The London School of Economics and Political Science

'Swimming Against the Tide': Trajectories and Experiences of Migration amongst Nigerian Doctors in England

Kjartan Páll Sveinsson

A thesis submitted to the Department of Sociology of the London School of Economics for the degree of Doctor of Philosophy, London, September 2015

Declaration

I certify that the thesis I have presented for examination for the MPhil/PhD degree of the London School of Economics and Political Science is solely my own work other than where I have clearly indicated that it is the work of others (in which case the extent of any work carried out jointly by me and any other person is clearly identified in it).

I declare that my thesis consists of 80,472 words.

Abstract

High emigration countries tell a confusing story of how migration cycles can contribute to the sustainable economic development of some poor countries in some ways but hamper it in others. A number of social, economic and political factors – on local, national and global levels – interact to influence success, or lack thereof, in activating diasporas to contribute to the development of their home countries. Various actors – including states, civil society, and minority groups – within the 'transnational social space' impact on migrants' capacity to send 'social remittances' and engage with transnational processes. This study looks at a particular cadre of highly skilled migrants – Nigerian doctors working in the NHS in England – as a lens through which to explore these broader processes. Africa has:

- 3% of the world's health-workers
- 11% of the global population
- 24% of the global burden of disease

Yet 28% of sub-Saharan African doctors have left the continent to practice medicine in a handful of OECD countries, with enormous social and economic costs to sending countries.

The NHS is highly dependent on overseas doctors – 28% are trained overseas, and 75% of these are from low income countries. Yet there is a long history of discriminatory practice towards overseas doctors in the NHS. Overseas doctors tend to be over-represented in lower grades, and under-represented in senior positions: the higher up the NHS hierarchy you look, the whiter the doctors become.

This study traces the migratory trajectories of 32 Nigerian doctors who have studied and/or worked in England, their experiences of professional development within the NHS, and their involvement in community and transnational activities that induce (or hinder) the transfer of skills and resources. Their narratives are connected to broader aspects of immigration policy, structural discrimination, and transnational processes to explore how their place within the transnational social space impacts on their ability to obtain transferable knowledge, and how they use this knowledge to make a contribution to the development of the healthcare sector in Nigeria.

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Acknowledgements

Firstly, my deepest, most heartfelt thanks to the doctors who took part in the study. Medical practitioners are notoriously busy, but with every interview, I was struck by the passion, honesty, vitality and generosity with which they engaged with my questions. I can only hope that the final result does them justice. This thesis is very much dedicated to them.

A number of people made my fieldwork much smoother – and more enjoyable – than it would have been without their help. First and foremost, the wonderful Anya brothers: Ike Anya's connections were invaluable and opened innumerable doors, and his thoughts, comments and insights made me see things clearly that I hadn't even realised were there; and Naz Anya – who made sure my stay in Nigeria was naija-proof – is without doubt the most hospitable person I've come across. Without Jimi Coker, who generously took the time to convince his colleagues to talk to me, my Nigerian fieldwork wouldn't have been half as successful. I am very grateful to MANSAG, and particularly Ibrahim Imam, for circulating my advert for interviewees, through which I met some fantastic people. And finally, I would like to thank Lord Nigel Crisp for very kindly taking the time to discuss some of my ideas, and sharing with me his wealth of experience and knowledge.

I always promised myself that if I ever finished a PhD thesis, I would thank Kuljit Sandhu for giving me my first job as a proper researcher. She was willing to take a chance on a budding young anthropologist, fresh out of a Master's degree with a painfully blank CV, and gave me that first, crucial break. If it wasn't for Kuljit, this dissertation would never have been written. I'm eternally grateful to the ESRC for funding my studies, to Rose Harris for being helpful way beyond her job description, and the Fees Team at the LSE Financial Support Office for being the consummate professionals that they are. Rob Berkeley and Omar Khan very helpfully offered the Runnymede Trust's collaboration, which helped secure my ESRC grant, and facilitated fieldwork. Carrie Friese gave me extremely helpful comments on my upgrade paper, which helped steer the thesis into the shape it has taken. Olivia Mena provided me with some sorely needed intellectual nourishment, friendship, and camaraderie throughout the whole PhD process. I am grateful to my two examiners, Caroline Knowles and Michael Keith, who made me sweat during the viva voce examination, but who ultimately provided me with a critical appraisal of the thesis, and some very helpful ideas on how to take my work forward. They skilfully balanced an honest and critical assessment against intellectual generosity and appreciation. And, of course, I would like to thank my parents, Lára and Sveinn, as well as my in-laws, Sigrún and Dermot, for their help and assistance, particularly at times when a PhD stipend wasn't quite sufficient to feed a family of five...

It is customary to reserve the final and most heartfelt thanks to one's family, and I have certainly been blessed with a wife – Phoebe – and three children – Kári, Sigrún and Una – who have endured a very preoccupied husband and father for four years. My children unwittingly spurred me on, (who doesn't want their kids to be proud of their old man?), and my wife helped me in more ways than I can count (as I type this, she is making sure the tables all look sufficiently credible). Without their support and patience, I doubt that I would have had the resolve to finish this behemoth.

However, I am going to break with convention, and reserve my closing thanks to my two supervisors. Suki Ali, my secondary supervisor, was solid as a rock in her support. Suki made me feel cared for and looked after, and gave me space to develop my own thoughts yet intervened in all the right times and places with insightful observations. My relationship with Claire Alexander, my primary supervisor, started way before the onset of my PhD. She was instrumental in enhancing my academic reputation through our collaboration in the Runnymede Academic Forum, and there is no doubt in my mind that her help and support secured my ESRC funding. I always looked forward to her comments as my thesis developed. She had a knack for spotting the holes in my arguments – never compromising in her critique, always generous in her appreciations – but also for calming my nerves whenever I've had one of my many wobbles. Claire, thank you for being a dear friend and the best supervisor a PhD student could wish for.

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1. Introduction

> At medical school in Nigeria they trained us to be the best: the best surgeons, the best physicians, the best doctors. Our professors spoke glowingly of their time at Harvard, at Guy's. Yet five years after graduation, having worked in urban and rural hospitals in Nigeria, I was frustrated. Frustrated by the mismanagement of the meagre resources available, the numerous avoidable deaths, the limited opportunities for training and development, the irregular pay. I was stagnating, losing my skills and focus. Like many before me I faced a decision: to continue to struggle to build up a faltering health system; to seek professional opportunities elsewhere; or to leave medicine.
>
> I chose to leave Nigeria. I didn't plan to migrate permanently but the opportunities in the UK were too great and going home seemed the wrong choice. Four years after arriving I hoped to move back and work for a year. I found it hard in the UK and missed home. But the pathway was inflexible and it felt too risky. If I returned there was no way to tell whether I would get stuck in the same rut that forced me to leave. Moving back permanently just seemed too daunting: too much of a gamble.
>
> Nine years on and I still feel guilty and question my decision. I want to help but I don't want to lose my job to do it. With a friend I started a blog, Nigeria Health Watch, and the Nigerian Public Health Network, but it takes all the time I have. I wish it were easier for me to share my skills. It seems all or nothing with migration. You either stay or you go. Very rarely can you reach a middle ground.
>
> Ike Anya (2010)

I first read Ike Anya's article in April 2011. My daughter had just been diagnosed with a difficult, long-term illness, so I had a keen interest in anything related to health and the NHS. I was spending most of my time in various hospitals, and had got to know the NHS better than most people would probably want to. Although I paid little attention to it at the time, in retrospect the number of overseas doctors we came in contact with was at once palpable and inconspicuous. Palpable, because we were as likely to be seen by overseas doctors as we were by British doctors during our countless hospital visits. Inconspicuous, because neither me nor my wife ever had a reason to give it much thought – it was perfectly normal. Yet reading Anya's article made me think; how many African doctors had cared for my daughter? In fact, when I started to think about it, I struggled to remember an NHS encounter not involving an African doctor, from my GP surgery, the maternity ward, A&E department and my daughter's oncology ward. This realisation took me by surprise. From my past life as a race equality policy analyst, I was well aware of the high proportion and long history of Indian doctors in the NHS, but the African presence had somehow slipped under my radar. A cursory glance at the literature, however, adduced that African health professionals in the NHS had been given scant academic attention at all, with notable exceptions.[1] Yet the statistics pointed towards a consequential social phenomenon. Sub-Saharan Africans make up

[1] Henry (2008); Mackintosh, Raghuram and Henry (2006)

1.7% of the UK's population, but nearly 10% of all doctors in the NHS. This figure alone should warrant sociological attention, but it was the wider issue which caught my interest: although there are more doctors working in the NHS (~140,000) than in all sub-Saharan African countries put together (~96,000), 14% of sub-Saharan African doctors leave the continent to work in the NHS (Clemens and Petterson, 2008).

As fate would have it, I came across Anya's article around the time I when I received my acceptance letter to join the PhD programme at the London School of Economics. My original proposal was to look at return migration of young professionals to the Caribbean, but my daughter's illness precluded any extended periods of fieldwork abroad. We needed to stay close to the NHS for the foreseeable future. Thinking about how I could re-focus my central topic of circular migration of highly skilled professionals without leaving England, it dawned on me that I was surrounded by a significant but under-researched sociological issue.

Coming from a large family of doctors myself, I reflected on the migratory histories of my own kin in Iceland. My grandfather – a surgeon and gynaecologist – had told me countless stories of his time in Chicago and Karlskoga, Sweden. I had myself spent my childhood years in Uppsala, where my father gained a PhD in neonatology. Even when we moved permanently back to Iceland, my father kept in close contact with his Swedish colleagues. We would go back to Uppsala every summer for him to keep himself on the cutting edge of latest knowledge. My sister followed in his footsteps to do a PhD in neonatology in Malmö, and her husband – a surgeon – regularly travelled between Reykjavík, Oslo, Lund and Copenhagen for operations.

For me, medicine was in its very nature a transnational endeavour, and the influence on the Icelandic healthcare system seemed self-evident: it was one of the world's best *because* of migration, not in spite of it. The stark difference in migratory experiences between my Icelandic family and the African doctors who nursed my daughter back to health was, it seemed to me, striking. For doctors in the global North, the transnational social space of medical migration represents a world of largely unrestricted opportunity. For doctors in the global South, on the other hand, this space is scattered with obstacles. Dr. R.O. – a prominent Nigerian surgeon who had had reached the pinnacle of his trade in the UK, and one of my key interviewees – described his journey through this transnational social space as "tough. It was very tough. It was always like you're swimming against the tide."

Rationale

In recent years, academics and policy makers have become enthusiastic about the possibility of a positive impact of highly skilled migration on the development of poor countries. Central to these debates is the idea that diasporas of highly skilled migrants are potentially a powerful force for development through transfer of resources and ideas back to their countries of origin. If the outflow of skilled professionals – brain drain – is an elementary problem for poor nations with high net emigration, then return migration – brain circulation – seems to be the self-evident answer. However, the evidence base for the link between skilled migration and development is weak. High emigration countries tell a confusing story of how migration cycles can contribute to the sustainable economic development of some poor countries but hamper it in others. Progress, or the lack of it, in activating diasporas to make a meaningful

and sustainable contribution to the development of their home countries depends on a complex morass of social, economic and political factors, on local, national and global levels. This study looks at a particular cadre of highly skilled migrants – Nigerian doctors working in the NHS in England – as a lens through which to explore these broader processes.

Many of the challenges identified in the broader literature on migration and development are crystallised in the migration of health professionals from sub-Saharan Africa, which represents brain drain of gargantuan proportions. Because health is one of the main yardsticks against which development is measured – three out of the UN's eight Millennium Development Goals relate to health – medical migration is key to any discussion on migration and development. As Docquier and Rapoport (2009: 684) remind us, "In developing countries, the size and quality of the medical sector is a key determinant of human development and economic performances". With nearly a third of all doctors leaving sub-Saharan Africa, it is imperative to think about whether diaspora doctors are able to make a contribution to the development of the healthcare sector in their countries of origin, which avenues are open to them to do so, and what stands in their way. As a number of scholars have recently argued (Brønden, 2012; de Haas, 2012; Glick Schiller, 2012), the task of deconstructing and critically examining where migration works for development, and where it does not, is a pressing one. Migration is a fact, and medical migration has rightly been identified as a major challenge to the development of the healthcare sector in sub-Saharan Africa. De Haas (2007) makes a convincing case that 'turning the tide' on migration from the global South to North is a policy pipe dream, unlikely to be realised in the foreseeable future. Medical migration out of Africa certainly shows no signs of abating, and it is difficult to see how the necessary conditions to stem the outflow of doctors will emerge in the short to medium term. There is therefore mileage in closely examining the process of medical migration to identify whether, and how, it could be made to work for development, and what is stopping it from doing so.

It is a truism that diasporas have certain unique qualities which makes them well placed to make a meaningful contribution to their home countries, and this applies to African doctors as well. They have cultural insight into how healthcare is practiced back home, and local knowledge of how to navigate often sensitive and volatile political landscapes. In addition, many will bring with them a passion and emotional investment which fosters the necessary commitment to long term engagement and sustainable development. This is not to say that diaspora doctors are morally obliged to make a contribution. It is important to heed Skeldon's (2008: 14) caution that "the responsibility for development is being increasingly placed upon the agency of migrants rather than on institutional structures". This is both unrealistic and unreasonable. However, even if not all Nigerian doctors are interested in engaging in transnational activities to contribute to development back home, those who do can have a significant impact nonetheless. As Portes (2003: 877) argues, migrant transnationalism can have macro-structural consequences: "Despite its limited numerical character, the combination of a cadre of regular transnational activists with the occasional activities of other migrants adds up to a social process of significant economic and social impact for communities and even nations." For Nigeria, doctors form an important part of this social process; the skills they learn in England can equip them with valuable tools to become efficient agents of change. In other words, Nigerian doctors are by no means *the*

solution to Nigeria's healthcare development, but given the right circumstances, they can be an important part of it.

For migrants to become effective agents of change, they need to learn new skills which they cannot learn or acquire in their home countries. For doctors, this necessarily includes steady career progression in their chosen specialism. However, previous studies (Anwar and Ali, 1987; Coker, 2001; Kyriakides and Virdee, 2003; BMA, 2004; Jones and Snow, 2010; Simpson, 2013) have revealed a that overseas doctors in the UK tend to be channelled into less prestigious specialisms and lower grades, which warrants a close examination of whether the migratory journeys of Nigerian doctors are conducive to them developing knowledge and skills which could usefully be applied to the development of the healthcare sector in Nigeria. If it is indeed the case that Nigerian doctors face a glass ceiling in their career development, and a curtailed choice of career path, it is important to identify where these lie, how they function, and whether this impacts on their ability to transfer social remittances back home.

Of course, debates rage on in terms of what constitutes 'development'. Bakewell (2008: 1342) argues that missing from most discussion on migration and development in Africa "is any critique of the concept of development under consideration; questions are posed about how migration affects the process of development, without asking what development means". These are important debates, but I will not engage with them *per se*. I take for granted that whether health related indicators of development – such as child mortality rate, health expenditure, doctor:patient ratio and burden of disease – go up or down is extremely important, that advances in these areas are incontrovertibly a good thing, and that there is a relationship between these factors and medical migration.

Thus, my aim is not to quantify diaspora impact, nor to gauge the extent of diaspora engagement. Rather, I examine the processes, institutions and avenues which Nigerian doctors are able to draw on and engage with to contribute to the development of the healthcare sector in Nigeria. I focus specifically on how their migratory journeys to England and through the NHS equips them with certain skills and knowledge which they can use to make a contribution back home, as well as how these efforts are hampered by various social processes and institutions. In a nutshell, then, my central question is this: *if* Nigerian doctors want to make a contribution back home, what helps them to do so, and what holds them back?

Aims and Research Questions

Context: Nigeria and the UK

Although Nigeria-UK migration is not representative *per se* of medical migration flows from sub-Saharan Africa to OECD countries, it presents an interesting case study on the extreme end of the medical brain drain problem, and offers insights into the paradoxical nature of medical migration flows and the often contradictory policy responses in Britain, Nigeria and internationally. With a population of over 160 million, Nigeria is Africa's most populated country; one in six Africans is a Nigerian. Furthermore, Nigeria is an economic powerhouse, and is Africa's second largest economy after South Africa. In spite of the vast amount of wealth to be found in the country – Nigeria is one of the world's largest oil producers – its

healthcare sector remains highly underdeveloped. The statistics make bleak reading, with Nigeria lagging behind the African average on key indicators of health (see table 1).

	Nigeria	African Average	Gobal Average	United Kingdom
Life expectancy at birth (years)	53	56	70	80
Under-five mortality rate (per 1000 live births)	124	107	51	5
Maternal mortality ratio (per 100,000 live births)	630	480	210	12
Births attended by skilled health personnel (%)	34	49	70	100
Physicians per 10,000 population	4	2.5	14	27.4
Nurses and midwives per 10,000 population	16.1	9.1	28	108
Government health expenditure per capita, USD	29.2	49.2	615	3,322
Government health expenditure as % of GDP	5.3	8.5	10.1	9.3

Table 1: Health statistics for Nigeria and the United Kingdom in 2011. Source: WHO (2013).

The notable exception is Nigeria's level of health professionals per capita, which is above the African average for both doctors and nurses. Nevertheless, both still fall well below the global average, and when coupled with Nigeria's below average spending on health, whether per capita or as a proportion of GDP, the inevitable conclusion is that the emigration of a large proportion of Nigeria's doctors – the exact figure is unknown, but estimates range from 14% to 40% – is part and parcel of the underdevelopment and general neglect of the healthcare sector.

Due to colonial ties, there is a long history of political association with Britain, as well as a well-established migration route, and there has been an incremental year-on-year increase in doctors leaving Nigeria for Britain since the 1990s, with the bulk of Nigerian doctors now practicing in the NHS migrating in the last 15 years. As with other migrant doctors from low income countries, Nigerians are likely to experience discrimination within the NHS.

Aims

The aim of the study is to explore the trajectories and experiences of migration amongst Nigerian doctors in Britain. Employing a biographical approach, the research focuses on the doctors' own narratives of migration, their experiences of professional development within the NHS, and their involvement in community and transnational processes that induce (or hinder) the transfer of skills and resources. These narratives are connected to broader aspects of immigration policy, structural discrimination, and global capitalism to explore how the 'social location' of Nigerian doctors – their place in social, economic and political contexts and structures – impacts on their ability to obtain transferable knowledge, and how they use the knowledge gained in Britain to make a contribution to development in Nigeria. How do immigration policies influence their trajectories? Does discrimination impact on their career choices and professional development? What is the role of global labour markets in their migration decisions, and how do they navigate global structures in their transnational activities? How do these factors impact on the doctors' capacity to turn brain drain into brain

circulation by transferring skills and attitudes – 'social remittances' – to support development in Nigeria?

The study critically engages with theories on highly skilled migration in a number of ways. Firstly, I draw on transnational migration scholarship to conceptualise migration as an ongoing process that begins way before the event of moving between countries, and continues long after it. Second, the study problematises the dominance of research on skilled migration in the financial sector (cf. Raghuram and Kofman, 2002). Third, focusing on a visible minority group not commonly associated with highly skilled migration allows me to explore the effects of race and discrimination. Furthermore, sociological research has not kept apace with the swift growth of west African groups in Britain. Nigerian born residents are one of Britain's most rapidly growing ethnic groups, doubling from 88,000 in the 2001 Census to 174,000 in the 2011 Census, yet this group has not attracted sustained academic attention. This invisibility "in analyses of race and ethnicity in Britain" (Knowles, 2013: 660) mirrors a wider social invisibility, where Nigerians fall "below the radar of public notoriety, official data and social policy. Consequently, Nigerian needs do not demand address" (ibid). The study will therefore make an empirical contribution to this small but growing literature, thereby adding to our understanding of Britain's 'new communities' and emerging super-diversity.

Research Questions

I hope to make an important contribution to the small but growing literature on medical migration from sub-Saharan Africa to OECD countries, and add to broader theoretical understandings of skilled migration. I address these issues through the following research questions:

1) What are the key characteristics of Nigerian doctors' migration trajectories?
2) How are Nigerian doctors' experiences shaped by their social location in Britain generally and the NHS specifically?
3) What kind of transnational activities do Nigerian doctors engage in to contribute to the development of Nigeria's healthcare sector?
4) How do their experiences contribute to and challenge broader understandings of transnationalism, highly skilled migration, and new migrations in the contemporary world?

Chapter Outline

2. Literature Review and Methodology: In this chapter, I survey the relevant literature relating to medical migration, and set out the theoretical framework and methodological approach guiding the research. The chapter is divided into three sections. First, I assess the empirical data on medical migration, including on why doctors migrate, the costs and benefits to sending and receiving countries as well as to the migrants themselves, and how these factors play out on global, national and local levels. Second, I introduce three key theoretical traditions on which I draw throughout my analysis, namely the Migration-Development Nexus, the New Economics of Labour Migration (NELM), and transnationalism. The main

insights I extract from these is that migration is not confined to a single individual, a clearly demarcated point in time, or two (sending and receiving) countries. Rather, it forms part of a 'transnational social space' which involves a myriad of different social actors and institutions, and is an ongoing process which starts long before the actual physical move, and continues to inform migrants' trajectories after they have settled in a new country. Third, I outline the main tenets of my methodology, and why it is suitable for my subject matter. Special attention is given to the 'biographical approach', which I connect to my previous discussion on NELM and transnationalism.

3. Policy Context: In this chapter, I begin with a deconstruction of the term 'overseas doctors', where I argue that the dichotomy between the superiority of UK/EEA doctors and the inferiority of overseas doctors is naturalised through the process of othering. I then briefly outline the most relevant policy developments from the inception of the NHS to the late 1990s. This is followed by an in-depth examination of policy developments from 1997 to the present in three policy areas: NHS recruitment, immigration policy and international development. I argue that the policy landscape changed dramatically during this period, from being relatively open and accommodating to overseas doctors to closing down and becoming increasingly hostile. By comparing developments in these three areas, I demonstrate how the policy priorities of the Department of Health and UK Border Agency – namely, staffing levels and border control, respectively – trump efforts of the Department of International Development to introduce policies based on circular migration and transnationalism.

4. Career Development – Racism, Discrimination and Opportunity: This chapter examines the main distinguishing features of Nigerian doctors' career development within the NHS. First, I assess how racism and discrimination impacts on the career development of Nigerian doctors in England. This takes a number of forms: 1) casual racism from patients and colleagues, with comments such as "which jungle are you from?"; 2) institutional racism, and the various structural constraints on career advancement; 3) complaints procedures and disciplinary measures, as a sub-section of institutional racism; 4) Nigerianness, otherness and cultural racism. Second, I will discuss the positive elements of training in England related by many interviewees, and how they learned valuable skills which could be applied to transnational activities to help develop the health sector in Nigeria. Although this was often the result of the actions of a benevolent individual – most interviewees said that they felt disadvantaged in the system, and were only able to overcome this by someone giving them a lucky break – most interviewees also said that their time in England had allowed them to develop professionally to an extent which was impossible in Nigeria.

5. Transnational Links and Development: Many (albeit not all) interviewees aimed at specialist training in the NHS with the explicit intention to learn skills that could be useful back home. In this chapter, I will examine how Nigerian doctors, both in the UK and in Nigeria, engage in transnational activities in order to contribute to the development of the Nigerian health sector. This section will build on the previous two chapters to look at how policy and discrimination impacts in various ways on the transnational links available to them. This includes visa restrictions, exclusion from networks, and the lack of a coordinated

hub to synchronise their efforts. Importantly, it was the most established doctors who were in a position to make the biggest commitment, exactly because they were established and had amassed enough gravitas and clout to make demands of their employers. One senior surgeon, for example, renegotiated his contract with his NHS trust, allowing an additional two weeks leave to practice in Africa. Those who were not yet established, however, often felt they lacked the authority to make such demands. Thus, even when there is passion and motivation to contribute back home, much of the time where they are establishing themselves is wasted, and of course some never get properly established. However, there were also ways in which they were able to circumvent these barriers, and engage in other ways such as blogging, coordinating UK based initiatives, or direct communication with colleagues back home.

6. Returning Home: This chapter is dedicated to the Nigerian fieldwork, and examines how returnees use skills, knowledge and contacts from their time in the UK in their own work back in Nigeria. I outline the various ways in which experience gained in the UK is used in Nigeria to develop the health sector, such as setting up or advancing specialised units, partaking in training of medical students, and acting as a bridge between British colleagues and Nigerian health initiatives. Special attention will be given to the Nigerian context, and the various challenges they face in their work. This includes funding issues and inadequate infrastructure, lack of support from the government, and frustration about not using their skills to their full potential. Conversely, many interviewees kept in close contact with their British colleagues, and were able to draw on their contacts in their work.

7. Conclusions: Here, I will draw together the main themes of the dissertation and discuss emerging issues. I identify three particular areas where my findings flag up gaps in the literature. Firstly, I argue that research on highly skilled migration has tended to gloss over the diversity of positions and experiences within this category, and that subsequently, the impact of 'race', racism and discrimination on their trajectories has been under-theorised. Secondly, I highlight how the transnationalism literature has tended to be too celebratory, often excluding the darker sides of transnationalism from analyses. Finally, I make the case that the theoretical model of 'transnational social spaces' is particularly well suited to researching the contours of the migration-development nexus.

2. Literature Review and Methodology

> African countries ... have only 3% of the world's health-workers although they represent 11% of the global population and endure 24% of the global burden of disease. (Onyebuchi Arah, 2007: 2)

Africa, England and Medical Brain Drain

As new and more reliable empirical evidence emerges, researchers are beginning to catalogue more confidently the impact of medical brain drain on the state of healthcare delivery in Africa. However, data remains inconclusive at best, hampered by the fact that "there exists no comprehensive and systematic bilateral database of the international flows of people for all countries, much less one that provides details about the migrants such as their occupation" (Clemens and Pettersson, 2008). Furthermore, the definition of medical migrants has been the subject of substantial academic debate, with some studies using country of training to define migrants (Docquier and Bhargava, 2006; Hagopian et al, 2005), but others using country of birth (Clemens and Pettersson, 2008). Each approach has its strengths and weaknesses: whereas country of training is well suited to measure loss of financial capital (such as investment in health professionals), country of birth is better placed to capture loss of human capital (such as losing your 'brightest and best' abroad). Whichever measure is used, however, continental comparisons clearly indicate that medical brain drain is particularly acute in sub-Saharan Africa. On average, 28% of doctors *born* in sub-Saharan Africa leave the continent (Clemens and Pettersson, 2008), whereas 20% of doctors *trained* in sub-Saharan Africa leave (Docquier and Bhargava, 2006). The vast majority of these doctors leave for a handful of OECD countries, most notably US, UK, Canada and Australia (Rutten, 2007: 20).

These general trends in sub-Saharan Africa are clearly observable in Nigeria. Again, different methodologies and unreliable data yield different results. Clemens and Pettersson (2008) estimate that in 2000, at least 14% of doctors born in Nigeria were working abroad. Ihekweazu, Anya and Anosike (2005), on the other hand, traced graduates from three consecutive years (1995-1997) from the College of Medicine of the University of Nigeria (UNN), and found that 40% were living abroad, predominantly in the US and UK. More recently, the Nigeria Medical Association (NMA) has estimated that out of "65,000 doctors registered in Nigeria, only 25,000 are currently practising in the country" (Kehinde, 2013), and the President of Lagos State University Teaching Hospital (LASUTH) has estimated that Lagos State – with a population of over 17 million – has less than 2,000 practicing doctors (News Agency of Nigeria, 2013).

Medical migration from sub-Saharan Africa throws up a number of issues for the topic of this study, with three key questions: why do health professionals migrate; who are the winners and losers of medical migration, and why; and what kind of strategies and solutions would achieve a win-win-win situation (for sending country, receiving country and migrant)? As policy implications will be discussed in detail in subsequent chapters, I will focus here on the first two points.

Doctors and Nurses

My original idea was to look at overseas health professionals in its widest sense, incorporating doctors, dentists and nurses. During the course of writing the literature review, however, it became clear that this was an overly ambitious task for a PhD thesis. The differences in background and circumstances between these different professions were too great. From a source country perspective, more nurses leave sub-Saharan Africa in raw numbers than doctors – 53,000 nurses against 37,000 doctors – but the proportion of doctors leaving is considerably higher – 28% of doctors against 11% nurses (Clemens and Petterson, 2008). Furthermore, training a doctor is significantly more costly than training a nurse, so the out migration of doctors represents a much greater loss of investment. At the other end of the migration chain, there are fundamental differences in the respective labour markets for medicine and nursing in the UK. Doctors are subjected to significantly more rigorous professional accreditation and scrutiny processes than nurses. Moreover, the medical career structure in the UK, where different routes within it will lead to different career outcomes, is more complex than it is for nurses. Ultimately, then, migratory and career trajectories are radically different for overseas doctors and overseas nurses. For these reasons, including dentists and nurses would essentially render the research comparative rather than descriptive and explanatory.

However, there are a number of similarities as well. These similarities are important in that they highlight how broader social attitudes towards migrants in general, and overseas health professionals in particular, impact on their life chances and migratory trajectories. Thus, in order to situate overseas doctors within wider contexts of medical migration, it is worth briefly highlighting some of the ways in which the experiences of overseas doctors and nurses overlap. As with doctors, overseas nurses have formed an integral part of the NHS since its inception, and nurses were recruited in great numbers from the commonwealth – particularly the Caribbean (Hardill and Macdonald, 2000: 684) – in the years following the second world war. In many ways, their treatment within the labour market is similar to overseas doctors. Olwig's (2015: 258) summary of the barriers facing nurses in Britain have an eerie resonance to the situation confronting doctors:

> Such problems included being channelled into the shorter training programme for practical nurses, even when they were qualified for the three-year programme training for registered nurses, being placed in low-prestige wards, such as geriatrics or psychiatry, and assigned to perform the least pleasant duties in the hospital, both during and after completion of their training.

Thus, doctors are not the only skilled staff who find themselves directed towards the jobs unpopular amongst British workers. On the contrary, evidence suggests that institutional racism operates at every level of healthcare delivery, with the 'snowy white peaks' of the NHS (Kline, 2014) surfacing amongst doctors and nurses as well as within governance and leadership.

Why Do Doctors Migrate?

The reasons underlying medical migration are complex, but the literature tends to talk about push and pull factors. Among the most cited push factors are low wages (Vujicic et al, 2004),

insufficient post-graduate training opportunities (Hagopian et al, 2005), career development (Kangasniemi et al, 2004), persistent shortages of basic medical supplies (Ahmad, 2005), and outdated equipment. Involuntary factors such as human rights violations, ethnic and religious tensions, political persecution, wars, and economic collapse are also cited as further push factors in some countries (ibid). Pull factors tend to mirror push factors, such as higher income and more buying power, better post-graduate training facilities and prospects for career development, access to enhanced technology, equipment and health facilities for medical practice, and living in economic and political stability (Astor et al, 2005).

The problem with these kinds of push-pull factor lists is that they often fail to connect the motivations and opportunities of individuals to wider structures which allow medical migration to happen on a massive scale. Indeed, de Haas points out that push-pull lists are "ad-hoc explanations forming a rather ambiguous depository of migration determinants" (de Haas, 2008: 9) and that ultimately, "the push-pull model is a *static* model focusing on external factors that "cause" migration that is unable to analytically situate migration as an integral part of broader transformation *processes*, and therefore seems of limited analytical use" (ibid: 11; original emphasis). Thus, push and pull factors influencing North-South migration are meaningless unless they are analysed in the social, political and economic contexts of both sending and receiving countries, as well as the dynamic relationship between the two. In other words, understanding the social significance of medical migrants' motivations, to draw on Castles and Delgado Wise's (2008: 9) observation,

> means developing a comprehensive analysis, which examines each specific phenomenon (such as migration) in the broad context of the overall dynamics of North-South relationships, and the interactions of the various spatial levels (local, regional, transnational, etc.) and societal areas (economy, culture, politics, etc.). In other words, migration cannot be understood adequately in isolation, but only as one integral aspect of the complex problems and challenges of contemporary global capitalism.

Who are the Winners and Losers of Medical Migration?

Problematising medical migrants' agency, aspirations, motivations and perceptions, and analysing these in broader contexts, leads to the second issue: the unequal distribution of the costs and benefits of medical migration, and how social, economic and political structures shape these outcomes. Much of the literature, especially in economics, applies a cost-benefit analysis to this question.

In terms of sending countries, there are three main areas of concern. Firstly, the depletion of health professionals leads to a loss of health services available, which is problematic for the obvious reason that the health sectors in sub-Saharan African countries already struggle to provide even basic healthcare to large parts of their populations (Connell et al, 2007). Out-migration of medical staff also represents a huge loss of investment for poor countries. Indeed, Mills et al (2011) estimate that Nigeria's loss of investment stands at $654 million. Secondly, health professionals – particularly physicians – play a pivotal leadership role in health sector institutions, and ensure that they develop effective strategies to advance public health. The loss of those who would lead and promote improvement of the health sector means that progress in this elementary development sector is massively reduced.

Finally, the migration of health professionals drains sending countries of an important component of the middle class. Physicians in West Africa, for example, are often leading social and political figures who are seen as contributing to the stability of the region (Hagopian et al, 2005). Bearing in mind these massive costs, there is a general consensus that the benefits of medical migration – chiefly remittances and brain gain through return migration – pale in comparison. Remittances in no way compensate for the loss of investment by sub-Saharan African countries and are by and large for private consumption rather than being reinvested in the health sector (Stilwell et al, 2003). Furthermore, skilled migrants are generally less likely to send home remittances. Doctors, for example, send fewer remittances than nurses (Connell, 2010: 152). As to skills transfer and social remittances, there is little evidence to suggest that return migration by health professionals is happening in any significant way, or that it is making an extensive and sustainable contribution to the development of the health sector in countries such as Nigeria.

At the other end of the migration line, receiving countries have a lot to gain from medical migration. Training health professionals is protracted and costly. In the UK, training a junior doctor takes 5-6 years and costs £220.000 (Rutten, 2007: 24). The estimated 12,000 African doctors registering with the GMC between 2000-2010 (Blacklock et al, 2012) will therefore have saved the British state more than £2.6 billion in medical training alone. In a health service which has suffered chronic staff shortages since the mid-1980s, medical migration allows quick relief to short term staff shortages at a minimal cost. Furthermore, Ahmad (2005) argues that the international makeup of the medical work force stimulates innovation in the health service and makes it more globally competitive.

Migration also promises significant benefits to medical migrants themselves, but often at a significant cost. As mentioned above, career development is recognised as an instrumental pull factor, in many cases considered more important than increase in wages. However, as they are habitually filling acute staff shortages, they often find themselves channelled into jobs below their skill level, or into specialisms not of their own choice (BMA, 2004; Raghuram, Henry and Bornat, 2010). Many also face racism and discrimination in the workplace as well as in everyday life (Hagopian et al, 2005).

As with push-pull factor lists, these kinds of cost-benefit analyses are helpful but ultimately unsatisfactory, and for similar reasons. The question of *how* and *why* the benefits of medical migration are so unevenly distributed are complex; in order to understand the nature of the problem, as well as think about solutions, it is necessary to take a holistic approach and look at the entire migratory process (Glick Schiller and Faist, 2010), connecting the experiences of overseas doctors to global, national and local contexts and processes.

Global context

Global migration of the highly skilled has increased "at about the same pace as trade, and has recently increased even more rapidly" (Docquier and Rapoport, 2009: 680). Medical migration follows this trend, and "given the rapidly growing global health care industry and the likely removal of some of the regulatory barriers to such trade at the regional, multilateral, and the national levels, trade in health services is likely to take on greater importance in the future" (Chanda, 2001: 2). Central to this development is the General Agreement on Trade in Services (GATS) of the World Trade Organization, particularly Mode

4 which stipulates the 'movement of natural persons'. As Aginam argues, "developing countries lack the capacity and economic clout to negotiate equitable and favorable trade rules with industrialized countries" (Aginam, 2010: 144). As a result, "GATS would most likely further undermine the precarious health sector in most of Africa by facilitating migration of African physicians and nurses to the West" (ibid: 139).

However, the impact of Mode 4 of GATS has so far had negligible impact on the outflow of doctors from Nigeria, partly because OECD and EU countries have avoided making requests to low income countries on services in the social sector, including health, which "these countries' governments should utilize to nurture their development" (Bankole and Oyjejide, 2005: 1). In fact, there has been limited effort – and certainly little progress – in developing multilateral frameworks on medical migration, whether liberalising or regularising. As Newland (2003) argues, "International migration policy is marginalized to a remarkable degree within global, as opposed to regional, inter-governmental organizations" which "reflects the extent to which migration continues to be seen as an issue that lies firmly within the prerogatives of the sovereign state, as well as the reluctance of states to be bound by international agreements pertaining to migration". Thus, most aspects of migration policy are still seen as the domain of nation states, where each and every state wants to control its own borders and select which migrants are allowed to enter to live and work.

National context

These global issues are intricately linked to both national and local processes. On a national level, many aspects of migration policies in OECD countries have been constructed to allow or even encourage medical migration to fill labour shortages. Amuwo (2009: 46) makes the point that host society policies are "reluctant to publicly recognize their dependency" on skilled labour. Indeed, recent trends in OECD migration policies are explicitly designed to target 'the best and brightest' (Kapur and McHale, 2005).

The place of overseas doctors in the British immigration system is severely under-researched. The two principal studies in this area – Kyriakides and Virdee (2003) and Raghuram and Kofman (2002) – predate the introduction of the Points Based System (PBS), hailed as the "biggest shake-up of the UK's border security and immigration system for 45 years" (CLG, 2008: 10). However, the PBS represents more continuity than rupture. As Raghuram and Kofman (2002: 2071) argue, the major concern of immigration policy from the 1970s onwards "has been about how to limit immigration whilst allowing a small amount of skilled migration". This continues to be the guiding principle of the PBS, and impacts on overseas doctors in Britain in a number of ways. For example, changes to immigration policy in 2006 obliged NHS trusts to prioritise "the resident work force before recruiting from outside the EEA" (WorkPermit, 2006). Thus, the NHS Careers website advises overseas doctors that "Competition for training posts is high, particularly in certain specialties and in certain parts of the country. Training posts in the popular specialties and in popular places are likely to be filled by resident doctors from the UK or European Economic Area (EEA)" (NHS Careers, not dated), relegating posts available to overseas doctors to the least popular ones. Historically, these have tended to be in lower grades and less prestigious specialisms. The migration policy context is further problematised because of its relationship with NHS

recruitment policy; as domestic staffing levels fluctuate between scarcity and surplus, immigration policies on medical migrants periodically loosen or become more restrictive.

Furthermore, overseas doctors suffer the xenophobic stigma attached to migrants in Britain. The suspicion with which migrants are treated in the immigration system very much extends to them too. Kyriakides and Virdee (2003: 287) aptly refer to this double bind as the "saviour/pariah construct" of migrant doctors. On the one hand, there has historically been a widespread acceptance that "the Health Service would have collapsed if it had not been for the enormous influx of junior doctors from such countries as India and Pakistan" (Lord Cohen of Birkenhead, cited in Kyriakides and Virdee, 2003: 288-9). On the other, overseas doctors have long been associated with low standards. Throughout the latter half of the 20th century, the view that only British or European doctors practiced to acceptable standards gained traction; "all else would provide an inferior quality of service. The significance of this development was that the 'overseas doctor' was used increasingly as a euphemism for 'black doctor' whose medical standards were 'inferior' to those doctors signified as 'non-white'" (ibid). Thus, while "migrant doctors have played a key role in the maintenance of the NHS, discrimination has sustained a racially stratified system in favour of British doctors" (Esmail, 2007: 833). Renowned GP and chronicler of racism in the NHS Aneez Esmail concludes that for many overseas doctors, the defining features of their careers are "service and betrayal" (ibid).

Local context

On a more local level, discrimination and racism prevent many overseas doctors in the NHS to progress and develop their full potential. The NHS is highly dependent on medical migrants. Over 28% out of approximately 140.000 doctors in the NHS qualified outside of the EEA (NHS Confederation, 2011), and 75% of these come from low income countries (Mullan, 2005: 1811), the highest proportion in the OECD (see table 2).

Country	No. of Physicians per 100,000 Population	Total No. of IMGs	% of IMGs in Workforce	% of IMGs from Lower-Income Countries	% of IMGs from the Three Other Developed Countries
United States	293	208,733	25.0	60.2	6.5
United Kingdom	231	39,266	28.3	75.2	2.5
Canada	220	15,701	23.1	43.4	22.3
Australia	271	14,346	26.5	40.0	35.5

Table 2: Characteristics of IMGs in medical workforces of US, UK, Canada and Australia. Source: Mullan (2005).

This has been a central feature of the NHS since its inception. According to Raghuram and Kofman (2002), the expansion of the British welfare state post 1945 increased demand for third world labour, which was channelled into less desirable sectors:

> Labour was largely sought from Commonwealth countries with a legacy of British-influenced educational and training systems. The predominance of skilled migrants from Third World countries was particularly apparent in the UK health sector. This migration was facilitated and even encouraged as it was

> seen as mutually beneficial within the 'family' of Commonwealth countries. This quasi-official concept has survived as the underlying ideology to the present day (ibid: 2072).

Anwar and Ali's (1987) overview mentions several official reports in the 1960s and 1970s into overseas doctors in the NHS, and by 1981, one third of doctors in the NHS were trained overseas, primarily Commonwealth countries and Pakistan (ibid: 9). These old colonial ties are still instrumental in shaping the flow of medical migrants into the NHS. The vast majority of doctors in the NHS are Indian, but considering the sheer size of India's population, as well as the rapid development of its health sector, this is not entirely surprising. Proportionately to their size, however, a number of sub-Saharan African countries supply the NHS with a colossal amount of doctors. 14% of doctors born in sub-Saharan Africa work in the NHS, which represents half of all sub-Saharan African doctors abroad (Clemens and Petterson, 2008). The vast majority of these come from former British colonies, such as Nigeria, Kenya, Uganda and Ghana.

Studies on overseas doctors in the NHS are scarce, but those that have been conducted have shown that in spite of the NHS's high dependence on migrant labour, there is a long history of ethnic inequalities in the NHS labour force. Overseas doctors tend to be over-represented in lower grades, and under-represented in senior positions (Jones and Snow, 2010). The higher up the NHS hierarchy you look, the whiter the doctors become (BMA, 2004: 10). Overseas doctors are routinely channelled into lower grade jobs, and often have less control over the direction of their career development than their white British colleagues, leading to criticism that the NHS uses overseas doctors "to swell the ranks of apprentices, then kicking them back before they can become masters" (Bulstrode and Lourie, 1997: 260). Much of this is can be attributed to the way in which medical migrants plug short term gaps in the labour market, which logically exist in lower grades and less prestigious specialisms. Robinson and Carey (2000: 102) suggest that this is indicative of "an exploitative relationship between the employer (the NHS) and the migrant".

Although the ethnic penalty suffered by overseas doctors in the NHS suggests systematic discrimination, a narrow 'institutional racism' analysis would miss important nuances in the relationship between migration, race and ethnicity, and how these three concepts interact to affect labour market participation. The measure of economic and professional 'success' in Britain is equally shaped by social networks and social capital.[2] These concepts have been used widely in migration studies to explain how resources available through social bonds can have diverse effects across groups and locations, and generate variations in migration patterns for different groups at different times and places. However, the tendency of network analyses to focus exclusively on 'ethnic' ties leads to a reification of ethnic groups, where "migrants and their experiences come across as distinctive and different from non-migrants with either migration or ethnicity seen as offering the

[2] Much of the transnationalism literature employs the concept of 'social capital' in its analyses. This term, and how it is used in social science, has become the focus of considerable debate, with some scholars claiming that "it is a research term that already has a large literature without yet having generated much consensus" (Haynes, 2009: 2). I do not wish to enter into these debates, and will therefore avoid the concept in my thesis. I find the theoretical framework of transnationalism sufficiently robust without it.

cementing glue to the networks that migrants form" (Raghuram et al, 2010: 626). Such analyses divert "attention from social and economic relations across cultural differences and boundaries" (Pieterse, 2003: 5), thereby missing the overlapping nature of social networks. Raghuram et al (2010: 636) demonstrate how exclusion from non-migrant networks within the health sector can hamper overseas doctors' ability to convert their social networks into social capital. "They may participate in non-migrant elite networks but the ability to convert this participation into economic capital through jobs is often limited by the processes of closure" (ibid: 627).

The important point is that the experiences and trajectories of Nigerian doctors in the NHS may not be inducive to allowing overseas doctors to develop skills that could be useful to their country of origin, thus paving the way for turning brain drain into meaningful brain circulation.

Theoretical framework

The Migration-Development Nexus

In recent years, there has been a surge of interest within academic and policy debates about the impact of international migration on the development of poor countries, which has resulted in a substantial body of literature. As de Haas (2012) reminds us, in the flurry of recent scholarship on the migration-development nexus, it is easy to forget that the relationship between migration and development has been the subject of rigorous academic and policy debate for decades, and that "in postwar Europe, the debate on migration and development has swung back and forth like a pendulum between optimistic and pessimistic views" (ibid: 10), guided by theoretical trends and paradigm shifts.

Most importantly for the present study, however, the 2000s witnessed a revitalisation of interest in the development potential of migration. Crudely generalised, there is a disjuncture between those optimistic about the 'win-win-win' capacity of migration, and those for whom migration is yet another mechanism to maintain global inequalities. Portes (2007: 19) observes that this disjuncture "has disciplinary overtones, with sociologists and anthropologists, most often found in the pessimistic camp and economists, especially neoclassical ones and those guided by the "new economics" of migration, supporting a much more optimistic assessment." In policy circles – which tend to be influenced by economics more than sociology – migration has almost become a panacea where international aid has failed. Castles and Delgado Wise (2007: 7) call this the new 'Migration and Development Mantra'. The core of this mantra is migrant remittances (Kapur, 2004), reportedly dwarfing international aid (Kpodar and Le Goff, 2011). However, attention has increasingly turned to other potential beneficial effects of South-North migration. Macro-economic models of migration flows, population concentrations, and the commercial efficacy of transnational networks, along with cost-benefit analyses of migration and the role of policy in this equation, have highlighted a number of ways in which the globalisation of migration can be beneficial. These are summarised by Castles and Delgado Wise (2008: 8) to include the transfer of skills and attitudes – 'social remittances' – which support development by turning brain drain into brain circulation. Circular and return migration, so the argument goes, allows

migrants to learn new skills in their host societies that they bring home with them and utilise to benefit the sending country. Alternatively, migrant diasporas can be a powerful tool for development without return migration being needed, by establishing professional links between sending and receiving countries. Ultimately, this will result in a positive spiral where economic development "will reduce outmigration, encourage return migration, and create the conditions necessary to utilize the capital and know-how provided by diasporas" (ibid).

In theory, this line of argument may sound plausible, yet the evidence base for the link between migration and development remains weak (Newland, 2003). The developmental potential of migration is by no means self evident, and a number of social, economic and political factors interplay to influence success, or lack thereof, in activating the diaspora to contribute to the development of their home countries. There is no shortage of theorising on brain drain generally, or medical brain drain specifically. Yet in spite of decades of policy debates and academic research, concrete practical solutions have eluded policymakers and practitioners in the field, and the complex relationship between migration and brain drain is not adequately understood or theorised. It is here that sociologists tend to point out the shortcomings of macro-economic models, which make a number of assumptions about the nature of migration flows, as well as the behaviour migrants of themselves, which do not always ring true.

