# 17 Recasting the "Brain" in "Brain Drain": A Case Study from Medical Migration

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# Introduction

For decades medical migration has primarily been viewed through the lens of "brain drain" (Bach, 2004; Mejía, 1979). The transfer of the value of medical knowledge and practice from sending to receiving states impacts the former and their ability to deliver medical services. The loss of those who have been trained by one state to another, which then benefits from this migration, has been problematized through the analytical lens of brain drain and very often through the calculative processes associated with migration across national boundaries (Martineau et al., 2004; Moullan & Chojnicki, 2017). In particular, the effects of migration from the Global South for national development and for modernization have been the object of discussions as well as policy initiatives (Department of Health, UK, 2001; Gish, 1971). The questions asked concerned the effects of skilled emigration, or brain drain, on source countries, of "brain gain" on destination countries, and of "brain waste," or in other words, the loss of human capital due to the lack of recognition and utilization of skills, for both individuals and destination and source countries. Of course, some positive effects of such migration, such as "transfer of knowledge" and the flow of remittances, have come to be recognized as well (Docquier & Rapoport, 2004; Lethbridge, 2004; Levy, 2003).

Although there have been attempts to refine and nuance the notion of brain drain through concepts such as "brain circulation," these concepts have largely been applied to migrant workers in sectors such as information technology (IT) (Saxenian, 2000); they are not usually used for medical migrants (but see Levitt & Rajaram, 2013). The reasons for this are, first, that although the conditions of recruitment of migrant medical workers have led to the circulation of migrants, the longer time period of this form of migration is different from the short-term nature of mobility experienced by many IT workers and scientists. Systemic knowledge plays a greater part in medical migration so that complete

and frequent transference between different health systems cannot be achieved at the same frequency as in the case of, say, IT workers, whose work is, by its nature, deterritorialized. Second, both the state and professional bodies have large investments in enabling and regulating the movement of health workers, unlike in the IT sector, so that mobility itself takes much longer to organize and arrange. As a result, the extent and nature of mobility of medical professionals is different to that of IT workers. Finally, the effects of the migration of health care workers are also much more asymmetrical (Marchal & Kegels, 2003; Pang et al., 2003). The negative effects of the migration of nurses and doctors not only on the skills base of the source country but also on the provision of health care in the source country (Kingma, 2006), alongside the fact that much of the movement of professionals is from the South to the North, has meant that such migration raises important ethical questions (Chikanda, 2004; Friedman, 2004). The ethics of migration are conceptualized within the terms of redistributive justice (Mackintosh et al., 2006; Runnels et al., 2011). It is argued that the erosion of human capital has a direct impact on the provision of welfare and can be measured in terms of falling health indicators (Stillwell & Adams, 2004).

Another more recent critique of brain drain is offered by Bradby (2014), who goes beyond a focus on migrants to argue that the commercialization of the health sector and the wider political economy of health and development within which medical mobility is set need much more attention. Following Bradby, this chapter also reverses the tendency of most research on mobile health professionals to emphasize the "drain" in brain drain, with its emphasis on spatial binaries such as North-South or urban-rural. Instead of focusing on the spatialities of the "drain" and the mobility of people it shifts the analytical lens to the spatialities of the brain (i.e., of medical knowledge). This is done through an investigation of the experiences of South Asian geriatricians in the UK's National Health Service (NHS). Section two discusses the context while section three explains the methods adopted. This is followed by sections four and five, where two aspects of the spatialities of knowledge are discussed. Section four draws attention to the importance of place and of encultured medical knowledges that migrants come face-to-face with and learn to imbibe once they move, while section five brings to light the ways in which medical knowledge is carried through the bodies of migrants who move from place to place; that is, how medical knowledge is mobilized. Thus, the chapter unsettles notions of migrants as seamless purveyors of knowledge across boundaries as is often assumed in the literature on brain circulation by emphasizing the "stickiness" of knowledge to places, and how passing through particular places shapes migrants' medical knowledge. However, it also shows that knowledge is mobilizable under particular circumstances. These two perspectives are important additions to the analysis of medical migration because together they offer a way of conceptualizing medical knowledge as "in motion," as having its own spatialities, embodied in the agency of actors and thus requiring the mobility of people, but also having place-based origins. Health mobilities, thus, no longer fixate only on the people who move.

