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Forging a Linguistic Identity, Overseas-trained South Asian Doctors in the UK

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Abstract

Contemporary social policy debates on community cohesion in the UK appear to have very prescribed identities for migrants centred around concepts of 'Britishness', having 'common values' and one national language, that is, English, for their successful integration. This paper draws on an empirical study of the integration and identity experiences of overseas-trained South Asian Doctors in the UK. The study involved in-depth interviews with 27 overseas-trained South Asian doctors practising as general practitioners (GPs) in three geographical locales with varying ethnic density and urban/rural mix in the UK. The study set out to explore how this group of highly skilled migrants integrated into the UK society, perceived their identities and whether they had acquired a sense of belonging to Britain. The key concepts examined included identity, context of migration, structural and socio-cultural integration. Their narratives show that while they drew on certain sections of British society for recognition and realisation of opportunity by embedding themselves in local social contexts, they also drew strength from their own religious/cultural and linguistic resources. This included engaging with the revolutionary writings of their own poets and scholars as a way of creative thinking, innovating and dealing with adversity. In addition to the adaptation, dealing with adversity in the UK and cohesion among the South Asian professional diaspora, the evidence shows that South Asian languages have played a significant role in maintaining transnational identities.

Keywords: *United Kingdom; South Asian doctors; identity; integration*

Introduction

In the last two decades or so, community cohesion in Britain has been an issue of concern, in which the role of established migrant communities and new immigrants to the UK has been scrutinised in the context of how well the migrants have integrated into British society. However, much of the existing literature in this area relates to the experiences of low or unskilled labour migrants.

McNair (2009) refers to migration as taking various forms whereby people migrate with different hopes and aspirations, have different needs and the kind of reception they encounter also differs from one another. Migration brings challenges and opportunities for the countries involved. An official report, *Community Cohesion and Migration* (2008, 3) referred to public service pressures and tensions between migrant and settled communities, although it also acknowledges that a significant contribution is made by many migrants to local communities and public services, in particular the NHS. While there are ongoing debates about issues arising from the community cohesion agenda such as migrants' identity, sense of belonging, common values, notion of community, with a substantial body of research now existing that

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relates to the experiences of migrants, generally, empirical evidence is lacking as to how the highly skilled migrants work through such issues.

This paper is an extract from my recent book publication *Elite Migrants: South Asian Doctors in the UK* which is based on a doctoral study that investigated the identity and socio-cultural integration experiences and perspectives of overseas-trained South Asian doctors in the UK (Farooq, 2020). The study involved in-depth interviews with overseas-trained South Asian doctors who practiced as general practitioners in diverse geographical contexts in the UK. This chapter discusses how the doctors in the study who are considered as elite migrants forged a linguistic South Asian identity within their professional diaspora as they integrated in the social fabrics of the British society.

It was considered important to study this group of migrants as overseas-trained South Asian[2] doctors form a significant part of the National Health Service (NHS) workforce. For example, in the late 1970s, 40% of hospital doctors and 20% of General Practitioners (GPs) in the UK were born overseas (Smith 1980). In 2008, overseas-trained South Asian doctors were described as the second single largest group of doctors working in the NHS after doctors qualified in the UK (Hann et al., 2008). Studies in recent years have acknowledged the high level of workforce participation by migrant workers required to alleviate medical labour shortages in the NHS. Despite having a disproportionately higher representation in the NHS workforce, little is known about the impact of the migration of these high skilled migrants, and the nature of the social aspects of their lives and the roles that they play in their local communities. It is within this context that this study set out to redress this imbalance, by investigating the integration experiences of this distinct group. One of the key research questions related to the examining of how overseas trained South Asian doctors perceive their own identities and view the communities around them and how such experiences fit in with the expectations of the Community Cohesion Framework for migrants. Only overseas-trained South Asian doctors who practised as General Practitioners (GPs) were included in the analysis, as GPs offer primary care services in the communities they practice and often have intimate relationship with local communities which this makes them an interesting group to study as they are likely to have a unique insight into the lives of their patients (Wise, 2010).

Research Context

In 2001, some of the UK's northern towns experienced violence involving clashes between hundreds of white and Asian youths and widespread damage to property and businesses. 'Community cohesion' consequently became a subject of significant interest and a focus for major policy intervention by the last Labour government when it was defined, in its simplest form, as the extent to which people feel part of a community. Following the race riots, as they were described by some (Worley, 2005), the Cantle Report (2001) was the first published report which pointed out that high levels of segregation between Asians and whites existed in schools and neighbourhoods that caused the riots. Community Cohesion Framework was developed as a government policy following the investigation related to the riots. The framework is said to have replaced the old policy of multiculturalism and has been subject to considerable political debate (Modood, 2008). For example, contributory factors such as economic deprivation and racism did not surface in such debates, rather, lack of community

[2] The term overseas-trained South Asian here refers to describe those doctors who obtained their basic medical degrees in India, Pakistan, Sri Lanka and Bangladesh.

cohesiveness was held responsible in the report for the riots (Werbner, 2005). A key component of cohesion was described as integration.

