Doctors Down Under: European Medical Migrants in Victoria (Australia), 1930-60

Fallon Kiran Mody

ORCID ID: 0000-0002-0596-7590

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Department of History & Philosophy of Science

School of Historical & Philosophical Studies

Faculty of Arts, University of Melbourne

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Abstract

The middle of the twentieth-century saw an unprecedented mass relocation of medical practitioners – through forced migration, military service, and as economic migrants. Between 1930-60, over three thousand medical migrants – that is, overseas-trained medical graduates – are known to have arrived in Australia. Their arrival was transformative as they challenged longstanding Australian legislative structures, and came to occupy critical gaps in local medical manpower. However, medical migrants in Australia are understudied. My research begins to redress what historians have called the 'conspicuous silence' or 'collective amnesia' that characterises nation-centric medical histories, where medical migrants are largely invisible. Through a series of case studies, underpinned by a prosopographic database documenting over two hundred 'European medical migrants', I examine the resettlement and professional lives of two broad groups registered in the state of Victoria between 1930-60: British and Irish medical migrants (the privileged invisible) and continental European medical migrants (the marginalised 'aliens'). Each case study can stand alone, and addresses an identified gap in the historiography. However, taken together, these case studies enable a more nuanced reflection of the differences and intersections between groups of medical migrants that historians have tacitly held as being too disparate to study collectively. Key outcomes of this research include the recovery and contextualisation of the 'special types of labour' medical migrants undertook; the impact of gender in the process; and the agency displayed by more marginalised groups of medical migrants.

Declaration

This is to certify that:

- the thesis comprises only my original work towards the PhD
- due acknowledgement has been made in the text to all other material used,
- the thesis is fewer than 100 000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signed: Fallon Mody

Date: 16 November 2018

Preface

This thesis is a 'thesis with publication'. It includes three publications reproduced in their entirety, and one chapter is an updated version of an early publication, which is reproduced in Appendix 6. I am the sole author of these peer-reviewed publications, and they have all been published. The article in descending order of publication are:

> Mody, Fallon. "Migrant Medical Women: A Case Study of British Medical Graduates in Twentieth-century Australia." *Women's History Review* (advance publication available online September 2018, https://doi.org/10.1080/09612025.2018.151382).
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> Mody, Fallon. "Revisiting Post-war British Medical Migration: A Case Study of Bristol Medical Graduates in Australia." *Social History of Medicine* 31, no. 3, (2018):485-509, https://doi.org/10.1093/shm/hkx009.
>
> Mody, Fallon. "The Intellectual Boys are the Ones in a Mess': The Unregistered Doctors Association in Victoria, 1951–56." *Health & History* 17, no. 1 (2015): 17-36.
>
> Mody, Fallon. "Racial Prejudice in the Medical Profession? The Case of Jewish Refugee Doctors in Australia, 1930-45." *Proceedings of the 1st Melbourne University Research Conference on History and Philosophy of Science* (University of Melbourne, 2013), 21-30. University of Melbourne, 2013.

These publications have been reproduced in accordance with the published self-archiving policies of each journal.

Additionally, the publications above and Chapter 7 benefited from feedback received from the following conferences and workshops:

> Mody, Fallon. "Professional Lives, Interrupted: 'Alien' doctors in Australia, 1930-80." Paper presented at the 15th Biennial Conference of the Australian and New Zealand Society of the History of Medicine (ANZSHM 2017), Australian Catholic University, Melbourne, July 2017.
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> Mody, Fallon. "A Question of Individual Determination? Immigrant Women Doctors in Victoria (Australia), 1930-1960." Paper presented at Workshop on Health, Medicine and Mobility: International Migrations in Historical Perspective, University of Prince Edward Island, Charlottetown, June 2016.
>
> Mody, Fallon. "Aliens and Alliances: Immigrant Doctors and State-Subsidised Health Care in Australia, 1930-1960." Paper presented at Biennial Conference of the European Association of History of Medicine and Health Conference, Cash and Care: Economics and Values in the History of Medicine and Health, Cologne, September 2015.
>
> Mody, Fallon. "Racial Prejudice in the Medical Profession? The Case of Refugee Jewish Doctors in Australia 1930-1945." Paper presented at the 1st Melbourne University Research Conference on History and Philosophy of Science, University of Melbourne, February 2013.

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Finally, to Raian – my best friend, and the man crazy enough to marry me. Thank you for reading every word of my thesis, multiple times over. This thesis would not have been possible without you. Taking my cue from Gina Linetti, who memorably declared that, 'the English language cannot *fully* capture the depth and complexity of my thoughts, so I'm incorporating emoji to express myself…': ♥ 🍎 😘. *Shukran kteer kteer*.

Table of Contents

Abstract ii

Declaration iii

Preface iv

Acknowledgements v

List of Tables viii

List of Figures ix

List of Third Party Copyright Material in Thesis x

List of Commonly-used Acronyms xi

Glossary of Terms xii

Introduction 1

Part I – Context 22

Chapter 01: Distinct Forms of 'Collective Amnesia': The Historiography of European Medical Migrants in Interwar and Post-war Australia 23

Chapter 02: The Structure, Practice and Politics of Medicine in Australia, 1930-ca.1970 45

Part II – Privileged & Invisible: Two Case Studies of British and Irish Medical Migrants 70

Introduction to Part II – Case Studies of British and Irish Medical Migrants in Context 71

Chapter 03: Revisiting Post-war British Migration: A Case Study of Bristol Medical Graduates in Australia [publication] 81

Chapter 04: Migrant Medical Women: A Case Study of British Medical Graduates in Twentieth-century Australia [publication] 108

Part III – Alien & Marginalised: Three Case Studies of Continental European Medical Migrants 134

Introduction to Part III – Case Studies of Continental European Medical Migrants in Context 135

Chapter 05: 'Are These Men Trained to Our Standard of General Medical Work … I Am Sure Not' – Re-examining the Social and Professional Responses to Jewish Refugee Doctors in Victoria, 1930-45 149

Chapter 06: The Intellectual Boys are the Ones in a Mess: The Unregistered Doctors Association in Victoria, 1951-56 [publication] 171

Chapter 07: 'Lost Years and Wasted Lives'? A Case Study of European Medical Migrants in Victoria, 1930 – ca. 1966 188

Conclusions 222

Appendices **232**

Appendix 1: Prosopography as a Methodological Approach to Writing Histories of Medical Migrants **233**

Appendix 2: Defining and Creating a List of European Medical Migrants Registered in Victoria, 1930-60 **241**

Appendix 3: The Prosopographic Database – Sources and Structure **250**

Appendix 4: List of Medical Migrants Registered in Victoria, 1930-59/60 **270**

Appendix 5: Example Biographical Dossier **295**

Appendix 6: Racial Prejudice in the Medical Profession? The Case of Refugee Jewish Doctors in Australia 1930-1945 [publication] **298**

Bibliography **309**

List of Tables

Table 1 Summary of medical migrants registered in Victoria, 1930-59/60 9

Table 2 Rank of medical specialisations by perceived prestige 68

Table 3 Summary of British medical migrants registered in Victoria by country and place of primary medical qualification (n=569) 73

Table 4 Summary of top ten overseas-born residents in Australia as a percentage of total population 75

Table 5 Summary of post-war British migration to Australia 76

Table 6 Updated 'Table 1 Overseas medical graduates registered in Victoria, 1930-60' 81

Table 7 [in publication as Table 1 Overseas medical graduates registered in Victoria, 1930-60] 86

Table 8 [in publication as Table 2 British and Irish medical graduates registered in Victoria, Australia, by year and place of graduation (n=563)] 87

Table 9 [in publication as Table 3 1952 Bristol graduates–career summary before leaving UK] 89

Table 10 [in publication as Table 4 1952 Bristol graduates–career summary in Australia, 1952-present] 98

Table 11 [in publication as Table 1. Summary of characteristics of British medical women registered in Victoria, 1930-1960 (n=55) 115

Table 12 [in publication as Table 2. Sample of British and Irish medical women by place of graduation.] 116

Table 13 [in publication as Table 3. Summary of known medical roles held by British medical women in Australia.] 121

Table 14 Summary of country and year of graduation from primary medical degree (n=87) 140

Table 15 [in publication as Table 1 Summary of conditions for non-British migrant doctors] 179

Table 16 Summary of first and last known medical roles in Australia 191

Table 17 Summary of last known primary medical role prior to arriving in Australia 192

Table 18 Summary of work undertaken during gap (unregistered) years (n=54) 193

Table A1 List of medical registers published in the *Victoria Government Gazette*, 1931-1960 242

Table A2 Summary of final count of medical migrants, by cohort, registered in Victoria, 1930-59/60 244

Table A3 Final sample of European medical migrants used to construct the prosopographical database 248

Table A4 Summary of changes to count of European medical migrants in Victoria, 1930-1960 249

Table A5 Prosopographic questionnaire 251

Table A6 Summary of additional primary sources used to populate biographical dossiers 253

Table A7 Summary of entries in Australian medical directories, by cohort 258

Table A8 List of 743 European medical migrants registered in Victoria, 1930-59/60 270

List of Figures

Figure 1 Map of Australia with states and territories, with capital cities and major towns labelled xiii

Figure 2 Map of Australia's population, 1921 Census 51

Figure 3 Map of Australia (excluding Tasmania) showing reach of Flying Doctor Service 52

Figure 4 Distribution of medical practitioners in Australia, 1933-66 64

Figure 5 Cartoon by Stewart McCrae, ca.1970 66

Figure 6 Net migration to Australia, 1901-60 74

Figure 7 Examples of advertisements recruiting British medical graduates in the *BMJ,* 1953 and 1955 78

Figure 8 Advertisement recruiting British medical graduates for country hospitals in Victoria 79

Figure 9 Year of arrival and registration of continental medical migrants (n=87) 139

Figure 10 [in publication as Image 1. Inaugural meeting of the Lithuanian doctors association in 1964 at the residence of Dr I. Kaunas] 186

Figure 11 Map of continental medical migrants in country towns, 1930-70 203

Figure 12 One mile march to protest Arthur Deery's dismissal from the Healesville Hospital 209

Figure 13 Summary of doctor:population ratios for 1947, 1954 and 1966 215

Figure 14 Map of Metropolitan Melbourne ca. 1964, with table describing the distribution of registered continental medical graduates in private practice, 1957 (n=28) and 1966 (n=42) 217

Figure A1 Sample of application form for temporary wartime license from Hungarian Margaret Karoly 261

Figure A2 An example of Medical Board of Victoria minutes documenting continental European medical migrant applications – summary for George Hermanis Kaire 263

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List of Commonly-used Acronyms

Acronym	Definition
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AMA	Australian Medical Association. The AMA was established in 1962, following an amalgamation of former state chapters of the British Medical Association in Australia
BMA	British Medical Association
DP	Displaced Person
GMC	British General Medical Council
GP	General Practitioner
IRO	International Refugee Organisation
L, M or F RCP	Licentiate, Member or Fellow of Royal College of Physicians
LSA	Licentiate of the Society of Apothecaries (Britain)
LMSSA	Licentiate in Medicine and Surgery of the Society of Apothecaries (Britain)
MBBS	Bachelor of Medicine, Bachelor of Surgery
MBChB or MB BChir	Bachelor of Medicine, Bachelor of Chirurgy; from the Latin *Medicinae Baccalaures Baccalaureus Chirurgiae*
MD	Doctor of Medicine
M or F RCS	Member or Fellow of the Royal College of Surgeons (UK)
M or F RACS	Member or Fellow of the Royal Australian College of Surgeons
NAA	National Archives of Australia
NHI	National Health Insurance scheme in Australia
NLA	National Library of Australia
NHS	British National Health Service
NSW	Australian state of New South Wales
PROV	Public Records Office of Victoria
QLD	Australian state of Queensland
RACGP	Royal Australian College of General Practitioners
SA	Australian state of South Australia
TAS	Australian state of Tasmania
UDA	Unregistered Doctors Association
UNRRA	United Nations Relief and Rehabilitation Administration
UK	United Kingdom
VIC	Australian state of Victoria
WA	Australian state of Western Australia

Glossary of Terms

Term	Definition
Alien	This term implied foreign nationality in Australia, i.e. immigrants who were not British subjects.
Alien doctor	This was a commonly used term to describe medical practitioners holding unrecognised degrees; Other commonly used terms included, 'foreign doctor', 'refugee doctor, and 'DP doctor'.
BMA in Australia	Describes the collection of Australian state branches or chapters of the BMA.
DP doctor	See 'Alien doctor'.
DP scheme	A post-war assisted passage migration scheme for European Displaced Persons implemented by Australia.
Enemy alien	Nationals from countries at war with Australia in World War I and II.
English conjoint	MRCS/LRCP – entry level qualification in the UK by the Royal College of Surgeons and the Royal College of Physicians.
European medical migrant	A catch-all category to describe the heterogeneous groups of predominantly overseas-born medical graduates registered in Victoria as a medical practitioner on the basis of their European medical qualification(s). Europe is broadly-defined, and includes British, Irish and continental European medical schools.
Heterodox medicine/practitioners	See 'Orthodox medicine/practitioners'.
Irregular medicine/practitioners	See 'Orthodox medicine/practitioners'.
Medical migrant	A catch-all category to describe the heterogeneous groups of predominantly overseas-born medical graduates registered in Victoria as a medical practitioner on the basis of their foreign medical qualification(s).
New Australian	Term popularised by Australia's first Minister for Immigration, Arthur Calwell, to describe non-British immigrants, typically from Europe.
Orthodox medicine/practitioners	There is no standard way in which historians of medicine describe categorise medical/healing practices. Orthodox or 'regular' practitioners refers to medical practice characterised by biomedical knowledge regimes, and as being distinct from 'irregular' or 'heterodox' practitioners. The latter 'irregular' or heterodox practitioners include Chinese medical men, chiropractors, herbalists, homeopaths and hydropaths.
Refugee doctor	See 'Alien doctor'.
Regular medicine/practitioners	See 'Orthodox medicine/practitioners'.
Scottish triple	MRCSEd/LRCPEd/RFPSG – an entry-level triple license jointly issued by the three Royal Colleges of Scotland: the Royal College of Surgeons of Edinburgh, the Royal College of Physicians of Edinburgh and the Royal Faculty of Physicians and Surgeons of Glasgow.

Figure 1 Map of Australia with states and territories, with capital cities and major towns labelled.



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Introduction

This thesis comprises a series of five case studies, each of which examines an episode in the collective biography of a group of European medical migrants – that is, graduates from European medical schools across Britain, Ireland and continental Europe – registered in the Australian state of Victoria between 1930-60.[1] It is estimated that over three thousand medical migrants arrived in Australia, mostly from Europe, during this period.[2] These arrivals represented the largest injection of foreign practitioners since the gold rush era of the 1850s.[3] Since then, Australia's geographic isolation, in combination with protective legislation and the establishment of local medical schools, had resulted in Australia's local medical workforce being almost entirely made up of locally-born and locally-trained practitioners.[4] By the 1930s medical migrants were barely a noticeable group.[5] However, this was soon to change. The arrival of thousands of medical migrants in the middle of the twentieth-century was transformative. By 1967, influential health economist Richard Scotton observed that, 'a decline in immigration … could seriously affect … particular areas which are already dangerously dependent on immigrant doctors'.[6] Medical migrants comprised a small fraction of the total medical workforce,[7] however, in the process of resettling as outsiders in a hierarchical medical profession, they had come to disproportionately occupy particular domains of medical work. A key outcome of this thesis is the recovery of the 'special types of labour' medical

1 In this thesis, the term 'European medical migrant' is used as a catch-all category to describe the heterogeneous groups of predominantly overseas-born medical graduates registered in Victoria as a medical practitioner on the basis of their European medical qualification(s). As such, Europe is broadly-defined, and includes British, Irish and continental European medical schools. The term 'medical migrant' is used over 'migrant doctor' because the latter term suggests individuals who are actively practising medicine, and does not accurately capture the (changing) work status of some groups who are the subjects of this study.

2 The number of arrivals quoted is an estimate since there are no reliable statistics that describe the flow of European medical migrants in and out of Australia. Therefore, the estimate is based on a triangulation of the following sources. Estimates of British/Irish doctors are based on: Last, 'Migration of British Doctors to Australia'; and Seale, 'Medical Emigration from Great Britain and Ireland'. The numbers of continental European medical migrants are harder to triangulate owing to more variable reporting and documentation of occupational information in the surviving records. John Weaver estimates approximately 102 resident continental medical migrants in 1942, see: Weaver, 'A Glut on the Market'. Egon Kunz estimates 370 doctors arrived as part of the Displaced Persons scheme. See: Kunz, *The Intruders*, 23.

3 Ibid.; Pensabene, *Rise of the Victorian Medical Practitioner*, 57-9.

4 This was not unique to Australia. One consequence of the development of regional or national systems of medical licensing was that medical registration laws were designed to align with local standards of medical education. These parallel developments underpinned the agitation by national groups of practitioners to professionalise medicine, and a consequence of this success was that the mobility of medical students and practitioners by the turn of the twentieth-century was largely dictated 'along imperial and linguistic lines' (Monnais and Wright (eds.), *Doctors Beyond Borders,* 5. See also, Grell et al., *Centres of Medical Excellence?*

5 Pensabene, *Rise of the Victorian Medical Practitioner*, 57-9.

6 Scotton, 'Medical Manpower in Australia', 985.

7 Ibid.

migrants undertook (or were assigned) in their new professional setting.[8] In doing so, my work begins to redress what a growing number of historians recognise as the 'conspicuous silence' or 'collective amnesia' in nation-centric histories of medicine where medical migrants are largely invisible, apart from select individuals who rose to prominence in their particular medical domain.[9] The implication of this silence is that medical migrants are irrelevant to national medical history unless they were exceptional.

Situating this study

Aside from the celebration of individual achievement, in the Australian context only very specific *groups* of medical migrants have been of historical interest. The observation by migration historians James Hammerton and Alistair Thomson that historians 'tend to move quickly past the British … to focus on the more dramatic and challenging story of the New Australians' aptly characterises the historiography of twentieth-century medical migration to Australia.[10] So far, it is the marginalisation of groups of continental European medical migrants or so-called 'alien doctors' – many of whom arrived as refugees and Displaced Persons (DPs) – that has received the most historical attention, notably from migration historians.[11] The majority of these studies focus on what historian Paul Weindling characterised as a 'regulatory approach' in that they uncover and explore 'a tradition of anti-alien administrative responses' by political actors.[12] There are very few studies of groups of continental European medical migrants which recover life histories or collective biographies of the group beyond their early marginalisation.[13]

British and Irish doctors, on the other hand, are invisible as a group in the historiography.[14] This invisibility appears to be underscored by the assumption that the privileges afforded British subjects in Australia, including British medical graduates, made them synonymous with their locally-trained counterparts. British colonisation of Australia in 1788 resulted in pioneering *orthodox* Australian medical practices and structures being modelled on

8 Simpson et al., 'Providing "Special" Types of Labour', 208.

9 Monnais and Wright, 'Introduction', 14; Simpson et al., 'Writing Migrants Back into NHS History', 392-396; Haynes, *Fit to Practise,* 202-06. It is not possible to exhaustively cite examples of these (auto)biographical accounts, most commonly remembered in wider national memory projects. See for example, Crockett, 'Officer, Doris Lyne'; and Blackburn, 'Lambie, Charles George (1891–1961)'.

10 Hammerton and Thomson, *Ten Pound Poms*, 11. NB: 'New Australian' was a termed popularised by Australia's first Minister for Immigration Arthur Calwell to describe non-British settlers or 'aliens' in post-war Australia.

11 Studies of groups of doctors have focussed on two specific cohorts of so-called 'alien doctors' – a commonly used term to describe practitioners holding unrecognised degrees; and often implied foreign nationality (not British subjects). For Jewish doctors, see: Rutland, *Take Heart Again*; Rutland, 'An Example of "Intellectual Barbarism"'; Weaver, 'A Glut in the Market'; and Winterton, 'Alien Doctors'. For post-war arrivals on the Displaced Persons scheme, See: Kunz, *The Intruders.*

12 Weindling, 'Medical Refugees in Britain and the Wider World', 455.

13 This feature is characteristic of the wider historiography too. See: ibid. I will discuss this further in Chapter 1.

14 Individual biographies and obituaries are the primary form of memorialising these individuals. See, MacLeod, 'Colonial Doctors and National Myths', 125-142.

