

Asian Women Medical Migrants in the UK

Parvati Raghuram

I. Introduction

The volume and geographical spread of Asian female migration as well as its impact on the sending countries has led to a rapid growth in research on such migration (Lim and Oishi 1996; Yamanaka and Piper 2003). Broadly speaking, there are two strands to this literature, that which focuses on intra-Asian migration (Huang and Yeoh 2003; Wickramasekara 2002; Chin 2003) and that which follows the broad contours of brain drain migration, from countries of the Third World to the First (Parreñas 2001; McGovern 2003). The extent of intra-regional migration in Asia, the conditions under which much of this labour is performed and the new forms of political and civil engagements that have emerged as a result have all evoked feminist attention (Yamanaka and Piper 2003; Piper 2003; Barber 2000). Research on the movement of women from Asia to work in OECD countries, particularly the US (Espiritu 2002; Parreñas 2001) and the U.K. (Anderson, 2000) echoes many of the same concerns. In much of this literature female labour seems to primarily involve body work, work where the female body or 'femininity' are implicated in the nature of work provided (see for instance, Gulati 1994). For instance, most Asian women labour migrants move to take up jobs as domestic workers, sex workers and nurses, professions that are defined by notions of femininity. As Bowlby, Gregory and McKie (1997) argue

such notions can act in oppressive ways to structure women's entry into occupations but also shape the form of international female migration.

However, women who move from the Third World to the First as well as within Asia also take part in the less feminised sectors of the labour market such as IT where gender exclusivity and male dominance are the norm, although such participation has received much less attention (but see for instance, Yeoh and Willis 2004; Raghuram, 2004a; Raghuram 2004b). Shortages in these sectors in many First World countries have reawakened debates about brain drain and more recently of 'brain circulation' (Saxenian 2001). These forms of migration are also encompassed in the burgeoning literature on highly skilled migration (see for instance, Iredale 2001) yet much of the literature on these topics does not acknowledge the presence of Asian women in skilled migration streams (but see Kofman and Raghuram 2004; Raghuram and Kofman 2004).

As more and more countries use labour market needs and the ability of migrants to fill skills shortages as important principles for selecting migrants, it is important to examine the ways in which Asian women too are significant players in skilled migration streams. Recognising the presence of Asian women in skilled migration expands the way in which we think of migrant Asian women and highlights the variations between women who migrate in different ways and through different routes. In this paper I take some tentative steps towards this by highlighting the presence of women doctors who migrate from the Asian subcontinent to the UK, working in a sector where the discourse around migration is relatively ungendered, but often implicitly masculinised. I suggest that migrant women too play an important

part in UK's professional labour markets and explore how recognising the presence of Asian women in medical migration can alter the ways in which we think of the presence of Asian women in the UK.¹

The rest of the paper is divided into three sections. The first section looks at some debates around migrant women's participation in the labour market and contrasts that with contemporary debates on the broader literature on women's participation in the professions. The following section outlines the extent of migrant women's participation in one sector, i.e. the medical sector of the labour market and the final section outlines some of the implications of these patterns for the way we think about Asian female migration.

Methodology

The data presented here is based on research conducted in a study of overseas doctors in the England in 2002. This involved collating and analysing secondary data produced by the Department of Health, The Medical Workforce Standing Advisory Committee (MWSAC) and the General Medical Council (GMC). Information obtained from these statistical sources was complemented by interviews with key personnel in the GMC, the Department of Health, the British Medical Association (BMA), an independent health consultant, the personnel directors of three hospitals and International Recruitment co-ordinators in two regions.

¹ Doctors form only one part of medical migration. Numerically even more significant is the migration of nurses who enter the UK either to work in the NHS as nurses or more commonly to work in the private sector, in care homes and in private hospitals. However, in this paper I am using the term 'medical migration' as an abbreviation of medical migration of doctors.

