

## Research paper

# Manifestations and negotiations of racism and 'heterophobia' in overseas-born South Asian GPs' accounts of careers in the UK

Julian M Simpson PhD

Research Associate, Centre for the History of Science, Technology and Medicine, The University of Manchester, UK

Dr Judith Ramsay PhD

Senior Lecturer in Psychology, School of Social, Psychological and Communication Sciences, Leeds Metropolitan University, UK

### What is known

- A substantial body of qualitative and quantitative reports bears witness to the existence of racism in British medicine.
- Migrant and minority ethnic doctors and aspiring doctors have been discriminated against when applying for jobs or entry into medical school, have tended to be concentrated in low-status medical specialties such as psychiatry, care for the elderly and general practice and in geographical areas deemed less desirable. More generally, they have faced racism in their working lives.
- Progress towards addressing racism in the NHS has been slow.

### What this paper adds

- Demonstrates the value of using oral history interviews to explore the experiences of overseas-born South Asian GPs. Doctors' narratives provide evidence of how certain BME and migrant doctors have historically been able to confront racism or avoid its manifestations.
- A reframing of racism in medicine as racism and 'heterophobia', understood here as the fear of difference, which supports an engagement with the spectrum of behaviours and practices that the term encompasses and a more nuanced appreciation of the nature of racism.
- A reflection on the ways in which BME and migrant doctors are able to operate successfully in a discriminatory environment. A suggestion that these insights have the potential to inform individual, collective and institutional strategies aimed at countering discrimination.

## ABSTRACT

This paper draws on interviews conducted for a wider oral history research project that focused on the experiences of South Asian doctors who worked as general practitioners in the UK's National Health Service (NHS) between the 1940s and the 1980s. It uses the evidence gathered to reflect on what doctors' experiences can tell us about the nature of racism in the NHS today. The doctors' narratives suggest that the discrimination faced by migrant and ethnic minority doctors has been multifaceted and their ability to avoid or challenge it has been underestimated. The existence and persistence of racism in British medicine is a well-documented phenomenon. Little attention has been paid to the

understanding that can be gleaned from instances where migrant and BME doctors talk about not having experienced racism or about having been successful in overcoming it. Nor do we have a detailed understanding of the range of experiences of discrimination and racism that migrant and BME practitioners have. The paper draws on theoretical notions of 'heterophobia', understood here as fear of difference, and psychological function to explore these issues. Discrimination affecting migrant and ethnic minority practitioners appears in these narratives as a complex and multifactorial process that is susceptible to disruption by individuals and groups. We conclude that the NHS should be

conceptualised as a racist and 'heterophobic' space where difference in a broader sense interacts with race. Closer analysis of how some doctors are able to function in such an environment can advance our understanding of discriminatory processes. Reframing our view of racism in this way and engaging with the experiences of a previous generation of

migrant doctors can assist the NHS, organisations representing migrant and BME doctors, and individuals in devising successful strategies to challenge racism, 'heterophobia' and discrimination.

**Keywords:** heterophobia, international medical graduates, NHS, positive psychology, racism

## Introduction

This paper contributes to an ongoing reflection on how the UK's National Health Service (NHS) might transcend its dysfunctional (Simpson and Esmail, 2011) relationship with Black and Minority Ethnic (BME) and migrant doctors by casting light on the nature of racism as it manifests in the organisation. It seeks to build on the insights of Bornat *et al's* (2009) work on South Asian geriatricians which makes the point that researchers' interest in manifestations of racism in healthcare should not result in migrant workers' counter narratives being ignored. In order to do this, it draws on a set of oral history interviews conducted in the course of a wider project about the role of South Asian migrant doctors in the development of British general practice between the 1940s and the 1980s. When it comes to understanding racism in British medicine, the views of BME migrant doctors reaching the end of their careers can be a source of valuable insights into the nature of discriminatory processes. Participants were able to reflect on their all but completed professional trajectories and speak without being overly concerned about the impact their words might have on their careers. Engaging with their experiences can serve to inform our understanding of the multifaceted dimensions of racism and how it might be addressed.