This is partly because researchers have only recently been able to say anything empirically meaningful about medical brain drain, "something which was out of reach until not long ago due to the lack of decent comparative data on international migration by educational attainment" (Docquier and Rapoport, 2009: 679). Thus, the pessimistic dependency theory models of the 1970s and 1980s, and the more hopeful outlook of the 1990s and 2000s, were largely constructed without a robust empirical evidence base, which in turn has hampered efforts to construct a coherent theoretical framework. Furthermore, researchers are inclined to apply a narrow lens to its subject matter, thereby missing wider social, cultural and economic contexts. For example, the causes and effects of migration tend to be researched and theorised separately, whereas "migration (1) is a process which is an integral part of broader transformation processes embodied in the term "development", but (2) also has its internal, self-sustaining and self-undermining dynamics, and (3) impacts on such transformation processes in its own right" (de Haas, 2008: 1-2).

Recently, a number of scholars have attempted to gauge the current state of theoretical progression on the migration-development nexus, and articulate areas that need to be developed and clarified in future research. De Haas (2012) argues that a nuanced analysis of migration and development must move beyond the dichotomies that have characterised much of the literature, where 'brain drain' is measured against 'brain gain', 'costs' against 'benefits', 'sending country' against 'receiving country', and 'negative' against 'positive'. More generally, Glick Schiller (2012: 96) calls for a 'global perspective' which interrogates "the ways in which institutions, opportunities and barriers for local, national and global transformation are everywhere mutually constituted within globe-spanning relationships of unequal power and transnational and translocal social movements of accommodation and contestation".

New Economics of Labour Migration and Transnationalism

De Haas (2008: 34) argues that a theoretical framework on migration and development "has to be able to account for the role of structure—the constraining or enabling general political, institutional, economic social, and cultural context in which migration takes place—as well as agency—the limited but real capacity of individuals to overcome constraints and potentially reshape the structural context." He suggests that the complexity and heterogeneity of migration-development interactions require pluralist theoretical orientations. I follow de Haas by drawing on two approaches particularly relevant for my research: new economics of labour migration (NELM) and the more recent focus on transnationalism.

Developed in the mid-1980s (see Stark and Bloom, 1985) as an antidote to rigid and individualised neo-classical models of migration, NELM moves away from the idea of migrants as autonomous individuals, making rational choices to maximise their income. Rather, the NELM approach places migrants firmly within a socio-cultural context where the household, rather than the individual, is the core decision-making unit. The economic impetus for migration is not an individual maximising his/her private gain, but families minimising risks by diversifying their sources of income. Thus, NELM considers social relations as its centre of analysis, and its main insight is to highlight the importance of non-economic factors as determinants. For example, migration networks are considered crucial to the development of migratory streams, where prospective migrants tap into their social ties for information and assistance, often throughout the migratory process. Furthermore, NELM stresses the importance of institutions and structural factors – such as policy, capital and relative deprivation – which had been neglected by the dominant neo-classical theories (Bakewell, 2007: 12). This makes NELM a sociologically powerful framework, as it firmly places the focus of investigation on social contexts, and allows variables such as information, social capital, and migrant networks and associations to form part of the analysis.

As a theoretical framework, NELM does not explicitly differentiate between levels of migrant skills, and implicitly focuses on manual or semi-skilled labour migration. In some ways, NELM is a limited tool for analysing highly skilled migration. Indeed, Nigerian doctors tend to belong to elite households for whom the need to diversify their sources of income is limited. However, Portes (2009) makes the crucial point that a key concept in NELM – relative deprivation – is well suited to analyses of professional migration. Relative deprivation, he argues, can influence the decisions of highly skilled migrants in two ways. Firstly, professionals can experience relative deprivation locally, where wage differentials with comparable professions "can create a powerful incentive to move abroad" (ibid: 13). Secondly, where local opportunities for professional development are inadequate or lacking, professionals may have little option but to seek opportunities elsewhere. "In these cases, the point of reference is professionals in First World countries, not because of their incomes, but because of their much better working conditions" (ibid: 14). This is important, because the literature on medical migration tends to overemphasise – and oversimplify – the role of wages as the primary 'push factor'. For Nigerian doctors in England, the reality is more composite, where a whole range of factors – including professional development, family ties, commitment to Nigeria, security, and emotional cost – are carefully weighed up against each other in constant evaluation of decisions. Even when the choice is stark, the underlying decision-making process is complex and intricate – hence Anya's (2010) multifaceted

dilemma whether "to continue to struggle to build up a faltering health system; to seek professional opportunities elsewhere; or to leave medicine".

Similarly, transnationalism calls into question many previous assumptions about the nature of migration. Rather than seeing migration as a simple movement of individuals and groups from one place to another, transnationalism takes a holistic view of migratory routes. Stressing spatial and temporal continuity and connections, transnationalism sees migration as an ongoing project which allows sustained exchanges across borders of not only people and capital, but also ideas, resources and practices. In other words, "Transnational migration is a process rather than an event" (Levitt and Glick Schiller, 2004: 1012). Faist and Fauser (2011: 1) argue that the transnational perspective "captures both the cross-border ties and engagements these actors sustain and the role played by institutions on the local, national and global level".

In the following chapters, I seek to locate the experiences and trajectories of Nigerian doctors within these wider contexts. It should be noted that the literature on transnationalism is colossal, with a vast amount of theoretical constructs and concepts, not all of which are relevant to the present study. I have therefore been selective in which tools I use from the transnational toolbox; rather than attempting here a comprehensive review of the literature, I confine myself to discussing the theories and concepts most suitable to my analysis. With this caveat, I consider the transnational lens to be appropriate for a number of reasons. Firstly, transnationalism undermines simple categories of 'home/sending' and 'destination/receiving' countries, and problematises concepts like 'permanent', 'temporary' and 'circular' migration. From this perspective, migrants can contribute to their home countries in many different ways; involvement is not dependent on 'return', but can be sustained even where migration is 'permanent'. This allows me to explore how Nigerian doctors use transnational processes and institutions to contribute to development in Nigeria without actually moving back. Secondly, transnationalism proposes that people can belong and commit to more than one place. Migrants who invest time and resources to establish themselves in their host country are not necessarily eroding their commitment to their home country. The opposite can actually be true, where success in the host society increases the migrant's capacity to contribute back home in meaningful ways. Raghuram et al (2010) maintain that access to non-migrant networks is a key factor in influencing labour market outcomes for overseas doctors, which in turn will shape their 'social remittances' capacity. Thirdly, transnationalism scholarship connects the emergence of transnational activities to the logic of capitalist expansion (Portes, Guarnizo and Landolt, 1999: 228). This is important, because global capitalism is intricately linked to the sharp increase in medical migration. The migration patterns of Nigerian doctors is influenced by global demand, and sustained by agencies and mechanisms specifically designed to meet the needs of the health care market.

Transnationalism also provides an antidote to what Glick Schiller (2005; 2007) calls 'methodological nationalism', where researchers "bring their ethno-gaze into their theories of society, as if everyone is always and necessarily constrained by some form of culturally based and ultimately territorially linked identity" (Glick Schiller 2005: 442). This, Glick Schiller argues, leads to a limited picture of transnational processes, where important connections fall outside the myopic focus on ethnic group and identity as the principal unit of analysis. Thus, methodological nationalism leads to:

> (1) the homogenization of national culture (2) the homogenization of migrants into ethnic groups – seen as bearers of discrete cultures – who arrive bearing cultural, class, and religious differences, and (3) the use of national statistics organized so that ethnic difference appears as an independent variable in the reporting of levels of education, health status, degrees of employment, and level of poverty. (Glick Schiller 2007: 43)

Glick Schiller's caution is valid and important, and my narrow choice of subject matter – Nigerian doctors in England – could easily fall into the trap of methodological nationalism. There is, however, the danger of throwing the baby out with the bathwater. As Castles and Miller (2003: 16) argue, both scholarship and policy tend to view migration and ethnic diversity as two separate issues. Guarnizo and Smith (1998: 10) link this tendency in migration studies specifically to transnational scholarship when they remind us that "transnational actions are bounded in two senses—first, by the understandings of "grounded reality" socially constructed within the transnational networks that people form and move through, and second, by the policies and practices of territorially-based sending and receiving local and national states and communities". Thus, disconnecting ethnic/national identity entirely from migration risks falling back into the postmodernist trap of considering "transmigrants as unbounded social actors ... implying their total disconnection from local constraints and social moorings" (Guarnizo and Smith 1998: 12). In these local constraints and social moorings, ethnic and national identity remain important structuring factors, albeit not the only ones. Thus, the flip side of Glick Schiller's (2005: 442) coin where "certain transnational connections have remained understudied and need to be examined and theorized" is a situation where scholarship misses "the enduring asymmetries of domination, inequality, racism, sexism, class conflict, and uneven development in which transnational practices are embedded" (Guarnizo and Smith 1998: 6). Both insights are important to this study. The transnational activities of Nigerian doctors in England certainly extend far beyond their own 'ethnic group', spanning migrant doctors of other nationalities and in other countries, colleagues in the royal colleges, and NGOs in England, Nigeria and worldwide. At the same time, however, 'Nigerianness' – both real and imagined – has a colossal impact on their migratory journeys and their capacity to engage in transnational activities. Therefore, I take my cue from Guarnizo and Smith (1998: 12) to "underline the actual mooring and, thus, boundedness of transnationalism by the opportunities and constraints found in particular localities where transnational practices occur".

Although transnationalism is a promising framework for the study of migration and development, it also has its pitfalls. Chief amongst these is that the literature has a propensity to be too optimistic, with a "tendency to conceive of transnationalism as something to celebrate, as an expression of a subversive popular resistance "from below."" (Guarnizo and Smith, 1998: 5). Faist's (2010: 11) list of migrant practices typically researched under the rubric of transnationalism is demonstrative of this tendency:

> These include, to give only a few examples, reciprocity and solidarity within kinship networks, political participation not only in the country of emigration but also of immigration, small-scale entrepreneurship of migrants across borders and the transfer and re-transfer of cultural customs and practices.

Conspicuous by their absence from this list are any social practices, processes or institutions which impact negatively on the ability of migrants to engage as social agents. Whereas transnationalism has produced a substantive body of work which focuses on the ways in which transnational activities take place, the institutions and mechanisms that stop them from happening have received much less attention. Thus, de Haas's (2008: 19-20) critique of social capital and network theory, which "do not indicate what are the external, structural factors as well as internal processes that counteract the tendencies that lead to increasing migration through networks", can be extended to transnationalism as well. Of particular importance for the present study, little has been theorised on how 'race', ethnicity and nationality interplay to impact on migrants' abilities to engage in transnational activities. As Ike Anya (2010) laments, "I wish it were easier for me to share my skills. It seems all or nothing with migration. You either stay or you go. Very rarely can you reach a middle ground." His impasse is shared by fellow African doctors, but escapes European ones. It is therefore perhaps the case that transnationalism over-states the point of fluidity. For Nigerian doctors, a highly racialised policy landscape and a harsh and discriminatory labour market can make this kind of fluidity difficult. For many of them, migration *does* become a once-and-for-all movement, at least in the short term. Even when avenues for transnational activities widens with time – as a result of, for example, a more secure immigration status or stable career prospects – the short term 'either/or' characteristic of medical migration to Britain can have long term consequences. Thus, there can be varying degrees of transnational activity, and an analysis of a particular transnational social space will need to consider how the wider social and economic landscape impacts on migrants' ability to engage in transnational processes, which social phenomena influence their trajectories, and how this changes over time.

Rather than directly undermining or contradicting the transnational framework, these limitations are attributable to inadequate academic attention to 'race' and racism, and forms part of the ongoing project of refining theory and adding to knowledge. Therefore, in spite of its limitations, transnationalism remains an exceptionally useful analytical framework for exploring the opportunities and constraints of highly skilled migrants – such as Nigerian doctors in England – to make a contribution to development in their countries of origin. For the purposes of the present study, the concept of 'transnational social spaces' is particularly apt. Most fully developed by Faist (2000a; 2000b), transnational social spaces refer to:

> combinations of ties, positions in networks and organizations, and networks of organizations that reach across the borders of multiple states. These spaces denote dynamic social processes, not static notions of ties and positions. Cultural, political and economic processes in transnational social spaces involve the accumulation, use and effects of various sorts of capital, their volume and convertibility: economic capital, human capital, such as educational credentials, skills and know-how, and social capital, mainly resources inherent in or transmitted through social and symbolic ties. (Faist 2000a: 191)

Parallel definitions, with different analytical foci and methodological orientations, have been developed by other scholars. For instance, Levitt and Glick Schiller (2004) refer to 'transnational social fields', and Guarnizo (1997) uses 'transnational social formations'. However, the strength of Faist's formulation is that it allows different levels of analysis to

form part of the inquiry. As Kivisto and Faist (2010) point out, Portes, Guarnizo and Landolt's (1999) emphasis on individuals and families is a methodologically useful point of departure, but their analytical approach does not "lend itself to a fuller theoretical articulation of the nature of the relationship" (Kivisto and Faist, 2010: 141) between 'transnationalism from above' – such as "transnational capital, global media, and emergent supra-national political institutions" (Guarnizo and Smith, 1998: 3) – and 'transnationalism from below' – such as "the informal economy, ethnic nationalism, and grassroots activism" (ibid). Similarly, Glick Schiller and Fouron (1999: 344) place the individual at the analytical centre of the 'transnational social field':

> A social field can be defined as an unbounded terrain of interlocking egocentric networks. It is a more encompassing term than that of network which is best applied to chains of social relationship specific to each person ... The concept 'transnational social field' allows us a conceptual and methodological entry point into the investigation of broader social, economic and political processes through which migrating populations are embedded in more than one society and to which they react.

Although it is not explicitly stated, both the 'fields' and 'formations' definitions are intellectually related to Bourdieu's concept of 'habitus' in that they are defined by the individual migrant, where the object of analysis is her/his position within the social structure. In this sense, Faist deliberately differentiates his formulation by using 'space', which he draws on from a different theoretical tradition:

> Space here does not only refer to physical features, but also to larger opportunity structures, the social life and the subjective images, values, and meanings that the specific and limited place represents to migrants. Space is thus different from place in that it encompasses or spans various territorial locations. It includes two or more places. Space has a social meaning that extends beyond simple territoriality; only with concrete social or symbolic ties does it gain meaning for potential migrants. (Faist, 2000b: 45-46)

Thus, Faist takes a more sociocentric view than his colleagues. By purposefully including social actors and institutions such as immigrant communities, civil society and nation states, Faist (1998: 217) is able to connect:

> the various forms of resources or capital of spatially mobile and immobile persons, on the one hand, and the regulations imposed by nation-states and various other opportunities and constraints, on the other; for example, state-controlled immigration and refugee policies, and institutions in ethnic communities.

This is an important insight, because the opportunities and constraints on transnational activities of Nigerian doctors are not confined to different levels of analysis. On the contrary, they can form part of 'transnationalism from below' (eg interaction with colleagues back home), 'transnationalism from above' (eg inequities in the global medical labour market), or in between (eg involvement in the international operations of the Medical Royal Colleges). As these different levels often interact and can be interdependent, they form part of a single transnational social space. A central aim of my thesis is to explore how "nation-states and

various other opportunities and constraints" (ibid) – such as NGOs, hospitals, immigration policies and institutional racism – shape Nigerian doctors' migratory trajectories, and how these external social actors impact on their abilities to engage in transnational activities. For this reason, I will follow Faist's sociocentric approach and use the term 'transnational social spaces' throughout the thesis.

Faist's formulation of transnational social spaces has allowed him to explore the place of migrants within the migration-development nexus. Faist (2008: 27) notes that:

> in recent years the notion of migrants' return as an asset of development has been complemented by the idea that even if there is no final return, the commitment of migrants living abroad could be tapped, not only, for example, through hometown associations but also through informal 'diaspora knowledge networks'

These knowledge networks are particularly important to this study. Indeed, only one of my interviewees reported being involved in hometown associations, and even for him, this was a fairly peripheral pursuit. However, what the doctors did engage in were various types of networks whose explicit purpose was to share and disseminate medical knowledge. These could range from loose and informal networks based on kinship ties to more structured and formalised organisations, such as sub-divisions of medical colleges, both English and Nigerian. In his examination of the role of migrants as transnational development agents, Faist (ibid: 31-32) gives special attention to what he calls 'epistemic networks' and their relationships with big players in development, such as international NGOs and governments:

> Scientists and professional experts share common models, theories, and sometimes even lifestyles characterised by high geographical mobility. The flow of ideas is ensured by reciprocity as exchange and reciprocity as a social norm. Recently, major political actors such as international organisations and state governments have started to focus on not only the emigration, re-migration or return of highly skilled professionals, but also on the formation of transnational networks. This shift of perspective is partly a result of the fact that while many of those categorised as highly skilled do not return to the regions of origin, they nonetheless form border-crossing epistemic networks and associations, which also sometimes extend into the countries of origin.

Nigerian doctors in England may or may not be formalised enough in their organisation to qualify for Faist's idea of epistemic groups, but the concept is nevertheless useful, particularly in the way epistemic groups transmit social remittances. "Epistemic networks and associations provide club goods, as distinct from private goods and public goods" (ibid: 34), which is important because doctors transmit and receive medical knowledge in the spirit of exchange and reciprocity, based as it is on an ethos of a 'community of practice' (Farrar, Hotez and Junghanss, 2013: 1278). Thus, knowledge shared through the 'club' of medical practitioners is then put into practice in Nigeria, to the benefit of the Nigerian public.

Importantly, Faist takes great care not to single out networks as an autonomous, or for that matter the most important, unit of analysis. Indeed, he concludes that although transnational groups, associations and organisations do play an important part in transmitting remittances – both social and financial – ultimately states have the power to structure the

crucial policy agendas of "migration control, immigrant incorporation and development cooperation" (Faist, 2008: 23), all of which impact greatly on transnational social spaces. Rather than seeing the nation state merely as something under threat from transnationalism, as well as diametrically opposed to it in conceptual terms, Faist argues that it should be seen as an actor in transnational social spaces, and a powerful one at that. Thus, "the concept of the national state or nation-state is critical to defining the opportunity structures in transnational social spaces and transactions connected to development" (ibid: 37). This relates directly to transnational social spaces as formulated by Faist, where each unit of analysis, at different levels of operation, form part of a single transnational social space:

> Transnational social spaces consist of combinations of social and symbolic ties and their contents, positions in networks and organisations, and networks of organisations that cut across the borders of at least two national states. In other words, the term refers to sustained and continuous pluri-local transactions crossing state borders. (ibid.: 23)

In order to accurately understand and describe this space, all units of analysis and their relationships to each other must be considered. In essence, then, this study heeds Faist's call for more attention "to be paid to how states structure transnational social spaces, for example, through the regulation of transnational migration" (Faist, 2008: 36). In doing so, I highlight how a number of social markers – such as 'race', ethnicity and nationality (which, it should be noted, Faist does not discuss) – impact on the relationship between migrants and states. If states influence the structure of transnational social spaces, they are themselves structured by particular understandings of these social markers.

My particular focus on the how the state regulates migration, and its impact on transnational social spaces, warrants a brief examination of citizenship. This is because specific notions of citizenship play a central role in the state's project to regulate and control not only immigration, but also the rights and responsibilities – and by extension the life chances – of immigrants once they have received clearance to live and work within the state's jurisdiction:

> ...immigration and citizenship law do not simply control the movement of 'migrants', but they are critical to the production of migrants and of citizenship as a social field. The law does not just give immigration flows a particular character but actively produces social relations. These social relations are premised on a citizen/non-citizen binary and on multiple differentiations between non-citizens. (Anderson, 2015: 43)

From a global perspective, as Anderson (ibid: 42) notes, the imbalances inherent in the rights which citizenship bestows depending on the state a citizen belongs to are "of crucial importance in a world of growing inequality. The resources to which citizens have access by virtue of their citizenship vary considerably, depending on the state. A citizen resident in, for example, Sweden can expect a very different level of state provision than, for example, a citizen of Liberia." Thus, citizenship is arguably a lottery of birth or a feudalistic privilege, "a status which for many is not attained on merit, and it results in substantially different life chances" (ibid). This includes differential access to live and work within the sovereign territories of different nation states, but also impacts on various aspects of migrants' lives once

access has been granted, such as uneven access to labour markets and disparities in labour market outcomes, or restricted rights to welfare and benefits. Thus, "immigration controls are as much about the construction of the internal borders of nation states as they are about the construction of external borders" (Shutes, 2015: 58). On a more national/local level, therefore, it is necessary to examine the different components which constitute the non-citizen category. If there are "multiple differentiations between non-citizens" (Anderson, 2015: 43), how are they played out along the lines of – for instance – 'race', gender and class? Dealing specifically with 'race' and racism, Sharma (2015: 99; original emphasis) argues that citizenship regimes are indeed replete with racialised understandings of social organisation:

> ...it is important that we understand the national form of state power as one that *inherently* organizes human 'society' *as a racialized community*, one in which citizenship operates to create a positively racialized 'nation' and a negatively racialized other. Such practices are profoundly consequential. In our world of nation-states, rights largely flow from *which* national citizenship one has as well as on whether or not one holds the status of national citizen in the places one lives and works.

Thus, the manifestation of the citizen/non-citizen binary within medical migration policies in Britain, as well as the ways in which this manifestation is employed by the British state and the NHS to meet their policy objectives, requires a careful unpicking. As we will see in Chapters 3 and 4, British government departments employ a variety of terms – such as International Medical Graduates (IMGs), overseas doctors, and medical migrants – to denote and reify the non-citizen status of doctors from outside of the UK/EEA. Furthermore, I will show how these processes have strong racialised undertones.

Another key concept on which I draw extensively in my analysis is 'social remittances'. Coined and developed by Levitt (1998; 2001), this notion has theoretical roots in transnationalism, and is a useful tool to explain how non-economic factors can form part of the development potential of diaspora groups. In essence, migration is a learning experience, where migrants add new norms, practices, identities and social capital (Levitt, 2001) to their repertoire of knowledge. In Levitt's formulation, there are three types of social remittances: 1) normative structures, which are "ideas, values and beliefs" (Levitt, 1998: 933); 2) systems of practice, which are "the actions shaped by normative structures" (ibid.: 934); and 3) social capital, which is based on the values and norms (ibid.: 935). Through cultural diffusion, these are transmitted to the sending country "between individuals, within organisations by individuals enacting their organizational roles, or through the looser, informally-organized groups and social networks that are connected to the formal organizations" (ibid: 936). Social remittances are key to discussing how Nigerian doctors contribute to development back home. Although some of my interviewees reported sending money back home, this did not feature in their accounts of contribution to development. Rather, they conceived of their own developmental potential in terms of how they could use the medical knowledge and skills they have amassed in England to inform practice back in Nigeria. In this way, social remittances are part and parcel of their transnational social space; Nigerian doctors' location within this transnational social space impacts both on the social remittances they are able to send, as well as how effectively they can transmit them.

If transnationalism offers a holistic theoretical approach to migration and development, this perspective can also lead to practical solutions to policy dilemmas. Glick Schiller (2012: 95) offers a number of ways in which a transnational research agenda can make a substantive contribution to public policy. These range from highlighting the roles migrants play both in their host countries as well as back home, to investigating the institutional infrastructure needed for successful diaspora engagement in development processes. Similarly, Portes (2007: 19) outlines five general principles – rooted in a transnational framework – for migration to lead to a win-win-win situation:

1. Cyclical labour flows, both of professionals and of manual workers, are generally preferable to permanent out-migration.
2. The cyclical character of migration should be grounded on a schedule of real incentives in both receiving and sending nations, so that return is voluntary and not coerced.
3. Governments of advanced nations should seek to cooperate with their sending country counterparts in creating the necessary infrastructure of health, education, and investment opportunities for families of migrant workers to remain at home and for migrants to be motivated to return.
4. Similar support should be provided in the construction of scientific and technological facilities which can receive returned migrant professionals and benefit from their knowledge transfers.
5. For migrants who settle permanently abroad, facilities should be created so that they can transform their journey into a cyclical one themselves through transnational investments and philanthropic activities at home.

I would add to this a sixth principle of migrants' rights. As de Haas (2012: 20) argues, restrictive immigration policies – aimed at reducing migrants' civil, residency and socio-economic rights – can intensify a number of risk factors for migrants, who as a result can be less inclined to engage in transnational activities. In a similar vein, Skeldon (2012) argues that poverty alleviation and migrant empowerment is linked to mobility, where motile flexibility to respond to changing social and economic conditions is key. Thus, for migration to work effectively for the development of sending countries, migrants must have fixed and absolute rights, securing equal access to the labour market and risk free mobility.

Finally, transnationalism also offers a substantive methodological point of departure. As a research programme, one of its strengths is that it connects everyday life on a micro-level to the meso- and macro-levels of social structures. Portes, Guarnizo and Landolt (1999: 220) argue that the most effective way to understand the institutional foundation of transnationalism is to study the life-histories, trajectories and activities of individuals: "From data collection based on individual interviews, it then becomes possible to delineate the networks that make transnational enterprises possible, identify the transnational entrepreneurs' counterparts in the home country, and garner information to establish the aggregate structural effects of these activities." They add that other units of analysis, "such as communities, economic enterprises, political parties, etc also come into play at subsequent and more complex stages of inquiry", especially when the aim is to contextualise the experiences of individuals in "their networks of social relations, their communities, and broader institutionalized structures such as local and national governments" (ibid). However, Guarnizo and Smith (1998) find this micro-structural starting point problematic. They argue

that "in privileging “personal knowledge,” researchers may develop a kind of solipsistic tunnel vision that altogether fails to connect human intentions to social structure and historical change" (Guarnizo and Smith, 1998: 25-26). Rather, they argue that transnational processes are in their nature complex social phenomena, which need to be approached from a meso-structural point of departure, "the point at which institutions interact with structural and instrumental processes. This would facilitate incorporating into one’s analysis both the effects of macrostructural processes and those generated by microstructures and practices" (ibid: 25). Both approaches have merit for the present study. My central focus is the migratory trajectories of Nigerian doctors, and how they themselves conceive, experience and 'do' transnationalism. Placing their perspectives front and centre is therefore methodologically imperative. At the same time, their experiences must be contextualised within wider frameworks of opportunities and constraints in order to avoid both Glick Schiller's (2007) methodological nationalism and Guarnizo and Smith's (1998) solipsistic tunnel vision. In this way, I hope to incorporate both structure and agency (cf de Haas, 2008: 34) into my analysis.

Methodology

My methodological approach builds on the insight from NELM and transnationalism that migration is not an individual process, but is influenced by a myriad of social relations. In order to draw as conclusive a picture as possible, the subject was approached from a variety of different angles. Qualitative interviews were conducted with various types of social actors, supplemented with quantitative data and policy documents. Fieldwork was conducted in England between September 2012 and April 2013, and in Nigeria during July 2013.

Data

In order to provide a broad socio-structural context, I have drawn on a number of secondary quantitative datasets and previous qualitative analyses. These include information on: the demographic profile of the Nigerian community in Britain (2011 Census; Labour Force Survey); highly skilled/medical migration to Britain (National Shortage Occupation List; List of Registered Medical Practitioners); Work Permit data from the UKBA; medical migration from Nigeria (Nigeria Medical Association); international highly skilled/medical migration (IOM; WHO). The statistical data is useful to contextualise my own qualitative material and to confirm the validity of individual experiences of racism, discrimination, immigration regulation, and so on.

With the aim of gaining insight into the structural constraints influencing the doctors’ experiences, relevant policy documents on medical migration to Britain were analysed in depth, specifically policies emanating from the Department of Health (recruitment policies and ethical guidelines), the UK Border Agency (the transition to the Points Based System as well as the ‘brightest and best’ approach to migration and the restrictions on who will be allowed to settle permanently in Britain) and the Department for International Development (circular migration and NHS involvement in international development). Particular attention was given to the development of these policies since 2000. It should be noted that healthcare in Britain is largely devolved, and for this reason I decided to focus solely on England. Some of the policies discussed here are therefore exclusive to England, whereas others concern

Britain as a whole. Policies were analysed following van Dijk's (1993: 249, original emphasis) paradigm on critical discourse analysis by "focusing on *the role of discourse in the (re)production and challenge of dominance*", which van Dijk defines as "the exercise of social power by elites, institutions or groups" (ibid: 249-50). I found this approach particularly useful, as van Dijk highlights "the ways in which racism is being reproduced in western societies through parliamentary discourse. Although seldom blatantly racist, such more or less 'moderate' discourse may nevertheless enact white group power ... while at the same time manipulating the public mind in such a way that ethnocentric or racist policies can be legitimised" (ibid: 280). Thus, the analysis of policies within the three policy agendas relevant to this study is "primarily geared towards the demystification of the self-proclaimed ethnic and racial tolerance of the elites, and the challenging of their widespread denial of racism" (ibid). The policy analysis was supplemented and contextualised through 12 semi-structured interviews with key players, including agencies that facilitate migration, migrant associations, and officials and policy makers concerned with medical migration. These interviews were intended to serve a dual purpose. Firstly, they were designed to triangulate the findings of the policy analysis, and to get a deeper sense of the thinking behind specific policies. Secondly, they allowed me to explore the doctors' trajectories from different angles, and to ease the analytical linkage of transnationalism 'from below' and 'from above'.

Furthermore, blogs, websites and online discussion groups relating to the highly skilled Nigerian diaspora generally, and Nigerian doctors in England specifically, were analysed. These included Nigeria Health Watch (nigeriahealthwatch.com), Medical Association of Nigerians Across Britain (www.mansag.org), The West African College of Surgeons, UK Forum (www.wacs-ukforum.org), Africa Recruit (www.africarecruit.com), Find a Job in Africa (www.findajobinafrica.com) and The African Leadership and Progress Network (africanprogress.net). These online resources gave important clues as to how Nigerian doctors in England present themselves publicly, the strategic objectives they choose to pursue in their transnational activities, and how they use online resources to engage with political and social events in Nigeria. In the analysis of this data, I opted for a relatively straightforward qualitative content analysis (Mayring, 2000).

Finally – and most importantly – I conducted in-depth interviews with 20 Nigerian doctors who work in the NHS, and 12 Nigerian doctors who have studied in England and/or worked in the NHS but have since returned home to practice medicine. In the interviews, I explored the doctors' own narratives of migration, and how they identify the key stages and junctures in their lives. Particular attention was given to events leading up to the decision to migrate, their reception into British society, their experiences of professional development within the NHS, their involvement in community and transnational processes that induce, or hinder, the transfer of skills and resources, and how their migration journeys relate to their values and goals. Furthermore, interviews with returnees explored in depth how they have used the experience and knowledge gained in the NHS to contribute to the development of the healthcare sector in Nigeria.

Sampling and Access

Sampling was purposive. I selected interviewees for their specific experiences or knowledge, and to capture the diversity and breadth of views within the sample group. Every effort was

made to have a broad sampling range in terms of gender, age, specialism, length of time in the UK, etc. to ensure that the sample is as representative as possible. Of the Nigerian doctors in England, 12 interviewees were men and 8 women, with the age range of 38-64. In terms of length of stay, 12 interviewees had arrived in England since 2000, six in the 1990s, one in the 1980s and one in the 1970s. Interviews were conducted across England, including in London, Oxford, Bristol, Manchester, Birmingham, Warwick, Leamington Spa, Norfolk and Grimsby. In Nigeria, 8 interviewees were men and 4 were women, aged 35-66. Their length of stay in Britain ranged from one to 25 years, and they had returned to Nigeria within the last two months to five years from the time of interview. Interviews were primarily conducted in south west and central Nigeria, namely Lagos, Abuja, Ibadan and Oshogbo. Due to security risks, I was unable to pursue leads in the northern and south eastern parts of Nigeria. In terms of the expert interviews, my emphasis was on acquiring a broad range of expertise, covering the main areas of policy and practice relevant to medical migration. As part of this, I interviewed: a former chief executive of the NHS; a former president of the Royal College of Surgeons of England; the director of African Health Policy Network; the Director of Equality and Partnerships, Department of Health; a Local Education and Training Boards (LETB) strategic advisor; a programme manager at the Tropical Health and Education Trust (THET); a programme director at the NHS; three representatives of three separate Medical Royal Colleges; a UKBA policy maker; and a DFID policy maker.

Access to Nigerian doctors in the NHS, as well as the expert interviewees, was organised and negotiated through a variety of means: 1) through contacts in third sector organisations, including the Runnymede Trust, the African Health Policy Network (AHPN), THET, Voluntary Service Overseas (VSO) and Africa Recruit; 2) through contacts in the Department of Health, NHS, English deaneries, the Medical Royal Colleges and black and minority ethnic (BME) networks in individual hospitals; 3) by contacting directly individuals with a public profile, such as commentators and high ranking doctors; 4) face to face meetings with doctors at various events, such as AHPN's 20:20 African Health Professional Network and diaspora meetings organised by the Medical Royal Colleges and English deaneries; 5) through an online advertisement, kindly disseminated by the Medical Association of Nigerians Across Great Britain (MANSAG) through their mailing list; and 6) snowballing. Access to interviewees in Nigeria was primarily negotiated through interviewees in England and snowballing. This method generated important data in itself. Indeed, the avenues of access were firmly lodged in the transnational social spaces within which my interviewees operated, giving me valuable insights into how these spaces operate in practice. Thus, many of the individuals my England based interviewees spoke about in relation to their own transnational activities were subsequently interviewed in Nigeria. However, this method was also limiting in that my Nigerian based interviewees were drawn from a relatively narrow pool. Diversifying points of access would undeniably have yielded a wider range of perspectives, but the time restraints of my Nigerian fieldwork (three weeks) impelled me to take a pragmatic approach to data collection. That said, I had originally intended my Nigerian fieldwork as a supplement to my English data, to give me a stronger feel for the wider transnational issues at play. During my fieldwork, it became apparent that the quality of the material was of greater import and consequence than I had initially envisaged, warranting an entire chapter dedicated to the analysis of the Nigerian data.

The negotiation strategy stressed the applied aims of the research, and that "political representation, civic and moral responsibility to engage, and the identification of good practice" (Clark, 2011: 485) stands at the heart of the study. This is supported by my involvement with Runnymede (a requirement of my ESRC grant), which provides avenues for dissemination of work. Generally, there was enthusiasm amongst my interviewees – both in the UK and Nigeria – about the applied nature of the research. There was consensus that policy and practice could be much better managed, and concern that these issues are neither well understood nor much thought about in policy circles. However, it is also likely that the specific research questions and applied focus also attracted those who are actively involved in transnational activities, but deterred those who are not. This introduces a certain bias in the sample, albeit a relatively extraneous one given the focus of the research on the transnational activities of Nigerian doctors.

Biographical Approach

In order to capture the richness of the doctors' experiences, I chose a biographical approach to the interviews. My point of departure was the framework developed by Halfacree and Boyle (1993), who outlined three key tenets of a biographical approach to migration. First, migration is not a one-off incident, but has temporal as well as spatial dimensions. Relevant trajectories can begin way before the event of migration, which is necessarily part of migrants' biographies. Second, migrants' decision-making processes are complex and multifaceted, and should be analysed holistically. Third, migration is a cultural phenomenon, predicated by social norms.

Applying Halfacree and Boyle's (1993: 334) conceptualisation of migration "which emphasizes its situatedness within everyday life" to Portes, Guarnizo and Landolt's (1999: 220) definition of "the individual and his/her support networks as the proper unit of analysis" in transnational research, a biographical approach allowed me to map key stages in their migration journeys and link these to wider social structures. For example, I explored what attracted my interviewees to medicine in the first place, and how this motivation informed their trajectories. Furthermore, immigration policies and social reception into British society have an impact on career development and labour market participation of Nigerian doctors, which may in turn influence future plans and expectations, including the possibility of return. The biographical approach also allowed me to tease out the significance of 'taken-for-granted' decision-making by enquiring around specific subjects, "building a picture of the migration decision from a variety of angles" (Halfacree and Boyle, 1993: 338) and allowing me to recognise the multifaceted and interlinking nature of migration decisions (Ní Laoire, 2000: 235).

The biographical approach presents a number of limitations, outlined by Findley and Li (1997). Principally, the method is not longitudinal. Data collection occurs at a single point in time, which risks missing the changing meanings of migrants' experiences. Furthermore, interviews can be biased by the researcher's 'migration angle', with valuable insights missed as a result. There is also a danger that some ideas are reified and given the "status of causal agents for analytic purposes" (Potter et al, 1990: 209). Given the time constraints of the research, it was difficult to fully resolve these methodological issues. However, some avenues were available. Firstly, Findley and Li (1997: 37) argue that giving research

participants the opportunity to comment on the interpretation of the data goes some way towards verifying that the researcher has "neither imposed an unacceptable angle on what had originally been said, nor mis-representated from the interviewees viewpoint their interpretation of the values and meanings attached to their lifecourse." Secondly, a number of other datasets – expert interviews, official statistics, and analysis of policy documents – allow me to triangulate the narratives of the doctors themselves. Finally, I am alive to the limitations of what my data permit me to say. Rather than making causal links, the data allows me to illuminate the structures and processes underpinning the doctors' narratives.

The final point merits a few further notes on the interrelationship between epistemology, methodology and method, and its implication for the results presented in this thesis. As Carter and Little (2007: 1316) argue, a qualitative framework founded on these three fundamental facets of research must be able to demonstrate consistency between them:

> Epistemology determines and is made visible through method, particularly in the participant–researcher relationship, measures of research quality, and form, voice, and representation in analysis and writing. Epistemology guides methodological choices and is axiological. Methodology shapes and is shaped by research objectives, questions, and study design. Methodologies can prescribe choices of method, resonate with particular academic disciplines, and encourage or discourage the use and/or development of theory. Method is constrained by and makes visible methodological and epistemic choices.

In order to shed some light on the epistemological limitations of my biographical data, I will work through these three facets by looking first at method and methodology, and then outlining how my choices impact on the epistemological foundation of my data. As already mentioned, my primary methodology was biographical, and my method of choice was, first and foremost, in-depth interviews with Nigerian doctors. This approach was chosen for pragmatic reasons. Doctors tend to be busy individuals, and so time intensive methods – such as ethnography – were likely to result in a low participation rate. I deemed biographical data collected through interviews to be the best available option to allow me to engage with the doctors' subjective experiences of migration without intruding excessively on their time. Although secondary statistical datasets were used to triangulate the data generated through biographical interviews, it should be stressed that these were not designed and collected specifically for the needs and purposes of this study. As such, their capacity to increase reliability and validity of the outcomes of the research are limited. Of course, the epistemological position of the data presented below is not contingent on reliability or validity; I am not aiming to present a full or causal picture. My choice of methodology and method necessarily entails a partial representation of Nigerian doctors' trajectories and experiences of migration. As such, the results outlined below are neither representative of Nigerian doctors as a whole, nor exhaustive in terms of the issues – challenges and opportunities – facing them.

It follows, then, that the nature of my methods and methodology necessarily implies a particular epistemology. In my presentation of the accounts described in this thesis, I engage with the doctors' subjective experiences of migration, rather than presenting an objective description of their trajectories. Thus, the epistemological status of the accounts which form the foundation of my analysis is not that of "static, measurable entities" (ibid: 1319) which

reveal a 'truth' about the "attitudes, motivations or beliefs of participants" (ibid.), but rather a product of the particular relationships I developed with my interviewees, and the interactions I had with them in the specific context of this study (ibid). In this respect, I concur with Becker (1996: 56) that the "point is not to prove, beyond doubt, the existence of particular relationships so much as to describe a system of relationships, to show how things hang together in a web of mutual influence or support or interdependence".

Ethics

Most of the ethical issues in migration studies address vulnerable migrants, such as refugees and irregular migrants (van Liempt and Bilger, 2009). My research participants do not fit into these definitions of vulnerability, and I judged standard ethical practice, as set out by the British Sociological Association, to be sufficient to resolve ethical issues. This includes informed consent (sought from and granted by all interviewees), anonymity and confidentiality.

The issue of anonymity and confidentiality is particularly important. Ideally, I would have liked to give a much deeper and clearer picture of my interviewees, their journeys and trajectories. This is, after all, the core topic of this thesis. However, many interviewees found themselves in fragile circumstances, whether this related to immigration status, job security, politics in Nigeria, and so forth. For this reason, it was imperative for my interviewees to remain anonymous. I have therefore given my interviewees their title followed by fictitious initials in place of their names.[3] I was also restricted in how much biographical detail I could disclose, with the unfortunate effect of limiting the sense I could give of my interviewees as persons. This can make the reading of this thesis slightly awkward in places. Furthermore, in Chapter 5, I discuss the online activities of three bloggers. It should be noted that these individuals feature in other themes and sections as well – they are doctors like the other interviewees, and I interviewed them according to the same thematic schedule, but with an added focus on their blogging activities. In my discussion on blogging, however, I give them a second pseudonym (blogger 1, blogger 2 and blogger 3), as connecting their comments elsewhere to their discussion on blogging would render them easily identifiable.

However, there were three further ethical issues that need to be disclosed. Firstly, my intention is for this research to have a strong applied component, both to policy and practice, which needs to be carefully managed. As part of my ongoing interest in the field of medical migration, my intention is to actively contribute to policy debates on this topic. I will invite participants to comment on and feed back into any writing arising from the data collected for this study.

Secondly, my status as a white researcher raises issues of positionality. Through my previous research, policy and advocacy work with vulnerable migrants, I fully understand "that dangers seen, unseen, and unforeseen can emerge for researchers when they do not pay careful attention to their own and others' racialized and cultural systems of coming to know, knowing, and experiencing the world" (Milner, 2007: 388), which has informed my approach to my interviewees throughout the fieldwork phase and analysis. In many ways, this seemed

[3] Due to the great diversity of ethnic, linguistic and religious groups in Nigeria – and the sometimes sensitive nature of ethnic politics – I opted for initials in place of pseudonyms. Due to my lack of knowledge of Nigerian names, I did not want to risk causing offence by attributing my interviewees with inappropriate aliases.

much less of an issue with the interviewees of this study than I initially thought. As doctors, they already occupy a social position of high status – invariably higher than mine as a PhD student. They had worked hard to achieve this status, and many had to combat racism in their careers. I was therefore unlikely to be seen as a threat, and if there were any unequal power dynamics emanating from race, these would have been offset by the power relations emanating from social status.

A more challenging question, however, was how to mitigate the effects of what psychologists call a 'self-serving bias' – a "cognitive or perceptual process that is distorted by the need to maintain and enhance self-esteem" (Forsyth, 2008: 429) – deriving from feelings of guilt. The topic of this study is emotive in various ways. My interviewees were glaringly aware that their services would be more useful back in Nigeria, and the decision to migrate had often been a hard one to make. For this reason, it would be entirely understandable if some would give an edited account of their thoughts and feelings. It is, of course, difficult to gauge exactly how any sense of guilt or nostalgia would have affected what my interviewees told me and how they put it into words. It is quite possible that they would have a hard time admitting certain aspects of their migratory journeys and decision making processes. However, I walked into each interview with this in mind, and tried to mitigate any bias through triangulation and approaching the same question from different angles. During data analysis, it struck me that the doctors had indeed given generally – and often painfully – honest accounts of their journeys and actions.

Conclusion

The aim of this chapter has been to lay the foundations on which to build the empirical data chapters below. In the literature review, I outlined the main themes and premises of the medical migration literature. This included a discussion on why doctors migrate, on the winners and losers of medical migration, and how these questions play out on global, national and local levels. Central to this review are the unequal labour market outcomes within the NHS, and how these differentials are determined by notions of 'race', racism and discrimination.

The outline of my theoretical framework briefly mentioned the new economics of labour migration, followed by a fuller outline of my main theoretical framework. I argued that the formulation of 'transnational social spaces' framed by Faist (1998; 2000a; 2000b; 2008) is particularly suited to the aims of this study. This is primarily due to its focus on a holistic, sociocentric approach to transnationalism, particularly its inclusion of the state as an important actor. Indeed, this insight is important enough to my analysis to warrant an entire chapter dedicated to dissecting the role of the state and the impact of its policies on the trajectories of Nigerian doctors in England.

Finally, I explained how I chose my methods to correspond to my theoretical framework, particularly how the biographical approach is congruent with the basic premises of transnationalism that migration is an ongoing project involving numerous actors. Furthermore, in order to connect transnationalism 'from above' and 'from below', I chose to approach my subject matter from a variety of methodological angles, including expert

interviews and a critical discourse analysis of policy documents. It is to this policy analysis we shall now turn.

3. Policy Context

> ...it is states which structure the triangle of migration control, immigrant incorporation and development cooperation. (Thomas Faist, 2008: 23)

In a speech given on 2 February 2012, Conservative immigration minister Damian Green outlined his intention to curb net immigration "while keeping us open to the brightest and best who will help drive economic growth" (Green, 2012). At first glance, the minister's decree looks like a reflection of public 'common sense' attitudes to migration, where policy should attract people "who will benefit Britain, not just those who will benefit from Britain" (ibid). Yet the policy of attracting the 'brightest and best' can be problematic. Skilled migrants entering the world's richest countries often represent a loss of human capital for the world's poorest. As Castles (2008: 261) argues, the "transfer of labour power and skills to the rich countries through labour migration is the latest form of development aid by the South to the North". Immigration policies which seek to attract the 'brightest and best' can directly undermine development policies and goals.

These policy tensions tell us important things about the position which highly skilled migrants occupy in British society. Behind the headlines are real people living out their lives, making life changing decisions about leaving their homes in search for greener pastures. When these decisions are made *en masse*, they can have a colossal impact on the stock of human capital of sending countries. Thus, at the other end of the migration chain, those countries whose 'brightest and best' are targeted by the global North can suffer 'brain drain' that they can ill afford.

As I outline in the introduction, the UK has historically been a major destination for doctors from low income countries, leading to the highest proportion anywhere in the OECD. This history stretches back to the inception of the NHS, and is reflected in a long lineage of official reports and policy documents on how the British state should manage this thorny issue. Overseas doctors[4] have often enjoyed a privileged status in the immigration system, but the 'pull factor' of open and welcoming immigration policies has proven to be a double edged sword. As staffing crises come and go, so does the benevolent stance towards overseas doctors move to and fro. These fluctuations have a profound impact on the legal status of overseas doctors which, in turn, can affect their career development. Examining and comparing developments in different policy agendas, and the changes they regularly bring about to the rights and responsibilities of overseas doctors, is instructive in how the government prioritises competing policy objectives, and how these priorities can directly influence overseas' doctors lives, ambitions and future prospects.

In this chapter, I briefly survey some of the most relevant official reports and documents relating to overseas doctors. I then examine in greater depth policy developments since the late 1990s onwards emanating from the three government departments most important to the transnational activities of Nigerian doctors: 1) the Department of Health; 2)

[4] The policy literature generally uses the interchangeable terms 'overseas doctors' and 'international medical graduates' (IMGs) in reference to doctors who are citizens of countries outside the UK, EEA or Switzerland, and who graduated from medical schools outside the UK (GMC, not dated). Throughout this dissertation, I will use the less formal 'overseas doctors' unless the context stipulates the use of IMGs.

the UK Border Agency (UKBA[5]); and 3) the Department for International Development (DFID). My objective with this examination of various policy agendas is to demonstrate the instrumental role they play in the transnational social spaces of Nigerian doctors. The brief historical overview draws attention to the flux and instability of these policy landscapes, as policy makers respond to changes in the social, economic, political and demographic realities of the UK. The more detailed analysis of policy since the late 1990s, on the other hand, highlights the powerful impact policy changes can have on overseas doctors. As we shall see, relatively minor changes in policy can dramatically alter their legal status in terms of immigration and employment, and consequently undermine their labour market position and thwart their ambitions. Policy agendas are certainly important landmarks in the transnational social spaces of Nigerian doctors, but the important point is that the doctors have little or no power to influence or challenge these policies, or how they affect their transnational social spaces.