The project also involved collection of primary data from a sample of overseas doctors. Semi-structured questionnaires were filled in by fifty-two doctors who had enrolled at induction courses run by two hospital trusts. Finally, interviews were conducted with twenty-one doctors. The sample was selected to incorporate overseas doctors who possessed a variety of social characteristics with respect to gender, speciality, nationality and grade. This paper is primarily based on an analysis of the statistical data collated and analysed as part of this study.

II. Migrant medical women : The contours of invisibility

The increasing feminisation of labour migration (Zlotnik 2003) and of UK's medical labour force (Royal College of Physicians 2001) have both received much attention in current academic literature. Yet the two bodies of work never intersect. Nor does the literature on medical migration from the Third World to the First World (Martineau et al., 2002) recognise that women too may form a part of this migration stream. Migrant women doctors then appear to fall through the interstices between the three competing debates on female migration, women and medicine and medical migration.

Migrant women

In general, the early stages of labour migration to Europe were heavily male. Female migrants primarily migrated as family migrants rather than labourers and the main labour migratory stream was a male migratory stream. However, some migration streams such as that from the Caribbean contained significant numbers of female workers (Phizacklea 1982) but it is the great increase in such migration in the past

decade that has drawn the attention of those researching migration and led to a recognition of the feminisation of migration (Castles and Miller 2003). The movement of women to take up jobs as domestic workers as sex workers or as nurses has signalled the growth in female labour migration and resulted in a rapid increase of interest in this topic (Ehrenreich and Hochschild 2003). The women in these narratives are primarily seen as participating in the new international reproduction of labour, whereby women from the less economically developed countries have moved to provide reproductive labour in higher income countries (Parreñas 2001). This has been a mark of most contemporary literature on the migration of women to the UK too (Anderson 2000; Buchan et al 2003). The most formalised care sector that women migrants seem to occupy is that of nursing. The centrality of migration as a plank in meeting rising demand for nurses throughout the First World and the dominance of women in nursing has meant that gender issues are important in the way nurse migration is understood and theorised (Bach 2003).

Discourses around such migration are gender sensitive both in the countries of origin (Ball 2004) and countries of destination (Buchan et al. 2003). For instance, it is argued that women's gendered roles, which are significantly influenced by familial ideologies and centre around households, where the dominant imperative is stability and stasis, are disrupted by migration and mobility. Mobility, and hence the transgression of gendered norms of caring for one's own family, are made necessary by the need for survival in the context of deepening global inequalities. This is the script around which female labour mobility is largely written.

This approach to thinking migration limits the way in which we think of migrant women's participation in waged labour. Current research highlights the way in which global inequalities that translate into imperatives of household survival drive female migration. Moreover, for women, these inequalities can translate not just into facilitating the household's survival, but also into individual survival within the context of violence, inequities and abuse within the household. Migrant women's participation in the economic sphere is then reduced to that of ensuring survival within the context of the overwhelming weight of capitalism and patriarchy. Work becomes a route to survival. Although, much female (and male) migration is indeed driven by these forces, I would like to suggest that it is important to think of female labour migration as being sparked off by other imperatives too. I would want to challenge the exclusivity of discourses of satisfaction of career aspirations and career promotion to male migration and to suggest that migrant women may invest in work per se and not just see work as a route to survival (Sassen 2000).

Women doctors in the UK

At the same time, current literature on women's labour force participation in the UK has recognised the extent to which women are participating in formalised labour market leading Linda McDowell to argue that women too are part of a wider culture of work marked by a 'remarkable shift of emphasis towards the notion of an obligation to participate in waged labour, regardless of household and family circumstances' (McDowell 2001: 454). Women are also entering middle class jobs in ever-increasing numbers, particularly the professions (Crompton 2000; McRae 1988; Evetts 2003). As a result there is increasing interest in women who take up

professional careers, especially around the participation of women in professions such as medicine (Riska and Wegar 1993; Riska 2001; Mink and Kuhlmann 2003).