# **South Asian Geriatricians**

Starting in the nineteenth century, the migration of doctors was part of a long-standing tradition of movement between South Asia and the UK. Development of a medical career often involved experience of overseas work so that movement across the Commonwealth countries, and especially to and from the UK and its colonies, was part of colonial history. Moreover, the reach of Western medicine was only made possible by this mobility as its spatial claims rested on movement – learning medicine from these Western centres and reproduction of its practices in hubs around the world (Raghuram, 2009). Hence, UK-trained doctors moved to countries like India (Fisher, 2004; Forbes, 1994), while Indian doctors moved to the UK to learn and to be trained. This movement also included the "White" Commonwealth, with doctors from Australia and New Zealand, for example, seeking training in the UK. Circulation gave antipodean doctors opportunities to see medical conditions that would only rarely be presented amongst their small populations (Armstrong, 2014).

Canada, on the other hand, appeared to have been a branch of the metropole, with doctors from the UK, including migrant doctors in the UK, going to Canada for short placements to learn specific skills. However, in the postcolonial period, once in the UK, immigration regulations, professional accreditation rules, social networks, and race *together* played a significant role in how migrant doctors were treated.

*Immigration regulations* have changed over time but have had some common features, most notably a sharp distinction between other migrants and migrant doctors, and a continuous tightening of migration rules since the introduction of the first regulation affecting Commonwealth citizens in 1962. Extant shortages in the medical labour market meant that just as immigration rules to reduce migration were introduced (see table 17.1), new forms of exemption were also created. These exemptions were based on expanding the notion of training and by using professional accreditation as a draw to find new workers.

To obtain *professional accreditation* and to practise in the UK, doctors must register with the General Medical Council. Although doctors from most Commonwealth countries had their qualifications recognized through reciprocal arrangements between the UK and their countries of origin, most of these arrangements were dismantled in 1985 with the introduction of a limited registration scheme for all doctors. This four-year limited registration clearly linked migration status to training so that doctors could only shift to permanent registration on obtaining advanced training. Career blockages, however, prevented

| Year | Begulation  |
|------|---|
| Tour | Togulatori  |
| 1962 | Voucher system was introduced.  |
| 1971 | Vouchers were abolished; work permit system was introduced.                     |
| 1985 | Four-year permit-free training scheme was introduced.                           |
| 1997 | Nature of training available to non-EU migrants was altered. Training typically |
|      | takes five years, but all training posts had shorter stay periods.              |
| 2006 | Non-EU migration was virtually closed. However, some non-EU recruitment         |
|      | has occurred through the Medical Halling Initiative.                            |

Table 17.1. Immigration rules affecting Commonwealth migrant doctors

migrant doctors from achieving the advanced training required for permanent registration. Doctors who had limited registration were, on the other hand, excluded from many career-grade posts, including entry into general practice.

However, *social networks* operated to allow some people through to higher posts, while others were blocked. Non-migrant networks were crucial to recruitment and they operated in *racist* ways to exclude non-White migrants. Barriers based in traditions of assumed superiority or straightforward prejudice presented substantial impediments to mobility inside the UK. For instance, letters of reference written by Indian doctors were considered inadequate for progression (Raghuram et al., 2010). The exclusivity or selective inclusion into networks formed by UK-trained doctors prevented entry and progression of South Asian doctors.

In sum, the medical profession in the UK had always been notorious for its privileged culture and closed systems and means of entry and progression (Mavromaras & Scott, 2006; Webster, 2002). As a result, migrant doctors found that despite the internationalization of the education they had received in South Asia and the dependence of the UK's NHS on migrant doctors, this international professional community had a preference for local graduates built into it, which was to direct their careers in ways that they had not expected.

One alternative was to move to particular parts of the country that were considered less desirable, leading to ethnic clustering (Raghuram et al., 2009). Another was to shift sideways into less desirable parts of the profession that were facing chronic staff shortages – specialties such as geriatrics, psychiatry, and general practice.