English and Scottish structure and practice.[15] An enduring legacy of this colonial relationship was the introduction and preservation of a mutually beneficial principal of reciprocity between Britain and its former dominions.[16] Graduates from medical schools in Britain, Ireland and many parts of the former British Empire could arrive and register to practise medicine in Australian states and territories without any further legislative barriers. Prior to the Second World War, British graduates leveraged this access to an extended medical market selectively and in relatively small numbers.[17] However, the introduction of the British National Health Scheme in 1948 catalysed what has been called an 'exodus' of British doctors to countries in the Commonwealth network.[18] Five times as many British medical migrants arrived in Australia between 1946-1960 than had in the previous three decades.[19] By this time, these practitioners too were relative outsiders.[20] Yet, the invisibility of groups of British medical migrants in the Australian historiography is largely perpetuated. In this respect, Australian medical historians have lagged behind their migration historian counterparts: since the 2000s, there has been marked growth in the number of histories exploring British migrant experiences.[21]

To summarise, the historiography to date is characterised by distinct types of collective amnesia, where groups of medical migrants are represented as marginalised (continental European medical migrants), or are largely invisible (British and Irish medical migrants). A novel aspect of the approach adopted in this thesis is that it intersects the two disciplines in which the current historiography sits – migration history, with a focus on 'alien' doctors, and medical history focused on 'exceptional' doctors. In this thesis, I examine the professional lives of groups of British, Irish and continental European medical migrants. The focus on the ethnicity of these doctors that has characterised the past studies (or the lack of them) was not prioritised when formulating the overarching research approach. Instead, emphasis was placed on two key factors: evidence of a primary or registrable medical qualification obtained overseas which immediately signalled a category of 'other' in Australian medical manpower terms; and a reliable, uniform indication that these individuals eventually worked as medical practitioners in Australia. These two factors were considered more crucial in framing a study that aimed to redress the invisibility of medical migrants in Australia through a study of their professional

15 Emphasising 'orthodox' here serves to highlight that Indigenous Australian healing practices comprises a much older history. The historiography on pioneering orthodox practices is too large to cite exhaustively. See for example, Dyason, 'Medical Profession in Colonial Victoria; Simpson, 'English Roots of Medical Education in Australasia'.

16 Haynes, *Fit to Practise,* 36-55.

17 Pensabene, *Rise of the Victorian Medical Practitioner,* 61-2.

18 Wright et al., '"Worse than Being Married"'.

19 Last, 'Migration of British Doctors to Australia'.

20 Poate, 'Capacity of the Medical Profession in Australia'; Pensabene, *Rise of the Victorian Medical Practitioner.*

21 See for example, Hammerton and Thomson*, Ten Pound Poms;* Wills, 'Passengers of Memory'; Jupp, *The English in Australia*.

lives, where the emphasis is squarely placed on the professional status of these men and women.[22]

Categories of medical migrant and the historiography: local vs global approaches

As discussed above, a novel aspect of my research is that I reframe who counts as a 'European medical migrant' in mid-twentieth century Australia to include British and Irish medical graduates. It is worth noting here that this approach is novel in the Australian context owing to the historiographical traditions briefly outlined above. However, the growing international scholarship on late nineteenth- and twentieth-century medical cohorts and medical migration has repeatedly demonstrated the value of not restricting studies of medical migrants by a single characteristic – be it ethnicity, religious affiliation, mode of arrival, or medical school.[23] Historians Julian Simpson, Stephanie Snow and Aneez Esmail recently discussed the significance of grouping overseas-trained doctors as a category of 'migrant doctor' in their study exploring the impact(s) of these doctors on the 'making of the NHS' in Britain.[24] The authors of this latter study capture beautifully the core points that influenced my own work, which is while

> it is important … to recognize the extreme diversity of experience behind the label of "migrant doctors" … constructing these doctors collectively as migrants in the National Health Service is essential to facilitate our understanding of a key dimension of the development of the NHS … It is, in this context, a label designed to facilitate an analytical reflection that highlights common points between the experiences of doctors who moved across national borders…[25]

Similarly, historian Delia Gavrus reflected on a recent edited volume examining the forced migration of European refugee neuroscientists in historical perspective, noting the limitations of generalisations and trends that emerge from studying narrowly-defined groups. Gavrus observes that:

> It may be instructive then to look at these two literatures — on the voluntary and the involuntary migration of physicians and scientists in the middle of

22 It is widely understood that multiple, intertwining social, cultural and political factors shape migrant identities and experiences. This thesis is limited to exploring themes as they emerged as relevant to understanding the *professional* trajectories of groups of European medical migrants.

23 For example, Wright et al., 'Worse than Being Married'; Mullally and Wright, 'La Grande Seduction?'; Crowther Dupree, *Medical Lives in the Age of Surgical Revolution*. This includes edited volumes that group case studies describing wider groups of tertiary-qualified migrants, for example, Marks, Weindling, and Wintour (eds.), *In Defence of Learning*.

24 Simpson et al., 'Providing "Special" Types of Labour'.

25 Ibid., 212.

> the twentieth century — in order to fully understand the unique details of each case.[26]

Although published more recently, both the above studies parallel the formulation of my own work, and reflect the rationale that shaped my own work: they signal a maturity of the historiography on medical migration.[27] These scholars too recognise the limitations of past approaches, and suggest the potential for future research to redraw categories or groups in order to extend historical understanding, as I have done in this study.

In doing so, I have grappled with the implications and limitations introduced by the process of creating the analytical category 'European medical migrant' to explore, with the primary aim of addressing the silences of existing histories. The eventual scope of this thesis and the methods adopted, that is the focus on European medical migrants, on collective professional lives, on a specific Australian state (Victoria), and the specific time period (1930-60) were driven by this primary aim, as well as the time limitations and resource constraints imposed on the viable scope of a PhD project. Therefore, it is important to ground the remainder of this thesis by introducing and discussing this scope further.

Scope and approach

From the beginning, the aim of this project placed the medical migrants themselves as a central focus. The arrival of medical migrants in twentieth-century Australia was contingent on satisfying the conditions of its prevailing immigration policies; as well as successfully registering as a legally-qualified medical practitioner. The latter relied on having your qualifications recognised by the relevant state medical board. 'White Australia' policy – or the federal *Immigration Restriction Act 1901* – effectively precluded a large cross-section of the global population from gaining authorised entry into Australia. The success of this policy is evident in the remarkable homogeneity of Australia's population. In 1933, for example, the Australian Census reported a non-European population of 0.99 per cent.[28] The 1901 Act was officially replaced by the *Migration Act 1958* which removed the controversial dictation test, but retained restrictions on non-European immigration.[29] The unofficial relaxation of 'White Australia' policy was only seen in the 1960s.

It was within this framework that the first appreciable group of medical migrants are known to have arrived in Australia – Jewish refugees fleeing National Socialism in the mid-late 1930s. Italian medical graduates were able to take advantage of a reciprocal recognition

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26 Gavrus, 'Émigré Scientists and the Global Turn', 366.

27 NB: Both publications arose from papers presented at conferences held in September 2012 and July 2013 respectively. I began my PhD candidature in July 2012.

28 ABS, 1933 Census.

29 The dictation test enforced between 1901-58 allowed immigration officials to subject non-Europeans to write 50 words in any European language prescribed by the officer. 'White Australia' policy was officially repealed in 1973 with the removal of reference to race from federal immigration policy. For an overview of Australian immigration policy and its implications on Australia's demographics from 1901-73, see: Jupp, *From White Australia to Woomera*, 5-20.

agreement brokered by the governments of the United Kingdom and Italy at the turn of the century to register in Australia.[30] However, many more Jewish refugee doctors arrived holding degrees that were not recognised in state medical acts, preventing them from legally practising medicine. These doctors were forced to either retrain, practice illegally, or abandon their profession.[31] Migrant numbers swelled following the end of World War II when Australia implemented an unprecedented immigration drive in response to the bipartisan political belief that Australia must 'populate or perish'.[32] Amongst the million immigrants who arrived in the following two decades were hundreds more continental European practitioners whose degrees were similarly not registrable.[33] In the late 1950s, following two decades of agitation, restrictive state legislation that was deliberately introduced to quell a feared 'influx of continental practitioners' were liberalised to allow foreign (non-British) qualifications to be recognised.[34] During this period however, and particularly in the post-war period, thousands of British and Irish practitioners are known to have arrived in Australia.[35]

The time period chosen for this study was therefore limited to the period 1930-60 to capture the arrival and registration of appreciable groups of medical migrants. It made sense to cap the time frame within the bounds of significant changes in Australian immigration policy to contain the study within a reasonable scope. The unofficial relaxation of 'White Australia' policy in the 1960s resulted in the first significant entry of professionally-qualified migrants from South Asia, as well as South African nationals of colour.[36] Therefore, the timeframe of this study was limited to arrivals up to 1960. This decision does not mean to imply that the histories of migrant arrivals after 1960 are unimportant, but to begin to limit the scope of the study to ensure the ability to complete a more in-depth analysis. Recently, scholars including Dimitria Groutsis and Peter Arnold have studied aspects of the migrant experiences of South-African doctors arriving in the 1960s and 1970s, however, the histories of cohorts of Asian doctors in post-war Australia remains to be written.[37]

Having drawn a broad category of analysis for this study – European medical migrants – and narrowed the focus to examining their professional lives, it was necessary to consider sources available to reconstruct their professional lives. Medical registers and medical

30 Weaver, 'A Glut in the Market'.

31 Rutland, *Take Heart Again*.

32 This widely used slogan was popularised by Australia's first Minister for Immigration Arthur Calwell, but was originally the title of a book by John Harold Gaffney published in 1943.

33 Rutland, *Take Heart Again;* Egon Kunz, *The Intruders*.

34 Ibid.

35 Last, 'Migration of British Doctors to Australia'.

36 Groutsis and Arnold, 'South African-trained Medical Professionals in the Australian Labour Market'.

37 Ibid.; Arnold and Lewinsohn, 'Motives for Migration of South African Doctors to Australia'. NB: Few historical analyses of South-Asian doctors in Australia exists. There is a considerable body of sociological and practise-based literature on the experiences of and policies governing migrant doctors or 'International Medical Graduates', particularly Asian and African migrants, in contemporary Australia. For example, Hawthorne, 'International Medical Migration'; Spike, 'International Medical Graduates: the Australian Perspective'.

directories are two obvious and commonly used sources by medical historians – the former provides definitive evidence that a practitioner was legally registered to practice medicine in a particular geopolitical area, the latter was a regularly published resource for tracing career pathways over time.[38] Hand-searching medical registers which typically published full names, addresses, place and year of medical qualification and date of registration would yield a list of foreign medical migrants in Australia. A compiled list of names would be a sufficient basis from which to harness not only medical directory entries, but any biographical information available in a multitude of published sources, including private repositories, genealogical databases, obituaries in medical journals, and records held in national archives, as well as oral histories.[39] Bringing these sources together promised to build a fuller picture of migrant medical work, particularly one which did not privilege medical elites who were more likely to be represented in archival records and (auto) biographical sources, for example.

Preserving the centrality of medical migrants themselves, coupled with the need to make sense of this multiplicity of available sources, led directly to the choice of prosopography – as what historian Katharine Keats-Rohan emphasises is 'a uniquely source-critical historical method' – as a key part of the methodological approach utilised in this study.[40] At the heart of 'new' or modern prosopographical method is the transformation of multiple and varied primary source material through uniform questioning.[41] There is considerable confusion over the term prosopography as a methodological approach that is related to but distinct from collective biography, although the two terms are often used interchangeably.[42] Additionally, historian Katharine Keats-Rohan observes that the meaning of prosopography as used in historical research is 'plural', making definitions of prosopography 'more descriptive than prescriptive.[43] Therefore, prosopography in this study aligns with the definition of historian Hilde de Ridder-Symoens as:

> A collective biography, describing the external features of a population group that has something in common (profession, social origins, geographic origins, etc.). Starting from a questionnaire, biographical data are collected

38 Dupree and Crowther, 'The" Medical Directory" as a Historical Source'; Weisz, 'Medical directories and medical specialization'.

39 Although the period of this study – 1930-60 – logically precluded reliance on oral history methods alone.

40 Keats-Rohan, 'Chameleon or Chimera? Understanding Prosopography', 26.

41 Prosopography has its origins in classical studies, however, these prosopographies are typically lexicons. For a discussion of the emergence of modern prosopographical techniques, see: Stone, 'Prosopography', 46-79.

42 Keats-Rohan, 'Chameleon or Chimera? Understanding Prosopography', 20. See Appendix 1 for further discussion.

43 Ibid. Some historians argue for a greater degree of prescriptiveness. See for example, Oldfield, 'Narrative, Biography and Prosopography', 35-60.

> about a well-defined group of people. On the basis of these data answers may be found to historical questions.[44]

The original population of interest in this study was defined as European medical graduates – where European is broadly defined to include British and Irish graduates – registered to practise medicine in Australia on the basis of their foreign qualification between 1930-60. However, this was soon redefined to limit the study to the state of Victoria for the reasons outlined below.

First, medical registrations were regulated at the state, not federal level, in Australia until 1978.[45] Therefore, to exhaustively compile a list of names of medical migrants would require access to thirty years of state medical registers for every state in Australia. At the time this study began in late 2012, none of the state medical registers were digitised, with the exception of the Victoria.[46] Considerable time and resources would be required to simply gather the names of the base population. Second, if the numbers of British and Irish graduates estimated to have arrived in Australia were accurate, the population size was estimated to range between two to three thousand practitioners – this was considered to be too large for a prosopography to be compiled by a single individual.[47] To maximise the completeness of the data captured for each individual, the scope was revised to a single state in Australia. The state of Victoria was chosen over all other Australian states because it is the second most populated state in Australia and was the most popular migrant destination *during the period under investigation* ensuring a sufficiently diverse population could be drawn upon. As historian Geoffrey Blainey summarised:

> The pace of immigration from Europe quickened, and more of the migrants settled in Melbourne. It had plentiful jobs … it was the first port of call for ships which came through Suez. Immigrants went in the train from Port Melbourne to the large camp at Bonegilla … Melbourne was the great gainer from the first phase of post-war immigration. Sydney was often depicted as a city of all nations, but post-war Melbourne was at first more cosmopolitan

44 de Ridder-Symoens, 'Prosopografie en middeleeuwse geschiedenis', as translated and cited in: Verboven at al., *Short Manual to the Art of Prosopography*, 39.

45 In 1978 a national examination was introduced under the guidance of the Australian Medical Examining Council. This council was overseen by a federal body, the Commonwealth Committee on Overseas Professional Qualifications. This Council formed in 1978 was replaced by the Australian Medical Council in 1985, which is still operational today.

46 The NSW government gazettes are now digitised and searchable on *Trove*, the digital repository managed by the National Library of Australia.

47 Seale, 'Medical Emigration from Great Britain'; and Last, 'Migration of British Doctors to Australia'. NB: The time and resource-intensiveness of prosopography is considered one of the biggest limitations of using this method. For a discussion, see: Keats-Rohan, *Prosopography Handbook*; Hall et al., *Legacies of British Slave-Ownership,* 262-89.

> … Some time in the mid-1960s most of the immigrants no longer arrived in ships … but came instead in aircraft which usually landed in Sydney …[48]

Despite Victoria's importance as an interwar and post-war migrant destination, very few existing studies focus on this state.[49] Equally importantly, being the home state for this project, Victoria was chosen over the more populous state of New South Wales to maximise access to important primary source material housed in public and private institutions.[50]

Table 1 Summary of medical migrants registered in Victoria, 1930-59/60.

	Full cohort registered in Victoria	Sample in this study	Percentage (rounded up)
British and Irish men	456	86	19%
British and Irish women	113	55	50%
Other European men and women	87	87	100%
Rest of the World men and women	87	OUT OF SCOPE	
Total	743	228	-

Source: Victorian medical registers, 1931-60.

Finally, in pursuing the common first phase in prosopography – the compilation of a list of names – a manual search of the medical registers of the state of Victoria published in the *Victorian Government Gazettes* from 1931-1960 captured 743 medical practitioners registered between 1930 and 1959/60 solely on the basis of an overseas medical degree (Table 1).[51] Of these 743 practitioners, 569 held British and/or Irish degrees (33 of whom only held an Irish degree), and 87 held degrees from other European medical schools. Additionally, a further 87 registrants were registered using degrees from other parts of the world.[52] The numbers of New Zealand doctors (69), in particular, was surprising since they appeared to have been counted as Australian in much of the preceding literature published on overseas medical practitioners in Australia.[53] Given the time-consuming process of creating a multi-source prosopographical database, it became clear early in the project that an additional sampling strategy would be required to restrict the study's population. Therefore, the 87 non-European qualifiers were kept

48 Blainey, *A History of Victoria*, 223-4.

49 For example, both Rutland and Weaver's work predominantly focus on New South Wales and Queensland respectively. This will be discussed further in Chapter 1.

50 See Appendix 3.

51 NB: The registration year and publication year of the medical register was not always the same. Additionally, the 1961 register appears to not have been published, therefore, the full count for 1960 was not available. For a detailed discussion of the inclusions and features of this list, see Appendix 2.

52 The breakdown of the 87 is as follows: New Zealand (69), South Africa (5), India (5), Pakistan (2), United States of America (2) and one each from Canada, Ceylon (Sri Lanka), Hong Kong, and Singapore.

53 Julian Simpson and his colleagues noted a similar conflation between British and Irish degree holders in the British context, in Simpson et al., 'Providing "Special" Types of Labour'.

out of scope for this thesis in line with the original aim to focus on European qualifiers. This, of course, represents both a limitation of this study as well as an opportunity for future research.

To make this additional strategy robust necessitated preserving the representativeness of the fuller population, prompting early reflection upon the 'extreme diversity' of the remaining 656 European medical migrants (Table 1).[54] Expectedly, further classifications revealed that the overwhelming majority were British/Irish graduates (569), and only 87 men and women held continental European degrees. Additionally, 113 out the 569 British/Irish graduates were women. Of the 87 continental European graduates, 19 were women. Therefore, to reconcile both the dominance of the British/Irish graduates, as well as enable a study of migrant medical women, it was decided to stratify the cohorts according to broad region of qualification, and randomly sample only the 456 British and Irish men, and 113 British and Irish women for further analysis (Table 1). This sampling strategy was adopted in consultation with the University of Melbourne's Statistical Consulting Centre to ensure that the quantitative implications of doing so were fully appreciated. Essentially, patterns found among the British and Irish cohorts of men and women were randomly sampled to be representative of the wider cohort, and patterns found in the sample could be tested against and/or related back to the main cohort. However, direct and simple statistical comparisons between the sampled cohorts would not be possible without further data collection. For example, *direct* statistical comparisons for career outcomes between British and Irish men and the British and Irish women could not be made.

Further limitations of this sampling strategy

The process of drawing analytical categories and samples for study necessarily comes with further limitations than those discussed above. The samples were drawn based on broadly grouping their primary or qualifying medical degree by place of graduation, differentiating between Britain and Ireland, and continental Europe. This approach relied upon the longstanding development of national medical systems which increasingly tied recognition of a medical degree to local medical standards, which in turn tended to restrict the mobility of medical students to obtaining medical degrees that would be recognised in the region or nation they intended to practice in.[55] Simply put, the focus on finding overseas medical graduates registered in Victoria relied upon the assumption that most, if not all, of these graduates would also not be Australian-born. That is, these men and women would also be migrants. This was of particular concern for the cohort of British and Irish degree holders, for while it was increasingly uncommon for Australians to travel to the UK for undergraduate medical study, it was still possible for them to do so. This assumption broadly held – only two men and one woman were found to be Australian-born in the sample drawn.

Similarly, the broad grouping of British and Irish graduates and continental European graduates relied upon the related, logical assumption that most of these medical migrants could not intersect between these two groups. For the reasons outlined below, this approach could only

54 Ibid., 221.

55 For a discussion, see: Grell et al., *Centres of Medical Excellence?*; and Bonner, *Becoming a Physician*.

retrospectively account for a single, notable exception: continental medical migrants who sought to retrain in the UK prior to migrating to Australia.[56] The extramural Scottish Triple was the fastest pathway available in Britain for growing numbers of Jewish doctors fleeing continental Europe who sought to retrain in the 1930s in the hope of securing their future professional careers in Britain, or the number of Commonwealth destinations open to them with a British qualification.[57] Local medical groups across Australia successfully mobilised to prevent the recognition of these requalifiers in 1938 after a German Jewish doctor, Moritz Meyer, fought to be registered in Victoria.[58] For a brief period, it was possible for these individuals to be registered in Victoria on the basis of a Scottish qualification, despite having first and primarily qualified in continental Europe. Meyer, for example, had originally qualified in Leipzig, Germany.[59] Since their continental degrees were not recognised, these individuals would have been recorded in the Victorian medical registers as holding only a British degree, and captured in my database as such. The example of these individuals clearly complicates classification into discrete categories. Moritz Meyer was randomly drawn in the sample of British and Irish men, and for consistency has remained there. In total, ten individuals – all men – were found in the wider cohort of 569 British qualifiers who intersect the two broad categories. It is immediately evident that their resettlement experiences will fit closer to that of the continental European medical migrant category. As I will discuss below, I believe the flexibility of the case study approach adopted to structure the analysis of the prosopography largely mitigates the challenge raised by individuals who intersect the analytical categories created. However, it is important to highlight challenges and limitations of the approach taken in this study.[60]

A third consideration was the complexity of the relationship between the United Kingdom and the now Republic of Ireland during the period, which included the mobility of medical students and medical graduates between the UK and Ireland was considered when broadly classifying cohorts. Ultimately, the decision to group British and Irish medical graduates together when stratifying the cohorts for sampling was based on these factors: recognition afforded the degree holders; ease of travel to Australia; as well as the high volume of Irish-born citizens who trained in Britain. Throughout the period 1930-60, all British and Irish medical degrees were recognised by the respective Victorian medical act in force, and British and Irish subjects could freely travel to Australia. That there were only 33 Irish medical graduates out of the 569 British and Irish medical migrants identified (Table 1) suggested that Australia was not as popular a destination for Irish graduates as was the United States of America, for example.[61] Therefore, British and Irish degree holders were grouped when the representative samples were drawn, and it was decided if the more detailed analysis of the sample flagged specific patterns

56 Collins, 'European Refugee Physicians'.

57 Ibid.

58 'Law Check on Influx of Foreign Doctors', *The Courier Mail,* 10 August 1938, 4.