A Note on Terminology – Unpicking the 'Overseas Doctors' Category

In much of the policy literature reviewed in this section, the interchangeable terms 'overseas doctors' and 'international medical graduates' are used synonymously in unproblematic ways. In order to fully understand the space overseas doctors occupy in the policy landscape, it is helpful to problematise this category, outline exactly how it is understood and used in policy, and then to unpick some of its more obscure connotations and meanings. On the face of it, 'overseas doctors' is a simple geopolitical term with its roots in legal understandings of Britain's place in Europe and the world. In essence, citizens who are not from the UK, EU, EEA or Switzerland are classed as 'overseas' or 'international'. According to the GMC (not dated), IMGs are doctors who:

- are nationals of countries outside the UK, European Economic Area (EEA) or Switzerland who graduated from medical schools outside the UK

OR

- are UK nationals who graduated from medical schools outside the UK, EEA or Switzerland

AND

- do not have European Community rights

As such, they do not enjoy the freedom of movement granted to EU and EEA nationals, but must apply for the relevant visa in order to enter and work in the UK. On paper, therefore, the overseas doctors category includes medical practitioners from anywhere in the world – including from other major OECD economies such as the US and Australia – apart from the UK as well as nation states inside the EU or the EEA. However, a breakdown of overseas doctors by country of origin shows that, in fact, a vast majority of 75% come from low

[5] Throughout much of this period, this government department was called Immigration and Nationality Directorate, changed to the Border and Immigration Agency in 2007, and then merged with UKvisas and HM Revenues and Customs to form the UKBA in 2008. I refer to its name at the time of writing (UKBA) when making a general point about immigration policy, whereas when I discuss time-specific policies, I refer to its name at that time.

income countries, mostly the Asian subcontinent and Africa. Table 3 shows the top countries of origin of foreign doctors practicing in the UK.

Source Country	No. of IMGs from Source Country (% of Workforce)
India	15,093 (10.9)
Ireland	2,845 (2.1)
Pakistan	2,693 (1.9)
South Africa	1,980 (1.4)
Egypt	1,592 (1.1)
Nigeria	1,529 (1.1)
Germany	1,523 (1.1)
Sri Lanka	1,422 (1.0)
Iraq	1,248 (0.9)
Australia	872 (0.6)
Spain	657 (0.5)
Greece	596 (0.4)
Myanmar	487 (0.4)
Jamaica	472 (0.3)
Italy	464 (0.3)
Bangladesh	464 (0.3)
The Netherlands	419 (0.3)
Sudan	395 (0.3)
Libya	394 (0.3)
New Zealand	305 (0.2)

Table 3: Country of origin of doctors in the UK. Source: Mullan (2005: 1812).

As already mentioned, this represents the highest proportion of doctors from low income countries in any OECD country. In the UK context, 'overseas doctors' is therefore close to synonymous with 'doctors from low income countries', the vast majority of whom will be black or Asian. The racial dimension of the 'overseas doctors' category in policy is further accentuated if we consider that migrants from the two top non-EEA OECD countries, Australia and New Zealand, have historically entered Britain through the UK Ancestry Entry Clearance – which is generally considered the preserve of white Commonwealth citizens – in great numbers. Thus, the terms 'overseas doctors' and 'international medical graduate' have strong racial connotations. In other words, 'overseas doctors' has become a proxy for 'race'. As Wang (2004: 1015) reminds us, "the word "proxy" captures the offhand, unthinking, "default" manner in which race often influences decision making." In policy terms, this is important:

> Despite the wealth of antidiscrimination laws that would seem to prohibit the use of race as a proxy in a wide range of contexts, much race-based decision making escapes legal sanction. Recent legal scholarship has been particularly critical of the prevailing model of intentional discrimination. Scholars have pointed out the inadequacy of individual adjudication under that model to account for the largest share of modern-day discrimination by illuminating the complex and subtle means by which race has come to carry its significant and pernicious associations. (ibid: 1015-1016)

Although Wang is referring to the US context in this instance, there are striking parallels with the UK immigration and health policy explored below. Under the Equality Act 2000, it is illegal to discriminate against anyone on the basis of a range of 'protected characteristics', including 'race' and nationality. Yet under policy changes made in 2006, discussed at length below, discrimination against primarily Asian and African doctors was written into policy based on their immigration status. As Anderson and Hughes (2015: 1) argue, this particular "position of migrants challenges liberal citizenship's claims to inclusion and equality and draws attention to the ways in which Non-citizens are formally excluded."

The majority of black and Asian doctors in the 'overseas doctors' category stands in stark contrast with the majority of white doctors in the 'UK and EU/EEA doctors' category. Of course, 'majority' is an operative word here, as the 'overseas' category includes white doctors, and the 'UK and EU/EEA' category includes black and Asian doctors. Nevertheless, in their aggregate forms, these categories represent a contrast between blackness and whiteness which gives us a particular vantage point from which to look at the inferior position overseas doctors occupy in the hierarchy of competing policy objectives. One way of interpreting this contrast can be gleaned from the perspective of otherness. As Baumann argues, othering involves setting up dichotomies, which give the impression of natural identities:

> Woman is the other of man, animal is the other of human, stranger is the other of native, abnormality the other of norm, deviation the other of law-abiding, illness the other of health, insanity the other of reason, lay public the other of the expert, foreigner the other of state subject, enemy the other of friend. (Bauman, 1991: 8)

If foreigner is the other of state subject, we can deduce that overseas doctor is the other of UK/EEA doctor. As Baumann argues, these dichotomies imply an ideal and its opposite, or norm and deviation, and are thus naturalised. We will see how this plays out in the lives and careers of the doctors in the next chapter, but at this point it is appropriate to point out that othering implies power differentials: "Power is implicated here, and because groups do not have equal powers to define both *self* and the *other*, the consequences reflect these power differentials. Often notions of superiority and inferiority are embedded in particular identities" (Okolie, 2003: 2; original emphasis).

Overseas Doctors and the State: 1948-1997

From the inception of the NHS in 1948, the proportion of overseas doctors rose steadily until it reached an estimated third of hospital doctors in 1971 (Jones and Snow, 2010: 12). The NHS experienced regular staffing shortages, and overseas doctors were by and large

welcomed by politicians and policy makers. Indeed, in his role as Minister for Health, Enoch Powell launched a campaign in 1963 which recruited 18,000 doctors from India and Pakistan who, he said, "provide a useful and substantial reinforcement of the staffing of our hospitals and who are an advertisement to the world of British medicine and British hospitals" (quoted in Jones and Snow, 2010: 12). Special exemptions from immigration controls coupled with malleable registration policies – by 1970, this included 90 medical schools granted recognition of medical qualifications and 'reciprocal agreements' with 23 countries (Kyriakis and Virdee, 2003: 288) – established a relatively easy route for Commonwealth doctors to enter, live and work in the UK.

In the early 1970s, doubts began to emerge about the soundness of the NHS's policies towards overseas doctors, and in 1975 the Merrison Committee, which was established to examine regulation of the medical profession, concluded in its report 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" (cited in Anwar and Ali, 1987: 10). As a result, recognition of medical qualification for full registration was withdrawn from all 55 Indian medical schools. Furthermore, a rigorous set of tests – initially called the Temporary Registration and Assessment Board (TRAB), but changed to the Professional and Linguistic Assessment Board (PLAB) in 1979 – was established to assess medical and linguistic skills of overseas doctors. Passing the PLAB tests would only entitle doctors to temporary registration, which could then be followed up by full GMC registration.[6] Thus, as Decker (2001: 27) notes, a central and lasting impact of the Merrison Report was the "introduction of a two-tier system of 'full' and 'limited' registration, which has made the procedure of medical registration of overseas doctors very complex". In response to an increasingly precarious policy landscape, coupled with an growing awareness that "overseas doctors are not progressing equally to their British trained colleagues once they are working in United Kingdom hospitals" (Community Relations Commission, 1976, cited in Anwar and Ali, 1987), overseas doctors began to organise in a bid to influence the debate. In 1975, the Overseas Doctors Association (ODA) was established, which took an active role in highlighting differentials in career prospects.

Up until the 1980s, overseas doctors had been exempt from work permit requirements. This special treatment came to an abrupt end in 1985, when the Conservative government decided to extend their work permit scheme to doctors. Although the Secretary of State for Social Services, Norman Fowler, acknowledged that overseas doctors had "enabled us to make good the shortfall in supply which arose from the inadequate number of graduates from our own medical and dental schools" (Hansard, 1985), he concluded that "it is now necessary to prepare for the position which the expansion programme was intended to achieve—that is, where the United Kingdom is essentially self-sufficient in its supply of doctors and dentists" (ibid.). This, Fowler argued, meant that overseas doctors' access to Britain needed to be curtailed:

[6] The PLAB tests are still a requirement today for overseas doctors who do not hold a GMC approved postgraduate qualification.

> Doctors and dentists from overseas who wish to become general medical and dental practitioners will need to comply with the relevant entry provisions for the self-employed. All other doctors and dentists, with the exception of those intending to undertake a period of postgraduate training, will be subject to normal work permit arrangements. (ibid.)

However, keen to "retain the important role which this country has traditionally fulfilled of providing postgraduate training to doctors and dentists from other countries who can come here for periods of specialist training before returning to put those specialist skills into practice" (ibid.), the government left open an important official loophole: overseas doctors qualified for a permit-free period of four years – known as Permit-Free Training – when seeking entry for postgraduate training. Thus, in spite of the complicated and ever changing nature of Britain's policies towards overseas doctors, their proportion of NHS doctors remained steady at around one-third until the late 1990s.

Before we turn to a more detailed examination of policy developments in the 2000s, we should briefly look at one final policy development in the 1990s which impacted on two of my interviewees. During the early 1990s, the European Commission judged that Britain was contravening EC directives on specialist training. In response, the Chief Medical Officer, Sir Kenneth Calman, established a group in 1993 to fundamentally reform the specialist training structure. The group published their report - *Hospital Doctors: Training for the Future* (Department of Health, 1993) – and the subsequent 'Calman reforms' acted on the recommendation "that a single training guide should be established, culminating in a certificate of completion of specialist training (CCST) that would meet the requirements of the EC directive" (Friend, 1997: 61). Although the Calman reforms were not explicitly concerned with overseas doctors or their place within the new training structure, questions about how overseas doctors should fit into the structure arose soon after the reforms were implemented. The reforms resulted in "a clear definition of programmes (type 1) that will lead to a CCST and those that will not (type 2)" (Milligan and Hutchinson, 1999). In other words, doctors who wanted to progress to consultant level had to undergo type 1 training. The structure of the training pathway resulting from the Calman reforms were complex, and although it is not necessary to outline them in detail here, some critical points should be highlighted. Importantly, the number of type 1 training programmes were fixed in order to control the number of consultants in each specialty, according to projected needs of the NHS. Trainees were then given a National Training Number, which allowed deans to follow the progress of trainees, as well as keeping oversight the amount of doctors within each CCST training programme, and when they would finish their training (Dr V Jadhav v. Secretary of State for Health [2003] 2304705/01). In order to get a National Training Number, the applicant would need to fulfil certain criteria, including the right to indefinite residence in the UK. Those doctors who did not qualify for indefinite residence could be given a Visiting National Training Number. However, they also needed to have sufficient time left on their work permit-free training to finish their training programme. This meant that few overseas doctors qualified for type 1 training, as the permit-free training period was limited to four years, the same as the recommended training time. These immigration rules were amended in 1997 to the effect that overseas doctors were no longer precluded from type 1 training on the

basis of their permit-free training. This caused some alarm amongst several deaneries, who were concerned about overseas doctors occupying a disproportionate amount of training programmes, "to the serious jeopardy of our ability to maintain the future supply of consultants to our hospitals" (Loveland, cited in Dr V Jadhav v. Secretary of State for Health [2003] 2304705/01). As a result of this, the Conference of Postgraduate Medical Deans (COPMeD), issued a statement in 1997, known as the Birmingham Declaration, intended to clarify the position of overseas doctors:

> Following the change in the United Kingdom immigration rules from 1 April 1997 any overseas doctors who remain as visiting registrars or who have FTTAs who wish to benefit from the changes in those rules and proceed to complete a CCST (Type 1) programme will be required to compete for and be appointed to vacancies on CCST Type 1 programmes.
>
> Any visiting registrars or FTTA holders appointed to the grade after the end of transition in their specialty and before 1 April 1997, who did not have sufficient PFT to complete a CCST Type 1 programme, will also be required to compete for, and be appointed to, CCST Type 1 programme vacancies. Otherwise they will be deemed to be in either fixed-term (Type 2) programmes or visiting registrars, neither of which can lead to the award of a CCST. (cited in Dr V Jadhav v. Secretary of State for Health [2003] 2304705/01)

This did cause some controversy. Responding to the Birmingham Declaration, the postgraduate dean of North-Thames Fast pointed out that overseas doctors who were already on training programmes would be required to:

> ...resign and re-compete for their own or equivalent posts, a process which has predictably caused considerable distress in those doctors and anger and disbelief in their trainers. It seems that your letter of the 4 August contains potential for further inconsistency and denial of natural justice to these doctors, who have believed that a CCST was their legitimate aim. (cited in Dr V Jadhav v. Secretary of State for Health [2003] 2304705/01)

Nevertheless, COPMeD stood its ground, and as a result, it became increasingly difficult for overseas doctors to meet the criteria for type 1 specialist training. Indeed, Milligan and Hutchinson (1999) note that "Overseas trainees have seen the goalposts move several times. Posts were lost during transition, then the Birmingham declaration removed at a stroke the advantages conferred by changes to immigration law."

Overseas Doctors and the State: 1997-2013

This period merits a close examination, for three reasons. Firstly, the policy developments during this period were particularly drastic, not only reversing the privileged position overseas doctors had historically enjoyed in immigration regulation, but effectively writing discrimination into policy as well. Secondly, these policy changes impacted greatly on my interviewees. Many were caught up in dramatic changes to registration rules or immigration status, with arresting consequences for their career development; others experienced difficulties when trying to help fellow Nigerian doctors to secure postgraduate training places

in the UK. Thirdly, this period coincided with an increased policy interest in circular migration.

Due to the NHS's high dependency on overseas doctors, Department of Health and UKBA policies are intricately linked but sometimes conflicting. The primary objective of the Department of Health is to "promote better health and well-being for the people of England" (Department of Health, 2008). As the largest single-payer healthcare system in the world, managing fluctuation in staffing levels vs. need has long been a major policy issue, and medical migration allows quick relief to short term staff shortages at a minimal cost. This would seem to sit well with the stated aim of UKBA of "improving the selectivity of the UK immigration system – ensuring that only the brightest and the best are able to come to the UK and work" (UKBA, 2012). UKBA and Department of Health policies have certainly afforded each other important concessions for each to meet their goals, but a number of tensions have also risen since 1997 between immigration and health policy. However, despite the clear evidence of the great cost of medical migration to developing countries, development policy hardly even gets a look in. Whereas the Department of Health and UKBA are involved in an intricate policy tango, the DFID agenda has very much played the role of a third wheel. The tension between immigration, health and development policies is all the more intriguing for the fact that the UK has been a leading force to get the development potential of migration on the global policy map (Van Hear, Pieke and Vertovec, 2004).

NHS Recruitment Policy and Ethical Guidelines

By the late 1990s, Britain had still not resolved the problem of self-sufficiency in terms of medical staff. In a drive to plug the many staffing gaps in the NHS, the Labour government published *The NHS Plan: A Plan for Investment, a Plan for Reform* in 2000, where 7,500 more consultants and 2,000 more GPs were promised over a four year period (Department of Health, 2000: 11). Although training, increasing pay and improving working lives featured as remedies to the chronic staffing shortage, the government was at pains to highlight the fact that it "takes years to train doctors" (ibid: 50). Whereas increasing domestic training was a long term strategy to ultimately become self-sufficient, the Department of Health concluded that:

> To further boost NHS staff numbers in the short term, the Department of Health will work with the leaders of the professions and with other government departments to recruit additional suitably qualified staff from abroad where this is feasible, meets service priorities and complies with NHS quality standards. The NHS will not actively recruit from developing countries in order not to undermine their efforts to provide local healthcare. (ibid: 55)

The last sentence deserves special attention. The NHS's aggressive recruitment drive coincided with a growing unease about the UK's central role in the global medical brain drain. As a result, an ethical Code of Practice on recruitment was developed in 1999, initially exclusively referring to nursing, but updated in 2001 to apply to all healthcare professionals, including doctors (Willets and Martineau, 2004: 6). In 2003, a list of 151 proscribed countries was added to the Code. It is important to note that the UK was the first OECD country to introduce a Code of Practice, and has remained on the front line in developing an

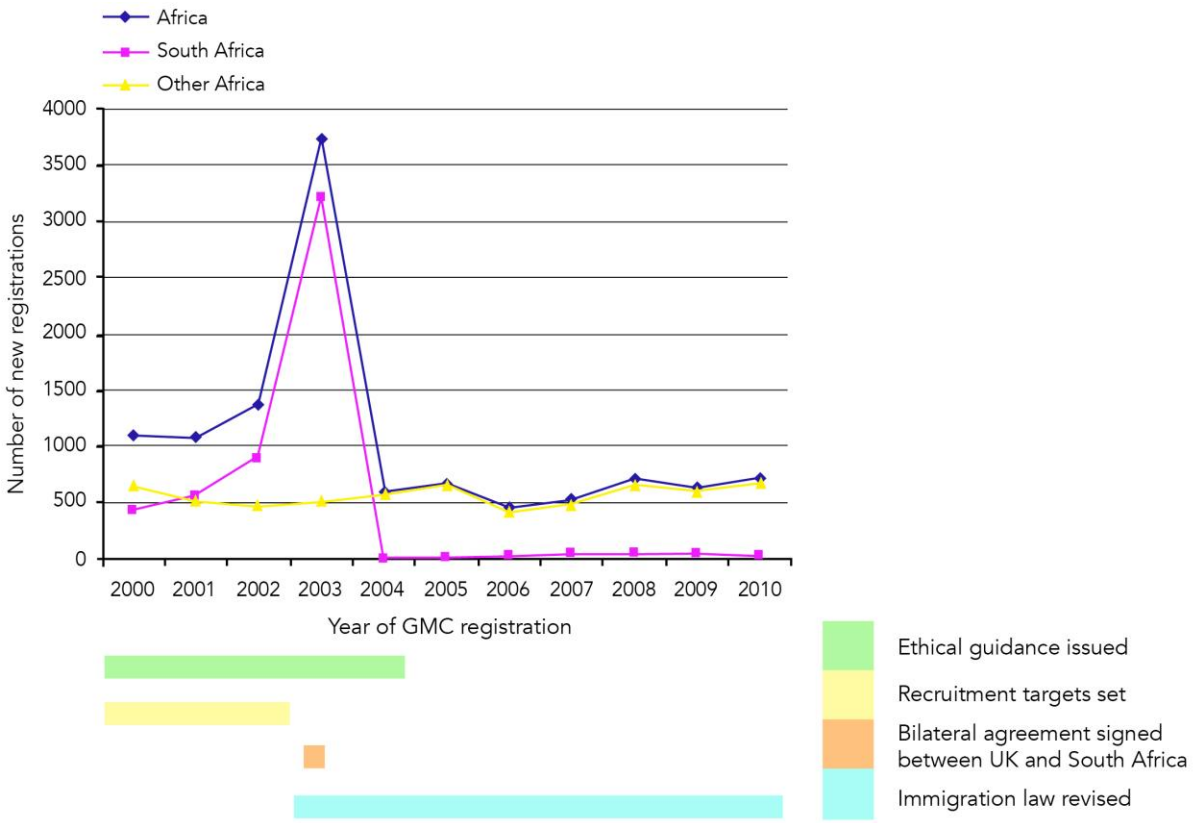
international Code. Nevertheless, the Code came under criticism for being a blunt instrument with inadequate statutory foundation, and particularly that it did not cover the private sector, including independent recruitment agencies (Buchan and Dovlo, 2004: 17). In response, the Department of Health updated the Code in 2004 (Blacklock et al, 2012) to cover private recruitment agencies, private health care providers, and temporary NHS staff.

Data on international recruitment in the NHS does not allow for a conclusive assessment of how effective the Code of Practice has been in reducing inflow of health professionals from low income countries. However, two notable studies – Buchan et al (2009) and Blacklock et al (2012) – used the proxy measures of GMC registration data and work permits to gauge the Code's efficacy. Buchan et al (2009) noted that the development of the Code from 1999 to 2004 did coincide with a fall in registration of overseas health professionals, but concluded that there are "multiple reported causes of this recent decline, including declining demand in the United Kingdom and the introduction of more stringent registration and entry requirements" (ibid: 8). Blacklock et al's (2012) study attempted to fill in these gaps by including three additional policy measures in their time series analysis of GMC registration data: recruitment targets, bilateral agreements, and immigration law. They conclude that when these other policy areas are taken into account, there is "no suggestion from the time trends in registration data that the code had an effect in reducing registrations by doctors trained in resource-poor countries" (ibid: 4).

If the Code of Practice had limited impact on NHS recruitment of overseas doctors, then which policy measures did? According to Blacklock et al (2012: 5), in "stark comparison to the ethical guidance to employers, the 2002 NHS recruitment drive appears highly associated with a change in GMC registrations, and is one explanation for the rise in new registrations by doctors trained in resource-poor countries which peaked in 2003–2005". Mr. G.G., who was a senior executive in the NHS during this period, explained how this recruitment drive had unintended consequences:

> I think when I was actually [working in the NHS], we very deliberately sought to expand the workforce. And we knew there were certain specialities where we didn't have enough doctors ... And we therefore decided to recruit abroad. So we opened the gates. And what I think was interesting is that we opened the gates for some specific areas, but we also got messages out there, by accident, that there were lots of jobs in the UK. So I had large numbers of Asian doctors, many bigger numbers in Asian, although I suspect it would apply to African doctors as well, but I didn't hear it.

Indeed, in the period from 2000-2010, there were 12,000 new GMC registrations from Africa. Much of these can be accounted for by registration of South African doctors, which peaked in 2003, but even when these are excluded, there remained a sustained inflow of African doctors. In graph 1 we can see that once South African GMC registrations – which plummeted from 3206 in 2003 to 4 in 2004 as a result of a Memorandum of Understanding between the UK and South African governments – are accounted for, the GMC registrations of other African doctors remained relatively steady at 500-700 per year over 10 years.



Graph 1: New GMC registrations from Africa, 2000-2010. Source: Blacklock et al (2012: 4).

Thus, it is clear that the policy imperative to increase the healthcare workforce in England trumped the ethical considerations regarding recruitment of health professionals from low income countries. It is true that overall GMC registration from overseas doctors began to fall from 2005 onwards, although the evidence suggests that this was due to changes in immigration policy rather than the Code of Practice. While these changes did reduce the overall registration number, they seem to have had limited impact on the number of African doctors registering in England. They did, however, have serious consequences for the career prospects of African doctors in the NHS, and as such deserve special attention.

Immigration Policy

As Blacklock et al (2012) conclude, the drop in GMC registration of overseas doctors from 2005 onwards was a result of dramatic changes in immigration policy, rather than the Code of Practice on international recruitment. This process was initiated in 2002 with the introduction of the Highly Skilled Migrant Programme (HM Government, 2005), which allowed exceptionally skilled or experienced migrants to enter the UK without obtaining a work permit. The immigration rules were amended in 2003 to make it more difficult to recruit overseas doctors for posts with suitable EEA applicants. Initially, this did not have much of an impact, as doctors were still on the 1999 UK shortage list of professions (Blacklock et al, 2012: 6). By 2005, however, the staffing shortage crisis was starting to subside "as a result of steps taken to increase very substantially the number of students (most of them British or EEA nationals) graduating in medicine in this country" (House of Lords, 2008). Thus, the

staffing crisis had turned into its opposite – whereas before, there were not enough doctors to fulfil the government's pledge to substantially increase its workforce, now the NHS was heading for a staffing glut. As overseas doctors tend to be older and more experienced when applying for training posts, UK and EEA doctors were at a comparative disadvantage. The Department of Health responded to this chain of events by influencing a change in immigration rules so that only graduates from British medical schools could qualify for the Permit-Free Training period introduced in 1985 (ibid), thereby turning the 'special exemption' status previously enjoyed by the medical profession on its head. These changes took effect on 3 April 2006. However, overseas doctors could still apply for training posts under the Highly Skilled Migrant Programme, and so a further attempt was made to exclude overseas doctors entering through this route as well, but this move was blocked by the Home Office (ibid). To circumvent the Home Office decision, the Department of Health issued guidance on 13 April 2006 that no overseas doctors should be appointed unless the recruiting primary care trust was able to demonstrate that there were no suitable UK or EEA applicants. This guidance proved highly controversial. Discussing the case in the House of Lords, Lord Chief Justice Bingham suggested that:

> To speak of the guidance being "issued" is to suggest a degree of official formality which was notably lacking. It appears that the guidance was published on the NHS Employers' website in terms approved by the Department, but no official draft, record or statement of the guidance has been placed before the House, which has instead been referred to an e-mail beginning "Dear All" sent by an official of the Immigration and Nationality Directorate of the Home Office in response to confusion caused by some earlier communication. (ibid)

The response of the British Medical Association reflected this sense of confusion and unfairness. They reported that numerous doctors who were fully entitled to work and practice medicine in the UK – such as refugee doctors or those on the Highly Skilled Migrant Programme – were being turned down on the basis of the Department of Health's guidance. In a strongly worded statement, the BMA chairman concluded:

> NHS is rapidly losing its international reputation as a fair employer. Some trusts are effectively telling doctors not to bother applying for jobs if they're from outside Europe, even if they've worked in the UK for years, or qualified from a UK medical school. It's shabby, it's unfair, and in some cases it may be discriminatory. (BMA, 2006)

The 2006 changes were complex and confusing, but in essence, they introduced a double blow: all doctors were now required to "apply for work permits and visas in accordance with normal immigration policy" and the NHS was obliged to prioritise "the resident work force before recruiting from outside the EEA" (WorkPermit, 2006). Further changes were made in 2006 limiting temporary registration to 26 weeks, forcing doctors already on training schemes before the changes took place to obtain work permits which often proved impossible. As the changes were retrospective, many overseas doctors who had started their postgraduate training before the changes were introduced were therefore faced with the choice of either leaving the country, or switching to a different, less competitive

specialty or a non-consultant career grade post. Some doctors were even forced to take on non-medical work while they waited for immigration clearance, GMC registration or a job offer, a situation that the NHS and Department of Health was aware of. As Mr. G.G. explained:

> So they came and did a temporary job, and they tried to get onto the training rotas and they failed. And eventually they went home poorer than when they came. And there were a lot of sad stories, because there was a sort of message out to the world that the UK was recruiting doctors. And we were, for a period. ... But you did get doctors coming here as taxi drivers, or coming here through some other route, and then trying to get jobs as doctors, which was quite difficult.

The discriminatory nature of these policy changes was so stark that the British Association of Physicians of Indian Origin (BAPIO) requested and were granted a judicial review on the guidance issued on 13 April 2006. The High Court ruled in BAPIO's favour and found the guidance unlawful, but the Department of Health successfully appealed the decision. This appeal was ultimately dismissed in the House of Lords:

> The guidance applied nonetheless to IMGs within all three [PFT, HSMP and refugee] categories without distinction or qualification. Whatever could legitimately have been done by way of more limited guidance, or by issuing general guidance subject to transitional provisions protecting those within category who did have a legitimate expectation, the actual guidance issued did not do. In these circumstances, it is not in my opinion possible or appropriate for the court to try to rewrite or qualify the guidance or to seek to uphold it in part. It follows that I agree that the appeal should be dismissed. (House of Lords, 2008)

BAPIO won their case, but not without human cost. The claimant in the judicial review, a young Pakistani GP called Imran Yousaf, came to the UK for post-graduate training in 2004 but got caught in the retrospective 2006 changes. Unable to find a job, and having amassed considerable debt, Dr Yousaf committed suicide in the course of the judicial review. His suicide sent shockwaves through the overseas doctors community and became a rallying point for action. Dr. E.A., a public health consultant who arrived in the UK in the early 2000s, explained to me how this inspired him to get involved in migrants' rights campaigning:

> And for me, that was the moment I became radicalised, if you like. Because that was also an election year, and there was lots of negative stuff about immigrants. And I tried to start a campaign, where I said that all the immigrant doctors in the NHS should wear a badge saying 'proud to be an immigrant'.

Importantly, the judicial review only ruled that the quasi-official guidance issued on 13 April was unlawful. The fact remained that primary care trusts were legally obliged to prioritise UK and EEA applicants for training posts, which effectively legalised discrimination. This made training posts all but impossible to come by for overseas doctors, save for posts in the least prestigious specialisms and least popular parts of the country. This state of affairs was cemented with the introduction of the Points Based System in 2008,

which was amended in 2010 to require all highly skilled migrants – including doctors – to hold a job offer before entering the UK (Blacklock et al, 2012: 6).

Concerned about Britain's international image, the Department of Health introduced the Medical Training Initiative (MTI) in 2009, which sought to reintroduce a route into training posts for a limited time only. The MTI falls under the Tier 5 Government Authorised Exchange of the Points Based System, and was specifically designed as a development tool employing the principle of circular migration. The idea is that overseas doctors can apply for time limited training posts where they develop professionally and learn new skills to put into practice once they have returned:

> Under the supervision of a fully qualified NHS consultant doctor, trainee doctors on the MTI receive core and/or specialty medical training to the same standards of UK national trainees. However, in most instances the training program is tailored to suit the MTI doctor's educational objectives and will take into account the type of work done by the doctor upon returning home. (Academy of Medical Royal Colleges, 2013b)

Thus, the stated aim of the Academy of Medical Royal Colleges is for the MTI to offer a package that not only suits the needs and ambitions of overseas doctors, but also equips them with valuable skills and resources to take back to their home countries. In other words, MTI had a clear development goal, based on the model of circular migration.

Tensions arose between UKBA and the Medical Royal Colleges regarding the length of stay allowed to participants of the MTI scheme. UKBA wanted to limit the period of training to 12 months, partly due to the government's drive to fulfil the Conservative Party election pledge to "take net migration back to the levels of the 1990s – tens of thousands a year, not hundreds of thousands" (The Conservative Manifesto, 2010: 21). As the Office for National Statistics defines a migrant as a "person who moves to a country other than that of his or her usual residence for a period of at least a year" (Anderson and Blinder, 2012: 3) for the purposes of calculating migration flows, MTI participants would not feature in official statistics on net migration. The Medical Royal Colleges, on the other hand, pushed for 36 months, arguing that 12 months was simply not enough time to deliver training to a sufficient standard. They finally settled on 24 months, which the Academy of Medical Royal Colleges still regarded as too short to adequately serve its purpose.

The efficacy of MTI as a tool for development is further reduced because of the ongoing Department of Health push to prioritise UK and EEA medical graduates for training posts. Thus, only "training capacity not required for planned UK/EEA training numbers is made available for overseas doctors" (Academy of Medical Royal Colleges, 2013b). In other words, the restrictions on the availability of training programmes offered through the MTI are near identical to those introduced in 2006 on Permit Free Training, to the same effect: the choice of training programme is severely limited for overseas doctors. These limitations can be circumvented when an applicant secures his or her own funding to cover the costs of the training programme, normally from their home country (Academy of Medical Royal Colleges, personal communication). For a programme specifically designed to promote the development of the healthcare sector in low income countries, it is somewhat ironic that doctors from low income countries can only choose their training programme when their own

governments shoulder the costs. Specialist training programmes are vocational, and doctors are required to do service in the NHS – clinical work and being on call – during their training; low income countries are therefore effectively supplying the NHS with subsidised labour over a 24 month period, a brazen case of "development aid by the South to the North" (Castles, 2008: 261). It is therefore hardly surprising that in the period from 2009 to early 2013, only 29 doctors from Sub-Saharan Africa had participated in the scheme, and only four from Nigeria (Academy of Medical Royal Colleges, personal communication).

Meanwhile, policies for overseas doctors who were not taking part in the MTI scheme became ever more restrictive. In April 2012, the British government terminated the Tier 1 (Post Study Work) route, which had allowed overseas graduates to stay in the UK for 24 months without sponsorship in order to find suitable employment. Instead, graduates who wanted to stay and work would have to qualify for a Tier 2 visa under the Points Based System:

> In order to switch into Tier 2 (General) following a period of leave to remain in the UK under Tier 4, non-EEA graduates must have a valid offer of employment from a registered Tier 2 (General) sponsor prior to expiry of their leave. The offer of employment must be for a graduate level role (NQF level 6 or above), with a minimum salary of £20,500 per annum or the 'appropriate level' for that occupation (whichever is higher). (APPG on Migration, 2015b: 30)

This policy was heavily criticised by both employers and universities. The main point of contention was that the UK was legislating away the UK's status as one of the most desirable destinations for talented overseas graduates. As Richard Bacon, Conservative MP and member of the APPG on Migration, put it, "the government's current approach to post-study work and student migration policy is jeopardising Britain's position in the global race for talent" (APPG on Migration, 2015a, 2015). Indeed, the All-Party Parliamentary Group on Migration maintained that the change in policy was responsible for an 88% drop in highly skilled non-EEA graduates staying on in the UK for work purposes (APPG on Migration, 2015b: 8).

Importantly, and in line with the reversal of the historical 'special exemption' status of health professionals, the timeframe given to doctors and dentists to find a job was significantly tighter than for graduates in other areas:

> Non-EEA graduates applying from within the UK for a Tier 2 (General) visa must do so prior to the expiry of their student visa. For courses lasting 12 months or more, the leave granted under a student visa lasts for the full length of the course plus four months after the course end date. Postgraduate doctors and dentists on a recognised Foundation programme are granted leave to remain for the full length of the course (up to a maximum of three years) plus one further month of leave after the course end date. (ibid: 17)

In other words, a postgraduate doctor had one month to secure employment, or else leave the UK. As we shall see in Chapter 4, this task is all but impossible for Nigerian doctors. It should be noted that these changes coincided with my fieldwork in the UK, and therefore did not affect any of my UK based interviewees as they all arrived before the post study work route was abolished. However, one of my Nigeria based interviewees had to cut short his

time in England, a turn of events he found particularly galling. The important point is that the suspension of any realistic possibility for overseas doctors to follow their postgraduate studies up with work experience, and the stringent nature of these policy changes above and beyond other categories of graduates, were part and parcel of the progressive erosion of overseas doctors' rights within the immigration system and the labour market.

As Glick Schiller (2012: 92) warns, "without full rights to work and settle in prosperous economies, migrants can hardly be seen as partners in the planning and organization of effective development projects in their homelands". Akin to NHS recruitment policy, changes in immigration regulation during the 2000s were largely inimical to ideas of development through circular migration. The scope for doctors from low income countries to get onto postgraduate training programmes of their own choice was uncompromisingly curtailed, and the gradual peeling away of their rights as migrants made prospects of transnational activities – such as occasionally returning home for short periods for medical missions – increasingly risky. Yet these changes coincided with a period of enthusiasm in policy circles about the development potential of diasporas, which raises a number of questions. What is the UK government's stance on medical migration? How does this stance translate to policy? Where do these policy priorities sit within the broader policy landscape?

Medical Migration and International Development

The start of the New Labour period coincided "with a striking, rather sudden turnaround of views, from pessimist 'brain drain' views, which dominated thinking on the issue before the 2000s, to optimistic 'brain gain' views on the same issue a few years later" (de Haas, 2012: 8). Thus, the paradigm on research and development policies became very much in favour of diaspora engagement, and de Haas's 'migration and development pendulum' had swung to the far end of the 'optimism' scale.

As is clear from the previous two sections, development policy does not operate in a vacuum, but is highly contingent on other areas of policy. Indeed, Faist (2008: 23) highlights the significance of "the triangle of migration control, immigrant incorporation and development cooperation", all of which are primarily structured by the state. In the UK, this is perhaps particularly pertinent where medical migration is concerned; the advancement of the development potential of diaspora doctors is conditional on two other policy areas that are not only high on the government's list of priorities, but also extremely emotive in the public discourse: health and immigration.

It should be noted that medical migration, and its developmental potential, has not been the sole concern of DFID. The Department of Health has taken an active role in the development of various policies relating to this, with its leading role on the Code of Practice on recruitment a prominent example, and much work has been the result of DFID and the Department of Health working closely together. The NHS also has an International Health Group which aims to capture and standardise the policy context through which the NHS engages in international development. However, due to the size and complexity of the NHS, it is perhaps inevitable that not all of its sections will be singing from the same hymn sheet. As Mr. N.D., a programme director in the NHS, explained, "when NHS people try and set up health links with developing countries, they often face barriers within their own NHS

organisations, because the majority of the NHS isn't aware that participating in international development is a valid part of NHS activity". Therefore, even where the NHS has a clear framework for NHS involvement in international development, it does not necessarily follow that all sections of the NHS are ready or willing to engage with this framework on the basis that they are their remit is strictly confined to healthcare in England.

Although the Code of Practice did not directly address 'brain circulation', it did signal an increasing awareness in official circles around the developmental impact of medical migration. The Code is discussed in some detail above, but a number of subsequent policy documents have touched directly on the contribution diaspora doctors can make in international development. It should be noted, however, that the trajectory of policy discussion on diaspora doctor engagement is less clear or straightforward than those examined in the previous two sections (recruitment and immigration). Indeed, as Blacklock et al (2012: 6) note, although the "United Kingdom government has referred to medical migration in several of its global policy documents ... their impact on either internal policy initiatives or GMC registration rates is unclear". This is indicative of the government's lukewarm position towards including diaspora doctors in their global health development framework.

One of the earliest, and arguably most important, contribution came from Lord Nigel Crisp (2007), who was Chief Executive of the NHS from 2000-2005. The report – *Global Health Partnerships: The UK Contribution to Health in Developing Countries*, or the Crisp Report – was commissioned by the Prime Minister and the Secretaries of State of Health and International Development to explore how UK expertise and experience could be used to improve health in low income countries. The working principle of the Crisp Report was that "leadership is local and *'Africans will sort out Africa's problems*'" (Crisp, 2007: 4; original emphasis), where the success of development efforts will depend on strong country leadership and a sense of local ownership. Acknowledging the UK's position as a global employer of health professionals, Crisp gives overseas doctors special attention, with a whole chapter – 'Tackling the staffing crisis' – and three out of the report's 16 recommendations directly relating to engagement of overseas doctors. It is worth examining these in depth.[7]

Crisp's three recommendations each wrestle with different elements of medical migration, but are all interlinked. Recommendation 11 looks at how the UK can "support international efforts to manage migration and mitigate the effects on developing countries of the reduction in training and employment opportunities in the UK" (Crisp, 2007: 121). Thus, in a nod to the 2006 changes discussed above, Crisp calls on the UK to alleviate the effects of brain drain – through strengthening the Code of Practice on recruitment or using country-level agreements – while simultaneously continuing to provide short term training and work experience opportunities in the UK. Recommendation 12 deals directly with overseas doctors ordinarily resident in the UK. Crisp proposes that the UK assists medical migrants to contribute to development in their home country, which could be done in two ways. Firstly, the UK should enable medical migrants to participate in partnership programmes which require them to return home for long or short periods. Secondly, the UK could design an NHS scholarship programme with the particular aim to develop service improvement in low

[7] For a full account of the recommendations, see Appendix 1.

income countries, open to candidates "over a five-year period while they worked on service development in their own country and developed their own experience and expertise with support from the UK and local institutions" (ibid: 17). Finally, recommendation 13 made a crafty reference the colossal benefits and financial savings medical migrants have brought the NHS, which have created a degree of indebtedness and accountability towards low income countries: "The UK should see itself as having a responsibility as the employer of a global workforce and seize the opportunity to help developing countries educate, train and employ their own staff" (ibid). Part and parcel of this would be to ensure "that immigration arrangements allow for trainees and those seeking work experience in the UK, who have a suitable sponsor, to enter the country" (ibid).

While the Department of Health and DFID welcomed the bulk of the recommendations made in the Crisp Report, they were less than enthusiastic about the three recommendations concerning involvement of overseas doctors. Firstly, they questioned the premise that training, work experience and exchange programmes in the UK had any benefits (a point I dispute in Chapters 5 and 6), and voiced concern about "its cost effectiveness and its contribution to outward migration" (Department of Health and DFID, 2008: 43). Secondly, the government deemed the prospect of offering training unfeasible on the basis that entry for "UK-based training in the health and development sectors is subject to UK immigration regulation, and particularly the new points-based system" and that migrants are prohibited from "taking up employment as a doctor in training unless there is no suitable UK or European Economic Area (EEA) applicant" (ibid: 43-44). Instead, the Department of Health would examine "options for a fair and effective system" (ibid: 44) for training opportunities aimed at overseas doctors; the result was the MTI, discussed above. Thirdly, DFID acknowledged the importance of exploring "options for enabling health workers to return to their countries of origin without it affecting their residency status in the UK" (ibid: 45), although at the time of writing nothing had come of this. Furthermore, DFID absolved itself from responsibility for structural oversight by taking the view that "where members of diaspora wish to work overseas, they should use existing channels – making arrangements with trusts and others locally, either in terms of setting up specific partnerships or arranging paid or unpaid leave to work with international agencies or organisations in their countries of origin" (ibid). Oversight over this process was therefore devolved to third sector organisations such as VSO, Africa Recruit, or the Global Workforce Alliance. Finally, the government downplayed its status as the biggest per capita employer of doctors from low income countries by arguing that medical migration "has been part of a general international trend towards greater employment mobility, which exists across many professions, and we are by no means unique in being a global employer" (ibid: 47). Instead of shouldering responsibility, the government concluded that they "anticipate non-government sectors will be planning how to take forward Lord Crisp's recommendations that are relevant to them" (ibid: 47).

Building on the principles set out in the Crisp Report, the Department of Health published *The Framework for NHS Involvement in International Development* in 2010. The framework is an impressive document, setting out an integrated approach to NHS involvement in global health. The framework acknowledges the role of diaspora health professionals in development where they "are often key players in supporting development

network" (NHS and Department of Health, 2010: 20). However, beyond recognising that "the positive economic, social and political connections that diaspora have with their countries of origin can be 'an engine of development'" (ibid), the framework does not set out a structured approach to diaspora engagement and has little to say about how their connections could be positively channelled. Furthermore, the section on 'Managing Participating Staff' examined practical issues such as breaks in service and pension provision, but made no mention of visa restrictions and residency status.

The government's lack of enthusiasm towards engaging overseas doctors in its development strategy was remarked on by a number of the more politically active interviewees. Dr. F.B., who is involved in several initiatives aimed at engaging diaspora doctors and coordinating their efforts, believed that DFID could certainly play a more central role in ensuring a more structured and synchronised approach to diaspora doctors' involvement in development projects:

> Dr. F.B.: But also, I think the policy for me now, is making sure that at least DFID funded programmes, health care programmes, at least in Africa, begin to say to people they're funding that they do need to engage with the diaspora, so that the impetus is also on *them*. Because there are a large number of DFID funded programmes in Africa, and if they're told by DFID, 'For this, you do need to demonstrate as part of your monitoring and evaluation, that you are engaging the diaspora', then we will begin to see a lot more being done.
>
> Me: In terms of DFID, how receptive are they to the idea of diaspora involvement in these programmes?
>
> Dr. F.B.: I think it will be a mixed picture. I think people lack knowledge that it's good to get the diaspora involved. The question is always *how*. How, in a way that doesn't hinder the programme. And that's what I'm saying, the reality is that the diaspora does not have the capacity and the capability. So if programmes are *asked* to involve them, they can involve them as individuals. And if there is an administrative function to enable that, then it will be much better. So again, I think they do acknowledge it, because many do involve them as individuals, in some cases, and they've seen evidence of that. But the question is, how do you do that so that you're ensuring value for money? Because this is taxpayers money at the end of the day, and you're still delivering on the outcomes. And I think for that, it needs a structure in place to be able to do that.

Dr. F.B.'s point is that money talks, and if DFID were serious about engaging overseas doctors in their health development work, her two suggestions – to make programme funding dependent on diaspora involvement, and a central administrative hub to coordinate diaspora involvement – are both simple and practical. This would seem to sit well with the Department of Health's working principle that aid provided should be "adequately co-coordinated – with initiatives from other development partners (UK and others) working as one (**the principle of harmonisation**)" (NHS and Department of Health, 2010: 8; original emphasis). Yet there has been little government attempt to harmonise the efforts of overseas doctors.

It should be stressed that the UK has a long and enviable track record on healthcare development issues, and has in many areas been a leading figure in developing international

strategies to improve global health. This makes the government's indifferent approach to diaspora doctors all the more puzzling, particularly since doctors from low income countries make up 25% of all NHS doctors, the highest proportion in the OECD. Developing a systematic approach to harnessing the wealth of experience and knowledge would seem self-evident. The government's defence that there is insufficient evidence that diaspora doctors are willing to engage does not ring true; many of the Medical Royal Colleges (albeit not all) have clearly defined, and successful, diaspora engagement programmes in place. The government's response to the Crisp Report suggests that enabling effective diaspora engagement would require unacceptable compromises from UKBA and the Department of Health. As de Haas (2007: 829) observes, the "suspicion remains that curbing immigration is a more important goal than contributing to development".

Conclusion

This chapter has traced the developments in three strands of public policy directly related to the transnational lives of Nigerian doctors: immigration, health and international development. Two key findings should be highlighted before we move on to exploring the doctors' own experiences of working in the NHS. Firstly, within the hierarchy of policy objectives, immigration and health policy trumps international development. The significance of this for Nigerian doctors will become apparent in Chapter 5, where I discuss their transnational activities. Secondly, I have argued that within the NHS, overseas doctors are considered, by and large, to be expendable goods that can be utilised as a quick fix solution to acute staffing crises. However, the medical establishment is nevertheless anxious to maintain a labour market advantage for 'its own'. This brings us back to the idea of 'othering' which I presented earlier in this chapter. If we accept that overseas doctors are the other of UK/EEA doctors, and that this othering entails unequal power relations, we can see how the othering of overseas doctors places them in a position of inferiority vis à vis their UK/EEA peers. This dichotomy is naturalised, thereby creating the powerful narrative needed to relegate overseas doctors to a second rate status. As Kyriakides and Virdee (2003) argue, policy developments point towards an increasing conflation between three categories: 'overseas doctor', 'black doctor' and 'inferior doctor'. In this way, the medical establishment in England is able to justify the exploitative methods by which overseas doctors are used to plug short term gaps in the labour market. The fact that overseas doctors' rights are extended and curtailed in line with the ebbs and flows of the labour market suggests that, in policy terms, they are seen as a resource that can be sourced and discarded according to the needs of the NHS. In this context, the "citizen/non-citizen binary underpins the justificatory logic that immigration controls on *non-citizens* are necessary in order to protect and prioritise *citizens*" (Anderson, 2015: 43; original emphasis).

At this stage, of course, this analysis is purely hypothetical, based as it is on an observation of the great overlap between 'overseas doctors' on the one hand, and doctors from Africa and the Asian subcontinent on the other. It is entirely possible that this is just a coincidence. In the next chapter, however, I will endeavour to put some meat on these hypothetical and statistical bones through exploring the place of Nigerian doctors within the policy landscapes discussed in this chapter. Drawing on my own qualitative data on the

migratory journeys and career development of Nigerian doctors, and supplementing this with secondary quantitative data on labour market outcomes for overseas doctors, I will demonstrate that in Britain – both within the medical establishment and in public discourse – Nigerian doctors are indeed subjected to the processes of othering.

4. Career Development: Racism, Discrimination and Opportunity

> I don't think I can fully explore, when I speak to you, that experience. To endure a lot of humiliation. And my family suffered. I have three children. I was not there for them. I was working all over the country. So when I look back sometimes, I ask myself, why did I stay? And why am I still here? So it's a difficult question. You get trapped in the system. So you appear to be stupid or foolish. But you're not, you are just trapped. It's a crisis situation. (Dr. L.A.)