Following on from such analysis, community cohesion became an important goal of British public policy. The diversity issues that were previously promoted under the remit of multicultural policy were now considered in a negative way and the emphasis is placed on acquiring a national identity perceived as 'potential super glue' for those communities considered to be too diverse and divided (Wetherell et al., 2007). Various detailed guidance reports were published by both local and central government to elaborate on the meaning of community cohesion and 'Britishness' creating a tension that has lead to ongoing debates (Craig and Flynn, 2012).

It is widely accepted that identities are socially produced and that they determine our relationships to the external world. Hence, studying immigrant identities is envisaged central to an understanding of the migrants' integration into mainstream British society (Jenkins, 1994, Nagel, 1994). The question of migrant identities became more pertinent than ever as identities are perceived to be necessary for community cohesion in the government's community cohesion agenda (Khan, 2007). Transnational ties have generally been assumed to represent a challenge to migrants' successful integration (Snel et al. 2006). Transnational ties are ties that extend beyond the territorial borders of the country (Schiller and Fouron, 1999).The current community cohesion framework also appears to echo this philosophy. For example, Denholm (2010, 11), the Director of Equalities and Planning NHS Health Scotland states in a working groups' report: *Modern communications can work in opposite direction to integration, by providing the opportunity to maintain external frames of reference that reinforce cultural heritage, rather than the 'bridging' of cultural divides.*

As stated above, a key government approach to community cohesion within the Community Cohesion Framework relates to the notion of 'Britishness' and having 'common values' for the successful integration of migrants. McGhee (2003, 382) refers to such an assumption as a 'highly problematic political project'. Gilchrist et al. (2010) argues that it is important to recognise how people 'define, resist or adapt' their identities in order to enhance our own understanding of their engagement with fellow citizens and with the government.

As the GPs are based in the community, their particular role as health care professionals brings them into contact with people from all walks of life. It was anticipated that their experiences can shed light on many of the above mentioned hotly debated topics related to community cohesion. In this paper, I will explore the empirical evidence of how the doctors in the study perceived their identities and how their experiences relate to the debates of the Community Cohesion Framework.

Methodology

The study included 27 in-depth interviews with overseas-trained South Asian doctors practising as GPs in three case study areas in the UK. The sample was selected by use of the snowballing method and a thematic analysis was undertaken by using the computer software Nvivo. The interviewees were aged between 50-76. The majority of doctors were concentrated in the age band 60-75. Following the approval of the ethical procedures from the University of Manchester, pre-piloting was undertaken followed by a pilot study to test and evaluate the question guide regarding the wording, clarity of the proposed questions, ease of

understanding, time needed to complete the interviews, the order of the questions and to ensure that the questions were focused on the core goals of the research. An interesting and important aspect was uncovered during this stage: the significance of the first language. The interviewees, somewhat hesitant at first to express themselves in their first language, then spontaneously switched into it and were articulating in poetry and prose in the South Asian languages. Based on this observation, the interviewees were given a choice to express themselves in the languages that they felt most at ease hence reducing the need for multiple interviews. It was anticipated that this would allow interviewees flexibility to tell their stories spontaneously in their own words with richness and detail. It also meant that any confusion arising from the use of particular words was instantly dealt with using standardised explanations (Wengraf, 2001). The main languages interviews were conducted in were Urdu and Hindi. The data is organised thematically under the topics that emerged during the interviews where the influential role of language and culture can be evidenced.

Findings and Discussion

Significance of Religious/Cultural Values in the Migratory Process

The causes of migration can be found in the cultural, political and social marginalisation of specific groups of people (Samers, 2010). However, Hagan and Ebaugh (2003) argue that the role of religion and spirituality in the stages of the migratory process has been neglected by scholars of both immigration and the sociology of religion, despite its prominence in immigrants' lives.

The research study provides detailed descriptive accounts of the interviewees' journeys from migration to settlement which sum up the economic, social, political and cultural practices involved in the migration process. Since the interviews in this study were conducted in South Asian languages, they provide an insight into the cultural/religious dimensions of the migration trajectories.

