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# Title Page

Title:

**Migrant Medical Women: A case study of British medical graduates in twentieth century Australia**

Abstract:

*The lives of medical women – with a few notable exceptions – remain marginal in the growing body of literature on 20<sup>th</sup> century migration of medical practitioners. This article examines the professional experiences and outcomes of a group of women who trained as medical graduates in Britain and migrated to Australia – both temporarily, but often permanently. In exploring the professional lives of these women, this article extends histories of migrant women in Australia to include middle-class, professionally qualified British women. The collective biography of this group of women reveals the broader socio-medical contexts by which they were shaped, in which they participated, and helped shape.*

Keywords: Australia, Medical Women, Migration, History

## Main text

This article explores the collective professional work of a group of 55 British medical women who migrated to Australia between 1930-60,<sup>1</sup> and stems from a larger project exploring the professional lives of European medical migrants registered in the Australian state of Victoria between 1930-60. This case study traces the pathways of these 55 women, connecting the social and professional constructions of gender and ‘medical women’s work’ in Britain and Australia, and explores how these women were shaped by and helped shape these spaces. Such narratives, I argue, are important in redressing the invisibility of migrant women, and women professionals, in histories of medicine and migration in Australia.<sup>2</sup> To date, the work of only a select few medical women in Australia are remembered as migrant contributions in large-scale national memory projects.<sup>3</sup> This gap is not unique to Australian scholarship either. There is a growing body of literature examining the unprecedented waves of migration of doctors in the twentieth-century, however, very few of these studies focus on medical women.<sup>4</sup> As migration scholar Parvati Raghuram aptly observes, this literature is ‘often implicitly masculinised’.<sup>5</sup>

British women comprised a significant part of Australia’s twentieth-century migrant intake, since Australia’s immigration policy for much of this period centred upon the preservation of a white, culturally-British nation.<sup>6</sup> Between 1945-60 alone, over half a million British settlers arrived both independently and under government-assisted passages; roughly half of whom were women.<sup>7</sup> As historians James Hammerton and Alistair Thomson reflect,

From all we know of the pressures of migration it should come as no surprise to find that British married women, like other women migrants, took up paid work at a higher rate than did non-migrants in both Britain and Australia.<sup>8</sup>

In doing so, migrant women played an integral part in altering the gender composition of Australia’s workforce, defying state-sponsored social conservatism that promoted fertility and domesticity as a woman’s primary role.<sup>9</sup> However, the work of British migrant women in Australia during the interwar

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<sup>1</sup> For readability, the remainder of this article will use ‘British medical women’ as a catch-all description for women graduates from medical schools across the UK (and rarely, Ireland). All but one of the women sampled were also not Australian-born. One woman was of Polish descent; the rest were, as far as can be traced, British or Irish subjects on entry to Australia.

<sup>2</sup> A similar point has been made for migrant women in other receiving contexts. See: Linda McDowell (2016) *Migrant Women's Voices: Talking About Life and Work in the UK Since 1945* (Bloomsbury); and Pamela Sharpe (2001) *Women, Gender and Labour Migration: Historical and Cultural Perspectives* (Routledge).

<sup>3</sup> For example, of Hungarian Clara Geroe (psychoanalyst) in Joy Damousi (2005) *Freud in the Antipodes: A cultural history of psychoanalysis in Australia* (UNSW Press); and British Ida Mann (ophthalmologist), see: Geraldine Byrne (2012) ‘Mann, Dame Ida Caroline (1893–1983)’, *Australian Dictionary of Biography*, Vol. 18.

<sup>4</sup> Exceptions include: John Armstrong (2016) *A System of Exclusion: New Zealand Women Medical Specialists in International Medical Networks, 1945–1975*, in Laurence Monnais & David Wright (Eds.) *Doctors Beyond Borders: transnational migration of physicians in the twentieth century* (Toronto University Press), pp.118-141; Anna von Villiez (2009) *The Emigration of Women Doctors from Germany under National Socialism*, *Social History of Medicine*, 22, pp.553-567; Atina Grossman (1993) *German Women Doctors from Berlin to New York: Maternity and Modernity in Weimar and in Exile*, *Feminist Studies*, 19, pp.65-88.

<sup>5</sup> Parvati Raghuram (2006) *Asian women medical migrants in the UK*, in: Agrawal, Anuja ed. *Migrant Women and Work* (New Delhi, India: Sage), pp.73–94.

<sup>6</sup> For a discussion, see: James Jupp (2002) *From white Australia to Woomera: The story of Australian immigration* (Cambridge University Press).

<sup>7</sup> Australian Bureau of Statistics (2016) *Historical Migration Statistics*; Reginald Appleyard (1964) *British Emigration to Australia* (ANU Press).

<sup>8</sup> A. James Hammerton and Alistair Thomson (2005) *Ten Pound Poms: Australia’s invisible migrants* (Manchester University Press), pp.210.

<sup>9</sup> Jock Collins (1988) *Migrant Hands in Distant Lands: Australia’s post-war immigration* (Pluto press).

and post-war period is largely hidden.<sup>10</sup> In part, this reflects the invisibility of British migrants in the historiography, which historians have recently begun to recover.<sup>11</sup> In part, this reflects the relative invisibility of the work of migrant women during this period.<sup>12</sup>

Of course, this study is a narrow history, of a group of privileged migrants, in a privileged position. Historians Laurence Monnais and David Wright point to the contradictions of categorising medical migrants who they argue occupy ‘interstices of power’ between the local medical elite and the general population – as qualified doctors, often from middle class backgrounds, medical migrants shared in the high social status afforded the profession.<sup>13</sup> However, as outsiders within the profession, they are more vulnerable to marginalisation and structural disadvantage.<sup>14</sup> The restrictions placed on European refugee doctors are a poignant example of the latter.<sup>15</sup> British medical women occupied a particular interstice of privilege in Australia – they, like their male colleagues, were able to register and practise freely in Australian states and territories, while medical graduates holding other foreign qualifications typically could not.<sup>16</sup> This was tempered, however, by the marginal position of medical women in Australia. As sociologist Rosemary Pringle observed, even ‘in the 1950s no one imagined that ... women would take anything other than a minority role in medicine’.<sup>17</sup>

Women in Australia and the United Kingdom (UK) shared experiences of contested entry into university medical schools, many of which operated quotas on the annual intake of women students.<sup>18</sup> This represents one of the reasons women remained marginal to their respective medical workforces for much of the first three-quarters of the twentieth-century. Health economist Richard Scotton produced one of the more robust sets of estimates describing Australian medical manpower for the period 1933-61, which rarely for the time also reported gender splits.<sup>19</sup> Scotton estimated that in 1933 seven per cent of the active Australian medical workforce were women. In 1961 this ratio had increased to 11 per cent, where there were an estimated 1,300 medical women compared to almost 12,000 men.<sup>20</sup> These figures roughly correlate to the British equivalent, where in 1931 a report using British census data estimated ten per cent of the active British medical workforce were women; and in 1961 this had increased to 16 per cent.<sup>21</sup> In both reports, the term ‘active’ is an important qualifier, since medical women were commonly cast as ‘wastage’ in a labour market context owing to the

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<sup>10</sup> Exceptions include the migration of British women as domestic workers, see: Paula Hamilton & B. W. Higman (2003) *Servants of Empire: The British training of domestics for Australia, 1926-31*, *Social History*, 28:1, pp.67-82; and Lisa Chilton (2007) *Agents of Empire: British Female Migration to Canada and Australia, 1860-1930* (University of Toronto Press). Other studies include, Emma Robertson (2016) ‘Belles from Bristol and Bournville in New Surroundings’: female confectionery workers as transnational agents, 1918–1928, *Womens History Review*, 4, pp.563-583.

<sup>11</sup> Hammerton and Thomson, *Ten Pound Poms*.

<sup>12</sup> Sharpe, *Women, Gender and Migration*.

<sup>13</sup> Monnais and Wright *Doctors Beyond Borders*, pp.18-20.

<sup>14</sup> Anne Witz (2004) *Professions and Patriarchy* (Routledge).

<sup>15</sup> Paul Weindling (2009) *Medical Refugees in Britain and the Wider World, 1930–1960: Introduction*, *Social History of Medicine*, 22(3), pp.451-459.

<sup>16</sup> *Ibid.*

<sup>17</sup> Rosemary Pringle (1998) *Sex and Medicine: Gender, Power and Authority in the Medical Profession* (Cambridge University Press), pp.32

<sup>18</sup> Mary Ann Elston (1986) *Women Doctors in the British Health Services: A Sociological Study of their Careers and Opportunities* (Unpublished PhD thesis, University of Leeds); Ione Fett (1975) *Australian Medical Graduates 1920-1972* (Unpublished PhD thesis, Monash University).