Career development is one of the central driving forces of medical migration (Kangasniemi et al, 2004; Hagopian et al, 2005), and, as such, warrants a comprehensive analysis. In the previous chapter, I began to unpick the concept of 'overseas doctors' as it is presented in policy and statistics. I argued that the racial undercurrent of the 'overseas doctors' category, as it is presented in policy, serves to justify their unequal treatment in the labour market. In this chapter, I will advance this analysis by exploring in depth how this category is understood and experienced by my interviewees. The contour of overseas doctors within the NHS hierarchy is crystallised in narratives around career development and prospects. This chapter therefore examines the main distinguishing features of Nigerian doctors' career development within the NHS. As will become clear, their experiences of carving out a career for themselves in the NHS is consistent with the observation that they are, by and large, used as a quick fix solution to staffing shortages, and that this state of affairs is underpinned and validated by notions of 'race' and racism.

The connection between racism/discrimination and the career development of overseas doctors in the NHS is important in its own right. Apart from the obvious infringement of social justice which stands at the heart of discrimination in the labour market, it is also costly to relegate a significant proportion of the workforce – 20% in the case of doctors in the NHS – to low prestige jobs with a reduced chance of promotion. Such practice increases the risk of ignoring talent by effectively narrowing the pool from which it is drawn. Furthermore, there is evidence that "a diverse workforce in which all staff members' contributions are valued is linked to good patient care" (Kline, 2014: 3). But there are broader issues at stake as well. If Nigerian doctors face discrimination within the NHS and are channelled into specialisms not of their own choosing, in the end they will specialise in roles suited to the needs of the NHS rather than the needs of Nigeria. This will have an impact on their ability to amass expertise and knowledge which will be useful back home.

The aim of this chapter, therefore, is twofold. Firstly, I will show how different forms of racism and discrimination shape the career development of Nigerian doctors in the NHS. This forms a complex web of interlocking relationships, ranging from inter-personal casual racist remarks to structural and institutional discrimination. Underlying this morass of discriminatory practices is the racialised notion of 'overseas doctors'. Within the hierarchy of the NHS, 'overseas doctors' are considered and treated as an expendable resource to plug gaps in the labour market. These attitudes were in fact established in practice long before

discrimination was explicitly formalised in policy in 2006, described in the last chapter. Secondly, I will explore how my interviewees connected stagnation and/or sacrifice in their careers to their own ambition and ability to contribute to the development of the health sector in Nigeria.

Discrimination in the NHS – *Plus Ça Change*...

The differential labour market position of overseas doctors in the NHS is well documented. As Goldacre, Davidson and Lambert (2004: 599) note:

> As has long been recognised, doctors trained abroad are over-represented at the consultant level in specialties that can be hard to fill. It is also well recognised that there are large numbers of non-white doctors who trained abroad in career grade hospital posts below the level of consultant and in inner city general practice.

Therefore, the findings of this study that racism and discrimination are pivotal shaping factors where career development is concerned were perhaps somewhat predictable. However, it is clear that overseas doctors are also disadvantaged in comparison to black British doctors (ibid.), which indicates that 'race' on its own is not a satisfactory analytical category. As I touched on in the Introduction and in Chapter 3, statistics on the labour market position of overseas doctors in the NHS suggest that they serve to fill labour shortage gaps. As table 4 shows, non-EEA doctors are highly over-represented in SAS (Speciality and Associate Specialist) grades, which include clinical assistants, hospital practitioners, staff grade, specialty doctors and associate specialists. These are non-training posts and do not allow the position holder to progress to consultant level.

	Total	UK		Rest of EEA		Outside EEA		Unknown
		HC	%	HC	%	HC	%	
All medical staff	151,631	102,973	69.8%	9,124	6.2%	35,378	24.0%	21,570
All Hospital grades	58,132	35,314	62.2%	4,211	7.4%	17,231	30.4%	4,212
Consultant	44,330	29,810	68.4%	3,022	6.9%	10,768	24.7%	2,342
SAS grades	13,802	5,504	41.8%	1,189	9.0%	6,463	49.1%	1,870
All training grades	57,972	40,160	72.7%	3,298	6.0%	11,750	21.3%	9,058
Registrar Group	42,849	28,099	67.8%	2,808	6.8%	10,550	25.4%	2,901
FY2	7,786	6,115	83.2%	333	4.5%	903	12.3%	1,117
FY1	7,207	5,843	93.1%	150	2.4%	280	4.5%	319
GPs (excl retainers)	35,527	27,499	77.6%	1,615	4.5%	6,397	18.0%	7,741

Table 4: 2012 UK medical workforce by grade and country of qualification. Source: BMA (2013).

Conversely, table 4 also shows that overseas doctors are only slightly under-represented at consultant level. Indeed, the proportion of overseas doctors at consultant level has increased significantly from 15% of consultants appointed before 1992 to 24% of those appointed between 1992-2001 (Goldacre, Davidson and Lambert, 2004). This is not to say that discrimination has been eliminated. Further analysis shows that overseas doctors who

have reached consultant level are clustered in certain specialisms, most notably geriatric medicine, psychiatry, learning disability, and genitourinary medicine (ibid.), whereas at the opposite end of the spectrum they are less likely to become consultants in surgery. In other words, overseas doctors tend to agglomerate in less prestigious specialisms, but are less likely to reach the top in more popular and competitive fields.

The accounts related by many of my interviewees are consistent with previous research on discrimination in the NHS. For example, many of my interviewees started their careers in the UK in non-consultant career grade posts, and some of them ended up as staff grade doctors. Furthermore, many of my interviewees explained how their choices were limited to less prestigious specialisms. For example, a large number of Nigerian doctors find themselves in psychiatry, echoing the way Indian doctors entered geriatrics in the 1970s and 80s. As Robinson and Carey (2000: 98) argue, "racism has led to particular concentrations of overseas doctors in specialties that are unpopular amongst white doctors, for example, geriatrics and psychiatry." Dr. E.A. explained the logic behind the analogous situation for Nigerian doctors:

> I went to a wedding of one of my class mates, here. And I was talking to one of my friends, who I knew from medical school, he was Nigerian and working here as well, in public health. And we were marvelling at the number of people there – because obviously there was a lot of people from our medical school there – who were doing psychiatry. Why psychiatry? Why, because psychiatry at the time was an undersubscribed specialty, they came from outside the UK, and wanted to very quickly get to, you know, consultant position. So why go for surgery?

Similarly, Dr. N.E., who is an associate specialist himself, speculated on the reasons behind the over-representation of overseas doctors in SAS roles:

> Until recently, until very recently, those who are called 'non-consultant grade doctors', they are seen as a, sort of, second class group of doctors. Specialist staff grade, you are there to fill up where the trainees cannot do something, if they go for lectures or talks or something, you're supposed to stand in and do their work. And these posts, the majority are actually occupied by people from outside the UK.

These reasons given by Dr. E.A. and Dr. N.E. on why overseas doctors are concentrated in non-training posts and less prestigious specialisms brings us back to the question of racism and discrimination. They have less influence over their career development exactly because the more popular career paths have been earmarked for UK and EEA doctors. Thus, discrimination and racism had two principal effects on the career development of my interviewees. On the one hand, their choice and power to direct their own careers was restricted to a far greater degree than their EEA counterparts, and on the other, it took considerably longer to achieve the goals they set themselves. This, in turn, impacts on their ability to contribute to development back home in Nigeria. Some would find themselves channelled into a specialism not of their own choosing, and struggled to see how their expertise could be of benefit to Nigeria. Others reported being stuck at a SHO level or a locum role, and not progressing. And many complained that the most productive years of their careers were taken up kicking against the pricks in a system where the odds were stacked against them.

The parallels with the narratives of previous cohorts of doctors from the Asian sub-continent are notable. The way in which Nigerian doctors are becoming overrepresented in specialties like psychiatry echoes the previous channelling of south Asian doctors into geriatrics. However, the comparison goes beyond their experiences of racism and discrimination, as it also extends into their capacity to engage in transnational activities. As Robinson and Carey (2000: 101) argue in their study on Indian doctors in the UK, a "central factor which shaped the experiences and plans of all respondents was racism in the UK, including within the medical system." This, they note, included plans to return to India to practice medicine. As will become clear, the various forms of racism and discrimination faced by my interviewees had a deep impact on their experiences and plans, including how they could engage in transnational activities to contribute to the development of the Nigerian healthcare sector.

Career Development and Institutional Racism

It is a truism that racism forms a complex and multifaceted framework of social phenomena. In my discussion of racism and discrimination, I will follow Rattansi's (2007: 1) lead in avoiding "easy, cut and dried answers" to the "large, complex and contentious issues" encapsulated by the simple term 'racism'. At the same time, however, it is important to heed Keith's (2013: 1374) warning that "Race may be an incoherent category but it retains significance because we act as if it has significance and, consequently, its effects are real." The racism and discrimination experienced by Nigerian doctors operates on different levels to various degrees of intensity, ranging from one-off casual racist remarks by colleagues or patients to systematic arrangements to keep them stuck at a particular place in the labour market. These diverse and often divergent sets of experiences have a cumulative effect. When Dr. L.A. says that "You get trapped in the system", he is referring to the total discriminatory praxis which confronts him as a Nigerian doctor – in short, institutional racism.

According to Ambalavaner Sivanandan (2000), an analysis of institutional racism must encompass the structure "of an organisation, which includes not only policies, practices, procedures, behaviour, but also the organic relationship between them and the dynamics that that throws up. That is how racism becomes institutionalised". This is an important insight, as the structure of the healthcare labour market does indeed comprise discriminatory elements which encompass "policies, practices, procedures, behaviour" (ibid.). Sivanandan's interpretation of institutional racism as a set of organic relationships between these elements therefore provides us with a useful point of departure for exploring the racialised dimensions of the various structural constraints on career advancement. Thus, in order to understand the bigger picture of how racism and discrimination impacts on Nigerian doctors, it is sensible to look at each component part separately, and then review how these different pieces fit together to form a whole.

As will become clear, racism in the NHS is a complex issue. For example, Black African doctors have to contend with a different set of issues than do their Black British colleagues. In other words, racism impacts on overseas doctors differently – and to a greater extent – than it does on British trained BME doctors. Thus, the deployment of 'race' to assess and categorise medical skills and knowledge as superior/inferior is done selectively. As we

shall see, the 'racial grammar' – "the social practices to which race gives rise; or the things race makes happen" (Knowles, 2003: 12) – within the medical establishment in England sometimes conflates 'black' and 'overseas', and sometimes distinguishes between them. This racial grammar – revolving to a great degree around notions of sameness and difference, corresponding to medical competence and medical incompetence – is complicated by a host of racialised social markers, including 'race', citizenship and ethnicity, and are manifested in a range of signifiers and symbols, such as skin colour, accent, demeanour, origin of medical degree, links to old boys' networks, headscarves, modes of patient interaction, and so on. Thus, in order to make sense of the dynamics of racism on different levels, it is important to deconstruct the simplistic folk theories of 'race' and racism which pervade the medical establishment – typified by Mr F.B., a policy maker at the Department of Health, when he remarked that "it's quite clear that colour is not an issue here. It's about ability." – replace it with an understanding of 'race' "that addresses divergent levels of scope and scale, for race is simultaneously very personal and built into the structures of societies and the global order of things" (ibid: 11). In my examination of the racial grammar of the medical establishment, I therefore take my cue from Knowles (2007: 7):

> Migration, displacement and differential access to nation states and their allocation systems, has produced a complicated mosaic of race, ethnicity and migration. The old axes of migration and racial alignment are overwritten by new systems, and we struggle to understand their racial grammar. The global inequalities produced by these new systems of migration pose urgent political questions about global dimensions of social justice and rights. These opposing tendencies, in which we deconstruct circumstances and grapple with their detail; as well as join things up and think about broader circumstances, are helpful. The micro/macro is a useful tension to maintain in developing our analysis of race, because it operates simultaneously at different levels of scope and scale.

Casual Racism – "Which jungle are you from?"

Although racism outside of the workplace was mentioned by a number of interviewees, this was not deemed to impact on their career development as such, and will therefore not be discussed here. Racism and discrimination within the workplace, on the other hand, was mentioned by the majority of interviewees as something which had a real impact on their working lives. As is the nature of racism, these experiences spanned a wide range of acts, attitudes and utterances. For the sake of clarity, however, they can broadly be discussed under the rubric of two sets of contexts: racism from patients, and racism from colleagues.

Patients

In many ways, racism from patients is simpler to describe and analyse. The relationship between doctor and patient is dynamic and of paramount importance to the very foundations of medical practice and ethics (Szasz and Hollender, 1956). Nonetheless, my interviewees tended to describe these relationships as relatively easy to manage, partly because a doctor is in a position of power and superiority over the patient. However, patient racism is hurtful and unpleasant, and makes the working environment full of tension and bad feeling. Some interviewees went so far as to suggest that patient racism is a reality which black doctors

simply have to learn to live with. Dr. A.L., who was working in an inner city GP surgery in south London, recounted an incident of patient racism, and its aftermath:

> Dr. A.L.: I don't know, I guess you get used to it? I don't know if you get used to it. Or if you become numb? I mean, I had a complaint last year about a patient, who walked in, and said he wasn't going to see me, because he said I was late. Erm, ok. So I explained and said I had an emergency, which they could see because I'd been walking up and down the ... But in his complaint letter, it was a racism thing, 'It was a black doctor'. And after I saw his wife, because she was acutely ill, I was quite kind to her because she was in quite a lot of pain, and I'd made sure she got sorted out right there and then. And his wife was quite ok, but he was the one who was not ok at all. And in the complaint letter, it was so funny, because he went, 'She was late, she was black, but guess what, she looks after my wife very well' sort of thing! [Laughs.] So when we were discussing it, and trying to get points and learn from the complaint, the practice manager just kept on saying, 'I wish this guy would just make up his mind about what it is that he's complaining about!' [Laughs.] You know!
>
> Me: Almost as if he was saying, 'Yeah, she's a good doctor...'
>
> Dr. A.L.: '...but she's *black*!' [Laughs.] Exactly! Yeah!

In this instance, Dr. A.L. describes a fairly typical scenario. Importantly, she separates the racist intent from her own abilities as a doctor. However, although many interviewees saw patient racism as more of a working life nuisance and everyday blight rather than something which had a direct impact on their career development, this connection can nevertheless be made. For instance, Dr. N.E. – a community paediatrician working in south east London – described the sequence of events leading to a patient filing a complaint against him. As Dr. N.E. himself points out, "most of the discrimination tends to be subtle", and in his case there was a clear alignment between racism from patients and colleagues. Dr. N.E.'s disciplinary procedures, and their significance, are further outlined below in the section *Professional Accreditation and Scrutiny*.

Colleagues

Although my data is unable to allow me to make any statistical claims, it is worth noting that older interviewees were more likely to mention casual racism and racist abuse from their colleagues. When asked about their experiences of racism, all of the older interviewees were able to relate one or more incidents of distressing and grotesque racist abuse. Dr. B.B. – a consultant surgeon based in the South West England – described an experience during one of his first operations in the UK in the 1980s, where a senior colleague received him with a familiar racial slur:

> Rather than saying, 'Who are you?' or 'Welcome to the team', the first question he asked me was, 'Which jungle are you from?' I was shocked. I remember, I was shocked. I wasn't ready for that question. He didn't even ask me for my name! He said, 'Which jungle are you from?' I couldn't answer.

Similarly, Dr. G.R. – a retired surgeon based in south London – related an incident which happened shortly before becoming promoted to consultant level:

> I was struggling in one of the centres, in London. And you can imagine this is the coffee room. So when we are operating, we come out to the coffee room. And I was a senior registrar, and I was 39, 40. That was my last job, in the [name of hospital], nobody wanted to go to the [name of hospital], but that was alright because I was a temp, I did six months and it was recognised towards my training. So very close to the time I got appointed, this guy came in, he was a general surgeon. My consultant was in the room, he came in, and there were medical students there, and juniors. So I was the senior resident. He pointed at me and asked me to leave the room. The coffee room. [Pauses.] What?! I was going to get angry. You have to remember that as a proud Nigerian ... if I would have gone Nigerian, I would have hit that guy so hard. Because I felt insulted in front of my juniors. And my consultant was there. And I had to remind myself, 'Look, you are very close to being promoted. Do you want to be fighting anybody at this time?' You know what I did? I left it.

In this way, the older interviewees explained that this was part and parcel of a Nigerian doctor's work during the 70s, 80s and 90s. No matter how angry and upset it made them, they simply had to accept and live with racism. At the same time, however, casual racism could have a real impact on career development, in that the situation got so bad for some interviewees that they felt they had to leave their post and look elsewhere for work.

Younger interviewees, on the other hand, tended to place a different understanding on the question of racism from colleagues. Some contended that they had not experienced aggressive inter-personal racism at all during their time in England. Nevertheless, experiences of overt and direct racism was disclosed by a number of younger interviewees as well, albeit in somewhat subtler ways than that described by older interviewees. Dr. F.S. – an ST3 (specialty training year 3) in acute medicine who migrated to England in the mid-2000s – recounted an incident which took place soon after landing a job in the East of England:

> Dr. F.S.: But when I moved to [town in East of England], it's predominantly white – white nurses and white doctors – so I had some ... I wouldn't say discrimination, but I had some problems there, with the nurses especially. And the consultant told me she was sorry, but she thought it was just because I was black. And because I'm Muslim as well, I cover my hair and I'm in [town in East of England], so that was why. The nurses were being very picky about everything, they complained about everything.
>
> Me: Ok. And how did that affect you?
>
> Dr. F.S.: Oh, gosh. I regretted moving...

This connects to the argument I made in the last chapter relating to the 'othering' of overseas doctors. Dr. N.M. – a consultant surgeon in the north of England, who had arrived in the mid-1990s – linked discrimination explicitly to notions of inferiority when discussing his experiences of racism within the NHS:

> Dr. N.M.: The other issue is about the support that you get when you work in this environment, if you are foreign, if you come from another society. It's slightly different, and I'm not surprised about that. People always look at you

> with suspicion. Because they don't really know you. You know, they will have to use the information that the press gives them, about you. Rather than try to really, you know, 'Who is this individual?' So they will first of all generalise, until you can now prove that you are not what they thought you are. So that puts you under a lot of pressure to wanting to always prove something. And in the process of trying to prove something, well, sometimes you may get it wrong. Because you are always struggling to try and prove that you can do it. I can give you so many incidences I've had in my career, here, where I go to theatre, take a patient to theatre, and the staff originally think, 'Hmm, who is this person? He can't do it!' And when you now do it, they say, 'Ooh, I didn't expect you to do that! I didn't expect you to be able to do it. I expected you to call somebody else to do it!'
>
> Me: And what do you think that's about?
>
> Dr. N.M.: It's about pre-determined, you know, impressions people have. And unfortunately, they can only get information from the press. If you want to know about people ... because people just feel that, once you come from somewhere else, especially Africa, you have to be inferior. Inferior intellect, inferior ability, inferior everything.

Dr. N.M. touches on something important here, which is that racism on the part of colleagues actually represents a wider sense of structural discrimination. As Dr. N.M. puts it, "I had to spend another seven years to be able to convince the system that, yes, I'm ready to be a consultant". Thus, in spite of these types of experiences of interpersonal racism being quite common, the younger interviewees' initial reaction to the question of racism would be to connect their experiences of racism to discrimination in the job market – in other words, they tended to view racism as a structural and systematic phenomenon, rather than something which is ad hoc and personal. I will explore this in greater depth below.

Institutional Racism – "And then I couldn't get a job"

'Institutional racism' in the NHS is not analytically separate from staff and patient racism, but incorporates it; this section should therefore be read as an expansion of the previous one. It is, however, important to place everyday racism within a broader structural context of policies and procedures. Indeed, this is how my interviewees tended to think about their own experiences of racism.

Policy Landscape

The last chapter mapped the policy landscape through which Nigerian doctors must navigate as part of their migration journeys. I paid special attention to the highly racialised category of 'overseas doctors', and how this category limits the avenues available to Nigerian doctors and fixes them to particular positions within the NHS hierarchy. This policy landscape is intimately linked to wider issues of racism and discrimination, and affects the career development of Nigerian doctors in a number of ways. As will become clear, many of the policy changes in the 2000s have steadily exacerbated these trends. Most dramatic and

damaging of these were the removal of medical practitioners from the UK occupation shortage list in 2005 and giving UK/EEA doctors preferential treatment meant that leave to remain in the UK was dependent on obtaining a work permit, which became increasingly difficult due to competition with UK/EEA doctors.

These changes certainly had a huge impact on those of my interviewees who were affected by them. Dr. F.S. explained how the 2005/2006 changes to immigration policy put her career on hold for an additional two years after passing the PLAB exams. Although she entered the UK on the Highly Skilled Migrant Programme, and should as such not have been subjected to the limitations of the Permit Free Training, she got caught up in the confusion surrounding unofficial guidance issued by the Department of Health in 2006:

> They changed the rules so that no immigrant doctors could go into training programmes. So I couldn't get a job. But I kept applying. I used to apply for sometimes up to 50 jobs a week. And I finished my PLAB in 2005, July. But I didn't get my first job until June 2007. So that's almost two years.

This, she told me later, had a decisive impact on her career trajectory. Whereas she started applying for surgical training posts, she gradually scaled down her ambitions to general practice, where she finally made some progress:

> Dr. F.S.: Because then, I applied for the GP job, my application was accepted, I did the first written exam, I passed. And then I was supposed to go for the interview ... I was supposed to go. And then I just got a letter saying, 'Sorry, you cannot proceed further'. And that was a huge blow.
>
> Me: And what reason did they give?
>
> Dr. F.S.: Because of changes in immigration rules. And even if I had what was called then HSMP, Highly Skilled Migrant Programme. But still, I was an immigrant [laughs].

Eventually, Dr. F.S. settled on a trust job in cardiology. Effectively, her choice was zero. Asked whether the changes in immigration policy had an effect on her career development, she said:

> Yeah, it did. Because I never wanted to do medicine when I finished. I wanted to do surgery. But surgery was a difficult area to get into. And medicine wasn't easy, but my first job was in medicine, and it would have been difficult to change into another specialty. So I just stuck with it.

During her two years in limbo, Dr. F.S. had a child, and was supported by her husband, who was also a doctor. This allowed her to focus on job applications without worrying about money, although anxiety about immigration status and career progression was a constant feature throughout this period of her life. However, the two other interviewees who were also affected by the changes had to take on non-medical jobs to make ends meet.

Dr. F.S.'s story illustrates how policy can have a direct impact on the career development of overseas doctors. The policy of giving UK and EEA doctors priority for training posts greatly reduces the options available for career development for Nigerian doctors, where the only hope of a training post is where UK and EEA doctors are

uninterested in working in that particular field of medicine. As a direct result of this policy, Dr. F.S.'s career path fundamentally changed – "If you look at my yearbook you'll have seen, 'Planned a residency in neurosurgery'" – but it also resulted in a number of lost years:

> Me: So did all these things have an impact on your career development?
>
> Dr. F.S.: Yes, because if I had been in Nigeria, I would have been a consultant ages ago. But now, I'm still in training. And now my consultant graduated in the same year as me. Which is, well ... it's fine.

An important thing to note is that Dr. F.S. was deeply involved in transnational activities aimed at developing the health sector back in Nigeria. She had organised medical missions to northern Nigeria, and the sense of making a contribution back home featured prominently in our interview. However, she was not able to dedicate as much time to these activities as she would have liked to, exactly because so much time and energy was expended trying to carve out a career in the NHS. Asked whether she regularly goes back to Nigeria, she replied: "Yeah, although the last time I went was in 2009. But I'm going this year. It's just because of the timing, labour rotations and things like that. So I haven't really had time to go back."

Although Dr. F.S.'s experience of having to rethink her aims and ambitions was not one shared by all the doctors, most of my interviewees nevertheless at the very least knew someone who did. Indeed, there was a general consensus that Dr. F.S.'s trajectory is a fairly common one, as Dr. N.M. explained:

> A lot of Nigerians came here and, for example, they were gynaecologists in Nigeria, trained gynaecologists. And they come here, and they couldn't practice gynaecology, they couldn't get into the programmes. So they went and became psychiatrists. Or they went and became GPs. Or they went and become something else. There are a lot of Nigerians who are in this position ... Because the policy changed, to make it easier to get into the system if you opt into going to certain specialties. Surgery was difficult, for example. So the people who wanted to be surgeons could not get into the system. Those who wanted to stay, went and did something else.

Policy also impacted on the transnational activities of some doctors in other, less direct ways. For instance, Dr. N.M. had helped a number of young Nigerian doctors onto short training programmes in England. I will discuss this in further depth in Chapter 5, but the important point here is that his endeavours had been made ever more difficult by immigration policy:

> Dr. N.M.: The first person I brought, initially they refused him a visa, and he had to wait for about a year.
>
> Me: When was this?
>
> Dr. N.M.: This was 2008, or 2009, that he came here. So he had to wait, initially when he applied, they refused him the visa. And then he applied again a year after, then they gave him the visa, and he came here. So that's one problem.
>
> Me: Do you know why they denied him the visa?

> Dr. N.M.: It's difficult to ... the reasons they give are usually not very coherent. You don't really use that information, because many times it doesn't make sense. And it doesn't have to make sense. You know, anybody can refuse anybody to come into their country. They don't have to give you a good reason. So we understand that, so the common reason is, 'We don't believe you're going to go back.' He came, he went back. When they eventually gave him the visa, he came, he went back.

On top of this, various administrative hurdles would be put in their path and then shuffled around, making them difficult to navigate:

> Dr. N.M.: The other problem we have is the ... it's not like what it used to be before. The GMC usually gives them, give you, a licence to operate, for example. At the moment, they changed the rules so it's almost impossible.
>
> Me: Right, so if they come here for a period of three months, say, they're not allowed to operate...
>
> Dr. N.M.: ...operate. Yes. So that's a problem. So they don't really get the maximum from what they could have got. And when I came, the rules were different. I was able to operate. The GMC gave me the registration to operate. The rule is that, now, I think that you have to be here for six months. And you have to be in a paid job, before you can be given a licence to be able to operate.

Later on in the interview, Dr. N.M. speculated on the real reasons for these various British authorities – UKBA, GMC, DoH, etc – making it difficult for doctors to obtain visas:

> There are so many hurdles, unnecessary hurdles, to people coming here to learn. And we know why, anyway, because they want to protect the jobs for British trained surgeons, or British trained doctors. That's the reason why they change everything, so that the people who are coming from outside the UK only come to spectate. And of course, if you come to spectate, you're going to leave early.

Immigration policies made other aspects of life difficult as well, most notably family life. A number of interviewees reported difficulties in obtaining immigration clearance for their families to join them in England. For Dr. M.C. – a gynaecologist who migrated in the mid-1990s – it took over a year to acquire a visa in order for his wife to join him:

> The initial challenge, in the beginning, was that when I got my first job, my wife was in Nigeria then, I wanted her to come and meet me in the UK, and immigration refused her a visa, saying that I cannot afford to look after her. So I had to go to appeal, and then immigration court, and they said, 'Well, that's stupid, are you saying that a UK doctor can't look after...?' So they revoked that, and eventually gave her the visa. So for about a year, she couldn't come to the UK.

Similarly, Dr. B.E. – a surgeon who spent 15 months in England but had since returned to Nigeria – had applied for his family to join him in England, but to no avail. When I asked him whether his wife and children joined him in England, he answered:

> Dr. B.E.: No, not at all, they were not able to come to the UK. That was another challenge I had. My wife is supposed to come easily to the UK on my Tier 2

visa. But the embassy contrived some very interesting obstacles. They just refused to give her the visa. So she couldn't come. It was quite disturbing, because she was supposed to be around for six months minimum. But they just found phoney reasons.

Me: Did they give a reason?

Dr. B.E.: They gave a reason, they said they asked for documents. The documents they asked for, she provided. And they also asked for a letter, from my employer, saying that my wife can come and join me, and I have enough job, and ability to provide for her, and that the unit is also ready to sponsor her. So I thought that was enough. Until they now said they'd refused the visa, and that the reason was that she didn't put a picture of us together. And number two, she didn't put the right certificate. They're not sure that the marriage still exists. But how would she get my visa, my passport? How would she get my head of department letter? And what she filled was exactly what I filled, the name of the children, the name of the husband. I just thought they were looking for an excuse not to give her the visa.

Me: What year was that?

Dr. B.E.: I left here in 2011, so that was 2012. And I think at that time, the government was really clamping down, they were just looking for reasons to cut as many people as possible.

Immigration policies, coupled with NHS recruitment policies, go some way towards explaining why Nigerian doctors cluster in certain specialisms. As Dr. A.L. described, many of her Nigerian colleagues were attracted to psychiatry. In line Dr. E.A.'s quote above, she attributed this partly to the fact that psychiatry represents an easier route for overseas doctors to reach consultant level. However, she importantly linked this to immigration policy as well:

> A lot of people went to psychiatry. I didn't. See, a lot of people didn't do general practice, because they felt you could go the pathway of psychiatry, and get a better ... a lot of my peers, we used to read together, we were eight. I'm the only one who did general practice, all seven others did psychiatry. Because it was considered an easier route for ethnic minority doctors ... And once people get to know about that, it's like water, isn't it? The least resistance. So they will start heading towards those jobs, *because they know that it's easier to get immigration approval for those jobs*. [my emphasis]

However, although the 2005/2006 decision seems like an obvious policy landmark, many of my older interviewees said that this merely formalised something that was practiced anyway. Indeed, the 2005/2006 changes to policy represent a short time period, and has only affected a relatively small proportion of Nigerian doctors in the NHS. They do have wider significance, however, than merely a time limited measure to temporarily provide UK and EEA doctors with a competitive advantage. In fact, they could be seen to represent a critical point where tacitly established discriminatory practices became formalised in policy.
In the words of Dr. E.A., who witnessed many of his colleagues struggle as a result of the 2005/2006 changes:

> I mean, you can neither say it's better nor it's worse. In the sense that now, the immigration laws kind of make that possible. In some ways it was worse 10 years ago. At least now, in an advert they will tell you that they will only consider EEA citizens, and if we don't find an EEA citizen... But in the past, it wasn't stated, but it was often applied.

This view was corroborated by Dr. A.L., who had a hard time passing the PLAB in the late 1990s. She explained what happened when she finally finished her exams:

> So when I passed it, I thought all my problems were over, not realising that that's when the problems all start! [Laughs.] Because you pass it, you get limited registration, which was fine, I paid for that. And then I couldn't get a job. Nobody would employ me. Because I was trained abroad, and they couldn't ascertain what the quality of the training was, and nobody was willing to take ... So they'd take me on for locum jobs, but they wouldn't give me a substantive job.

This had a tremendous impact on her. In the eight years between arriving in England and landing her first substantive medical job, she took an administrative job in a hospital office to keep herself afloat financially, which she described as a demoralising time in her life:

> I was going to do a whole career change. I was going to give up medicine. After doing the house job, and not getting any posts, for me, out of all the years, that's the one time where I've been really, really low. It was a case of, 'Right, that's it, I'm done with medicine. I'm going to do something else'. I started to apply for IT jobs, I was even going for interviews! And it was just a case of, 'I can't do this anymore'.

For many of my interviewees, therefore, their careers represented long and arduous journeys where every two steps forward was followed by a step backwards. When I asked Dr. N.E. about where he was in his career, gave me a detailed answer of his title, and the journey he had embarked on to get there. The NHS hierarchy amongst doctors is complex and somewhat confusing, with a number of grades and different career pathways. However, Dr. N.E.'s answer is worth quoting in full, because it serves as an illustrative example of how small tweaks in policy can place overseas doctors in a disadvantaged position:

> Dr. N.E.: My grade is called Associate Specialist. Because, what happened was, when I started as a registrar, by the time I was a registrar – within that year, I think '96 – they introduced what was called the Calman training, where you needed a number. At that time there was this fear in the NHS that, 'Oh, there's a lot of trainees coming up, and they're going to need consultant positions, and we don't have that, so we need to restrict the entry.' So they started what they called this Calman number. And we were the victims of that number. Because, as somebody who had just come, spent one year, somehow I was not qualified – let me use that term – to get a Calman number.
>
> Me: Why not?
>
> Dr. N.E.: Because I hadn't spent enough time in training. I did one year clinical attachment, I did registrar training. But by then, there was a new training pathway, so you needed to do training through SHO grade. Then you're no longer registrar, you become specialist registrar. That's actually when the term was introduced. There was some confusion around the change, then, in '96/'97.

> So, getting a Calman number became a big issue then. And remember, the next port of call should be senior registrar, and that year I was invited to senior registrar interviews, but I wasn't taken in. But after that, I was no longer invited for interviews, because I was not given that training number, I'm not recognised as somebody in training. So what I had to do then, was make a lateral move. To the non-career grade, becoming a non-training grade doctor. At this stage, there are two arms of development. You can develop as a trainee, through training, which then leads you to, finally, consultant. Non-career, you start at what you call staff grade. And I had to take a step backwards, actually, because the issue was also that I've only had hospital training abroad. And you needed to have a number of years of training in the UK to qualify for that training number. So I was deficient in that area. So I then became a staff grade, I became a senior house officer again, it was a retrogressive step. And I needed to show people that, 'Look, I have practiced in a hospital as a junior doctor in this country.' And then, because I went into that staff grade post, and because I had so much experience I became an Associate Specialist. And as an Associate Specialist you are operating at consultant level. But, you are not a consultant.

As Dr. N.E. explains above, non-consultant grade doctors are seen as a "second class group of doctors" whose main role is "to fill up where the trainees cannot do something, if they go for lectures or talks or something, you're supposed to stand in and do their work". For Dr. N.E., the idea that he had been channelled into a non-consultant career grade post exactly because he was Nigerian was beyond a shadow of a doubt.

Dr. B.B. had a similar experience to Dr. N.E. in that the changes to medical training following the Calman reforms of the UK medical training system set his career back several years.

> Calman caught up with me. You can't get a permanent job, unless you're a British citizen, or you have right of abode in the UK. You had to get a work permit. Which I had to do. So I had a work permit for four years before getting my full residency and getting my British citizenship. That delayed my progress for about five years. So Calman caught up with me. Then, during that period, I didn't go to Nigeria.

These entrenched discriminatory practices – both informal and formalised – were to a large extent rooted in the casual racism and everyday discrimination described above. But they were also implicit in the modus operandi of many of the official bodies tasked with regulating the medical profession, to which we will now turn.

Professional Accreditation and Scrutiny

As Raghuram and Kofman (2002) point out, skilled migrants working within welfare sectors are subjected to significantly more professional scrutiny than their counterparts in the private sector. This includes assessment and scrutiny from governmental and professional bodies, which means that "those wishing to work have not only to gain immigration clearance but also to obtain professional accreditation from regulatory bodies" (ibid.: 2072). Part of this oversight is a rational and reasonable pursuit of standardised medical practice, although discriminatory practices – including within the PLAB exam and GMC registration and

licensing – have been clearly documented (BMA, 2004: 14-15), and have often provided a flashpoint for discontent. Nevertheless, most of my interviewees accepted the accreditation process as a necessary and imperative requirement of practicing medicine in England, even if it is time-consuming and costly. However, governmental and professional scrutiny is not limited to accreditation, but continues throughout the career of a doctor, most notably by the threat of disciplinary measures such as complaints, Fitness to Practice Panels or being struck off the Medical Register.

Given the nature of medicine, and doctors' position of responsibility, this level of scrutiny is rational; most interviewees conceded this to be a necessary and reasonable result of their overseas training and accepted that it would cause delays to their careers. As already mentioned, most interviewees accepted the PLAB process as a necessary part of their migratory routes. Dr. F.R., for instance, spent a year working along his masters degree, doing a variety of unskilled hospital jobs, such as care work, to fund his studies.

> Dr. F.R.: My routine used to be, get up as early as 6am, because I used to live in south east London, and then I'd have to travel into central London, where the school was. And when school finished, around 5pm, then I'd have to travel from school to [south west London], to work until about 11pm, and then go back to [south east London], which is a long way. And life went on like that for about a year. So it was intense.
>
> Me: But you were a qualified doctor at this point.
>
> Dr. F.R.: Oh yeah, I was. But I was very conscious that there was nothing I could do with my medical certificate. Because you have to demonstrate that you can work as a doctor. And the only way you do that is, either you write the PLAB examinations, or the faculty exempts you on the basis of their ability to prove that you have those competencies. But you have to prove yourself first. So yes, all that time I was a doctor, but in my mind, I expected that. I didn't expect to waltz in and say, 'Hey, I'm a doctor!' You know, otherwise anyone can do that, and probably kill a few patients in the process.

At the same time, the doctors also expected to be treated fairly and equally within these processes. However, there is evidence that this is not the case. For instance, during the time of my fieldwork, the MRCGP (Membership of the Royal College of General Practitioners) examination, which all GPs must pass before practicing as accredited general practitioners, came under fire for highly unequal outcomes for different groups of doctors. A definitive study by Esmail and Roberts (2013) had unequivocal results:

> There were substantial differences in pass rates between candidates who were black or minority ethnic and those who were international medical graduates when compared with white UK graduates. Compared with white UK graduates, all the other five groups defined by ethnicity and region of primary medical qualification did significantly worse at their first attempt. (Esmail and Roberts, 2013: 1)

These differences are indeed substantial: white British candidates are four times as likely to pass the examination than British trained BME doctors; and they are fourteen times more likely to pass first time than overseas doctors, even when controlling for prior attainment

(ibid: table 1). RCGP are not unique in this instance; the findings from Esmail and Roberts' (2013) study echo those on postgraduate examinations within the Royal College of Psychiatrists (Tyrer, Leung, Smalls and Katona, 2002) and Royal College of Physicians (Dewhurst et al, 2007).

This state of affairs was commented on by a number of interviewees, many of whom had firsthand experience of re-sitting postgraduate examinations. Dr. G.J., for instance, had to sit the MRCGP examination four times – the maximum number of attempts allowed – before he finally passed it. This set his career development back several years:

> That was quite hard for me. I was actually applying for all sorts of jobs, not just general practice. In fact, general practice was a bit of a plan b, in case my other plans fell through. Which they did, but I did the GP exam again and again, and I couldn't pass it. So I couldn't understand it. In Nigeria, I was top of my class. But here, I couldn't even pass the GP exam! I couldn't understand it.

Dr. G.R. explained why this level of failure is a particular problem for overseas doctors. Referring to the surgeons' exam, he outlined how repeated failure took its toll on the confidence and motivation of overseas doctors:

> Yeah, I mean, guys who come from all over the world, maybe they're best in their class, and come to a place where 20% are going to pass. What's going on here? What kind of exam is this? So a lot of people were really frustrated, they were very depressed. The more you failed it, the more you panicked. And there was a method of study in the UK which actually was quite different. Anyway, that was the issue, it wouldn't have affected some of the other candidates in the same way, UK candidates. You were panicking because you had been selected from a third world country, as a bright chap. You now come here to – for the first time! – start failing exams! You've never failed an exam in your life! You were always top of the class! But of course, most of that had nothing to do with your ability. It had to do with the method of study, and how to pass these exams.

The important point here is that ever increased scrutiny necessarily lengthens the time of limbo, where overseas doctors are only progressing at a slow pace, and cuts short the timeframe within which they can operate at a higher level of medical practice. When I asked Dr. N.M. whether his colleagues' perceptions of the inferiority of African doctors had impacted on his career, he explained how, for him, the constant pressure to prove his credentials represents a waste of his time which could have been put to better use:

> You know, you go through a prolonged period before your skill is recognised. So the system ... you know, I trained in Nigeria for seven years. Ok? I came here, I had to do another seven years before they can recognise the same level of skill to be a consultant, here. So, you know, that's a difficulty. If a surgeon trained in the UK moved to Australia, they won't make him go through seven years. So the system, it's not an individual thing, the way the system is, it forces you to take that path. Really, I don't need seven years, I told you that I was doing [surgical procedure] after two months. So why did I need to stay seven years before I could be allowed to be an independent consultant, in [surgical procedure]?

Dr. N.M. returned to this point later on in the interview, further outlining the logic: "So maybe I would be able to give even more. Contribute even more. Because while I'm waiting, that's contribution I cannot make, because I don't have the opportunity to make those contributions."

Once all hurdles of accreditation and getting a job have been passed, the scrutiny continues in other forms, most importantly through various complaints procedures. As the GMC itself words it, a number of their "activities together amount to the 'regulation' of doctors" (GMC, 2014). To this end, the GMC sets "standards for the period of their training and carry out detailed checks to make sure that doctors receive the training they need to provide good care for patients", sets "the standards and values of doctors, so they know how they should behave when they are with patients", carry out regular checks "to ensure they continue to be up to date and able to provide a good level of care", investigating complaints about doctors, and if they find that a doctors poses a sustained risk to patients, they "patients by restricting their practice or suspending them" or "in very serious cases we may have to remove them from the medical register" (ibid.), otherwise known as being 'struck off'.

The issue of suspension came to public attention during my time of fieldwork, when the Sunday Telegraph splashed a story alleging that the "vast majority of doctors who have been struck off in the past five years were trained abroad" (Leach and Donnelly, 2012). This issue is raised regularly in the right-leaning press, and the framing of this particular discourse is worth dwelling on. Two issues are notable. Firstly, the Sunday Telegraph's use of data is telling, both in regards to which data is highlighted and ignored, as well as the way it is presented:

> The full extent of the danger presented by foreign doctors working in the health service can be revealed.
>
> New figures from the General Medical Council (GMC) show that the vast majority of doctors who have been struck off were trained abroad.
>
> The revelations will add to concerns that NHS patients are not adequately protected from health professionals from countries where training is less rigorous than in the UK, and from those who are unfamiliar with basic medical practices in this country.
>
> The figures, disclosed for the first time and obtained by *The Sunday Telegraph* using freedom of information laws, show:
>
> • Three quarters of doctors struck off the medical register this year were trained abroad.
> • Doctors trained overseas are five times more likely to be struck off than those trained in the UK.
> • The country with the biggest single number of doctors who have been removed or suspended from the medical register, is India, followed by Nigeria and Egypt.[8]
>
> (Leach and Donnelly, 2012)

In the title of the article – *Revealed: 3 in 4 of Britain's danger doctors are trained abroad* – The Sunday Telegraph highlights the proportion of overseas doctors of all doctors who have

[8] For the full article, see Appendix 2.

been struck off. The framing of the data thereby intentionally exaggerates the scale of the problem. Indeed, missing from the story is the proportion of overseas doctors who are struck off. Although The Sunday Telegraph gives the total numbers of doctors in the UK as well as those struck off, these are not translated into percentages. However, The Sunday Telegraph's own figures show that only 0.5% of overseas doctors have been struck off the GMC register, revealing a very different story to the one framed by the authors. Furthermore, a total number of 33 Nigerian doctors were struck off in the period 2008-2012, which is just under 1% of all Nigerian doctors on the GMC register. Although this means that Nigerian doctors are four times as likely to be struck off than white British doctors, of whom 0.25% were struck off, such a low total number certainly permits the possibility that institutional racism is a significant factor.

Secondly, the use of anecdotes is equally revealing. The Sunday Telegraph immediately reach for Daniel Ubani, who has become the human face of medical 'gross negligence':

> In 2008, the pensioner David Gray was killed by a German-trained doctor, Daniel Ubani, who gave him ten times the recommended dose of pain relief while working as a locum.
>
> Dr Ubani, who was born in Nigeria, was working his first shift in this country and later said he had never heard of the medication diamorphine, which is not commonly used by GPs in Germany, before he administered it.
>
> (Leach and Donnelly, 2012)

Thus, although Daniel Ubani trained in Germany, the authors see reason to highlight that he was born in Nigeria. This begs the question: if the issue is about the quality of medical training, why bring up his ethnicity? This introduces a certain slippage in the narrative, where medical training is used as a stick with which to beat 'immigrant' doctors. In other words, the problem was Ubani's Nigerianness, rather than his German training.

The Sunday Telegraph is, of course, a newspaper, with its own reasons to frame the debate in a certain way. Yet the construction of Leach and Donnelly's story is telling in that overseas doctors are by definition second rate and a 'threat' to British patients, mirroring wider anxieties amount immigration and 'swamping'. With such an overall low rate of removal from the medical register, it is clear that the training and competence of overseas doctors is not a threat to British patients. Rather, it is their otherness which is seen as dangerous. The possibility of institutional racism as an explanatory factor is not entertained.

The framing of overseas doctors in the press as 'danger doctors' is certainly significant in its own right, and provides an insight into their place within wider public perceptions and discourses. However, these stories also raise a more specific point about the interplay between racism and policy. As Simpson and Esmail (2011) demonstrate, the Ubani case triggered a sequence of policy responses which focused on clamping down further on overseas doctors and the ways in which they are accredited and scrutinised, while ignoring the systemic failings within the NHS labour market:

> So far, the arguments have focused on the competence of European doctors working in the UK NHS and on failures within the healthcare system. What has not been addressed is the question of the type of roles that migrants are expected

> to take on and the kind of pressures they are exposed to, as a result, in the NHS. (ibid.: 208)

In this way, "the British medical and political establishments have placed a great deal of emphasis on questioning the abilities of non-UK doctors who come to work in the UK" (ibid.: 209), while avoiding the issue of how these establishments use overseas doctors to fill gaps in the labour market, typically "found in under-resourced and unpopular parts of healthcare systems" (ibid,: 208) such as "primary care in inner-city areas, (ex-)mining communities, and areas with high migrant populations; provision of care for people with mental health difficulties; and care for the elderly" (ibid.: 210). This lop-sided policy response left the structure of the labour market intact, but intensified disciplinary procedures and their targeting of overseas doctors.

A number of my interviewees had experiences of disciplinary measures. As already mentioned above, Dr. N.E. had two separate complaints made against him, one by a patient and another by a colleague, both of which went to a tribunal, and one of which led to a disciplinary hearing. During the hearing, he was prevented from seeing patients, whilst still drawing a salary, until he had won the case on appeal. He could certainly see how his behaviour – which, he contended, was normal in Nigeria – could have been interpreted as aggressive and inappropriate. Yet he also argued that the complaints procedures were allowed to go further than necessary, a process in which racism played a part: "Of course, as with anything, you always have a part to play in it, I wouldn't say otherwise, but I've had to undergo, recently, two disciplinary processes, which to me had some elements of discrimination in it." When I asked him who had been responsible for adjudicating his hearing, he said:

> Well, that's another issue, because I'm looking back now ... if you really wanted to be fair, and to be seen to be transparent and fair, maybe you should have got somebody who knows about my culture, to adjudicate. So you bring to me, all blue eyed, Caucasian people to sit in judgement of me, to ask me questions. And when I'm saying about this ... actually, there was a comment that was made, you know, "so when you're asked, you say it's because you're a Nigerian man". And I retorted, I replied in my rebuttal of the report. I said, "I was saying that to bring some understanding and enlightenment to the issue. Now you're turning it against me, that I'm saying that because I'm a Nigerian man, I can do anyhow I like. That's not what I'm saying! My words were twisted. I'm trying to tell you what happens culturally. We're expressive, tactile, all that, and *you* are now using it against me, seeing it in a negative light." Because that's not what I meant, you see. I wasn't making excuses, I was only trying to bring some understanding.

Thus, although Dr. N.E. explained his behaviour with reference to his Nigerian culture, he was not hiding behind this Nigerianness. Nonetheless, he felt this very Nigerianness take centre stage in the disciplinary process: "If I wasn't somebody from my particular ethnic group, it may not have got to that stage". Dr. N.E.'s chief complaint was that mitigating circumstances were not taken into consideration. For him, the case was based on a cultural misunderstanding, which could easily have been rectified by less drastic means. In this way, Dr. N.E.'s experience of the disciplinary process corresponds to Dr. E.A.'s perspective of sitting on the other side of the table as part of a disciplinary panel for the GMC:

> Dr. E.A.: So I think it's also the way the system, the institutions are set up, the organisations are not set up to deal with difference. ... And I see it now, because I now do work for the GMC, and sitting on some of their panels and chairing some of their panels. And sometimes a case will come to the panel of a foreign doctor, where the rest of the panel, who are white, will reach a certain conclusion. And I have said to them 'Actually, from my perspective, what they did here wasn't, you know, I can say, in all honesty, they thought they were doing the right thing', putting it in that context. And that's what I mean. When those incidents happen, I sort of think to myself, 'If I wasn't sitting on this particular panel, they would have found this person guilty'. So I'm able to bring that perspective.
>
> Me: Are they receptive to your comments, when you make them?
>
> Dr. E.A.: Erm, I can argue quite hard.