Several interviewees talked about the perceived superiority of UK qualification in their countries of origin and the value that it adds to one's human capital. The motivations for migrating to the UK were also described in a cultural context. Culture can be defined in terms of language, religion, and values (Castles and Miller, 2003). The interviewees described how they were influenced by the revolutionary literary writings and Urdu poetry of their era. The following Pakistani origin interviewee explained this by reciting the following poetic verse which he said had been inspirational for him in his decision to migrate; it also indicates how his faith shaped his way of thinking:

> *When I was young, I used to read this Urdu poetry which I found very inspirational:*
>
> *Mohabat mujhe un jwanu se hey,*
>
> *Sitarun pa jo dalten hein Kamand.*
>
> *[Explains the meaning] The poet says, 'I love those kinds of people who have the ability to capture stars by throwing a noose at them, what is meaningful here is that one must not make poverty or other problems as an excuse, My own interpretation of this is that you try, God will then help (gp2s).*

For gp2s, reaching out to the stars equated to coming to the UK which was considered a huge achievement in his era, and he proved that with a show of determination he was able to do

what may have been undoable for many. An Indian origin doctor articulated similar views by reciting a different poetic verse that he had found inspirational with regard to migration:

> *You see I was very much influenced by this poetry verse in my youth,*
>
> *Tufan ki zindgi pe sadqe hazar janein*
>
> *muj ko gawara nahien sahil ki moat marna*
>
> *What exactly it means is that I like storms because they bring challenges and I like to live a life which is challenging, challenge inspires you to do something, you are in the middle of a storm and you work hard to reach the seashore but after you reach the seashore, there is no more struggle left. Tufan [storm] is another name for doing something extra-ordinary and I would rather give thousand lives to a life that is spent in doing something to fight with injustices, I preferred to migrate than to sit helplessly and do nothing, but I also hoped to return one day (gpm8).*

A third of the doctors in the study referred to the strong cultural influences and values that they had been brought up with and which included the belief in *takdir* (destiny). Sayeed (2006) described takdir as

> *He who makes the plans and you are destined to it by your creator.*

One interviewee of the Hindu faith commented that his future was destined this way:

> *It's got to do with destiny; it's not what you decide you would do (gp2b).*

Similarly, another interviewee explained that his Muslim faith provided guidance for him:

> *We (as Muslims) believe that any migratory movement is a blessing for you (harkat mein barkat hai). We come from a risk taking culture, its ingrained in us, we took a huge journey, crossed many seas, just a few pounds in our pockets, because we had faith in us, in our ability and hard work (gp7b).*

The migrants' creative use of religion in the above quotes is clearly evident, not only in their decision-making processes, but also with regard to its provision as a spiritual resource. Their accounts show that the psychological effects of religious values resulted in their commitment towards enduring the hardship of migration (Hagan and Ebaugh, 2003). The findings add to our knowledge as to how the interviewees used creative ways forward, where aspects of culture, language, religion and values, became integrated in the organisation of the migratory process.

From Migration to Settlement and General Practice

Migrants often occupy low level positions in the labour market on entry point as a result of a combination of factors such as arriving from a poor country to a rich country, unfamiliarity of local ways of working, lack of proficiency in English, few or no local networks. This segmented structure of the labour market is owed to the migratory process; however, an important question is the extent to which migrants have a fair chance of upward social mobility (Castles and Miller, 2003).

The doctors' in the study are highly skilled migrants, however, their accounts referred to poor working conditions in the NHS upon arrival in Britain, inaccessibility of training posts which

are crucial to become specialists, a perception of a glass ceiling which led to their departure from hospital jobs and subsequent entry into the General Practice. Though the term 'institutional racism' was only used by a few of the interviewees, their accounts identified several ways in which structural factors served to disadvantage them and confirmed that the phenomenon of their geographical concentration in deprived and remote areas was not accidental; instead, it was a result of what the interviewees perceived as the systematic structural inequalities embedded in the NHS.

These findings raise questions concerning the functional aspect of the integration of overseas-trained South Asian doctors as the definition of community cohesion describes a cohesive community as one where people from different backgrounds have similar life opportunities. The interviewees' accounts related to entry into General Practice and unequal geographical clustering clearly demonstrate that they were denied equality of opportunity. The unequal spatial distribution pattern of overseas-trained South Asian doctors shows that there are parallels to be drawn with that of the experiences of low/unskilled Asians who acted as 'industrial replacement' labour. Robinson (1988, 467) commented that the concentration of Indian GPs in practice areas following the departure of the UK qualified GPs migrating in search of more conducive environments can be considered as a replacement labour force, though in 'different economic sectors and at different levels in the occupational hierarchy'.