Two concepts are used here to explore the nature of racism as understood through the narratives developed by UK-based, overseas-born South Asian General Practitioners (GPs) in oral history interviews. Albert Memmi's (1994, p234) twin notions of *racism*, discriminatory attitudes grounded in historical notions of racial categories based on perceived biological differences, and 'heterophobia', the fear of difference and a process which affects non-racialised groups, support a reflection about the ways in which racism could be sidestepped if perceptions of difference were undermined. 'Heterophobia' is understood here in its literal sense of fear of difference as opposed to fears of, or opposition to, certain types of sexuality. The literal meaning of 'heterophobia' provides a useful tool to

explore doctors' experiences and how they may inform contemporary practice in the NHS. This paper aims to show that at least some – although clearly not all – of the instances of racism in the NHS can be ascribed to 'heterophobia'. In developing this argument we seek to draw attention to the need for a greater understanding of how varying forms of discrimination intersect (McCall, 2005) in a way that results in the persistence of discrimination within organisations such as the NHS which are nominally committed to promoting equality and diversity (Healy *et al*, 2011). This refined understanding could in turn inform different approaches to addressing racism in the UK healthcare system. We also draw on the work of proponents of positive psychology (Seligman and Csikszentmihalyi, 2000) and more specifically their critique of psychologists' tendency to focus on dysfunctional rather than positive human behaviours. Building on the insight behind this, we argue that historical enquiry can be used to locate positive examples of migrant doctors from racialised groups overcoming and sidestepping discriminatory processes or operating 'normally' in a dysfunctional system.

This paper begins by reviewing current evidence of racism in the NHS. It then presents the methodology used and provides a more detailed explanation of the theoretical concepts that support our analysis. Two key themes that emerged from the research are then outlined and discussed. The first is that a number of participants felt that their ethnicity was not necessarily detrimental to their careers and/or relationships with patients and colleagues and that a range of other factors shaped their professional trajectories and experiences. The second is that, at times, South Asian doctors successfully negotiated situations where they might otherwise have been subjected to racism. The conclusion offers a reflection on the implications of these findings for future research on racism in medicine and in the NHS and points to the implications that this work might have for contemporary equality and diversity practice in the NHS and beyond.

## Literature review

Since its inception in 1948, the UK's National Health Service (NHS) has been structurally dependent on the labour of migrant and ethnic minority doctors (Simpson *et al.*, 2010). In 2010, 37% of doctors registered in the UK had trained abroad (General Medical Council, 2011, p22). Racism and discrimination have shaped their day-to-day experiences and professional trajectories (Gish, 1969; Smith, 1980; Coker, 2002; Cooke *et al.*, 2003; Jones and Snow, 2010). They have been over-represented in low-status medical specialties such as psychiatry or geriatrics (Esmail, 2007; Bornat *et al.*, 2009; Raghuram *et al.*, 2011; Simpson *et al.*, 2010); work in less affluent areas of the UK (Taylor and Esmail, 1999; Raghuram *et al.*, 2009); and have been denied educational or professional opportunities as a result of discriminatory practices in medical schools and within the NHS (Collier and Burke, 1986; Esmail and Everington, 1993; Cooke *et al.*, 2003). Migrant and BME doctors are both 'saviours' and 'pariahs': essential to the functioning of the NHS but not afforded the resulting status that might be expected to be associated with such a central role (Kyriakides and Virdee, 2003, p287). Despite ample evidence of racist employment practices, there has been limited progress when it comes to addressing them (Esmail and Everington, 1997; Kalra *et al.*, 2009). We take the view that there has been too little focus on the spectrum of behaviours and attitudes that racism in the NHS encompasses and that conceiving of discrimination in the NHS as the product of racism, 'heterophobia' and overlapping processes of marginalisation can help us to better understand racism in medicine. Moreover, work on racism in this area has, as traditional psychological approaches did, focused on dysfunction rather than on function and 'pathology' rather than resilience. Evidence gathered in the course of oral history research can contribute to a reflection around a theory of function that can inform engagement with racism.

## Methodology

An oral history approach was used to examine the roles of South Asian doctors in the development of British general practice between the late 1940s and the early 1980s. The decision to focus on the development of general practice was made in light of the significant concentration of South Asian GPs in the field, particularly in deprived working class areas. Participants were all born outside the UK. South Asian doctors born in the UK were excluded on the basis that the experiences of UK-educated and -trained doctors

would be deserving of a separate study focused on their specific experiences.

Thirty-seven participants had migrated after completing their medical training in the Indian sub-continent and three migrated as children. These three doctors were included in the sample as it was felt that their perspectives might cast additional light on our historical understanding of this period by offering a counterpoint to the perceptions of participants who migrated as medical graduates. Six of the doctors interviewed were female and 34 male. Most were born in the Indian subcontinent but two were members of the South Asian diaspora who had studied medicine in the Indian subcontinent prior to coming to the UK. The doctors worked in a range of areas of England, Scotland and Wales, but no Northern Ireland-based practitioners were recruited. Ethical approval was obtained from the Committee on the Ethics of Research on Human Beings of the University of Manchester. The Medical Research Council and the University of Manchester provided funding.