Furthermore, disciplinary procedures can be used as tools of control. Dr. A.L., for instance, had problems with her GP partner:

> I resigned from my job because my GP partner felt he couldn't take [laughs] he couldn't take being spoken to, or being told what to do, by a female. And a black female at that! And his aim, as he told me – because he reported me to the GMC – was to get me struck off the register. And so I would not be able to practice as a doctor in this country. ... So I had to have a GMC clinical competence review. And it took a whole year, and at the end of it the GMC said there was nothing wrong with my practice.

The source of this excessive scrutiny and harsh treatment was commented on by a number of interviewees. Of course, they tended to concur with the principle of scrutiny within medicine, but many nevertheless felt that much of the trouble overseas doctors had was based on misperceptions in both directions. Overseas doctors would be perceived as crass, inappropriate and insensitive by patients and the medical establishment, but could at the same time find it difficult to read cultural sensitivities and therefore behave in ways which could be interpreted as being such. When I asked him why he thought the rate at which Nigerian doctors were struck of the GMC register was higher than for their white British counterparts, Dr. N.M. explained that this was partly down to a lack of support to overcome cultural differences:

> I think one of the reasons is that they don't get good support, where they work. They don't get orientated very well, about the system. See, there are certain things, practices, in Nigeria, as a doctor, which is ok in Nigeria. It's not ok here. Some of the doctors don't know it's not ok. That you can't do that. So many times, it's only when they do it, and they get into trouble, that they know it's not ok. The way they relate to people, and the way they see ... for example, Nigerians, generally, are very friendly people. They want to come to you. They don't stay away and deal with you from a distance. They want to be as close as possible. In Nigeria, it's normal for someone who is a stranger to hold you, to pat your back, someone you've never met before, it's ok. Body contact is not seen as a big deal. No. It's normal. But here, it's not. So if you're a Nigerian doctor, and you're doing that to your patients, you have trouble here. In Nigeria, that's normal! So there are so many little things, that many of them have not actually

> been told, been educated, to say, 'Look, you're not in Nigeria now, you're in the UK, and these are the things you don't do'. Simple things.

These 'simple things' could, in fact, be very fundamental differences in cultural understandings, but also be taken for granted as the way things should naturally be. Dr. F.F. gave a good example of how different taken-for-granted understandings fundamental to medical practice – the doctor/patient relationship – could be difficult to recognise and manage:

> In the first six months, it was more of an adaptation. Different culture, different people, different psyche, different psychology. And coming from a background where things are done differently. In Nigeria, the patients look at us, the doctors, as gods. We can never be wrong. Alright? But here, the doctors respect the patients more. Alright? The culture is different. The patient is more important here.

To sum up, then, the ways in which institutional racism manifests in professional accreditation and scrutiny is manifold and complex, but has the accumulative effect of depicting overseas doctors as medically second rate and inferior. As a result, many of my interviewees described how they were made to feel as though they should simply know their place, lest they be upbraided and put in their place by force.

Nigerianness, Otherness and Cultural Racism – "If I was black British, I would not have had the same problem"

In chapter 3, I explored the term 'overseas doctors' in policy through the lens of otherness. I argued that the dichotomy between the superiority of UK/EEA doctors and the inferiority of overseas doctors is naturalised through the process of othering. Central to this process is a particular understanding of 'culture' and its relationship with identity. As Baumann (1996) argues, the word 'culture' in British public discourse does not function as an analytical abstract; rather, "it has to be filled with standardized meanings, that is, specified as a substantive heritage that is normative, predictive of individuals' behaviour, and ultimately a cause of social action" (ibid: 12). In this way, 'culture' becomes an epistemological tool to understand and make sense of ethnic diversity. This is an important insight, because it further problematises analyses of race-based discrimination. Similarly, Kuper (1990) maintains that the rhetorical power of 'culture' is that it is a social concept – as opposed to the biologically based 'race' – and thus has strong de-essentialising attributes, at least superficially. However, this presents a danger that 'racial' understandings of difference are reintroduced through the back door: "The idea of culture could actually reinforce a racial theory of difference. Culture could be a euphemism for race, fostering a discourse on racial identities while apparently abjuring racism" (ibid: 14). Thus, whereas it is no longer acceptable to discriminate on the basis of 'race', it is nevertheless reasonable to make judgements based on 'culture' and otherness.

Many of my interviewees commented on this, and voiced the opinion that the discrimination they face goes way beyond their blackness. A number of interviewees outlined how employers would often reject them on the basis of their Nigerian training. Dr. E.A., for

instance, described a confrontation he had with a prospective employer with whom he had applied for a prestigious job in Cambridge:

> Dr. E.A.: ...he said, 'Well, have you worked in the NHS before?' And I said no. And he said, 'Well, I'm not sure you will be able to do this job without having worked within the NHS'. And I said, 'Well, the *advert* doesn't say anything about NHS specific experience.' It said relevant, 'have had relevant experience'. ... So that sort of took me aback, because I didn't feel comfortable with that. And then I went for the interview, consequently. And that was interesting in itself, because at the end of the interview I didn't get the job, and they said they would give feedback to people who didn't get the job. ... And I was told that I wasn't making eye contact enough, I wasn't communicating well, and that their suggestion was that I do a placement, in [my specialism] in the NHS before I apply for another registrar job. And I said to the consultant, 'I don't understand how doing a placement in the NHS is going to give me communication skills, and it sounds like you don't think I have good communication skills.' And I think what it was, because they knew that legally they couldn't say, 'You need to spend time in the NHS', because I would challenge that, so it was couched in... So I suppose there are things like that, incidents like that.
>
> Me: In terms of this incident, what do you think the real reasons behind were?
>
> Dr. E.A.: I think ... I think there's a number of things. I think there is an element of prejudice.
>
> Me: About...?
>
> Dr. E.A.: About ... I wouldn't say it was race, I imagine that if I was Black British, I would not have had the same problem. But I think it was of otherness. I think the sad thing is that they couldn't see beyond... The things that they disqualified me for, I could very easily have remedied.

What Dr. E.A. was drawing my attention to was the way in which his prospective employer changed the story and modified the justification not to give him the job: in the first instance, 'relevant experience' becomes 'NHS specific experience', and finally settles on 'lacking communication skills'. The real reason, Dr. E.A. deduces, is a distrust of his Nigerianness. References to 'NHS specific experience' and a lack of 'communication skills' are a veiled allusion to the fact that Dr. E.A. is not British, and does not have the skills to work in a British institution. With striking parallels to the Sunday Telegraph story explored above, 'training' becomes a euphemism for otherness.

This line of narrative was common amongst my interviewees, many of whom reported being told one way or another that their rejection was not down to lack of merit or attainment, but because of their Nigerian training. Dr. A.L. offered a particularly interesting perspective on this. She was born in the UK, and had spent a significant part of her childhood there. She spoke with a perfect English accent, and said that people would often be surprised when she would refer to herself as Nigerian. Thus, her assessment of how attitudes towards her changed once it was established that she trained in Nigeria is particularly notable. She gave an example of a job interview, where she had called beforehand to obtain information about the post:

Dr. A.L.: So I'm walking into this big conference room, and I walk in, and they go, 'Oh, you're black!' And I said, 'Oh, yeah, sorry, is that a problem?' And they said, 'Oh, no, you didn't sound black on the phone. Where are you from?' I said, 'Oh, I'm from Nigeria'. And they said, 'What university did you go to?', and I said, 'University of Nigeria', and they said, 'But you don't talk Nigerian'. And I said, 'Sorry, I don't quite understand what that means'.

Me: So do you think it's also about the fact that you're Nigerian, as well as that you're black? Do you think you'd have been treated differently had you been black British?

Dr. A.L.: Definitely. Definitely. I mean, on paper, because when you apply for jobs, they've got the paper, but they don't know who the individual is. They look at medical school. So that sets you off completely. I don't have proof of this, but I know that it's ... there are so many times, I called up every single time. Everybody that I applied to, I call them up. Because I feel that if you don't know who I am, I can write anything on a piece of paper. But if you see me, and you can hear me, and you get to know what I can do, you get to know what I am capable of. So sometimes they'd go, 'But, you're name ... you went to school in...?' Or, 'Oh, hold on, did you put in an application?' I'd say yes. 'Hold on, I'll look for the application', and then they'd say, 'Oh, but you went to...' There was always a 'but', it didn't match, you know, what I presented and what was on paper. It didn't seem to match.

As Dr. C.N. explained, this perception of the inferior quality of Nigerian training would frequently set her career development back:

And then you do things like, when I got my registration, I'd go to people, I'd go to general practitioners to get some advice. And they'd say to me, 'Ooh, because you trained in Nigeria, nobody really knows about the quality, they're scared you might make a mistake. So why don't you start from the beginning?' So I had to do a house job again.

The doctors' perception of disadvantage relative to their black British counterparts is supported by statistics. As Goldacre, Davidson and Lambert (2004: 597) note: "Specialist medical practice in the NHS has been heavily dependent on doctors who have trained abroad, particularly in specialties where posts have been hard to fill. By contrast, UK trained doctors from ethnic minorities are not over-represented in the less popular specialties." Thus, the percentage of overseas doctors "was significantly high, compared with their overall percentage among consultants, in geriatric medicine, genitourinary medicine, paediatrics, old age psychiatry, and learning disability" stands in contrast to the career trajectories of British BME doctors who have trained in the UK, who "had specialty destinations similar to those of UK trained white doctors" (ibid.).

Importantly, Mr. F.B., a policy maker I interviewed at the Department of Health, used the Goldacre, Davidson and Lambert study to argue that disparities between the career prospects of overseas doctors *vis à vis* UK trained doctors were not linked to 'race':

There was a very good study that was done at Oxford, looking at medical students, and those who trained in the UK, irrespective of nationality, did far better than those who trained overseas. Which means that, you know, if you've

> been in a medical school for five years, if you've done a house job, people know you, they feel comfortable with you, they can see you, they start looking at you, not with the perspective of colour or nationality, but your ability. And so you will progress far better. And again, I think if you look at the number of people of Asian origin, who are making huge strides in the UK health field, it's quite clear that colour is not an issue here. It's about ability.

The non-sequiteur of the final sentence notwithstanding, Mr. F.B. employs a very simplistic, 'common sense' understanding of 'race' and racism, denying the actuality of the very racial grammar he himself was deeply entrenched in. Of course, his stance should not be considered received wisdom amongst policy makers, and this line of argument was contradicted by Mr. G.G., who was a senior executive in the NHS during the early 2000s:

> But there was clearly overt racism, people not wanting Asians or Africans in senior jobs, and you saw people cluster, in the medical profession, in the jobs that didn't have, sort of, real long-term tenure or long career posts; clinical assistants, or hospital practitioners, these were two grades or posts. Nowadays it's probably trust doctors. But you saw people clustered.

Reactions to Racism and Discrimination – "Let's keep our heads below the parapet'

Those interviewees who had experienced racism and discrimination had plenty to say about how it impacted on them. Clearly, these incidents were unsettling and upsetting for those who experienced them. My interviewees described an immense array of scenarios where racism and discrimination undermined not only their integrity as doctors, but their very personhood as well: the disappointment on losing out on prestigious jobs which they were more than qualified for; their confidence gradually eroding with each unsuccessful job application; the isolation of being the only black and Muslim woman in the hospital; feelings of hurt resulting from degrading comments from colleagues and patients; the frustration of seeing the careers of their British colleagues rocket while they themselves were stuck or going backwards. Dr. L.A. captured the immense sacrifices many overseas doctors have to make to advance in their careers, and the toll racism takes in the process:

> I spent the most active part of my adult life working for people who are not necessarily more intelligent, or able. Not necessarily. But I feel there was some sort of immorality that, even if you work so hard, and you're paid little, you don't go to private parties, you don't do anything. Even working hard with a young family. But at least you should be able to look back and say "I achieved this!" ... Even when you write papers, sometimes they refused to sign it. You write a paper, you take it to the consultant, he knows that if you have publications, it helps you to increase your profile. He said he will get it, but he will never get back to you.

However, none of my interviewees reported making a formal complaint about racism or discrimination – whether institutional or from individuals – and following it through to its conclusion. Dr. E.A. referred to this as "an immigrant thing of 'let's keep our heads below the parapet'. If you raise the issue of discrimination, you might get kicked out. We're just trying

to settle down, you know, they're letting us *be* here." Indeed, Dr. E.A. illustrated his point with an anecdote on a discussion he had with his cousin about the incident where his Nigerianness lost him a job, described in the previous section:

> I remember when I was discussing the incident with my cousin, I was saying, you know, that I wanted to formally complain about the Cambridge incident. And my cousin said to me, 'If you make a formal complaint, you will never work in public health in the NHS'. And I remember being very frustrated and saying to him, 'But it's chicken and egg, because if I don't complain, and one day I will eventually get a registrar job, and then I will eventually become a consultant, and eventually do well, and people will say, 'Look, E.A.'s doing well, that's evidence that there's nothing wrong with the system". And I felt really locked in, you couldn't say anything. And funnily enough, that's what eventually happened. Because people say, 'Oh, look at E.A., he's a consultant in [London hospital]'.

Examples of this were rife in my interview data. When I asked Dr. F.S., whose subjection to racism from a nurse is described above, whether she made a formal complaint about the incident, she replied: "No. No, I didn't. You know, if you complain, because you're passing through and only there for a short time, nobody will side with you, really. The consultants are those who are going to continue working with those nurses, so..."

This is not to undermine the agency of my interviewees, or to portray them as helpless victims. Indeed, although it might be tempting to view the doctors' reactions as internalising discrimination and external constraints, such an analysis would be misleading. Racism did not defeat them. Although some were so despairing that they considered a change of specialism, or even giving up on medicine altogether, they continued to develop their careers in spite of adversity. Dr B.B., for instance, argued that the only viable weapon in the fight against racism in medicine is to prove the racists wrong, as demonstrated by his reaction to the 'Which jungle are you from?' jibe:

> I got upset, and went and reported it to [the professor]. [Whispers] 'Forget it.' He said, 'Don't worry, forget it, forget it. Just learn, just learn. Just learn! You're going to come across discrimination along the line, here. Ignore it, just learn.' And it was a very good attitude. I learnt. And he said, 'The answer to discrimination is excellence. Excellence.' When you are looking for jobs, you have to have something extra. Something *extra*.

In any case, racism is not all-embracing and all-encompassing in British medicine. Rather, it can make overseas doctors' journeys longer, harder, and less predictable than for their European counterparts. The decision not to challenge racism could therefore be viewed as a rational and conscious choice to minimise the ethnic penalty they suffer in the labour market. As Dr. L.A. explained, challenging racism tends to act as an impediment to career development:

> I think it's a common experience! I say that because, after experiencing that for a time, I shared my experiences with some people who have been able to meander their way through the system. And they say, 'Don't fight it. Don't fight it. If the man says you're not good enough, say thank you very much. What do you want me to do? Then do what the man wants you to do, just move there. And while you're there, try to prove to that person that you're not what the person said. You

never know when you hit your luck'. So you keep going like that until you're lucky, you get somebody who gives you the right reference, or recommends you. And you make progress. But before that – that's why it took me so long – before that time, I would write back and challenge it. 'I know that this is not right, this is wrong.' You want to point out all the good things you did, and refer to the comments that were made in the course of the post. But this guy, he spoke to me and said, 'LA, these people will always abuse you. If you cannot take this abuse while you're in training, go back to Nigeria'.

Racism and Labour Market Outcomes – "As an immigrant doctor, you're always climbing that pinnacle"

When taken together, the combined discriminatory practices described above add up to a hefty package: workplace racism from patients and colleagues; policies which effectively legalise discrimination; unbalanced professional accreditation and scrutiny processes; structural disadvantage in hiring practices; cultural racism which renders their Nigerianness as inferior; and psychological but systematic repression of any challenges to racism and discrimination. Regardless of whether these are conscious acts or not, the cavalier and unforgiving treatment of Nigerian doctors serves to reinforce their status as outsiders, whose primary purpose is to serve the English healthcare system as cheap, casual and flexible labour. This substantial and wide-ranging body of evidence of discrimination makes perfect sense of the hard data which "suggest that ethnic minority doctors are less successful in securing posts in the NHS" (Jaques, 2013). Unsurprisingly, white doctors have the highest success rate at 13.8%, whereas – importantly – black doctors have the lowest success rate at 2.7% (see table 5).

Ethnicity	No of doctors who applied	No of doctors appointed	Success rate (%)
White	28,745	3967	13.8
Asian or Asian British	43,954	2514	5.72
Mixed	5450	188	3.45
Black or black British	16,055	433	2.7
Other	7211	375	5.2
Undisclosed	2111	486	23.02
Total	107,893	7811	7.24

Table 5: Success rate of applicants to consultant, staff and associate specialist, and trust doctor jobs at hospital trusts in England in 2012. Source: Jaques (2013).

Thus, whereas white doctors would need to apply for an average of seven jobs to land a post, black doctors need to apply for 37 jobs. Importantly, Jaques' (2013) study does not distinguish between overseas black and black British doctors. If Goldacre, Davidson and Lambert (2004) are correct in their conclusions that the career trajectories of black and Asian British doctors are aligning with white British doctors, we could expect the success rate of black overseas doctors to be even lower.

The exact figure notwithstanding, it is clear that black overseas doctors have a significantly poorer success rate than their white British colleagues, which substantiates my interviewees' complaints that they would apply for what appeared to be endless jobs before actually being successful. As Dr. C.N. put it: "I must have sent out around 300 or more applications in various forms, either for attachments, or for a job. And there was no response." This, of course, is highly demotivating and demoralising.

This brings us back to the discussion on the concept of 'overseas doctors' in the policy chapter. The statistics are entirely congruous with the argument that overseas doctors are channelled into certain sectors. Many of my interviewees had a suspicion that this was the case with their own career development, although they were unable to point to a particular incident as conclusive evidence. Dr. A.L. explained how she felt that she was forever struggling to progress in her career, to little avail: "But as an immigrant doctor, you're always climbing that pinnacle to get to whatever it is that you've set yourself. But I never thought it would be that hard. I never thought I'd have to prove myself so badly." Dr. L.A., however, recounted how he was denied a prestigious training position in surgery, which he described as his 'big break in England'. Dr. L.A. had already been offered the post, but needed the approval of the postgraduate dean, who refused:

> Dr. L.A.: I went in to see him. He said, because I'm a Nigerian, I'm not going back home. And if I did that job, I'll end up taking the job from a British person. And that if I wanted to continue to work in England, I should go and work in an area where there is need, area of need.
>
> Me: For England?
>
> Dr. L.A.: For England, yes. If I wanted to work in the UK, I should consider emergency medicine, or general practice. It was in 1999.
>
> Me: And they told you this?
>
> Dr. L.A.: They told me that! They said, 'You're not going back home. In our experience, Nigerians don't go back home. You want to remain in England. So I know you want to be in this country, and if you want to be in this country, you've got to ask yourself, where do *we* want *you* to work'.

This sequence crystallises how the othering of Nigerian doctors, and the subsequent naturalisation of the dichotomy which renders Nigerian doctors inferior, serves the pragmatic purpose of justifying channelling them into certain roles – roles which suit the needs of the NHS, but not necessarily the doctors themselves, or Nigeria. When asked why he thought his career progression had been so much slower than his white British colleagues, Dr. L.A. suggested that the way in which overseas doctors are deliberately held back amounts to exploitation:

> Dr. L.A.: Because I was not given the opportunity to access structured training programmes. And the reason for that is because I was needed for a different purpose. In the system.
>
> Me: So do you think they were channelling you...?

> Dr. L.A.: Yes. I think so. My personal view, I call it indentured slavery. It was a form of slavery, that's what I call it.

In essence, then, the various policies, procedures and practices described in the sections above impact on Nigerian doctors' abilities to engage in transnational activities. These policies have a propensity to delay and divert career development, with the accumulated effect of reducing the time, energy and capacity Nigerian doctors are able to devote to transnational activities throughout the course of their careers. Referring to a discussion he had with colleagues at the Royal College of Physicians, Dr. E.A. succinctly explained how Nigerian doctors' transnational efforts are impeded by policies and practices which disadvantage them in the labour market:

> And they said, 'We have diaspora doctors who are members of the Royal College, but they don't seem to volunteer when we advertise, when we need help, and all this'. And I said, 'Well, one of the issues as well is when you come from outside the UK, often you're running behind your peers'. You know, when I came here, my peers who graduated in the same year, in the UK, some of them were already becoming consultants. Because the experience I had abroad didn't really count here. So I'm starting at zero. And so, when you're doing that, you have less time or scope to take on extra work, whether for the Royal College, or the General Medical Council, or whatever.

It is clear that racism and discrimination are a real and palpable presence in the working lives of Nigerian doctors. However, it is important not to lose sight of their central reason for migrating: that England offers opportunities for professional development which are non-existent in Nigeria. Although most of my interviewees could relate numerous stories about how racism and discrimination affected their career development, they were also able to convey positive experiences. These were often the result of the actions of a benevolent individual, such as the consultant who took Dr. F.S. under his wing:

> I kept applying to different places. Because even now, I go back and look at the rejection letters, just to remind myself, you know? 'We're sorry that we cannot offer you...' and things like that. I think I called a hospital – I think I applied to every hospital in England – and they said, 'Oh, contact this consultant, he's very good, he takes his time for people'. And he just asked me to write an application letter, and I did, and they offered me clinical attachment. And he was very helpful as well, he allowed me to examine patients, help in theatre, although under the GMC rules we're not supposed to. But he did, because he saw that I was keen. But it was a good experience. Everyone was so helpful.

Thus, although most interviewees said that they felt disadvantaged in the system – where they were only able to overcome this by someone giving them a lucky break – most also acknowledged that the NHS had allowed them to develop professionally in ways which would have been impossible in Nigeria, and had positive experiences of interaction with colleagues. Indeed, many of my interviewees explained how they have learned valuable skills in their NHS careers, which can be applied to transnational activities to help develop the healthcare sector in Nigeria.

Conclusion

If the last chapter dissected the structure of the British state's stance towards overseas doctors, this chapter has situated the lived realities of Nigerian doctors within it. Of course, it is important not to lose sight of the fact that their English training had made them better doctors than they could have hoped to become in Nigeria. However, it is also clear that various forms of racism afflict their lives and impact on their career development in several ways. In addition to casual racism suffered from patients and colleagues, the state has formalised certain aspects of discrimination in policy which is difficult at best, and impossible at worst, to negotiate, ignore or elude. If, as I argue in Chapter 3, these policies are specifically designed to disadvantage overseas doctors *vis-à-vis* UK/EEA doctors, then this chapter has demonstrated how successful they have been. The statistical evidence showing significantly poorer labour market outcomes for overseas doctors corresponds perfectly with my interviewees' experiences of carving a career out for themselves in the NHS. The effects are that Nigerian doctors take longer to achieve their goals, have less control of their own career development, and are less likely to reach top positions in their fields.

The question, then, is how these different manifestations of racism, and their impact on the trajectories of Nigerian doctors, function within the transnational social space. If, as Faist (1998; 2000a; 2000b; 2008) claims, states and their policies are instrumental in shaping transnational social spaces as well as migrants' capacity to operate within them, we would expect the policies outlined in Chapter 3 and the effect they have on the career development of my interviewees, outlined in this chapter, to have a significant bearing on the transnational lives of Nigerian doctors. However, the dynamics between states, civil society and Nigerian doctors are complex, and require a careful and detailed examination. This is the subject of the following chapter, where I explore how my interviewees engaged with transnational networks and processes in order to apply their skills and knowledge to the development of healthcare provision in Nigeria.

5. Transnational Links and Development

I feel a duty to pass on to them the skills acquired in England. (Dr. L.A.)

The last chapter was dedicated to looking at the key characteristics of Nigerian doctors' career development in the NHS. I argued that a mass of discriminatory practices influenced their career development above and beyond what UK/EEA doctors can expect. The result is that they have less control over their career development than their European counterparts, and often find themselves channelled into low prestige specialism and non-training posts. This is important in its own right, but there are wider implications as well. Many (albeit not all) interviewees aimed at specialist training in the NHS with the explicit intention to learn skills that could be useful back home. In this chapter, I will connect the aims and ambitions of my interviewees – and the many obstacles they faced in realising them – to their transnational imaginary. I will examine how Nigerian doctors, based both in the UK and in Nigeria, engage in transnational activities in order to contribute to the development of the Nigerian healthcare sector, and how their trajectories impacted on their ability to do so. As I have already explained, it is not my aim to quantify transnational engagement of Nigerian doctors, or to assess their impact on the development of the health service in Nigeria. Rather, I will explore the social factors which affect the transnational activities of Nigerian doctors in the NHS, either facilitating and advancing their efforts, or hampering them.

In this chapter, as well as the next one, the concepts of 'transnational social spaces' and 'social remittances' become particularly important. Upon reading the following two chapters, therefore, it is helpful to remember that I follow Faist's (2000a; 2000b) sociocentric understanding of transnational social spaces, which incorporate various "combinations of ties, positions in networks and organizations, and networks of organizations that reach across the borders of multiple states" and, importantly, "denote dynamic social processes, not static notions of ties and positions" (Faist, 2000a: 191). These ever evolving ties, networks and processes within transnational social spaces both influence the extent to which Nigerian doctors can amass skills and knowledge, and are the vehicles through which they can transmit them as social remittances, or conversely, are barriers to doing so. This is important, as the aim of this chapter is to establish how various social actors, institutions and practices – such as policy and government departments; hospitals and the medical establishment; third sector organisations; discrimination and racism; communication; migrant organisations; colleagues back home; and, of course, the doctors themselves – interplay to influence the shape of the doctors' transnational social spaces, and thus their ability to transmit social remittances through them. In other words, like Faist (2000a: 192), I want to connect:

> the various forms of resources or capital of spatially mobile and immobile persons, on the one hand, and the regulations imposed by nation-states and various other opportunities and constraints, on the other; for example, state-controlled immigration and refugee policies, and institutions in ethnic communities.

This chapter is divided into three main sections. Firstly, I will give an empirical account of how transnationalism and transnational networks affect Nigerian doctors and their migration trajectories. I look in detail at three stages of their journeys. I start by giving a brief account of the background to their motivation to engage in transnational activities. I then move on to examine in greater detail how they draw on transnational networks within the main period of actual migration. Finally, I explore how and why they make the choice to either stay in England or to move back home to Nigeria. This choice was never final or clear-cut. Rather, it represented a constant negotiation and re-evaluation of their plans, ambitions and objectives.

Secondly, I explore how my interviewees engage in transnational activities with the explicit aim to contribute to development in Nigeria. These could take many forms, including medical and training missions, direct communication with colleagues back home, blogging, or tapping into various networks involved in transnational work. The important point is that changing circumstances call for new approaches to transnational engagement. Thus, a constant negotiation and re-evaluation of plans, ambitions and objectives require the development of strategies to circumvent barriers to engagement and find novel ways to engage with development back home.

Finally, I will look at which factors pave the way for Nigerian doctors to send social remittances back home, and which factors hamper it. This section will build on the previous two chapters to look at how policy and discrimination impacts in various ways on the transnational links available to them. This includes visa restrictions, exclusion from networks, and the lack of a coordinated hub to synchronise the skills, energy and effort of Nigerian doctors.

Becoming Transnational – How Transnationalism and Transnational Ties Affect Nigerian Doctors and Their Journeys

Background and Motivation

A key contribution of the transnationalism literature to the development of migration theories is the emphasis on migration as a process which extends beyond the actual physical action of moving. Transnational processes begin to have an impact on the trajectories of migrants early on in their biographies, often well before they have even made a decision to migrate (Raghuram, Henry and Bornat, 2010: 629). In this formula, events leading up to the point of migration are an important cog in the wheel for understanding the transnational activities of migrants, as those events may give important insights into the logic behind migration and the motivation of migrants. Thus, in order to understand how Nigerian doctors engage in transnational activities to contribute to the development of the Nigerian healthcare sector, it is helpful to take the long view of migration by going back in their migration biographies and explore key events which influenced their trajectories.

I found no evidence to support the claim that the prospect of migration plays a part in some African doctors' decision to go into medicine in the first place. Rather, my interviewees almost uniformly explained that the decision to study medicine was determined by "society, the middle class, and their admiration for professional occupations ... even from primary school, secondary school, I think it was believed that if you were good at something, you

should be aspiring to do something professional. So a doctor, a lawyer, an accountant" (Dr. T.H.). However, it was certainly true for many of my interviewees that the seeds of transnational enterprise were sown early on in their career development.

Dr. F.R., for example, outlined how he made the decision to specialise in public health. Upon graduating from medical school, Nigerian doctors typically go on to do a housemanship, which is a yearlong rotation through various clinical disciplines. This year presents a newly graduated doctor to his/her first opportunity to practice medicine, under supervision, during which s/he is expected to make a decision as to what aspect of medicine s/he wants to specialise in (Abdulraheem and Rahman, 2009). Dr. F.R. did his housemanship in Lagos.

> And then, like every graduate in Nigeria, you then go on to do one year of youth service. So my one year of youth service was a very, very interesting period for me, because for the first time in my life, I was completely separated from relatives, friends, going to an isolated, rural village somewhere in the north of the country, where I was the only doctor serving a population of about 500,000 people, who only had one ill-equipped cottage hospital. With no doctors, no qualified nurses, and only voluntary health workers. And here I was – a fresh medical graduate, with some skills, having to do complex deliveries, complex surgeries, see all sorts of patients. So I grew up very quickly [laughs]. It was daunting! So that one year moulded me in many ways. And it determined the eventual career path that I followed.

During his year in the north of Nigeria, Dr F.R. decided that a public health approach to medicine would be of most use to the poverty-stricken northern regions of Nigeria, reasoning that preventative – rather than interventional – medicine would best serve the poor populace of Nigeria. However, he felt that the training on offer in Lagos was insufficient to equip him with the skills and knowledge he would need to engage with the specific public health problems he was interested in resolving.

> And I decided, 'Ok, it's time to do community medicine',[9] but I didn't have any qualification in community medicine, I didn't have much theoretical understanding of community medicine. So I decided I wanted to enrol in [name of prestigious London medical school], and then do further studies in community medicine.

Thus, it was Dr. F.R.'s first hand experiences of practicing medicine in the highly underdeveloped north of Nigeria which compelled him to choose a specialism with the explicit aim to contribute to the development of the Nigerian healthcare sector. Finding the training on offer in Nigeria insufficient, this desire in turn directed him towards the UK.

Of course, it would be misleading to portray Dr. F.R.'s motivation as typical. My interviewees all had a different set of reasons, incentives and rationales for getting involved in transnational work. However, certain elements of Dr. F.R.'s story resonates with the experiences of a number of other interviewees. Most did a year of youth service, and described this encounter as having a significant impact on them. Furthermore, they also commonly chose a UK post-graduate training programme not available, or of insufficient

[9] Public health is known as 'community medicine' in Nigeria.

quality, in Nigeria, whether or not this was – at the exact time of making their decision – with the specific aim to learn skills which would benefit Nigeria. For some, like Dr. F.B., this came later. Dr. F.B. did not specifically choose her specialism in the UK with Nigeria in mind. Her focus was, in the first instance:

> ...to get my post-graduate qualification, which enabled me to work in the NHS. So I did that, and then got into the NHS and started working as a doctor, at a number of hospitals. I did that for a number of years. I got my fellowship, and then I decided to go into management. So I went and did a masters in management at [name of university], and then started working in management aspect of healthcare. And I've been doing that ever since. Managing from the point of view of trying to understand how best to run healthcare systems. Because I felt that was one of the areas of weaknesses that we have [in Nigeria], while we might have a lot of skills, but if you don't manage your resources properly, then there's always a challenge.

I do not wish to imply that certain types of experiences will lead to particular forms of migratory trajectories, or that there are common pre-migration experiences amongst those Nigerian doctors who do wish to contribute to development in Nigeria. However, for most of my interviewees, their experiences in Nigeria were linked to what the medical migration literature generally considers a key factor behind the migratory patterns of doctors, namely professional development. My interviewees were certainly unequivocal that they migrated to England first and foremost because they wanted to develop their skills and talents as far as they could. Clearly, there were several other reasons given for migrating, yet professional development was cited as the most significant one by a vast majority of the doctors. This is important, because although personal fulfilment was certainly a strong impetus for aspiring to become a better doctor, they also voiced a strong wish to develop their skills in order to benefit their future patients in Nigeria. After all, at the time of migration, many of the doctors had the explicit intention of returning to Nigeria. In this sense, the idea of 'making a contribution' featured strongly in their narratives about professional development. They wanted to become better doctors in order to have more to give. The proviso here, obviously, is that there is most likely a bias in my sample in that most people who agreed to be interviewed by me where those who were concerned about development back home, and wanted to make a contribution in some way. It is impossible to say whether this is typical of Nigerian doctors in the UK. The fact remains, however, that amongst the interviewees in my sample, the ethos of 'making a contribution' was strong, and intricately linked to their desire to develop their skills, as Dr. N.M. explained:

> One of the reasons why people leave their country, me, for example, I didn't want to go, but I knew that I would rot away. You know, professionally, if I stayed. I didn't want to just do the simple things. I felt like I had the ability to do the big things. And I'm not going to be able to develop myself to be able to do the big stuff in Nigeria. So I wanted an environment where I can flourish, and at least convince myself that, whether I could do it or not. And also get to do it, and develop myself to do the big stuff, in medicine. So many of these young people, who are highly talented Nigerians, they cannot stay in Nigeria. Because it will not give them what they want, it does not nourish them, and develop them. But every individual is different, the way you feel inside is different. Some people

> just feel ok, and want to stay in Nigeria. And they don't see the need to get out. For me, I didn't feel like that. I felt, 'No, I want more. I want to develop myself'. Because I felt like I could then give more. So, it's only when I got out, that I saw, 'Oh, yes, I was right, I can give more'.

Transnational Social Spaces and Networks

If the transnational social space makes its mark on migrants before the act of migrating, it decidedly comes into its own during the actual transition period. A common feature running through the narratives of the interviewees was the ways in which they drew on networks throughout the migration process. The ways in which Nigerian doctors tap into networks in order to fulfil their migration objectives is in many ways congruent with Vertovec's (2002: 3) account of the operational forms of networks:

> For migrants, social networks are crucial for finding jobs and accommodation, circulating goods and services, as well as psychological support and continuous social and economic information. Social networks often guide migrants into or through specific places and occupations. Local labour markets can become linked through specific networks of interpersonal and organizational ties surrounding migrants.

Information about viable avenues for migration – such as available post-graduate training programmes, funding options, immigration laws, accommodation, etc. – was usually solicited in advance from acquaintances who were already established in England.[10] This would often begin before they arrived in England. Dr. T.H., for example, was weighing different destination options. She was seriously considering Ireland due to familial connections there, but changed her mind based on advice she had been given from colleagues:

> So someone advised me, I also had a classmate in Ireland, advised me that if I did get registration in one European country, it would be equivalent. So because of my situation, they advised that it would be better if I came to the UK first. So that's how I got here. So instead, I came here, in April, and I wrote the exams in July.

These networks continued to provide them with information and support once they had arrived in England. Several interviewees referred to help from more established Nigerian colleagues in 'navigating the system', much of which felt like entirely alien territory. This could extend to every part of everyday life, as Dr. G.R. explained:

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[10] Although the support described by my interviewees was invariably from personal contacts, some organisations offer more formalised assistance. For example, MANSAG runs an 'education and mentoring scheme' with the express purpose of assisting Nigerian doctors through "active mentoring to individuals within mainstream British institutions" (MANSAG 2014a), a function which they advertise on their website:

> Dr B.A. qualified in a medical school in Nigeria and came to the UK to pursue postgraduate training. He studied for and passed the PLAB test with support of some key members. Thereafter he was thrown into the training job market. With no UK experience, he was having major difficulties with securing a post. Through our Education and Mentoring scheme, MANSAG was able to arrange for a clinical attachment for him in a UK hospital. The 3 months spent in that attachment provided BA the exposure to UK medical practice which he required. He performed well at a subsequent job interview that enabled him undertake a period of training in a UK hospital. He has since completed his training and returned to Nigeria. (MANSAG 2014b)

> Life wasn't very comfortable here. It was very rough. You are not at home, and sometimes you get very lonely. But I was fortunate because I was married and had children. But that created different problems. Who's going to look after them? What do you do when they have a runny nose and fever? That kind of thing.

However, it was help with professional issues which was most pressing. This is, of course, unsurprising, as developing their career was not only a primary purpose of migrating to the UK but also what made migration a viable option in the first place. Much of this advice took the form you would expect: where to find job advertisements; how to fill out forms; how to conduct yourself in job interviews; the importance of small gestures, such as speaking to prospective employers in person to establish a personal relationship; and so on. Equally interesting, however, and in many ways more significant, was the advice on what *not* to do. On this matter, two categories of advice were particularly striking, namely advice on which jobs and career options were viable and which were out of bounds, and advice on dealing with racism and discrimination.

On the first category, a running theme throughout many interviews was to manage their expectations. Certain specialisms were deemed unattainable for Nigerian doctors, and pursuing them would be a waste of time. Similarly, many interviewees outlined how they would be advised against applying to the more prestigious institutions in the more desirable parts of England. Dr. T.H. captured this succinctly when she described the advice her husband, who is also a doctor, received when he first arrived:

> And again, he met up with friends, who had migrated as well, and one of them said, 'You know, if you look at London, you're not going to get a job. And if you look at these specialties, you're not going to get a job. And as long as you open to that, just phone up all the trusts.'

Dr. T.H.'s husband finally found a fixed term post in psychiatry, but did not have problems finding work thereafter, a point to which we will return later.

Advice on how to deal with racism and discrimination was in the same vein. In essence, the advice given to my interviewees was that they would inevitably encounter racism and discrimination in their careers, that challenging it would amount to career suicide, and that the only way to survive it was to learn to live with it. Thus, the responses to racism described in Chapter 4 of 'keeping your head below the parapet' had become received wisdom amongst Nigerian doctors in England. Dr. L.A., for instance, referred to the Royal Colleges and their subdivisions as a 'mafia' which responds to accusations of racism by closing ranks. As a result, Nigerian doctors would not risk arguing against this authority.

> Because it's too much palaver. You don't want to involve yourself. When you think of what you went through ... Like the chap who gave me the advice that I don't adhere to, he said, 'Whatever he offers you, just take it. Take it on your chin. Even if they write that you're an idiot, take it on the chin. As long as you have a job, just keep going. One day you'll make your luck.' That's why it takes so long, it's like, happy go lucky. That's not a good way to spend one's life.

As I outline in Chapter 4, overseas doctors tend to cluster in less prestigious specialisms – most notably psychiatry – and lower grades. If social networks "often guide

migrants into or through specific places and occupations" (Vertovec, 2002: 3), then network theory offers a particular explanation of the reported concentration of Nigerian doctors in specific specialisms within the NHS. Dr. T.H.'s anecdote highlights how tapping into a network with a particularly high proportion of psychiatrists exposes a recent arrival to the particular opportunities that this specialism has to offer:

> Dr. T.H.: So I was applying for jobs, but I was never invited to any interview. And they said it was because I didn't have references from here. So that was one main thing. And I didn't have any experience from here, clinical experience. So they advised me to try and get those two things.
>
> Me: Ok, who were 'they'?
>
> Dr. T.H.: Basically people I'd met here, so foreign doctors that were working here, they said I would need references from here. Because on my application I would have references of doctors I had worked under, in Nigeria. ... And what happened was, a friend saw me, he was a staff grade in psychiatry, and he said he had an uncle or something, and they could help me get a job in psychiatry, if I wanted. But then, I said no, I didn't have the mental capacity to work in psychiatry [laughs]. So I turned that down. I think this was in August or something. And that same August, the same friends said, 'How are you going to survive?'
>
> Me: Was this a friend from Nigeria?
>
> Dr. T.H.: Yeah, so these are people who have also moved over.

This observation, however, should not detract from the argument advanced in Chapter 4 that discrimination – both in policy and practice – plays a crucial part in this clustering. Indeed, Dr. T.H. touches on this herself, where Nigerian colleagues suggest that she enter psychiatry exactly because she had problems advancing in other specialisms. Networks and discrimination could therefore be perceived as two vectors which converge at a critical point. As such, each reinforces the other. Thus, while it is important to analyse the nature of networks tapped into by the Nigerian doctors, it is also crucial to highlight the limitations of this aspect of the transnational social space. This is an important insight, because the literature has tended to idealise transnationalism "as an expression of a subversive popular resistance "from below."" (Guarnizo and Smith 1998: 5). In the case of Nigerian doctors, it is debatable whether these transnational networks opened doors or closed them. Transnational networks certainly helped many of my interviewees to settle into life in England, professionally as well as socially. Friends and colleagues would offer assistance and counsel, but with the benefit of hindsight, some interviewees questioned whether this was necessarily always sensible advice. It is notable that those who spoke of a career-defining 'lucky break' invariably referred to white British/European colleagues in this context. Thus, the authority of compatriots to guide them onto sound career paths was often limited, and could even encourage them to take – as Dr. A.L. remarked – 'the path of least resistance'.

This brings us back to Dr. T.H.'s husband, whose colleagues advised that "if you look at London, you're not going to get a job. And if you look at these specialties, you're not going

to get a job." The fact that he ended up in psychiatry, and had no problems finding work thereafter, illustrates this process well. On the one hand, we have a highly racialised labour market (detailed in Chapters 3 and 4) which discriminates against overseas doctors in favour of UK/EEA candidates, underpinned by both policy and practice. On the other, we have transnational networks which conduct overseas doctors into specific specialisms. Between them, these two processes form a feedback loop which Nigerian doctors can only break out of with difficulty.

Dr. G.R.'s career trajectory offers an interesting insight into these processes and their impact, because he resisted the temptation to give up on his ambitions, and ultimately built up a very successful career in surgery. As he explains above, he arrived in London with no support network, and was having a difficult time orienting himself and finding a suitable career path in his chosen sub-specialty. His plan had always been to specialise in a field which would be useful in Nigeria, and he had been in discussion with a colleague in his former university in Nigeria on what type of specialism within surgery would be most suitable to Nigeria's healthcare needs. He had successfully sat the surgical examination in Britain, but due to the lack of opportunities, he came close to considering a radical career change.

> When I came to London, I knew nobody. So I had to start fresh. I didn't really have any support network. I didn't even know I was supposed to have a support network. And after I trained in [sub-specialty] as a registrar, I met a guy where I was doing a temporary job as senior registrar, and he said, 'G.R., what are your plans for life? Because we notice that you are a locum.' And I said, 'Yes, originally I was going back to Nigeria after my training.' I was doing a lot of temporary jobs, because I didn't know what to do, really. I was now a fully fledged [sub-specialist], but I hadn't got a senior registrar position. Which was a requirement to be a consultant in Britain. And he said, 'What do you want to do?' I said, 'I want to be a general practitioner. Because if I'm going to be in the UK, I must look for the avenues that are easier for me to survive.' General practice was full of people who could not make it as consultants in the hospitals.

In this instance, Dr. G.R. contemplated giving up on the highly competitive and prestigious field of surgery and opting for general practice, exactly because he could see that this is what overseas doctors tend to do. Due to a glass ceiling, he argued, there were few black senior registrars and thus no exemplars of black success in medicine. "Not that it wasn't possible. You needed a bit of luck, and you needed sponsorship. Nobody told me to have a godfather" (Dr. G.R.). However, his white British consultant was impressed enough by his skills to persuade him to steer the course with surgery rather than switch over to general practice. For this, the right contacts were crucial:

> And this guy told me, 'Go back to London, go to a teaching hospital, and get a godfather.' How do you do that? If you're somebody's student, and you went to his department, he would know you, recognise you. You have a character, you have an identity. I had nothing. I was just another foreigner. But I was fortunate, I went into one of the local teaching hospitals in London, and I actually met a guy who was very pleasant to me. And he helped to guide my training thereafter.

The point of both TH's and GR's anecdotes is that transnational networks are not necessarily always empowering. Faist (2010: 11) points out that the transnational turn in academia represented (amongst other things) the means to focus on migrant empowerment and to bring "migrants 'back in' as important social agents". And yet, the transnational networks on which many of my interviewees relied placed distinct restrictions on the possibilities open to them. Raghuram, Henry and Bornat (2010: 624) make a similar claim when they argue that "in most empirical research on migrants' labour market prospects, it is only migrants who are put under the spotlight. Non-migrant networks, their ability to reproduce privilege, and how migrants fit into and rework such networks often escape attention." This analytical omission, they conclude, leaves "little room for exploring how these networks relate to and are formed alongside the networks of non-migrants" (ibid: 627). Applying this to Nigerian doctors, we can deduce that there is, indeed, a dynamic relationship between the transnational networks they draw on to meet their migration objectives and the non-migrant networks which they struggle to penetrate. Dr. E.A. outlined the difference between migrant and non-migrant networks, and the possibilities and options they are able to open up:

> Dr. E.A.: I had two cousins who were born here, who grew up here, and who are both consultants in the NHS. And they were quite useful in advising and helping me navigate the system.
>
> Me: Was that just in terms of advice, or did they put you in touch with people? Was it kind of...?
>
> Dr. E.A.: It was mostly advice. Mostly advice. They didn't put me in touch with people, it was advice. But I was very lucky, one of my friends, a consultant that I worked with ... a very committed, progressive woman, who wanted to help me, and was keen to do that, and recognised where I was coming from, and what I was able to do.

Indeed, most interviewees viewed the UK medical establishment as an old boys' network at best or mafia at worst, which could only be broken into if you were lucky enough to impress one of its members to such an extent that s/he would take you under her/his wing. This, however, could be very difficult to achieve. This was partly because of a catch 22 situation, where you need the right contacts in order to get the right contacts. However, some interviewees deliberated whether they were purposefully excluded from networks exactly because they were Nigerian, and thus intended for the tasks British doctors did not want to do:

> You can't believe it, there was a job I did ... any time there was ... I was supposed to be a registrar in the evenings, any time we have a social activity, in the department, sometimes the department had to go out, if I wasn't on call, they would change the rota to put me on call. So that I would be the junior doctor on call so that every other person can go to the club, the Christmas party, or whatever. And numerous examples like that. (Dr. L.A.)

Going Back or Staying Put?

Another central plank in the transnationalism literature is the ways in which it has challenged traditional notions of migration as a one-off, one-way movement of individuals. Vertovec (2002: 2) has even suggested that 'migration' may be an analytically flawed term to describe the transfer of highly skilled migrants. Instead, he argues, "'movement' or 'mobility' may be more apt terms. This is because migration has connotations of permanency or long-term stay, whereas the movement of many highly skilled persons tends, today, to be intermittent and short-term". This contention may be true for certain types of highly skilled migrants, particularly those working in private sectors such as finance and information technology, on whom academic research has tended to focus. However, Raghuram and Kofman (2002: 2072) make the important point that an "examination of the migration of skilled persons in welfare sectors−which are usually controlled by the government and professional bodies−produces a very different account of migration", which can largely be attributed to the double whammy on overseas doctors of immigration controls (which private sector migrants are subjected to) and professional accreditation (which they are not). This further drives home the significance and import of the state and its policies.