The feminisation of the medical workforce in Western Europe, in particular, the gender balance in medicine in Nordic countries and the anticipation of achieving such a balance in the UK has spurred a lot of interest in women's experiences of the medical labour market (White 2001). Their gendered experience of work (Gjerberg 2001), particularly the sexual division of labour both within (Brooks 1998) and across specialities (Gjerberg 2001) the extent to which the entry of women alters the nature of the profession (Kmietowicz 2001) and elements of professional practice (Tanne 2002) and whether the entry of women is a response to changes in the nature of the profession (Lapeyre 2003) have all been debated in this literature. In the UK this interest has also focused around the impact of the rise in the number of women doctors, as anticipated from the dominance of women in medical school students, on the labour force (Coyle 2003). It has especially led to anxieties about the labour force implications of feminisation of this end of the spectrum of the medical work force and what are seen to be its essential consequences, an increase in the number of doctors working part-time (Dowie and Langman 1999). However, such debates remain strangely silent regarding the labour market participation of migrant women.

Implicit in the gaps between these two debates is the notion that while British-born women are playing an increasing part in the professions, migrant women's role in the labour market is confined to those sections of the market that provide commodified forms of reproductive labour that are poorly remunerated. However, this neglect of

migrant women is occurring in a landscape where medical migration is becoming increasingly discussed, debated and problematised.

Medical migration

Migration of workers in the healthcare sector spans a range of occupations and specialities from nursing to care work, pharmacy and allied health professions such as physiotherapy. However, one of the largest employers of migrant professionals is medicine². Migrant doctors form a significant part of the healthcare labour market giving rise to many debates on the practices and policies influencing this form of migration. The cornerstone of such debates has been the increasing dependence of many First World countries on medical migrants, especially those drawn from the Third World (Stillwell et al. 2003; Bach 2003). There has been a long history of medical migration to the UK (Anwar and Ali 1987; Decker 2001). Twenty-six per cent of doctors currently working in the NHS in the UK have been trained overseas. In England this percentage has grown from 22 per cent in 1991 to 25 per cent in 1996 and 31 per cent today. The growth rate in the number of UK qualified doctors between 1991 and 1996 was 1.5 per cent as opposed to 4.6 per cent for all non-UK qualified doctors (MWSAC 1997).³ The relative proportions of UK qualified doctors working in Wales and Scotland have also been falling and Wales registers an even higher dependence on overseas doctors than England. The dependence on doctors who qualified outside the UK is therefore increasing.

² In this paper I have deployed the term medical migrants to mean migrant doctors.

³ The data that has been analysed here only focuses on England. Data on country of qualification broken up by ethnicity are not available in the other three countries that make up the UK - Northern Ireland, Scotland and Wales. However, as the dependence of Wales and Scotland on overseas doctors is even greater than in England (Raghuram and Kofman, 2002) the theoretical debates are situated in the context of the UK more widely.

For instance, the UK's 'NHS Plan' drawn up in July 2000 commits it to hiring 7,500 more hospital consultants, 2,000 more GPs by 2004 of which it is recognised that a number will be recruited from overseas (Department of Health 2000). With health set to be a major issue in the UK general elections of 2005, the delivery of health services and labour force issues will continue to occupy political minds. Some of the staffing pressure will be met locally from the 1000 extra undergraduates who are now being trained in the UK but the targets are ambitious: a 31 per cent increase in home entrants to medical college between 2000 and 2005. At the same time there is increasing concern that the number of applications for medical places from local students is dropping (Seyanne et al. 2004) and this along with natural wastage figures (through drop outs, retirement and death, for instance) means that the pressure on overseas recruitment is likely to continue. Even where the aim of self-reliance on locally qualified doctors is professed it is recognised that this only involves limiting the dependence on overseas doctors at its current proportions.

Recognition of the problems of this dependence on overseas doctors has fuelled significant debates on the migration of doctors. Most of this work commissioned by organisations like the British Medical Association, DFID and the ILO (Martineau et al. 2002; Bach 2003), aim to evaluate the nature and extent of this dependence on migrant labour and its effects. The impact of such migration on the health needs of the sending country, especially on the ways in which wealthy countries are depending on and benefiting from the medical training provided in countries of the Third World has come under scrutiny. While much of this debate focuses on the effects on national labour markets, training and therefore at the scalar level of the state, there is now

increasing recognition that these effects must also be calculated at the level of the individual (Martineau et al. 2002).