Participants were provided with an information sheet detailing the nature of the project. They were allowed time to reflect on whether they wished to participate, given the opportunity to ask questions and informed that participation was entirely voluntary; they were free to withdraw at any time or to decline to respond to any particular question. Written consent was obtained from all of those interviewed prior to conducting interviews and data obtained from participants were stored securely. Participants were recruited via a combination of convenience and snowball sampling. This involved recourse to professional and personal contacts, approaching doctors listed in the Medical Directory and Medical Register or mentioned in archival material that was consulted for the project, attending events such as alumni reunions and professional gatherings where a large number of South Asian doctors were in attendance and obtaining contact details from organisations such as the Royal College of General Practitioners and the Small Practices Association. Potential participants were approached in writing (by letter or email) and a follow-up telephone call was made to doctors for whom a number was available and who did not respond to the initial approach.

Interviews were carried out using a modified life story approach to oral history research. Participants were invited to reflect on their lives and careers up to the 1980s with the main focus being on their work as doctors. The nature of racism in the NHS was one of the key issues explored. The analysis of racism in the NHS that we present here is grounded in a phenomenological approach to oral history evidence which places values on the meaning contained in participants' descriptions of their engagement with the world (Kirby, 2008). Interviews were transcribed and analysed

critically using inductive reasoning. This enabled the identification of the themes which are presented here: the multifaceted dimensions of racism and the ability of participants to transcend or sidestep the manifestations of racism. We take the view that the historical nature of this evidence does not preclude it from informing our understanding of the present. This position is anchored in a conception of history which views it as a social science (Berridge and Stewart, 2010) that has much to contribute to our understanding of society and to current policy debates (Rowbotham, 1977; Thompson, 1991; Tosh, 2008; Woolcock *et al*, 2011; Cox, 2013). We drew on social theory to provide a framework within which the significance of the narratives of participants is discussed.

## Concepts and relevance

The notion of 'heterophobia' as defined by Albert Memmi can serve to broaden our understanding of the nature of discriminatory processes in the NHS. Memmi – who in the original French uses the term *hétérophobie* – distinguishes between racism, which can be related to perceived biological difference, and the concept of 'heterophobia' – literally the fear of the other (Memmi, 1994). This fear can lead to discriminatory behaviours which affect a range of groups, racialised or not – for instance women or disabled people. Memmi argues that these concepts should be used alongside each other with a view to gaining a better understanding of the nature of exclusionary processes. In his view, specific interventions are necessary to deal with different types of 'heterophobia' – racism being confined in this context to the manifestation of beliefs and feelings grounded in notions of racial superiority. The point made by Memmi is not that the term 'racism' cannot encompass discrimination based on other forms of difference (it can and he explicitly recognises this) but that distinguishing between the two encourages a reflection on the precise nature of the processes involved (Memmi, 1994). These twin concepts of 'racism' and 'heterophobia' will be used to inform our reflection on the nature of discrimination within the NHS. The fact that doctors belonging to a 'racialised' group (i.e. one identified on the grounds of visible phenotypical difference, such as skin colour) are discriminated against within the NHS does not necessarily signify that this discrimination is always grounded in what Memmi defines as racism as opposed to 'heterophobia'. Distinguishing between differing forms of discrimination, rather than using racism as an overarching term, can help to better understand the nature of the intersecting processes involved and can inform approaches aimed at tackling discrimination.