In the case of geriatrics, the nature of its patient group – frail older people – meant that the specialty suffered from a marginality within medicine and, as a result, UK-trained medical students tended to find it unattractive at a time when, in the mid-twenieth century, the treatment and care of older patients had become a pressing issue for the new NHS (Bridgen, 2001; Denham, 2004; Jefferys, 2000; Martin, 1995; Pickard, 2013). A crisis of staffing throughout the

1960s meant that the dependence on overseas-trained doctors in the field of geratrics was great (Rivett, 1998; Smith, 1980). Since its inception, geriatric medicine had been a "Cinderella specialty," its image being affected by ageist attitudes towards the patient group, older people, and its appeal limited amongst medical practitioners by a lack of access to acute beds and thus to private practice . These are general characteristics shared by the specialty internationally, however, developments in the UK, which proved to be pioneering, owed much to the historical coincidence of two factors: (1) early recognition of the possibility that some conditions in old age were recuperable; and (2) the inception of a socialized medical service in 1948. This led to the growth of geriatrics in a sustained way in the UK, unlike in other parts of the world (Bornat et al., 2016).

The growth of this fledgling specialty led to high staffing demands and shortages, especially in cities beyond the acknowledged centres where the discipline had developed. Moreover, the pyramidal nature of medical staffing meant that there was a large demand for those at the lower rungs of the medical hierarchy – in training posts. This offered an opportunity for migrant doctors who were struggling to get into higher training, so that by 1974, 31 per cent of consultant geriatric posts and 60 per cent of registrar posts were filled by overseas-trained graduates, the figures having risen from 15 and 33 per cent respectively in 1967 (British Geriatrics Society [BGS], 1975). A survey found that 40 per cent of geriatricians who were appointed as consultants in England in 1981–2 were overseas graduates (Goldacre et al., 2004). Migrant doctors were over-represented in hospitals in poorer areas, away from the more desirable locations in southern England and the teaching hospitals preferred by non-migrant doctors (Raghuram et al., 2009).

The coming together of two marginalized groups, older patients and South Asian doctors, suggests an interesting set of research questions around career training and work satisfaction amongst South Asian doctors working in the geriatric specialty, strategies for negotiating racism, cultural stereotyping, and career hierarchies and intercultural treatment issues. A case study of one particular specialty also provides an opportunity to investigate how individual doctors transformed the structural limitations of movement into opportunity. The next section outlines the primary research method adopted for this study – oral history.

## Method

Oral history interviewing was chosen because it leads to rich, greatly nuanced theorizing as well as adding directly to knowledge of particular experiences (Thompson & Bornat, 2017). As a method, oral history has contributed a great deal to understanding migration processes, with the opportunity to explore decision-making, networking, encounters, and reflection over time (Thomson,

1999). This project drew on two main empirical sources. The first was the group of seventy-two interviews conducted in 1990-1 by a team led by Professor Margot Jefferys with the pioneers of geriatric medicine in the UK (Jefferys, 2000). Those interviewed often mention the role of overseas doctors in the history of the specialty, however only one doctor of South Asian origin was included (Bornat et al., 2012). In order to fill that gap, a second dataset of sixty interviews was conducted by generating oral history interviews with retired and serving South Asian geriatricians (henceforth SAG interviewees). Interviewees for this second project were recruited through networks of overseas doctors (for example, the British Association of Physicians of Indian Origin), the British Geriatrics Society, and through snowballing as the project progressed. The project adhered to the ethical guidelines of the British Sociological Association and the Oral History Society. The proposal was successfully reviewed by the Open University's Human Participants and Materials Research Ethics Committee and the NHS's National Research Ethics Service (NRES). In response to NRES requirements, the invitation letter clarified the participants' right to anonymity and their right to withdraw participation, procedures for guaranteeing participant security, questions relating to mental competence, and how researchers might deal with possible criminal disclosure should this occur.

The SAG interviewees include doctors trained in India, Bangladesh, Sri Lanka, Pakistan, and Myanmar, ranging in age between forty and ninety-one and arriving in the UK from the early 1950s onwards. Two thirds of the interviewees were retired or semi-retired and had arrived in the UK prior to 1976. All except one had worked as consultants, and some also held academic posts such as that of professor. All except five of the interviewees were male. The interviewees were geographically dispersed but with clusters in the North West, Wales, and the northern fringes of London, reflecting some of the main centres where South Asian geriatricians had contributed to the specialty (Raghuram et al., 2009).