The gendered nature of such migration has however rarely received attention. The limited research on medical migration undertaken so far (Findlay et al. 1994; Robinson and Carey 2000; DTI/Home Office 2002) has not been sensitive either to the role of women in such streams or to the labour market participation of women who accompany such migrants. There has also been no discussion or analysis of migrant women's contributions to medical labour markets. As a result little is known about how migration is experienced differentially by men and women and 'the voice of women migrant workers in particular is rarely heard' (Bach 2003: 30).' We 'know little, for example, about whether the experience of employment fulfils their expectations, the degree to which they consider migration a temporary or a more permanent decision, and under what circumstances they would consider return.' (Bach 2003: 30).

Occupational structures provide a way of understanding the lives of women and of explaining social change (Crompton and Harris 1998). National context is very significant in influencing how women's participation is structured as the organisation of the profession within national boundaries influences how women experience participation in the workforce. Internal differentiation within the profession is particularly influenced by a complex set of factors (Crompton and Le Feuvre 2003) that are nationally mediated and this is even more true for migrant women who not only negotiate nationally regulated occupational structures but also nationally created

and enforced immigration regulations. My route into this analysis is therefore through occupational structures.

The rest of this paper attempts to address the lacuna identified above by focusing on the labour market conditions, on occupational niches, and immigration regulations which influence the labour force participation of women doctors. I suggest that migrant women doctors too form an increasingly important part of UK's professional labour market.

III. UK's medical labour market and conditions of migration

The conditions of medical migrants' entry into the country and into the labour force vary depending on country of birth, country of qualification and educational institution from which the qualifications were obtained (Department of Health 1998). For career purposes migrant doctors are usually defined not by their country of origin or their right to residence but their country of qualification. Regulatory bodies within the medical profession emphasize the place of qualification in their determination of who constitutes a foreign doctor. The NHS census thus differentiates between those who are UK qualified, European Economic Area (other EEA) qualified and overseas doctors (i.e. those who qualified outside the EEA).⁴ For example, the large number of medical students who come from countries such as Malaysia to study medicine in the UK may not be considered as overseas doctors.⁵

⁴ As the UK is part of the EEA, people who qualified in countries outside the UK but within the EEA are classified as 'other EEA'. Similarly as 'other EEA' is also overseas, those from outside the EEA are classified as 'other overseas'. However, for the purpose of this paper, they are identified as 'EEA' and 'overseas' rather than 'other EEA' and 'other overseas'.

⁵ Given the fact that the data is based on country of qualification and not origin does mean that UK born doctors who qualified in other countries will be identified as overseas qualified and therefore for

These differences in classification and data collection reflect the differences between doctors in terms of rights of settlement and the recognition of their previous employment. Doctors who have qualified in the EEA have rights to enter and remain in the UK and their qualifications are accredited in line with regulations that have harmonised European qualifications (Directive 1993/16).

Doctors from non-EEA countries, on the other hand, have much more limited rights - either to work or to settle. Recognition of qualification varies along a number of vectors, primarily country in which medical qualifications were obtained. However, even applicants from the same country may find that their experience and qualifications are differently recognised based on the medical colleges from which they graduated or the hospitals in which they worked. Moreover, this recognition will also depend on the extent of labour market shortages in their speciality. Thus, for most non-EEA doctors the route to working in the UK is quite convoluted and complex.

The primary mode of entry for overseas doctors is currently through a permit-free training system that allows doctors who have passed an English language exam as well as the exam conducted by the Professional and Linguistics Assessment Board (PLAB) to register to practice in the UK. Most junior doctors enter the NHS through this route. This scheme allows doctors to enter and work in the country for the period required for training (Department of Health 1998). The period of stay varies with the nature of training sought from a minimum period of 12 months for pre-registration

the purposes of this study as migrants. However, these numbers are likely to be few and should not significantly affect the analysis.