Reflecting on the significance of function as opposed to dysfunction can also serve to generate new approaches to engaging with discrimination in the NHS. Since the late 1990s, there has been a growing recognition within the field of human psychology (Seligman and Csikszentmihalyi, 2000) that there is immense value to be had from not only observing, treating and seeking ways of managing human dysfunction, but also from complementing these endeavours with an effort to identify, understand and promote areas of positive human function. There is a growing appreciation that there are significant rewards to be reaped from attempting to harness an understanding of factors that allow humans to flourish, rather than solely focusing attention on the negative aspects of human experience (e.g. mental illness). With its psychological roots in the humanistic tradition of striving for self-actualisation (Rogers, 1951, 1980; Maslow, 1954), positive psychology research has covered much ground. This includes insight into psychological states of being such as 'flow' (Csikszentmihalyi, 1990, 1998). Human beings enter a state of flow when their own desire to carry out a task (in psychology, this is termed 'intrinsic motivation') is balanced against the need to carry out the task ('extrinsic motivation'). The individual is absorbed effortlessly and pleasurably in the task at hand; what is important is to have sight of one's goals and have feedback on one's success or otherwise in attaining the goal. Other research has involved looking at the role of personality factors (Chamorro-Premuzic *et al*, 2007); an individual's social networks (Adams *et al*, 2011); the daily experience of positivity (Kahneman *et al*, 1999); the conceptualisation of moral elevation (Haidt, 2003) as a human emotion (arguably the opposite of moral disgust, it is the warm, positive feeling one experiences when one is the recipient of, or witness to a kind or selfless event); and the development of models of human wellbeing (Lyubomirsky and Layous, 2013). This body of research is now recognised as having made significant theoretical contributions to the field of psychology which have important practical applications when it comes to understanding effective human functioning. Our suggestion is that the critique of traditional psychology developed by proponents of positive psychology is highly relevant to the context of racism in British medicine and can help to inform a reflection on how its manifestations might best be dealt with.

## Findings

### Difference and discrimination in doctors' narratives

Incorporating into our understanding of racism instances where ethnic minority doctors report not

being subject to its effects can encourage us to think about discrimination in the NHS as being the product of both racism and 'heterophobia'. A number of participants did not describe feeling treated differently because of their ethnic background and in fact were keen to emphasise that racial discrimination should not be seen as a determining factor in their professional careers.

'I know lots of Asian doctors have been discriminated but maybe the way we were brought up or behaved...we have never been discriminated. If I was ever discriminated, only by the other Asian doctors...because I was a woman...'

You...said that you felt that some Asian doctors said they were discriminated against in the UK but you felt that wasn't the case for yourself, why do you think that was?...

'I don't know...I think we may be an exception...our background is...we talk well, we are the...generation that read Enid Blyton and you know, went to school and...sang hymns...we had that English sort of background...our head teacher was a New Zealander and most of our teachers, Australian, some English.' (GP36)

'Discrimination depends on two people, who you are and how you conduct yourself...In that, I feel that language is important...If you speak the kind of language which is spoken in England then you have no problem.' (GP35)

Although they recognise or hint at the existence of discrimination within the NHS or wider society, these participants suggest that they were in possession of particular attributes that enabled them to gain acceptance more readily than other migrants. This does not necessarily signify of course that indirect forms of discrimination could not affect these doctors. They worked as GPs in working class parts of the north of England and the Midlands which suggests that they may have been subjected to discriminatory employment patterns which directed South Asian doctors towards areas that were less popular with UK graduates. Reflection on these two extracts raises issues about how factors such as speech patterns and cultural background could serve to shape discrimination and how being able to negotiate British culture as a result of exposure to a traditional colonial-type education could help doctors to build successful careers. GP36's allusion to gender-based discrimination and to a sense that male South Asian doctors discriminated against women also points to the utility of conceiving of discriminatory attitudes within the NHS as being the product of racism understood as racism and 'heterophobia'. It suggests that members of ethnic minority groups themselves can at times support the institutional processes resulting in the marginalisation of ethnic minority doctors on the grounds of difference. The participant's views indicate either the existence of a problematic practice, a problematic perception on her part – she was not from Pakistan and later specified

that she felt it was mainly Pakistani doctors who engaged in such behaviour or an element of both. Irrespective of the merits of the view expressed, it invites recourse to different tools to understand the mechanisms of racism and discrimination within the NHS. 'Heterophobia', the fear and rejection of difference, of the person who speaks with an unfamiliar accent or is marginalised because of their gender can thus be seen to be a major contributor to the negative work experiences of migrant doctors who are constructed as different. One female doctor (GP41) described how being in a relationship with a white partner could be a way for male South Asian doctors to blend in. She felt that opportunities for female South Asian doctors to build social networks in this way were more limited for cultural reasons and that this contributed to the marginalisation of female migrant doctors. As well as language and gender, attitudes towards alcohol could also be seen as resulting in marginalisation even when doctors felt that they were not ostracised on the grounds of their ethnicity.