The doctors in this study described the push factors for entry into General Practice as: harsh working conditions, mostly working as junior doctors despite having several years of experience under their belt in the country of origin, frequently moving to temporary jobs in high demand areas, and being pigeon-holed in the least desired specialties. Most of them stated that they were stagnating in jobs that did not relate to their career progression and there was no career path planned. However, a few stated that, they had progressed to the post of a registrar, although they knew that they were going to be held back at some stage, as they had seen it happening so frequently with their friends /colleagues. Many were unable to pass part of the postgraduate qualification exams partly as their clinical experiences did not relate to the desired qualification. Return home was not an option, since being engulfed in the migratory process, for many, the only viable option was that of General Practice.

The role of institutional racism in the NHS was acknowledged by several of the doctors in the study:

> *The bad thing here is that if you were competing with a local doctor, no matter how good you were, the English or the Scottish will always get the job. There is discrimination, and the thing is you could not even complain about it as it would be noted and then it will follow you wherever you go for the job and then you will have difficulty (gp3b).*

The above quote suggests that the interviewees were well aware of widespread discrimination and victimisation, but felt unable to complain as a result of the existence of power inequalities and the likely implications for them if they were to speak up against powerful people. This can be evidenced in the account below:

> *One of my friends decided to take it all the way to GMC to defend his case and won, there they asked him the question that it appears in the court that this is a case of racism, do you want to pursue it further, he said, look I am living in a sea, I don't want to be enemy with crocodiles.(laughs). He said I have got a few more years to go; I want to live peacefully with the crocodiles (gp9s).*

The above findings affirm Collins's (2001) findings in a study undertaken to address the implementation of Tackling Racial Harassment in the NHS, A Plan for Action (1998) in which he concluded that the fear of victimisation was a significant factor in the non-reporting of numerous racial harassment cases (Collins, 2001).

Sense of belonging to Britain

As stated previously, the current community cohesion debates around 'Britishness' tend to revolve around allegiance to the nation state, that is, Britain and British values. In this section, I will explore perceptions that the interviewees had of their Britishness.

It is often assumed that the relationship of post-colonial people to Britain commenced only at the point when they or their ancestors embarked on their journey to Britain but this fails to take into account their exposure and conditioning under colonial rule (Sayyid, 2004). All the interviewees in this study expressed a strong identification with British identity, though the reasons for this identification were complex. As a post-colonial people, already primed, they had a pre-disposition towards a sense of belonging to Britain, a nation they held in high esteem. They had experienced pre-migration exposure to British education from an early age, a medical education model mirroring that of the UK, and positive reception into the UK, that has had a long lasting effect. The interviewees felt a deep affiliation with the UK, despite the fact that they experienced some level of exclusion. For example, the evidence showed that institutional racism contributed towards siphoning these doctors off to general practice who had come to the UK with full of ambitions to become specialists and consultants in specified fields. Not only that, such system also led to their clustering in the area practices that were least desired by the UK qualified doctors.

There was a tendency to look at the larger picture rather than dwell on individual experiences, and there was a sense of gratitude among all the interviewees towards Britain as they could relate to the opportunities that Britain offered. The following interviewee explains how he interprets his sense of belonging to Britain:

> *There is a saying in our culture that you should be' namak halal' which means one should be loyal to the benefactors, even if you have only had a pinch of salt from them. When I came, I only had £.8 on me and now with God's grace, I have achieved so much, my children have done well, I have a nice house, status in the community; medicine and Britain have been good for me (gp7s).*

Another interviewee stated:

> *We only had a few pounds in our pockets; we owe to this soil and people (gp1s).*

For many of the interviewees, the construction of social belonging involved the freedom to be able to maintain their multiple identities which they believed the UK offered:

> *... if you can be Indian, you can work in Britain, you know, if you are okay... your language is alright,.. you are good in your job you know, if you do it err what is the word, 'conscientiously'… and you keep a relationship with your colleagues, your friends you know professionally,... why should you have to lose any identity you can still celebrate your Eid, Diwali whatever, you know in your own time and place... (gp3s).*

Regarding identification with British identity, the interviewees frequently evaluated new situations through their old frame of reference, which was their own cultural/religious value system and drew meanings from what they already knew:

> *Adaptation...that question is very debatable, very hot question, if you take the religious point of view, there is a story that Umar Ibn Khattab,[the second Caliph of Islam] was going from one city to another and was wearing silk that day. People objected and said to him, hey, how come you are wearing silk when Islam forbids men to wear silk? He said, the area that I am going to go, they wear silk there. So, my learning from that is that 'jaisa desh waisa bhais' [equivalent to 'if you are in London, do as the Londoners do'] (gp8s).*

Multiple identities

Brah's (2007) asserts that individuals are situated across various processes of identification which change and lead to configuration into a specific pattern in a particular set of both social and psychological circumstances, making a particular identity prominent at a given time. The doctors' accounts showed that multiple identities were in process. Examples include the practicing of various identities such as religious, cultural, linguistic and professional identities as well as how one's phase of life impacts on identity.