<sup>19</sup> Richard Scotton (1967) *Medical Manpower in Australia*, *Medical Journal of Australia*, pp.984-990.

<sup>20</sup> *Ibid.*

<sup>21</sup> Elston, *Women Doctors in the British Health Services*, see table 3.5, pp.63.

observed higher rates of early retirement of women (compared to the average male medical career) when they married and/or had children.<sup>22</sup>

The differential distribution and working patterns of women in medicine is now familiar in the historiography.<sup>23</sup> The first generations of medical women carved out niches in the medical market, particularly in women's and children's health that leveraged the utility of their gender.<sup>24</sup> Outside of general practice, 'women's work' in medicine included medical missionary work and preventive medicine. It is important to emphasise that many medical women aspired to this work, and used these positions from which to influence policy and practice.<sup>25</sup> However, medical women generally faced discriminatory practices and more limited opportunities that reflects the gendered barriers that were common in medicine. For example, as advancement in medical knowledge increased specialisation in medical practice, women were more likely to be found in less prestigious specialisms, including anaesthesia, psychiatry and radiology; they were less likely to be a partner in a general practice; they were less likely to be promoted in the hospital system.<sup>26</sup> Women were also less likely to have participated in organised medical politics, for example, in the British Medical Association or the Royal Colleges.<sup>27</sup> The impact of these gendered barriers was emphasised for later generations of medical women – who were more likely to marry and have children – particularly as they sought to balance a career with the majority responsibility for domestic chores and child-rearing.<sup>28</sup>

Of the 569 British medical graduates registered in Victoria between 1930-60, twenty per cent were women. On average, one British medical woman was registered for every three women who graduated from the local medical school at the University of Melbourne in Victoria in the same period.<sup>29</sup> Although this latter measure is admittedly crude, for example, it does not account for interstate migration of women from other medical schools, it suggests that British medical women accounted for a significant injection of women entering the local medical market. This significance is compounded by the patterns of work displayed by these women – over three quarters of the 55 women who are the subjects of this case study worked in Australia, and this is likely an underestimate.<sup>30</sup> Recovering these women's stories then presents an opportunity to challenge the mainstream representations of medical migration as a male phenomenon, and to expand national histories of medicine to reflect the diversity of the individuals who shaped it.<sup>31</sup>

The analysis presented here is underpinned by a prosopographical database, the detail of which comprises the first section of the remainder of this article. The second section discusses these women's emigration from Britain. This section reveals the complex, interwoven reasons medical

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<sup>22</sup> For example, Witz, *Professions and patriarchy*; Ellen S More (2009) *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850-1995* (Harvard University Press); Kaarin Michaelsen (2005) 'Union is Strength': The Medical Women's Federation and the Politics of Professionalism, 1917-30, in Krista Cowman and Louise A. Jackson (eds.) *Women and Work Culture: Britain c.1850-1950* (Routledge), pp.161-76; Anne Hardy and Lawrence I Conrad (Eds.) (2001) *Women and Modern Medicine* (Rodopi); Pringle, *Sex and Medicine*.

<sup>23</sup> Ibid.

<sup>24</sup> Ibid. See also, Alison Bashford (1997) Separatist Health, Changing Meanings of Women's Hospitals in Australia and England, c. 1987-1920, in L.R. Furst (ed.), *Women Physicians and Healers: Climbing a Long Hill* (Lexington), pp.198-220.

<sup>25</sup> Ibid.

<sup>26</sup> Ibid.

<sup>27</sup> Ibid. See also, Louella McCarthy (2018) Finding a Space for Women: The British Medical Association and Women Doctors in Australia, 1880–1939 *Medical History*, 62(1), pp.91-111.

<sup>28</sup> Fett, Australian Medical Graduates; Elston, Women Doctors in the British Health Services.

<sup>29</sup> A total of 393 women graduated from the University of Melbourne between 1930-60. See Fett, Australian Medical Graduates.

<sup>30</sup> The medical work of ten women could not be reliably confirmed.

<sup>31</sup> Christiane Harzig (2001) Women migrants as global and local agents: New research strategies on gender and migration, in Sharpe, in P. Sharpe (ed) *Women, Gender and Labour Migration*, pp.15-28.

women sought to migrate, and how it reflects wider political and professional changes including the effects of two World Wars and the introduction of the British National Health System in 1948 as they affected these women. This section provides fresh insight into the motivations for British medical women to migrate. The final part of this article turns to the work of these women in Australia. This section is structured thematically, exploring these women's transitions and their engagement in medical politics respectively. Together, this section reveals the importance of networks – including the Queen Victorian Memorial Hospital; the structural disadvantages medical women in Australia faced, extenuated by the lens of migration; and the ways in which these women exerted their agency in their professional spheres. This article concludes by reflecting how this case study of migrant medical women helps enrich Australia's medical and migrant history, by complicating representations of privilege and marginalisation, as white, middle-class British medical migrants who leveraged (consciously or not) their position, set against the social and professional conservatism directed at (medical) women who wished to work.

### **The sample of women in context: a brief note on method**

This article draws its evidence from a database created using a random, representative sample of 55 out of 113 British and Irish medical women registered in the Australian state of Victoria between 1930-60.<sup>32</sup> The database contains detailed career information and biographical information for these women, and draws on a range of primary and secondary sources. The main sources are the entries in British and Australian medical directories,<sup>33</sup> the General Medical Council lists, and the Victorian medical registers. However, supplementary information was drawn from a mix of other sources, including registers of births, deaths and marriages in Australia, Britain, and Ireland; the national archives in the UK and Australia; and archives held at the Wellcome Library; the State Library of Victoria; and the various collections held at British and Irish universities from which these women graduated. Information was gathered also from semi-structured interviews and correspondence with surviving family members; and rarely, with surviving practitioners themselves. Some of the more prominent women have been the subjects of biographies, or had detailed obituaries dedicated to them; some women also feature in their husband's biographies, autobiographies and obituaries. Finally, the database records all medical publications, newspaper and other print media these women have authored, or are featured in.

It is important to note that the completeness of each individual's record is uneven, as is the reliability and completeness of many of the primary sources from which this study draws. Women are notoriously difficult to trace in available historical records, and this set was not immune to many of the contemporary practices that rendered women invisible, and therefore difficult to trace over time. For example, medical directory entries variably reported change of names; immigration officials routinely recorded their occupational status as 'housewife'. Additionally, medical directory entries rely entirely on self-reported career information; similarly, biographical and autobiographical accounts include the author's own interpretations.<sup>34</sup> The reliability of each source was considered on inclusion in the database, and throughout this article, each source is individually reported where possible.

**[Insert Table 1 around here]**

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<sup>32</sup> This approach ensures the sample of 55 reflects the probability distribution of the characteristics of the larger population of 113 women. For a full discussion of the methods of the wider project, see: Fallon Mody (2018) Revisiting post-war British medical migration: A case study of Bristol medical graduates in Australia, *Social History of Medicine*, 31(3), pp.485-509.

<sup>33</sup> The British entries were recorded every ten years, from 1931-2001. The Australian directories were published irregularly. Entries were recorded for 1935, 1948, 1957, 1966, 1978 and 1990. Where necessary, the 1954 and 1964 editions were consulted.

<sup>34</sup> Gidon Cohen (2002) Missing, Biased, and Unrepresentative: the quantitative analysis of multisource biographical data, *Historical Methods*, 35, pp.166-76.

## Leaving Britain, 1920-59

Of the 569 British medical graduates registered in the state of Victoria, over eighty per cent arrived after the war. This pattern is mirrored in the random sample of 55 women drawn for this study – only 14 women were registered between 1930-45 (Table 1). This reflects both the Depression of the 1930s that saw a greater degree of return migration to the UK, and subsequently the Second World War, which halted all but war-related travel. Similarly, the challenging economic climate of post-war Britain is an obvious framework within which these later migrations were conceived. In their study of post-war British emigration to Australia, James Hammerton and Alistair Thomson found that ‘limited prospects ... figure as the single most important triggers’.<sup>35</sup> This finding resonates for this study, including for earlier migration of medical women as you will see.

This section explores the overarching professional contexts for women in medicine that might have contributed to or inspired these women to leave Britain. However, the motivating factors that describe any migration decision – that is, the decision to leave, as well as the choice of destination – is more complex than the traditional push/pull framework, as historians have now established.<sup>36</sup> Life histories and micro analyses repeatedly highlight that rarely can a migration decision be explained by a single factor. In harnessing a wide array of biographical information to reconstruct the journeys of British medical women to Australia, a similar array of interacting motivations was revealed. Therefore, while the professional context emerged as critical factor that underpinned these women’s migrations, in the following discussion I also interweave these other factors which, I argue, enriches our understanding of the interplay between social and professional identity which shaped the mobility of British medical women in the twentieth-century.