'I personally never came across any prejudice...but in general some of the doctors sometimes did say 'Well, really they are just using us' but...I wasn't aware of it...Whatever social circle or academic circle I happened to go [into], I was invited. I was most welcome...The problem is...when we came, we were not given any introduction or...a foundation course – 'How to move in the society'...I still remember when I went to [a prestigious medical dinner] Professor...who was the President [of a Medical Organisation]...he asked his beautiful daughter 'Come on, take Dr [participant's name] and...give him some drinks and so on' and she asked me 'What would like to drink – shall I bring you sherry or so?' I said 'No thank you, I don't drink alcohol' (laughs) so she brought me soft drink. Nowadays of course soft drink probably is considered alright...In those days, if you didn't drink sherry...you were funny you see (laughter).' (GP30)

Conversely, another participant who grew up in the UK, speaks with a local accent and engages in popular British pastimes described how he felt that he was not perceived as different to the extent that others were surprised to hear third parties refer to him as being Black.

'I was chairman of the...[local branch of a national organisation]...and we got a letter from some Black voluntary organisation congratulating the [organisation on] having a Black chairman. And the look of amazement on the people's face when that was read out was interesting...and I was then asked to go to a meeting in London about trying to create a Black movement. And I remember the white researcher doing the work with us said to me after about half an hour 'You don't know why you're here do you?'. So I don't want to sound not connected and empathetic to these issues but I must admit I've got to say I wasn't personally deeply hurt and so to me it was a social issue like poverty and all the other

social issues rather than...something that stood out for me as my passion.' (GP20)

This kind of narrative was not universal but it does invite us to reflect on how we should understand racism in the NHS. Conceiving of the NHS and the wider context provided by British society as both racist and 'heterophobic' enables us to understand the narratives presented here as a reflection of the multi-faceted nature of the discrimination that doctors encountered.

### Talking of negotiating racism and 'heterophobia'

Seeing manifestations of racism and discrimination as the product of racism and 'heterophobia' reveals how doctors were able to successfully build careers in spite of the racist social and professional environment that they found themselves in. By the early 1990s, around 16% of GPs working in the UK originated from Bangladesh, India, Pakistan or Sri Lanka (Gill, 2002, pp107–111). The fact that one in six patients in the NHS were registered with Asian doctors (in many cases in overwhelmingly white areas such as the Welsh valleys), without this becoming a major social issue, is noteworthy. Given the undoubtedly racist nature of British society at the time, it is conceivable that white patients could have refused en masse to consult South Asian doctors. The perceived social utility of migrant doctors would seem to have been a factor in mitigating racist reactions. This is illustrated by the following account which indicates that the presence or absence of 'heterophobia' in a particular situation could serve to activate or neutralise racism.

'If there was any Asian person walking down the road [in a town in the North of England in the 1970s], they will say 'Hello Doc, how are you?'...Everybody who was there in that town, black, brown, they were mostly Indian and Pakistani doctors who were there...They were all in the medicine at the [local hospital]. And so they were well...respected...When I moved down to London I saw the different aspect of it. In the hospital, they knew you as a colleague but when you went outside, because London is a cosmopolitan city...it is a world of its own and once you are out of the protective atmosphere of hospital boundaries you are a 'paki' for them.' (GP7)

'Heterophobia' is, unlike an entrenched belief in racial superiority, susceptible to being overcome by familiarity or the recognition of doctors' social function. As a result, some participants felt that by persevering in their roles in the face of initial reluctance on the part of local populations to consult a South Asian doctor they were able to be accepted as professionals providing a service.

'In the beginning it was very hard to get accepted...In my practice, when I...retired, I had 2,200 patients...and I

probably had say thirty or forty patients who are not white...the rest of them are local people...We must have...accepted each other otherwise they would not have stayed with me for...more than one generation...I didn't see much difference at all...They accepted me as a doctor, trusted me and I said 'Well, I'll do...what I can'...There were others doctors there, white doctors there...but I didn't lose very many patients.

You said it was difficult to be accepted – in what way?

'Oh well obviously you can't blame them you see, if somebody from here goes in a village in Bangladesh and starts a practice, particularly a man...I don't think many patients will go and see them...and the women of course never go near his sight...So it is a similar situation here.' (GP4)

This description connects the experiences of South Asian GPs to a rejection of difference which manifests in various parts of the world. Another doctor explicitly attributed negative media and patient attitudes towards South Asian doctors to a fear of the unknown which gradually ebbed away.