House Officers through to a maximum period of four years for doctors working in other training grades, although applications for extensions may sometimes be considered.

Some doctors enter through the International Fellowship Scheme and the Managed Placement Scheme which recruit high level employees, usually consultants. The former is offered for a fixed period usually two years and is available only in specialities that have severe shortages, while the latter posts although initially offered on a temporary basis can develop into full-time permanent posts. Entry of doctors through both schemes is still relatively small. Recruitment through these schemes is more likely to be influenced by the Government's guideline for ethical recruiting, which restricts the countries from which the UK government is permitted to actively recruit (Department of Health, 2001a). In particular, active recruitment from developing countries is not encouraged unless the government of the country has specifically permitted the UK to undertake a recruitment programme (p. 10).

Notwithstanding these differential conditions of entry/stay for overseas doctors, the proportions of overseas doctors to total increased from 23 to 26 percentage points between 1995 and 2000. These are largely doctors who have qualified in countries of the Third World, particularly in the new Commonwealth, and who have for long dominated medical migration (Mejía 1978). India was the largest source country for doctors in the 1970s (Mejía 1978) and continues to be important even today as shall be shown below. The entry of such doctors to the UK is seen as mutually beneficial within the 'family' of Commonwealth countries as the doctors obtained postgraduate

medical training in the UK whilst also meeting labour shortages in UK's medical workforce (Decker 2001).

However, anxieties over the recruitment of doctors from the Third World (Bach 2003; Bach 2004) has led to increasing recruitment of doctors from the EEA and an attempt to shift the balance of recruitment to EEA countries. The number of EEA qualified doctors in the NHS is therefore increasing. Between 1995 and 2000 the proportion of EEA qualified doctors increased from 3,320 to 3,640. However, the proportion of EEA doctors still remains at about 6 per cent of the total hospital medical workforce.

Migrant women doctors

Women form an important part of the migrant medical workforce with over half the number of people seeking registration in the second half of 1998 being women (GMC 1999). A survey of hospital medical staff in England undertaken by the Department of Health in their annual dental and medical workforce census shows some interesting patterns (Department of Health 2001b). In 2000 40.2 per cent of EEA doctors, 36.75 per cent of UK qualified doctors and 26.2 per cent of non-EEA doctors were women. As such, it is the EEA qualified medical migrant workforce that is the most feminised. However between 2000 and 2002, the proportions of women amongst the two latter cohorts increased so that women formed 37.8 per cent and 27.42 per cent of all doctors qualifying from the U.K. and overseas regions respectively (Department of Health 2003). In 2003, 28.13 per cent of overseas doctors were women.

Women consultants only account for less than a quarter of all consultants and these proportions vary from 22 percent for EEA qualified to 18 percent for those who qualified in overseas countries (Department of Health 2001b). Forty-six percent of EEA qualified doctors in training are women while 32 percent of overseas qualified doctors in England are women. These figures suggest a history of strong gender differences, which are being eroded amongst younger doctors. This pattern also resonates with the increasing proportions of women amongst medical school graduates in the UK with women now accounting for over half of the total (MWSAC, 1997). On the other hand, 62 per cent of all UK qualified doctors in the Non-Consultant Career Grades (such as associate specialists, trust clinicians, Staff grade etc.) are women, these figures dropping to 42 per cent and 22 per cent for EEA qualified and overseas qualified doctors.

These figures also vary by speciality (Department of Health 2001b). In the surgical group the proportion of women employed is uniformly low - less than 15 per cent of all surgeons are women. Women are particularly well represented in Paediatrics, with more EEA qualified women than men being employed in this speciality. Women from overseas countries are over-represented in Obstetrics and Gynaecology with 16 per cent of all staff in this speciality having qualified outside the EEA. Overall, a pattern of gender difference by speciality seems to be more significant than that by country of qualification, with the least discrepancy between men and women amongst those who qualified in EEA countries and the most in overseas countries.