The 1920s – when most of the interwar women were graduating from medical school (Tables 1 and 2) – was a precarious time for medical women, particularly in the UK where all but two of these women graduated from (Table 2). The large number of men returning from active duty following World War I, back to medical school or to their practices, created the perception of an impending oversupply of doctors.<sup>37</sup> Women, who had been admitted to medical school in unprecedented numbers during the war, were suddenly faced with a return to pre-war conditions.<sup>38</sup> This included the reintroduction of marriage bars, and the privileging of a man’s right to the limited number of employment opportunities available. Government-sponsored conservatism towards women prevailed. Women were encouraged to marry and prioritise family and domestic responsibility.<sup>39</sup> Quotas limiting female entrants were reintroduced in medical schools across Britain, and prominent public hospitals introduced quotas for the appointment of women to hospital posts. Some institutions, for example, the Manchester Royal Infirmary banned women entirely. Despite formal protest by both the British Medical Association and the British Medical Women’s Federation, women were also paid less in public hospital and public service posts.<sup>40</sup>

**[Insert Table 2 around here]**

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<sup>35</sup> Hammerton & Thomson, pp.64. See also, Table 2 on pp.65.

<sup>36</sup> Ibid.; Sharpe, *Women, gender and labour migration*.

<sup>37</sup> Elston, *Women Doctors in British Health Service*, pp.296-360.

<sup>38</sup> Ibid.

<sup>39</sup> Many historians have argued that women were encouraged to embrace this as a social duty. Recent scholarship has begun to nuance this consensus on the ‘triumph of conservatism’ in post-war Britain. The following provide useful reviews: Adrian Bingham (2004) ‘An Era of Domesticity’? *Histories of Women and Gender in Interwar Britain*, *Cultural and Social History*, 1, pp.225-233; and Martin Pugh (2015) *Women and the Women’s Movement in Britain since 1914* (London: Palgrave), particularly chapters 3 and 4.

<sup>40</sup> Elston, *Women Doctors in British Health*, pp.296-360; and Michaelsen, ‘Union is Strength’.

Throughout the 1920s and early 1930s there was a shrinking pool of opportunity for medical women. Apart from general practice, the most accessible posts were in salaried public health roles.<sup>41</sup> Historian and sociologist Mary Elston's review of the literature suggests that although women were broadly encouraged to follow in the footsteps of first generation medical women and seek opportunity overseas, interwar women graduates were relatively slower to take up these opportunities.<sup>42</sup> There was a slackening of interest in traditional sources of employment for medical women: the Colonial Medical Service and medical missionaries. The contemporary view suggests that the pathways of medical women in the interwar period *out of the UK* is best understood by considering prevailing conditions there. However, the career profiles of the 14 interwar women do not suggest they were driven by desperation or lack of opportunity in the UK. Half of them secured hospital experience before leaving, for example. This broadly corresponds to Elston's in-depth review of available British studies – although difficult, most interwar women graduates managed to find some hospital work.<sup>43</sup> Elizabeth White (née Cooper) is an excellent, if not exceptional, example of the former.

Cooper graduated in medicine with honours in pathology from the University of London in 1929, and obtained a Diploma of Public Health the following year. Cooper met a young physicist from New Zealand, Frederick White whom she had married in London in 1932. A year earlier, she joined Leonard Colebrook's team of bacteriologists as an assistant at the Bernard Baron Research Institute at Queen Charlotte's Hospital in London. This team studied puerperal sepsis – a bacterial infection of the uterus. Between 1936-37, they demonstrated that this condition could be treated using the new antibacterial drug Protonsil, and later using sulphonamides.<sup>44</sup> Their discoveries contributed to declining mortality rates from puerperal sepsis, prior to which 20-30 per cent of all infected women died.<sup>45</sup> White's contribution included several publications, including in the *Lancet* detailing the possible transmission of haemolytic streptococci by dust in hospital wards.<sup>46</sup> Hers was a promising career. However, her husband was appointed chair of physics at Canterbury University College in Christchurch in 1936, and they left for New Zealand shortly afterwards.

Elizabeth White's trajectory segues into another common reason afforded to medical women's mobility: following their husband's career. This does not hold for the 14 interwar women in this study, ten of whom were unmarried on leaving the UK. Finally, only three of the 14 women had a personal connection to Australia that might also explain their journey there – Minnie Varley (Australian born), Anne Gibb (whose husband was Australian), and Doris Officer (whose mother was Australian). A multitude of reasons – personal and professional – can be assigned to these women's journeys. These interwar pathways can also be understood as a particular expression of the mobility and opportunity afforded medical women in the broader British world.<sup>47</sup> Six of the 14 interwar registrations – Margaret Aikin, Winifred Corke, Doris Officer, Muriel Rippin, Minnie Varley, and Wilhelmina Wagenmaker – are known to have left Britain between one and five years from graduating (Table 1). However, ten of these 14 – including Elizabeth White – originally left the UK for destinations other than Australia.

Margaret Aikin and Winifred Corke, for example, both found initial posts in obstetrics at the Royal Free Hospital in London and in general medicine at the Royal Manchester Children's Hospitals

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<sup>41</sup> This was divisive issue among medical women in Britain at the time, with opponents seeing these 'dead end' roles as setting back the wider agenda of progress for medical women. For a discussion, see: *Ibid.*

<sup>42</sup> *Ibid.*, pp.296-360

<sup>43</sup> *Ibid.*

<sup>44</sup> PM Dunn (2008) Dr Leonard Colebrook, FRS (1883-1967) and the chemotherapeutic conquest of puerperal infection, *Archives Dis Child Fetal Neonatal Ed*, 93, pp.F246-48.

<sup>45</sup> Graham Ayliffe and Mary English (2003) *Hospital Infection: From Miasmas to MRSA* (Cambridge University Press), pp.136-37.

<sup>46</sup> Elizabeth White (1936) On the possible transmission of haemolytic streptococci by dust, *Lancet*, 227, pp.941-944; Elizabeth White (1933) On the Source of Puerperal Infections with Anaerobic Streptococci, *BJOG: An International Journal of Obstetrics & Gynaecology*, 40, pp.630-632.

<sup>47</sup> The 'British world' is an explicit adoption of the concepts posited in: Carl Bridge and Ken Fedorowich (2003) *The British World: Diaspora, Culture, Identity*, (London: Frank Cass).

respectively. Corke moved from Manchester to Liverpool to complete the Diploma of Tropical Medicine and Hygiene before accepting a position in the Malayan Medical Service. Aikin also served in the Malayan Medical service. Australian-born Minnie Varley came to Edinburgh to complete a medical education that had been interrupted due to ill-health, with the aim of joining her eldest sister as a missionary in Nigeria.<sup>48</sup> Varley also worked in a hospital in New Zealand before returning to Melbourne.

Aikin and Corke married while overseas – Corke to a British ex-serviceman turned planter in Malaya; Aikin to a Presbyterian clergyman. Two other pre-war arrivals – Mary King (medical officer) and Catherine Williamson (ophthalmologist) also married while living in Asia. The latter were evacuated during World War II, along with Corke, from Singapore and Hong Kong respectively. The Aikins left Singapore a fortnight before it fell, arriving in Australia ahead of Reverend Aikin's appointment with the Presbyterian church there in 1942.<sup>49</sup> Three other women were known to be living in Asia during the war, and were registered in Australia in 1942, however, no further detail can be traced. Of the 14 interwar arrivals, only Olive Buckley and Wilhelmina Wagenmaker's pathways are directly attributable to their professional development. Buckley, the daughter of the Baron of Wrenbury, graduated with an MBBS from Oxford in 1925. Her *curriculum vitae* included hospital experience at King's College Hospital in London, and membership of the Royal College of Physicians.<sup>50</sup> She had been awarded a Rockefeller fellowship, under which she arrived as a resident medical officer to the Queen Victoria Memorial Hospital for Women in Melbourne in 1933 to 'further her postgraduate experience'.<sup>51</sup> As was common with travelling unmarried medical graduates of both sexes, Buckley's stay was temporary. Similarly, Wagenmaker spent a year as a resident at the Queen Victoria Hospital, before returning to Edinburgh in 1938.

Buckley had also wanted 'to travel and to see Australia'.<sup>52</sup> Australia was not yet the desirable migrant destination it was to become in the post-war years.<sup>53</sup> This is reflected in the pathways of these women, which were circuitous, circumstantial and unplanned. Individual aspirations and inclinations regulated each woman's journey, but the imperial connections between their early career destinations – Australia, Britain, Hong Kong, Ireland, Malaysia, New Zealand, Singapore and Nigeria – are equally apparent. These women were able to express their own matrix of personal and professional ambitions within a framework of accepted, understood and established mobility afforded female British subjects. Indeed, in the case of colonial medical work and missionary work, it was considered their duty.