'It is possibly [to do with] unknown things because at that time a lot of South Asian doctors came to this country, almost one third of the doctors in...hospitals...were from South Asia and they found it a bit difficult to accept and they found possibly the standard of education or their performance may not be the same as doctors of this country. But when they saw the performance of the Asian doctors they thought they are as good as the British doctors. So I'm sure they accepted after that.' (GP13)

The passage of time and the demonstration of professional competence were seen as contributing to a number of South Asian doctors' ability to negotiate and overcome racism within the NHS. This applied to encounters with patients but also with fellow clinicians. This suggests that outsiders might be better accepted and racism better dealt with if there was a greater understanding and appreciation of the social roles performed by migrants. As one female GP in the North of England put it when asked if she had been treated differently because of her gender or ethnicity: 'When they needed help, they were not concerned about who I was.' (GP24). This can be at least partially explained by hypothesising that systemic 'function' can be observed when the recognition of the social utility of a person belonging to a racialised group outweighs the importance given to 'heterophobic' considerations and results in the marginalisation of racist responses.

'Function' in this context also emerges from the strategies of resilience adopted by participants and direct challenges to discrimination. One example of this was the establishment in 1975 of the Overseas Doctors' Association (ODA), a group founded and led by South Asian doctors working in the NHS. Its representatives held meetings with government

ministers, influenced policy and obtained representation within mainstream professional bodies such as the British Medical Association and the General Medical Council (GP5, GP6, GP18). One participant described being successful in medical politics.

'Doctors knew [of] my...involvement in the health service in various roles and they were able to judge my ability to communicate, my thoughts on racism, my thoughts on integration and my ability to work with the local population and they expressed their confidence...by electing me...When they see the doctors perform, they are able to exercise their better judgement and this vote of confidence is also a vote of confidence not only by the brown doctors voting for the brown...it is also an endorsement of the native British doctors thinking that this doctor...is the one doctor I can trust for my welfare and to protect the patients...And this election of people like me was...made possible by the exercise of the vote by the ordinary British GPs and the consultants and the specialists of all kinds... that says that they are open-minded and they are not incurably racist.' (GP5)

The use of the expression 'incurably racist' here is an intriguing one, particularly when employed by a clinician. It hints at the fact that there might be different types of racism that may or may not respond to 'treatment' and that racism understood as racism and 'heterophobia' is susceptible to being dealt with by undermining constructions of difference.

Racism was also at times described as negated by direct challenges rather than because doctors undermined the process of othering that supported its manifestations. Indeed, the establishment of the ODA was a direct response to the discrimination that migrant doctors felt they were facing in the NHS (GP6). Other participants talked of being able to take individual action.

'Some of the colleagues...would cause difficulty for other people...I would...wade in, you know and I would say 'You shouldn't speak to him like that...I think you should apologise to him'. So, I have been known to do that once or twice...'

What sort of problems arose that led you to responding in that way?

'...For instance, I used to do a session in [hospital in the North of England] as a casualty clinical assistant. And I thought...one consultant particularly spoke very roughly with some of the Indian subcontinent...junior house officers...I wouldn't tolerate things like that...I'd go straight to the person, I'd tell him 'You're wrong, you apologise to him', right. Whether they felt intimidated by my direct approach or not they did comply because I wouldn't let it go until they had complied.' (GP12)

'There's no hostility, no open hostility no. Because... that was...part of my joining condition. That...any hostility come, that patient will be thrown out of [the] practice. So there was no open hostility.'

And did you find that that policy was taken on board by the practice and that patients understood it as well?

'Oh yes...one patient was thrown out and since then nobody has said a word against it...One patient said 'No I don't want to see the Indian doctor'...and I heard it, that patient was thrown out...Both the Irish doctors agreed to it...they said 'It has been agreed and we won't have you here'.' (GP19)

The fact that both of these instances of direct challenges to racism are presented as successful raises the question of what conditions need to be in place to make such interventions possible. The first quote was from a doctor who presumably felt able to speak out without being overly concerned about the impact that this might have on his career prospects. It is also worth noting that the session he discusses took place in an emergency department in the North of England, the type of post that was hard to fill in the first 40 years of the NHS. In the case of the second extract, the choice to work in general practice, in particular in the type of area that many UK graduates considered undesirable, may have empowered this participant to make this request. The reference to Irish colleagues is intriguing in this context. It is possible that South Asian doctors were in a better position to challenge racism when taking on roles in areas where there was little competition from white British (English) male doctors and where consequently, their demands for dignity at work were taken seriously. The presence of these accounts in doctors' narratives invites us to reflect on how, in appropriate contexts, migrant and ethnic minority doctors can be empowered to challenge discriminatory processes. The precise mechanisms whereby collective and individual initiatives could lead to successful challenges to racism being mounted deserve further investigation.