59 Ibid.

60 For a discussion of the methodological challenges of utilising life histories and multiple sources, see: Putnam, 'To Study the Fragments/Whole'.

61 Jones, 'Irish Medical Emigration to the United States in the 1950s'.

with respect to the cohorts of men and women holding Irish degrees, a case study of Irish-born qualifiers could be attempted in the future. A further limitation of this thesis, therefore, is that it does not fully explore the group of Irish-born medical graduates in Victoria. Once again, this is an avenue for further research.

Two final notable limitations of the adopted approach described above are discussed here. First, it cannot provide insight into the work of medical migrants who never sought or successfully regained legal recognition as medical practitioners in Victoria. The use of the Victorian medical registers to identify medical migrants for this study increases the likelihood that those individuals worked in their professional capacity. This is particularly notable for the continental medical migrants who faced a greater number of barriers to re-establishing their professional status, as will be discussed. Therefore, only examining the professional activity of legal registrants might understate the marginalisation and overstate the professional successes and contributions of this group of continental European medical migrants. However, there are very few records that reliably document the occupation status of medical migrants whose degrees were not recognised, and many applicants for migration concealed their professional qualifications when it became known that Australia sought to restrict the numbers of such migrants.[62] To a large extent, they only become visible as overseas-qualified doctors in the available archives when they reveal their professional identity, typically by applying for legal recognition.

The Victorian Medical Board archives illustrates this process. It contains a working register of unrecognised doctors who applied to sit the newly introduced examination from 1958 onwards.[63] This reveals a number of individuals who, despite multiple attempts, appear never to have passed this exam.[64] Similarly, the records of the Unregistered Doctors Association preserved by Egon Kunz reveals hundreds of names of post-war medical migrants who were once unregistered.[65] A brief cross-examination with medical registers and medical directories revealed that a large proportion of these individuals eventually gained registration – some are included in this study, some in other states in Australia, some after the period with which this study is set. These sources are fragmentary; and it may never be possible to compile a definitive list of these individuals. However, an exhaustive search was deemed beyond the scope of this thesis. The work of the doctors in this study in their unregistered capacities is discussed in Chapter 7, and partially reflects the likely experiences and work undertaken by their counterparts who never regained legal status as a medical practitioner. The findings in this chapter suggests an avenue for future research.

62 Kunz, *The Intruders*.

63 Public Records Office of Victoria (PROV), VPRS 16392, Foreign Register.

64 For example, between 1956-64 inclusive, there were 121 applications to the Victorian medical board (including applicants from the 1942 scheme), the majority of whom arrived in Victoria before 1960. Of these, cross-referencing with medical registers and medical directories showed only 72 gained registration in any Australian state or territory.

65 Noel Butlin Archives, Q53 (1970d). E.F. Kunz papers.

Second, the focus on medical migrants who were legally registered also precludes any insights into medical work that did not strictly require this status between 1930-60 in order to make a medical living. This includes all 'orthodox' medical work that did not involve private practice or direct financial engagement with patients. For example, diagnostic work in universities and hospitals as pathologists, and strictly biomedical or science teaching and/or research positions in university and private research units. Legal registration was also not required for alternative and allied medical and health practitioners, ranging from psychology to Chinese medical practice.[66] Therefore, insights gained from this thesis do not reflect the experiences, work or contributions of medical migrants who did not require medical registration in order to practise. Historian Phillipa Martyr's study of the breadth of medical practice in Australia from the arrival of the First Fleet to the revival of alternate therapies in the 2000s highlights the limitations of histories of medicine that do not include the full breadth of practise, as well as the role of early settlers who practised across the spectrum of medical and health work.[67] Similarly, Jacqueline Templeton's history of the first homeopathic hospital in Melbourne – now the Prince Henry Hospital – documents the significance of medical migrants particularly from American medical schools in shaping the development of homeopathy there.[68] However, as medical sociologist Hans Baer observes, the history of alternative medicine in Australia is understudied, therefore, our 'collective amnesia' of the role of medical migrants in shaping these structures and practices is limited to the existing historiography, and represents another avenue for future research.[69]

Case study approach to medical migrant pathways: Local responses and 'special types of labour'

The sample of 228 medical migrants comprised the starting point for the remainder of this thesis. The prosopographic database constructed from research into these lives documents the career trajectories of the sampled individuals from graduation to retirement. Appendix 2 outlines the construction and population of this database in detail, including the primary and secondary sources used to reconstruct each individual's professional lives. The resulting database on these 228 individuals at last count has over 8,000 field of information collectively attributed to them. This database was a dynamic research tool and was being constantly updated throughout the life of this thesis. Therefore, some of the early limitations discussed above – including the migrant practitioners identified from other parts of the world, highlights a recurring issue in this study. That is, the scope of a PhD thesis does not exhaust the potential of the databases constructed, despite the sustained and early scaling back of scope that I have detailed above. (The scope of the database to inform future research is discussed in the concluding chapter of this thesis.)

66 Pensabene, *Rise of the Victorian Practitioner*, 33-56.

67 Martyr, *Paradise of Quacks.* See also, Baer, *Complementary Medicine in Australia and New Zealand*, 16-33.

68 Templeton, *Prince Henry's*.

69 Baer, *Complementary Medicine in Australia*. NB: This gap includes histories documenting Aboriginal healing practices and traditional knowledge, the commercial knowledge and practical use of which is better understood. See: Savigni, 'Alternative Medicines Based on Aboriginal Traditional Knowledge and Culture'.

Therefore, in deliberating which findings or perspectives to explore and pursue, I chose to focus on specific cases rather than a general overview that is typical of some prosopographic studies. This approach served the dual purpose of addressing limitations in the existing historiography, as well as mitigating limitations imposed by the stratified sampling approach discussed above to creating a prosopography. The other important limitation a case study approach mitigates is that it does not flatten or diminish obvious and important differences between *and within* groups of medical migrants drawn for analysis.[70] This has been repeatedly identified as a limitation of some prosopographies.[71] Rather, it enables a detailed discussion of the implications of these differences.

While this was partially addressed by deliberately drawing three distinct sub-categories of European medical migrant for analysis – British medical men, British medical women and continental European medical men and women – further analysis revealed additional patterns that were considered too important to ignore. For example, distinct differences were seen in early resettlement and career pathways for British medical men invited to Australia as part of the medical elite versus those who arrived as relatively inexperienced, rank-and-file individuals under general migration schemes. Similarly, the career outcomes of Italian medical graduates who arrived while their degrees were still recognised under the existing reciprocal agreement, or continental graduates able to work outside of private practice, demonstrated vastly different early resettlements experiences compared to former private practitioners holding degrees that were not recognised until the 1950s. Finally, the local professional response to groups of individuals varied – for example, continental European graduates holding unrecognised qualifications demonstrated clear patterns that reflected local responses to groups of medical migrants. Historian Paul Weindling has called this the administrative response – of government, of professional associations, of the public – to groups of medical migrants.[72] In seeking to contextualise the career pathways of these individuals, it became clear that, even for the most documented groups, the historiography itself was limited. Many of the studies documenting the administrative response to continental European doctors, for example, ignore the agency of these doctors, as well as the implications of the intertwined debates over the introduction of a national system of universal health care and the scope of private practice in shaping the protectionist response to the arrival of Europeans fleeing or displaced by National Socialism and the Second World War. Two of the case studies in this thesis (Chapters 5 and 6), therefore, re-examine local professional responses to these specific groups.

For the remaining three case studies, I draw on the work of historian Julian Simpson and his colleagues who apply the concept of 'special types of labour' to describe the recurring pattern that described the work of medical migrants in the British National Health Service.[73] Simpson highlights a common theme in studies of medical migrants, namely, their propensity to settle in less affluent areas, and/or to work in fields of medicine that were considered less

70 Crosland, *Science Under Control*, 175.

71 Ibid.; MacLeod and Nuvolari, 'Pitfalls of Prosopography', 760-762.

72 Weindling, 'Medical Refugees in Britain and the Wider World'.

73 Simpson et al., 'Providing "Special" Types of Labour', 208-9.

prestigious by their local counterparts.[74] The patterns of participation of successive generations of medical migrants reflect the often overt ways in which medical migrants were directed to, or found themselves occupying these spaces.[75] These observations find parallel meaning in exploring the wider collective biography of each of the three broad groups of medical migrants examined in this thesis.

Australian historian Matthew Klugman's social history of the Blood Bank in the state of Victoria illustrates this point in the Australian context.[76] Work at the Blood Bank was salaried, repetitive, and lacked long-term career advancements. Additionally, it was a medical specialism – pathology – that lacked prestige.[77] The Blood Bank suffered sustained staffing problems, exacerbated by high rates of enlistments in the lead up to the Second World War, and the global shortage of pathology specialists afterwards. The importance of the work of the Blood Bank itself was not questioned, particularly as blood transfusions underpinned the success and reach of surgery. Klugman documents the importance of medical migrants to the success of the Blood Bank, who partially mitigated its sustained staffing problems. In *Blood Matters*, Klugman documents an example of the 'special type of labour' that medical migrants occupied.

In thinking about the types of work medical migrants undertook, Mathew Klugman's work also serves to illustrate the disjoint between the career aspirations of medical practitioners and the evolving medical and health care needs of local communities in the state of Victoria. It reflects the gaps created by internal medical hierarchies, where the prospects and prestige of the work did not correspond to the needs of the immediate community. The character and creation of these gaps *are specific to geopolitical spaces*, and reflect the structure and scope of practice in that particular region. For example, in the British NHS, medical migrants are found to occupy many low-status hospital-based specialisms, for example, geriatrics.[78] In Canada, where the provincial regulation of medicine together with the implementation of its version of universal healthcare created gaps in distribution within provinces, medical migrants often cluster in the more isolated areas.[79] That is, 'special types of labour' are specific to a medical market, its own geopolitical hierarchies and the established modes by which a medical practitioner makes a living or aspires to make a living. This background is discussed further in Chapter 2 of this thesis.

Each of the five case studies in this thesis can stand alone. Each examines different, yet overlapping time periods but with sensitivity to the social and professional implications of the smaller group of individuals under examination. However, taken together, they build a layered and complex picture of what it took for groups of medical migrants to re-establish themselves in Australia, and the agency they displayed as they navigated and occupied these

74 Ibid. See also, Wright and Mullally, '"Not everyone can be a Gandhi"'; Raghuram et al., '"Without Racism There Would Be No Geriatrics"'.

75 Ibid.

76 Klugman, *Blood Matters*, in particular 69-87.

77 Ibid., 69-87.

78 Raghuram et al., '"Without Racism There Would Be No Geriatrics"'.

79 Wright and Mullally, '"Not everyone can be a Gandhi".

spaces. Historians Laurence Monnais and David Wright observed in their recently edited volume *Doctors Beyond Borders* that medical migrants occupy 'interstices' between the medical elite and the general population; that they might simultaneously occupy a privileged position as a highly-skilled individual in general society, but also face marginalisation within their professional sphere.[80] Essentially, the metaphor they invoke – the interstitial spaces of a rib cage – points to the multi-layered, intersecting categories of medical migrant. The overarching outcome of the approach adopted in this thesis is to outline the bounds of these layers as they emerge for medical migrants in Australia, highlighting that these are categories of 'other' whose collective experiences can and must be understood separately. A second outcome of this thesis is to highlight that despite these differences, these individuals can be collectively bound together by the distinct patterns of medical work – or 'special types of labour' they undertook: as doctors in country areas; as doctors for newly-arrived migrants; as advocates for marginal groups they occupied; as continental Europeans lobbying for their degrees to be recognised; as British medical women working after marriage, or participating in local medical politics.

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80 Monnais and Wright, 'Introduction', 12.

The structure of this thesis

This thesis is divided into three parts, bookended by this introduction, the conclusion and the appendices. The **Conclusion** includes a reflective summary of the key outcomes of this PhD project; a brief discussion of the future research enabled by the constructed prosopography; and a reflection on how this research enables a reflection of the present position of medical migrants in contemporary Australia. **Appendices 1-5** provide important supplementary context and further detail on the construction, population, and management of the prosopographical databases that underpin this research project. It is important to reiterate here that this is a 'thesis with publication'. Three chapters of this thesis are reproductions of published peer-reviewed journal articles, and one is a revision of an earlier publication. The original version of the latter is reproduced in **Appendix 6**.

Part I – Context

This section contains two chapters. **Chapter 1** comprises a detailed exploration of the historiography documenting medical migrants in Australia. In Chapter 1, I demonstrate how the research questions and choice of method(s) emerged from a critical exploration of the approaches and focus of past studies documenting medical migrants in Australia, as well as the global body of work on medical migration. In this chapter, I highlight how narratives of medical migrants have almost exclusively focussed on the marginalisation of so-called 'alien doctors'. In contrast, British and Irish doctors are remembered individually, their stories are scattered and absorbed into histories of health and medicine shaped by research agendas centred on the primary theme of nation-building. I demonstrate how one set of medical migrants are invisible in the literature owing to assumptions of British privilege, and the other stops with accounts documenting their marginalisation. Together they accounted for the most numerically significant clusters of medical migrants in the Australian medical profession in the mid-twentieth century. A common gap in the literature documenting both discrete groups of British and Irish-trained doctors and continental European doctors was the lack of scholarship documenting their professional lives.

Chapter 2 comprises an outline of the Australian medical context groups of medical migrants found themselves in. In particular, I trace the intertwined development of the scope of general practice in Australian states, with a particular focus on Victoria, and the debates surrounding the introduction of a system of state-subsidised universal healthcare that began in the early 1920s. This chapter highlights the complex relationships between the federal and state governments, the key professional organisation for medical practitioners, the British Medical Association (BMA) in Australia, and friendly societies that shaped the structure, form and regulation of the delivery of primary and hospital health care over the period 1930 to the early 1970s. The BMA in Australia was the largest professional body for medical practitioners in Australia, and is introduced as a key influencer in the local profession, as are the state medical boards and local universities. In this chapter I discuss what I argue are aspects of medical practice and the politics of medicine that have been poorly-developed and over-generalised in existing histories of medical migrants in Australia, namely the uncritical representation of the high income and status of Australian medical practitioners enjoyed through this period,

which has ignored the marked and public mobilisation of rank-and-file practitioners against the introduction of a national system of healthcare predicated on contract-based or salaried medical practice.

A second interrelated focus in this chapter is an examination of the scope of private practice, which for much of this period reveals that general practitioners in Australia are better described as private practitioners who performed a self-determined combination of general and specialist practice, in the form of fee-for-service. A notable exception included contract practice or lodge practice for friendly societies who offered subscribing members and their dependents subsidised access to basic health services. However, the local medical profession bitterly opposed this relationship and the power of friendly societies – under lay control – to determine their work and income. This dominant mode of practice framed the basis of the professional disputes over national health schemes; and, as I will argue, had important implications for the reception and resettlement experiences of the European medical migrants who are the subjects of this study.

Part II – Privileged & Invisible: Two case studies of British and Irish medical migrants

This part of the thesis begins with a contextualised overview of the arrival of the cohort of British and Irish medical migrants registered in Victoria, against the backdrop of general migration pathways available to white British and Irish subjects between 1930-60. This discussion provides important context for the subsequent two case studies examining aspects of British medical migration to Australia. In particular, I highlight the privilege afforded white British subjects wishing to migrate, particularly in the early post-war years. I also discuss how the freedom of movement and multiple channels of migration facilitated the recruitment and migration of British medical graduates who wished to practise in Australia. It is these privileged pathways for British medical migrants that sets them apart from the continental European medical graduates arriving during the same period. However, it is the extended assumption that this privilege made British medical migrants synonymous with their Australian-trained counterparts that has rendered British and Irish medical men and women, including the work they undertook, largely invisible in the historiography to date. The introduction provides the broad migratory frame for the arrival of the sample of 86 British and Irish medical men and 55 medical women analysed in this thesis; and backgrounds the two case studies developed from this analysis.

Chapter 3 presents a case study of a group of Bristol graduates in post-war Australia. For this case study I use a transnational approach to analyse the migrations of a group of Bristol graduates who migrated to Australia after the Second World War. British historians have positioned the motivations of British-born, British-trained doctors to migrate in the post-war period as either primarily ideological – those who opposed the introduction of 'socialised medicine' in the UK – or economic, driven by the poor prospects within the early structure of the British National Health Service (NHS). Post-war British medical migrants are, however, understudied. This case study – reproduced as the journal article published in *Social History of Medicine* – details the transnational lives of a group of Bristol medical graduates in post-war Australia. Their medical lives are used as a case study to explore prospects in the NHS—

particularly for general practitioners (GPs), contextualising these doctors' decisions to migrate. It continues by tracing the subsequent careers of this Bristol group in Australia. In doing so, it highlights the role of medical networks in understanding motivations to migrate, and the early readjustment of medical migrants to Australian cultures of medical practice. It also reveals the integral role British medical migrants played in alleviating GP shortages, not just in rural Victoria, but in rural Australia.

In **Chapter 4**, the specific social and professional participation of the sample of British and Irish-trained medical women is examined. This case study is also reproduced as the journal article published in *Women's History Review*. The lives of medical women – with a few notable exceptions – remain marginal in the growing body of literature on 20th century migration of medical practitioners. As migration scholar Parvati Raghuram observed, this literature is often 'implicitly masculinised'.[81] In this case study, I explore the professional lives of these women to redress this latter trend, as well as to extend 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 – including prevailing attitudes to medical women in the professional context, and legislative barriers such as marriage bars in the public service. Chapter 4 presents a mirror to the previous chapter, highlighting the implications of gender in the transition and participation of British/Irish medical migrants in Victoria. In particular, I highlight the different networks migrant medical women connected to, and how these women used these networks to influence the development and debates of issues they were passionate about. This included women's rights, family life, and medical practices.

Together, these two case studies present an important corrective to the historiography documenting the migration of medical practitioners from Britain. In particular, it challenges two common assumptions in the representation of 'wastage' of British medical manpower through migration.[82] First, it highlights how contemporary representations of 'wastage' in the British NHS was gendered: men migrated, while women married, which is a representation that has remained unchallenged in historical scholarship. Second, these two case studies demonstrate how these notions of 'wastage' can be further complicated when considered in transnational terms. The Bristol group demonstrated the role 'wasted' British graduates played in providing primary care in rural and country Australia. Similarly, the work of migrant medical women from Britain highlights how patterns of participation of these women in Victoria highlights important niches they cultivated and occupied in shaping medical practice for their peers and in forwarding women's issues in the public sphere.

81 Raghuram, 'Asian Women Medical Migrants in the UK', 73-4.

82 See for example, Abel-Smith and Gales, *British Doctors At Home and Abroad.*

Part III – Alien & Marginalised: Three case studies of continental European medical migrants

The next part of this thesis begins with an introduction of the broad migration context that describes the arrival of the 87 continental European medical migrants eventually registered in Victoria. This also outlines the marked patterns seen in their registration in Victoria, reflecting the contested nature of their registration as medical practitioners.

Chapter 5 presents a case study of the Victorian profession's response to Jewish medical migrants who arrived in Victoria as refugees between 1930-39. Historians have seen the professional and social responses to these doctors as an expression of racial prejudice – in particular anti-Semitism – in the Australian medical profession. In revisiting this historical episode, I argue that the role of racial prejudice must be balanced with an account of the medical political context to a greater extent than existing studies have so far done. This is particularly important given that medical historians regard 1938 as a pivotal moment in the history of Australian medical structures – it marks the medical profession's victory over the federal government by preventing the inclusion of medical services in the proposed National Health Insurance Scheme.[83] This case study interweaves the significance of contemporary medical politics and argues that a fuller interpretation of the administrative or gatekeeper response to groups of Jewish medical migrants must include one that explores a professional group reacting to the implications as well as the race of these men and women. Chapter 5 is a revision of an early publication, *Proceedings of the 1st Melbourne University Research Conference on History and Philosophy of Science*. **Appendix 6** contains a reproduction of this publication which comprises an early version of the arguments developed in this chapter.

In **Chapter 6** the political activity and group agency of another group of continental medical migrants is examined; agency exerted during what I call their gap years – or years these doctors spent unregistered owing to the restrictive legislation in force in the state of Victoria. Among the group of individuals registered after 1956 were those who mobilised to form the Unregistered Doctors Association (UDA) in Victoria—a cross-cultural migrant group that lobbied to liberalise state medical legislation in the early 1950s. The story of the UDA highlights the active role highly-skilled migrants played in the complex renegotiation of their professional status in post-war Australia. This chapter is a reproduction of an article published in *Health & History*. It offers one of the few accounts of the administrative response to unregistered medical migrants that accounts for the agency of these men and women themselves. In many past studies, these doctors are represented as a passive group.[84]

Finally, **Chapter 7** presents a case study of the majority group of continental European medical migrants who were private practitioners. In exploring the career patterns of these migrants, the implications of this group of unwanted, unwelcome medical migrants is more fully outlined. The patterns revealed through an analysis of their work demonstrates the unique, sometimes niche areas of medical practice these practitioners occupied both in the interwar and early post-war period – in particular in country health, war service, and immigrant health. This case study complements chapters 3 and 4, demonstrating the similarities in the 'special types

83 See, for example, Gillespie, *Price of Health*, 87-109.

84 Weindling, 'Medical Refugees in Britain and the Wider World'.

of labour' these groups of medical migrants undertook in Australian communities. However, this case study also reveals the particular contours of resettlement for groups of continental European medical migrants, from Italian medical graduates who were immediately registrable to those who endured sometimes decades long gaps before they were entitled to registration. The social response to these groups of doctors who were seen as 'aliens' in Australian communities once again highlights the complexities of intersecting categories that migrants occupy – notably for this case study as a much-needed doctor contrasted against their obvious foreignness. In *Sex and Suffering,* historian Janet McCalman argues that

> multiculturalism was born and nurtured in schools and hospitals, and it was the hospitals' migrant employees who perhaps achieved the most on behalf of their fellow migrants.[85]

The thrust of her argument is that the daily encounters between patients and hospital staff that birthed understanding, empathy and compassion where before there had been mistrust, suspicion and hostility. This case study set over the period – 1930 to ca.1966 – highlights that these encounters transcended the hospital system, and are echoed in the lives of every one of these doctors, who in the process of resettling as medical migrants were unconsciously expanding the boundaries of Australia's medical landscape.

