justify their actions, the Metropolitan police issued crime figures which identified the perpetrators by appearance. The media, took this information, and presented the general public with a tide of propaganda which linked crime with Britain's young black population. The media argued that the recommendations of the Scarman Report should be reconsidered, alleging that the 'problem' of the inner cities was one of 'black crime' rather than police harassment.

The Falklands conflict provided the Conservative government with the opportunity to define 'British nationality'. The 'victory' in the south atlantic was hailed as the result of the spirit of Empire and

'British national identity' which this entailed. For the Thatcher government, 'British national identity' was clearly embodied within British colonial exploitation and Empire. By definition, those who had been the subject of British rule, were excluded from this idea of 'national identity'. The white inhabitants of the Falkland Isles were British by virtue of their culture. Black migrants from the New Commonwealth with a different culture, therefore, had a distinct 'national origin', and were thereby excluded from being British.

This period also saw the British 'professional' occupation of medicine achieve its desire to restrict entry of commonwealth doctors even further by arguing they should come within the regulations of immigration legislation as other migrant workers did. This was enacted by Norman Fowler in April 1985. Migrant doctors (excluding EEC doctors) were for the first time subject to the full regulations governing the issue of work permits under the existing immigration legislation. Only sponsored doctors were exempt, but even they could only stay in the UK for a maximum of four years. The racialisation of black migrant doctors was now complete.

The ideology of professionalism was utilised to justify this action. The occupation persuaded the government that effective, structured training programmes for migrant doctors should be introduced, in order that proper training could be provided. This, it was argued, would ensure that migrant doctors would not drift into service jobs with little training or supervision. In this way, 'professional standards' could be almost guaranteed. The 'trade off' for this new initiative, however, was the strict regulation of entry of black migrant doctors through the work permit system.

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(8) BMJ, 2, 26-4-1975; p156.

(9) BMJ, 2, 26-4-1975; p155.

(10) Lancet, 1, Pt 2, 19-4-1975; p901.

(11) BMJ, 2, 31-5-1975; p512.

(12) BMJ, 2, 31-5-1975; p512.

(13) The ODA was formed in response to the publication of the Merrison Report. One of the major concern of the organisation was that migrant doctors as a specific group within medicine, had not been formally requested to provide evidence to the Committee.

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CHAPTER VII:

CONCLUSIONS

The primary objective of the research was to identify and examine the circumstances and processes surrounding the migration and racialisation of doctors from the Indian subcontinent. The analysis of the historical record presented above shows that this racialisation process was the outcome of a historically complex set of ideological articulations between professionalism on the one hand, and racism and nationalism on the other.

The main conclusion to be drawn from the research in relation to this process of ideological articulation, is that during the process of racialising black migrant doctors, whereby 'professional' criteria were used to problematise black migrant doctors, the occupation's claims to 'professional' status were themselves reinforced.

The occupation constantly used the language of professionalism to justify its position regarding black migrant doctors. This discourse focused on maintaining 'professional' standards through the formal testing of the competence of black migrant doctors. The occupation was, therefore, able to present itself as the defender of clinical standards, and by implication, the guardian of quality medical provision through the NHS. In this

way, one result of racialising black migrant doctors, was that the ideology of professionalism which justifies and legitimates the occupation's special position was reinforced.

In other words, the occupational racialisation of black migrant doctors met its primary objective of securing the self-interest of the occupation by marginalising these doctors within the occupational structure of medicine, and therefore, ensured the best training posts were available to white British-trained doctors. Simultaneously, however, the racialisation of black migrant doctors also operated to reinforce the very ideology (the ideology of professionalism) which allowed the occupation to be successful in this racialisation process in the first place.

If the occupation had been serious about its concern over the 'professional' standards of black migrant doctors, however, it could have utilised the energies expended in racialising black migrant doctors to campaign to create a comprehensive and systematic training programme for <u>all</u> junior doctors. This, however, was not forthcoming until black migrant doctors had been included within the immigration regulations

that applied to all other black migrants in 1985. This is further evidence that the occupation wished to secure the existing career structure and the position of white, British trained doctors within it, rather than improve the training, and therefore, the medical standards of all junior doctors.

The analysis of the historical evidence also supports the theoretical assertion made in Chapter II, that ideas are not 'free floating' entities unconnected to existing material conditions. In both the specific case of occupational racism and within the broader political context, racism emerged in response to the specific material conditions operating at the time.