## Conclusion

Interviews with participants provided evidence both of the need to conceive of the NHS as a racist and 'heterophobic' environment and of the fact that, in some instances, South Asian doctors were able to overcome the obstacles presented by a discriminatory work environment. As we pointed out at the outset, we know a lot less about these instances than we do about the fact that racism and discrimination have persisted in the NHS over the years. Naturally, we do not claim that the views discussed here are representative of those of all migrant and BME doctors, let alone those of other migrant and BME staff. The experiences of these South Asian GPs do however suggest that a shift in the focus of research into racism in the NHS to enhance our understanding of the dynamics of

situations where racism does not manifest or is overcome would be a fruitful line of enquiry for future research. As well as a focus on the circumstances in which 'function' occurs, an exploration of racism and 'heterophobia' in the NHS would also enable us to gain a greater understanding of the changing nature of racism in the NHS and of the ways in which different forms of discrimination intersect in a diverse workforce.

Developing a body of work around these questions would generate a wealth of material of direct practical use in the context of the NHS. It could inform institutional attempts to mitigate the effects of racism and heterophobia. The experiences of participants point to the potency of interest convergence when it comes to overcoming discriminatory behaviours (Cashin, 2005). Greater efforts to articulate a common agenda between patients, UK-trained healthcare staff, migrant practitioners and other marginalised groups may therefore prove to be a useful strategy in addressing manifestations of racism. This could involve a greater recognition within the NHS itself of the historical role of migrant workers in its development (Simpson *et al.*, 2010). Migrant doctors and other marginalised groups have, over the years, developed individual and collective strategies that have enabled them to function within the organisation. Identifying these strategies and disseminating information about them is of relevance in contemporary contexts. They can inform the thinking of organisations representing migrant and BME doctors. They can also empower individual clinicians by enabling them to develop personal strategies informed by the experiences of others. The work of the ODA in the 1970s and 1980s could serve as a model for migrant doctors for example. Its modes of functioning could be adapted to a contemporary context by using social networking to discuss relevant issues and provide support. This type of approach could contribute to helping doctors function as effectively as possible in the NHS until it makes greater progress when it comes to dealing with racism. Deepening our awareness of the multiple and intersecting dimensions of discrimination and building an understanding of how doctors belonging to marginalised groups have successfully challenged these processes has the potential to significantly enhance both our understanding of the nature of racism in the NHS and our ability to counter its manifestations.

#### ACKNOWLEDGEMENTS

We wish to thank the participants who gave up their time to take part in this study.

#### CONFLICTS OF INTEREST

None.

#### REFERENCES

- Adams R, Santo J, Bukowski W (2011) The presence of a best friend buffers the effects of negative experiences. *Developmental Psychology* 47(6):1786–91.
- Berridge V, Stewart J (2010) History: a social science neglected by other social sciences (and why it should not be). *Contemporary Social Science: Journal of the Academy of Social Sciences* 7(1):39–54.
- Bornat J, Henry L, Raghuram P (2009) 'Don't mix race with the specialty': Interviewing South Asian overseas-trained geriatricians. *Oral History* 37(1):74–84.
- Cashin S (2005) Shall we overcome? Transcending race, class, and ideology through interest convergence. *St. John's Law Review* 79(2):253–91.
- Chamorro-Premuzic T, Bennett E, Furnham A (2007) The happy personality: Mediation role of trait emotional intelligence. *Personality and Individual Differences* 42: 1633–9.
- Coker N (2002) *Racism in Medicine: An agenda for change*. London: King's Fund Publishing.
- Collier J and Burke A (1986) Racial and sexual discrimination in the selection of students for London Medical Schools. *Medical Education* 20(2):86–90.
- Cooke L, Halford S, Leonard P (2003) *Racism in the Medical Profession: the experience of UK graduates*. London: British Medical Association.
- Cox P (2013) The future use of history. *History Workshop Journal* 75(1):125–45.
- Csikszentmihalyi M (1990) *Flow: The Psychology of Optimal Experience*. New York: Harper and Row.
- Csikszentmihalyi M (1998) *Finding Flow: The psychology of engagement with everyday life*. New York: Basic Books.
- Esmail A (2007) Asian doctors in the NHS: service and betrayal. *British Journal of General Practice* 57:827–34.
- Esmail A, Everington S (1993) Racial discrimination against doctors from ethnic minorities. *British Medical Journal* 306:691–2.
- Esmail A, Everington S (1997) Asian doctors are still being discriminated against. *British Medical Journal* 314(7094): 1619.
- General Medical Council (2011) *The state of medical education and practice in the UK*. [www.gmc-uk.org/FINAL\\_WORD\\_VERSION\\_STATE\\_OF\\_140911\\_1\\_.doc\\_44213428.doc](http://www.gmc-uk.org/FINAL_WORD_VERSION_STATE_OF_140911_1_.doc_44213428.doc)
- Gill P (2002) General practitioners, ethnic diversity and racism. In: N. Coker (ed) *Racism in Medicine: An agenda for change*. London: King's Fund Publishing, pp99–120.
- Gish O (1969) *Britain and the Immigrant Doctor*. London, UK: Institute for Race Relations.
- Haidt J (2003) Elevation and the positive psychology of morality. In: C. Keyes and Haidt J (eds) *Flourishing: Positive psychology and the life well-lived*. Washington DC: American Psychological Association, pp275–89.
- Healy G, Bradley H, Forson C (2011) Intersectional sensibilities in analysing inequality regimes in public sector organisations. *Gender, Work and Organisation* 18(5): 467–87.