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85 McCalman, *Sex and Suffering,* 340.

Part I – Context

Chapter 01: Distinct Forms of 'Collective Amnesia'[86]: The Historiography of European Medical Migrants in Interwar and Post-war Australia

The extent to which European medical migrants – a category comprising medical graduates from a British, Irish or continental European medical school – are remembered, and even how they are remembered is firmly located in two disciplines in the Australian context. The historiography documenting European medical migrants in twentieth-century Australia has been unquestionably influenced by the different pathways, privileges and reception afforded British and Irish doctors compared to their continental Europeans or so-called 'alien' counterparts.[87] The existing literature is largely focussed on particular ethnic groups that were marginalised, reflecting the trends that have defined the historiographical genres they are situated in and with which this thesis intersects. Essentially, historians of immigration have not concerned themselves with British and Irish doctors in Australia for they were not seen as a marginalised group; while medical historians have largely ignored the arrival and presence of groups of medical migrants in interwar and post-war Australia. The most common narratives of migrant doctors in medical history are medical biographies which, as historian Roy Macleod reflects, sit 'somewhere between … family history and the fraternal obituary'.[88] At its core is the question of who historians have counted as 'migrant', as well as when and which migrant stories are considered historically significant.

The experiences and narratives of refugees in Australia captured the interest of historians in the 1970s, when immigration studies blossomed in Australian history departments. Writing in 1981, historians Richard Bosworth and Janis Wilton reflected that 'historians have been strangely disdainful of the history of our European migrants. By default, the field has been left to demographers, sociologists … and other social scientists'.[89] This gap was shortly reversed owing to the prominence afforded historical research as Australia's bicentenary in 1988 approached.[90] Today, the 1980s marks a period in Australian historiography that saw a large volume of studies published on Indigenous Australians, women, and minority migrant groups.[91] The latter included over seven thousand European Jews forced out of their homeland, who arrived in the 1930s, and half a million post-war migrants – including 170,000 Displaced Persons (DPs) whose resettlement was facilitated by the International Refugee Organisation. These post-war settlers, or 'New Australians', arrived under Australia's unprecedented post-war immigration program, and represented the largest injection of cultural diversity Australia's

86 Simpson et al., 'Writing Migrants Back into NHS History'.

87 Two major differences were that (white) British subjects had unrestricted rights to travel to and settle in Australia, while non-British subjects ('aliens') required landing permits. The second difference is specific to medical practitioners. By 1930, British and Irish medical qualifications were automatically recognised in all Australian states and territories, while most other medical qualifications (with the brief exception of Italy and Japan) were not.

88 Macleod, 'Colonial Doctors and National Myths', 126.

89 Bosworth and Wilton, 'The Study of European Migration to Australia', 222.

90 Gare, 'Britishness in Recent Australian Historiography', 1145-55.

91 Ibid.

communities had seen since the Gold Rush era in the 1850s.[92] They were drawn from a wide cross-section of European countries, including Germany, Greece, Italy, Hungary, Malta, Poland and Sweden.[93]

It has been sociologists and demographers exploring migrant diasporas, as well as a handful of historians interested in the cultural, economic, political and social impact of migration, who have examined the sustained negative administrative response to distinct non-British groups of medical migrants or 'alien doctors'[94] – Jewish doctors, DP doctors – whose arrival disrupted established norms.[95] This negative response is commonly contextualised against a backdrop of a homogeneous society that clung to its Britishness, and whose response to non-British settlers was distinctly racially-driven. In many of these studies the medical profession is portrayed as an equally homogeneous community enjoying 'high income and status',[96] whose responses are varyingly influenced by its conservative element who rejected non-British medical migrants on the basis of their ethnicity, or its more mercenary element who rejected alien doctors on the basis of their potential to compete with locally-trained graduates. In these studies, the arrival of hordes of British migrants is largely ignored. The histories of this group of continental European medical migrants typically ends with the liberalisation of medical legislation in the late 1950s.

The consideration of British settlers as migrants – a term that even today carries negative connotations of 'other' – is more recent.[97] As Thomson and Hammerton observe in their study of post-war British migrants, 'when Australians talk and think about migrants, for the most part they mean migrants from non-English speaking countries'.[98] In parallel to the arrival of interwar Jewish refugees, and the post-war population expansion program, British and, to a lesser extent, Irish migrants arrived in equally unprecedented numbers. Between 1945-60, over half-a-million British and Irish settlers arrived in Australia, a large proportion of whom were facilitated by assisted passage schemes.[99] As British officials became increasingly concerned with the post-war 'brain drain' of British intellectuals in the 1960s and administrators began quantifying the medical manpower needs of the National Health System, the extent of doctor emigration from the UK was revealed. John Seale, a member of Fellowship for Freedom in Medicine, the anti-NHS group, became a prominent figure in the debate over the extent of

92 For an overview, see: Jupp, *From White Australia to Woomera*, 6-18.

93 Ibid.

94 'Alien doctors' was commonly used to describe medical practitioners holding unrecognised degrees; and often implied foreign (non-British) nationality.

95 See: Salter, 'Prejudice in the Professions'; Kunz, *The Intruders;* Rutland, *Take Heart Again*; Rutland, 'An Example of "Intellectual Barbarism"'; Winterton, 'Alien Doctors'; Weaver, 'A Glut in the Market'; Weaver, 'Pathways of Perseverance*,* 49. NB: Weaver's recent publication is a revision of 'A Glut in the Market'.

96 See for example, Kunz, *The Intruders,* 31.

97 Thomson and Hammerton, *Ten Pound Poms*, 11.

98 Ibid.

99 ABS, Historical Migration Statistics (2016).

and causes for the exodus of British doctors.[100] Seale's research (controversially at the time) estimated that in the ten-year period between 1954 and 1963 alone, over 4,000 British doctors permanently migrated to Australia, Canada, New Zealand, Rhodesia and the United States of America.[101]

In histories of Australian medicine, it is the Britishness of the profession, reflected in the number of interlinks between British and Australian professional and semi-professional entities, regulations and structures, that is varyingly disentangled.[102] British medical migrants are remembered in two distinct sub genres of Australian medical history. The first, predominantly produced by academic historians of medicine, are institutional and political histories of medicine and health. In this body of work, particularly when focused upon the nineteenth century, a period that saw orthodox practitioners actively engaging in strategies of medical professionalisation, historians varyingly explore the extent of the British influence and legacy – occasionally embodied by identifiable British medical men – seen in developing Australian medical structures and practice.[103] The second, and larger body of work on British and Irish medical migrants in twentieth-century Australia, comfortably settles into what medical historians Peter Hobbins and Kathryn Hillier describe as the wider 'historiographic genre that remains predominantly (auto) biographical'.[104] In this study, Hobbins and Hillier identify the repeated representations of Australia's geographic isolation in the historiography they were examining – the development of medical research institutions in Australia – as a 'methodological artefact'.[105] This observation resonated in my own critical exploration of how British medical migrants have been documented, where the assumptions of a British practitioner's assimilability in the Australian medical context can be equally seen as a 'methodological artefact'.

An unprecedented number of British doctors arrived in Australia after the Second World War, only some of which were facilitated by the Australian-based profession.[106] However, historians have shown little interest in exploring these migrations – excepting the (auto)biographical accounts of the migrant medical elite – thereby implicitly perpetuating the assumption that British and Irish medical migrants were synonymous with the local profession.[107] As discussed above, as British migrant experiences are being recovered and

100 Seaton, 'Against the "Sacred Cow"', 424-449.

101 Seale, 'Medical Emigration from Great Britain and Ireland'.

102 For example: Dyason, 'Medical Profession in Colonial Victoria'; Gandevia, 'A History of General Practice in Australia'; Evan, 'The Development of Paediatrics in Australia'.

103 For example, Dyason, 'Medical Profession in Colonial Victoria'; Pensabene, *Rise of the Medical Practitioner in Victoria*.

104 Hobbins and Hillier, 'The History and Historiography of Australian Medical Research', 2.

105 Ibid., 2.

106 Last, 'Migration of British doctors to Australia'; Seale, 'Medical Emigration from Great Britain'. The patterns of British medical migration will be discussed further in Part II of this thesis.

107 It is not possible to exhaustively cite examples of these (auto)biographical accounts, most commonly remembered in wider national memory projects. See for example, Crockett, 'Officer,

explored by historians, the assumption that British settlers, particularly post-war British settlers, eased into Australian life has been contested and nuanced. Historians of medicine in Australia have lagged in this respect, perpetuating the invisibility of rank-and-file British and Irish medical graduates.[108] In part this reflects the developing status of medical history as an organised academic discipline in Australia.[109] It also reflects the lack of interest in twentieth-century medical history: recent academic histories still largely address the colonial era.[110] Histories of twentieth-century Australian medicine tend to be more narrowly focussed: on the World Wars;[111] health administration;[112] professional bodies;[113] and large public institutions.[114] Individuals or groups outside of political figures or eminent practitioners are secondary in these narratives, and where they feature, the perspective is often celebratory or commemorative.[115]

In this chapter I introduce and critically discuss these disparate historiographies documenting European medical migrants in mid-twentieth century Australia, against a backdrop of relevant studies of medical migrants in a more global context. In doing so, I demonstrate how the research questions and approaches adopted in this study extends the existing literature, but also how this body of work has influenced the methods and approaches adopted in this study. The remainder of this chapter comprises two main sections, the first examines the representations and approaches used by migration historians to explore the cohorts of continental medical migrants arriving in interwar and post-war Australia. The second

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Doris Lyne'; and Blackburn, 'Lambie, Charles George'.

108 The term 'invisible migrants' was first used by Charlotte Erickson to describe British migrants in the United States of America in the nineteenth century. I adopt its meaning here as described by Thomson and Hammerton, to reflect the invisibility of the British migrants in the historiography. See, Thomson and Hammerton, *Ten Pound Poms*, 9-15.

109 This contrasts with Britain, in particular, where history of medicine as an academic discipline has flourished, and is sustained by Wellcome Trust funding. In Australia, the largest association for historians of medicine is the Australian and New Zealand Society of the History of Medicine of which only a minority of members are professional or academic historians. For a discussion, see Rogers and Warner, 'Remapping the History of Medicine: Fifteen Years of "Health and History"', 1-4; Macleod, 'Colonial Doctors and National Myths, 125-142.

110 These works are too large to list exhaustively. For notable examples, see: Martyr, *Paradise of Quack*; Coleborne, *Madness in the Family*; Anderson, *The Cultivation of Whiteness*; Dyason, 'Medical Profession in Colonial Victoria'. Exceptions include, Bashford, 'Race, Colonialism and Tropical Medicine';

111 For example, see the special issue of *Health and History* published in 2015 on World War I.

112 Evans, 'An Australian Experiment in Medical Administration 1939-64'; McLeod, 'DGMS Rupert Downes and Australian Army Medical Preparations for World War II'.

113 Muir, *The Medical History Society of Victoria, 1953-2006*.

114 There are dozens of published histories of public teaching and base hospitals. For a cross-section, see: York, *The Rachel Forster Hospital 1922-2000;* Gregory, *A History of the Mater Hospital*; McCalman, *Sex and Suffering;* Press, *The History of St. Margaret's Hospital Darlinghurst, 1894-1994*; Hyslop, *Sovereign Remedies*; Bolton and Joske, *History of Royal Perth Hospital* (1982). For other large public institutions, see: Langford, *Innovation, Technology and People in Australia's Royal Flying Doctor Service*; Klugman, *Blood Matters;* Russell, *Melbourne Medical School, 1862-1962*.

115 See for example, Healy, *Australian Doctors and Dentists in the Great War*; Neuhaus and Mascall-Dare, *A Century of Service by Medical Women to the Australian Army and its Allies*; Harris and Stocks (eds.), *A History of Physicians at Princess Alexandra Hospital 1956 to 2006*.

presents a re-reading of current histories of medical institutions in Australia, with a particular focus on representations of British and Irish doctors arriving in Australia in the same period. In conclusion, I draw upon the global body of literature to identify three dominant themes currently missing in Australian accounts: an examination of gender; the role of developing universal health care systems in understanding medical migration; and the type(s) of work migrant doctors undertake. Overall, I demonstrate how the broad methodological approach – of using a biographical approach combined with the research questions explored in subsequent case studies – emerged from a critical exploration of the existing historiography.

Histories of migration and group narratives of 'alien doctors'

There are very few biographical accounts of 'alien doctors' or continental European medical migrants in Australia. Only a handful can be found, for example, in the *Australian National Dictionary of Biography*.[116] Non-British doctors in mid-twentieth century Australia have almost exclusively been considered as a collective group of 'other' in the local context. One of the earliest academic explorations of European medical migrants in Australia came in the form of social scientist Moira Salter's 1974 analysis of 'prejudice in the professions'.[117] Salter's study was published in an edited book series, *Racism: The Australian Experience*, which set out to find 'proof of racism in Australia'.[118] Salter's study was followed by social historian and demographer Egon Kunz's controversial monograph *The Intruders: Refugee Doctors in Australia* (1975), which examined the treatment and experiences of qualified doctors resettled in Australia under the DP scheme (the earliest post-war migration scheme introduced for non-British migrants).[119] The work of Salter and Kunz was associated with the Australian National University's Social Science Research Council, partially funded by the Department of Immigration.[120]

Salter's examination of the professions, in which she uses the medical profession as a case study, concluded that there was little evidence of racial prejudice influencing the experience medical migrants had in Australia. Rather, she argued, there was even a degree of tolerance and flexibility shown towards them. I agree, in principle, with Salter that the medical profession was not *solely* concerned with the ethnicity of these doctors (a point I will return to in a later chapter).[121] However, her interpretation was based on the large numbers of overseas medical graduates (585 in total between 1948-1952) granted registration in Australia. This cohort

116 This includes, for example, Charles Haszler who was one of the DPs who circumvented the restrictions on foreign medical qualifications by serving in Papua New Guinea. see: Speer, 'Charles Haszler (1907-1973)'. Other examples include: Carmody, "Leopold Dintenfass (1921-1990)" who was a medical researcher; Brett, 'Geroe, Clara Lazar (1900–1980)' who was a psychoanalyst; and Zanadvoroff, 'Goloubev, Nikolai Pavlovich (1888–1965)' who was a GP.

117 Salter, 'Prejudice in the Professions', 67-75.

118 Ibid.

119 Kunz, *The Intruders.*

120 Macintyre, *The Poor Relation*, in particular 165-175.

121 See Chapter 5.

included British/Irish graduates, as well as other foreign qualifiers.[122] For the stated aims of her study, a distinction should have been made between British-trained doctors and other foreign doctors because, apart from good cultural reasons for making such a distinction, the local profession openly differentiated between the two groups. This is reflected in the gross numbers recorded: the majority held British or Irish qualifications which were afforded reciprocal recognition. What Salter establishes most clearly is the comparative privilege afforded this latter group, a point that was not lost on her.

Salter concluded her study by drawing an analogy between the differential treatment of medical migrants to the tariff applied to commodity imports – implying there must be merit in the profession's argument that non-British doctors had comparatively inferior medical qualifications, and the profession regulated this by placing levies in the form of obstacles to registration as an effective way to sift them out.[123] This conclusion is problematic, particularly because it is uncritically based on sources generated by the gatekeepers of the medical profession, particularly the British Medical Association (BMA) in Australia.[124] For example, she does not consider or address that these 'levies' were themselves based on impressions rather than concrete evidence that this was, in fact, the case. Nor does she consider the possible motives and embedded bias that may have underscored the BMA's position. These representations require careful interrogation.

Finally, the period Salter investigated, 1948-1952, marks one of unprecedented population expansion, which is today recognised as the beginning of multicultural Australia.[125] Although the term was not applied then, Salter's peers, notably at the Australian National University, had been engaged in sociological studies of migrants since the 1950s, and they had long-established the growing number of problems of access to available social services among Australia's new non-English speaking population.[126] An increasing number of 'New Australian' patients spoke little or no English, making the medical services of their medically-qualified compatriots all the more valid in these communities. Therefore, a more robust exploration of the question of racial prejudice in understanding the reaction of the local medical profession is needed. It is also essential to interrogate, rather than appropriate, the claims and actions of the profession's gatekeepers and standard setters. It would also require a full reconsideration of the period under investigation: Salter avoids the earlier interwar period when large numbers of Jewish refugees, some of whom were doctors, were granted humanitarian visas to resettle in Australia.

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122 Salter, 'Prejudice in the Professions', 69.

123 Ibid., 70.

124 NB: The Australian Medical Association was founded in 1962. Until then, the BMA operated in Australia as a series of state chapters, loosely governed by a federal committee. (referred to in this thesis as the 'BMA in Australia'. See: Chapter 2.

125 Jupp, *From White Australia to Woomera*, 19-36.

126 These peers include sociologist Jean Martin and demographer William (Mick) Borrie. Salter's work is part of nine studies commissioned by the Department of Immigration. For a discussion, see Macintyre, *The Poor Relation*, 165-75.

From the mid-to-late 1930s, members of the Australian profession regularly denounced the quality of European medical education against Australian standards. Common reasoning publicly deployed by members of the profession included: the decline in quality of continental medical schools under the Nazi regime; the idea that continental medical students specialised too early and were therefore not suited to Australia's predominantly general practitioner environment; and, that many of these doctors did not have adequate English language proficiency.[127] However, only in 1942 – over a decade since the arrival of the first Jewish doctors – was the profession forced to implement a standardised assessment to judge unrecognised doctors' medical competence, albeit on a temporary basis. Under this federal scheme, historian John Weaver estimates that almost sixty per cent of applications in New South Wales and Victoria were successfully assessed as competent practitioners according to Australian standards.[128] At the end of wartime measures these licensees were granted full registration in all states.

Salter's study is important, however, as it is the most comprehensive outline of the introduction and deployment of the reciprocity clause in Australian state medical acts which occurred at the turn of the century. Australia had a devolved governance structure that extended to medicine. The state-based system of regulating medical practice created idiosyncrasies at the geopolitical level, however most state medical acts contained measures to protect local practitioners. In the early 1900s, all states amended their medical acts to ensure that no foreign medical qualifications – with the exception of British and Irish degrees – were recognised automatically. Instead, foreign applicants had to demonstrate, amongst other things, reciprocity with their home country. If Australian medical graduates could register and practice in for example, Russia, then Australian states would grant reciprocal recognition to Russian medical graduates seeking to register in Australia.

As historian Tony Pensabene observed for the state of Victoria, but is equally applicable to the other states, the insertion of this reciprocity clause

> was a simple and automatic means of limiting the flow of foreign doctors … The clause helped overcome the problems the Medical Board experienced in determining the acceptability of foreign diplomas. No subjective assessment … was required.[129]

These reciprocity clauses were employed to just such effect thirty years later, when the first Jewish refugee doctors arrived in the 1930s. Salter does not make a connection between the introduction of these clauses and the sustained minimal exposure most Australian practitioners

127 See for example, 'Alien Doctors – Attitude of B.M.A. – "Would Oppose Lowering of Standards", *The Sydney Morning Herald,* 22 January 1938, 11; 'Law Check on Influx of Foreign Doctors – Victoria, N.S.W. To Change Registration Conditions', *The Courier Mail,* 10 August 1938, 4; Norman Dunbar, 'Migrant Doctors Plead for a 'fair-go', *The Argus,* 19 November 1951, 2.

128 Weaver, 'A Glut on the Market', 32 – see Table 1.

129 Pensabene, *Rise of the Victorian Medical Practitioner,* 128.

had to European medical education and standards that were not British or Irish.[130] Instead, she appropriates the rhetoric employed by the profession who publicly represented (and possibly believed) all continental European degrees to be substandard and the continental medical migrants themselves to be unsuitable for practice in an Australian professional setting for the reasons outlined above.

Salter's analysis is also the only study that considered British-trained doctors and other foreign graduates together as a group of medical migrants. As you will see, without exception the remaining literature is focussed on specific cohorts who arrived in interwar and post-war Australia. Under a broad number of labels – alien, DP, and/or refugee doctors – their experiences are examined and remembered within the broader contexts and trends that define Australian immigration history, with varying degrees of deference paid to the contexts of health and medicine at the time.