Most of the research on feminisation of medicine in the UK has concentrated on women who work in General Practice, as this is a preferred occupational sector for women

doctors (Brooks 1998; Crompton and Le Feuvre 2003). This picture is slightly different for migrant doctors as since 1979, overseas doctors without a right of residence in the UK were not allowed to enter General Practice and these restrictions were extended to assistant and locum posts in 1985.⁶ Furthermore, General Practice trainees were not allowed to enter under the permit-free training scheme so those aspiring to enter General Practice had to meet the requirements of other business people wishing to obtain a permit to work in the UK, including evidence of their ability to invest 200,000 pounds into their practice (MWSAC, 1997). This meant that there had been little intake of new migrants into this part of the medical workforce. However, these rules were altered in November 2001 and overseas doctors are increasingly entering General Practice training schemes. The effect of this trend is just beginning to be felt.

Of the total number of 33564 General Practitioners (GPs) practising in England in 2002, 80.88 per cent are UK qualified, 4.3 per cent have qualified in EEA countries and 14.8 per cent have qualified in overseas countries. However, the proportions of overseas qualified doctors increases among the GP registrars (i.e. GPs in training). Of the 2231 GP registrars only 68.9 per cent are UK qualified, while 25.8 per cent are overseas qualified and 5.38 per cent are EEA qualified.

Amongst UK qualified female doctors working in the NHS in 2002, 38 per cent are in General Practice while these figures drop to 27 per cent among EEA qualified and 19.8 per cent for overseas qualified women. However, here again the numbers of registrars or GP trainees is increasing. Thus in 2002, only 4.3 per cent of the overall

⁶ Locum posts are short-term temporary posts and this form of work can be compared with contract work. Locum posts are usually not recognised for experience or for training more formally but this is a complex field because there are also differences between locum appointments for training (LAT) and locum appointment for service.

GPs were overseas-qualified women but 11.2 per cent of all GP registrars were overseas-qualified women (Department of Health 2003).

Currently, India is the single largest supplier of migrant doctors to the UK. For instance, 1051 of the 1870 people who obtained limited registration to practice in UK from the General Medical Council (GMC 1999) in 1998 had qualified in India and this may be compared with the two next biggest sender countries for that year - Pakistan and Nigeria with 108 registrants each. Doctors who qualified in India have been the second largest group of registrants for all registrations (Full, limited and provisional) with the GMC for a number of years. These figures have dropped from 1229 in 1996 to 882 in the year 2000 but the proportion of Indian qualified doctors has remained high, ranging between 10 and 12 percent within these five years. In comparison only 5 per cent of doctors registering to practice in the UK had qualified from South Africa while doctors qualifying in the UK have formed just over half of the registrants (GMC 2002).

Unfortunately existing data sources do not permit a gender breakup of the data by country of qualification. The National Health Service (NHS) census data provides accurate gender breakups but the country of qualification data is not accurate for individual countries (personal communication NHS Census office). The other major data source, the General Medical Council's database of doctors who have registered to practice in the UK on the other hand provides accurate data on the basis of country of qualification but does not contain a gender breakup. Anwar and Ali (1987) who conducted a seminal study of overseas doctors in the UK also do not provide gender breakups. Immigration data sources such as the Work Permit data are inappropriate

for an analysis of the migration of doctors as most doctors do not enter the UK on work permits (see above). 1.6 per cent of work permits given in the year 2000 were for health professionals of which only 0.5 per cent went to doctors (Dobson et al. 2001).⁷ Only doctors who are entering career grade posts can obtain work permits but most doctors who enter the UK do so for training purposes and therefore enter through the permit-free training immigration category. Their entry would therefore not be registered in the Work Permit data. Existing data sources therefore do not provide a gender breakup for doctors by country of qualification. However, as we shall below women are well represented amongst medical migrants from the Asian subcontinent.

Asian women doctors in the NHS

A subset of doctors whose ethnicity is marked as Asian and who had qualified outside the EEA can be identified through existing Department of Health statistics on doctors working in the National Health Service.⁸ These doctors are clearly identifiable as Asian women migrants from Bangladesh, India, Pakistan and Sri Lanka and further analysis is limited to this group. Of these four countries, the extent of migration from India is the largest but as already suggested the sources cited above do not permit a more fine-grained analysis.