A crude analysis of my data would contradict Vertovec's contention. There is certainly more than a grain of truth in Anya's (2010) succinct turn of phrase when he writes: "It seems all or nothing with migration. You either stay or you go." Indeed, the supposed open-ended and fluid nature of migration implicit in much of the literature is perhaps another aspect of the propensity of transnational theories to be overly optimistic and romanticising. Yet such an analysis would miss important nuances. Faist (2000a: 191) notes that transnational social spaces "denote dynamic social processes, not static notions of ties and positions." Again, this stresses the importance of temporal as well as spatial dimensions to migration, and suggests that transnational networks, processes and activities change over time.

The transnational social spaces described by my interviewees were characterised by constant re-examination of their career ambitions, re-evaluation of their social status as migrants, and renegotiation with their social environment. These were marked by endless dilemmas and psychological struggles. Their own choices as to which country they should dedicate their working lives were certainly never either/or, but the constraints placed on them often made this dichotomy a reality, and many of those who had come to England with the specific aim to return home with a new set of skills had come to the conclusion that their migration was most likely permanent, or at the very least long term. This was usually a gradual process, and my interviewees tended to downplay their own agency in this progression. Although some described coming to this conclusion little by little, many also described a sudden realisation that their circumstances had developed past the point of no return. Thus, although my interviewees were 'transnational' in many ways, once they began to establish themselves in England, they actually became less transnational in a number of important ways, because those options were not open to them:

> Because my intention was that I was going to finish my training and go back. Maybe the pressure on me was that I would try and do just that. And then with time, I began to realise that probably, this is home as well. I think psychologically, when I did do that, it made the whole difference. And it just

> didn't matter to me anymore, you know, whether I did that or not. And with time, if there was an opportunity either to go back or to change the way I had planned things before, I could do that with time. But I was powerless at that time to do anything different. So there was probably no point fretting about it. (Dr. T.H.)

Furthermore, career development and professional fulfilment had to be weighed up against an often strong sense of duty to return home. Dr. N.M., for instance, had been sent to the UK to train in a particular surgical procedure, and had intended to stay for two years before returning home. However, shortly before returning, his boss in England called him to say that he would be happy to support him if he wanted to stay. Dr. N.M.'s account of why he changed his mind illustrates well the numerous dilemmas many of the doctors had to navigate:

> Dr. N.M.: And I had already started buying stuff to take home [laughs]. I had already planned everything, I was going back. With my family, my wife and two kids. And I told my wife, this is what my boss said. If I want to stay, he's happy to support me. My wife said, 'You can't say no to that offer'. And I asked the children, 'Do you want to go back to Nigeria? Or do you want to stay?' Of course, you know the answer. They'd been here for about three years ... So both of them decided that I should stay. For me, I didn't want to stay. I wanted to go.
>
> Me: Why did you want to go?
>
> Dr. N.M.: The reason I wanted to go, I felt like, you know, the hospital has invested something in me, and I want to go and give them back what they have invested. They have an interest, and they want me to do something, so I thought I'd go back and do that. Then I started gathering information about what was happening at the hospital I left. Whether, if I went back, I'm actually going to be able to do anything. And the information I got was that they were not really ready for me at the time I was going back. So if I went back, I would have nothing to do. Because to be able to do anything, you have to have the basic structure in place to enable you to do [surgical procedure]. Surgery is just a small part of the whole thing. So being a surgeon, you have to be sure that all the basic structure is in place for you to function. And I thought, 'Hmm, I'm going to be really frustrated.' You know, if I went at that time. I wouldn't do anything for the next two to three years. I will have lost all the skill I've acquired, and even at the time I can start, I will be feeling not very confident about myself, and my ability to deliver. So I thought about all that, and I thought, 'I should not go home now, at least'.

Dr. N.M. touches on a number of important issues here, including the complex and often conflicting relationships between different considerations, such as the wishes of his family, his own sense of duty, and career progression. However, I would like to draw special attention to the last point Dr. N.M. makes, which I will revisit in Chapter 6, echoing a fear that a number of interviewees – both England and Nigeria based – commonly expressed, namely that the Nigerian healthcare system simply lacks the resources and infrastructure to absorb and make use of their skills. "What is the point of going back", Dr. C.N. argued, "if I can't use the skills I have?"

Under these circumstances, the doctors who decided to stay in England had to rethink their commitment to Nigeria, and how to fulfil what they felt was an obligation to 'give back'. Consequently, they had to devise new transnational approaches which would allow them to contribute to development back home. In other words, as their circumstances changed, so did their strategies.

It should be noted that a number of interviewees mentioned how exposure to the NHS instilled values which meant that working within the Nigerian healthcare system became unpalatable. During the time it took to establish themselves professionally, they settled comfortably into English life and the ethics of the NHS. When asked whether she had plans to go back to Nigeria, Dr. A.L. explained how her husband had already moved back several years earlier, and that her own return was her foremost preoccupation. The primary stumbling block to fulfilling this aim, however, was the nature of the Nigerian healthcare system:

> I want to go back home because my husband is there. But I also want to go back home because I want to be able to practice there. As I said, the system is a private system. So I'm not going to go back 'for the good of' Nigeria'. Or 'for the good of' mankind'. I'm going to go back to be able to make money. That's why I haven't gone. My husband has been there for seven years. And I could have gone back, but I haven't done so. And I don't tell him this, because I don't think he can understand. Unfortunately, if you work in the NHS, and you work in England, you want what's here for yourself, you know, you want it for back home. It's not feasible. Why? Because we don't have the setup, we don't have the government support. The government doesn't think of health as a priority. It's not a priority at all.

At first glance, the reasons given for continuously delaying moving back to Nigeria seem to lend themselves to a 'myth of return' (Anwar 1979) analysis. In her updated study of Pakistanis in Britain, Bolognani (2007: 59) argues "that, for the pioneer generation, the ‘myth of return’ justified a socio-economically motivated migration." This may very well apply many Nigerian doctors. However, a 'myth of return' analysis would gloss over the fluidity of lived realities within the transnational social space. The dilemmas, paradoxes and conflicts expressed by my interviewees – both UK and Nigeria based – did not merely serve to justify migrating to and working in England. On the contrary, they were very real concerns and were a source of anxiety, soul searching and constant renegotiation and reassessment. Indeed, the question of return permeates the entire migration process. As we shall see in the next chapter, return does occur, but as with migration, return is not a snapshot of a single moment in time. Rather, return is typically a long, drawn out process – the actual, physical 'return' can take place many years after the decision to move back home has been made. Some may change their minds during this process, often more than once, and others never truly make up their minds one way or the other. Amongst my UK based interviewees, meanwhile, the hardship and exploitation they faced in England only hardened their resolve to not let their struggle be for nothing. Dr. L.A., who was close to retirement and reflected on what a career built in England could mean for him and Nigeria, had been very transnationally active in later stages of his career, but was determined to dedicate his knowledge and experience exclusively for the good of Nigeria. When asked why this was important to him, Dr. L.A. responded: "I feel that when I retire, and I look back, I will be very sad if I don't do that. Because I don't feel

valued. I don't feel valued in the NHS. Even though do the hardest work, I do the dirtiest work, I don't feel valued by the NHS. Only valued in so far as making life easier for others. In Nigeria, I can make a real difference."

Similarly, Dr. N.M. – who admitted to a certain sense of guilt for not returning to his hospital in Nigeria as he had initially said he would do – decided to look for new ways of giving back to the Nigerian healthcare system without going back. He outlined how his feelings of guilt had compelled him to seek out his former boss on a visit to Nigeria, and offer to pay back the money which the hospital had given him to train in England:

> Dr. N.M.: And he thought about it, and he said, 'No, I won't let you do that.' And I said, 'Why? I want to pay back.' And he said, 'I want to continue our relationship, between you and this hospital. I don't want that to be jeopardised.'
>
> Me: So he could see value in you staying here?
>
> Dr. N.M.: Yes, he could see the value. And he said, 'No, I don't want you to pay back. How much is it anyway? It's not going to make any difference to the hospital finances. Because it's very little money, anyway. It doesn't make any difference, and it doesn't make any sense to take the money back'. So he said no. So I said, 'Fine, ok'. And then I started thinking about how I'm still going to pay back, for at least their support. So I now came up with an idea to help bring some hospital doctors to here. So when they go back, they will be better. So I brought, over the years, I brought two consultants from the same hospital I worked, surgeons, to come to this unit. I sourced the funds from elsewhere, so they don't have to pay anything. And the hospital didn't have to pay them. I organised the funds, myself. I paid for their flight. Not my money of course, but I did the work to find the money, and I brought two surgeons from Nigeria. The hospital [in England] was aware of what I was doing, they allowed it, and I got them trained, and they went back, and did a good job. What they learnt here, they were able to start practicing. I checked on that later [laughs].

The role of 'the myth of return' in Nigerian doctors' decision making notwithstanding, my interviewees' narratives indicate a correlation between career development and participation in transnational activities. Importantly, ability to engage in effective transnational activities seemed to increase with seniority in the NHS, as well as stability and security in terms of both work and immigration status. It was the most established doctors who were in a position to make the biggest commitment, exactly because they were secure enough in their positions to make demands of their employers. The older interviewees, who were more established professionally and had taken up British nationality, were more confident in demanding concessions from their employers to allow them to spend more time working in Nigeria. Dr. L.A., for example, had reached consultant level in surgery, and had his contract re-written to give him an additional two weeks leave to practice in Africa, and had to fight to keep it in.

Those who were not yet established, however, often felt they lacked the gravitas and comportment to make such demands. They tended to be more worried about the effects on their jobs and career prospects, and were more guarded towards asking their employers for a sabbatical. Thus, even when there is passion and motivation to contribute back home, much

of the time where they are establishing themselves is wasted – the longer this state of uncertainty, the shorter the period in their working lives where they dedicate time and resources to their Nigerian work. Of course some never get properly established. Dr. B.B., an established consultant surgeon who is very involved in transnational activities both in England and Nigeria, made this point in stark terms:

> The younger doctors, they're too busy thinking about their own survival. How are you supposed to have time to worry about back home when you're worrying about PLAB, worrying about immigration, worrying about getting a job, worrying about discrimination? No, you don't have time to worry about back home when you're trying to survive over here.

This is not to imply that younger, less established doctors inevitably give up and relinquish their commitment to Nigeria. There were also ways in which they were able to circumvent these barriers, and engage in other ways such as blogging, coordinating UK based initiatives, or direct communication with colleagues back home. However, these strategies were in many instances a response to restricted mobility. Thus, Vertovec's (2002: 2) argument that it is "transnational networks that precondition, arise out of, and perpetuate the intermittent and short-term patterns of movement typifying contemporary skilled workers" is extraneous to Nigerian doctors in England, at least in the early stages of their careers when other factors – such as policies and discrimination – may trump this. Indeed, the reverse may be true: curtailment of mobility can lead to a different set of transnational networks and activities.

Transnational Social Spaces and Social Remittances

If we accept that "the high-intensity exchanges, new modes of transactions and activities that require sustained cross-border travel and contacts that are characteristic of transnationalism" (Al-Ali, Black and Koser, 2010: 579) are only partially applicable to Nigerian doctors in England, we can begin to explore how they circumvent the impediments placed on their physical mobility and develop new strategies to make a contribution to development in Nigeria. These strategies aimed at constructing the means to send 'social remittances' (Levitt, 1998) back home. These could be divided into two categories. Firstly, the doctors developed several strategies to enable them to share their knowledge and expertise without actually moving back to Nigeria, through medical and teaching missions, blogs, communication with colleagues back home, and facilitating information exchange. Secondly, some interviewees aimed at using their time in England to amass skills, knowledge and experience with which they would return home to Nigeria. The latter category will be discussed at length in the following chapter. Here, I will focus on how they reconcile permanent settlement in England with their commitment to Nigeria, and outline which social, economic and political factors impacted – positively or negatively – on their abilities to do so.

Medical Missions and Teaching

Although the younger doctors were unable to maintain "sustained cross-border travel" (Al-Ali, Black and Koser, 2010: 579), several were involved in medical missions to Nigeria.

These could only be done intermittently, and the actual time spent in Nigeria was often minimal; typically two weeks at a time. Most of their time and effort was spent organising the mission from England. Success therefore relied on good and competent contacts in Nigeria, as well as reliable lines of communication. In this way, the doctors served as a bridge between Nigeria and England. At the Nigerian end, they draw on their contacts back home to identify the most urgent medical needs at each time and place, as well as to set everything up so that the mission runs smoothly once they arrive. From England, they would bring the skills and expertise that they had acquired, enlist British colleagues to join their missions, and would often source and ship over decommissioned equipment from the NHS. Dr. F.S. explained how it works:

> Dr. F.S.: Well, of course we've got family there, so they will get us permission to do the programme, they will get permission to use the hospital in the locality where we will be going.
>
> Me: That's family back home...?
>
> Dr. F.S.: Family back home, because we've got a few doctors and pharmacists in the family as well, so they've agreed to sort that out. And then they will do a publicity thing, where they tell people that we're coming, so those people will come to the hospitals on those days. And we'll get volunteers as well. So at the moment, one of my cousins who is also a doctor, he is going to contact a local Nigerian medical association, in that state, ask them if they want to work in conjunction with us. We'll get volunteers from that as well. And then we're going to get some supplies from here. There is a charity also, an organisation, that provides that. So we'll take those with us.

Additionally to practicing medicine during these mission, many interviewees expressed keenness on imparting their experience and expertise through training. Again, these would typically be short courses and sessions, and would in some instances be combined with the medical missions, as Dr. F.S. explained:

> Like, emergencies for instance. You get a lot of emergencies there. There isn't maybe the experience of doing them, because they don't have things like advanced trauma, life support courses there, they don't have the advanced life support courses. So when somebody has a cardiac arrest, you just have maybe one person doing chest compressions, oxygen, they might not get oxygen because it will have to be paid for. So something that I would like to do is to provide training on these courses.

For the reasons outlined above, the older interviewees were able to dedicate more time and energy in Nigeria than the less established doctors. Dr. L.A., Dr. B.B. and Dr. G.R. had become very active in various organisations such as the West African College of Surgeons UK Forum and would spend many weeks or even months every year practicing and teaching medicine in Nigeria. Dr. L.A. gave a detailed account of how this work is organised:

> So the aim is training and service, mostly training, sharing of skills. Like the first [name of surgical operation] in Nigeria was done in 2010 was part of this outreach. [This type of operation] is now an established programme. It was done

> by Dr. R.O.[11] Before he left. He did that in Nigeria, and then mentored the local [surgeons]. And they are proficient in it now. Again, in Ghana, they never done laparoscopic surgery. In the teaching hospital in Kumasi, that we're going to. So if you are able to get it to start, it might happen. So the idea is then to get a group of surgeons, they come in to do some work, the hospital can then work formally with that individual. So they can know that I can visit again, they can ask me questions, we can form collaborative research. The problem we have is funding, because a) you don't have too much leave to take, and b) how many times can you buy yourself a ticket to travel, and c) how much can [inaudible] sponsor you? But hopefully, we hope that as time goes on, you know...

Of course, ability for medical and training missions is not exclusive to overseas doctors. As I mention in Chapter 3, there is a long history in the UK for taking a leading role in global healthcare development issues in which medical missions have featured prominently. Indeed, many of the Medical Royal Colleges have a strong tradition of engaging with and initiating overseas development programmes. All Medical Royal Colleges have international operations which aim to support development projects across the globe, and many of them actively seek to engage overseas doctors in their international development work. However, the colleges vary greatly in their enthusiasm for the transnational potential of overseas doctors and/or skill in co-opting their efforts. For instance, the Academy of Medical Royal Colleges – an umbrella academy which promotes and co-ordinates the work of the different colleges – has an International Forum (AoMRC IF) which has made a concerted effort to include overseas doctors in their development work. During my fieldwork, I attended an AoMRC IF meeting where doctors from various countries – including Nigeria – outlined their transnational work, and how these relate to the aims of AoMRC IF. This effort has certainly become established within a number of colleges. Dr. J.D.,[12] a former president of the Royal College of Surgeons of England, explained how overseas doctors were becoming more integral to their international development work:

> I, through my work, both in the College of Surgeons, and when I was president of the Association of Surgeons, set up a system whereby we would not give material help, not even give practical, operative help, but provide training. So that we would go off and run courses and try and train the local faculty ... And we have an organisation called the Overseas Surgical Development Fund, now called the International Development Committee of the Association of Surgeons, and one of the chairmen is a Nigerian. He has now taken some time off to set up some training courses in Nigeria, and so on ... So there are people around who are using their talents to support efforts overseas, educationally, basically support through the diaspora, and the way the diaspora works.

Of course, dedicating a section of their work to engaging overseas doctors requires time and resources on behalf of the Medical Royal Colleges, whose international operations often comprise small teams with limited budgets. This begs the question of what, exactly,

[11] Dr. R.O. is a prominent surgeon who lived and worked in England for several years, but had since moved back to Nigeria where he was practicing medicine. I interviewed him in Nigeria.
[12] Dr. J.D. is not Nigerian, but a former president of the Royal College of Surgeons of England whom I interviewed as part of my 'expert interviewees' cohort.

overseas doctors have to offer above and beyond their white British colleagues. A number of interviewees outlined several advantages:

> The way I put it is, my colleagues here, if we both went to Nigeria, they wouldn't be able to function. Because they would need to work in a totally different way. But if you know how, you know, I can go to Nigeria and I know how I need to modify my immunisation strategy, for it to be effective, in Nigeria. My colleague would just try to apply the western way of doing things. And that's actually what DFID does, in lots of things. (Dr. E.A.)

This view was corroborated by Dr. M.T., the white British head of International Operations at one of the Medical Royal Colleges. Overseas doctors, he maintained, had a deeper knowledge of the intricacies of the healthcare systems in their home countries as well as a cultural and sociological insight into how healthcare is practiced locally. To illustrate his point, Dr. M.T. explained how one of his Nigerian colleagues has important insights which British doctors generally lack:

> I'm thinking about issues like, how does hierarchy work within a West African hospital? Where do the actual levers of power lie? You know, these are the things that British [specialists] working there need to know, because they may be trying to deliver some piece of work, and not understanding why it's not working: it's because they don't understand the sociology of the place in which they're in. And also, I guess this would be an anthropological insight into the people, the patients. Because obviously when you're doing [specialist] practice, a lot of the time you're trying to persuade [patients] to accept or adopt a particular form of treatment. Well, whether or not they accept it depends on a whole range of belief systems that they may or may not have, about health and so on. And yet again, he just brought some insight there which none of the UK [specialists] had, but is very relevant to a doctor practicing in that context.

Not all the colleges had a good reputation for engagement, however. For instance, a number of GPs described how they had made numerous attempts to get onto the radar of the Royal College of General Practitioners (RCGP), but had no response. Curiously, RCGP has a strong international team, and published in 2011 a 10 Year International Strategy. In this, one of the six strategic priorities was dedicated to "Strengthening support for international and overseas member" (RCPG, 2011: 6). Nevertheless, the instances where the Royal Medical Colleges did successfully engage overseas doctors in their development work demonstrated that they could be a powerful vehicle for activating and managing the transnational activities of overseas doctors.

Information and Communication

Vertovec (2004) rightly identifies advances in telecommunications as a key component of transnational social spaces. Faist (2008: 36) concurs:

> Because of the apparent increase in interconnectedness through long-distance communication, facilitated face-to-face communication and interaction through travel, the diffusion of ideas and knowledge, economic, cultural and political life across the borders of states has become more dense and extensive.

Indeed, these modes of communication were certainly exploited in various ways and utilised to maximum effect, especially by those interviewees who were unable to spend much time in Nigeria.

Direct Communication with Colleagues Back Home

Telecommunications featured significantly in the narratives of my interviewees, and was an important mode of communication with friends, family and colleagues back home. Medical and training missions were for the most part organised over the telephone and through teleconferencing. Another significant use of telecommunications was interpersonal communication where the doctors would give advice to colleagues over the phone, which would typically be informal and ad hoc in nature. Many interviewees described how colleagues in Nigeria would call them to talk through specific cases or problems. They might email x-rays or other medical information to their counterparts in England, who will in turn discuss the medical problem with them over the phone. Dr. G.J. explained how it works:

> Yes, so, a lot of my colleagues in Nigeria, old classmates, will sometimes ask me for help. They may have a specific medical issue that they are not sure about, so we can talk on the phone about it. They will tell me what they think about it, and I comment on that or make different suggestions. I do this several times every month.

Similarly, Dr. N.M. described how he had regular contact with a colleague in Nigeria. Interestingly, however, he also outlined how these informal discussions gradually grew into something more formalised, and provided the basis for a more institutional approach to managing social remittances:

> He started a [surgical procedure] programme in Lagos. Almost every operation he does, even before he does it, we will discuss it, he will call me, I will talk, I will send email, he'll say, 'This is what I want to do, this is how I'm going to do it, what do you think?' After he's done it, 'This is what I've done, these are the problems, what do you think I should do?' And he did that for years. And we were just friends, it's not because, we don't work in the same hospital or anything. And he was able to make very good use of me. And I thought, 'So I'm still useful to people in Nigeria!' He decided to invite me to Nigeria when he founded the [surgical procedure] association of Nigeria. So I was the first guest lecturer for that meeting. So I went to give a talk, to open the inaugural meeting. So that was just last year. Because he wants that relationship to continue. And he's trying to do what he can to get foreign trained Nigerians to come and contribute to the development of that specialty, in Nigeria.

Thus, although much of the communication with colleagues in Nigeria was informal and extemporised, it could also take a much more formalised shape. In this respect, the UK divisions of organisations such as the West African College of Physicians and the West African College of Surgeons played a particularly important role. Dr. B.B. and Dr. L.A., who were both strongly involved in work with these organisations, dedicated a significant amount of their time giving advice about both medical and operational issues. Thus, whether communication with colleagues back home is interpersonal and ad hoc or institutional and

structured, overseas doctors act as a bridge between Nigeria and England. Again, Dr. M.T. was able to confirm this from the perspective of International Operations at one of the Royal Medical Colleges. He used Dr. B.B., whom I subsequently interviewed, as an example:

> Dr. M.T.: He's introduced us to the right people. He's also exerted an influencing role. He's kind of done a translational exercise. Again, it's similar: we've got a project, there's been some delays in it, it's not working, and we can go to B.B. and say, 'B.B., what's the problem here?', and he'll say, 'Well, the problem is that you haven't done this, or this is what they're expecting, or this is what they want to see.' Stuff that we just wouldn't have seen or known. But at the same time, he's also speaking to the West Africans, you know, 'The college really needs you to do this', or ... so he has influence both on us, and on the West Africans, because he is West African himself.
>
> Me: But he also understands, I guess, the system over here?
>
> Dr. M.T.: Yes! Exactly! Yeah, he can translate in both directions.

Blogs and Online Networks

According to Freedom House's (2012) *Freedom on the Net* report, "Nigeria is home to a diverse blogosphere, with entertainment blogs drawing the most readers and a growing number of Nigerians blogging about their personal lives or social activism issues. Blogs have gradually emerged as an important platform for discussion and a source of reliable news for many users." A number of interviewees were active bloggers, writing for a Nigerian audience – whether back home or in England – about all aspects of being a Nigerian in England, not necessarily health related. However, three interviewees established blogs with the central theme of healthcare in Nigeria, and how diaspora doctors can contribute to it. I shall refer to them as blogger 1, blogger 2, and blogger 3 in this section. It should be noted that these three interviewees were key interviewees on other subjects as well, and are quoted throughout the thesis under different pseudonyms. Their comments here render them easily identifiable, which is in itself not problematic, as much of what they say is in the public realm anyway, but for this reason it is important that their comments here cannot be linked to other, more sensitive comments elsewhere.

A large part of the rationale for blogging was that online information reaches beyond the medical community in Nigeria, and can engage other important constituents of healthcare as well. Blogger 3 argued that an effective healthcare system involves numerous medical actors, including nurses, pharmacists and physiotherapists, as well as non-medical professionals such as administrators, managers, human resources and policy makers. Although the three bloggers acknowledged the importance of medical and training missions to Nigeria, they also maintained that this alone did not contribute to bringing about the structural change needed in Nigeria to make healthcare provision more efficient. Blogger 2 felt that medical missions help the health economy in some ways, but that they are also "often tokenistic, out on a limb, not integrated in any systematic and effective, sustainable way, into the structure and delivery of a comprehensive health system. And that's why it's gone on for years, but it's never made any real difference." This belief influenced the formation of the Public Health Foundation of Nigeria (PHFN), which endeavours towards a different

approach. Through PHFN, blogger 2 wanted to influence the healthcare system so that medical missions are no longer needed. He detailed the logic behind the Foundation:

> Blogger 2: What we desperately need, is to look at the health system, and not the activities that deliver health.
>
> Me: Is that something you can work towards, even if you're not actually physically in Nigeria?
>
> Blogger 2: Absolutely.
>
> Me: Can you tell me about how you do that, yourself?
>
> Blogger 2: So we formed the Public Health Foundation of Nigeria. And part of what we do...
>
> Me: Sorry to interrupt, is that UK based, or is it more transnational than that?
>
> Blogger 2: It is registered in the UK, and also registered as a charity in Nigeria. So basically, what we do, is that, first of all, we spelled out our objectives, our strategic objectives. Capacity building in the health system, and in the workforce. You know, policy advocacy. And peer support. So capacity building is very important to us. Like last week, I should have, on behalf of the Foundation, travelled to Nigeria to do a session of teaching and training in epidemiology and community medicine, for final year medical students in the University of Lagos. The only reason why I didn't go is that we didn't have the proper amount of funding. So we're looking for funding, to make sure we have enough funds to do these sort of things. But it's about, the point I made earlier, that there wasn't adequate exposure to community medicine and epidemiology for me, while I was in medical school. And I want to change that. That's part of what we want to change in the Public Health Foundation of Nigeria. Building the capacity. But, it's not just building the capacity of doctors. It's building the capacity of the tiers of health professionals beneath that level. Voluntary health workers, community nurses, district nurses, who actually go out to meet the people, in those villages where doctors will not stay. That's what we want to do.

The strategic objectives blogger 2 refers to are outlined on their website (Public Health Foundation of Nigeria, not dated):

> **Objective #1**
> Bridging The Gap between Nigerian UK health profesionals [sic] and Federal Ministry of Health
>
> **Objective #2**
> Re-energise Nigerian health community in the Diaspora to re-engage with the health sector in Nigeria
>
> **Objective #3**

Hearing From Senior Government Officials on their priorities for health care and operational strategies to identify support areas

Objective #4
Identify and publicise the role of links partnerships and research collaborations in improving the health of Nigerians

These objectives resonate with Meyer and Brown's (1999) observation that "through the expatriates, the country may have access not only to their individual embodied knowledge but also to the socio-professional networks in which they are inserted overseas". Importantly, several interviewees who were not directly involved with the blogs reported both using and contributing to them. Dr. N.E., for example, explained that he frequently uses blogs for both receiving and conveying information:

> So, in 2009, these young men set up a forum on Nigerian health issues, in London. So I participated. And there's an email which was going round about Nigerian health issues which I commented on, and some of them posted on this board about the lack of latrine facilities, that UNICEF is talking about millions of Nigerians having no toilet facilities, and therefore defecating outside. And I'm pointing out the fact that even doctors are not appreciating the importance of simple, basic hygiene, communicable disease control, and all this.

Bloggers 1 and 2 argued that this specific type of information sharing was only possible for diaspora doctors. Blogger 1 explained why:

> I'm always interested in Nigeria, through my blog called Nigeria Health Watch, which is something you can do as a Nigerian not in Nigeria: tackle difficult questions about health, on the blog, in a way that in Nigeria would be self-censoring. Because my boss might say, 'I don't like this', and so on.

Indeed, this was one of the *raison d'être* of Nigeria Health Watch: "We are not afraid to take on the difficult topics that many commentators choose to ignore, while also trying hard to keep health and healthcare issues firmly on the political agenda in Nigeria" (Nigeria Health Watch, not dated). In this way, blogs can serve the double purpose of facilitating knowledge transfer between England and Nigeria and openly discuss issues which would be subjected to gagging Nigeria.

In addition, blogger 3 established two online ventures close to what Vertovec (2002: 11) describes as a promising prospect in the transnational strategies of highly skilled migrants: "Another kind of transnational network affecting skilled worker movements are represented by on-line networks for information exchange and recruitment among occupational professionals." Blogger 3 described these ventures, and her account merits quoting in full:

> I set up a programme called – that was in, I think, 2000 – Find A Job in Africa,[13] which is really an online portal. The initial focus was on the diaspora, for them to be able to be aware of opportunities back in Africa, and the focus was really initially on private sector, because that's when a lot of private sector started developing and expanding. And also, they tend to have an attractiveness in terms

[13] www.findajobinafrica.com

> of luring people, and their jobs are more open and transparent. So I started that. And by nature of it being online, that means anybody can apply, so it's actually a lot of people *in* Africa are also using it now, which is also a good benefit, because what it means is that it has the ability to retain skills in Africa. Because it's all about opportunities. And from there, I started thinking about, 'What are the root causes?' You can deal with some of this, so put in the portal and people applying, and employers having wider access to skills, that's one thing. But actually, having a good human resource framework and policies is another thing. And so I set up Africa Recruit,[14] and that is sort of an online platform where you can bring together key decision-makers and stakeholders, to discuss issues, to share best practice, and inform policy.

It should be noted that these blogs and online portals did not operate in isolation, but had intimate links with various parts of the transnational social fields. PHFN, for example, was initially set up with a start-up grant from THET. Furthermore, as bloggers 1 and 2 explain, both PHFN and Nigeria Health Watch have close links to policy makers and politicians in Nigeria (even if, as we shall see in the next section, this work produces limited results). Similarly, blogger 3 is firmly embedded in civil society through her work with high profile charities such as Comic Relief, and works as an adviser to a number of UK government departments. Thus, all three bloggers are involved in a variety of work within the three levels of the transnational social space – the state, civil society, and minority groups (Faist, 2000b) – where their online resources serve both as a mouthpiece for Nigerian doctors and as a bridge between different parts of the transnational social space.

Working with Policy Makers and Lobbying Politicians

Most interviewees recognised that the development of the Nigerian healthcare sector would require more than a solely medical intervention. Systematic structural change is essential, they argued, for developing a functioning healthcare system. For this reason, many of them were also actively working with policy makers in Nigeria, or seeking to lobby politicians. As outlined above, influencing healthcare policy in Nigeria formed a central plank of organisations such as PHFN and Nigeria Health Watch. However, several interviewees also tried to influence policy in a personal capacity. In doing so, they would draw on their own expertise to make the case for particular policies or healthcare interventions. Dr. N.E., for example, had extensive experience working on disability issues within the framework of community paediatrics, and had written a report in the early 2000s on this topic for the Federal Ministry of Health in Nigeria. "And I addressed the minister, and I said, 'Look, this is an area I was sent to study, I've been studying this, I've been practicing this, in England. Now, I think it is time for this kind of thing, setting up this kind of service in Nigeria.'"

Although Dr. N.E.'s involvement with policy makers and politicians was a personal venture rather than forming part of the work of an organisation, it is nevertheless interesting to note that in one of his anecdotes, contact had been facilitated by more formalised organisations such as MANSAG and PHFN:

[14] www.africarecruit.com/

> Two years ago, there was a webinar. The junior minister of health was in the USA, and we were all linked by webinar to his presentation. And I posed this question about the lack of disability services in Nigeria. He actually threw a challenge to me. He said, 'Well, in Africa, we don't think so much about disability.' I said, 'Why not?' And I remember him saying, 'Oh, you're in London', and all those things. And I said, 'I'm a paediatrician. I'm not talking about an aging population, I'm talking about children.' And he said, 'Why don't you write something. Why don't you tell us about your proposal.' And I said, 'Is that a challenge?' He had thrown down the gauntlet. And then I met him in Manchester in 2011, the MANSAG annual conference, and I met him. I said, 'Look, you said that I should write something.' And he said, 'Yeah, let me know when you're coming to Abuja.'

A number of interviewees had attempted to lobby politicians in the same way as Dr. N.E., but they also reported not getting very far with it. A common complaint was that Nigerian politicians have little interest in engaging the diaspora, and either ignore offers from diaspora doctors to share their knowledge and skills, or fail to act on them. The Public Health Foundation of Nigeria, for example, were actively trying to engage the Federal Ministry of Health in Nigeria in their work. As Blogger 2 explained, however, much of their efforts was greeted with inertia:

> So in the past, in 2008 and 2010, we organised a conference, where we brought politicians and representatives of the Ministry of Health, from Nigeria, brought them to London, sat down with them, had conversations with them, engaged them in discussions about what their plans are for the health system, where they need support, where the gaps are, what we do, what we can do, what we can support them to do. So we did that in 2008, we did that in 2010. And in 2012, we didn't do it. And the only reason we didn't do it, is that we sat down and reflected, and asked ourselves, 'We've done that two times, what have we achieved? Not very much.' So ... and it's part of the frustration of working in an environment like Nigeria. People talk. They love to talk. But when it comes to the doing, and when it actually comes to committing funds ... putting your money where your mouth is, that's the hard part. But we've got to keep on pressing them, because one thing we could do is, we could say, 'We're relatively comfortable here, why do I need to sweat myself for people who are not ready to listen?' But if the politicians and government officials are not ready to listen, the people who are bearing the brunt of it, are the ordinary people on the streets who cannot afford medical care when they need it. So giving up is not an option for us.

Although this experience was common, it was not unanimous. Dr. B.B., in contrast, said that his status as a consultant in England opened doors for him in Nigeria that would otherwise most likely be closed. It should be noted, however, that Dr. B.B. had built up a strong reputation as an excellent doctor and formidable development agent. He had spent decades travelling regularly to his region – one of Nigeria's poorest – often risking his life in order to deliver medical care to those who could not afford it. This had earned him a great deal of respect from both doctors and politicians, both in Nigeria and in England. The important point, however, is that he distinctly connected the 'Englishness' of his medical training to the access he had to power and resources:

> The fact that I was a UK consultant put me on a higher pedestal, with the people in power. Now, the president of the country is my personal friend. He calls this house. When I was personal physician for the governor ... he calls this house. So it put me in that higher position. And that's why I had the opportunity to go to the state, and they gave me a blank cheque. To organise training, for doctors and nurses, technicians, in the UK.

Social Remittances – Opportunity and Abeyance

For my interviewees, a central reason for training and working in England was to acquire skills and knowledge which would be of benefit to Nigeria. In this section, I will discuss some of the factors that affect overseas doctors' capacity and ability to transmit social remittances. The first thing to mention, then, should be the very skills and knowledge they acquired in England. In spite of the impediment of racism and discrimination to their career development, as outlined in Chapter 4, all interviewees nevertheless acknowledged that their training and work experience in England had granted them a skill set which they would not have obtained in Nigeria. Therefore, their experiences and trajectories cannot be depicted as 'brain waste'. This is important, because all interviewees were of the opinion that they had acquired skills and knowledge in England which could be used to the benefit of Nigeria:

> Yes, at the end of the day, having said all this, the level of the postgraduate education I have in Nigeria had a lot of deficiency. Especially in intellectual aspect. I was happy to be able to bridge that gap. Because of all the issues that have told you, I feel ashamed, and pained. Sometimes ask myself about that achievement, was having all those abuses and difficulties worth achieving what I think I've achieved. That is the question I need to address, what I spend my life doing. The remainder of my active life. Which comes back to what you're doing [with this study], which is trajectory. I feel that for my experience, my Western experience, health education, development of medical education and delivery of care in Nigeria. (Dr. L.A.)

It should be clear from the sections above that Nigerian doctors have developed several strategies to engage in transnational activities, and to make use of the opportunities presented within transnational social spaces to transmit social remittances. They draw on their unique location between two worlds to instigate various enterprises with the aim of transmitting experience and expertise from England to Nigeria, whether in a private capacity or through more formalised organisations, whether through medical and teaching missions or through information exchange. Nevertheless, the pathway to distributing social remittances is strewn with obstacles: an over-reliance on migrant networks and an exclusion from non-migrant networks; the constraints on mobility through immigration controls and pressures of career progression; channelling into less prestigious specialisms and lower hospital grades; years of career development lost or wasted due to discrimination.

At this point, it is worth taking a step back to consider the bigger picture. In Chapters 3 and 4, I argue that the othering of overseas doctors places them in a position of inferiority. This dichotomy between the superiority of UK/EEA doctors and the inferiority of overseas doctors is naturalised, thus providing a rationalisation for treating overseas doctors as second rate workers who can justifiably be relegated to a subordinate position in the labour market.

This characterisation of overseas doctors informs both the people who determine their careers and the policies that affect them. As I indicate in Chapter 4, this is how much of the media portrays overseas doctors as well.

I would argue that this position of perceived inferiority hampers the transmission of social remittances of Nigerian doctors in several ways. Many of these have implicitly been outlined above, but it is worth stressing that my interviewees themselves sensed that they were only wanted in England to serve a specific purpose: to fill gaps in the labour market. Those who actively engaged with development programmes in government agencies or departments – such as DFID, DoH or the NHS International Health Group – were painfully aware that overseas doctors are not valued as efficient agents of change. Nigerian doctors, they argued, engage in transnational activities in spite of, rather than because of, these agencies. Indeed, some interviewees were worried that a commitment to Nigeria would send out the wrong signals, as Dr. E.A. explained:

> And I think it's interesting, because I think an English doctor who goes off to do a year in Zimbabwe, white English doctor, is probably viewed positively, you know, for his interest in global health, or whatever. But I think a Nigerian who goes back to do a year in Nigeria, it's more like, 'Are you really committed to a career in the UK?'

Thus, they receive little in the way of support, encouragement, resources or consultation to pave the way for social remittances, whether in terms of mobility or information exchange.

I have already outlined the factors which retard the mobility of overseas doctors, severely curtailing their ability to take part in medical and training missions. However, a couple of additional points need to be made. We may remember from Chapter 3 that DFID took a dismissive stance towards the potential of overseas doctors taking part in its involvement in global health. A number of interviewees commented on this. Dr. E.A., for instance, argued that overseas doctors are not systematically included in international development strategies: "In international development, for instance, they are investing in aid. Are you asking the Nigerian public health experts in the UK what they think of your DFID strategy? The answer is a definite no."

As a result, there are few structures, programmes or resources in place which systematically harness the transnational efforts of Nigerian doctors. Vertovec (2002: 12) notes that the "long-distance networks among local and foreign-based professionals can provide highly important channels throughout which run flows of capital, skill, managerial know-how and information." This is what a number of interviewees were trying to establish, but struggled to do so. For long-distance networks to be effective, they need funding and structure. Dr. F.B. explained the importance of these:

> You know, for there to be a structure that enables this, you do need dedicated resources. You can't do this on the passion and volunteerism of the diaspora, expecting them to do this, to organise themselves. That's not going to happen. Somebody needs to put money down to enable that organisation to happen, to enable that network to happen, to enable the capacity building and signposting to happen. Because everyone is doing it off their own back.

In terms of medical and training missions, my interviewees were generally of the opinion that Nigerian doctors are by and large devoted to Nigeria and are keen to use their skills to develop its healthcare sector. However, they also argued that the cards are stacked against them, exactly because their desire to contribute to development is incompatible with their purpose of filling certain gaps in the labour market:

> I think the vast majority, the vast majority ... I've only come across one Nigerian doctor who said he'd completely given up on Nigeria, 'I don't even want to hear the word. I'm in England now, I'm British, I'm making my career here, my children are safe here.' But on the whole, people want to help, they want to go back. But the system doesn't let them. It's not very easy to take time off. It's not easy if you're trying to clock up the years to get your residency and then your citizenship. You don't want to move around, you want to be here, you want to develop your career in the NHS. Like I said, you've already started off some years behind your peers, so then to take off more years to go and work in Africa as well. (Dr. E.A.)

Dr. L.A. was of the same opinion:

> So, obstacles. Money is a big problem there. What helps the process? What helps the processes is how to overcome obstacles. The NHS, part of the problem is that we have to go with our annual leave, or study leave. The hospital will not pay for your overseas leave. So there's an opportunity cost. So that discourages ... More people would have volunteered if we could buy tickets, if I came to you and said, 'Look, you got enough donors, and were going to pay for your feeding and accommodation.' People would volunteer. Not many people want to buy their own ticket and then give their skill freely.

The solution to this, Dr. L.A. argued, was to coordinate the efforts of Nigerian doctors in a way which provides consistency and harmony of care: "So I want more from this model of going every year to stay for a week, to a seamless system whereby you have a standing committee of doctors who want to give their time." However, funding and resources was an eternal stumbling block to this aim. As mentioned above, some interviewees were experimenting with online portals to synchronise doctors, but were struggling to do so. Furthermore, organisations such as the West African College of Surgeons had established a more integrated programme to engage the diaspora, but still suffered from a lack of funding. Part of the problem, according to Dr. F.B., was that overseas doctors were not taken seriously as agents of change:

> The frustration, obviously, is as I said the capacity and the capability of the diaspora to be able to succeed. Some people want more robust evidence, but it's a chicken and egg situation. Without putting things behind it, they're expecting full time people, staff who are working full time, got a day job, doing this out of passion, to be able to pull together things on the same level as some of the big NGOs. Well that's not going to happen.

Conclusion

The transnational lives of Nigerian doctors are extensive, diverse, and robust. They engage in a wide variety of transnational activities with the aim of using their skills and knowledge for the good of Nigeria. These activities range from ad hoc phone conversations with old class mates in Nigeria to organised and complex rotas for surgeons to travel to Nigeria for operations and training sessions, and everything in between. However, Nigerian doctors do not operate unrestricted within their transnational social spaces. The policies outlined in Chapter 3 and the discrimination described in Chapter 4 impacts greatly on their capacity to engage transnationally. As the contours of the social landscape changes, so do their strategies to engage with Nigeria.

If we bring this all back to the core concept of transnational social spaces, I hope to have demonstrated how the various social actors, networks, institutions and processes which shape the transnational social spaces within which Nigerian doctors operate are indeed all interconnected, both within and between micro, meso and macro levels. It should be clear that – at least where Nigerian doctors in England are concerned – 'transnationalism from below' is to a large extent structured by, and dependent on, 'transnationalism from above'. My findings are certainly congruent with Faist's (2008: 21) observation that "national states structure the transnational spaces in which non-state actors are engaged in crossborder flows, leading towards a tight linkage between migration control, immigrant incorporation and development cooperation." These findings problematise "the idea that transnationalism as applied to immigration is transnationalism ‘from below’, in contrast to the transnationalism ‘from above’ that is manifested by global corporations and governments" (Kivisto, 2001: 560), as advocated by Guarnizo and Smith (1998).

Of course, opportunities and barriers to engagement are not confined to the UK end of the transnational social spaces of Nigerian doctors. On the contrary, my UK based interviewees sorely complained about a distinct lack of interest in their services in Nigeria, whether from colleagues or politicians and policy makers. Furthermore, a number of the interviewees who had moved back to Nigeria echoed what my UK based interviewees said about the lack of a structured approach to engaging diaspora doctors. They stressed that UK based doctors have a lot to offer, but that they were often too far removed from Nigeria to adequately identify the most pressing needs, and that their efforts were often too ad hoc to be effective. Asked whether Nigerian doctors can make a contribution without actually moving to Nigeria, Dr. F.O. said it in order to do so, there need to be "clear mechanisms for doing a needs assessment in Nigeria. And being able to objectively match the skills with what is needed. It needs to be more structured than it currently is". This is an important point, which I have thus far given little attention in my analysis. I will explore the relationship between Nigerian doctors in England and their counterparts in Nigeria further in the following chapter.

6. Returning Home

> I think that I wanted to come back because this is where I'm from. And I think that where there's a need, that's where my skills should be. In my mind, the UK has enough of me, or people like me, that they could manage. Whereas here, it doesn't. And I think it's valuable, the more of us that come back at a certain level, who have had training elsewhere, are of more value. If we can come back in enough numbers. (Dr. A.W.)

Return migration is sometimes referred to as the "great unwritten chapter in the history of migration" (King, 2000: 7). Whereas other migratory routes have been thoroughly researched and theorised, much remains to be understood about how and why migrants decide to return, what they do when they go back, how their social environment influences their chances of success, and how they contribute to the development of their home countries. In theory, there is much that returning migrants have to offer high emigration developing countries. This should particularly be the case with doctors, for two simple reason. Firstly, health is one of the chief gauges of development, where the extent and condition of a nation's healthcare system is indicative of its overall economic and developmental performance (Docquier and Rapoport, 2009: 684). Secondly, professional progression is usually cited as a central motivation for doctors to migrate from the global south to the global north, where doctors seek to acquire skills, knowledge and experience through training programmes not available to them in their countries of origin. Logically, therefore, returning doctors should be well equipped to contribute to that vital domain of human development – the healthcare sector – in their home countries.

Research on return migration has tended to study this topic as a sociological issue in its own right, connected to but separable from migration. In this chapter, I will demonstrate that return migration is an integral part of the entire migratory journey. For my interviewees, the prospect of migration and the question of return emerged concurrently. Thus, to understand return migration, it needs to be analysed within the dynamics of the entire migratory journey. This extends to how we should conceive and analyse transnational social spaces. As per the previous chapter, the concept of transnational social spaces is particularly important here, but with the added twist of the dynamics of return. The doctors still occupied the same transnational space upon their return, only their location within it – and thereby their relationship with other actors within the space – had changed.

There are no reliable statistics available for how many Nigerian doctors return home after studying or working abroad, reflecting a broader paucity of data on return migration of sub-Saharan African doctors (Mills et al, 2011). Anecdotal evidence suggests that this is neither widespread nor systematic (Adzei and Sakyi, 2014). Portes (2003: 877) may be right in his contention that even when numbers are relatively small, "the combination of a cadre of regular transnational activists with the occasional activities of other migrants adds up to a social process of significant economic and social impact for communities and even nations." However, it is simply impossible to tell whether returning Nigerian doctors are able to make a structural and sustained impact on the Nigerian healthcare system. Yet, return migration does occur. Thus, it is crucial to understand why some doctors choose to return, how the skills and

knowledge learnt in England convert to the Nigerian context, what obstacles they encounter in their efforts to use their skills and knowledge to develop the Nigerian healthcare system, and the strategies they develop to overcome these obstacles. I try to answer these questions by exploring the return journeys of twelve Nigerian doctors who had spent time training, studying and/or working in England, and had – for a variety of reasons – decided to return to Nigeria.

Most of my Nigerian based interviewees' narratives of their sojourns in England and career development in the NHS echo those of my UK based interviewees, described in the previous two chapters. As one of my central arguments is that return migration must be understood and theorised as an inseparable part of the entire migratory journey, and that the doctors occupy the same transnational social space upon return as they did whilst in England, it is important to keep this in mind throughout the chapter. Thus, to avoid repetition, it is helpful for the reader to consider my Nigerian based interviewees as essentially the same cohort as my UK based interviewees. The challenges and opportunities outlined in Chapters 4 and 5 equally apply to the trajectories of the interviewees I discuss below. The one fundamental difference is that the doctors in this chapter had made the decision to move back to Nigeria, whether permanently or temporarily. There were, however, three notable exceptions. The journeys of Dr. D.C., Dr. R.S. and Dr. B.E. differ in that their return to Nigeria was not entirely voluntary, as they were forced to leave the UK before they had achieved their goals. Importantly, their migration trajectories were interrupted by policy. Because of this, their narratives are particularly important, because they fill in key gaps in the data I collected in England, the very nature of which left one imperative question unanswered: what happens when doctors are forced to leave?