The interviewees also talked about having identities that transcend borders, that is, transnational identities. Notwithstanding, that they had formed strong attachments to their respective places of settlement in the UK, their multiple identities are reflected through speech. The interviewees' frequent code-switching between English and their first language throughout their interviews is one example of maintaining their sociolinguistic hybrid identities (Bhatt, 2010). The following interviewee describes his feelings in a poet's expression regarding the implications arising from having multiple identities:

> *Hum Log Sumandar Ke Bichrey Huey do Sahil hein*
>
> *Is Paar Bhi Tanhai Us Paar Bhi Tanhai*
>
> *[Translation: we people are like the two separated seashores that feel apart from each other]*
>
> *The people from there [India] say you live in England now and become Valaytey [Westernised] and the people from here say we are Hindustani or Pakistani... (laughs) that feeling is there. Yes that is there, love for home country (gp5s).*

The interviewees may also have sought to shore up a privileged elite identity in order to compensate for an insecure racial identity. The spaces such as the Rotary Club, The Lions Club, as well as golf and tennis clubs, became spaces of elite networks that worked to connect interviewees with place and the medical diaspora community at-large. The leisure pursuits combined sport with socialising activities, developing social and cultural capital (Valentine, 2001). The following interviewee's account shows how Asian food and hospitability also played its part in forging diasporic solidarity assisting in the integration process (Lakha and Stevenson, 2001):

> *It was mainly Asian doctors when my husband joined the 'Rotary Club' with a few white doctors, they used to come and enjoy the meals that we cooked on a rota basis and spent some time together, 'Rotary' was a good thing for mixing (gp1b).*

Several interviewees from both Muslim and Hindu faiths talked about how they incorporated their own religious identities into the medical professions and strived to become good doctors. For example, the following interviewee makes links with the deliberate instructions of Prophet Mohammad:

> *For me, it's[being a doctor] a form of worship. It s sunnah*[3] *to treat others, our prophet often treated sick people (gp7b).*

Another interviewee explained how he integrated his religious teaching into his work:

> *I also believe in spirituality alongside bio-medicine model of treatment. I would often write a verse from the Quran on prescriptions which was a prayer for healing and was appreciated by white patients too. You see, we all walk separate roads in life but we have a golden bridge called duas [prayers] that link our lives together. Once a white patient came up and asked me what this Arabic verse meant, I explained it was a prayer from me that may he be granted good health. He was very happy to hear that (gp7s).*

The above accounts lend support to Parekh's (2007, 133) critique of Community Cohesion Framework. Parekh asserts that religious identities constitute the axis of one's life and provide an overarching framework within which individuals define and relate their other identities.

It was evident from the interviewees' accounts that they constituted diaspora identities in the UK. Diaspora here refers to an identity based on a common ancestral homeland, however, one dispersed with a sense of marginality in the country of residence (Sahoo and Maharaj, 2007 Vol 2, foreword note). The accounts of the majority of interviewees confirm that the bounded solidarity among them developed as a result of surviving in a racist environment. Two thirds of the interviewees, of both Pakistani and Indian origin, stated their interest in poetry and were actively engaged in collective poetry readings. The poetry verses they recited were from the South Asian poets of their era, in particular, Faiz Ahmed Faiz, a well known Pakistani poet who wrote extensively in protest of the post-colonial conditions afflicting South Asia, such as continued poverty, the neglect of the poor, inequalities and injustices, hunger and oppression (Zulfiqar and Husein, 2011). The type of poetry they recited would suggest that they used their love of literature to help overcome racism. One of the volumes of autobiography of African-American writer and poet, Maya Angelou (1997), I Know Why the Caged Bird Sings in which she metaphorically refers to a bird that is struggling to escape its cage, illustrates how she turned to her literary work and seized upon the power of words to help her cope with racist oppression.

The poetry readings highlight the significance of the role of South Asian languages (Urdu/Hindi) and social spaces in promoting inter-group cohesion which appeared fundamental for individual and group survival. Language appears to have played a significant role as a form of social capital in intergroup cohesion, and poetry in the Urdu/Hindi medium has been used for being revolutionised as well as revolutionise others.