There is a distinct change, however, in the post-war arrivals, both in volume and in the concerted choice of Australia as a destination (Table 1). Of the 41 women registered after 1945, only three had worked in another country prior to arriving in Australia. The two broad interrelated factors that formed the framework within which a million migrant journeys were conceived in the post-war period swept doctors up too: the austerity of post-war Britain, and the sustained recruitment campaigns by Australian authorities across England, and other parts of the UK. Australia's post-war immigration drive is well documented, and in the early post-war years, British settlers were overwhelmingly preferred.<sup>54</sup> The inducements included cheap fares, from the free passage offered to ex-servicemen to the £10 assisted passage scheme. Between 1946-60, an estimated 580,000 assisted or free passages were undertaken by British settlers.<sup>55</sup>

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<sup>48</sup> Personal (19 August 1925) *The Argus*, p.18.

<sup>49</sup> No homes for two-child family says visitor (20 February 1942), *News*, p.5.

<sup>50</sup> Membership of the Royal College of Physicians (MRCP) was gained by examination, and was a marker for those aspiring to hospital consultant posts.

<sup>51</sup> Dr Olive Buckley (12 October 1933), *The Argus*, p.10

<sup>52</sup> Peer's Doctor Daughter Here (10 October 1933). *Herald*, p.1.

<sup>53</sup> For a discussion, see: Hammerton and Thomson, *Ten Pound Poms*, particularly pp.28-47.

<sup>54</sup> *Ibid.* See also, James Jupp (2004) *The English in Australia*, pp.28-31 and 131-139.

<sup>55</sup> *Ibid.*

For doctors, a third thread intertwines with this broader post-war migratory climate: the introduction of the British NHS in 1948. When the British Medical Women's Federation noted that after 1948 'the position of women was apparently satisfactory and the Federation could ... be relatively content', they were referring to the theoretically levelling nature of the NHS career ladder, which originally proposed a seven-year pathway to consultant from graduation. Women and men had equal opportunity under the system. However, the lack of consideration given to women in the early planning of the NHS meant that existing barriers for women aspiring to both a family life and consultant status were formalised under the new scheme.<sup>56</sup> Increasingly, postgraduate pathways implemented by the Royal Colleges were premised on a full-time working week. Married women with young children were least able to pursue these pathways. Women in post-war Britain continued to be disproportionately distributed across the medical workforce. They were now also more likely to be married with children, following unprecedented rates of marriage after the Second World War.

Twelve of the 41 post-war women were unmarried on arrival in Australia; the marital status of six others is unknown. On registration in Victoria, these eighteen women averaged five years since completing their primary medical degree. Ten of them were in junior hospital roles, and a further two were in senior hospital posts, including with specialist qualifications – one in surgery and the other in anaesthetics. (Table 3 documents the last known primary occupation for the sample.) Their departures align with the broader trend describing departures from the NHS by doctors around the seven-year mark when, for example, the diminished prospects of reaching consultant was clearer.<sup>57</sup> It was these women who experienced a different set of gendered experiences, most commonly in their inability or struggle to cultivate the informal networks and sponsorship to progress further in hospital-based specialties.<sup>58</sup> This included the required number and length of posts in a chosen speciality to qualify for the membership or fellowship examinations of the Royal Colleges. In this context, Australia and other Commonwealth destinations also represented an opportunity to cast wider in search of career progression. The British influence on the development of orthodox medical structures in Australia had established and sustained a number of embedded interconnections between the two medical systems. Importantly for these doctors, this included a number of Australian public hospitals that were accredited by British medical colleges. In this sense, Australia afforded British doctors a comparatively low-risk career progression strategy – especially if their original intention was to return.

**[Insert Table 3 around here]**

It was the disconnect between opportunities for married women and unmarried women that prompted criticism, consideration and consternation in the early NHS.<sup>59</sup> Women, however, were not alone in being disenfranchised by the new health system. The challenges facing young general practitioners particularly in the first two decades of the system is also well documented.<sup>60</sup> British born-and-trained doctors left the NHS *en masse* to Australia, Canada, New Zealand and other Commonwealth countries.<sup>61</sup> I have discussed the comparative appeal of Australia for migrating British doctors in the post-war period in more detail elsewhere.<sup>62</sup> This historiography, however, perpetuates contemporary representations of how manpower problems of the NHS were gendered:

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<sup>56</sup> Rosemary Stevens (2003) *Medical Practice in Modern England: the impact of specialization and state* (London: Transaction Publishers).

<sup>57</sup> Pringle, *Sex and Medicine*; Elston, *Women Doctors in British Health Service*.

<sup>58</sup> *Ibid.*

<sup>59</sup> *Ibid.*

<sup>60</sup> Martin Gorsky (2008) *The British National Health Service: a review of the historiography 1948-2008*, *Social History of Medicine*, 21, pp.437-60.

<sup>61</sup> Brian Abel-Smith and Kathleen Gales (1964) *British Doctors At Home And Abroad* (Hertfordshire: Cordicote Press); David Wright, Sasha Mullaly and Mary Colleen Cordukes (2010) 'Worse Than Being Married': the exodus of British doctors from the National Health Service, *Journal of the History of Medicine*, 65, pp.546-75; Mody (2018) *Revisiting post-war British medical migration*.

<sup>62</sup> Mody (2018) *Revisiting post-war British medical migration*.

men migrated, women married. Very little is known about the group of women who left the NHS, and the UK, except a passing generalisation by Brian Abel-Smith which suggested women doctors left because they were married to foreign nationals.<sup>63</sup> This latter finding expectedly does not hold for this study – only four of the 41 post-war women had any traceable familial connection to Australia.

Various expressions of opportunity in a family context, however, are apparent. *The Argus* reporting on recent arrivals in 1947 to Australia, noted that ‘23-year-old Dr Yvonne Capon accompanied by her parents ... and brother Brian [an engineering graduate] ... believe there are more opportunities, especially for young people, in a young country’.<sup>64</sup> The Horwills chose Australia as their retirement plan. Sir Lionel Horwill – the last British judge to leave India, noted on his arrival in 1950 that his medical wife Vera Horwill and their two children would soon join him from England. *The West Australian* reported that ‘it was because of the prospects ... that Australia offered their children that Sir Lionel decided to come’.<sup>65</sup> Peter and Denise Sherwood were one of fourteen medical couples. The Sherwoods left Bristol with their two children in 1956, on the Ten Pound assisted passage scheme. Denise Sherwood recalled the austerity of post-war Britain, and her recollection of the choice they made to migrate reflects the interplay between family responsibility and professional prospects:

[Our] main reasons for coming to Australia were that it was in the British Commonwealth, English speaking, our degrees were accepted by all states, and the financial rewards seemed good ... another reason for coming was the cheap fares ... and the national health service changed the conditions of work in GP/other work [greatly]; this latter change affecting family, finance, as well as professional life.<sup>66</sup>

To summarise, although the number of women departing in the post-war years was small in absolute terms, Britain appears to have been losing active medical women as well as men. This observation has been lost in the literature, because the historiographical focus so far has been on the national story of the British NHS. Women were a fractional component of migrating doctors in absolute numbers. As Mary Elston notes, it was the participation of women in the NHS that became ‘a minor industry’ in Britain in the 1960s, as administrators sought to improve medical staffing problems in the NHS.<sup>67</sup> Hidden in these studies are clues that the mobility of Britain’s medical women carried over and intensified from the interwar years. For example, a survey of graduates from the Royal Free Hospital in London between 1945-64 – one of the oldest and largest medical schools for women – published in 1969 found that of the 1,055 women who responded, 185 were overseas at the time; and 307 had spent some time overseas.<sup>68</sup> A quarter of the 163 non-respondents were also overseas at the time the survey was sent out.<sup>69</sup> In total, almost half the women graduates from the Royal Free Hospital had once left Britain or were overseas at the time the study was published. Earlier smaller studies, including two published in 1964 of Birmingham and Sheffield graduates found that between 10-14% of women surveyed were overseas at the time of the survey.<sup>70</sup> These latter studies offer valuable statistical context, and places the arrival of 113 British medical women in the one Australian

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<sup>63</sup> Abel-Smith, *British Doctors Abroad*.

<sup>64</sup> Nestor Passengers - Welcomed, *The Age* (11 October 1947), p.9.

<sup>65</sup> Legal Work Ended, *The West Australian* (21 September 1950), p.11

<sup>66</sup> Correspondence with Dr Denise Sherwood, 21 March 2016.

<sup>67</sup> *Ibid.*

<sup>68</sup> Ann Flynn and Frances Gardner (1969) The Careers of Women Graduates from the Royal Free Hospital School of Medicine, *British Journal of Medical Education*, 3, pp.28-42 - Tables 1 and 1b.