The latter trend begins with the next account by Egon Kunz. Published in 1975, *The Intruders: Refugee Doctors in Australia* is a monograph detailing the experiences of post-war alien doctors. *The Intruders* was an off-shoot publication of Kunz's larger project examining DPs who arrived under the DP scheme between 1947-52.[131] Many professionally qualified DPs, including doctors, were forced to work as unskilled workers under this scheme, which committed each applicant to a two-year labour contract with the federal government. These DP doctors arrived after the war and their ability to legally practise medicine was determined by the medical act of the state they were resident in. On this matter, the federal government, although sympathetic to the idea of liberalising medical licensing regulation to make full use of the skills of DPs, had no jurisdiction over the states.[132]

Kunz traced and critically analysed the recruitment and early resettlement experiences of DP doctors. Kunz himself had been a DP. He was Hungarian by birth and fled to Australia during the Hungarian communist uprising in 1956.[133] His closeness to the subject simultaneously highlights both the strengths and the weaknesses of his monograph. He was deeply outraged at the treatment his fellow DPs experienced at the hands of an unwelcoming medical profession. He deplored the waste of valuable medical skills in post-war Australia. To him, every moment these doctors remained unregistered was a moment unwantedly wasted – they were 'lost years and wasted lives'.[134] The extent of this loss was compounded, in his view, by the comparative success and contributions made by those DP doctors recruited to serve in the Australian territories of Papua New Guinea and Antarctica, where state laws did not apply.[135]

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130 Ibid. This is discussed further in Chapter 6.

131 The DP scheme was a post-war assisted passage scheme for Displaced Persons in European camps following the end of the Second World War. DPs were offered resettlement in Australia on the condition of a two-year labour contract with the Commonwealth government. This is discussed further in Chapter 7. See also, Persian, PhD thesis.

132 Kunz, *The Intruders*.

133 For a discussion of Egon Kunz's experiences as a DP, see: Persian, PhD thesis, 15-18 and 235-242.

134 Kunz, *The Intruders*, 93.

135 Ibid., particularly 8-9, 52-9, and 89-92.

Kunz had access to and the trust of his fellow DPs. The standardised surveys he sent out as part of his broader study exploring DP experiences resulted in a high rate of return from DP doctors (and other professionally qualified DPs).[136] Many of these men and women were willing to share their stories and experiences with Kunz, often under the promise of anonymity, since many had since successfully re-established themselves as practising professionals in Australia.[137] Kunz's approach was, therefore, methodologically distinct from Salter, particularly in the way that it championed the voices of the DP doctors themselves. His interpretation was influenced by the perspectives of these doctors. The evidence he drew upon relied heavily on the testimonies of these doctors, including some collected by them in the 1950s when unregistered doctors mobilised in state-based groups to challenge the restrictions on their ability to practise.

Kunz's position contrasts Moira Salter's sharply. He argues that in Australia

> recent and conscious policies of the Australian medical profession … running counter to developments in medically advanced countries … succeeded in preserving a situation of undersupply and retarding the growth of specialisation … In this context the almost indiscriminate exclusion of non-British graduates … was not only part of the objective to keep its numbers low … but also a precondition of its continued power to resist the development of specialisation.[138]

For Kunz, the arrival of European-trained doctors in Australia – with what he argued was *more* advanced training, particularly in specific competitive specialist domains of medical practice – was perceived as a real threat to the high income and status enjoyed by the average Australian practitioner.[139] His analysis is to date the only one that attempts to frame the post-war DP doctor's experiences against the prevailing structure and practice of medicine.

Kunz's analysis of the structure and practice of medicine – including his interpretation of the problems and prejudices enabled by them – has had an enduring influence on the subsequent literature.[140] The next two studies of continental medical migrants in Australia were undertaken by Suzanne Rutland, a historian of Australia's Jewish diaspora (including refugee/ migrant arrivals). She explicitly adopted Kunz's framework without challenge – particularly the argument that non-British doctors threatened the high income and status of local doctors. This is unsurprising given Rutland's focus was on the Jewish diaspora more broadly; her work which was published in the 1980s can be situated in a contemporary trend that focussed on recovering Australian histories of migration.[141] Rutland was privately contracted to write a history of the

136 See: Kunz, *Displaced Persons,* 145-162 for a discussion on tertiary-qualified DP experiences.

137 Noel Butlin Archives, E.F. Kunz papers – The intruders files.

138 Kunz, *The Intruders*, 32.

139 Ibid., particularly 38-43.

140 NB: Almost every subsequent study of medical migrants and migrant health in Australia by scholars in a number of disciplines cites Egon Kunz's work, particularly his general conclusions.

141 Gare, 'Britishness in Recent Australian Historiography'.

Fellowship of Jewish Doctors of New South Wales, which was published in 1983.[142] She also authored a journal article on the experiences of Jewish refugee doctors in New South Wales (NSW) in 1987.[143]

Rutland's work adds an important dimension to the body of work on continental medical migrants in Australia, for it mainly describes the experiences of the interwar arrivals, who were predominantly Jewish refugees. She highlights how NSW soon became a hub for Jewish refugee doctors because the University of Sydney was one of three Australian universities to introduce a three-year retraining pathway for these doctors. The University of Melbourne, in Victoria, where many Jewish refugees first arrived, adopted a much harsher stance: it required such doctors to complete its full six-year degree.[144] Therefore, many of those who chose to retrain, travelled to Sydney where they created their own support network – the Fellowship of Jewish Doctors – while undertaking retraining. But the Fellowship also helped moderate the discriminatory and unfair attitudes adopted by the NSW medical profession. The latter ranged from introducing a quota of eight alien doctors completing the shortened course that could be registered annually, to protesting the appointment of these doctors as resident medical officers in hospitals.[145]

Rutland's work details and celebrates the activity of the Fellowship in NSW, through which, she argues, 'new lives rose from the ashes of the holocaust'.[146] It provides significant insight into the creation and importance of migrant-led Jewish networks in the re-establishment of these doctors' professional status.[147] Rutland's analysis connects the histories of Jewish refugee doctors with the wider discipline of Australian migration history. Her work reminds us that the migrant status of these doctors must be accounted for in multiple contexts, both social and professional—an omission Kunz is guilty of making in focussing solely on the power dynamics of the medical profession.

Rutland's account is enriched by the trust and position she occupied in the Australian Jewish community in NSW. Drawing on a broad set of oral interviews with members of the Fellowship, she squarely placed the early experiences of the interwar Jewish doctors within the broader framework of popularly-held negative attitudes towards migrant Jews. This included from the established Australian Jewry, who feared the influx of European Jews in the 1930s would jeopardise their position in Australian communities. Additionally, she argued that anti-Semitism must be included in any interpretation of Jewish refugee doctors' experiences in

142 Rutland, *Take Heart Again.* Rutland wrote this monograph after she completed a Master of Arts at the University of Sydney, and before she began a PhD there.

143 Rutland, 'An Example of "Intellectual Barbarism"'.

144 This was owing largely to public protest by the University of Melbourne's medical students. See: 'For Jewish Migrants', *The Argus,* 27 July 1938, 13.

145 Rutland, *Take Heart Again.*

146 Ibid., v.

147 The arrival of over seven thousand Austrian, German, Polish and other eastern European Jews diversified a predominantly Anglo-Jewish community in Australia by, for example, the arrival of Yiddish-speaking members, Zionists, Bundists, liberal and ultra-orthodox Jews. See: Rutland, *Jews in Australia*, 66-78.

Australia if it is to provide a full account of this particular historic episode. However, she then moderated this claim, concluding that:

> The general xenophobia of the Australian public, further influenced by anti-Semitism, was particularly strong in the period under discussion. In the years 1933-54, when most Jewish refugees arrived, Australians had not been exposed to non-British European migration … Added to these general problems was the "proverbial jealousy of the medical profession" and the fear of economic competition.[148]

The question of anti-Semitism informing the medical profession's response to Jewish refugee doctors was revisited over twenty years later by legal historian John Weaver. Weaver examined the interpretation and amendments to state medical legislation in Australia with respect to the Jewish migrant cohort. Drawing predominantly on archival sources, he used the debates surrounding the recognition of Jewish refugee doctors in the interwar and war period to conclude, similar to Rutland, that anti-Semitism helped drive the negative professional response these doctors faced. Weaver argued that:

> Rarely did protectionists openly espouse anti-Semitism, although bigotry was not completely absent from [medical] boards. Competition was the medical profession's declared enemy; however, a strictly economic explanation for protectionism is insufficient.[149]

His evidence is largely drawn from the minutes of the medical boards of Queensland and New South Wales, together with the applications from predominantly Jewish refugee doctors for the temporary wartime refugee doctor licensing scheme introduced by the Commonwealth government in 1942. His analysis is framed by the perspective of how a contextualised study of historical changes to law can 'highlight foibles to inform moral and ethical behaviour in our time'.[150] His representation of the Australian medical profession is sympathetic to Kunz, arguing that in this particular historical episode 'conflicts of interest are covered by assertions from professionals that they can determine what is best for the public'.[151] Both Kunz and Weaver draw on and highlight a system of medical professional regulation in Australia that gave self-interested parties – in this case the medical profession – too much power.

The final account of alien doctors in Australia by Peter Winterton, a medical professional and part-time academic historian, extends this interpretation. Winterton lamented the 'dearth of compassion' shown to alien doctors by the Western Australian medical profession.[152] He concluded that it was the action of sympathetic publics and country parliamentary representatives, and not the medical profession, that was largely responsible for

148 Rutland, 'An Example of Intellectual Barbarism', 256-57.

149 Weaver, 'Pathways of Perseverance', 42-72.

150 Weaver, 'A Glut in the Market', 3.

151 Ibid.

152 Winterton, 'Alien Doctors', 67.

the liberalisation of the state medical act with respect to alien doctors in Western Australia. His study also links this outcome to the unique conditions of that state. Western Australia was reliant on other states for its supply of medical practitioners and was also less-populous. That it eventually became the first state to legislate a defined pathway in 1949 by which it could recruit and direct the services of alien doctors was heavily influenced by such state-specific shortages of doctors.[153]

At first glance this body of work, spanning from the mid-1970s to 2016, appears to cover the history of groups of continental medical migrants in Australia from a number of approaches and frameworks. Each element examines a unique set of primary sources, ranging from surveys and interviews, to archival sources held by various state and federal bodies, to biographical material. The strength of the combined narrative is predominantly in the explication of the political or 'administrative response' to medical migrants, that is, the development and deployment of protectionist policies by the Australian medical profession.[154] However, it is enriched by an examination of the lived experiences of those medical migrants who were prevented from re-establishing themselves as medical practitioners. There are, however, gaps and limitations in these studies that warrant further research.

First, Kunz's influential conceptualisation and representation of the Australian medical profession is flawed. A substantial part of his argument – that the local profession feared unwanted competition from DP doctors – was based on Australia's apparent lack of full-time medical specialists and the influential perception held by the Australian medical elite that European-trained doctors specialised too early. Kunz loosely and retrospectively applied a conceptual framework proposed by Thomas McKeown in 1965 where he posited three phases of development of a nation's medical service, with each phase representing increasing specialisation.[155] In the 'first phase', a nation's economic development and/or population distribution over large areas necessitated a high doctor:population ratio. In such an environment, according to McKeown, there is little or no difference between a GP and a specialist. All geopolitical regions experienced this 'primitive stage', but at the time of writing, McKeown singled out Australia as rare case since it had relatively high living standards and a dense population, but GPs were still performing specialist procedures. McKeown saw these phases as a natural (almost inevitable) progression as nations developed.[156] His argument against remaining in the first phase was that specialist training reduced the likelihood of causing harm

153 For a discussion, see: Kunz, *The Intruders,* 76-77.

154 Weindling, 'Medical Refugees in Britain and the Wider World'.

155 McKeown, *Medicine in Modern Society*, 169-172. NB: the following discussion is based on my Masters dissertation, see: Mody, MA thesis.

156 The other two phases McKeown identified are: the 'second phase' describing a medical workforce where specialists are explicitly distinguished according to 'training and appointment', and GPs refer patients to a relevant specialist where required. The 'third phase' is where medical practice is completely specialised and fragmented, and the medical system loses equilibrium between specialisation and general practice. The final phase is a spin-off of the second phase. McKeown noted one danger in the last two phases were that GPs become increasingly glorified middlemen, compromising the quality of primary care available to the general population. Ibid.

through professional incompetence, and he saw Australia as unique for not encouraging further specialisation amongst its medical population.

McKeown concluded however that the task of pinpointing an optimum distribution of GPs to specialists for a given country is fraught with complexity and suggested that either one of the three phases might better serve a particular nation despite similarities in the population size and economic wealth of nations. Simply put, McKeown's position is not a normative one. He does not argue that either one of the three phases represents an optimal end-point, nor does he argue against the role/relevance of GP-specialists. Kunz, however, applies a more literal interpretation of McKeown's research. He argued that Australia's profession was 'primitive' in being 'under-specialised', and the progress towards increased specialisation was deliberately retarded by Australian practitioners to maintain their 'high income and status', despite it being 'patently unsatisfactory'.[157] Kunz does not deeply evaluate these claims.[158] Neither does he allow for the existence of a heterogeneous medical profession. As I will discuss in the next chapter, the wider medico-political context, particularly the debates over introducing a state-subsidised health service during the interwar and early post-war years, brought to the forefront and further catalysed internal divisions between groups of practitioners (as well as practitioners and the federal government). These contemporary issues, I argue, also shaped the response to continental medical migrants, which I explore further in Chapters 5-6. For Kunz, however, continental medical migrants were unquestionably more advanced in their training and specialist experience and therefore were seen as a considerable threat by the Australian profession.

A second gap in the historiography is that both Rutland and Weaver only examine Jewish doctors. Thus, examining prevalent anti-Semitic attitudes becomes an obvious consideration. However, many of the criticisms they both raise to support this argument, including the Australian profession's weak claims about the suitability of 'alien doctors', can be equally applied to non-Jewish arrivals in the post-war period, as Kunz demonstrated. Rutland's and Weaver's argument – that prevalent anti-Semitic attitudes informed medical legislation – can only hold if you privilege the power of such ideology in driving the policies adopted by state medical boards and the BMA in Australia, which were subsequently formalised in changes to medical legislation in 1938.

Neither Rutland nor Weaver argue this. They concede the multiplicity of factors that appear to have driven the adoption of such restrictive legislation. For example, Weaver observed that:

157 Kunz, *The Intruders,* 31-38.

158 Ibid.

> While some members of the boards and a few politicians lacked the socio-political imagination to recognize the perils of their times they were not anti-Semitic but parochial.[159]

Similarly, Suzanne Rutland concluded in 1987 that the difficulties faced by Jewish refugee doctors in Australia must be 'understood in the light of more general factors'.[160] One way in which to do this would be to trace the pathways of *all* continental medical migrants, merging the interwar Jewish refugee arrivals with the post-war arrivals (the latter which were not predominantly Jewish).[161] A fuller examination might reveal or repeal a greater role for anti-Semitic attitudes within the medical profession in shaping their response to these doctors.

Finally, this body of work is limited to a distinct episode in the forced migration of these doctors: the negative administrative responses to their arrival in Australia. In the introduction he wrote to a special issue on refugee doctors, historian Paul Weindling highlighted the richness and different perspectives that a life-course approach can reveal – one that extends our understanding of the experience of refugee doctors beyond their marginalisation.[162] Although both Winterton and Rutland partially adopt biographical approaches, the scope of their studies is limited. Only Winterton concluded his study by briefly summarising the lives of twenty-four alien doctors that went on to comprise the migrant medical elite in Western Australia, his father being among them.[163] Rutland similarly focused briefly on the outstanding accomplishments of Jewish doctors most extensively in *Take Heart Again* – this work included those first and second generation Jewish migrant who (re)-trained in Australia. Her primary focus in this monograph was to write a sensitive history of the Fellowship and these brief biographical sketches are secondary to her main research aim.[164] Therefore, the most significant gap in the histories of continental medical migrants in Australia is the lack of any insight into their collective professional lives. As a collective, they are remembered as a marginalised group.

Medical histories and individual narratives of British medical migrants

In stark contrast to narratives of 'alien doctors' in Australia, the most prominent narratives of British and Irish medical migrants in twentieth-century Australia are almost entirely (auto) biographical accounts of elite medical men and women, documenting and often celebrating their contributions to Australian medicine.[165] These are typically framed by a nation-centric approach. The heritage of these men and women, complicated by the enduring legal status of British subjecthood in Australia,[166] is not central to these narratives. Instead, their origins are often

159 Weaver, 'A Glut in the Market', 31.

160 Rutland, 'An Example of "Intellectual Barbarism", 256-7.

161 Kunz, *The Intruders,* 21-30.

162 Weindling, 'Medical Refugees in Britain and the Wider World'.

163 Winterton, 'Alien Doctors', 77-82.

164 Rutland, *Take Heart Again*, v.

165 These are too many to cite in completion. See for example, Malcolm Allbrook, 'King, Gordon (1900–1991)'; Harper, *Plaster and Paint*; Heywood, 'Daws, Joyce Margaretta'.

166 Australian citizenship as a legal category was created in 1948, and only in 1984 was British

simply indicated by a record of events: country of birth; place of study; and last held position. The most prominent examples of such narratives can be found in entries in large-scale national memory projects, including the *Australian Dictionary of Biography*, and for women in *The Encyclopaedia of Leadership in Twentieth-Century Australian Women.*

The British legacy and the oft accompanying portrayal of Australia as a bastion of British medical tradition is an embedded feature of the genre of Australian medical biography. As historian Roy MacLeod observed of the early entries published in the *Australian Dictionary of Biography:*

> … there are striking silences. Women, Aborigines, Europeans other than Britons do not feature prominently, nor among the medical entries … there is a sentiment that might be construed as favouring 'independence' of mind and action, mildly anti-British in its tradition, although qualified by acceptance of British models, adapted to local circumstance.[167]

However, even in this genre, there are studies that challenge this qualified acceptance of British models and practices. For example, historian Belinda Robson wrote a biography of the psychiatrist Eric Cunningham Dax for her PhD thesis in which she drew upon extensive interviews with Dax and many of his peers.[168] Her work serves as one of the most sensitive analyses of the experiences, transition and legacy of a British medical migrant in Australia – albeit one who was exceptional.

Englishman Cunningham Dax arrived in Melbourne in 1951 to take up the prestigious post of medical superintendent of the Victorian Mental Hygiene Authority. The Authority was in desperate need of administrative overhaul to align itself with recent advancements in the care of mentally-ill patients.[169] One interviewee recalled that early local attitudes to Dax's appointment could be summed up as, 'Who is this pommy bastard come out here to tell us what to do?'.[170] This statement hints at a form of professional pride in a distinctly Australian profession that had matured by then, dominated as it was by locally-born, locally-trained men.[171]

The tradition of Australians travelling to Britain or Ireland for their undergraduate study had waned in the preceding decades, owing to a combination of the increased cost of doing so coupled with the growth in prestige and output of Australia's local medical schools. For Australian residents, travel was increasingly reserved for specialist postgraduate hospital experience.[172] The quote however also challenges the rosy portrait of collegiality between

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subjecthood as a legal citizenship status in Australia removed. For a discussion of this, see: Chesterman, 'Race and British Subjecthood in Australia', 30-39.

167 MacLeod, 'Colonial Doctors and National Myths', 134.

168 Robson, PhD diss.

169 For a discussion of the changes in psychiatry and the role and regulation of mental asylums at that time, see: Lewis, *Psychiatry and Society in Australia 1788-1980*.

170 Quoted in Robson, 'Memories of Eric Cunningham Dax', 69-87.

171 Scotton, 'Medical Manpower in Australia'.

172 This is discussed further in Chapters 3-4. For a discussion of a similar evolution for New

Britain and Australia that was often contemporarily expressed.[173] For example, Belinda Robson found that Dax was perceived by some local practitioners as an 'upper-class English gentleman who looked down on colonials … He brought with him the reputation of 'advanced' ideas from England … which aggravated the sense of hostility to his 'outsider' quality.'[174] Her interviews with his peers elicited the extent to which Dax's arrival while widely anticipated in mainstream media represented a snub to the local applicants for the job. The depth of the reforms he shortly instituted further served to aggravate. Other interviewees in her study suggested that an outsider was required to achieve the level of reform, which would have included 'stepping on too many toes' of friends within the local psychiatry community.[175]

Robson's biography of Cunningham Dax exposes a tension in the emerging relationship between post-colonial British and Australian medical structures and development. The nature and evolution of this relationship, as discussed above, has been varyingly explored in greater detail in a large body of work that also varyingly captures the legacy of British and Irish medical graduates in Australia: institutional histories of university medical faculties, public hospitals and prominent research institutions.[176] The expectations and experiences of British/Irish migrants in these accounts are often used to highlight the comparatively underdeveloped or underfunded state of Australian medical institutions. For example, in her history of the Royal Women's Hospital in Melbourne, historian Janet McCalman documents the early resettlement experience of Irishman Kevin McCaul who arrived in Melbourne in 1951 as the Hospital's new director of anaesthesia.[177]

> The new doctor was shown proudly around the hospital. The operating theatre had a strange metal contraption suspended over the operating table: 'What's that' 'That's the old gas lighting', 'Oh, said McCaul without

Zealand medical graduates, see: Armstrong, PhD thesis, 67-94.

173 There are too many examples to support this statement to cite exhaustively here. For much of the twentieth-century, for example, it was still common for Australian-born and trained doctors to refer to England as 'home'. The correspondence columns of the *Medical Journal of Australia,* the *British Medical Journal* and *Lancet* are full of such representations. The following letters illustrate this: see, '"General" Practice in Australia', *BMJ,* 1945, 580; and John Anderson, 'Postgraduate Education', *BMJ,* 1946, 792. The records of correspondence between the London and Australian state branches of the BMA provide further examples. See: BMA House archives (London), Reciprocity of Medical Practice in Australia. Of course, this collegiality is embedded within mainstream Australian allegiance to Britain. For a discussion, see: Alomes, *A Nation at Last?*.