Of the 6371 female overseas doctors employed in NHS hospitals in 2003, 3541 or 55.6 per cent were of Asian ethnicity. In the same year 27.36 per cent of overseas

⁷ Entrants through such modes come on a work permit but they are much fewer in number and in 1999 only twelve percent of work permits issued to Indians went to the Health sector while 52 per cent went to computer professionals (Stillwell et al., 2003)

⁸ This data is not available for General Practitioners.

qualified Asian ethnicity doctors were women. The proportion of Asian women doctors has grown slightly since 2000 when of the 8850 overseas qualified doctors of Asian ethnicity 6455 were men and only 2395 or 27.06 per cent were women.

These doctors are entering as sole migrants to work in the labour force as well as through family reunification as spouses of other doctors (Raghuram, 2004b). It is important to recognise these multiple routes through which women migrants enter the country and into the labour force because simply using labour migration data to understand labour market contributions of female professionals can miss the contributions that family migrants (who are often women) make to the labour market. For women in particular, family reunification is a primary mode of entry but this form of arranging mobility does not preclude labour market participation.

How does one account for this increasing presence of Asian migrant women in the medical labour market? Crompton and Harris (1998) in their cross-country research of women in the medical profession suggest that women doctors are less likely to withdraw completely from the labour market than women in other professions as the medical career is more likely to be conducive to part-time work and to temporary withdrawals from the labour market than managerial career.

However, for migrant doctors, obtaining a professional training and clinical experience in the new country acts as a major impetus to participate in the labour force. Most doctors come into the country to obtain specialist training and current immigration regulations governing their entry and stay are based on notions of enhancement of human capital through migration. As the training element is

emphasised in such discourses of migration, the notion of maximising human capital, i.e. medical skills during the period of stay becomes crucial. This is particularly enhanced by the nature of medicine, as a profession where 'keeping in touch' and the ethos of continuing medical training is particularly prevalent. These skills are enhanced both through hands-on work but also through taking professional examinations, which then enable further migration. For instance, in some specialities the taking of specialist examinations requires the doctors to have some experience of working in UK's medical service. Familiarity with UK's medical system is therefore at minimum useful but often critical for gaining membership to the specialist Royal Colleges. The membership of Royal Colleges has for long been accepted (with some exceptions) as an international standard in the profession. As Iredale suggests these standards also 'enable mobility of western trained professionals around the world while limiting the ability of non-western trained professionals to move' (2001: 11). As a result enhancing human capital by working in the National Health Service and then obtaining transferable accreditation becomes crucial for medical migrants.

These pressures to work are further exacerbated by the immigration regulations influencing the entry and stay of doctors. As stated above, most doctors currently employed in the NHS are employed in the training grades and therefore enter the country through the permit-free training scheme. Although there is some possibility of extension of stay, current regulations mean that overseas doctors find that the period of their stay is unclear so there is limited period within which such professional development must be achieved. The insecurities in terms of stay also places pressure on doctors to obtain transferable accreditation as they can expect to either return to their home country or to migrate to another country.

For those with limited immigration status (permit-free training) part-time work may prove impracticable since no allowance is made under the Home Office provisions for part-time training. Given the time limits on period of residence it is important for those with training aspirations to enter the labour force as full-time employees. Hence, Crompton and Harris's (1998) suggestion that the medical career is flexible may not be pertinent for overseas doctors.

The participation of women in the medical labour force becomes even more crucial because the voluntaristic nature of immigration means that the migrant doctors must themselves bear the cost of migration. There is no relocation package to soften the cost of migration. Hence, in the early years after migration, migrant women may enter the labour market simply to help to bear the cost of migration.