<sup>69</sup> *Ibid.*

<sup>70</sup> Unfortunately, no note was made of women who had spent time overseas in these latter studies. See: John Lunn (1964) A Survey of Sheffield Medical Women Graduating over the years 1930-1952’, *Medical Care*, 2, pp.197-202; Andrew Whitfield (1969) Women medical graduates of the University of Birmingham 1959-63’, *BMJ*, 3, pp.44-46.

state of Victoria alone, within a broader, continuous pattern of mobility of Britain's medical women. In this section, I explored the intertwined motivating factors and underlying professional contexts that shaped these women's decisions to leave the UK.

### **Lives and careers in Australia, 1930-80**

The sampling strategy adopted in this study means that there is significant overlap between arrival, working lives, death and departure. For example, by 1945, fifteen years after the first woman sampled was registered in Victoria, three of the fourteen women from the interwar cohort had left. By 1960, when all the 55 women in the sample had arrived in Australia, eleven women had already left. The majority of the women, however, settled permanently in Australia (most in Victoria) – eight out of the 14 interwar arrivals, 30 of 41 post-war arrivals.<sup>71</sup> These women were also more likely to settle in metropolitan centres – 39 of the 55 women only lived in a state capital.<sup>72</sup> The earliest death was of Minnie Varley aged forty-five, whose funeral notice records that 'she died suddenly' in 1945.<sup>73</sup> This was followed by Winifred Corke who died in 1949, aged forty-nine. The next two recorded deaths – that of Mary King and Doris Officer – were both in 1967. The immediate post-war decades mark the peak of the group's collective activity.

King and Officer also highlight the differential pursuit of a medical career displayed by these women. While Mary King had long retired from medicine, Doris Officer's death marked the end of a 37-year-career in infant and maternal welfare in Australia. Table 3 documents the final occupations recorded for the 38 women who spent the remainder of their careers in Australia. These careers, which spanned several decades, shows expected trends as their experience and work progressed. This includes a larger number of women working as general practitioners (13), specialists (10), and in public health (8). Therefore, the remainder of this section is structured thematically, focussing on their early transitions in Australia, and for those who stayed, their later political participation, as these themes highlight the contours of Australian medicine, and the spaces women were afforded and forged within it.

#### **Transitions**

The transition to a new working life is a key factor in many migration stories, and is often particularly complex for women.<sup>74</sup> This section will discuss the early transition experiences of these women, highlighting the barriers, enablers and networks that feature in the early experiences of this group. For much of the period in question, Australian doctors were predominantly in private practice, with GPs commonly performing a more complex set of procedures than was common in the UK, particularly surgery.<sup>75</sup> Salaried roles were less common, typically restricted to junior residencies, some diagnostic and administrative roles in hospitals; as well as state-funded public health roles.<sup>76</sup> The most prestigious roles were honorary hospital positions, as consultants. Additionally, a national health insurance scheme was never enacted unlike in the UK; the post-war national health scheme that was passed in 1953 differed significantly from the British NHS notably in preserving a direct fee-for-service relationship between GPs and patients, which was partially-subsidised by the government.<sup>77</sup> Pensioners and ex-servicemen were the only social groups entitled to free GP consultations after

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<sup>71</sup> The settlement status of two post-war arrivals is unknown. This pattern of settlement reflects the attitudes of post-war migrants from the UK to Australia, who were more likely to view their migration as permanent. See, Hammerton and Thompson, *Ten Pound Poms*.

<sup>72</sup> This contrasts sharply with the trend for male British doctors to work in country towns. See: Mody, *Revisiting post-war British medical migration*.

<sup>73</sup> Family notices, *The Argus* (2 April 1945), p.2.

<sup>74</sup> Sharpe (ed) *Women, Gender and Labour Migration*.

<sup>75</sup> Scotton, *Medical manpower in Australia*. For a discussion, see: Mody, *Revisiting post-war British medical migration*.

<sup>76</sup> *Ibid*.

<sup>77</sup> James Gillespie (1991) *The Price of Health: Australian Governments and Medical Politics 1910-1960* (Cambridge University Press).

1953. Prior to that, free primary and hospital care depended on the goodwill of the doctor, or by passing a means test respectively. Therefore, making a medical living in Australia was not only more vulnerable to economic downturns (as patients could not afford the out-of-pocket cost of a consultation), establishing a private practice required considerable capital outlay. Additionally, aspiring specialists required appointments to honorary hospital positions as well as getting referrals – both of which relied upon establishing strong professional networks.

Australian-born Minnie Varley was unusual in starting work as a solo general practitioner (GP). The cost of purchasing a practice was often prohibitive for recent graduates – local or migrant – particularly during the Depression.<sup>78</sup> It appears that Varley was effectively ‘squatting’, and her ability to appropriate her family home in an affluent suburb gave her a considerable head start. Many male migrants – including those with the capital to purchase a practice – struggled to break into the metropolitan market in Australia well into the post-war decades.<sup>79</sup> As you can see from Table 3, three other women started their Australian careers in general practice – Constance Napier did some locum work in Newcastle in 1952, as did Moira Palmer in 1957. Jane Caldwell arrived in 1956, and worked as a GP until 1961. It is likely that some of the sixteen women whose early work in Australia cannot be traced also undertook locum work (Table 3).<sup>80</sup>

One feature of Minnie Varley’s early transition back was her association with the Queen Victoria Memorial Hospital. The Hospital and the Victorian Medical Women’s Federation (VMWF) comprised the heart of local women’s medical activity. The founding of the ‘Queen Vic’ in 1896 as a ‘hospital for women, run by women’ also prompted the founding of the VMWF, and the two entities had a long-lasting collaboration.<sup>81</sup> For the first 30 years, the Queen Vic was the only hospital of its kind in the southern hemisphere, and drew medical women from across Australia.<sup>82</sup> It was integral for women seeking careers in increasingly competitive specialisms for much of its life – until 1956 when men were appointed as resident medical officers for the first time owing to persistent staff shortages.<sup>83</sup> In the 1930s, the Queen Vic succumbed to increasing pressure to become a teaching hospital, and accepted its first students in the late 1930s.<sup>84</sup> It also changed its rules to limit honorary appointments to one per person, to create further opportunity for younger staff.

The honorary appointment system where practitioners provided unpaid services to hospitals remained prevalent in Australian hospitals well into the 1970s – this is much later than in Britain.<sup>85</sup> A prestigious honorary appointment depended on a form of cultivated respect, patronage and recognition that again even many local men failed to break into.<sup>86</sup> At the heart of it, particularly in the most populated urban centres of Australia, was the BMA-university-hospital nexus.<sup>87</sup> In Victoria, the predominance of Australian-born, University of Melbourne trained men in honorary positions and prestigious lectureships was propagated across hospitals, particularly in consultant surgeon and

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<sup>78</sup> Ibid.

<sup>79</sup> Mody, Revisiting post-war British medical migration.

<sup>80</sup> The BMA in Australia – the largest membership body for doctors – insisted for much of this period that the profession was in danger of over-crowding. Despite this, the lack of locum relief was regularly discussed.

<sup>81</sup> Emma Russell (1997) *Bricks or Spirit? The Queen Victoria Memorial Hospital Melbourne* (Australian Scholarly Publishing).

<sup>82</sup> Ibid. See also, Louella McCarthy (2003) *Idealists or Pragmatists? Progressives and Separatists among Australian Medical Women, 1900–1940*, *Social history of medicine*, 16, pp.263-282.

<sup>83</sup> Russell, *Bricks or Spirit?*

<sup>84</sup> Ibid.

<sup>85</sup> Robert Evans (2005) *The Transformation of Australian Hospitals between the 1940s and the 1970s*, *Health and History*, 2, pp.101-125.

<sup>86</sup> Ibid; See also: Evan Willis (1989) *Medical dominance: The division of labour in Australian health care* (Allen & Unwin).

<sup>87</sup> Tony Pensabene (1980) *The Rise of the Medical Practitioner in Victoria* (ANU Press).

physician posts, with the notable exception of the Queen Vic.<sup>88</sup> Ten women started their Victorian career at the Queen Vic, and another four women shortly started working there. The nature and range of these early engagements reflects the strength of the Queen Vic as a prominent employer of medical women, and its role as a health care provider for women in the community. Doris Officer began her medical career there in 1930 as a clinical assistant to the antenatal department, and also the children's out-patients' department from 1932. Joan Spong was first appointed to the Children's Hospital in Melbourne. Spong suffered from muscle weakness after developing polyneuritis, following a bout of chicken pox. Her disability 'proved a major handicap' at the Children's Hospital, and 'she was advised to apply for a registrar appointment in radiology' at the Queen Vic.<sup>89</sup> Aileen Connon, a recent graduate from Belfast, joined the Queen Vic in 1956 as a registrar in obstetrics and gynaecology. The hospital by this stage was a recognised teaching institute for those aspiring to membership of the British Royal College of Obstetrics and Gynaecology.<sup>90</sup>

Although the Queen Vic attracted a high number of these women, it was not the sole recipient. One of Spong's peers from London's Royal Free Hospital, Yvonne Capon, was one of only three women appointed as a junior resident medical officer at the Royal Melbourne Hospital in 1947. She was the only woman who was not also a graduate from the University of Melbourne.<sup>91</sup> Other hospital appointments included Muriel Rippin's in 1934 as a resident medical officer at The Coast Hospital in Little Bay, New South Wales.<sup>92</sup> Mary Howson, a recent Edinburgh graduate, arrived in Melbourne in 1947 to join her brother who was already living there.<sup>93</sup> Mary Howson had secured a junior residency at the Children's Hospital in Melbourne, and on arrival reported she intended to stay two years. In this latter respect, Howson's intention foreshadows many of the younger arrivals who took up hospital posts.