- Jones E, Snow S (2010) *Against the Odds: black and minority ethnic clinicians and Manchester, 1948 to 2009*. Lancaster: Carnegie.
- Kahneman D, Diener E, Schwarz N (1999). *Well-being: The foundations of hedonic psychology*. New York: Russell Sage Foundation.
- Kalra V, Abel P, Esmail A (2009) Developing leadership interventions for black and minority ethnic staff. *Journal of Health Organisation and Management* 23(1):103–18.
- Kirby R (2008) Phenomenology and the problems of oral history. *The Oral History Review* 35(1):22–38.
- Kyriakides C, Virdee S (2003) Migrant labour, racism and the British National Health Service. *Ethnicity and Health* 8(4):283–305.
- Lyumbomirsky S, Layous K (2013) How do simple positive activities increase well-being? *Current Directions in Psychological Science* 22(1):57–62.
- Maslow A (1954) *Motivation and Personality*. New York: Harper.
- McCall L (2005) The complexity of intersectionality. *Signs: Journal of Women in Culture and Society* 30(3):1771–1800.
- Memmi A (1994) *Le racisme: description, définitions, traitement*. Paris: Gallimard.
- Raghuram P, Bornat J, Henry L (2009) Ethnic clustering among South Asian geriatricians in the UK: an oral history study. *Diversity in Health and Care* 6:287–96.
- Raghuram P, Bornat J, Henry L (2011) The co-marking of aged bodies and migrant bodies: migrant workers' contribution to geriatric medicine in the UK. *Sociology of Health and Illness* 33(2):321–35.
- Rogers C (1951) *Client-centered Therapy: Its current practice, implications and theory*. London: Constable.
- Rogers C (1980) *A Way of Being*. Boston: Houghton Mifflin.
- Rowbotham S (1977) *Hidden from History: 300 years of women's oppression and the fight against it*. Pluto Classic: London.
- Seligman M, Csikszentmihalyi M (2000) Positive psychology: An introduction. *American Psychologist* 55(1): 5–14.
- Simpson J, Esmail A, Kalra V, Snow S (2010) Writing migrants back into NHS history: addressing a 'collective amnesia' and its policy implications. *Journal of the Royal Society of Medicine* 103(10):392–6.
- Simpson J, Esmail A (2011) The UK's dysfunctional relationship with medical migrants: the Daniel Ubani case and reform of out-of-hours services. *British Journal of General Practice* 61:208–11.
- Smith D (1980) *Overseas Doctors in the National Health Service*. London and Thetford: Policy Studies Institute.
- Taylor D Jr, Esmail A (1999) Retrospective analysis of census data on general practitioners who qualified in South Asia: who will replace them as they retire? *British Medical Journal* 318:306–10.
- Thompson E P (1991) *The Making of the English Working Class*. London: Penguin Books.
- Tosh J (2008) *Why History Matters*. Basingstoke: Palgrave Macmillan.
- Woolcock M, Szreter S, Rao V (2011) How and why does history matter for development policy. *Journal of Development Studies* 47(1):70–96.

#### ADDRESS FOR CORRESPONDENCE

Dr Julian Simpson, Contemporary Historian, Research Associate, Centre for the History of Science, Technology and Medicine, The University of Manchester UK, Manchester M13 9PL, UK. Email: [julian.simpson@manchester.ac.uk](mailto:julian.simpson@manchester.ac.uk)