In the case of occupational racialisation within medicine, within both the IMS and the NHS, competition for jobs (and the privileged access to high material rewards and status which is associated with these jobs) was the material basis for the occupation aiming to 'problematise' Indian doctors. Within the IMS, an explicitly racist discourse was invoked in order to defend the high status and material rewards associated with being a medical officer in the service, at a time when increasing 'Indianisation' of the service was

threatening the position of these British doctors. Within the NHS, increased competition for scarce junior hospital training posts, supposedly caused by too many black migrant junior doctors entering Britain to train and work, was the material basis for the production of a racist discourse to problematise black migrant doctors.

In the case of the broader political context, the post-1945 racialisation of British politics was the outcome of concerns over competition between the white indigenous population and black migrants for scarce resources in employment, housing and social services. This ideology of racism was a modified reproduction of earlier forms of racism which were grounded in Britain's involvement in the slave trade and the expansion of Empire. Plantocracy and pseudo-scientific racism arose out of the need to justify the economic gains made from the exploitation and subordination of black people throughout the world, which contributed to the development of British capitalism. It was also demonstrated that racism as an ideology of exclusion/inclusion could be made largely redundant if the material circumstances warranted. The need to recruit black personnel, both doctors and soldiers, for Britain's war effort against Nazism, illustrated this.

The spectre of Nazism and its subsequent defeat, was also implicated in the historical transition from the overtly racist discourse of Britain's colonial past, to a more covert and implicit racism which manifested itself in post-1945 Britain. Nazism had relied on an overt racist ideology which advocated the purity of the Aryan 'race'. The German people were destined by natural superiority to be the leaders of humankind.

The defeat of Nazism, by implication meant that the racist ideology that legitimated it was no longer a valid basis on which to justify and rationalise political and national activities. Both the British State and the occupation of medicine could no longer rely on an explicit racist discourse to defend its interests. The supposed 'national' differences of culture replaced differentiation by 'race' as the basis for an ideology to justify exclusionary/inclusionary practices. This transformation is not surprising given the suggested symbiotic relationship between the ideologies of racism and nationalism identified in Chapter II.

This process of transformation occurred within the broader political context with Powellism in the late 1960's and early 1970's, and with the issue of

nationality legislation in the late 1970's and early 1980's. Within the occupation of medicine, lack of competence in English became the central issue. Language, which operates as a primary indicator of 'national origin', became the basis of group categorisation. Lack of competence in English was understood to refer primarily to black migrant doctors, and it was to this group of doctors the proposed assessment procedures were primarily addressed. In both the broader political context and the occupational situation, the ideology of nationalism replaced the original racist meaning, and became the basis of exclusionary/inclusionary practices.

The interrelationship between the racism of the broader political context and occupational racism, indicated by the above discussion concerning the transformation from overt to covert racism, also emerges from the analysis of the historical record. This interrelationship occurs very early on in the development of the 'race' concept. We have seen that medical men such as Robert Knox were heavily involved in the creation and reproduction of the idea of 'race' and 'nation', where his notion of 'nation' was grounded in his concept of 'race'.

It is reproduced again in three forms in the the late 1960's and early 1970's. First in relation to the issue of 'nationality' (see above). Second, the general political campaign for health checks on newly arriving black migrants was given added authority by the involvement of the occupation of medicine in the debate. Third, in relation to the 'numbers game' and the evocative language of 'immigration invasion'.

There was a rupture in this relationship in the early years of post-1945 migration, which was due in part to the general political debate being held in private within Cabinet, while the official State position was one of an 'open-door' policy. The occupation of medicine were obviously excluded from this closed debate, and therefore, operated on the basis of official State policy by encouraging the migration of doctors from the Indian subcontinent to fill vacant junior hospital posts.

It was indicated in Chapter VI that black migrant doctors were not the only doctors working in the NHS who are marginalised within the 'professional' occupation of medicine. Women doctors appear to have a similar profile of disadvantage. This research could,

therefore, have implications for how investigations into the position of women doctors should be carried out. If the disadvantaged position of black migrant doctors can be explained in terms of them being a racialised fraction of the 'professional' occupation of medicine, then women doctors may represent a 'gendered fraction'.

Women generally are subject to gender ideology, where they are associated with supposedly specifically 'female' thoughts and activities. Women doctors could be subject to a 'professionalised' version of this ideology within the occupation of medicine. As a consequence they could tend to be relegated to those medical jobs which are defined on the basis of gender ideology as most suitable for women, and therefore, face restricted access to what would by implication be the more prestigious 'male' medical jobs. Alternatively, gender ideology could be used to justify women's exclusion from the occupation in the first place. This could partly explain the adverse weighting procedure used at St George's Hospital Medical School.

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