This chapter is divided into two main sections. Firstly, I will outline the passage home in some detail. I begin by looking at three interviewees who were reluctantly compelled to leave England before they had achieved their goals. I then widen the focus to look at key events and issues leading up to return amongst all interviewees, including considerations about career development and concerns about the impact on their families. The section concludes by looking at their reintegration into the Nigerian healthcare system, how they negotiate conflicting needs and obligations, and the strategies they employ to overcome challenges. Secondly, I explore how the skills and knowledge amassed in England translate to the Nigerian healthcare system. The constructive elements of this consist of applying their skills directly to healthcare delivery, transmitting knowledge to junior colleagues, and drawing on the transnational links they had fostered with colleagues in the NHS to facilitate their work in Nigeria. On the flip side, some interviewees acknowledged that their English training had somewhat distanced them from the healthcare needs of Nigeria, and that a period of transition and adjustment was needed to fully apply their skills and knowledge to the Nigerian context.

The Journey Back

The first thing to say about the returnees' trajectories is that their journeys back home were rarely straightforward. There was no typical journey back. Some of them returned after a brief stint for utilitarian purposes, such as obtaining a masters' degree, and had always

intended to return by the end of it; others returned after nearly 30 years of service in the NHS; and others yet were forced to return against their will. However, all the interviewees had one thing in common: for all of them, moving back was a long, protracted process. As such, there was no discernible beginning or end to this course of action. In this section, I will outline how decisions were not so much made as constantly reassessed, and describe the various issues and dilemmas which my interviewees needed to resolve throughout their decision making process. I begin by detailing the range of challenges the return journeys posed to my interviewees, and conclude by discussing the ways in which these challenges were overcome or mitigated.

Challenges of Return Migration

Much like the decision to migrate, the decision to return is a long term project which begins way before the actual physical move. Indeed, for many of my interviewees, the matter of return went hand in hand with the decision to leave in the first place. Both were borne of the same puzzle of migration in that leaving inevitably raised the question of whether they would ever return, and if so, when and how? Thus, return permeates the entire migration process. For some, like Dr. P.L., the issue of return was not much of a question – it had never really occurred to her to stay. She had studied and worked in England on two separate occasions, first as part of an elective attachment during her undergraduate studies, and later for an MSc programme followed by a clinical attachment. For her, the transnational social space constituted the means to acquire new skills and knowledge for the express purpose of bringing new ways of thinking and practicing back to Nigeria:

> I guess I may be misguided, but I'm really a patriot. I've been to England, I've seen how things work. And I wonder: what possible contribution am I going to make to that system? Perhaps not much. They have it all. But in terms of what contribution I can make to my own system – a lot. I can make a lot of contribution to my system over here. And for me, I always wanted to come back home. Don't get me wrong, I can always go back to England, but it would be to learn something new, or to gain more experience. Or maybe another attachment. Or to gain a new qualification. But I don't see myself staying there, living there and working there.

Others had a more ambivalent relationship with return. Dr. K.T., for instance, had been living in Nigeria for one year after living and working in England from the early 1990s to the early 2010s. For him, it had been very important to keep the channel back to the NHS open. Initially, he had only intended to come back for three months, but the Nigerian hospital had asked him to sign up to a whole year. He successfully negotiated a yearlong sabbatical from his NHS post. By the time I interviewed him, Dr. K.T.'s sabbatical was drawing to a close, but he had still not made up his mind as to where he wanted to be:

> Dr. K.T.: I still have my job there, I took a sabbatical leave. My job is still kept for me.
>
> Me: So do you think you might be going back to the UK?
>
> Dr. K.T.: Erm, possibly, because [this hospital] wants me to stay, they're trying to offer me contract, but the UK has said that they're not going to give me

> another year sabbatical leave. So I have to make up my mind where I want to stay. But yeah, I'm still not decided. But I must admit that I'm more useful in this environment than in the UK. Because I can contribute more to the health of Nigerians, especially here in this Intensive Care Unit.

Thus, the 'if and when' question weighed profoundly on my interviewees throughout the migration process, but the question of 'where and how' was equally important. Before getting into a substantive discussion of these dilemmas, I will first describe the circumstances of the three interviewees whose return was involuntary. Following this, I will explore in detail the many challenges posed by the journey back.

Forced Return

In Chapter 3, I explore in detail how various UK policies impact on overseas doctors' trajectories, and argue that the policy landscape has tended to impede their career development. In particular, the changes to immigration policy in 2006 – where NHS trusts were required to prioritise UK/EEA applicants for training programmes – placed them in a disadvantaged position *vis-à-vis* their UK/EEA counterparts. In Chapter 4, I outlined how these policy changes impacted on the career development of Nigerian doctors in England. However, my English data did not allow me to examine the full impact on those who were forced to leave England as a result of their implementation. Indeed, these policy changes were also felt in Nigeria. Two interviewees – Dr. D.C. and Dr. B.E. – outlined how these changes had affected them personally. Furthermore, Dr. R.S. got caught out by the scrapping of the post-study work visa in 2012. In order to gauge the effects of policy, I will briefly summarise how these policy changes impacted on these three doctors' trajectories. The important point about these three stories is that UK immigration policy severely restricted the options available to the doctors. Indeed, their experiences demonstrate how the UK healthcare system tends to consider overseas doctors as a resource, but ignore the potentially beneficial effects which a good use of their time could bring not only to themselves, but also to their country of origin.

Dr. D.C. moved to England in 2004. His plan had been to obtain a Master's degree and follow this up with a residency programme. His Nigerian hospital was not credited to offer residency, so he was not progressing in his career. Dr. D.C. took great care to plan his time in England well, and finished Part 1 of PLAB[15] before he left. During his MSc, he finished PLAB 2, and also opted for sitting the exam for Membership of the Royal Colleges of Physicians "since that would make it easier for me to get into the system". Following his MSc, Dr. D.C. switched from his student visa to HSMP[16] status and got a job as Senior House Officer, albeit in the capacity of a trust grade doctor. By the time he was ready to apply for training posts, the 2006 changes to immigration policy had taken effect:

> By that time it was getting more and more difficult to get training positions, and I was realising more and more that I really would be of better use to the system if I go back to Nigeria. I just realised that everything has been done there, and

[15] Professional and Linguistic Assessment Board.
[16] Highly Skilled Migrant Programe.

> I'm just going to be working at a low level, while there is still a lot left to be done here. And I just kept thinking that maybe it's time to go back.

Dr. D.C. applied for numerous training posts but never got so much as a reply – "because they normally say, 'If you don't hear from us by so-and-so date, then you are not successful', so I didn't even get any interview or invitations, at all" – whether these were for his preferred specialism or general medicine. When I asked him about his emotional reaction to this constant stream of rejection, Dr. D.C. confessed that it had taken its toll:

> You keep getting disappointed, and you keep feeling that there is some discrimination. But I looked at myself, I didn't train there. And you want people who trained there, because they know your system better, so maybe they're entitled to that. But I felt disappointed, because I take myself to be a very, very good doctor, and my grades have always been very good, so I always feel that I should have a chance to prove myself. But I just never got it.

Dr. B.E., on the other hand, had returned back to Nigeria for a set of reasons connected to staffing shortages in his Nigerian hospital. After his training elsewhere in Europe, he had returned to Nigeria to find that he was unable to perform surgery connected to his specialism, and felt that that his skills were slipping. He applied for a UK based training programme through a British surgeon he had met in Nigeria, and left Nigeria in 2010:

> So I was there for 15 months, then came back. My plan was to stay for at least two years, or 18 months. But the problem was that in my unit here, there were two people, a professor and another young colleague, [who left the hospital for family reasons]. So now, there was only the professor, so there was acute need for me to come back. I just had to come back, 15 months into the programme.

Once more, however, he became increasingly concerned about skill attrition, and therefore decided to apply for another clinical fellowship in England. He had kept in close contact with his English colleagues, who drew his attention to a post in their trust and encouraged him to apply. At this point, Dr. B.E. had strong links with colleagues within the trust in question, but in spite of the personal recommendation from people within the department, he was not even offered an interview:

> Dr. B.E.: I think, basically, because they get several applications. And you know that the ruling in UK now, is if you have a job opening, and then an EU applicant who fulfils the requirement, they are the first priority. So they just pick those people who apply from the EU. So later on, when I didn't get any reply from them, I wrote to the head of the department, and I said 'Wow, I applied' ... so he wrote to them in personnel, and they said that, yes, I applied. But it's basically because I didn't tell them, notify them that I applied. They said they'd prefer me, because I've worked with them, so they know what I can do.
>
> Me: So even someone at the standard that you are...?
>
> Dr. B.E.: ...is being cut off. I was shocked. Because I'd written that I'd worked with them for 15 months on the form, so I just thought that would be a big plus. And I even used one or two of my colleagues as referees. But they just short-listed the EU candidates. They just followed the rules [laughs]. The people in

> personnel didn't show my colleagues, or the head of department, all the forms. It was just, 'We have ten applicants, 5 people from EU, three fulfil the criteria', and they just interview them. I don't think they even looked at the other applications.

In other words, Dr. B.E.'s application never reached the hiring panel. It was pulled out by administrative staff, working on the assumption that his application could safely be dismissed because there were qualified UK/EEA candidates applying for the job, thus demolishing his plans for a two year clinical fellowship in England.

Similarly to Dr. D.C., Dr. R.S. had gone to England for an MSc programme, and had intended to follow this up with first hand work experience to take full advantage of his time in England. He had particular ambitions to establish links with international organisations such as WHO, and reasoned that England would be an advantageous place to make the relevant connections. However, during the MSc programme, the British government cancelled the Tier 1 (Post Study Work) visa, thereby removing his only viable route to stay in the UK:

> Many people also want to experience what it's like to work in the UK. Even if they want to come back, they want to mix with people. They want to get experience based on the things that they have studied. Because, I was trying to, when I was in the UK, I was trying also to do a bit of work with WHO. Because I think it's going to enhance my visiting. But the academic work, the time, and all that, it's not really there. But, the post-study visa, it was cancelled. After my study, I wanted to do six months work with WHO, United Nations, or some NGO in the UK. So I will know how these things work, so I can have firsthand experience, working experience. And I think that is just very important. Other than just go for theoretical knowledge, and come back.

What Dr. R.S. found particularly grating was that the UK was willing to be at the receiving end of a flow of money from citizens of poorer countries, but not allow them to stay for a limited time period following their studies in order to make the most of the investment they had made. Dr. R.S. had to take out a loan to afford not just the university fees, but also the cost of living:

> Dr. R.S.: What I actually did, was ... there is what we call cooperative society. So I took some loan from cooperative. And that's what I actually used to finance my education.
>
> Me: So was that a big loan?
>
> Dr. R.S.: Yes, that was a big loan. A big loan. A BIG loan [laughs]. Millions of Naira [laughs].

Career Concerns

Because my interviewees had migrated to England in order to specialise, they returned with a highly specific set of skills. A common anxiety, therefore, was that the Nigerian healthcare system would lack the capacity to absorb and make full use of their skills. Along with generic concerns – such as problems relating to power cuts, reliable access to clean water, and hospital infrastructure – shared by all the interviewees, most also listed specific concerns,

particular to their specialties. Although the scope and nature of these concerns varied greatly – ranging from the quality of post-operative care and skill level of specialised support staff to the availability of psychiatric medication and administrative competence of hospitals – they all shared one common trait: they all related to practice and procedure considered routine and taken for granted in England. In other words, they considered these points essential for them to make full use of their skills. For this reason, many interviewees took great care to plan their return in meticulous detail, most importantly in relation to the job they would go back to. For Dr. R.J. and her husband, who was a surgeon, planning their return took over five years:

> Coming back, I'd say the driver was also from my husband. We moved back when he got a job. He tried for one in 2001/2002. Started interviewing and all. But something happened, something with the administration in that hospital, and they stopped hiring. And for other reasons as well, he needed a bit more time, because coming back is difficult. Anyone who tells you differently, doesn't know! It's difficult. So in 2005, so in another three years, another post came up, somewhere else. And they were so keen, that they actually sent someone over from here to come and talk to him! But then he also had been coming, see this is where the role of people coming intermittently, because all our family, parents, siblings, most of them are here, we were still coming every year. And on one of our trips home, I think in 2004, we heard of a [specialist surgical] medical mission taking place in Lagos. So he went along to that, but just observed the first time. I think he got there on the last day. And they said there was another one the following year, 2005. And then he actually came for that, for about a week. So there he was told that they were thinking of now opening up their own unit, there was no unit up until that time, and would he be interested in coming back. So it started from there. We went back after our holiday, and they continued to contact us. And the chief medical director was on holiday in the UK, and came to see us. So he started setting up the unit from there, in terms of equipment, what we need, and so on.

Dr. R.J. herself, meanwhile, had held five different posts since their return, before finally finding a job suitable to her skills.

The importance of carefully planning and setting up the return, and the perils of not doing so, were illustrated by Dr. B.E., who was placed under extreme pressure from his hospital to return back to Nigeria sooner than he would have wished. He described his frustration of returning to a job in a hospital which lacks the resources and facilities to make effective use of his skills. Asked whether it ever occurred to him to stay in the UK, he replied that the temptation had been strong:

> Well. [Laughs]. That was quite a controversial situation. When I was leaving here, I didn't resign. So I took a leave of absence. And technically speaking, because of the acute need here, I had already promised that I was coming back. I think that was the main drive to come back. But really, when you're in the UK, you feel, 'Why do I have to go back?' And for one, like I've told you, you come back, and you're not sure you'll be able to use the skills you've gathered. Number two, you have the systemic problems that we face. Even when you are able to work, power supply may be off, water may not be there. Different challenges that you know you're going to face when you come back home.

As it turned out, his fears had been well founded:

> It was a real challenge for me, to come back. Really, it was a big decision. I initially refused, I argued, argued and argued. But the chief medical director said, 'Look, if you don't come back, the unit will most likely collapse. The professor is getting old, he cannot hold the whole unit and its trainees in the unit. There are people who need our service. What do you want to tell them?' So I had to come back. It was basically a renegotiation. And of course, all out of deception, because they told me that the theatre was ready, everything was set, that they've done the new ... by the time I come back, they were still doing the theatre!

These challenges within the Nigerian healthcare system were confounded by a sense that some of their colleagues who never left Nigeria were less than enthusiastic about their return. A number of interviewees speculated that some of those who never left saw them as a threat to their authority, and that this distrust impeded their efforts to help develop the Nigerian healthcare sector. As Dr. R.J. explained:

> Talking about differences in qualifications, because I have my first degree from here, and then postgraduate qualifications from UK. And I was told, 'Oh, that. That doesn't count for anything.' I worked very hard to get this, why would it not count for anything?! This was one of the most senior colleagues. In the same specialty! I was quite taken aback. Why would you say that? You know that healthcare delivery over there is better than here. You can't say it doesn't count for anything. You can say I need some period of adjustment, because the presentation of some diseases is different. But it can't count for nothing...

Generally speaking, however, my interviewees did not see this as a major problem for themselves or their careers per se. Although they confessed that this could hold up their assimilation back into medicine in Nigeria, they also felt that they were more than capable of progressing in spite of the disapproval of some senior colleagues. Rather, they saw it as an emblem of how far the Nigerian healthcare system has to go to become functional, as Dr. M.C. explained:

> Now, coming back, you're faced with a challenge. The challenges is that a lot of the local based doctors look at you as a threat. Ideally, you're not a threat, you could train them. But they look at you as a threat, because they feel that you have a skill that they don't have. And sometimes, that is a friction as well. So it makes you very careful of how you ... When I got back, I went to work with one of the big private hospitals in Nigeria. The challenges I had with them is that the structure is very loose. For example, they don't have a risk assessment manager. They don't have quality assurance. They don't have protocols. They're still learning all of that. But those are things I expected for a hospital. So that there's a standarisation of care. But suggesting this to them, it's like, 'Oh, but we've been doing this for a long time, why do we need to change it?' ... And then they say things like, 'Change takes a long time.' No. Not with health. With health, change should be immediate. You don't need a long time.

At the same time, however, most of the interviewees felt that junior colleagues were generally enthusiastic about their skills and knowledge, a point I explore in further depth below. The stumbling block, as Dr. R.O. outlined, is that more senior colleagues, who are in a

position to decide who takes part in the training of medical students and junior doctors, are unenthusiastic about employing returnees for that role: "The teaching hospitals are the ones that really should be absorbing these people, but the capacity, the will, and the attitude is not there to accommodate people like that."

Personal and Family Issues

Of course, the conundrums and dilemmas of return were not restricted to considerations of professional development. Another major concern was the impact migration had on the doctors' families. Firstly, the issue of security looms large for Nigerians generally, and was commented on by a great number of interviewees. Many were concerned about the pervasiveness of violent crime, terrorism, corruption, civil unrest and fraud, which they juxtaposed against the relative safety of England. Even the more prosperous areas of Lagos were deemed dangerous to live in, and that the security measures which had to be taken to keep their families safe would significantly affect their quality of life. Things like adequate housing – ticking a long list of boxes, including proximity to the workplace, relative safety of the area, and quality of schools for their children – took a long time to establish, and in some cases advanced in tandem with the doctors establishing themselves professionally, as Dr. M.C. explained:

> As I was getting busier here, my income was increasing, so I was able to afford looking after my family. Because my wife wasn't working, all through this my wife wasn't working. So as I was getting busy, it was easier to get money and send over there [to England] to look after my family. Because one of my wife's concern was that, are we going to be able to have the same quality of life if we totally decide to move to Nigeria? She wasn't in agreement at the initial stage. But we staged it ... So then it became apparent that I couldn't be travelling at short notice any more. So at that time, we made a decision, and we put a time frame for when the family needed to come back. So by July 2011, my family moved back. Remember that the process starts November 2008.

In thinking about the impact of return on their families, the doctors were particularly concerned about the welfare and future prospects of their children. Schools and educational standards were, unsurprisingly, key considerations. The interviewees were generally of the opinion that education was of higher quality in England, unless you were prepared to pay substantially for private education in Nigeria,: "If I'm there, I don't have to worry about the school which my children will attend. Here, you have to worry. Public schools are not of a good standard, and we have to pay for private schools really exorbitant fees" (Dr. B.E.).

Furthermore, the question of culture and belonging played an equally important part. On this issue, however, interviewees were divided into two opposing camps: those who thought their children would be better off growing up within British culture and learning British values, and those who wanted to instil in their children a strong sense of Nigerianness. Dr. R.O., for instance, felt so strongly that his children's future lay in England that he did not bring his family with him to Nigeria: "It wasn't even discussed in our house, that my kids would come here to school. It's a no-brainer." Similarly, Dr. M.C. took his children's bond with England extremely seriously, and considered this one of the principle dilemmas of

return: "You have to remember as well, I was developing a family. Which is my children. Which, you know, they were born and bred in England, they had never been to Nigeria before. So they were purely British. So there was also the issue that, OK, any decisions I make will affect them." Conversely, Dr. D.C. cited his children's future as one of the deciding factors for returning: "Then, culturally too, I thought my kids are better off here. To be honest. I had one boy when I left, and my wife, who used to visit, we had another baby there. And I just looked at them growing there, and I thought they are better off growing here. That's being very honest, that's what I thought." Thus, although the interviewees had differing opinions on the best place for their children to grow up, they all agreed that, in light of the transnational nature of their careers, the welfare of their children was one of the most important considerations in terms of their career decisions.

For all of the reasons listed above, most of my interviewees said that the temptation to stay in England had been strong, and that the decision to move back had not been taken lightly. Indeed, some had been forced to come back by powers beyond their control, and would have liked to stay in England for the foreseeable future. Several also made the point that they were keeping their options open – although they were committed to working in Nigeria, they did not rule out relocating back to England, and were keeping their GMC licence to practice in case they might need it in the future.

Negotiating Conflicts and Overcoming Challenges

As is clear from the previous section, return presented the doctors with a raft of challenges which had to be negotiated and – ideally, but not always feasibly – overcome. In order to do so, they needed to adopt or develop strategies to resolve conflicting issues. In this section, I will begin by addressing the various challenges raised above, which could roughly be divided into three thematic categories: 1) the conflict between staying and returning; 2) the challenge of finding a suitable role for their skills; and 3) how to reconcile their career ambitions with the needs of their families. I will then widen the scope by looking at some broader themes and issues emanating from these.

Staying in England would in many ways have been an easier option for the doctors. Indeed, all interviewees bar one said that the decision to come back had been hard, and that the temptation to stay in England had been strong. They had a good life in England, and on balance felt that the NHS had been a good place to develop as a medical practitioner. Economic and political stability, low crime rates, good working conditions and career prospects, and a solid infrastructure for healthcare delivery were juxtaposed against the challenges of corruption in political life, volatile security situation, poor working conditions and the perils of skills attrition, and a largely dysfunctional healthcare system. Indeed, several interviewees noted that their colleagues in England – both English and Nigerian – had thought they were mad. "With the actual coming back, the actual physical move, we were packing up, selling our home. And everyone looked at us and said, 'Nah, you're not going anywhere'. And we thought, 'We shall prove you wrong. We are going!'" (Dr. R.J.).

Making what was generally considered a retrogressive career move required a strong counter-narrative. The doctors needed "a bloody good reason" (Dr. R.M.) to move back to Nigeria. This reason was located in an ethical framework, within which the fulfilment of

being a successful doctor in England was replaced, or supplemented, by an ethical line of reasoning and satisfying a sense of duty. Furthermore, the doctors argued that their work had more impact in Nigeria, which gave them a sense of self-worth. Whereas they would only be a small cog in the NHS machinery, they maintained that they could make a real difference back home:

> In terms of quality of life, it probably is better out there than here. But if you're looking at your overall service to society, your usefulness to society, I think Nigerian doctors are probably more useful to the system here than they are in the UK. Because if you look at the proportion, in the UK there's 60 million. The population of Nigeria is 160 million. If you look at the number of qualified doctors in the UK, and then qualified doctors in Nigeria, the ratio is in favour of people coming back to Nigeria, to improve the doctor/patient ratio. (Dr. L.K.)

Interestingly, the doctors frequently couched descriptions of their work with the phrases "making a contribution" and "giving something back". In this way, the doctors were able to reconcile the loss of their life in England through the narrative that their time in England made them even more valuable to the development of the Nigerian healthcare system.

This sense of making a real difference in Nigeria in turn laid the foundation for strategies dealing with the spectre of skills attrition and the worry that their skills would not be fully utilised. The desire to make a contribution to the development of the Nigerian healthcare system was a driving force of return, and so the doctors developed several strategies to overcome the structural barriers to doing so. As I outline above, the medical establishment in Nigeria did not necessarily greet them with open arms, and even where there was enthusiasm for their skills and knowledge, there was not always the capacity to absorb them. Therefore, the doctors needed to find innovative ways to make an impact. These could take various forms. Dr. M.C., for instance, had been putting out feelers for the prospect of return for a couple of years prior to moving back:

> So when I got to Nigeria, I realised that the skills I have, nobody has them. Now, these are skills that are commonly available in the UK. Maybe you will have one or two people in each hospital who have those skills. But it wasn't, at least to the level that I was used to, it wasn't available here. So for me, it was an opportunity. It was an opportunity to come back and offer something that will not necessarily have been available if I wasn't here. So I came back, and spoke to lots of the hospitals around, and it was as if there was no, the structures to absorb the foreign trained doctors, there was not a lot of them.

Frustrated by the resistance of his colleagues, Dr. M.C. established his own clinic in Lagos. This presented him with a new set of challenges. The first of these was how to staff the clinic:

> The initial concern – and anybody I speak with in England, the first thing they say is, 'Oh, we've heard about the post-operative care in Nigeria, how do you...?' When I was working as a doctor in England, my work is as a doctor. I'm just the doctor. I have a lot of support people. So I do my surgery, and I know that the person is going to be well looked after, because there's teams in place. So for example, I need a good recovery nurse, there's anaesthetists involved, when I go to the ward I will look after the patient, but I know that the margin if risk is very little. In Nigeria, one of the things you have to do, is you have to be involved in all aspects of the patient care. Just to reduce your errors. And that's how I've

been able to reduce my morbidity and mortality. Now, that can have a lot of stress on you. But the way that we've been able to address that is that whilst you're doing that, you're training your staff to know what to look for, and what you expect them to be able to do. So with that, you're training them with your UK background. So a lot of my staff is Nigerian trained, and they've never left Nigeria. But you look for people who are not already formed in their habit. You can still adjust their methods. You can still train them.

In this way, Dr. M.C. was able to recreate the working conditions he was used to in the NHS. This took a lot of time and effort, but Dr. M.C. argued that this was a long term project which would yield dividends down the line – for himself, his clinic, his patients and his junior colleagues whom he was training to an English standard. Clearly, the 'Englishness' of his training and skills stood at the centre of this project. As Dr. M.C. pointed out, he prides himself of his mortality and morbidity rates, which in turn earn him and his clinic a reputation for safety and competence. Thus, he attributed the success of his clinic to the 'Englishness' of the service: "That may be because people say, 'Oh, this guys is a UK doctor, he's going to be safe.' So people come here a lot."

The success of Dr. M.C.'s clinic threw up another problem, which was echoed by a number of interviewees. His time in the NHS had instilled in him a certain attitude towards healthcare, which should not only be the preserve of the wealthy. Indeed, the doctors commonly referred to the 'free at the point of delivery' ethos of the NHS as something they admired and agreed with, and considered the elitism and restrictedness of the Nigerian healthcare system one of the least palatable aspects of working back home. Dr. A.W. summed this up neatly: "I'm not a private healthcare physician. I trained in the UK, I trained in the NHS. This is the first time I've done private work, in my whole life." When I asked her how she felt about this aspect of her work, she responded: "Psychologically, it's difficult. I don't talk money, I can't talk money. When I have to talk money ... I try not to, I leave it to the billing department. I'm just here to treat the patient, I can't deal with the discussion about money. I'm used to delivering healthcare free at the point of delivery." Of course Dr. M.C., who was running his own clinic, did not have the option of avoiding the issues of payment, and was conscious of the fact that his services were, at the time of interview, the preserve of wealthy Nigerians. However, his clinic was expanding rapidly, which gave him the legroom to think about how he could extend his service to those who were unable to afford it, whilst still running a financially viable business:

Dr. M.C.: There's two issues. There's the business issue, the business side, and the clinical side. The clinical side is for me to offer good practice to somebody. The business side is to make sure that I can afford to. So you have to look at the two. And from the expansion point, we're looking at not only covering the expensive areas of Lagos, trying to cover the people with the low and medium income as well.

Me: And how do you do that?

Dr. M.C.: Well, the first thing we want to do is, I mean, these are future plans. We're thinking of setting up a foundation, a women's health initiative. So you can look for money. And when you start offering the low income people, you can use some of the funds you generate from that to cover the cost from that. Because the cost of running a

> healthcare business in Nigeria is huge. One, the light. You know, you have to run on diesel all the time. So it's a huge cost. So if you don't want to compromise on your quality, payment has to come from somewhere ... Cause it's a shame that you can offer all this fantastic treatment, but the people in the low, medium socio-economic group cannot afford it.

Similarly, Dr. K.T. had realised during his visits home that his specialism was in short supply in Nigeria, and that he could therefore enter into a niche area within which there was limited expertise. He had been recruited by a major private hospital in Lagos for the specific task of setting up an Intensive Care Unit. As mentioned above, he had not yet decided whether to stay permanently in Nigeria or go back to England, but the notion of being "more useful in this environment than in the UK" had enough appeal to make him consider staying on. Importantly, however, Dr. K.T. also claimed to have developed the ICU to a standard which he felt was on par with English hospitals, and thought he might not be as attracted to staying if he was working far below this level.

Of course, not everyone opted for setting up a new clinic or ICU, and so other doctors needed to find different ways to mitigate the loss of the working conditions of the NHS. Some of those who were unable to refashion their Nigerian jobs to an English standard, as Dr. M.C. and Dr. K.T. were doing, found succour in teaching. Dr. P.L. – from whom return had been more or less non-negotiable – said that her time in England had certainly helped her become a better doctor.

> But it has created some kind of void as well. I can never hope to match what I did there in the UK. Because we don't have the infrastructure. We are short staffed. We don't have equipment. So what I've been able to achieve is, in terms of ... maybe imparting knowledge. I try as much as possible, at every point. 'This is what I learnt. This is what I know. This is what I know it to be.' If it's different from what people have known before. Alright? I try to share my knowledge with many people.

Furthermore, Dr. P.L. also sought professional fulfilment outside her role as a hospital doctor, and was increasingly taking part in research projects, the value of which she learnt in England:

> Positively, it has also impacted on me in terms of research. Because now that I know how to do a wider range of [molecular techniques], so I'm involved in research that most of my other colleagues don't dare to do. Because they just don't have any idea how to do it. I'm currently working on research in which I'm hoping to use a range of [molecular techniques] which I learnt in the UK. So that is a plus, for me, because it makes me feel fulfilled. That I can decide to do any research of my choice, without feeling that I'm being limited.

As mentioned above, the needs of their families and future prospects of their children was an important factor in the decision-making process of the doctors, and was itself riddled with conflict and tension. As per career progression, the interviewees developed various strategies to manage the impact on their families. Of course, the interviewees had differing opinions of where their children's future should lie. Dr. D.C., for instance, felt strongly that his children would be better off growing up in Nigeria. Indeed, this was a compelling reason

for him to move back. For him, then, return dovetailed nicely with the best course for his children's future. Conversely, Dr. R.O. had left his family in England, and spent a lot of his time travelling between England and Nigeria. For him, dividing his time in this way had the added benefit of keeping in close contact with his English colleagues, whom he was able to call on during his visits. At the same time, Dr. R.O. was increasingly thinking of his role as a son, and emphasised how important it was for him to reconnect with his mother:

> My mum's [in her late 80s]. I spent the last twenty years not really engaging with my mum. I know she's going, well, my father died ten years ago, I know she's going to die some day. But now, I get to have lunch with my mum every weekend. That's fantastic! Money can't buy that. So at least I have nice memories of her if she dies to tomorrow.

Meanwhile, Dr. R.J. emphasised the value and importance of maintaining a certain sense of Englishness in her children. In the same way as Dr. R.O., she linked her children's bond with England to her own professional relationships in the NHS. Asked whether she keeps in touch with colleagues in England, she said:

> I still have friends there, who are colleagues. And other friends. I'm hoping to go this year again, we go every other year. And I want the children to even remember, because they were born there [laughs]. My son, who came back at the age of three, and he's like 'I don't remember anything!' We've been back a few times since then, and he doesn't remember much. He's ten now. So we're hoping to go this summer, so that he can be reminded. Now he's ten, he will remember next year. So, I keep in touch.

Taking a step back, it is evident that in spite of a diverse set of circumstances, two clear themes can be identified. Firstly, return was never an easy option, and required colossal sacrifices. This was most pronounced in their narratives around professional development and fulfilment, and how their choices affected their families. Secondly, the common denominator in the doctors' strategies to deal with the challenges of return is a tendency to look towards transnational processes for a resolution to their dilemmas. Thus, a more general explanation can be found in the transnational social space, in that the main coping strategies employed by my interviewees were drawn from it. The fact that they had experience from abroad gave them a great sense of purpose. From their perspective, they had a unique set of skills which made them exceptionally well placed to engage with specific challenges facing the Nigerian healthcare system, whether this related to setting up an Intensive Care Unit, establishing a new surgical procedure, introducing basic managerial practice such as auditing to their hospital, or taking part in international research programmes. Importantly, it was not only the clinical and/or managerial skills and knowledge learnt in England which allowed them to introduce new ways of thinking about and practicing medicine. Additionally, it was their place in the transnational social space itself – their knowledge of how it functions, how to navigate it, and how to draw on networks within it to meet particular objectives – which enabled them to engage with the Nigerian healthcare system in new ways which local doctors could not, a point which will be further developed in the next section.

To conclude, then, there are two key points in this section that I would like to highlight. Firstly, that circumstances change. The transnational social space is not static, nor

is the migrant and his/her relationship to the space. This relationship is continuously renegotiated. Dr. R.O. eloquently described this constant flux when I asked him whether he had always intended to return to Nigeria:

> Twenty years ago, yes. Ten years ago, no. Fifteen years ago, no. Five years ago, hmm, maybe. But the NHS also changed. The NHS also changed significantly ... Whereas when I started, I loved my job. By 2008-9, it was no longer an enjoyable job. So with that, I was thinking, 'I don't want to continue like this for another fifteen years. I can't do that.' So I had to look at other things to do. Now I think, because I had my training, I used to go away for two weeks, or one week, to Mozambique, or to Sierra Leone, or Kenya. And I'd come back rejuvenated for another month, and then think, 'I have got to find someplace else to go now, this place is getting to me again!' So that was that.

Secondly, the power of the transnational social space to influence the doctors' trajectories did not diminish upon return. If anything, it became even more pronounced and important to them. In spite of the ebbs and flows of the space, it continued to shape the doctors' trajectories and inform their working lives, even after they have made the decision to 'settle' back home. Once transnational, always transnational, to coin a phrase.

How do Skills Translate?

The previous section is premised on the assertion that the doctors considered the skills and knowledge they acquired in the NHS to be of great value to Nigeria, and that for this reason, they were well placed to contribute to the development of the healthcare sector. Indeed, the majority of my interviewees maintained that their choice of specialism had been made explicitly to serve the needs of the Nigerian population. Characteristically for the doctors on the whole, Dr. R.S. outlined his own thinking when deciding on a specialism:

> I chose family medicine because, to me, I think, in Nigeria, honestly speaking, I think we need more family physicians. Although we need more of other specialties. But I like to have a broad knowledge in almost all areas of medicine. And also to be able to help my people with the little facilities that are available in the country.

When I asked him what attracted him to the MSc programme in Public Health he completed in England, he referred back to the health needs of Nigeria:

> There are a lot of public health issues in Nigeria, presently. If you compare Nigeria to other, developed countries, you see that Nigeria is far, far, far behind when it comes to good healthcare, and good policy making, also. And Public Health is a course that, kind of, open your eyes to the area of public health needs of the country. And how you can assess international health, to be able to fund those public health issues.

Dr. R.S.'s line of reasoning was echoed by a large majority of my interviewees, regardless of their choice of specialism. All were able to outline a solid argument for why they chose their particular specialism and post-graduate studies in England, and which distinct section of Nigeria's burden of disease they were aiming to challenge. This transfer of skills and knowledge, however, is not seamless or uncomplicated. In this section, I will explore the

doctors' own evaluation of this project. First, I will look at the ways in which they were able to put their time in England to good use. I then proceed to explore some of the difficulties in applying their skills and knowledge, including how their experiences in England actually got in the way of their goal of developing the Nigerian healthcare system.

Positives

In spite of the many challenges faced by the doctors upon return, there was a unanimous belief amongst my interviewees that, on balance, their time in England had made them better doctors and more valuable assets to the Nigerian healthcare system. When I asked how it had made them better doctors, and if their experiences from England helped them to make a meaningful contribution to development, the interviewees generally launched into long, detailed and passionate answers. These could be divided into three broad categories: 1) learning things which can be applied in Nigeria; 2) learning things that can, in turn, be taught to others in Nigeria; and 3) making contacts and links in the UK on which to draw to a variety of ends.

First, then, are skills and knowledge which could be directly applied in their own work in Nigeria. The range of different types of examples given was broad, and related to most aspects of healthcare delivery. Obviously, many of these concerned their chosen specialisms and particular techniques they had learnt in England. For example, Dr. R.O. stated that he had received exceptional training, "even compared with my UK peers, I knew that I had wonderful training", which allowed him to work anywhere in the world. This training had given him access to jobs at the highest level within the NHS, where applying advanced technology was, as Dr. R.O. phrased it, "routine":

> A lot of the advances, we lag behind a lot, in the technological advances – especially for surgery – in Nigeria. So those advances, one was able to bring back here. And I'll give you an example ... I did [a specific surgical procedure] for the first time in [southern Nigeria]. There was a press conference, the Commissioner came! And I did five a week in [England]. Just, routine. And you're thinking, 'This shouldn't be celebrated. This should be taken for granted. And how can we make sure it's taken for granted, and not celebrated?' So those things always got me thinking that these people can get a lot more better than they're getting at the moment.

This argument was echoed by most of my interviewees: Dr. K.T. was developing an ICU operating at NHS standards; Dr. J.F. was importing the latest psychiatric medicine to treat children with ADHD; Dr. R.S. was introducing the principles of strategic management, commissioning, and project management to his hospital; and so on. The bottom line is that they were all introducing cutting edge thinking about and practicing medicine to the Nigerian healthcare system.

Other examples were broader and more generic. Alongside their elevated level of training, as well as knowledge and understanding of the latest medical advances, they developed confidence to push their skills to the limit. This confidence allowed them to seek out new knowledge "that most of my other colleagues don't dare to do" (Dr. P.L.) and apply it

to their work. In other words, their NHS training had opened their eyes to what medicine is able to achieve:

> There's quite a number of challenging cases that we are not able to deal with here, confidently. I'm able to do them now. I'm more confident now, operating in this climate. It's because we have been trained on how to do it. I have been trained, first and foremost, to recognise them, identify them, make an accurate diagnosis. But I've also been trained in how to intervene, and manage the complications. So we have broadened our scope, we have broadened our horizon, in terms of what we can do. (Dr. L.K.)

Furthermore, patient care and interaction was cited by a number of interviewees as something which set them quite clearly apart from their colleagues. They explained how doctors in Nigeria are generally considered – by themselves as well as others – as occupying a higher place in the hierarchy than their patients, whom they treat accordingly. This, they argued, is an unacceptable attitude in England, where the patient is treated with deference by the doctor, not vice versa:

> Dr. D.C.: Relationships with patients, completely different. I learnt that we treat patients very, very badly and non-courteously here. And that's a big difference. I learnt how to communicate with patients, I learnt how to treat them – not just the medical part, but communication wise and courtesy wise. Yeah, very big impact on me.
>
> Me: How do the patients respond to you when you interact with them differently from other doctors?
>
> Dr. D.C.: Much, much better. Even up to today, in clinics, you see patients fighting over that they want to see me alone, rather than a lot of people. And it's not that I'm a better doctor than my colleagues, I just talk to them better.

This was not merely a question of courtesy and respect, but also impacts on clinical outcomes, as Dr. L.K. explained:

> At the centre of the medical universe is the patient. Without the patient, there is no medicine. So the patient is most important. And that really changes a lot, because as a doctor you must see the patient as ... as giving you the privilege to make a difference. And I tend to put myself in the position of the patient. 'You're a surgeon, I must trust you! So it's a privilege I'm giving you.' It's not just about medicine, it's about managing patients. And managing the patients is not all about illness. There are a lot of things that will make a difference to the outcome.

Respect for the patient was part and parcel of a wider attitude towards healthcare delivery which the doctors learnt in the NHS. Several interviewees mentioned how encountering the 'free at the point of use' principle had fundamentally changed their stance towards their own role in delivering healthcare. The NHS ethos was juxtaposed against the Nigerian healthcare system, within which patients pay for even inadequate service, and good quality healthcare was prohibitively expensive for anyone but the extremely wealthy. Although none of the interviewees considered themselves to be in a position to change the

structure of the system, many tried in different ways to extend their services to those who were unable to afford them. Some of these were structured and ambitious, such as Dr. M.C.'s plan to establish a women's health foundation servicing poor Nigerians, outlined above. Others were more ad hoc in their approach. Dr. J.F., for instance, was working in the field of child psychiatry, and faced the double dilemma that both the government and parents tended to be sceptical about the value of his work:

> The drawback, really, is that over there, they give a lot of government funding. The government will pay for assessment, intervention. But here, they have to pay out of their own pocket. Sometimes I will buy the drugs for them [laughs]. And I do that, otherwise there's no point. They've given me the opportunity to learn about this problem, with children. And I can't just go, just because they're so poor, they can't afford it. So I just have to buy it sometimes [laughs]. It's quite different.

A number of interviewees also commented that their time in the NHS had taught them the importance of administration and a disciplined approach to running a healthcare service. Indeed, Dr. D.C. considered this to be one of the most important things he had learnt in England: "I learnt that, well, we don't have a system! We don't have a definite health system. We don't audit, which is one thing I really learnt there. That is vital for you to know what you are doing. If you're going to improve on your system, you have to know what your system is doing." Dr. D.C. felt strongly about the importance of auditing, and described how he had called a meeting with his boss – also a UK trained doctor – to discuss how to implement it within his hospital:

> Dr. D.C.: He said, 'No no, they will think it's a witch hunt, not yet, maybe we will not be ripe for that.' So they won't understand that it's for the purpose of improving, they think it's for the purpose of getting who had the fault. But I really sat and talked to him, that we need to start some sort of auditing.
>
> Me: Did you get anywhere?
>
> Dr. D.C.: No, I didn't, I'm too small in this system, but I'll keep pushing [laughs].

Others, however, had reached a position of influence, and were using it to prompt the proper running of their institutions. Indeed, Dr. R.J. had landed a job with a heavy management component at a private hospital. As she was listing the modes of working she had brought with her from the NHS, an administrator came into her office and handed her a bill, which she used to make a specific point:

> The person who came in just now, he's a facilities manager, and there are some dues from the local government. I mean, it looks somewhat exorbitant, but, and you have funny things that happen here, so if someone there says, 'Well, if you don't want to pay the full thing, you can pay us half, but you'll have to give us some part of that half you're not paying'. So that's why I said to him, 'Is this the standard charge? Why are we being made to pay this?' So, 'It's a big facility', so we're being made to pay that amount. 'That's the standard charge. Please go and pay that'. So if anybody's going to scrutinise this, five, ten, twenty years time, '[Local government], what is your charge? [Hospital], what did you pay?' It is the same. It does seem exorbitant to me, but that is what's on the books, and it

> has to be done. All these short cuts that we like to do. I mean, I see their point, what rubbish. But if you're in the UK, you'll have to pay for your TV licence, which is what that is. And you wouldn't argue, with the council, to say, 'Oh, it's too much!' No, you pay it! So things like that that I'm used to from the UK.

In this instance, Dr. R.J. is describing the pervasiveness of corruption in Nigeria. The bill from the local government – equivalent to a TV licence – seemed exorbitant to her. She could, however, halve the bill by paying a bribe to a local government official. This way of thinking, she argued, was risky, because an audit several years down the line could show discrepancies between the bill and the amount paid. Thus, Dr. R.J. resisted the sway of corruption by juxtaposing the way things are done in Nigeria against what she would be expected to do in England.

The second category relates to the different ways in which the doctors could relay their skills and knowledge to their colleagues in Nigeria. In many respects, the activities in this category are relatively straightforward: the doctors teach junior colleagues what they have learnt in England. The main point is that the interviewees generally thought that the lack of high quality training was one of the biggest factors holding back the development of healthcare in Nigeria. When asked about the main challenges facing the healthcare system, SA immediately picked this out as the main obstacle: "First of all, training. Because most of the doctors here that are doing the training, that are training medical students, half of them don't have adequate knowledge of how to train people. Many of them are trained locally, so they don't know how things should be done properly." Those who had undergone rigid training themselves in some of the world's best medical schools and hospitals, they argued, were better placed to teach junior doctors to a high standard, a view endorsed by Dr. K.T.'s students:

> [My students] are very happy for me to be around with them, to teach them, and they just say that the way I practice, they haven't seen that way of practicing before. So they're quite happy, they've seen a difference in the way I do things. And even when I was away for three months last year, when I came back you could see the sign of relief on their faces, 'Oh my god, you're back again, thank you!'

Obviously, teaching hospitals were the primary site to achieve good quality training, and several interviewees were working within their setting. However, as I outline above, a number of interviewees made clear that teaching hospitals often lack the capacity or will to incorporate returnees.

Nonetheless, the doctors were able to impart knowledge in other ways. For example, Dr. M.C.'s aim was to establish a women's health clinic operating to an NHS standard, but argued that the paucity of medical training in Nigeria meant that he had to train up his own staff to a level he found acceptable. At the time of our interview, Dr. M.C. had trained his staff to the point of no longer having to supervise every detail of his patients' care, but he also expressed higher ambitions for training:

> We are in the first part of this process. The first is stabilising here. The second is the foundation. The third is training. So we're going to start a training course as well. But, you know, a lot of the time ... I'm not going to be the only trainer.

> We're going to actually share it with a lot of doctors from the UK. Because you need a lot of facilitators. You need somebody who's equal or better than me to facilitate the training. So, they might need to come over here, run courses, and then do like a mentorship for a while, people might need to go to the UK, spend some time and come back.

In this quotation, Dr. M.C. touches on another aspect of imparting knowledge, which relates to the transnational social space. Because the doctors rated the quality of their English training so highly, they were keen to assist junior doctors to access training programmes in the UK. Through their own journeys, they had learnt how to navigate the transnational social space and to make it work for their career progression. Therefore, many of them were supportive of junior colleagues who would ask them for advice on how to get on to training programmes or time limited work placements in the UK, and were willing to use their contacts and knowledge of the English system to act as brokers between Nigeria and the NHS

It should be noted, however, that the 2006 changes in immigration policy were making this prospect increasingly remote, as Dr. K.T. explained:

> Because the NHS is shutting the door, it makes it very difficult. Otherwise, for example, in my unit, I, as a consultant in intensive care, if I'm going back to the UK and I say, 'Ok, can I get one or two people to come in and do one year, or two, in intensive care medicine, and they go back to Nigeria'. But now, because they've shut the doors, they have to make sure there are no EEA doctors who can fill that post. Unfortunately. There's a lot they could offer, but because of the change in immigration law, it's very difficult now.

This state of affairs was lamented by a number of interviewees, who felt that the UK's stance was both drastic and harmful. In the absence of any international agreements on medical migration – for example, in spite of the UK's best laid plans, an international Code of Practice on recruitment has not materialised – Nigerian doctors simply go elsewhere, such as the US, Canada, South Africa and Saudi Arabia. These were seen as unhelpful substitutes, on the basis that training in the UK is not only amongst the world's best, but also because the ethos in the NHS centres around principles of public health, and because Nigerian doctors in the UK were most likely to come back.[17] As Dr. A.W. put it:

> If you are in the NHS, you do see people who need help, who need health intervention, who are poor, who are socially deprived, and there's almost a certain link to where you come from. So it's easier for you to feel the need to come back, and do something. Or whether in the US, where it's all private, you don't really see that, I don't know. But yes, certainly, the returnees are a lot more from the UK than they are from the US.

Importantly, many of the doctors considered a programme which would allow young Nigerian doctors to complete a time limited period of training in the UK as something which would potentially have a positive effect on the Nigerian healthcare system. At the time of my Nigerian fieldwork, of course, such a programme already existed in the Medical Training Initiative. However, none of my interviewees had heard about it.

[17] This was a view taken by a number of my interviewees, based on their own anecdotal observations. Of course, no statistical data is available to verify these claims.

I should added that acting as brokers in this way did present the interviewees with a dilemma. On the one hand, they knew that few of the junior doctors they helped into training abroad would ever come back. On the other hand, they also felt obliged to assist junior doctors, and deduced that without their help, they might make all the mistakes they had made themselves. Furthermore, they also reasoned that a stint in England would make any Nigerian medical graduate into a better doctor, and that the paucity of medical training in Nigeria meant that junior doctors should probably do their specialist training elsewhere. On balance, therefore, they were generally content to share their knowledge of the transnational social space with their junior colleagues.

This brings us to the third category of ways in which the doctors' time in England impacted on their work in Nigeria, namely how they utilised their contacts and links in England to meet their objectives in Nigeria. As previously mentioned, a large number of interviewees said that they were purposely keeping their GMC registration. One interviewee aimed at leaving Nigeria again, and this time permanently, and one had not made his mind up whether to stay in Nigeria or move back to England. The remaining ten, however, were committed to working in Nigeria for the foreseeable future, yet wanted to keep their options open. In the main, their plans involved time-limited trips to England for short courses or further training:

> I think my experience [in the NHS] was absolutely fabulous. Would I go back and work in the UK? I wish not, because I've chosen this career. But I don't know my future, so I'm retaining my licence in the UK. Would I go back to the UK to train? Yes, I would. But I would go to almost anywhere in the world to train. I mean, I'm going to, I'm thinking of going to Germany, maybe later this year, just to learn some new things. I'm going for a course in England as well, and I should have gone to a course in England just finished this week. So, you just keep on updating yourself. Once your foundation is strong, then you're ok. (Dr. M.C.)