174 Robson, 'An English Psychiatrist in Australia', 82.

175 Ibid.

176 For an overview, see: Bryder, 'History of Medicine in Australia and New Zealand', 302-318.

177 McCalman, *Sex and Suffering*, 247-51, 275-8.

> thinking twice, 'Fanny by gaslight'. The story flashed around stuffy Melbourne "like wildfire and those gaslights came down" …[178]

Such accounts are intended to portray a particularly conservative and prideful local profession. In doing so, however, it also highlights the different, sometimes turbulent experiences of British and Irish doctors in Australia. For example, McCalman found that 'McCaul arrived to find the hospital had a new anaesthesia machine which no one could use'. [179] And one of McCaul's diary entries notes, 'I had nobody to discuss this with, nobody knew anything about obstetric anaesthesia.[180] McCalman quotes McCaul's diaries extensively, in which he documents the challenges of bringing a different ethos of practice and expectation across national borders; of implementing changes in practice; and even his surprise at his being the first Catholic employee at the hospital in decades.[181]

This pattern can be repeatedly, if not easily, found in similar histories of public hospitals.[182] Anthea Hyslop's history of the Ballarat Base Hospital – a country hub in Victoria – records a similarly complex post-war British migrant experience. She recounts the details surrounding the recruitment of a Dr Noel Orchard in 1955 as a salaried, full-time pathologist on a three-year contract. Hyslop observes, '… but alas, within six months, Dr Orchard's determination was concentrated on leaving Ballarat, and indeed Australia, as soon as possible.'[183] In Orchard's case, Hyslop argues that his departure was 'not for a lack of appreciation'.[184] Instead, it was a combination of the enormous workload, the scarcity of technical support and practices within the hospital that in Orchard's view were substandard. One of the members of the Hospital's committee observed that Dr Orchard 'had not yet adjusted himself to Australian conditions'.[185] Such observations point to, but do not fully discuss, the processes and varying experiences of the level of adjustment faced by British medical migrants. Hyslop's analysis suggests, for example, that hospital staff only fully appreciated these differences *in situ*. Following Orchard's unexpected resignation, a member of the hiring committee drew more explicit comparisons, warning a prospective replacement in London that

178 Ibid., 248.

179 Ibid., 249.

180 Ibid.

181 Ibid., 247-51.

182 The presence and recruitment of British and Irish doctors is taken for granted in many of these histories, therefore, finding and aggregating these accounts required prior knowledge of individual names or manually searching discussions of appointment, retirements, staffing, and staffing shortages, to capture instances of migrant doctors. As discussed in the Introduction, a motivation for including British and Irish doctors in this study was driven by the repeated instances they were referenced but the absence of systematic studies of their experiences.

183 Hyslop, *Sovereign Remedies*, 325.

184 Ibid.

185 Ibid, 325-6.

> the Australian scene is that of people who are individualists to a certain extent, who can be often be led where they will seldom be driven … In other words, social distinctions are less apparent than elsewhere …[186]

The experiences of Dr Orchard in 1955 contrast with those of Dr John Begg – a Scotsman with a medical degree from Aberdeen – appointed as the hospital's new medical superintendent in 1960. Begg 'had spent a decade as a medical superintendent in Australian hospitals', before coming to and then easily settling into his new role in Ballarat.[187] These juxtaposed accounts highlight the varying experiences of British/Irish-born, British/Irish-trained doctors while adjusting to Australian conditions.[188] They also suggest the potentially significant role that British/Irish doctors played in staffing country hospital posts in the absence of local interest. For example, Gordon Forth and Peter Yule's history of Warrnambool Base Hospital records how

> the search for pathologists began in 1955, but it proved impossible to attract an Australian pathologist to Warrnambool … Finally, in July 1958, with a fair bit of relief, the committee received an application from Dr John Reid of Edinburgh.[189]

Dr Reid, also an Edinburgh medical graduate, had a decade of experience in West Africa, and was practising as a pathologist in south Edinburgh when he applied for the post. He later recalled of his early experience in Warrnambool how the 'term "country hospital" was looked on as a dirty word' by local members of the Australian profession.[190] The extent to which British migrant doctors occupied low-status medical positions in Australia is poorly understood. Until now, the historiography has suggested that this was the domain relegated to the alien doctor.[191]

In reflecting on the ways in which British and Irish doctors in Australia have been represented and remembered by historians of medicine and health, there are lessons to be drawn from migration history. One British migrant, Joan Watson, reflected in 1998 to historian James Hammerton how British immigrants are remembered more broadly in Australia. She wrote, 'the history books tell of the deeds of the higher echelons of society … whereas the stories of ordinary people are never told'.[192] As historian Sara Wills observed, 'British migrants have … been the passengers of an Australian post- imperial forgetting'.[193] While there remains an individual biographical record of prominent British and Irish medical practitioners, these accounts offer little or no insight into the professional lives, group dynamics and professional

186 Ibid., 326.

187 Ibid.

188 Ibid, 323-4.

189 Forth and Yule, *A History of the Warrnambool and District Base Hospital*, 139-40.

190 Interview with Dr John Reid by the authors, ibid.

191 Kunz, *The Intruders*.

192 Hammerton and Coleborne, 'Ten-pound Poms Revisited', 86-96.

193 Wills, 'Passengers of Memory', 95.

participation of what was a significant cohort of rank-and-file British medical migrants in Australia.[194]

In the absence of studies of the collective group of British medical migrants in Australia, it is necessary to turn to the international literature documenting medical migrants to reflect on other potential gaps in the literature. A prominent example is the work of David Wright, Sasha Mullaly and Mary-Ellen Cordukes, whose study of British medical migrants in Canada marks a revival of interest in British medical migration since the 1960s.[195] These authors document the role British medical migrants in Canada played in reducing inequalities in the distribution of medical manpower between Canadian provinces, highlighted by the tendency for these migrants to practice in non-urban settings, as well as the role these doctors played in saving the 'embryonic' universal health insurance systems introduced in 1966.[196] As they observe, in some cases this role was 'ironic', given many of these doctors migrated to Canada because of their dissatisfaction with conditions in the newly introduced British National Health System (NHS).[197]

A related set of studies by British historians have more recently examined the gap left by these migrating British doctors, which have been filled by medical migrants arriving in Britain.[198] These studies, which explore wide groups of medical migrants, offer further examples of the importance of writing medical migrants into national histories of medicine. For example, Parvati Raghuram and her colleagues' analysis of interviews with South-Asian migrant doctors in the NHS not only demonstrated particular expressions of prejudice and privilege within the NHS, but also how South Asian medical migrants playing a significant role in shaping the development of geriatrics in the UK.[199] These studies offer examples that critically explore the experiences of groups of medical migrants as they transitioned into their new professional settings, and reflect on how in doing so, they were critical to the operation and success of national healthcare systems.[200] That is, these studies sophisticate the 'brain drain, brain gain' argument by examining the full experiences of groups of doctors through the process of migration – from home to host, from resettlement to re-emigration.[201] These studies highlight the complexities of such migrations despite being voluntarily undertaken. They also complicate the tendency for historians to privilege the mode of travel – forced migration versus

194 Last, Migration of British Doctors to Australia.

195 Wright et al., 'Worse than Being Married'.

196 Mullally and Wright, 'La Grande Seduction?', 67.

197 Ibid., 73.

198 Raghuram et al., 'Without Racism There Would be No Geriatrics'; Simpson et al., 'Providing "Special" Types of Labour'; and Haynes, *Fit to Practise,* 105-138.

199 Raghuram et al., 'Without Racism There Would be No Geriatrics'. See also, Bornat et al., 'Migrant Careers in Geriatric Medicine'.

200 Ibid. See also,

201 For an historical overview of the 'brain drain' of medical practitioners, see: Wright et al., '"Brain Drain" of Physicians".

economic migration – in formulating studies of medical migrants.[202] As historian Delia Gavrus recently observed in reflecting on a publication documenting the forced migration of refugee neuroscientists:

> It may be instructive then to look at these two literatures — on the voluntary and the involuntary migration of physicians and scientists in the middle of the twentieth century — in order to fully understand the unique details of each case.[203]

The research questions and approaches emerge

As has been demonstrated, of the thousands of medical migrants known to have arrived in Australia in the interwar and post-war period, only the considerably smaller cohort of so-called alien doctors has been extensively studied as a marginalised group who arrived as DPs and refugees. These analyses have convincingly argued that the ability of these doctors was clearly not at the heart of the negative administrative response to them. Instead, scholars have offered a number of competing interpretations for understanding the profession's resistance to licensing 'alien doctors' to legally practise medicine in Australia. These interpretations range from racial motivations that reflect the wider xenophobia prevalent in Australian society, to economic ones that describe a particularly protectionist professional culture of Australian medicine at the time. These accounts are focussed on the most common approach historian Paul Weindling has identified in studies of refugee doctors in the receiving context – the negative administrative response to them which prevented their registration and legal practise as medical practitioners.[204] Therefore, in these studies, British and Irish graduates – are implicitly portrayed as accepted owing to the established recognition of British and Irish medical degrees in all Australian states.

The wider historiography documenting British and Irish medical migrants in Australia is seen in (auto)biographical accounts of medical elites and institutional histories either to accept or challenge this notion, albeit in a peripheral manner. The former body of work has the theme of nation-building at its heart and, therefore, the migrant status of British and Irish practitioners is secondary. The latter, while similarly geocentric, is more sensitive to the international differences between British and Australian professional practice, despite the shared colonial past. In these accounts, the experiences and contributions of a handful of British and Irish medical migrants are portrayed as more complicated, hinting at, but not fully exploring, British and Irish medical migrants as one of the many categories of 'other' in the professional context. Migration historians have recently begun to recover histories of British and Irish migrants in Australia, slowly redressing their invisibility in Australian communities, this trend has not extended to include medical migrants.

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202 Stahnisch and Russell, (eds.) *Forced Migration in the History of 20th Century Neuroscience and Psychiatry*; Weindling, 'Medical Refugees in Great Britain and the Wider World'.

203 Gavrus, 'Émigré Scientists and the Global Turn', 366.

204 Weindling, 'Medical Refugees in Great Britain and the Wider World'.

When considered together, the distinct forms of collective amnesia at the heart of the historiography of medical migrants in mid-twentieth century Australia is apparent: one set are marginalised; the other are largely invisible. In critically examining these two disparate bodies of literature together, however, it is clear that there is a common gap: the lack of research describing the professional lives and experiences of these European medical migrants (broadly defined) in Australia. The potential of taking such an approach is seen in the broader literature documenting the lives and lived experiences of groups of medical migrants. For example, such studies can: reveal the development and dissemination of medical knowledge across national boundaries;[205] complicate the legacies of medical migrants in their new counties of settlement;[206] highlight the impact medical migrants have had and the ways in which they have participated in national issues;[207] uncover new ways in which to understand the structures, cultures and politics of medicine in a geopolitical area;[208] and nuance our understanding further by examining gendered experiences of medical migration.[209]

What many of the studies included in the wider historiography documenting medical migration share in common is a focus on reconstructing the professional lives of these migrants, using a variety of biographical approaches – from collective biography, prosopography and oral history – to elicit the patterns, networks, identity-formation, contributions and group experiences of medical migrants. To date, there has not been an extensive collective biographical study of European medical migrants in Australia. Therefore, a significant gap in the literature on medical migrants in Australia can be addressed by doing so. By formulating a study that combines previously disparately-held groups of medical migrants, there is an opportunity as Gavrus observes, to develop a deeper understanding of the meaning and implications of being an outsider attempting to integrate into a set of systems and practices different to your own. Furthermore, there is the opportunity to highlight the differences and shared experiences of discrete groups of outsiders.[210] The historiographies documenting British/Irish and continental medical migrants in Australia to date assumes the differences between the two groups are so insurmountable that it precludes such an analysis. However, a critical reason for this appears to be the divide between the two historiographical positions: one is solely concerned with the process and mode of migration; the other solely with the development of Australian medicine.

A key question that emerged from this critical exploration was to ask, what fresh perspectives could be gained by studying these two groups together since they share in common

205 See: Crowther and Dupree, *Medical Lives in the Age of Surgical Revolution*.

206 See: Zamet, PhD diss., Weindling, 'Impact of German Medical Scientists on British Medicine'.

207 See: Wright et al., 'Worse than Being Married'; and Mullally and Wright, 'La Grande Seduction?'.

208 See: Fleck, *A Transatlantic History of the Social Sciences*; Jenkinson, 'A Prosopography of Scottish Shop-keeping Doctors in the Late Nineteenth and Early Twentieth Centuries'; Armstrong, PhD diss.

209 See: Armstrong, PhD diss; Grossman, 'German Women Doctors from Berlin to New York'; von Villiez, 'Emigration of Women Doctors from Germany under National Socialism'.

210 Gavrus, 'Émigré Scientists and the Global Turn in the History of Science'.

the act of arriving and re-establishing themselves in a new professional setting. However, as historian Ann Curthoys cautions:

> … histories of colonisation and empire make it impossible to place British alongside non-British immigration as *simply* [emphasis mine] another form of migration, however desperate the circumstances of particular British immigrants, like the convicts, may have been.[211]

That is, a study which aims to explore a more broadly-defined group of medical migrants in the Australian context must account for not just the legacy of British colonialism, but also 'the extreme diversity' of groups of European medical migrant in Australia.[212]. The latter includes the implications of the different pathways they took to arriving there. A second question was to consider the other common gap in both studies, which was the lack of insight into the life course or professional lives of these men and women. Who were they? What professional work did they do? The importance of addressing this gap is emphasised when considered against the findings revealed in the international scholarship on twentieth-century medical migration as discussed above. The overarching aim of the research project therefore emerged – to meaningfully write medical migrants into Australian histories of medicine; as did the overarching approach – to do so through an analysis of their collective lives.

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211 Curthoys, 'Does Australian History Have a Future?', 150.

212 Simpson et al., 'Providing "Special" Types of Labour', 212.

Chapter 02: The Structure, Practice and Politics of Medicine in Australia, 1930-ca.1970

In the previous chapter I highlighted that a crucial gap in the historiography – particularly as developed to contextualise the reception of continental medical migrants in Australia – is the uncritical representation of medical practitioners as a homogeneous group enjoying 'high income and status'.[213] However, the medical context has not been the primary frame underlying these analyses and this lack of focus, I argue, has impinged on a fuller understanding of the reception and subsequent pathways of medical migrants in Australia. An original contribution of this thesis is to interweave the implications of the development and politics of medicine into how we understand the histories of European medical migrants in Australia. In this chapter, I provide this context for the case studies that follow by discussing the changing structure, practice and politics of Australian medicine between 1930 and the early 1970s.

This topic represents a complex array of constituent parts, so it has been necessary to selectively develop those aspects that I consider to be critical to understanding the pathways of medical migrants. This includes the regulation of medical practitioners, particularly the prerequisites that determined who could be registered as a legally-qualified practitioner throughout this period (entry into the profession). Second is the scope of medical practice (making a living). Third, is the formal and informal regulation of these two aspects and the implications of this interplay (medical politics). It is important to note that this chapter traces national developments and trends. However, there was no such thing as an Australian medical system at the administrative or regulatory level. Since white settlement of Australia in 1788, it was the boundaries of newly established colonies that defined this development (Figure 1). The federation of Australian colonies to form the Commonwealth of Australia in 1901 did not include nationalised legislative power over health matters, with the exception of quarantine. Each of the six states retained a large degree of autonomy, which included the legislative power over health, hospital and medical acts.[214] The autonomy of the former colonies meant that on Federation each state already had its own distinct histories of development and regulation of health care and its base of orthodox and heterodox medical practitioners. This differential development continued throughout the period under investigation.[215]

213 Kunz, *The Intruders,* 31, 46*;* Rutland, 'An Example of "Intellectual Barbarism"', 46.

214 To avoid confusion, I will refer to 'federal' and/or 'state' government to describe Australia's different levels of governance. If unqualified, the word 'state' refers to the geographical states of Australia.

215 For an overview of the state-level differences in regulation and delivery of health care, see: Roemer and Roemer, *Health Manpower in the Changing Australian Health Services Scene*, particularly 9-11, and 63-69.

Background: The basis of the medical profession in 1930

By 1930, orthodox medical practitioners had firmly established themselves as the predominant supplier of medical services in Australia. In the wake of World War I, the emphasis had shifted to the development of medical research and specialisation, and the extent of the role of the federal and state governments in the delivery of healthcare.[216] Neither of these two outcomes were inevitable or easily achieved.[217] In the first half of the nineteenth-century, the Australian marketplace for the provision of medical services was competitive and pluralistic, despite early introduction of basic medical registration in the colony of New South Wales (NSW).[218] Migrating (mainly British) medical practitioners had 'brought with them a determination to implement the medical reforms of a common register, equal legal rights for all qualified practitioners, and restrictions on those not qualified'.[219] The introduction of the 1858 Medical Act in Britain catalysed Australian colonies to renew efforts to introduce stronger legislation which included raising the minimum training standards to protect local medical graduates from unwanted competition. In Victoria, where the organisation of the profession had been traditionally stronger, this legislation was enacted in 1862; and in NSW in 1900.[220]

However, a major source for achieving a wider set of reforms and professional control in Australian colonies (later states) lay in the body of orthodox practitioners convincing their respective legislatures of the legitimacy of their claims to a knowledge-base underpinned by scientific rigour.[221] Equally important was the increasing acceptance by citizens of the superior therapeutic efficacy offered by these practitioners – an efficacy that was less apparent before the biomedical and technological advancements of the late nineteenth and early twentieth centuries.[222] In NSW, for example, proposed laws which would consolidate the authority of orthodox practitioners were defeated twice (1875 and 1880), owing to strong legislative support for heterodox practitioners.[223] In Victoria, the orthodox profession was only successful in its lobby to amend the medical act in 1906 to include raising the minimum medical training requirement from three to five years, as well as introducing the principle of reciprocity in

216 Thame, PhD diss., 1-36; Hobbins and Forsyth, 'Mobilising Medical Knowledge for the Nation', 59-79.

217 A detailed discussion of the former is out of scope for this thesis. See instead: Dyason,'Medical Profession in Colonial Victoria'; Pensabene, *Rise of the Victorian Medical Practitioner*; Lewis and MacLeod, 'Medical Politics and the Professionalization of Medicine in NSW,'; and Patrick, *History of Health & Medicine in Queensland*.

218 The earliest relevant legislation was introduced in the colony of NSW in 1838. For a discussion, see: ibid. For an overview of medical pluralism in Australia, see: Baer, *Complementary Medicine in Australia and New Zealand,* 16-33.

219 Dyason, 'Medical Profession in Colonial Victoria', 194.

220 Ibid.; Lewis and MacLeod, 'Medical Politics and the Professionalization of Medicine in NSW'.

221 The meaning of 'science' here is a contested term. For a discussion, see: Bynum, *Science and the Practice of Medicine in the Nineteenth Century*; and Shortt, 'Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century'.

222 For an overview, see: Porter, *The Greatest Benefit to Mankind*; Jordanova, 'The Social Construction of Medical Knowledge'.

223 Bak, 'Homeopathy and the Defence of Medical Pluralism in Nineteenth-Century NSW'.

determining the recognition of foreign practitioners.[224] These changes can be attributed to growing public confidence in the potential of orthodox medicine. As parliamentarian John Mackey observed during the debate over the Victorian bill, 'during the last thirty years, the science of medicine, and also of surgery, has become completely revolutionised'.[225]

By 1930, all states had enacted their own medical act, and established a state medical board – largely comprised of medical practitioners – to administer it. These acts did not ban heterodox practitioners, who could still provide medical services to patients for a fee. Owing to the lobby of homeopaths in Victoria, for example, there was provision in that state's act to register only one graduate from particular American homeopathy schools. However, unregistrable practitioners were not allowed to: assume the title 'medical practitioner'; perform autopsies; be appointed to a range of posts, including in public hospitals, mental health sanatoria and as ships' surgeons. Practitioners were required by law to register with the relevant state medical board before commencing private practice – this included interstate relocations by Australian-born and trained practitioners. Technically state boards had the power to prosecute against infringements. However, as was largely the case the world over, it was weakly enforced.

Until 1935, there were only three medical schools in Australia. The University of Melbourne (VIC) first enrolled medical students in 1862, followed by the University of Sydney (NSW) in 1883, and the University of Adelaide (SA) in 1885. No further medical schools were established until 1936, when the University of Queensland opened its medical school. The other two states – Western Australia and Tasmania – opened their first medical schools in 1957 and 1961 respectively. Until then, Western Australia and Tasmania relied on other states and overseas to train and supply their medical practitioners. The three states with medical schools wielded a considerable degree of influence, from regulating the supply of local graduates to shaping the training of Australia's future medical workforce. In the absence of a national accrediting body, all three Australian medical schools structured their courses to ensure ongoing accreditation with the British General Medical Council (GMC), which in turn guaranteed Australian graduates the ability to practice in the UK. As with many other imperial legacies shared between the UK and Australia, Australian medical faculties' accreditation with the GMC continued quite late, in this instance to 1985.[226] However, the establishment of Australian medical schools created a point of departure between the earlier base of predominantly British practitioners trained 'according to a multiplicity of standards',[227] and the emerging groups of locally-trained graduates who, by virtue of going to one of three schools, shared a greater degree of uniformity in their primary medical training.[228]

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224 For a discussion, see Pensabene, *Rise of the Victorian Practitioner*, 33-56.