Only four women were appointed as specialists on arrival, all in the post-war period. Joan Robinson, a graduate from Leeds in 1944, was attached to the Queen Vic as an honorary obstetrician; she held a postgraduate qualification from London's college of obstetricians.<sup>94</sup> Joyce Daws was head-hunted by the Queen Vic's honorary general surgeon, Lorna Sisely, to fill a surgical registrar position in 1956.<sup>95</sup> Daws was working at the Royal Free Hospital where she had been since winning a postgraduate scholarship in surgery in 1952. That same year, Daws became one of the few female Fellows of the Royal College of Surgeons in London.

Kathleen Blott, a Bristol graduate, was one of two appointed anaesthetists. Blott went to the Ballarat and Base District Hospital in 1954, when post-war shortages of doctors in Australia was exacerbated in rural and country centres. Rural hospitals had restricted access to funding, and were varyingly equipped.<sup>96</sup> Blott was hired as a full-time salaried anaesthetist, together with another British woman Heather Lopert (not in sample). Lopert reportedly found the facilities at the hospital so

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<sup>88</sup> Lists of hospital appointment published in the Medical Directory for Australia editions, 1935-66. Women are easily identified since it was editorial practice to print women's names in full, and initials for men.

<sup>89</sup> Yvonne Hurley and John Callander, Determined Medical Pioneer despite her own disability, *Sydney Morning Herald* (4 November 2010).

<sup>90</sup> Membership of the Royal Colleges was now considered a requirement for a specialist appointment. The Royal College of Obstetrics and Gynaecology required a minimum of two six-month residencies at recognised teaching hospitals. The Queen Vic gained that recognition in 1949. See, Russell, *Bricks or Spirit?*, pp.58-60.

<sup>91</sup> Medical Directory of Australia, 1948. NB: Capon is incorrectly listed as a graduate of the University of Melbourne in this list.

<sup>92</sup> Woman Doctor At "The Coast" (22 April 1934), *The Sun*, p.12.

<sup>93</sup> The Life of Melbourne, *The Argus* (16 November 1948), p.9.

<sup>94</sup> There were two British qualifications available for obstetrics and gynaecology. The Diploma (DRCOG) aimed at GPs, and the MRCOG aimed at consultants.

<sup>95</sup> Obituaries – Dame Joyce Daws, *The Cairns Post*, Aug 27, 2007.

<sup>96</sup> Many public hospitals in post-war Australia including in the capital cities, were under-resourced. This was only amplified in rural areas. See, for example, Anthea Hyslop (1989) *Sovereign Remedies: A history of the Ballarat Base Hospital 1850s to 1980s* (Allen and Unwin).

primitive that she was reduced to tears when she was first saw them.<sup>97</sup> Blott was one of only fourteen women in the sample who ever lived and/or worked in a rural or country setting in Australia, despite there being greater opportunities available.<sup>98</sup> The isolation, lack of professional development, and long hours deterred many practitioners from country practice, and continues to be a challenge for health administrators today. Many distinctive features of Australian medical practice have stemmed from attempts to address this issue.<sup>99</sup>

Medical women were a rarity in regional towns, stemming from a combination of the increased conservatism towards women in practice in these areas, and perpetuated by the lack of appropriate facilities.<sup>100</sup> For example, many regional hospitals could not accommodate resident women medical officers well into the 1950s, and most did not have married quarters.<sup>101</sup> Many of the women in this study in non-urban settings were married, and as often as not their husband's post is directly attributable to their early rural settlement. Denise Sherwood's first Australian home, for example, was in Ararat (Victoria). Her husband, a fellow Bristol medical graduate, was sponsored by the Victorian Department of Health for an appointment with the Ararat mental institute.<sup>102</sup>

Muriel Rippin became as far as is traceable the first woman to set-up subsidised private practice in Bungendore in 1934 – a small town, 38km from the Australian capital Canberra. As the *Goulburn Evening Penny Post* reported,

After a period extending over the past 11 months the Bungendore Medical Association has at last been successful in its quest for a medical officer, and on Thursday last, Miss Muriel Rippin ... who practises under her own name, arrived in Bungendore with her husband, Captain Stonelake ... [who] hopes to benefit in health through the climate here; he was badly gassed during the war.<sup>103</sup>

Bungendore's attraction for Muriel Rippin was clearly as much financial as it could be professional. In an interview in 1982, Rippin recalled she lived in a little wooden house, and regularly encountered patients with 'tonsilitis, bronchitis, pneumonia, and tummy problems. I don't seem to remember anything very serious, apart from the man who swallowed [a] bone one night'.<sup>104</sup> She later left Bungendore because she 'needed a little bit of postgrad study which at that moment I couldn't afford'.<sup>105</sup> She settled for a short residency at the Melbourne Children's Hospital instead.<sup>106</sup>

The local community periodically donated towards a fund, managed by the lay Bungendore Medical Association to subsidise – or rather incentivise – a medical practitioner to reside there.<sup>107</sup> Such arrangements were common in many country towns, where population numbers were too small to support a private practitioner, and state government assistance – in the absence of state or federal government control over medical practitioners – was limited to providing grants to boost the size of the income guarantee.<sup>108</sup> The Sherwoods, for example, later moved to Flinders Island under a contract with the Tasmanian government, who offered a subsidised scheme and relaxed regulations to attract a

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<sup>97</sup> Hyslop, *Ballarat Base Hospital*, 302-355.

<sup>98</sup> Scotton, *Medical manpower in Australia*.

<sup>99</sup> This includes the Royal Flying Doctors Service, Bush Nursing Centres, and the Wireless Health Service.

<sup>100</sup> Catherine Harding (2010) *Away from the Mainstream: Medical women in one region of rural New South Wales*, *Health and History*, 12, pp.42-60; Ian Braybrook (1993) *Gweneth Wisewould Outpost doctor* (Harcourt).

<sup>101</sup> See for example, *Decision On Resident Doctor*, *Riverine Herald* (28 November 1949), p.1

<sup>102</sup> Dr Denise Sherwood correspondence.

<sup>103</sup> Bungendore, *Goulburn Evening Penny Post* (11 July 1934), p.6.

<sup>104</sup> National Library of Australia, Interview with Muriel McPhillips (nee Rippin) by Beryl Armstrong (1982).

<sup>105</sup> *Ibid.*

<sup>106</sup> *Ibid.*

<sup>107</sup> Bungendore, *Goulburn Evening Penny Post*, 16 January 1935, p.8.

<sup>108</sup> Lack of doctors in country (23 June 1939), *The Age*, p.3.

full-time doctor.<sup>109</sup> While there, Denise Sherwood was pregnant with their fourth child, and she recalled being ‘consulted unofficially’, which included looking at skin lesions and removing blemishes.<sup>110</sup>

Denise Sherwood and Muriel Rippin hint at the extent to which gender relations and family dynamics were critical in shaping the transition and working lives of these women as well. Marriage and family is a dominant feature for this cohort. Of the 55 women, 29 women were married on arrival, six married shortly afterwards, and two were married but arrived without their husbands.<sup>111</sup> The marital status of six women remains unknown. Therefore, the ability and working conditions for married medical women in Australia features strongly in the collective patterns of their early resettlement.<sup>112</sup> In Australia, a combination of factors combined to provide little social and economic encouragement for a married woman to work throughout the period 1930-1966/7.