Both interview schedules used a life-history approach, asking participants to talk about their childhood, upbringing, education at school and college, and subsequent training and careers. The South Asian doctors were also asked about their training in their home countries and after arrival in the UK, about their reasons for migration to the UK, and arrival and subsequent career progression in the UK with a focus on opportunities, barriers, and sources of support (for a discussion of the use of the two datasets, see Bornat et al., 2012). Both sets of interviews were analysed following a grounded theory approach, drawing out key themes after ten interviews had been completed, transcribed, and reviewed by the team. A common coding strategy was then developed and used iteratively with new themes being added as these emerged in later interviews. The project also drew on literature and archival searches of the institutional histories of the development of the NHS. In what follows, we draw on the data to discuss the

spatialities of knowledge that constitute brain drain. We consider how knowledge was attached to place and how migrant doctors mobilized the knowledge they had acquired between places.

# "Sticky" Knowledge and the Importance of Place

Opportunities for learning and promotion became available to migrant doctors, many from the Indian subcontinent, who were prepared to switch to geriatric medicine (for similar trends in psychiatry and general practice, see Esmail, 2007; Simpson et al., 2010; Smith, 1980). Yet even in geriatrics, medical knowledge was encultured in that it involved place-based learning that was dependent on cultural codes and ways of understanding (Williams, 2006; Williams & Balaz, 2008). Professor John Brocklehurst was interviewed by both Jefferys and again for the SAG project because he had a particularly good reputation amongst the interviewed South Asian doctors as a teacher, colleague and clinician and, of course, as the first professor of geriatric medicine in the UK. He was asked what he thought was necessary if South Asian doctors were to succeed:

- BROCKLEHURST: Well they certainly needed to integrate a bit with the rest of medical society which was not always easy to do. They had to be competent, and good and er [*pause*], I just really don't know otherwise.
- INTERVIEWER: When you say integrate, how do you see that process? BROCKLEHURST: It would depend on going to take part in meetings in the hospitals, running the general hospitals sort of staff meetings and that sort of thing. On the whole I think most of these doctors would take part in clinical sessions with everybody else, and I guess they probably found that even more difficult than did the home products. Although for young people coming up speaking on presenting patients and so on, to a crowd of hard boiled consultants and their next rank down is not easy I'm sure. ... But, er, I don't think there was any special criteria that didn't apply to all people on their way up in the ladder. (Professor Brocklehurst, male, retired professor of geriatric medicine, born 1924, UK, BL catalogue C1356/62)

Being mobile means finding ways to engage with knowledge and practices that are already present in particular contexts, in this case the hospital ward and also the hierarchy of the medical profession. As Professor Brocklehurst points out, this was a process that was challenging even to young doctors whose whole medical training had taken place within the UK. For those from elsewhere, it meant learning and being able to practise their skills within a context that might feel familiar on the surface (because of shared histories of medical training across the Commonwealth), but which had its own practices and protocols.

Mobile doctors became aware of this and described various ways in which they experienced formal and informal processes of induction into the life and working conditions of a hospital doctor. At times, this place-based knowledge was difficult to access, or somehow obscured by local dialect or by practice:

You know our junior jobs in India, consultants, they were quite strict, but again here of course things were totally different. You have to be up in right time, you have to be in the ward in right time, you have to prepare the cases for the consultant or registrar even for the ward round. You have to discuss with the sister and nurses what is going on, what is the present situation. You have to see sometimes persons hourly about their present condition. If any [complain, you have to determine] what is going wrong so that we could feed [that information to] the registrars and consultant. So it was very busy. I was very busy when we were working, but at the same it was rewarding for me because I was always getting new experiences, you see, which were so different than what I did. (Dr. Das Gupta, retired consultant physician, born 1933, India, arrived UK 1965, BL catalogue C1356/06)

In their turn, South Asian doctors drew on this experience when they came to set up their own departments and learning opportunities. In their interviews, they describe how they produced the conditions under which access to encultured knowledge was facilitated:

Because to develop a department one has to make it attractive, you know, one has to make it good enough for yourself as well as for the others who could come and work with you and for you. And to get that you have to have support from your colleagues which fortunately, you know, I had. But it may not have been the same with everybody. (Dr. Kumar Sinha, male, retired consultant physician in geriatric medicine, born 1937, India, arrived UK 1968, BL catalogue C1356/21)

Importantly, these medical workplace cultures were not simply national or given. They were created in particular places. Because of the nature of the specialty, geriatrics came to be established not in the most prestigious teaching hospitals in the south of England, but in district hospitals in the north of England, in Wales and in Scotland, in towns and cities such as Hull, Leeds, Manchester, and Cardiff. One place that became particularly influential was Sunderland, an industrial city in the northeast of England, where few non-migrant doctors wanted to work. It was not only a peripheral part of England but also seen as peripheral within the region, insignificant compared to the hospitals that were attached to Newcastle University, for instance:

And there were two hospitals here. I think one was the Royal Infirmary, [the] other was Sunderland General. So when you mention earlier in your discussion about the workhouse, Sunderland General used to be workhouse. Infirmary was the elite type of hospital so you will see more local graduates working in Royal Infirmary than Sunderland General. (Dr. Bansal, male, consultant physician in geriatric medicine, born 1947, India, arrived UK 1973, BL catalogue number C1356/04)

Moreover, medical knowledge did not simply consist of habits of working but involved considered styles of arranging care for patients. In the case of geriatrics this involved rearranging the spatial practices involved in geriatric care. One such rearrangement was the development and adoption of an age-related admission policy. All patients who were above a particular age - sixty-five when this was first established in Sunderland by pioneers like Dr. Oscar Olbrich and Dr. Eluned Woodford Williams, but later seventy and seventy-five in other centres - were admitted into a single ward irrespective of their reason for admission. This policy recognized that geriatric patients often did not have a single condition; rather, they were likely to have multiple pathologies requiring special skills and services related to the process of treatment (access to psychogeriatricians, physiotherapists, etc.) as well as to discharge (e.g., involvement of a rehabilitation team and/or social services) (Kafetz et al., 1995). Geriatricians working with an age-related admissions policy thus developed and deployed a set of composite team-based skills that were developed in particular places that had staked a claim to innovativeness and thus became renowned centres of learning. Those who worked in Sunderland often ascribed their career success to having been trained in a setting where the new specialty of geriatrics had a particularly good reputation and to the learning environment in dealing with these multiple pathologies that this policy afforded.

An age-related admissions policy was also adopted and adapted by many of those who passed through Sunderland, increasing Sunderland's fame as a centre of innovation:

I wanted to take geriatrics into what I used to do in Sunderland. To get fully functional, full-scale outpatient and patient facilities for [the] elderly. And as I said, within five years I was admitting all admissions over the age of seventy. (Dr. Hajela, retired consultant physician in geriatric medicine, born 1933, India, arrived UK 1956, BL catalogue number C1356/18)

From integrating care to subspecializing, there were local trends established in what constituted good geriatric care. Geriatric knowledge as a medical practice was thus being developed within particular spaces, wards, hospitals, and areas of the country, and in relation to the social and generational characteristics of a particular patient group. However, those who were encultured into these particular practices took their knowledge out to other centres, as discussed in the next section.

## Mobilizing Knowledge

Despite the limits and challenges set by the contexts in which various forms of medical knowledge were exercised and developed, migrant doctors were able to mobilize knowledge. This mobilization became important not only for the migrants but also for the cementing of certain practices developed in centres of knowledge as the preferred models of care. It institutionalized knowledge developed in particular places by showing its more universal relevance.

Centres of good practices such as Sunderland and also Manchester were not only claiming good practices, but were becoming reified as centres of learning through which those in the learning stages of the medical career hierarchy (especially as registrars and senior registrars) had to pass to claim knowledge (Bornat et al., 2016). It was by passing through these centres that one claimed to be knowledgeable. As one SAG interviewee recalled, having been through a centre of learning clearly gave him an edge and shaped his career decisions:

[I]f I were to make a career in [the] UK, geriatric medicine was perhaps a better career for me, especially being trained in Sunderland. But again, as I said, the career progression was so rapid in Sunderland that, you know, I just rode with it.
INTERVIEWER: And how did you feel about going into geriatric medicine then?
No problem because what I was seeing [was that] geriatric medicine there was [a] very appealing branch because ... funnily enough we also had a first special dedicated six bed ward for MI [myocardial infarction] care in Sunderland.
(Dr. Hajela, male, Retired Consultant Physician, b 1933 India, arrived UK 1956, BL catalogue number C1356/18)

A career in geriatrics became appealing because of the spatial practices of the ward (having dedicated beds for subspecialties) and admissions (as we saw in Sunderland) of the eminence that such spatial practices, spearheaded by individuals like Woodford Williams and Oscar Olbrich, had given to centres adopting such practices. Passing through these centres gave geriatric trainees pride in their field but also a form of capital that they could use to develop their careers elsewhere. Association with such centres of learning (and their pioneers) thus shaped career trajectories.