225 Victorian Parliamentary Hansard, Medical Practitioners Law Amendment Bill, 5 December 1906, 3444.

226 In 1985, the Australian Medical Council was formed. For a discussion, see: Smallwood et al., 'The Australian Medical Council, 566-7.

227 Pensabene, *Rise of the Victorian Medical Practitioner*, 59. Pensabene is referring to the spread and number of hospitals, universities and licensing bodies in mid-late nineteenth century Britain offering medical education.

228 Of course, the experiences of and opportunities afforded medical students varied by gender.

Arguably it was the composition of the Australian medical workforce that represented the most singular change to the structure of the profession in the first three decades of the twentieth century.[229] Australia's reliance on the UK to both train and supply its medical workforce waned. Increasingly, travel to the UK was reserved for postgraduate hospital-based training, since the development in Australia of robust postgraduate and specialist programs was comparatively slower.[230] The expansion of state medical schools in response to the increasing demand for medical services and the growing attractiveness of medicine as a prestigious and stable middle-class career, meant Australian states became progressively self-sufficient in terms of supply of medical graduates. The locally-born, locally-trained male graduate came to dominate the workforce.[231] Although women had gained entry into the profession in the late nineteenth century, the number of women whose families were willing to finance an expensive medical degree remained limited in the early decades of the twentieth century.[232]

In concert with the anticipated growth of local medical schools, most state medical acts were amended in the early 1900s. This had two aims. Firstly, to privilege local institutions, which from their establishment offered five-year medical degrees[233] – longer courses than most of their overseas counterparts.[234] And secondly, to prevent undue competition from overseas practitioners. The latter – with the exception of British and Irish degrees – were effectively shut out of the Australian medical market by the inclusion of reciprocity clauses in state medical acts,[235] and by the local medical schools modifying their recognition of prior overseas study (*ad eundem*).[236] The University of Melbourne's medical faculty, for example, modified their rules in 1908. From that point onwards, it required graduates holding unrecognised degrees to complete their full five-year course.

Therefore, all other foreign medical graduates were effectively shut out of state medical markets from 1905-06, unless they were willing to retrain at one of the three local schools. Although British and Irish practitioners enjoyed unrestricted rights to register and practice in Australian states, the numbers arriving dropped after 1911. For example, in Victoria, only 117 British-trained graduates were registered between 1911-33, where in 1933 there were a total of

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For Australia, see: Hutton-Neve, *This Mad Folly*.

229 Pensabene*, Rise of the Victorian Medical Practitioner,* 61-2; Poate, 'The Capacity of the Medical Profession in Australia'.

230 Historian Douglas Haynes argues that British training hospitals encouraged this travel, and relied upon medical migrants to relieve temporary hospital staffing shortages in Britain. See, Haynes, *Fit to Practise,* 80-101.

231 Poate, 'The Capacity of the Medical Profession'.

232 Fett, PhD diss., 236-255; 301-08.

233 This was lengthened to six years in 1923.

234 For example, the GMC in the UK set a minimum of five years in 1892.

235 Following Australian federation in 1901, the GMC set about re-establishing what had previously been automatic recognition of British qualifications from around the Empire. For a full discussion, see Salter, 'Prejudice in the Professions'.

236 Ibid.

over 1,400 doctors registered.[237] This downturn has been attributed to the improving conditions for practice in the UK as a result of the 1911 *National Health Insurance Act*, which motivated fewer British doctors to migrate in search of better professional working conditions.[238] For the duration of World War I, the movement of British doctors was subsumed by the war effort. By November 1917, over half of the British medical profession had been called up to serve, and in the face of insufficient medical manpower, recruited within the British Empire.[239] It is estimated that the war interrupted the careers of almost nine thousand British medical men.[240] Following the end of the war, there are no signs that British doctors sought to migrate in large numbers to Australia during the 1920s.[241]

Throughout the early decades of the twentieth-century, privately-run charitable hospitals were also being replaced by a growing system of public hospitals.[242] Although the earliest of these institutions shared a common origin as charitable institutions that aimed to provide care to those who could not afford it, public hospitals progressively relied on state government funding.[243] As one medical practitioner Arthur Brown succinctly, if somewhat simplistically, summarised in 1951:

> In the last fifty years … medical science developed new techniques which required new equipment, and this equipment was expensive. The owners of private hospitals were not prepared to invest money in these things, which were therefore concentrated in the public hospitals. There was thus created a great distinction between the smaller, more comfortable private hospitals and the barrack-like, but incomparably more efficient public institution. Gradually this distinction caught the eye, first of the doctors and then of the general public, who awoke to the realization that the better-off people were debarred from the most efficient and effective treatment.[244]

While more robust histories have now been developed to disentangle and explore the development of hospitals in Australian states, Brown's blunt assessment describes important shifts in the operation of Australian public hospitals in the first few decades of the twentieth century. This included the introduction of private paying beds in public hospitals, and their

237 Pensabene, *Rise of the Victorian Medical Practitioner,* 64-65.

238 Digby, *Evolution of British General Practice*, see Chapters 5 and 12 in particular.

239 Haynes, *Fit to Practise,* 49-54.

240 Official statistics record 12,720 doctors in the armed forced and 11,482 in civilian practice on 1 January 1918. See: Abel-Smith, *The Hospitals,* 263, and 278-9.

241 Last, 'Migration of British Doctors to Australia'.

242 Ibid.

243 Early Australian public hospitals mirrored British models, and were established out of philanthropic ideals that was 'part of the cultural baggage accompanying all British immigrants' (Dyason, 'Medical Profession in Colonial Victoria', 203). However, unlike in the UK, state governments always had some involvement in the system.

244 Brown, 'Development of Australian Hospitals in the Last Fifty Years', 40-41.

increased reliance on state-funding.[245] For example, in the state of Victoria, in 1900 the government contribution to public hospitals almost matched public donations, at approximately £62,000.[246] In 1944-45, the majority government contribution exceeded £500,000.[247] During this time, the divisions or scope of the provision of hospital care – both in-patient and out-patient – came under increasing authority of the medical professionals,[248] not lay governing boards. With this arose new intra-professional disputes over access – both what group of citizens were eligible for free out-patient care, and how prestigious hospital appointments and the ensuing control over hospital beds were determined. At the heart of these developments were the doctors themselves, who, as historian Robert Evans concluded, had 'conflicting obligations affecting hospital development' in Australia.[249] Not least because of the importance of the latter on doctors' intellectual pursuits and livelihoods.

Private practice - that is providing medical services in exchange for a fee – was the mainstay of making a medical living. Thus, new graduates relied upon establishing themselves as such. Recent graduates could apply for resident hospital work, typically as six-month or year-long appointments. However, the majority trend was for young graduates to quickly leave resident positions and attempt to establish themselves as private practitioners, typically in solo practice.[250] This trend continued for the better part of the twentieth-century. The 1921 Census, for example, found that almost 70 per cent of the Australian profession reported themselves as 'on their own account', compared to roughly seventeen per cent who were employees.[251] The impetus to cultivate a patient list, as well as to stay connected with advancements in medical science, however, can be linked to the desirability for private practitioners to remain connected to the growing number of public hospitals in an honorary capacity. This was either as a clinical assistant, or as the more prestigious honorary consultant surgeon or physician. Essentially, medical practice varied according to the entrepreneurship and ambition of individual practitioners. Pensabene's survey of practice in Victoria between 1900-30 found a high degree of variance from the recommended 10s 6d in the fees charged by practitioners, which ranged from regularly giving free services to charging a guinea for a consultation.[252] Surveys of the distribution of practitioners also found marked differences in the distribution between rural- and urban-based practitioners, reflecting the concentration of Australia's population in its urban

245 Thame, PhD diss., 259-270; Evans, 'The Transformation of Australian Hospitals'.

246 Office of the Government Statist, 'Statistical Register of Victoria', 15.

247 Charities Board of Victoria, *Annual Report for the Year ended June 1945*, 17.

248 This has been almost invariably linked to the growth of specialist knowledge in medicine. See, Weisz, *Divide and Conquer*. NB: Both Evan Willis for Australia and Rosemary Stevens for the UK argue for a strong role played by political and social forces that sit outside of the medical profession. See: Willis, *Medical Dominance,* 78-9; Stevens, *Medical Practice in Modern England*, 4-6, 85-89, 158-165.

249 Evans, 'The Transformation of Australian Hospitals', 103.

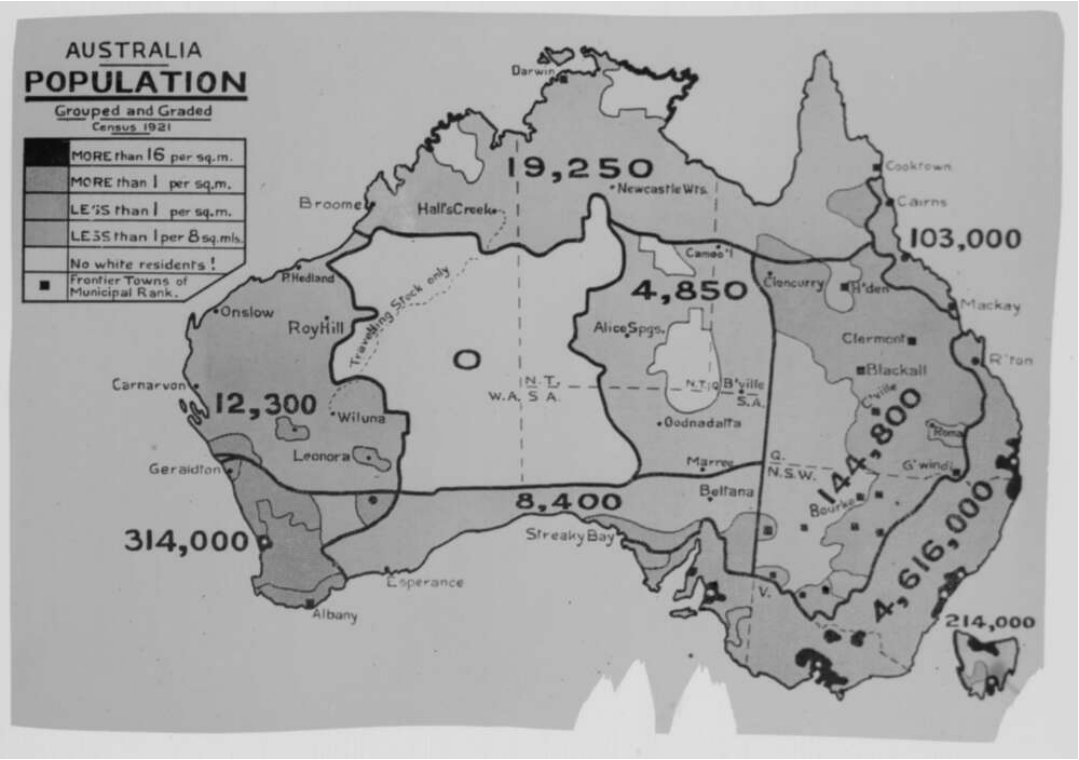
250 ABS, 1921 Census.

251 Gillespie, *Price of Health*, 5.

252 Pensabene, *Rise of the Victorian Medical Practitioner,* 57-81.

centres (Figure 2). The distribution within its major cities also varied, reflecting the relative wealth of urban shires.[253]

Figure 2 Map of Australia's population, 1921 Census. State and territory legend (in alphabetical order): N.S.W. (New South Wales), N.T. (Northern Territory), Q. (Queensland), S.A. (South Australia), V. (Victoria).



Source: National Library of Australia.

The issue of differential access to primary and hospital medical care between the more densely-populated urban centres and Australia's country towns and outback settlements was only partially alleviated by growth in public infrastructure and the increasing affordability of motor vehicles that reduced the distance between a patient and their doctor. The adequacy of medical services in Australian country towns was a constant source of debate between state governments, philanthropic organisations and the medical profession. This challenge lead to the development of the innovative flying doctors service which began in 1934 and continued to expand in the following decades (Figure 3). Another development worth noting is the establishment of district bush nursing hospitals in a number of states. This was often funded by subscription, additionally boosted by private endowments.[254] In Tasmania, the state government took over the privately established Tasmanian Bush Nursing Association in the 1920s, demonstrating the particular difficulties faced by smaller, less-populous states in maintaining a privately-funded service. In Victoria and other more populous states, the Bush Nursing Hospitals were maintained by subscription of £1 per year, with a required minimum of 100 subscribers.[255] The bush nursing movement placed trained nurses in rural towns to

253 Ibid.

254 Bardenhagen, PhD diss., 37-82.

255 Priestley, *Bush Nursing in Victoria, 1910-1985,* 29.

provide essential midwifery services, and support young mothers.[256] However, the scope of these nurses work often extended beyond this remit, particularly in towns without a doctor – and this raised criticism from the members of the medical profession who objected to 'unnecessary interference'.[257]

Figure 3 Map of Australia (excluding Tasmania) showing reach of Flying Doctor Service in red and reach of wireless communication in blue.



Source: National Library of Australia, Flynn, John, 1880-1951, cartographer.

The growth of public health programs under state direction, linked to the development of preventive medicine, also expanded in the first three decades of the twentieth century.[258] Although responsibility for individual policies that promoted 'national hygiene' in Australia was distributed differently between departments, each state government instituted and continued to administer a number of public health programs.[259] This included a system of mental health sanatoria, vaccination programs,[260] school medical services, infant and maternal health welfare

256 Ibid.

257 Ibid. Quote: 'Doctor and Bush Nurse', *The Mercury,* 5 June 1929, 7.

258 Thame, PhD diss., 1-36.

259 The development of the national hygiene movement in Australia was underpinned by advocacy of preventive as well as curative medicine, see: Thame, PhD diss.

260 By 1930, NSW was the only state without a compulsory vaccination program. See: ABS, *Australian Year Book 1930*.

services, sanitation, occupational health and quarantine services.[261] The latter was the only source of federal jurisdiction, and the Commonwealth Department of Health was established in 1921 in response to the urgent and recognised need to coordinate the prevention and containment of infectious disease.[262] Beyond this top-level similarity between the states, as medical administrators Ruth and Milton Roemer noted, the structures and regulation of public health programs in Australia 'defies generalisation'.[263] It is out of the scope of this thesis to discuss these differences in detail.[264]

Finally, by 1930 the organisational bodies representing the professional interests of medical practitioners had consolidated their activities under the banner of the British Medical Association (BMA). The BMA in Australia operated as a collection of state branches, each individually affiliated to the parent body in the UK. State branches of the BMA oversaw a variety of activities on behalf of the profession, including lobbying state and federal governments. In 1912, shortly after a state branch was formally constituted in Tasmania, the last of the state branches to be formed, the first federal committee for BMA branches in Australia was created. The committee had no autonomous power. However, its constitution afforded it the authority to represent members of the local BMA branches when negotiating 'any matter affecting the relations between the government [federal and state] and the medical profession'.[265]

Importantly, in 1913 the new federal committee successfully elicited from the incumbent Prime Minister Joseph Cook a promise that the profession – via the BMA in Australia – would be consulted on any future policy that might have an impact on the profession.[266] This lobby was prompted by the introduction of a national health insurance scheme in the UK in 1911, which Australian-based practitioners widely anticipated would, as British policy traditionally had, influence Australian public policy.[267] Membership of the state branches of the BMA grew steadily in the first decades of the twentieth-century, resulting in its increasing authority as the representative body of active medical practitioners. For example, the Australian College of Surgeons, one of the first specialist colleges established in Australia in 1927, conceded all political activity to the BMA.[268] By 1930, it was conservatively estimated that each branch represented an average of 85 per cent of the total number of medical practitioners in that state.[269] A recent article by historian Louella McCarthy suggests, however,

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261 Thame, PhD diss., 1-37, 147-339.

262 However, the power and authority of the federal Department of Health was never very strong. See: Ibid.; and Gillespie, *Price of Health*.

263 Roemer and Roemer, *Health Manpower in the Changing Australian Health Services,* 9.

264 For a full discussion, see: Thame, PhD diss., 1-37*;* and for the second half of the twentieth century, see: Ibid.

265 AMA, *More Than Just a Union,* 42.

266 Gillespie, *Price of Health,* 7-15, 90-97.

267 Ibid.

268 Wilde, PhD diss., 19, 129-154.

269 Pensabene, *Rise of the Victorian Medical Practitioner,* 186-7; Poate, 'The BMA in Australia

that Australian medical women had a more turbulent relationship with the BMA in Australia, which resulted in different proportions of women members.[270]

Perhaps the most prominent example of the role the BMA played in Australia is seen in its negotiations with the friendly societies operating in each state. The relationship BMA branches had with the friendly societies in each state can be described as bitterly acrimonious.[271] Friendly societies in Australia were established in the latter part of the nineteenth century. They provided a viable alternative for social groups not at either end of the social spectrum: the indigent who were eligible for means-tested treatment free-of-charge at out-patient clinics attached to major public hospitals; and the wealthier sections of society for whom cost was a lesser consideration. Friendly societies in Australia offered working middle-class men (and later women) coverage including medical services, and in the cost of membership included coverage for his dependents. In Victoria, for example, membership of friendly societies grew from 98,985 in 1900 to 164,899 by 1929/30.[272] This translated to an increase from 274,223 consultations in 1900 to 434,410 in 1930[273] (roughly 20 per cent of the total state population). The proportion of an average practitioner's income that depended on panel practice was variable. However, the vehement and protracted nature of the negotiations over both capitation fee (fixed) rate and the scope of panel practice contracts hints at the depth of the dependence doctors had on this income stream.[274]

In 1913 the federal committee of the BMA in Australia called for a means test to limit membership of friendly societies.[275] The BMA sought to exclude people who could afford private – that is, fee-for-service – treatment from accessing subsidised medical services through the friendly societies. However, over the proceeding five years no agreement could be reached, with negotiations temporarily postponed during World War I. In January 1918, practitioners around the country resigned from their contracts with friendly societies. Only in 1920 did the BMA in Australia successfully negotiate a Common Form Agreement with friendly societies, which included a strict means test for society members seeking medical benefits to exclude those who could afford private treatment. Additionally, panel practice consultations were limited to general services, and members were required to pay for an increasing list of services, including minor operations, anaesthetics, midwifery and orthopaedic services. From the perspective of practitioners, the anxiety around this issue is better understood in parallel with the competition that private practitioners – estimated to comprise over three-quarters of the medical

– Development during Fifty Years', 63.

270 McCarthy, 'The British Medical Association and Women Doctors in Australia, 1880–1939'.

271 Pensabene, *Rise of the Victorian Medical Practitioner,* 147-58; Gillespie, *Price of Health,* 7-14.

272 Victorian Parliamentary Papers, Reports of the Proceedings of the Government Statists in Connection with Friendly Societies, 1880-1934.

273 Ibid.

274 Gillespie, *Price of Health*, 7-9. For a discussion of friendly societies, see also, Cromwell and Green, *Australia's Friendly Societies.*

275 Ibid.

workforce – faced as they lost patients and scope of specialist practices to the hospital system.[276] Another major reason, particularly for early graduates, was the need to quickly recover the cost of medical school and to accrue the capital outlay required to establish themselves in practice.

In 1924, for example, the fees at the University of Melbourne cost £25 annually, when the nominal wage was roughly £4/week.[277] On graduation, doctors without substantial family support to enable them to buy an established practice (and the associate goodwill and debts for the practice), was required to either work as an assistant in an established practice, or 'squat' in a suburb to grow their patient list organically. The latter often came with the risk of damaging relationships with the established practitioner in that suburb. In this context, panel practice offered a steady source of supplementary income.[278] For example, the lowest agreed capitation fee for lodge practice was in Victoria – 20 shillings in urban centres, 25 shillings in outer regions, where friendly societies recorded £210,000 of expenditure to cover members' medical attendance and prescribed drugs in 1925.[279] The 1925 Royal Commission on National Insurance found approximately 40 per cent of Australian medical practitioners were contracted to a friendly society.[280] However, it carried with it a stigma of restricting professional autonomy and dependence for practitioners; and a marked lower status for members following the introduction of means testing. For their part, practitioners were often accused of poorer quality of care afforded their panel patients (which the BMA in Australia repeatedly denied).[281]

'I would rather go pea picking than work as a contract doctor'[282]: Medical work, universal health care and preserving 'cash for care' in Australia, 1930-53

The discussion so far has centred on the foundations of the structural and regulatory elements of medical practice in Australia to the period 1930, highlighting that while the pluralism and diversity of the medical workforce changed significantly, the entrepreneurship and individualism that defined the dominant mode of medical practice in the late nineteenth remained a central feature for the first three decades of the twentieth-century. Against this background, the remaining two sections will now turn to the work of the practitioners themselves. These developments were fundamentally shaped by the state and federal governments gradually assuming the responsibility of ensuring that every Australian had access to basic medical services, and the numerous debates that characterised the policies developed to achieve this

276 For example, in 1921, it was estimated that only 16.7 per cent of the Australian medical workforce were employed or salaried. Source: ABS, Census of Australia, 1921.

277 Gillespie, *Price of Health,* 6.

278 The Royal Commission on National Insurance in 1925 reported the dependence on these contracts was most acute for early medical graduates in metropolitan areas. See: Commonwealth of Australia. Royal Commission on national insurance and Millen, *Fourth and Final report of the Royal commission on National Insurance*.