Marriage and fertility were integral to Australia’s post-war ‘populate or perish’ plan.<sup>113</sup> Women had a duty to reproduce, and additional incentives were introduced to encourage childbirth. Although many Australian women gladly left their wartime jobs to resume full-time homemaking, and ex-servicewomen rejected opportunities to enrol in vocational training to do the same, more married women chose to remain in the workforce compared to pre-war statistics.<sup>114</sup> Married *migrant* women were at the forefront of this post-war trend – they worked in unprecedented numbers by Australian standards.<sup>115</sup> Conservative views on family, the labour market and a woman’s role in Australian society were pervasive and enshrined in state and federal law. This included marriage bars that continued to be operational in the public sector, coupled with unequal pay. It was legal in all Australian states and territories for women to be paid up to one quarter less than a man.<sup>116</sup> Although the marriage bar was temporarily repealed during both World Wars, they were reinstated. Economic historians Tom Sheridan and Pat Stretton noted that the popular magazine *Women’s Day* ‘were surprised’ that 60 per cent of its readers were against married women working when surveyed in 1956. Their ‘unease hinged upon what was seen to be the best interests of young children’.<sup>117</sup>

The medical profession was not at the forefront of championing change for medical women. For example, as late as 1980, the Royal Australian College of General Practitioners was the only one of the medical colleges offering a formal retraining scheme for married women seeking to return to practise. South-African medical researcher Priscilla Kincaid-Smith (not in sample) moved to Melbourne in 1958 with her Australian husband. She remembers what a

terrible shock [it was]. I’d just come from one of the top jobs in London to a place where no one wanted to have a bar of me and employ me because I was a married woman. What made me most angry was the way everyone I spoke to thought it

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<sup>109</sup> Peter Sherwood (1958) Tasmanian Island Practice, *The Practitioner*, 181, pp.199-204.

<sup>110</sup> Dr Denise Sherwood correspondence.

<sup>111</sup> One of these women was shortly divorced, but the marital status of the other woman is unclear.

<sup>112</sup> Pringle, *Sex and Medicine*, p.32.

<sup>113</sup> The Minister for Immigration and Information Arthur Calwell, Commonwealth Parliamentary Debates, House of Representatives, 2 August 1945, Vol. 184.

<sup>114</sup> Collins, *Migrant Hands*, pp.43-44. Jean Martin and Catherine MG Richmond (1968) *Working Women in Australia* (Melbourne: s.n.).

<sup>115</sup> Ibid.

<sup>116</sup> Australia could not ratify the International Labour Organisation’s ‘Equal Remuneration Convention’ held in 1951 because states, not the federal government, legislated these matters. In 1960, only Australia, India, Ireland, Malaya, Switzerland and South Africa had a marriage bar operating in civil service. The marriage bar was removed at the federal level in 1965, and most states followed shortly after.

<sup>117</sup> Tom Sheridan and Pat Stretton (2004) ‘Mandarins, Ministers and the Bar on Married Women’, *The Journal of Industrial Relations* 46, pp.84-101.

was totally justified. You can't have women taking men's jobs, that was the sort of attitude.<sup>118</sup>

Although marriage bars had existed in the British civil service, they were largely abandoned after the Second World War. It is likely that some migrant women only fully appreciated these differences after arriving.<sup>119</sup>

A quarter of the British medical women who arrived in Australia spent some portion of their working life in a public-sector role, where both unequal pay and marriage bars applied until 1966/7. The impact of this would have been variable for these women, and the existing sources cannot accurately illustrate the extent to which it affected their careers and their family. One family member shared a letter their mother – a doctor in this sample whose migration followed separation from her husband – wrote of her experience with the Victorian Department of Health:

I came in at [age] 32 in 1956 ... I worked for 14 years as a "temporary" because I was a married woman (therefore no promotion, no overseas scholarships, no superannuation) and by the time I was awarded permanency I was: a) divorced and b) post breast cancer. So I was put on "limited" instead of full superannuation. My pension was thus reduced ...<sup>120</sup>

This quote is important because it reflects known practices in many Australian states before the marriage bar was officially removed in 1966.<sup>121</sup> Women including this doctor who were committed to or sought a full-time career in public health would have been disproportionately affected by these practises. This particular doctor's promotion coincided with her divorce being finalised in the early 1970s.<sup>122</sup>

#### Medical politics and the Victorian Medical Women's Federation

Women are conspicuously absent in the mainstream political histories of medicine in Australia. Participation in medical politics, however, was voluntary and required women to have the time to dedicate to it. Ione Fett's study of Australian medical graduates found that when segregated by marriage, unmarried women were most likely to have career patterns that matched medical men.<sup>123</sup> Many married women were unable to or unwilling to pursue specialist careers, let alone participate more in unpaid work in medical associations.<sup>124</sup> Even the sole medical women's group the Victorian Medical Women's Federation repeatedly discussed the poor numbers of membership, low rates of subscription and poor attendance at events.<sup>125</sup> At any given time, the annual reports of the Federation suggest between 10-20 per cent of local medical women were members.<sup>126</sup>

The Federation struggled throughout its history to gain momentum owing to its limited membership numbers. However, it remained the only state association for medical women, and its

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<sup>118</sup> Melissa Sweet (2000) 'Professor Priscilla Kincaid-Smith: A Remarkable Woman', *Australian Doctor*, <https://www.australiandoctor.com.au/news/professor-priscilla-kincaid-smith-remarkable-woman> Last Accessed 24 August 2017.

<sup>119</sup> The extent of this is difficult to gauge. The British Medical Womens Federation and the BMA in the UK did not publish advertisements in the BMJ or the MWF journals if it had unequal pay scales for men and women. The MWF actively vetted this. See: MWF archives, G.8-39 Posts, pay and conditions of service, career opportunities, etc, Archives of Wellcome Library.

<sup>120</sup> Letter by Dr AB to her family in 1982/3, anonymised on request.

<sup>121</sup> Marian Sawyer (Ed.) (1996) *Removal of the Commonwealth Marriage Bar – A Documentary History* (Women's Electoral Lobby), pp.25-37.

<sup>122</sup> Communication with family of Dr AB.

<sup>123</sup> Fett, *Australian Medical Graduates*.

<sup>124</sup> Elston noted similar patterns for British medical women in the NHS.

<sup>125</sup> Minutes of meetings of Committee of VMWS, MS11710 Boxes1879/2-5, Victorian Medical Women's Society Papers, 1912-1980, Archives of the State Library of Victoria.

<sup>126</sup> *Ibid.*

spheres of influence extended to representation on various boards and councils, including particularly longstanding relationships with the Free Kindergarten Union, the Victorian Baby Health Centres Association, the National Council of Women and the National Council on the Aging.<sup>127</sup> The Federation, similar to its British counterpart, sought to work with the British Medical Association (BMA) in Australia, and had representation on the state chapter's council. It also took active interest in contemporary issues facing women and their health in Australia, including the movement to abolish marriage bars and to gain 'equal pay, for equal work'. The Federation also worked with the Queen Vic to pilot hospital-based re-training schemes to encourage married women back into medical work.<sup>128</sup> Through the VMWF, medical women were able to simultaneously create and maintain professional networks, and have a voice in major issues.

Seventeen women in this study were members of the Federation – this represents roughly forty per cent of the women who spent any time in Victoria. The relatively high participation rate among migrant women possibly indicates the importance of female-only networks and support in adjusting to Australian life. Members had to be nominated by existing members; the only concerted recruitment efforts were directed at recent graduates from the University of Melbourne.<sup>129</sup> Therefore, for most of the migrant medical women, their membership would have resulted from direct relationships with colleagues at work, or by word-of-mouth. Apart from the direct connection with the Queen Vic, it appears the tendency for migrant women to settle in urban, rather than country, settings facilitated their ability to get involved in the Federation, and through it, in medical politics and wider issues affecting women. One list of members from 1969 shows that roughly 20 per cent of members had British or Irish qualifications.<sup>130</sup>

Some migrant women, through the VMWF, placed themselves in positions to also actively influence outcomes. Doris Officer, for example, served as president from 1945-46, and remained an active member of the executive committee for a number of years. Officer, in fact, was entrenched in this network – having worked at Queen Vic, and served as honorary secretary of the Victorian Baby Health Centres from 1937. Officer's 1948 meeting with the head of the Public Service Board prompted the Federation to form a deputation to lobby for equal pay for men and women in the public system.<sup>131</sup> This was an issue that the Federation monitored and participated in until women won the right to equal pay in 1967. Others, including Joan Spong and Joan Robinson, were longstanding members of the executive, and served periods as assistant secretary (1960/1) and treasurer (1961/2) respectively.<sup>132</sup>

Finally, Joyce Daws served as the Federation's representative on the state BMA branch council from 1964-66, and again from 1972. One of her peers, Sandra Hacker AO remembered that Daws 'entered the world of medical politics with gusto'.<sup>133</sup> Daws never married, and by this stage she was an established, and well-known thoracic surgeon in Melbourne. In 1958 she was appointed senior honorary surgeon at the Queen Vic – a post she held to 1985. She also worked as an honorary assistant in the thoracic unit at the Royal Melbourne Hospital between 1958 and 1967, and at Prince Henry's Hospital from 1967-87.<sup>134</sup> Daws went on in 1975 to become president-elect of the Victorian BMA branch. She was also the first woman to do so in the 123-year history of the BMA in Australia. Daws commented of her appointment, 'I hope I have achieved something for women as a result of this election. I hope at some time, other women will stand for office and succeed'.<sup>135</sup> Her comment reflects the lack of women in prominent political positions in medicine. However, through the

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<sup>128</sup> Ibid.