Part and parcel of this strategy to keep their options in England open was to nurture their links with former colleagues in the NHS. The strength and intensity of these links varied to a great extent. Whereas some doctors kept in regular contact with their English counterparts, others said that they were slowly losing touch. Nevertheless, keeping their links active and themselves fully lodged in their networks was of acute importance to a number of interviewees. Dr. R.O., for instance, kept in touch with colleagues both by travelling to England, and through long distance communication:

> I still keep in touch with the people in my trust, because there are certain things that I still need, that I cannot get here, like the expertise of my nurses. Because I'm a [specialist] surgeon, there are specialist nurses who do certain things, which we don't have any in Nigeria. So if I need those things, often I just use BBM [BlackBerry Messenger], or email them with a picture, and say, 'What shall I do about this?' And whenever I go, I talk to them, there are times they keep materials for me to bring back, and stuff like that. So that's still very important.

Importantly, Dr. R.J. used her contacts in the NHS not only to keep up to date with the latest medical developments, but also to discuss which types of treatment would best suit the needs

of a country with limited resources. When asked whether her links are useful in her current work, Dr. R.J. responded:

> Certainly. In terms of, you know, there's a patient I had to deal with, and I needed to speak to one of my friends, who is a cardiothoracic surgeon, as to what would be the next best thing, because they couldn't afford the surgery, what else could they do? What else is available? What are you guys doing in the UK now? That kind of thing. So yes, very much so.

Dr. M.C., meanwhile, taps into his networks in similar ways to Dr. R.O. and Dr. R.J., but added that he also draws on his links to bring NHS specialists to Nigeria. This applies both to Nigerian and British colleagues in the NHS:

> Now, our future, my future, is to be able to work with people that are over there. For example, the clinic will get bigger, and I might need to go on holiday, or I might need to employ a second person to work with me. So it's highly likely that I will be looking into the UK workforce, because at least I know that their training has been well sorted, and stuff like that. So, yes, we still keep in touch, yes, they come around ... I still work with some of the UK doctors as well. Some of them do surgery here. About two weeks ago, I did a surgery, with a Nigerian surgeon who is based in one of the teaching hospitals in London. We did a surgery together.

In this instance, Dr. M.C. is serving as a bridge between the Nigerian healthcare system and NHS doctors – English or Nigerian – who are keen to work in Nigeria. He is in a good position to do so for two principal reasons. Firstly, he has already developed relationships with NHS based doctors, and has established a wide network of colleagues on whom he can call for different purposes. Secondly, his reputation as a competent doctor – premised, as I argue above, on its 'Englishness' – makes his clinic a safe bet for doctors to dedicate their time to. Thus, first hand familiarity with each others' work establishes a relationship of trust and respect, which in turn clears the pathway for NHS doctors to do work Nigeria.

Those who had not been in a position to form strong links in the NHS, or where their relationships had petered out, nonetheless developed other strategies to keep links with England. Dr. D.C.'s spell in England was cut shorter than he had intended, and had therefore not developed close relationships with colleagues in England:

> Unfortunately, because I was doing an academic course, I didn't have very close relationships with the pathologists. And when we are even doing the course, I wasn't thinking of coming back. It was really later that I decided to come back, ... I didn't even think about it, to establish that link. If I had gone ... I think I probably went for this a little too early. If I finish my programme, the way I am now, and assuming I'm going to the UK now, for a master's, then my approach would be very different. Because my approach would be gaining links which would help me in collaboration when I come back. That would be my focus, but if wasn't my focus then, because I wasn't thinking of coming back.

Nevertheless, Dr. D.C. exploited other transnational avenues. For instance, he regularly accesses and contributes to his former university's alumni website. Through this, he kept up to date with latest theoretical developments within his field, as well as posting presentations

or drafts of research papers on which his colleagues would comment. The internet had the further advantage of helping him to introduce new thinking to his Nigerian colleagues.

> The coming of internet has helped a lot. When I got back, new things don't get here until very late. So if I say that dopamine is not good for acute [can't hear] injury, and they all look at me like crazy, 'Dopamine is good, and we have to use it'. And I go and bring the evidence, and they really don't take it because there's no guidelines. But with time now, everybody is abreast with new things.

Thus, the alumni website and his knowledge of how to discover up to date research kept Dr. D.C. one step ahead of his colleagues, and helped him to reinforce his arguments that certain changes were needed in the way they practice. Furthermore, Dr. D.C.'s time in England had also introduced him to the work of international health organisations, particularly the International Society of Nephrology (ISN).

This brings us to another important aspect of the transnational social space, namely the role played by international health organisations, and links between national and/or regional organisations, in facilitating transnational activities. A number of interviewees were linked to such organisations, and had invariably got involved with their work in England. Dr. R.O., who had been instrumental in establishing the UK forum of the West African College of Surgeons (WACS UK), still informed their work: "Although I'm no longer there, I still participate in their teleconferences and their outreach programmes, I still go there to work with them." As I argue in chapter 5, the two members of WACS UK I interviewed in England serve a bridging function between Nigeria and England. The fact that Dr. R.O. – whom they both considered a great friend and respected greatly as a surgeon – had moved back to Nigeria further facilitated collaboration, as they now had a trusted individual with extensive knowledge of both medical worlds to smooth the path for outreach programmes.

That said, some organisations were more diligent and active than others. In chapter 3, I claimed that some, but not all, Medical Royal Colleges in Britain have well developed diaspora engagement programmes, a point to which I returned in chapter 5. Before returning to Nigeria, Dr. R.J. had made several attempts to get involved with various NHS development initiatives, but always found them "really wishy washy. There was nothing where one could say, 'Ok, I'd like to be part of this, I'd like to be part of that'." Her attempts to engage with British medical institutions continued in Nigeria, but without luck:

> I have also written to the Royal College of General Practitioners, of which I'm a member. They have an international arm. And I'd written to them, because they asked for their members who are no longer in the UK to give their names in, so that we can foster links. And I've written to them four or five times, sent my CV, and never had a response. So my sense is that – I don't know whether it is, maybe it isn't, it might be my perception – whether it's an old boys' network, if you know somebody, that's how you get in, rather than having some kind of clear application process that takes you from one step to the next. And maybe that's the problem with the NHS as well. I have no idea how to be part of that.

Negatives

Although the interviewees were all of the opinion that their time in England had made them better doctors than they would have been had they stayed in Nigeria, they were also candid

and realistic about some of the negative sides to their English training. Chief amongst these was that they may have developed new and advanced skills, but a prolonged period abroad was likely to have distanced them from the medical needs of Nigeria. Broadly speaking, JC argued that harnessing the knowledge and skills of diaspora doctors in order for them to make a real and sustainable impact – whether they stayed in England or moved back to Nigeria – would require a structured approach. For this to happen, he maintained, there needs to be a "mechanism of doing a needs assessment in Nigeria. And being able to objectively match the skills". More specifically, a number of interviewees conceded that they might "need some period of adjustment, because the presentation of some diseases is different" (Dr. R.J.). Thus, although they had acquired advanced skills in England, these had been tailored to a different composition of medical needs, and therefore did not automatically translate to the healthcare needs of Nigeria:

> I came into the course hoping to study community medicine that would equip me to work in a tropical setting. That was specifically what I wanted to do. That was my central reason. But after doing the course for one year, one of the things I quickly realised was that the focus of public health teaching there is broader than the typical needs of a developing West African country, like Nigeria. So I realised that I had been trained, but I was more equipped to practice public health in England than I was to practice community medicine in Nigeria. (Dr. R.M.)

Connected to this point was that the methods and techniques learnt in England were not always accepted by their colleagues. This issue was discussed at greater length above, but merits a brief revisit. Not all of my interviewees were able to carve out for themselves working conditions within which they could practice medicine under ideal circumstances. Many had yet to break into a position of authority and decision making, and as such had little room for manoeuvre to establish their way of working and thinking:

> I came back mid-way through my training. So I wasn't my own boss. So I have a boss, and I have colleagues who don't always agree with my own thinking. They don't even agree with the knowledge. And you have to know how to go about things, or you will end up being ostracised. Which is one of the problems that people face. So sometimes I have to agree with things I don't really agree with. And gradually see what I can change. But it's really, really gradual. (Dr. D.C.)

Furthermore, the fact that their skills and knowledge had developed way beyond the capacity of the Nigerian healthcare system also meant that the medical practice they wanted to introduce often required expensive treatment. This was considered a particularly acute problem in a country with a largely poor population like Nigeria, where individuals pay for their own treatment, even at state hospitals. Therefore, some interviewees queried the utility of skills requiring treatment which patients were unable to afford, even where costs are modest:

> There's a big problem with applying clinical things here. That's one of my biggest challenges when I came back. In know what to do. I know what ought to be done to improve. But I can't do it. Because of cost. The resources are not there at all. So I have a patient with, say, anaemia, and they're supposed to have [can't hear, 18.26], supposed to start with a certain dose. After so-and-so months

> it's not working well, you double the dose. But to get people to take even the one dose [shrugs] ... because it's very expensive. You can't double it. Same thing with [can't hear] problems. You have lots of drugs, you use the basic ones, it doesn't work, you're supposed to go to the next ones. They can't afford it. Some aren't even available because the patients can't afford, so it's not worth bringing it in. So that's the biggest challenge I have, the resources. Because patients pay for themselves here. (Dr. D.C.)

If we add to this the broader, structural challenges facing the Nigerian healthcare system, and its limited capacity to absorb returnees, we can see why the doctors were concerned about skills attrition. Thus far, the discussion on the policy landscapes which shaped the transnational social spaces of the returnees has exclusively revolved around UK policies. Conspicuous by its absence is any examination of Nigerian policies which impact on the transnational activities of the returnees. This is not due to an omission in the analysis. In fact, the lack of attention given to Nigerian policies on returning doctors stems from the fact that there are none. Regardless of my line of enquiry – whether through my contacts, internet searches, or direct contact with relevant government departments in Nigeria – I was unable to find any evidence of coherent policy thinking on diaspora doctors. It does not follow that successive Nigerian governments are unconcerned with medical migration; some of my interviewees did mention various government officials or ministers who had initiated a conversation or initiative, but these tended to fizzle out before leading to anything resembling established practice. Rather, the Nigerian state has – for whatever reason – lacked the capacity, will or resources to develop a comprehensive strategy to harness the skills and knowledge of its diaspora doctors, whether still abroad or returned home. This does not mean that the Nigerian state is inconsequential to the trajectories and activities of returnees. On the contrary, the lack of strategy to incorporate returnees into the healthcare system was cited by my interviewees as one of the biggest stumbling blocks to putting their skills and knowledge to proper use for the good of Nigeria. As we shall see, this compounded the absence of the Nigerian state in a number of other areas of life as well, such as utilities and infrastructure.

Conclusion

It should now be clear that for Nigerian doctors, return does not represent rupture to, or an endpoint of, their migratory journeys. Return is not analytically separate from migration, nor does it close a circle. On the contrary, return is a integral part of the ever-evolving journey that is migration, and as such, represents both change and continuity. This is certainly true when return occurs, but as we saw in chapter 5, it is also true when return does not occur. As I point out in the introduction to this chapter, the narratives of the returnees are inseparable from the narratives of my interviewees in England. The issue of whether to stay in England or return to Nigeria cuts across the entire migratory journey. Nigerian doctors in England constantly grapple with the question of return, whereas returnees in Nigeria continue to think about the implications of their homecoming, and whether return is permanent or temporary.

If we accept that return is inseparable from migration, we can then deliberate what this means for transnational social spaces, both analytically and theoretically. As the doctors move from one end of the migration chain to the other, their place within the transnational

social space changes, and thus different actors, process and ties come to the fore while others recede in importance. Yet the space itself remains the same. If Nigerian doctors choose to continue working within and through transnational social spaces upon return, the same "combinations of social and symbolic ties, positions in networks and organizations, and networks of organizations" (Faist, 1998: 216) continue to either help or hinder their efforts. Of course, the strength and intensity of these ties, positions and networks can increase or decrease as their location changes, but regardless of which end of the migration chain they are, they still have to navigate and negotiate the same state institutions, hospitals, medical colleges, colleagues, NGOs, communication technologies, and so on. Viewing the doctors' narratives through the lens of transnational social spaces, therefore, makes sense of the paradox of being fully committed to working in Nigeria whilst still keeping the option open of working in England again.

Beyond these general observations, two specific points should be made. First is the importance of mobility. As we saw in the previous chapter, doctors are able to contribute to development without permanently moving back to Nigeria, but restricted mobility limits the benefits of their efforts. The same applies to returnees. Their ability to engage within the transnational social space is not limited to mobility, but it is certainly limited by it. Communication and technology did provide those – like Dr. D.C. – who did not travel regularly to England with channels through which to draw on contacts and/or access the 'club goods' of medical knowledge. Undoubtedly, though, those who did sojourn regularly to England – such as Dr. R.O. – were more easily able to sustain and nurture their links with various actors in the transnational social space, thereby keeping themselves fully lodged in the transnational networks which provide them with invaluable support for their work and keeps them up to date with the latest advances in medicine.

Secondly, this chapter demonstrates the power of states within transnational social spaces. At the UK end, a variety of social factors – such as discrimination – play a crucial part in the doctors' ability to become effective transnational development agents, but the most important factor is policy. Whereas the doctors were able to overcome social obstacles – albeit often with difficulty and at a price – policy obstacles were much harder – and often impossible – to navigate around. Furthermore, policies are often also ad hoc and difficult to anticipate. Similarly – and yet in stark contrast with the imperious presence of the British state – the Nigerian state impacts greatly on the transnational activities of the doctors through its absence of support and inability to absorb them into the healthcare system. This point brings us back to the importance to incorporate both structure and agency into the analysis of transnational social spaces. The doctors were certainly able to explain in detail how their particular training was useful to Nigeria. However, it is much more difficult to gauge whether this happens on a structural level. We can probably assert without much controversy that there is little effort on behalf of the Nigerian state to systematically match skills to needs, and the doctors I interviewed built up a career in Nigeria in spite of the Nigerian state rather than because of it. However, this also implicates the structure of the English end of the transnational social space. If the NHS channels Nigerian doctors into specialisms to suit its own needs, it is very unlikely that the skill set of Nigerian doctors as a cohort will also suit the healthcare needs of Nigeria.

And yet, in the face of harsh realities and serious challenges, many of my interviewees were optimistic. They certainly saw themselves as part of a positive change which could, if nurtured, lead to real and sustainable progress within the Nigeria's healthcare system:

> In terms of the health sector, two things have happened. Standards have gone down. In some places, people are trying to build them up, and I give Lagos State a lot of credit for that, trying to improve the healthcare services. But training has gone down. But at the same time, people are coming back. So, you meet up with likeminded people, who are forming little groups – hospitals, clinics, services. So, it can only be a positive thing, to encourage people to come back. Either permanently, or coming and going. That will certainly raise the standards. (Dr. R.J.)

7. Conclusions

> It had been there for a while, an early morning disease of fatigue, a bleakness and borderlessness. It brought with it amorphous longings, shapeless desires, brief imaginary glints of other lives she could be living, that over the months melded into a piercing homesickness. She scoured Nigerian websites, Nigerian profiles on facebook, Nigerian blogs, and each click brought yet another story of a young person who had recently moved back home, clothed in American or British degrees, to start an investment company, a music production business, a fashion label, a magazine, a fast-food franchise. She looked at photographs of these men and women and felt the dull ache of loss, as though they had prised open her hand and taken something of hers. They were living her life. Nigeria became where she was supposed to be, the only place she could sink her roots in without the constant urge to tug them out and shake off the soil.
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> Chimamanda Ngozi Adichie, *Americanah* (2013: 7)

The transnational imaginary has a tendency to evoke strong emotions amongst those who migrate – guilt towards the country and the people who you left behind; pride in your ability to succeed in an alien land with a competitive market, or alternatively, shame in your failure; homesickness; excitement of adventure; doubts whether you made the right decision; relief that you managed to break free from the iron cage which is the lack of opportunities back home; remorse that you are no longer there to do your bit to rectify them. Throughout this thesis, I hope to have adequately portrayed the sense of internal conflict, moral and practical dilemmas, and the ceaseless renegotiation and re-evaluation which characterises so much of the doctors' migratory journeys. Indeed, all of my main conclusions flow from and depend on the observation that migration is invariably an emotive journey. Of course, external constraints and/or lack of restrictions impact deeply on the sentiments and passions of migrants. Circumstances change, new opportunities arise, unforeseen obstacles need to be overcome. With this, opportunity structures to engage with the homeland also change, and so new strategies must be devised to negotiate and manage their future plans and ambitions. This constant negotiation must take place socially – with the various social actors, institutions and processes with whom they are in dialogue with as part of their transnational activities – as well as internally – with their own emotions, goals, desires, hopes and dreams.

This simple observation is entirely congruent with the basic premises of the theoretical orientations of transnationalism. The narratives of my interviewees show how migratory journeys are projects in perpetual progress. This is not a particularly original insight, but it is nonetheless worth explicitly making the point – implicit in the chapters above – that transnationalism is an exceptionally useful theoretical framework for researching how migrants are able to use the knowledge and skills acquired abroad to make a contribution to development in their home countries. However, I also hope to have elicited three areas where the transnationalism literature is somewhat lacking, and where further theoretical developments should take place. First is that the conception of highly skilled migrants which – juxtaposed as it has been against unskilled migrants – has paid inadequate attention to the diversity of experiences and circumstances within this category. Second is the tendency within the literature to romanticise transnationalism, thereby glossing over some of its darker

aspects. Third is the role of the transnational social space in the migration-development nexus. I will explicate these three concerns in turn.

Highly Skilled Migrants – Immune from Racism?

As Raghuram and Kofman (2002: 2071) note, the majority of "recent research on skilled migration focuses on those working in the financial sectors and there has been very little work in Europe on the migration of people in welfare sectors." This limited focus has shaped the literature on highly skilled migration in a number of ways, most notably by understating the role of the state in structuring the life chances of migrants. Indeed, Raghuram and Kofman (ibid: 2086) conclude that where the welfare sectors are concerned "some of the specialised ways in which government regulations, both of immigration and those governing medical labour force have been altered to meet the specificities of the internal labour market." They are absolutely correct in this assessment. The rights of overseas doctors – both in terms of professional and immigration status – have changed to suit the ebbs and flows of the labour market.

Connected to this neglect of the role of the state is another important omission in the literature on highly skilled migration, namely the importance of 'race', racism and discrimination. Raghuram and Kofman (ibid) touch on these absences, but do not fully develop their thoughts on them. Of course, racism and discrimination are not confined to the state and its policies. However, I have demonstrated that where the labour market position of overseas doctors is concerned, the British state plays a crucial role in legitimising particular understandings of the relationship between 'race' and medical competence, which in turn is used to justify differential labour market outcomes. This is important, because there is a widespread assumption – both within academia and outside it – that highly skilled migrants are largely immune to the affliction of racism, exactly because their skill sets trump any misgivings the host society might have about their ethnicity:

> From most Northern states' point of view, there is the task of separating wanted and welcome migrants from (economically) wanted but (socially and culturally) unwelcome migrants. Migration officially welcomed, such as those of highly-skilled professionals, is usually cast as part and parcel of a desirable process of globalisation and the almost inescapable competitions for the 'best brains' from all over the world. However, at the same time, those fulfilling crucial tasks in labour markets but who are not necessarily welcome, especially workers in the service economy, agriculture, but also asylum-seekers, are often portrayed as constituting a threat to national security, cultural homogeneity and social cohesion in the North. (Faist, 2008: 38)

This may very well be true for certain types of highly skilled migrants, but as I have demonstrated in the chapters above, it is clearly not the case that Nigerian doctors are liberated from the constraints of racism in their careers. Although the NHS depends on them for its very survival, they are nonetheless routinely portrayed as a threat: in certain sections of public discourse, to patients; within the medical establishment, to home grown doctors. In both of these cases, moves to contain this threat has involved subjecting them to control through legislation, way beyond what UK/EEA doctors can expect. Thus, although the

distinction between highly skilled and unskilled migration has merit, it should not be overstated. As Robinson and Carey (2000: 1003) argue, the dynamics of migration to the UK amongst Indian doctors in the mid to late twentieth century in many ways bears resemblance to their unskilled compatriots. Although a comparison between different Nigerian migrants of differing skill level is beyond the scope of this study, it is clear that 'race' and racism still cut across Nigerian doctors' experiences of working and living in England, in spite of their status of highly skilled migrants. As we saw in Chapters 3 and 4, much of the discrimination they face is specifically designed to keep them in the lower rungs of the labour market.

This has implications for theory. I agree with Faist's (2008) supposition that states should be regarded as one of the primary units of analysis of transnational social spaces. For overseas doctors in England, the state plays a central role in relegating them to less prestigious specialisms and lower grades, which, in turn, affects their capacity to take part in transnational work. At the other end of the migration chain, as outlined in Chapter 6, the Nigerian state does little to harness the talents of its diaspora doctors, making it very difficult for them to find structure and suitable avenues to make their efforts effective. Paradoxically, therefore, the Nigerian state stands in their way by hardly being there at all. For this reason, I have not only included the state in my analysis, but placed it front and centre, and would argue that my analysis would have been entirely inadequate had I not done so. Moreover, the role of the state also has implications for policy analysis, which I examine in further depth below.

Transnationalism – Is there a Dark Side?

Throughout this study, I have relied heavily on selected strands of the transnationalism literature to make sense of the doctors' trajectories and experiences of migration, as well as the social, economic and political environments within which they operate. As I outline in Chapter 2, I carefully selected the tools from the transnational toolbox most relevant to my subject matter. I chose the core theoretical model for this study – transnational social spaces – because it seemed the best fit to my data. With my data laid out in the four preceding chapters, it is appropriate to summarise how the activities of my interviewees could usefully be conceived as taking place within transnational social spaces. Although fluidity is a defining hallmark of transnational social spaces, it is helpful to highlight some highly simplified examples of interconnectedness to drive home the importance of a holistic analysis. Rather than attempting to comprehensively and accurately chart the transnational social spaces my interviewees operated within – the thesis as a whole is intended to do so – I will briefly draw up some illustrative examples of the plethora of linkages in the transnational social space.

Faist (1998: 217, original emphasis) initially conceived transnational social spaces as "*triadic relationships* between groups and institutions in the host state, the sending state (sometimes viewed as an external homeland) and the minority group", but later adds civil society in both host and sending countries (Faist, 2000b), thus expanding his focus to a pentadic relationship. As an ideal type, this makes sense in light of my data. Key actors could indeed be roughly divided into these categories. The reality, however, is somewhat more messy. From an egocentric point of view, it is clear that some doctors not only engaged with

all five spheres, but in many ways belonged to all of them as well. Dr. E.A., for instance, suffered the same discrimination as other interviewees, but he also routinely sat on disciplinary panels for the GMC. Furthermore, he took an active part in DFID's work on international health. Thus, although Dr. E.A. would, according to Faist's model, belong to the 'minority group', he was also a member of civil society, and worked hard to influence the state on various policies. Similarly, Dr. B.B. was a special advisor to the international operations of one of the Royal Medical Colleges, a role to which he was particularly well suited due to his intimate links with civil society, as well as politicians and policy makers, in Nigeria. Indeed, Dr. B.B. had political ambitions for himself in Nigeria. If successful, his journey will have moved his centre of gravity as a transnational actor through three stages, firstly lodged in the minority group, then moving on to civil society, and finally to the Nigerian state.

It is equally instructive to view this from a sociocentric perspective, where, again, reality is messier than Faist's model. For example, it can be difficult to draw a clear line between state and civil society where healthcare delivery in England is concerned. In England, the state is by far the biggest actor in healthcare delivery. However, many of the institutions charged with training and regulating doctors can be solidly embedded in civil society – such as the GMC – or straddle the line between civil society and the state – such as the Royal Medical Colleges or NHS trusts. This is not to undermine Faist's formulation, but rather to emphasise the fluid and untidy nature of transnational social spaces. If we move on to examining which actors and institutions affect whom, we are again met with a cluttered picture. The British state affects Nigerian doctors by recruiting them in great numbers when their labour is needed, and curtailing their rights when their labour is redundant. The Nigerian doctors affect the state by heeding its invitation to work, and then failing to vanish when they are no longer needed. Civil society in England, meanwhile, presses the British state to curtail Nigerian doctors' rights in order to guard British doctors' interests, and is in turn incorporated into the state's strategy to do so. The Nigerian state is affected by the British state in that its pool of doctors shrinks, so civil society in England teams up with civil society in Nigeria to deal with health problems which the emigrated doctors would otherwise have dealt with. Nigerian doctors in England want to take part in this venture, but find it difficult because the British state and civil society has restricted their rights to a degree where it is risky to do so.

This is clearly a picture simplified to the point of caricature as well as being incomplete – there are countless connections in addition to those outlined above – but the important argument here is that the structure and functioning of the transnational social space is not always benevolent towards, or empowering for, migrants. As I mention in the introduction, transnational social spaces constitutes a world of near unlimited opportunity for doctors in the global North, but presents doctors from the global South with a range of obstacles, thus controlling and restraining their trajectories to a far greater extent. This brings me back to Guarnizo and Smith's (1998: 5) charge that there is a "tendency to conceive of transnationalism as something to celebrate, as an expression of a subversive popular resistance "from below."" Indeed, there is a propensity in the literature to romanticise migrant agency and ascribe too much focus on the empowering aspects of transnationalism, particularly where mobility and cross-border flows are concerned. Migrant agency should most certainly occupy a prominent place in sociological theory, and the transnationalism

paradigm has unquestionably infused migration literatures with a much needed dose of agency. However, if migrants are telling us that "It seems all or nothing with migration. You either stay or you go" (Anya, 2010), sociologists need to weigh up their agency against the structural constraints they face, and the control they are subjected to. For Nigerian doctors, it is true that the transnational social space contains various opportunities for them. There is no doubt that they become better doctors in England than they could have hoped to become in Nigeria, and gives them greater job satisfaction. Furthermore, as is evident from Dr. E.A. and Dr. B.B., overseas doctors are able to navigate the transnational social space and exploit it to meet their objectives, not only in regard to their own ambitions in medicine, but also their commitment to contribute to healthcare delivery in Nigeria.

Thus, my suggestion that structural constraints need to be accounted for in transnational analyses should not be taken to mean that Nigerian doctors are somehow extraneous to the dynamics of transnational social spaces. On the contrary, as they interact with and influence the various spheres of the transnational social space, they become an inseparable part of its constitution. At the same time, however, it is important not to ignore the darker sides of transnational social spaces. In themselves, these spaces are intrinsically neither bad nor good, but they can have positive or negative effects on migrant trajectories. By incorporating "nation-states and various other opportunities and constraints" (Faist, 1998: 217) into my analysis, rather than adopting a more egocentric approach, I hope to have shown that migrant agency matters, but so do the structural constraints within which they operate. In the final analysis, I would conclude that the most severe constraints placed on Nigerian doctors in the NHS emanate from the state, along with particular understandings of 'race', racism and discrimination. Within these constraints, Nigerian doctors try to adapt to changes in their circumstances by reorientating themselves and developing new strategies to engage with Nigeria. As Faist (1998: 217) notes, "transnational lives in themselves may become a strategy of survival and betterment."

The Migration-Development Nexus – Where does Transnationalism Fit?

This leads us nicely into the final problem to explore, which is how transnational social spaces fit into the migration-development nexus. Faist (2008: 36) argues that the "new enthusiasm on migration and development overlooks the tensions between migrants as transnational development agents on the one hand, and states of origin and destination on the other hand." My data substantiates this argument. Restrictive immigration controls and punitive professional regulations, limiting the rights and opportunities of migrants, are major obstacles for Nigerian doctors to engage in transnational activities. At the other end of the migration chain, however, the opposite is also true. The disregard and indifference with which the Nigerian state treats its diaspora doctors equally serves to frustrate their efforts to engage. As Faist (2008: 33) reminds us, "for the disaspora [sic] option to succeed, there needs to be an attractive infrastructure in place in the countries of origin."

Let us then revisit Portes's (2007: 19) five general principles for migration to lead to a win-win-win situation:

1. Cyclical labour flows, both of professionals and of manual workers, are generally preferable to permanent out-migration.
2. The cyclical character of migration should be grounded on a schedule of real incentives in both receiving and sending nations, so that return is voluntary and not coerced.
3. Governments of advanced nations should seek to cooperate with their sending country counterparts in creating the necessary infrastructure of health, education, and investment opportunities for families of migrant workers to remain at home and for migrants to be motivated to return.
4. Similar support should be provided in the construction of scientific and technological facilities which can receive returned migrant professionals and benefit from their knowledge transfers.
5. For migrants who settle permanently abroad, facilities should be created so that they can transform their journey into a cyclical one themselves through transnational investments and philanthropic activities at home.

If we examine how my data relates to these principles, we will see that each one of them impacts on the extent to which Nigerian doctors can engage in transnational processes. Firstly, as we can see by comparing Chapters 5 and 6, it is clear that those doctors who moved back had a significantly bigger impact on the Nigerian healthcare sector than those who stayed on in England, a point which my England based interviewees would most likely concur with. The reason for this is simple: by dedicating all of their professional time to Nigeria, as opposed to small parts of the year, Nigeria becomes the main beneficiary of their skills and knowledge. Secondly, incentives for cyclical migration is lacking both in England and Nigeria. In England, immigration policies and professional development structures decidedly disincentivise circular migration by making it too risky. In Nigeria, opportunity structures to are sorely lacking, rendering return an uninviting option, and short jaunts – for medical or teaching missions, for example – of limited impact. As we saw in Chapter 6, those doctors whose return was involuntary felt that their professional development had suffered as a result of their stay being cut short. Thirdly and fourthly, the British government is certainly engaged in health development work across Africa – including in Nigeria – but little of it is specifically aimed at creating the right environment for returnees. As I explain in Chapter 3, the British state shows little interest in the potential of overseas doctors as effective development agents. Fifthly, there is little effort made in either England or Nigeria to effectively match the skill set of Nigerian doctors in the NHS to the healthcare needs of Nigeria. The structures, programmes, institutions or resources to achieve this are extremely limited. In Chapter 3, I outline how the British state devolves this responsibility to the third sector, and in Chapter 5, I argue that the third sector lacks the capacity to take it on. Furthermore, in Chapter 6 I show how these structures are simply not there in Nigeria. Finally, drawing on de Haas (2012: 20; original emphasis), I added a sixth principle, relating to migrants' rights, where restrictive immigration policies "*reduce* the development potential of migration ... by infringing on migrants' residency and socio-economic rights and by effectively pushing migrants into permanent settlement." This is arguably the most important principle where Nigerian doctors are concerned. Indeed, the first, second and fifth principles above are entirely predicated on migrants' rights.

Taken together, these six principles, and the ways in which they relate to medical migration between Nigeria and England, indicate the need to widen the scope of inquiry within the migration-development nexus. As de Haas (2007: 833) argues:

> This points to the fundamental importance of applying a broad concept of development in conceptualizing the causes of migration, which goes beyond a narrow focus on income indicators and integrates the reciprocally related economic and social dimensions of development. Increases in wealth, but also improved education, infrastructure, security, access to media and other information sources tend to stimulate migration because they raise people's aspirations as well as their actual capabilities to migrate.

It should be remembered that Nigeria is considered a 'middle income' country, and one of the world's fastest growing economies. In spite of its status as one of Africa's two economic powerhouses (the other being South Africa), Nigeria scores badly on key indicators of health, even compared with other sub-Saharan African countries (see table 1), a situation largely attributable to extreme inequality, corruption and political instability (Gyimah-Brempong, 2002; UNICEF, 2015). Indeed, many of my interviewees said that they are uncomfortable with social developments in Nigeria, and are therefore hesitant to return home. It is therefore not only economic development that matters, but also a mismatch between the direction of social development in Nigeria on the one hand, and the values the doctors have come to adopt in England on the other. As Dr. A.L. succinctly put it: "In Nigeria, you have this saying: if you can't beat them, join them. And they say you will eventually end up joining them. And I don't want to lose my ethics, and lose my morals, lose the person that I am."

To summarise, then, I would argue that a clear and detailed analysis of the transnational social spaces within which migrants operate sheds a great deal of light on the role of migrants within the migration-development nexus. The holistic approach of transnational social spaces is well suited to scrutinising the role of migrants in development from a variety of angles, connecting as it does 'transnationalism from above' and 'transnationalism from below'. This gives us a fuller picture of the opportunity structures available for migrants to take part in transnational activities. Not only do transnational social spaces allow for analysis of how these structures manifest on different levels – macro, meso and micro – but also the dynamics between them.

Back to the Central Question

Having outlined these three theoretical themes which I have sought to shed light on, we can now revisit my central question, which I posed in the introduction: *if* Nigerian doctors want to make a contribution back home, what helps them to do so, and what holds them back? The answer to this question should now be clear. Migration has a lot to offer Nigerian doctors which they could use to promote health development in Nigeria. The training they receive in England is greatly superior to what they can hope for in Nigeria. This is, of course, the chief reason why they migrate. In itself, this represents the most important route for Nigerian doctors to contribute to development back home, and brings us back to the key concept of social remittances. As we have seen, Nigerian doctors both remit normative structures – "ideas, values, and beliefs" (Levitt, 1998: 933) – and systems of practice – "the actions

shaped by normative structures" (ibid). Thus, it is not only the direct application of skills and knowledge which counts – although this is important – but also particular ways of doing and thinking about medicine. This is why many of my England based interviewees favoured training missions over medical missions, and why my Nigeria based interviewees stressed the importance of 'imparting knowledge' to their Nigerian colleagues.

In theory, then, Nigerian doctors should be able to make a real and substantive contribution to Nigeria without actually moving back, particularly through "border-crossing epistemic networks and associations" (Faist, 2008: 31), and in practice, they do this to the best of their ability. Indeed, they have proven to be adept at achieving this under uncongenial conditions, adjusting their strategies to adapt to changes in their circumstances. However, the question is whether their efforts, energy and enthusiasm is efficiently harnessed. I would argue that it is not. It is, of course, beyond the remit of this thesis to quantify this, but my qualitative data points to several characteristics of their migratory trajectories which support my conclusion that the current contours of the transnational social space hampers their efforts to become effective agents for development.

Firstly, their career development in England tends to steer them towards the healthcare needs of the English population, rather than the Nigerian population. Thus, once they are fully trained specialists, their skill set may be further removed from the needs of Nigeria than they originally intended. Although there is certainly a need for qualified and competent psychiatrists in Nigeria, for instance, the need for other specialists – such as public health physicians, surgeons, paediatricians and gynaecologists – is arguably more acute. Secondly, the great number of hurdles Nigerian doctors have to overcome usually sets their careers back several years relative to their UK/EEA counterparts. As transnational engagement seems to increase with professional seniority, this reduces the proportion of their careers which they can dedicate to working in or for Nigeria. Furthermore, many of these hurdles make meaningful transnational activities risky or impossible, particularly when their mobility is heavily curtailed. Thirdly, in order for Nigerian doctors' efforts to be utilised to full capacity, there must be competently functioning institutions which are able to objectively match their skills to the healthcare needs of Nigeria, and provide viable avenues for them to put their skills into practice. Currently, there are few structures in place which are designed to harness and channel their skills and knowledge, either in England or in Nigeria.

As I write these conclusions – in September 2015 – the National Health Service is, once again, prominent in the headlines of Britain's national newspapers, for all the wrong reasons. The King's Fund (2015: 1) predicts this year to be "the most challenging in the recent history of the NHS – financial problems are now endemic among NHS providers, with even the most prestigious and well-run hospitals forecasting deficits." As per previous crises in the NHS, the availability of doctors takes centre stage in national anxieties about the future of healthcare in Britain. Doubts have been raised that the 5,000 new GPs the government has promised by 2020 will ever materialise (Campbell, 2015), and fears are growing that financial pressures are leading to "unprecedented numbers of junior doctors applying for certification to work abroad" (Toynbee, 2015). Due to "insufficient money, and not enough trained staff to employ even if the money was there", the NHS "won't cope, meaning that either standards will fall, or some people won't get treatment. When this becomes apparent, there will be national outrage" (Filochowsky, 2015). The danger is that this crisis – revolving

as it does around funding and staffing levels – will sway the English healthcare system to fall back on its old habit of dealing with crises with the quick fix solution of recruiting staff from developing countries. This, of course, would demand modifications to policy to allow overseas doctors to easily enter and work in England. However, relaxing certain aspects of immigration control for overseas doctors would have to be matched by increasing their rights, lest England contributes further to the drain of physicians from countries that desperately need to retain their human capital. Nigerian doctors have to be able to decide their own career trajectories, partake in the English labour market on an equal footing, and have access to organised and structured networks to make the best use of their efforts for the good of Nigeria. As long as these criteria are not met, Nigerian doctors' journeys through the transnational social space will continue to consign them to 'swimming against the tide'.

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Appendices

Appendix 1: Recommendations from *Global Health Partnerships: The UK Contribution to Health in Developing Countries* (Crisp, 2007)

Recommendation 11
The UK should support international efforts to manage migration and mitigate the effects on developing countries of the reduction in training and employment opportunities in the UK by:

- Using codes of practice, country-level agreements and other means to shape and manage the migration of health workers and encourage all other developed countries to do the same
- Continuing to provide, by agreement with developed countries, some training and limited periods of work experience in the UK
- Creating exchange programmes for training and work experience for UK and developing countries health workers.

Recommendation 12
The UK should assist migrants from developing countries to contribute to health in their home country by:

- Enabling migrants from developing countries to return home – for long or short periods – through participation in partnership programmes
- Creating an NHS service scholarship programme, perhaps as part of an existing one such as the Commonwealth Scheme, specifically to support service improvement in developing countries. It would be open to candidates from developing countries – resident at home or abroad – over a five-year period while they worked on service development in their own country and developed their own experience and expertise with support from the UK and local institutions.

Recommendation 13
The UK should see itself as having a responsibility as the employer of a global workforce and seize the opportunity to help developing countries educate, train and employ their own staff by:

- Committing a significant part of the future aid flows already designated for health to create employment opportunities and scale up the training and education of health workers in developing countries
- Supporting international efforts to scale up the education, training and employment of health workers in developing countries
- Developing plans to play its part effectively in this through:
  – bringing leaders in health, education and development together with the relevant government departments to plan jointly
  – identifying the areas where it could make the most impact and the organisations and approaches that would be the most effective
  – reviewing existing training, scholarship and partnership programmes and enhancing them as appropriate
  – considering the incentives for UK organisations to work with trainees in the UK and abroad and amending them as appropriate
  – ensuring that immigration arrangements allow for trainees and those seeking work experience in the UK, who have a suitable sponsor, to enter the country.

Appendix 2: The Telegraph Article

Revealed: 3 in 4 of Britain's danger doctors are trained abroad

The vast majority of doctors who have been struck off in the past five years were trained abroad, new figures from the General Medical Council show.

The full extent of the danger presented by foreign doctors working in the health service can be revealed.

New figures from the General Medical Council (GMC) show that the vast majority of doctors who have been struck off were trained abroad.

The revelations will add to concerns that NHS patients are not adequately protected from health professionals from countries where training is less rigorous than in the UK, and from those who are unfamiliar with basic medical practices in this country.

The figures, disclosed for the first time and obtained by *The Sunday Telegraph* using freedom of information laws, show:

• Three quarters of doctors struck off the medical register this year were trained abroad.
• Doctors trained overseas are five times more likely to be struck off than those trained in the UK.
• The country with the biggest single number of doctors who have been removed or suspended from the medical register, is India, followed by Nigeria and Egypt.

In total, 669 doctors have been either struck off or suspended by the GMC over the last five years.

Of those, only 249 were British (37 per cent) while 420 (63 per cent) were trained abroad – whereas one-third of doctors on the register were trained abroad, and two-thirds in Britain.

In recent years, a series of cases have raised concerns about the competence and language skills of overseas doctors.

In 2008, the pensioner David Gray was killed by a German-trained doctor, Daniel Ubani, who gave him ten times the recommended dose of pain relief while working as a locum.

Dr Ubani, who was born in Nigeria, was working his first shift in this country and later said he had never heard of the medication diamorphine, which is not commonly used by GPs in Germany, before he administered it.

A series of other cases at the GMC have included Vladan Visnjevac, struck off after a baby girl he was delivering died of a fractured skull and brain injuries when he used forceps wrongly, and Navin Shankar, who failed to diagnose a young woman’s cancer over six years before her death.

Julia Manning, chief executive of centre-right think tank 2020 Health said: “These figures are really worrying and shocking. I think we need to take a really hard look at the assessment of all doctors coming into this country.”

Mrs Manning said she was concerned that the European Working Time Directive, which restricts doctors’ hours, had left hospitals relying too heavily on locum staff, including those who were not familiar with British medical practices or the routines of the NHS.

“If I was a hospital chief executive looking at these figures I would be going to work tomorrow to check just how rigorously have we assessed our own doctors,” she said.

Worst five countries by number

	Average number of doctors in UK since 2008	**Struck off or suspended**
India	25,989	123
Egypt	2,957	33
Nigeria	3,564	33
Pakistan	8,139	32
Iraq	2,257	18

Under the current system, British hospitals and medical agencies which hire doctors are not allowed to test the language skills of those from EU countries to seek if staff will be able to communicate safely.

Until now, Britain has interpreted EU law as meaning that doctors who qualify in any of the 27 countries must be free to work elsewhere, without restriction.

The coalition has promised to change the law, so that doctors will have to prove they can speak English before they get work here, but the changes are bogged down in discussions in Brussels.

Many of the problems with locum medics arose after Labour’s 2006 GP contract meant that family doctors were able to give up responsibility for out-of-hours care, with private agencies taking over.

In recent years, locums have been increasingly used to plug gaps in care, because of shortages of doctors thanks to Britain’s strict adherence to the European Working Time Directive, which limits their hours.

Since a 48-hour maximum week came in two years ago, the number of doctors who trained elsewhere in Europe but are registered to work in the UK has risen by 13 per cent.

Those who come here from beyond Europe are subject to a language test, and a multiple choice exam, which can be taken repeatedly until it passed, before a practical assessment is made.

The new figures from the GMC give the first detailed picture of the problem facing medical regulators.

Last night, there were calls for extra safeguards and training to ensure that any doctor working in this country is familiar with the drugs and procedures used in this country.

The newly disclosed figures also suggest that the picture is worsening.

Of the 39 doctors struck off by the General Medical Council this year, 29 were trained outside the UK – 75 per cent of the total – whereas in 2009, 41 of a total of 67 doctors struck off came from overseas, 61 per cent of the total.

The figures show that India has the highest number of doctors who have been suspended or struck off the register with 123. Nigeria and Egypt also fare badly, each with 33 doctors subject to the measures since 2008. Eastern European countries account for 27 such cases.

When the numbers of doctors disciplined is compared with the total number working here from each country, the highest proportion of those who have been struck off or suspended come from Cameroon.

Since 2008, there has been average of 18 Cameroonian doctors working here at any one time. Of those, one has been suspended, and one struck off. Mexico, Cuba, France and Uganda were the countries with the next highest proportion of doctors subject to the disciplinary measures.

The country with the best record is Hong Kong. Despite having an average of 773 doctors working in the UK since 2008, none have been struck off or disciplined by the GMC.

Similarly, New Zealand has had an average of 600 doctors working in Britain, but none have had those measures taken against them. Next best were Iran, Slovakia and the United States.

There are around 253,000 doctors on the medical register. Around 92,000 were trained abroad, an increase of around 2,000 over the past year.

Of those, more than 25,000 were trained in Europe and around 67,000 were trained in other countries.

Doctors from outside Europe have to take a test before they can work in the UK, but the GMC can refuse entry to those from medical schools which do not meet its official standards or those agreed internationally.

There have been long-standing concerns about the difficulties of monitoring the standards of training in distant overseas countries.

In 2010, graduates from seven medical schools from Nigeria were banned from seeking work in the UK, because of alarm over falling standards of training.

Corruption in medicine remains common in India, most often in the form of bribes to gain access to treatment.

In 2010, the president of the Medical Council of India was accused of accepting bribes to certify medical colleges which did not meet basic standards.

The investigation was closed earlier this year, after insufficient evidence was found to support the claims.

Last month, the same council barred 27 doctors from their register for their part in setting up fraudulent medical courses.

Some doctors claimed they were running two medical colleges simultaneously, while other courses claimed to have far more consultants to train students than they actually did.

Niall Dickson, chief executive of the GMC, said the health service would not have survived without the contribution from overseas doctors, and that it was important not to demonise tens of thousands of professionals who had brought their skills to this country.

He said: "We absolutely acknowledge that when it comes to the serious end of the scale, those from overseas are more likely to appear, and we have set about a series of reforms to address this."

The regulator is reviewing the tests set for doctors from outside the EU, having raised the language standard requirements, and is about to pilot a new induction programme so all doctors who are new to UK practice undergo extra training about how medicine operates in this country and the ethical and professional standards they are expected to meet.

From this month, all UK doctors will also have annual checks of their competence, under a new licensing system called revalidation.

Dr Umesh Prahbu, national vice-chairman of the British International Doctors Association, said he believed the reasons why overseas doctors are far more likely to be struck off were complex and varied.

He said: "The NHS is known for having problems with discrimination and racism and I think this is part of it."

Dr Prahbu said that patients were no more likely to lodge complaints about doctors trained overseas than they were about those from the UK, yet when it came to referrals from NHS trusts, foreign doctors were far more likely to be referred to the GMC.

Analysis of the 2008 to 2012 figures shows that among cases of those struck off, 17 per cent of those involving UK-trained doctors began with a complaint from a patient, compared with 11 per cent in the case of those from abroad.

Dr Prahbu, medical director of Wrightington, Wigan and Leigh NHS foundation trust, said other problems stemmed from cultural differences and communication problems, more than from differences in clinical training.

Dr Prahbu, who trained in India, said the technical training was very similar to that in the UK, but it was more difficult to learn about the "softer" skills and ensure that patients felt treated with courtesy.

A Department of Health spokesman said the checks being introduced would "ensure that the small number of dangerous, often overseas trained, locum doctors who do not understand the British medical system are stopped from treating patients."

The doctors disciplined by the GMC include:

Dr Vladan Visnjevac, 59
Bosnia and Hercegovina
Obstetrics registrar at St Peter's Hospital, in Chertsey, Surrey
Struck off in April 2008 after using three times the proper force on forceps to deliver a baby in 2002. The girl died of a fractured skull and brain injuries.

Dr Sabah Al-Zayyat, 55
Pakistan
Consultant paediatrician at St Ann's Hospital, in Haringey, north London
Granted 'voluntary erasure' from the medical register on health grounds in February 2011 after failing to diagnose the broken back of Peter Connelly – the 17-month-old, known as Baby P, who died as a result of abuse. It meant she avoided a misconduct hearing.

Dr Navin Shankar, 62
India
GP at Wigmore Lane Health Centre in Luton, Beds
Relinquished his registration with the GMC in February 2011 after failing to diagnose "persistent" cancer symptoms in a young woman over a six-year period. The woman died aged 26 in August 2007.

Dr Benjamin Obukofe, 44
Nigeria
Doctor at Spire Leicester Hospital, a private hospital in Leicestershire
Suspended by the GMC in September this year after being found guilty by a court of sexually assaulting two colleagues at the hospital. Given a suspended prison sentence and put on the sex offenders register for seven years.

Dr Oluwaseyi Farombi, 43
Nigeria
Mental health doctor across the South East
Struck off in January this year after the GMC discovered he was a criminal with a record of deceit that spanned more than a decade. He has been on the run from police for three and a half years after failing to show up at his trial for fraud in 2009.