The view that shared experiences of being an immigrant enables diasporas to develop a sense of belonging to each other that they may never have otherwise developed is also supported by a study of South Asian engineers in Silicon Valley. Saxenian (2001) argues that historically the Indian society has many layers that divide its communities such as religion, region, and

[3] The teachings of the Prophet Mohammad (The Fiq of Medicine, 2001)

language; however, the Indian identity proved to be more powerful for the immigrant South Asian engineers in Silicon Valley than any other distinction. Allen (1971, 168) states that this type of common identity among immigrants has developed as a result of their experiences of marginalisation in Britain as well as an ideology of past shared experiences of exploitation, namely colonialism. However, their accounts in relation to how they integrated into the medical world, as well as into British society can also be described using the concept of 'professional diaspora' a concept applied by Neiterman and Bourgeault (2012) in their research study with immigrant physicians residing in Canada. The authors contend that the creation of a collective identity of these physicians owed its existence not to the traditional ethnicity denominator which is considered imperative for the creation of diasporic communities, but rather from other forms of shared values and meanings, that is, from a shared professional identity. The accounts of the interviewees suggest that they formed professional diasporas based on ethnicity as well as professional identity. Almost all the interviewees talked about supporting other colleagues and friends in personal and professional difficulties. The following account shows how the interviewee was able to help another member of the diaspora despite the fact that he had stereotypical views about Indian origin Hindu doctors:

> *I have Hindu friends but I never ask them for help because they never help their own, some of them come to me for help. Dr X, [Hindu] was having problems getting into the local golf club, so he came to me and I introduced him and he managed to get in (gp2s).*

Castles and Miller (2003, 248) contend that cultural difference is perceived as a threat to national identity, which is assumed to be based on cultural homogeneity in UK society. The language and culture of the migrant has become symbolic for 'otherness' and are 'markers' for discrimination. While shedding such distinctiveness is regarded as a positive step in order to be successful and integrate in the adopted country, retaining such attributes is considered as an indication, on the migrants' part, as an aspiration towards separatism. The interviewees' accounts show how they attempted to negotiate among themselves the terms of integration and how they mediated, not only with the wider society, but also within their own groups. Retaining their own cultural/religious/linguistic aspects is considered by the majority as a mode of resistance and an act of decolonisation rather than an aspiration of separatism (Bhatt, 2013). For example, Dadabhoy (2001) refers to his fear of being called a 'coconut' for not fully adhering to Asian cultural norms. The type of poetry (revolutionary, and written by poets who took on a literary campaign against colonialism) recited collectively by the interviewees can be seen to strongly relate to the mode of resistance adapted in the post-colonial context.

Integration of cultural values in Entrepreneurship

In seeking to understand the contributions of overseas-trained doctors in General Practice, and the types of social relations in which they were embedded, it was considered important to explore their experiences in the context of entrepreneurship though this social phenomenon previously has only been associated with low/unskilled migrants.

Ballard (1994) regards migration itself as an entrepreneurship activity, whereas Zhou (2008) states that some immigrant groups and ethnic minorities are more likely to be entrepreneurs than others in the pursuit of socioeconomic mobility. Bygrave and Hofer (1991) define an entrepreneur as someone who perceives an opportunity and creates the organisation for its pursuit. Entrepreneurship is described an effective strategy of circumventing labour market

barriers and is employed by ethnic entrepreneurs to move up socioeconomically in the host society (Zhou, 2004). The interviewees' accounts show that their own agency, perseverance and faith contributed significantly towards risk management:

> *I didn't know how the patients were going to react to me, My salary depended on the number of patients so I had to increase the size of the surgery, I was single handed but by the grace of God, I turned it around. When I started my practice, houses were being demolished; a lot of them left me. My practice size was, I can remember the exact number, 2737 after 3 months, I had 1700 patients. I lost more than 1000 patients (gp9s).*

Many of the interviewees talked about reviving GP practices which had been neglected by the departure of the UK-trained doctors to more affluent areas as can be evidenced by the following interviewee's account:

> *We brought jangal mein mangal you can say (meaning Merriment in the woodland).*

The interviewees in their accounts emphasised 'we' when talking about innovations and frustrations. They functioned collectively to reinforce values and norms that they derived from their own cultures and mobilised resources to achieve their goals. The doctors in the study also acknowledged each others' expertise and called upon their own cultural resources in problem solving and creative thinking techniques. They described getting involved in poetry gatherings where they would have collective reciting of poetry which served as a forum for reviving strength and enthusiasm. They described idioms from their own languages from which they drew strength. An example is when an interviewee was talking about losing half of his patients' list when he took over his practice from a white doctor. He believed that his race had played a part in this process. He explains how he coped with the challenges involved with this situation, reciting the following verse in Urdu:

> *Tundai e Baad e mukhalif se na gabra e eqab*
>
> *Ye to chilti and tujey uncha uraney kaliey*
>
> *[Translates]: Oh bird, don't get troubled by the strong wind blowing from the opposite direction, It blows only to make you fly higher)*

Another doctor recited lines from a late 13th century Persian poet that are also commonly used in conversations by Iranians today:

> *There were tensions/conflicts between us [Asian] as there was competition among them and backbiting but I remembered what Shaikh Saadi had said that you must not backbite and say things about others that you cannot say to their face...(gp8s).*[4]

Coping with racism

Initial responses were interesting as almost all the doctors in the study denied experiencing overt or covert racism and appeared to believe that racism did not impact on the doctor-patient relationship. Their responses seem to fit in with what (Beagan, 2003) refers to 'professional socialisation' which aims to produce neutral doctors for neutral patients with a

[4] Shaikh Saadi , full name in English: Muslih-ud-Din Mushrif ibn Abdullah) is one of the major Persian poets of the medieval period. He is recognised not only for the quality of his writing, but also for the depth of his social thought. LEVY, R. 2012. *The Persian Language (RLE Iran A)*, Routledge.

belief that one must, as a standard of clinical practice, treat everyone neutrally, and objectively, as if they were cultureless, classless, raceless and genderless. Denial may well also be related to the high level of confidence that they possessed and their middle class status (Shaw, 2010).

Evidence suggests that specific cultural values were incorporated by individuals who referred to cultural proverbs which emphasised optimism rather than pessimism:

> *We have a saying in our culture that Jis thali mein khao, us mein ched mat karo (translation, don't make holes in the plate that you eat out of),it implies that you take care of it because it is providing you with food. There are good and bad aspects of every person and my personal philosophy is.. what is he or she to you... there may be 99% bad in you and 1% good in you, if there is even 1% implied by me then you are excellent for me, I should not concentrate on your 99% (gp5s).*

A significant number (two thirds) of interviewees talked about their exposure to South Asian poetry and how they utilised its power of communication as it provided psychological resistance and facilitated hope. They talked about regularly attending poetry readings which provided social support from their diasporic links. These collective gatherings were attended by interviewees of both Pakistani and Indian origins, providing not only a cushioning effect against adversity, but also promoting cohesion between these groups. This coping strategy may be particular to their relatively elite class and educational background.

In general, the interviewees were reluctant to talk about racism. Instead their narratives tended to centre on constructing themselves as successful professionals. The majority were of the opinion that white patients, having made an informed choice to join their practice did not have any negative attitude towards them, however, when probed further, a few could recall some incidents where the ethnicity of the physician did matter.

The realities of working in a rundown urban area in which fear of racism was real were described by several of the interviewees:

> *I am not conscious of racism usually, but I used to keep some verses from the Quran in my pocket to ward off danger. It was rough areas, drug dealing, prostitution, pimps, domestic violence, child abuse, you name it, it was everything....I once went to visit my Hindu doctor friends in their practice, what did I see? Both husband and wife are hiding under the table because they were being physically attacked by some white drug users (gp2s).*

The above account is interesting in that the interviewee denies being 'conscious' of racism, however, his described action is contradictory, as keeping Quranic verses in his pocket as a protective shield is a pre-mediated action. Two other interviewees also mentioned incidents in which they were physically threatened by unknown drug users who had barged into the practice and demanded drugs. These incidents were only casually mentioned and it appeared that the interviewees expected to take these incidents in their stride. The class identities of the interviewees were exposed in their accounts regarding Asian people, in particular Asian women, as evidenced in the following quotes:

> *I've seen women from lot of other Muslim countries, they really I think they are much more conservative here or have become over the last 10 years, than people in your Pakistan or in India, even Muslims there in India they don't dress like this here and that's why you feel more different, I think you have to, you just can't have a very rigid appearance or your ideas so you'll never mix up*

> *with anybody. Sometimes I get female patients and it's really difficult to even examine their ears as they are so fully covered (gp3s).*

Ballard (1994) and more recently Ang (2003, 141) contended that a powerful strategy adopted by those who are marginalised or excluded from white structures or western hegemony is that of claiming one's difference and turning the re-adopted cultural identity into symbolic capital. Cultural resistance has long been an important part of Indian history. For example, the use of cultural symbols was utilised during the independence movement to combat the denigration and devaluation of their cultures experienced by Indian people were perceived as 'uncivilised and uncouth' by the coloniser. This included Indian elites such as Gandhi who started wearing the traditional dhoti instead of western attire (Brah, 2007).The above account illustrates that the interviewee had little comprehension that this adaptation of Muslim women may be a coping strategy, and a reaction to the rejection experienced in British society. The evidence suggests that the interviewees' strategy revolved instead around adopting a symbolic identity of their medical profession rather than their cultural identity. It shows how elites' strategies differ from non-elites in dealing with racism. It was interesting to note that the interviewees also forged a linguistic identity among their professional diaspora which provided them with support that was not available elsewhere. The interviewees' responses echoed what Burr (2003) argues, that is, that language is about more than simply expressing ourselves. Burr (2003, 4) adds:

> *It is through the daily interactions between people in the course of social life that our versions of knowledge become fabricated. Therefore social interaction of all kinds and particularly language is of great interest to social constructionists.*

Burr refers to the work of Whorf (1941) who believed that it is a person's language that determines the way the individual perceives the world. Burr adds that:

> *.....this means that the way a person thinks, the very categories and concepts that provide a framework of meaning for them are provided by the language that they use.*

Conclusion

The discussion in this paper has shown the complexity involved in the formations of identities, and has challenged the notion of one national identity (British). The evidence showed that identities were inter-related and experienced simultaneously. All the interviewees strongly identified with a sense of 'Britishness' evaluating their experiences in the context of their own cultural/religious interpretations together with positive experiences in the UK. Furthermore, the evidence showed that multiple identities appear to reinforce interviewees' overall sense of belonging to Britain and being British. The evidence has consistently shown the significance of the role played by the South Asian languages in dealing with adversities and maintaining transnational identities. The findings of this study strengthen Gilchrist et al's (2010) argument that it is important to recognise how people 'define, resist or adapt' their identities if we are to enhance our own understanding of their engagement with fellow citizens and with the government. The findings also show that interviews in first language facilitated doctors greatly to reconstruct their experiences and to explore their meaning. It also highlights that they have a sustained attachment to their country of origin which is reflected by their linguistic identity.

Opposition to different languages and cultures is justified on the basis that as the official language, English is crucial for economic accomplishments, and that migrants' own cultural and linguistic attributes are insufficient for success in a modern secular society (Castles and Miller, 2003, 248). In contrast, there is qualitative evidence clearly demonstrating that the main Asian languages of Urdu/Hindi play an important role in the strengthening of bonding social capital and offer culturally sensitive coping mechanisms. The findings in this study show that all the interviewees stated they were proud of their ethnic/religious and linguistic identities alongside their newly acquired British identity. Their accounts showed how they integrated their own cultural values positively in their work ethos and adaptation to Britain, and drew strength from the revolutionary writings of poets from their era. The empirical evidence shows that their own cultural/religious/linguistic identities posed no competition to their newly constructed diasporic identities and British identity. However, being British was only one of a range of identities experienced by the doctors in the study (Parekh, 2007, 134). The interviewees' sense of belonging to Britain was described in relational terms and was based on Britain's ability to offer better opportunities than the countries of origin and the freedom to practice cultural identities. This shows that the concept of Britishness needs to be re-defined and broadened to encompass the views and experiences of its minority communities.

Language is another area to be considered. The findings of this study suggest that community languages played a significant role in the cohesion and entrepreneurial activities of the overseas-trained South Asian doctors. Bilingualism was somewhat acknowledged and promoted in the old multicultural policy, whereas this has been diluted by the community cohesion policy framework as more emphasis is placed on having one common language. The findings of this study showed that languages contain social values and attitudes, cultural practices and social norms that the interviewees called upon in times of adversity, and drew enormous strength from. In a BBC report,5 CILT, the Centre for Information on Language Teaching and Research, said that research showed that language learning enhanced individuals' educational attainment and that language maintenance does not mean they will be less proficient in English or less adapted to life in British society. CILT patron Sir Trevor McDonald went on to state that the UK has access to a diverse range of languages which could be of great benefit to the economy. The findings in this study support the argument endorsed by Sir Trevor McDonald when he argued in the above mentioned report that Rather than thinking in terms of an 'English-only' culture, we should be promoting 'English plus'.

It is useful to have one national language, but English does not need to be the single predominant language of communication. Similarly other languages do not need to be confined to their own language communities, as evidence in this study shows that they have much to offer to a wider learner community. The BBC report goes on to say that New Cross Hospital in Wolverhampton has integrated Punjabi into its foundation year modern apprenticeship in health and social care, which is certainly a positive step forward and should be regarded as exemplary.

The findings also highlight that the unique perspective which I as a researcher bring to these narratives is enhanced because many of the interviews were carried out in Urdu/Punjabi and then translated - revealing insights that would never have been possible had they been conducted in English.

[5] Bilingual pupils 'are an asset http://news.bbc.co.uk/1/hi/education/6103176.stm

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