However, it is not only people's careers that benefited from association with Sunderland – both the centre and its policies were also dependent on mobile bodies. Thus, the success of centres such as Sunderland was made possible when doctors who passed through them extended its reach by following practices that they had learned there. These place-based practices of innovation spread out to influence how others thought good geriatric medicine should look like and what might be the ideal solutions to the problems of caring for the growing numbers of older people. For instance, Sunderland's age-related admissions policy was adopted and adapted by many of those who passed through Sunderland, increasing Sunderland's fame as a centre of innovation and helping to establish age-related admission as a preferred style of care.

Geriatricians who passed through such centres also considered where they might have the most impact and where they might have the best chance to adopt and adapt these innovations when making decisions about their career. One SAG interviewee went for a post in Mansfield, deciding to develop the practice he was familiar with from his time at St James's University Hospital in Leeds:

It's a mining town. Small town. Very little Asian population there. Mostly indigenous. The geriatric provisions in those days were very poor. There were something like 260 long-stay beds in three hospitals and there was one geriatrician there already. And very little support to develop the services from the management side, mainly because of cost. And it was convenient for everybody else, like the general physicians, to dump their patients into geriatric medicine and forget about them. So it was a kind of dead end that you go into a place where the service is mostly long-stay service, nobody goes home, dies there. There wasn't any nursing home in those days.

People had the conception then, they believed very firmly, that they have worked all their life, paid taxes, they have got the right to stay in hospital for whatever length of time is needed, you see.

And the facilities for rehabilitation, treatment, et cetera were also poor. Staffing level was very limited ... It was very convenient for the GPs, you know. In between their times they come and write out a few prescriptions and go away, you see. And so in that way they didn't really contribute much towards treating and rehabilitating elderly ill patients at the hospital. (Dr. Rahman, male, retired consultant physician and geriatrician, born 1935, Bangladesh, arrived UK 1967, BL catalogue number C1356/10)

This doctor recognized the potential that the blank sheet gave him to practice the learning he had acquired in Leeds. It would allow him to set his own mark. As such, professional growth for these migrant doctors was intimately tied to practising innovation in new territories and spaces, thus extending the reach of these forms of innovation. It offered a way of forwarding their field.

## Conclusion

This chapter takes a different tack from previous studies of brain drain. It focuses on the mobility of knowledge rather than the mobility of groups of individuals, and in doing so highlights how medical knowledge is more than what is learned as physical and organic, as it is also social and spatial, and makes five specific contributions to the literature on brain drain.

First, the chapter goes beyond the nation as the preferred spatial analytical scale at which medical migration is discussed by showing how migrants benefited from and contributed to medical knowledge and innovation at other levels – in this case both in small towns and cities in certain parts of the UK and in particular specialties. In doing so, it changes the scale at which the transfer of health workers is studied. It explores how the loss of value through emigration and as a consequence of race is partially rescued by moving into less desirable parts of the medical profession. However, these newer, less well-regarded areas of the profession also offer scope for advancing overseas doctors' professional careers and the opportunity to gain satisfaction and make one's name.

Second, medical knowledge is not simply removed from one country to another but comes up against encultured knowledges that operate locally. Migrants learn these knowledges in certain places but also take them beyond those places to new sites, spreading forms of good practice and medical innovation. The spatialities of knowledge and those of migration are therefore intertwined, and in this process, the "brain" in brain drain does not stand still. As seen in the case of centres such as Sunderland, places can become crucial to claims to become a model for medical practice. Thus, medical knowledge is based on enculturations of practice in place. Moreover, such knowledge requires mobilizing (circulation) in order to become established as a preferred way of practising medicine. Location and mobility are two aspects of the complex nature of the knowledge that is called forth in discussions of medical migration.

Third, by focusing on geriatrics, a specialty that did not exist in the countries of origin of the migrants we interviewed but was becoming instituted in the British medical system, we have been able to complicate the story of medical migration by showing how the structures migrants encountered offered opportunity for new knowledge to be developed and disseminated as well as opportunity for career development. In sum, the multiple actors, institutions, places, and people involved in the recognition, validation, and circulation of knowledge shows that the migrant is only one part (albeit an important one) of the terrain of mobile medical knowledges. The transfer of value across borders leads not only to deskilling but also to the acquisition of new skills not available in the sending countries. Moreover, the skills that are acquired are not simply transferred to migrants, but rather they are co-developed by migrants in their new contexts. Hence, knowledge and skills should not be considered as a fixed-sum game. Focusing on skills rather than migrants shows how knowledge and innovation has been driven by migrants. The implications of our research, therefore, are that migrant mobility should be analysed as more than the movement of migrants; the spatialities of medical knowledge should also be considered as mobilizing health requires and involves more than mobile bodies.