<sup>129</sup> Ibid.

<sup>130</sup> Ibid. This amounted to 45 out of 254 members listed.

<sup>131</sup> Ibid.

<sup>132</sup> Ibid.

<sup>133</sup> Joyce Daws Obituary.

<sup>135</sup> Barbara Hooks (8 Jan 1975), *Woman Surgeon Breaks Through*, *The Age*, p.X.

VMWF, British medical women found a local network from which they could extend influence over matters important to them – for Joyce Daws, the nationalization of health care; for Doris Officer, infant and maternal health. According to her biographer, some of Officer’s last words were, ‘Bother, it’s Health Week and I won’t be there’.<sup>136</sup>

## Reflections and conclusion

The patterns this study elicited insist upon a complicated reading, one that highlights the intersection of social and professional forces in shaping the particularly unique ‘interstice of power’ that British medical women occupied in Australia. The aim of this paper has been to interweave this multiplicity of factors, to create a cohesive narrative that describes British medical women in mid-twentieth century Australia. How are migrant medical women remembered in Australia? The simple answer is selectively. For example, four women in this sample – Doris Officer, Joyce Daws, Helen Connell and Aileen Connon – received Australia Day honours; some of these women have been memorialised, notably in the *Australian Dictionary of Biography*. Their migrant status and related experiences, however, are eclipsed by themes of nation-building and the assumption these women were not migrants.<sup>137</sup> A related question then is who do we pick to remember, and how do we choose to remember them?

Some studies single out medical elites and measure success against a familiar matrix in medicine: the achievement of consultant status (for specialists), practice partnership or sole ownership (GPs), or a similar level of marked seniority. Outstanding success in medicine is reserved for those who make significant, original contributions to their field, or to the structures and defining institutions more broadly. Roughly half the women in this study satisfy these conventional measures. Historian Carolyn Rasmussen considered the extent of the leadership medical women in twentieth-century Australia displayed. Rasmussen describes leadership as conscious participation, in fulfilling natural inclinations and ambitions, women who participated in the medical workforce were automatically part of creating and consolidating new norms, actively ‘enlarging opportunities for future women’.<sup>138</sup> By this latter measure, the women in this study played a prominent part in mid-twentieth century Australian medicine.

These perspectives whilst valid, are inadequate to fully capture the complexity represented by this group of women because it reinforces women’s role on the fringes of medical practice, separated by power, ‘pay and prestige’.<sup>139</sup> At the other extreme, celebratory accounts of pioneering women portray heroines who overcome these barriers, and prevailed against all odds. Medical historian Louella McCarthy labelled this the ‘victims or pioneers’ approach, and recognizes that historians continue to ‘search for and celebrate women doctors this way’.<sup>140</sup> A criticism it is worth noting levelled at histories of migrant lives too.<sup>141</sup> This study, in trying to be sensitive to these critiques, focussed on integrating these migrating women’s lives into a narrative that balanced the impact of structure, group dynamics and agency. As historian Anne Marie Rafferty observed, ‘women, wherever they are located in time and space, appear simultaneously to use and be usurped by their gender’.<sup>142</sup>

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<sup>136</sup> Cheryl Crockett, ‘Officer, Doris Lyne (1898–1967)’, *Australian Dictionary of Biography*, National Centre of Biography, Australian National University, <http://adb.anu.edu.au/biography/officer-doris-lyne-11288/text20143>, published first in hardcopy 2000, accessed online 18 April 2018.

<sup>137</sup> Hammerton and Thomson, *Ten Pound Poms*.

<sup>138</sup> Rasmussen, *Medicine*.

<sup>139</sup> *Ibid.*

<sup>140</sup> Louella McCarthy (2006) *Filtered Images: Visions of Pioneering Women Doctors in Twentieth-Century Australia*, *Health & History*, 1, pp.91-110.

<sup>141</sup> See, for example, James Hammerton and Catharine Colebourne (2001) *Ten-Pound Poms Revisited: Battlers’ Tales and British Migration to Australia 1947-1971*, *Journal of Australian Studies*, 25, pp.86-96.

<sup>142</sup> Rafferty, *Women and Modern Medicine*, 3.

Of course these women were not simply a single homogenous group. What binds their stories together is the gendered lens with which the rest of the profession and society viewed them, and how these views constrained or challenged each woman's personal and professional ambitions. Considered as a collective, an important story of migration and working life emerges instead: one that highlights the role of medical women as, if not quite the 'agents of empire' of an earlier era,<sup>143</sup> then still an important feature of British-Australian imperial connections that left a significant legacy of participation in Australian medicine. Thus migrant medical women deserve a place in Australia's history of twentieth-century migration, and its history of medicine not solely because a subset of these women had conventionally successful lives, but because in reframing their participation as a cohort of migrant workers, their significance becomes much more apparent. Their collective biography is subsequently inseparable from the wider history of medical women in Australia; and their collective participation, following traditional and non-traditional pathways for medical women, enriches how women migrants in Australia might be remembered.

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<sup>143</sup> See for example, Chilton, *Agents of Empire*.

## Tables

**Table 1 Summary of characteristics of British medical women registered in Victoria, 1930-60 (n=55).**

	Total	Year graduated from primary qualification			On arrival in Australia			Marital status			
		1920-1935	1936-1945	1946-1960	Held postgraduate qualification	Worked in another country	Average years since graduation	Married before leaving UK	Married on arrival in Australia	Married while living in Australia	Unknown
Interwar registrants, 1930-45	14	14	-	-	7	10	14	2	8	2	1
Post-war registrants, 1946-1960	41	4	10	27	16	3	8	23	21	3	6
<b>Total</b>	<b>55</b>	<b>18</b>	<b>10</b>	<b>27</b>	<b>23</b>	<b>13</b>	<b>9.5</b>	<b>25</b>	<b>29</b>	<b>5</b>	<b>7</b>

**Table 2 Sample of British and Irish medical women by place of graduation.**

PLACE OF PRIMARY QUALIFICATION		Women - ALL	Women – sample (1930-45 group)#
ENGLAND	Birmingham	3	0
	Bristol	4	3
	Cambridge	4	1
	Durham	8	2
	English conjoint*	25	12 (4)
	Leeds	1	1
	Liverpool	2	1
	London	26	12 (4)
	Manchester	8	5 (2)
	Oxford	5	1 (1)
	Sheffield	1	1
SCOTLAND	Aberdeen	5	4 (1)
	Edinburgh	9	7 (2)
	Glasgow	4	1 (1)
	Scottish double/triple^	3	1 (1)
	St Andrews	7	3 (1)
WALES	Wales	3	2
NORTHERN IRELAND	Belfast	7	5 (1)
IRELAND	Dublin	3	2
		N=113**	N=55 (N=14)
	Total degrees	123	63 (18)

\* Nine women had conjoint and another degree, 6 from London medical schools, Cambridge (2) and Oxford (1). ^One woman also had degree from Manchester. \*\*Place of qualification for one woman is unknown.

	Full sample of women (n=55)			Permanent settlers in Australia (n=38)	
	Last occupation before arriving (interwar)	First occupation on arriving (interwar)	Last known occupation in Aus (interwar)	First occupation on arriving (interwar)	Last known occupation in Aus (interwar)
General Practice (inc. locums)*	2 (0)	4 (1)	13 (2)	4 (1)	13
Hospital - General	14 (0)	17 (4)	9# (3)	10 (0)	-
Hospital - Honorary (all)	1 (1)	0 (0)	1	-	1
Specialist practice (inc. hospitals)	4 (1)	4 (0)	11	3 (0)	10 (0)
Teaching	1 (0)	0 (0)	4 (1)	-	4 (0)
Research	1 (1)	3 (0)	2 (1)		
Public Health (inc. missionary)	7 (4)	4 (0)	9 (4)	3 (0)	8 (0)
Other (inc. military service)	0 (0)	1 (1)	1	1 (0)	-
Retired/Not working (inc. temporarily)**	7 (2)	6 (2)	3 (1)	6 (0)	3 (0)
Unknown/cannot be classified*	18 (5)	16 (6)	10 (3)	11 (0)	3 (0)
Total	55	55	63 <sup>^</sup>	38	42 <sup>^</sup>

**Table 3 Summary of known medical roles held by British medical women in Australia. \*This is likely an underestimate, however, until the 1970s it was rare for practitioners to declare 'GP' in medical directory entries. \*\*This is also likely an underestimate, however, women rarely declared career gaps in their medical directory entries.**