It is also likely that the cultures of labour force participation are imported from the country of origin. Feminisation is a marker of the Indian medical workforce too (Abidi 1988; Chidambaram 1993). The national level data is at best patchy but data provided by the Delhi Medical Council for the National Capital Territory of Delhi suggests that of the 15234 medical practitioners registered under the Delhi Medical Council in April 2002, 5816 are women (personal communication with Delhi Medical Council). Similarly, figures for those entering medical colleges in one southern Indian state, Karnataka suggests a continuing trend of participation by women. Of the total 2489 students admitted in the year 2001, 1144 were women and 1245 were men (personal communication Registrar of a Karnataka medical college). In India, this labour market participation is part of rising expectations within the middle classes that

women too should contribute to the labour market. The speciality in which women dominate too are imported so that there is a much stronger presence of migrant Asian women in a speciality such as Obstetrics and Gynaecology than amongst UK trained doctors. This pattern is similar to that observed in India. This sketchy account of the increasing presence of migrant women doctors in the UK medical profession points towards the need for greater research in the area.

IV. Discussion

Recognising the participation of women migrant doctors in England's medical labour force, I would argue, disrupts many of the received assumptions about migrant women, particularly women from the Indian subcontinent. The insertion of women medical migrants into discourses of female migration extends the continuum along which migrant women's labour force activities are currently understood. Migrant Asian women it appears contribute not only to the less formalised and regulated elements of the reproductive sector but also to state regulated sectors such as nursing and medicine. They thus contribute actively to the reproduction of the welfare state and to different forms of labour. They are also represented in the more highly remunerated professions and even at the top of such professions. Thus, the social stratification that is seen in the countries of origin is also visible amongst migrants in destination countries suggesting that the identities of Asian women migrants have to be understood not only by their femininities but also through other analytical lenses, particularly occupation, class and ethnicity.

Secondly, in most migration literature human capital enhancement has remained the prerogative of male migrants. While women now are seen to move in order to improve their economic positions vis-à-vis their position at home, it does not necessarily recognise that women may want to improve their skills. However, women too may decide to move in order to further their careers, to acquire new skills and not just to make money. This suggests that it is not enough to understand female migration from the Third World to the First as a question of survival (Sassen 2000). Or, putting this another way, the identity of the person whose survival is secured through migration needs to be conceptualised not just in terms of bodily or physical survival, but also within the context of the aspirations they bring with them which include professional satisfaction, career progression and development and enhancement and validation of skills.

Thirdly, recognising migrant women's career aspirations also involves including female migrants in narratives of work that are becoming increasingly recognised and validated for non-migrant women in the First World (McDowell 2001). It asks questions about the ways in which migrant women too are increasingly recognising paid work as central to their identities and expands the scope within which female migrant identities can be understood. In particular, given that it is argued that women who do succeed in this new masculinised economy are often those who assume masculine ways of being (Reay 2004: 31) we have to ask ourselves what implications does the participation of Asian women in these masculinised economies have for the ways in which we think and understand Asian migrant women's femininities. In particular, does participation in such professions also alter the ways in which Asian women have to 'manage' their ethnicities.

Fourthly, much female migration research focuses on the family as the primary unit through which women make sense of their migration and make migration decisions. In some cases women's migration is caused by the failure of the household and particularly of men within the household to provide for the family. Women then migrate in order to provide financial support to the family (Raghuram and Anderson, 2004). On the other hand, such women are blamed for having failed to perform their caring duties within the household, of not being available to care for their family (Parreñas, 2003). As such women are seen to migrate both in spite of their families and because of their families. Yet the relationship between the family and female migration can be more complex. While, the family provides an important context in which migration of women and men occurs and should therefore be recognised in migration literature, it is also important to open the discourses around female migration to sites over and beyond the family. Thus we have to ask ourselves whether migrant women too do not make their migration decisions on the basis of workforce participation alone. How does individual gain jockey with familial commitments in migration decision? What role do discourses of individualism and careerism play in shaping the migration of Asian females, discourses that are usually denied to female migrant women, particularly Asian migrant women? How is the complex re-formation of women's labour within the middle classes all over Asia shaping Asian female Labour migration? (Da 2003; Ryan 2002). These are pressing questions for future research.

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