Fourth, our case makes the question of intersectionality in care more complex by drawing on an example of racialised migrants who were highly skilled and

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whose educational success in their countries of origin placed them high in the occupational order. Arriving in the UK to further their training, they moved down within the hierarchy of medical specialties in order to move up into consultant roles rather than inhabit the multiple forms of non-consultant career-grade roles that were mushrooming in order to fill the service requirements of the NHS. They got opportunities to train themselves and eventually to train others into the version of geriatrics that they had shaped in their local contexts. Much of the literature on intersectionality, often led by the experiences of Black women, has focused on those who have been multiply disadvantaged – by class, race, and gender. This chapter has attempted to complicate that picture by exploring the experiences of South Asian men, many of whom came from middle-class backgrounds but faced discrimination at the intersection of hierarchizing processes due to colour, citizenship, and immigration status and country of qualification.

Finally, we want to end by pointing to the continuing relevance of these issues today. It has become commonplace to argue that a large degree of care mobility is driven by the care needs of ageing populations in the West. Although much of this literature has focused on the justifiable shortage of social care, medical care requirements also remain extant. Moreover, the shortage of social care has effects on medical care. Between 2013 and 2015, delays in transferring patients from the hospital rose 31 per cent in the UK and in 2015 accounted for 1.15 million bed days, with 85 per cent of the patients occupying those beds aged over sixty-five (Oliver, 2016). The demand for hospital care in the UK is weighted towards older age groups with around 7.6 million (41 per cent) of the 18.7 million adults admitted to hospital in 2014 being sixty-five years or above (NHS Benchmarking Network, 2015) even though in 2014 people sixty-five or older formed only 17.7 per cent of the UK's population (Office for National Statistics, 2016). Of course, not all the health care requirements of this population needs to be met by geriatricians, but the demand for geriatricians will nevertheless grow. In the US, it is estimated that 17,000 old age specialists are required to care for the 12 million geriatrics in the population (Olivero, 2015). However, in 2010, only 75 people entered geriatric training programs in the US (Mangipudi, 2017). Similarly, in Canada, there were only 242 certified specialists, of whom 35 per cent were aged fifty-five or over (Heckman et al., 2013); estimates of the numbers vary, but it has been suggested that around 700 certified specialists are required to adequately treat Canada's geriatric population. Although efforts to address the shortfall have been instituted in all these countries with the introduction of special programs (e.g., the Geriatrics Workforce Enhancement Program and the Medical Student Training in Aging Research Program in the US; the Resident Geriatrics Interest Group and the National Geriatrics Interest Group in Canada), geriatrics continues to remain a shortage specialty. Moreover between 2001-02 and 2017-18, the geriatric specialty declined in actual and population-adjusted (-58 positions, -23.3%) filled positions when

hospice/palliative care was omitted (Petriceks et al., 2018). For instance, in the US, over 20 per cent of all training posts in geriatrics remain unfilled (Fisher et al., 2014). In comparison, in the UK in 2017 only 4.2 per cent of the training posts were vacant (British Geriatrics Society [BGS], 2017); this comes after real concerns about the shortage of geriatricians. Thus in 2010, while the number of acute and general physicians increased by 23.3 per cent, there was concern because not only had the number of consultant geriatricians in the UK fallen by 1.6 per cent from 1,129 to 1,111, but there was also concern that almost 10 per cent of these consultants were over sixty years old (BGS, 2010). These concerns are particularly acute given the lack of development of geriatrics as a specialty in most parts of the world so that direct overseas recruitment into the specialty is only a long-term option; it involves a degree of local training (BGS, 2017).

To conclude, our chapter offers a distinctive take on the question of transnational value and transfers. It highlights how race and the lack of transferability of some credentials has led some South Asian migrants to take a step back in their careers. However, it also relates how these migrants found new kinds of learning and added value not only to the labour market but to the knowledge and training involved within the health service. The chapter thus argues for going beyond narrating medical migration through the language of "drain" to instead focus on the places and spaces through which medical knowledge (the "brain") is acquired, adapted, and performed.

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