279 Gillespie, *Price of Health,* see: Table 1.3, 11.

280 Royal Commission 1925.

281 Ibid.

282 Leo Bamber, as quoted in, 'Telegraphic News – Doctors and National Insurance Scheme', *Narandera Argus and Riverina Advertiser*, 25 November 1938, 2.

outcome.[283] As contemporary commentators Dr Michael Bollen and Professor Deborah Saltman reflect:

> The recent history of general practice in Australia has been linked closely with the development of health insurance: from the time of the friendly societies, through a range of government sponsored national health schemes, to the present day …[284]

From the 1924 commission on national health insurance to 1939, the BMA in Australia – in both its federal and the state representative committees to varying degrees – successfully campaigned against the inclusion of medical benefits in a national health insurance scheme.[285] This process crystallised the authority of the medical profession in determining the provision of health services; exposed the varying and precarious relationships between states and their friendly societies; and brought to the forefront the importance of the concept of the fee-for-service relationship between a doctor and patient – with minimal government intervention. That is, the BMA in Australia lobbied against models privileging contract practice or salaried practice as the dominant mode for delivering medical services to the public. As many commentators have established, this largely successful lobbying had important ramifications for the future development of state-subsidised health care in Australia.[286]

However, the events surrounding the introduction of a national health insurance scheme revealed much about the state of the profession itself. It exposed an internal fragility. Historian James Gillespie identified as a growing divisiveness, which became particularly evident during the Depression of the 1930s, between the majority of medical practitioners working in private practice (GPs) and aspiring full-time specialists.[287] Historian Bryan Gandevia, argues that the 'genesis' of the 'rift' is to be found in the social and professional environment within which nineteenth-century and early twentieth-century practitioners found themselves in.[288] At its core was the scope of work and the status of GPs in Australia.

As discussed, since the turn of the century, the medical workforce in Australia was almost exclusively in private practice. For example, in 1933, there was an estimated 4,874 active medical practitioners in Australia – 4,160 of whom were in private practice.[289] Full-time salaried positions were largely restricted to state and federal public health roles, resident medical officers in hospitals, and some full-time salaried hospital positions. The traditional view that consultant roles in the hospital system should remain honorary (unpaid) prevailed in

283 For a discussion, see: Thame, PhD diss., 340-50.

284 Bollen and Saltman, 'A History of General Practice in Australia', 3.

285 The Australian BMA's Federal Committee was replaced by the Federal Council in 1933.

286 Notably, Gillespie, *Price of Health*; and Crichton, *Slowly Taking Control*.

287 Gillespie, *Price of Health,* 57-63, 98-104.

288 Gandevia notes that 'it is a mistake to look for 'causes' [of problems with national medical schemes] in the period after World War Two', see: Gandevia, 'History of General Practice in Australia', 56.

289 Scotton, 'Medical Manpower in Australia'.

most Australian states, with the notable exception of Queensland.[290] One feature of Australian practice that stands out relative to international terms was the blurred boundaries between general and specialist practice that also persisted well into the 1970s. That is, the 'polyvalent' general practitioner remained a dominant component of the medical workforce in Australia, despite the growth of medical knowledge that made competence in all the emerging branches of medicine virtually impossible. As Gandevia observed in 1971, this polyvalency 'became a characteristic, indeed a tradition of Australian general practice; "physician and surgeon" read the brass plate until very recent years, and the doctor might have equally reasonably have added obstetrician, gynaecologist and anaesthetist'.[291]

It is impossible to discover the exact proportions of GPs versus full-time specialists working in Australia for much of the twentieth-century. In 1972, John Dewdney summarised, 'it is [now] not difficult to differentiate between general practice and specialist practice, but it is less easy to differentiate between general practitioners and specialists'.[292] However, the debates surrounding the development – or lack of – viable full-time specialist medical careers offers clues to the extent to which general practice remained the mainstay of making a medical living. For much of the first half of the twentieth century, a combination of factors characterised the early development of medical practice in Australia and made the viability of a full-time specialist career unsustainable for all but a handful of city-based practitioners. Gandevia echoes many contemporary commentators in categorising the primary causes to be a combination of isolation, status, and 'demanding and unremunerative practice'.[293]

The essence of Gandevia's narrative is that the polyvalent GP was birthed by necessity. In country areas, in particular, the nearest hospital was too far away for easy access, and practitioners could not afford to limit their scope of practice. To do so had an unthinkable human cost attached to it. This form of self-reliant practice was sustained, however, despite growing acceptance that mastery of all domains of medical knowledge was beyond the capacity of a single practitioner. To an extent, Australia's geographical vastness coupled by its population sparseness, particularly in country and remote areas continued to partially justify this trend (Figure 2).[294] However, in the more populous urban environments, arguably a more dominant reason was the Australian GPs' 'reluctance to prune' specialist practice from their daily routine – for both intellectual and economic reasons.[295]

Gandevia argues this aspiration germinated in medical schools where students were given a generalist medical education.[296] Owing to its commitment to maintaining British

290 Gillespie, *Price of Health,* 73-86.

291 Gandevia, 'History of General Practice in Australia', 54.

292 Dewdney, 'The Health Professions', 277.

293 Gandevia, 'History of General Practice in Australia', 54-55.

294 See also, Scotton, 'Medical Manpower in Australia'.

295 Blackburn, 'The Growth of Specialism in Australia During Fifty Years'.

296 Gandevia, 'History of General Practice in Australia'. This view is corroborated by a number of commentators. See for example, Russell, *The Melbourne Medical School*; Dew, 'Developments of Undergraduate Medical Education'; Geffen, 'A Brief History of Medical

GMC accreditation, this was typically structured as a year of basic science, two years in pre-clinical subjects (anatomy and physiology), and the rest devoted to bed-side clinical training in hospitals.[297] Douglas Gordon noted in his contribution to the history of the first medical school established in Queensland in 1936 (Australia's fourth):

> The aim of producing a medical graduate immediately capable of doing some surgery, delivering babies and giving anaesthetics, still prevailed, though most were by then doing a year of residency [in hospitals] before going out into general practice.[298]

Practitioners were trusted to limit themselves to services and procedures they felt competent to perform. None of the states, with the exception of Queensland starting in 1936, mandated formal registration of specialist qualifications. This lack of urgency to formally regulate the scope of practice suggests the extent to which this was an ingrained feature of practice.

In the early decades of the twentieth century, the development of specialism and the debates over specialisation is as prominent in Australia as it was in other countries.[299] As in the UK, specialist groups were formed as sections of the BMA, with the earliest section being ophthalmology in the 1910s.[300] This has been interpreted as reflecting the early impetus for practitioners to stifle competition from opticians.[301] Advances made during World War I in anaesthesia, blood transfusion, pharmacology, and plastic surgery filtered rapidly into the Australian army medical practitioner's toolkit.[302] Local universities offered very few formal post-graduate qualifications. However, at the end of the War, medical officers in the Australian forces were funded to pursue six months of postgraduate training in the UK. This saw a significant injection of postgraduate specialists into mainly metropolitan centres of Australian states.[303] Returning army doctors lead the way in the development of specialties and post-graduate education in Australia.[304]

In the 1920s, BMA specialist groups were rapidly established for orthopaedic surgery (1923), obstetrics (1925), general practice, radiology, and neurology and psychiatry (1927), and anaesthesia (1929). The surgeons were the only group to formally and independently

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Education and Training in Australia'.

297 Geffen notes the influence of the American model advocated by Abraham Flexner's influential 1910 report on the Australian system of medical education, see: Ibid., S19-22.

298 Gordon, 'Genesis of the Faculty of Medicine', 13.

299 Weisz, *Divide and Conquer,* xvii-xxix.

300 This differs from the practices in continental Europe where such groups were located in specialist hospitals and clinics. See, Weisz, *Divide and Conquer,* 3-83.

301 Pensabene, *Rise of the Victorian Medical Practitioner,* 133-46.

302 McIntosh, 'The Development of Post-Graduate Training in Medicine in Australia'; Blackburn, 'The Growth of Specialism in Australia During Fifty Years'.

303 Ibid.

304 Ibid. See also, Newton, Honours diss., 7-17.

organise themselves when the Australian College of Surgeons was founded in 1926.[305] It was also in the 1920s that a smattering of the newer British specialist qualifications including the diplomas in anaesthesia, child health, and obstetrics and gynaecology appear in entries in state medical registers and Australian medical directories.[306] The implicit acceptance of the GP-specialist is reflected in the code of ethics established by the BMA in Australia, which was firm on the etiquette of referrals between GPs and specialists (who could be either a GP or a full-time specialist), on advertising specialist practices on their name plates, and required GPs offering specialist consultations to maintain separate rooms.[307] Additionally, the BMA explicitly warned off the practice of fee-splitting between a referring GP and the recipient specialist.[308] It was more ambiguous, however, on providing definitive guidelines on who could lay claim to specialist practice.[309]

This fluidity of a practitioner's scope of practice despite being ingrained, was not without its detractors. The impetus for the surgeons to organise themselves came from a desire for consultant surgeons to differentiate themselves from GPs performing surgery, and from the maligned but prevalent practice of fee-splitting. Initial membership to the new college of surgeons was selective and required a commitment by a fellow to obtain a formal qualification in surgery within five years of being admitted. By March 1929, the College had 320 fellows.[310] Following the establishment of the (Royal) Australian College of Surgeons,[311] a steady number of specialist associations were formed, starting with an Australian College of Physicians in 1933, then by anaesthetists and radiologists in 1934 and 1935 respectively. Tellingly, neither of the two most prestigious medical colleges in Australia – for physicians and surgeons – required its members to 'confine their practice to their specialty'.[312] Instead, entry was based on a qualification exam.

The most definitive change in limiting the scope of a practitioner's practice, which had a marked impact on the variety of what was increasingly considered the domain of a specialist, came via a multitude of developments – both organic and concerted – in the public hospital system. The most obvious was the increasing monopoly hospitals had in diagnosing and treating rare(r) conditions owing to their ability to invest in the latest therapies and technologies

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305 Wilde, PhD diss., 25-44.

306 A number of postgraduate diplomas were introduced in the UK in the 1920s by both university medical faculties and the Royal Colleges. Many of which targeted GPs who, like in Australia, were GP-specialists. The Fellowship of the Royal College of Surgeons (FRCS) and Membership of the Royal College of Physicians (MRCP) remained the hallmarks of aspiring consultants.

307 Newton, Honours diss., 19-21.

308 NB: Fee-splitting or 'division of fees' describes the practice of a GP and another medical practitioner agreeing to share a percentage of a fee (a commission) for each referral. This practice was common for aspiring specialists, including those without additional postgraduate surgical training. For a discussion, see: Wilde, PhD thesis.

309 Gillespie, *Price of Health,* 20.

310 Newton, Honours diss., 61-2.

311 The College was granted a Royal Charter in 1931.

312 Gillespie, *Price of Health,* 20.

available. Other examples included the introduction of paying beds in public hospitals as a means of alleviating the pressure for external sources of funding, which coincided with these beds being reserved for honoraries attached to that hospital.[313] Another was the successful campaigns encouraging expectant mothers to seek obstetric services from hospitals and not their GPs. Claudia Thame has documented the growing numbers of Australian-based women in the 1920s and 1930s choosing to enter hospital to give birth.[314] GPs found it increasingly difficult to gain access to public hospital beds unless they were attached to the hospital in an honorary capacity – either as clinical assistants or as consultants. It is perhaps one of the reasons that former university chancellor and practitioner Sir James Barrett proposed that almost two thirds of the profession in Victoria were involved in some honorary work.[315] It is also for this reason that small private hospitals founded and run by GPs in suburban and country areas continued to exist.

Although there were no formal regulatory measures that restricted the scope of medical practice in Australia, the development and administration of hospital-based practices and a system of specialty colleges informally regulated the extent of GPs ability to practice in specialisms (but not vice versa). The recognition of general practice as a specialist branch of medicine in its own right was decades away, as was more uniform regulation of general and specialist practice. Although there was an appetite for clearer boundaries within the profession, the lack of a sustained push from within the profession suggests the extent to which other features and complexities of Australian practice quietened the agitation in the 1920s.

The size of Australia's population and the relative unaffordability of medical consultations and specialist procedures, particularly during the Depression of the 1930s, played its part in restricting the viability of full-time specialist careers further. There are numerous examples of even eminent metropolitan-based honorary surgeons and physicians of the public hospitals whose incomes were buoyed by private general practice.[316] The prevailing economics of making a medical living was determined by the supply of practitioners versus the ability for patients to afford their services. This competition for a more limited pool of paying patients must also be invoked to qualify the sustained life of the GP-specialist in twentieth-century Australia.[317] A symptom of this is seen in the dependence GPs had on panel practice for friendly societies.

The Great Depression emphasised the gap that existed between those eligible for membership of a friendly society and those whose annual income enabled them to afford any medical service they required. It is in this context that conversations about national insurance arose as the private practitioners of this period faced a looming economic crisis: a growing

313 A similar shift has been documented in the UK. See, Honigsbaum, *Division in British Medicine*.

314 Thame, PhD diss., 240-339.

315 As quoted in, Gillespie, *Price of Health,* 20.

316 See for example, Dammery, 'Medical Fees: Lodge Practice', 47-48; Gillespie, *Price of Health,* in particular 3-24.

317 Ibid.

proportion of the population – namely the middle classes – could not afford their services. Amidst increasing public pressure to widen the net of eligibility allowing access to the free out-patient public hospital system, the most serious perceived threat to private practice were the following federal government's proposals. First, the conservative Lyons government sought to nationalise hospital governance. Second, and more controversially, plans were revived to introduce a health insurance scheme similar to the British scheme introduced in 1911.[318] The proposed scheme was for all Australian workers to pay a compulsory contribution and in exchange they could access an array of services including medical benefits. The success of the medical benefits section, however, hinged on GPs accepting a fixed capitation fee similar to the existing friendly society panel system, to ensure its on-going affordability.

State branches of the BMA representing GPs, who were their majority member type, saw the National Health Insurance Bill as the federal government's first step towards abolishing private practice in favour of a salaried national medical service and there were internal revolts between the BMA's Federal Council and the state branches over the form the bill took. A central issue was the proposed capitation fee of 11 shillings which was seen as too low.[319] This resulted in the BMA Federal Council back-flipping from broad acceptance of the scheme in 1937 to a publicly-aired revolt in 1938. *The National Health and Pensions Insurance Act* passed but was never implemented.[320] The events of 1937-38 marked the beginning of a long, divisive struggle over the best models to provide greater access to medical services while protecting fee-for-service for individual GPs.[321] This struggle was both internal – between rank-and-file GPs and the medical elite (who increasingly were older, established specialists); and external – largely between the BMA and the federal government. There was an overwhelming lack of support for a fully salaried service. As one doctor, Leo Bamber, proclaimed in 1938, 'I would rather go pea picking than work as a contract doctor'.[322]

In the intervening sixteen years, until the *National Health Service Act* was passed in Australia in 1953, what emerged was gradual acceptance by all BMA state branches that the only acceptable national health scheme would be one that allowed patients to choose their own doctor, and for doctors to set their own fees.[323] This struggle between the BMA and federal government peaked in the late 1940s with the election of a strong Labor government

318 NB: There was a brief failed attempt at introducing a similar bill in 1928. For a full discussion, see for example, Gillespie, *Price of Health,* 87-108*;* and Crichton, *Slowly Taking Control?,* 35-38.

319 NB: This fee roughly extrapolates to £2,000 annually for a patient list of two thousand.

320 James Gillespie attributes this to a combination of weaknesses in the Act which drew further deliberations between the government and the BMA, rural employers, and trade unions. Additionally, one of the primary champions of the bill, Prime Minister Joseph Lyons died in April 1939. For a fuller discussion, see: Gillespie, *Price of Health,* 87-110.

321 Gillespie, *Price of Health,* 166-194*;* and Crichton, *Slowly Taking Control?,* 19-20, 43-47.

322 'Doctors and National Insurance Scheme', *Narandera Argus and Riverina Advertiser*, 25 November 1938, 2.

323 For further discussion, see Crichton, *Slowly Taking Control?,* 19-20, 43-47; and Gillespie, *Price of Health,* 166-194.

lead by John Curtin in 1943.[324] First, the Victorian branch of the BMA successfully defeated the federal government's *Pharmaceutical Benefits Scheme* act in 1944, which the High Court of Australia ruled as unconstitutional.[325] In response, the federal government successfully amended its constitutional powers to include the provision of welfare allowances for medical and dental services, so long as this did not include any form of civil conscription. The latter clause formed the basis of the BMA's second High Court victory over the federal government's amended pharmaceutical scheme in 1948: forcing doctors to use a form was ruled as a type of conscription of doctors. Only 70 out of 10,000 voting doctors dissented when the BMA Federal Council proposed the second High Court challenge.[326] In 1949, Labor was defeated in federal elections. Robert Menzies became Prime Minister under a coalition Liberal-Country party government.[327]

Incoming Prime Minister Menzies appointed Sir Earle Page – leader of the conservative Country Party – as the coalition government's minister for health. Earle Page was a former country-based GP-surgeon and a long-standing member of the BMA in Australia. Both Menzies and Page had been involved in the failed 1938 attempt to introduce a national health insurance scheme – Menzies allegedly resigned over this issue.[328] Page outlined his aims for a revised national health scheme and revealed the extent to which he was sympathetic to and influenced by what was now BMA policy. Page declared, 'we must aim at restoring the position, prestige and fullest usefulness of the general practitioner. His intimate contact with and knowledge of the patient make it vital that his opportunities to use all modern technique should be preserved'.[329]

A series of acts, developed in consultation with the BMA in Australia, were passed, starting with the 1953 *National Health Service Act* or the 'Page scheme'. Despite sharing a name, the Australian National Health Service contrasted sharply with its British equivalent. Sir Theodore Fox, editor of the *Lancet* from 1944-64, famously described the Page scheme as 'private practice, publicly supported'.[330] Under this scheme, there was no direct state-control over the provision of primary or hospital care. Private practitioners could locate their practices

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324 NB: John Curtin assumed Prime Ministership following the forced resignation of Robert Menzies in 1941, and the weak leadership and unpopularity of Arthur Fadden. Labor's victory in the 1943 election was a record, and was the first time since 1916 that the party controlled both the upper (Senate) and lower house (House of Representatives). They won 49 of the 74 seats in the House of Representatives (to 23 for the Coalition); and they won all 19 Senate seats that were contested.

325 Attorney-General (Vic); Ex rel Dale v Commonwealth ("Pharmaceutical Benefits case") [1945] HCA 30; (1945) 71 CLR 237 (19 November 1945).

326 British Medical Association v Commonwealth [1949] HCA 44; (1949) 79 CLR 201 (7 October 1949).

327 For a discussion of the close relationship between the BMA in Australia and the Liberal party, see: Mackay, 'The Australian Medical Profession as a Pressure Group'.

328 Robert Menzies was a cabinet member in the coalition government under Joseph Lyons (1932-39), and was Prime Minister from 26 April 1939 -1941. Earle Page was briefly Prime Minister following Lyons' death in April.

329 Earle Page, 'In Defence of Federal Plans – Flank Attack on Health Problems is Surest', *The Age*, 14 February 1951, 2.

330 Fox, 'Private Practice Publicly Supported', 988–94.

wherever they wished. GPs could continue to charge a patient whatever they judged best. And a system of private and public hospitals could continue to operate. The federal government committed to paying patients a fixed rate back for all known medical services and procedures, including a daily rate for an occupied public or pre-approved private hospital bed. Australians were encouraged to subscribe to health insurance schemes to cover the difference, by law insurance companies were required to match the state contribution. For the minimum premiums available in 1960, for example, an insured person could recover on average 80 per cent of a general practitioner's fee and 60 per cent of hospital and specialist fees.[331] A second part of Page's scheme was the Pharmaceutical Benefits Scheme which subsidised the cost of prescribed drugs listed in the British Pharmacopoeia. Pensioners (including war veterans) were the only Australian citizens entitled to fully subsidised service under the Pensioners' Medical Service.

'Staunchly united'? The Page Scheme and specialist practice, 1953-72

In 1960, Ian Grant, a past president of the Royal College of General Practitioners, highlighted to his British audience how Australian consultants and GPs 'staunchly united' against the introduction of a national health scheme that was 'completely unacceptable'.[332] However, the repeated challenges to federal or state intervention in medical affairs came at a significant cost to the profession. As James Gillespie argues, it was a stark reminder of the disconnect between the BMA's largely specialist federal council membership, compared to the rank-and-file state members who were almost entirely GPs.[333] The form Australia's first universal healthcare model took, and its slow growth of full-time specialist practice, shared a common root cause: the political and economic dominance of the hybrid private practitioner.[334] However, the development and regulation of specialist practice in Australia compounded the fracturing between GPs and specialists over the scope of GP-work, and the prestige associated with that work.

By 1951, Sir Charles Blackburn, a prominent physician and then chancellor at the University of Sydney, reflected that:

> It is in some respects unfortunate that … the instruction a student receives in his clinical years is given entirely by consultants or specialists, and that he has no contact at all with the general practitioner. It is but natural under such circumstances he should come to regard specialism as the goal … and general practice as the unhappy lot of those who drop behind in the race.[335]

There had long been differential prestige attached to types of medical work, which reflects the hierarchical nature of orthodox medical structures and practices in many countries.[336] In this,

331 *National Health Act 1953.*

332 Grant, 'Medical Services in Australia and New Zealand', 140.

333 Gillespie, *Price of Health,* 57-63, 98-104.

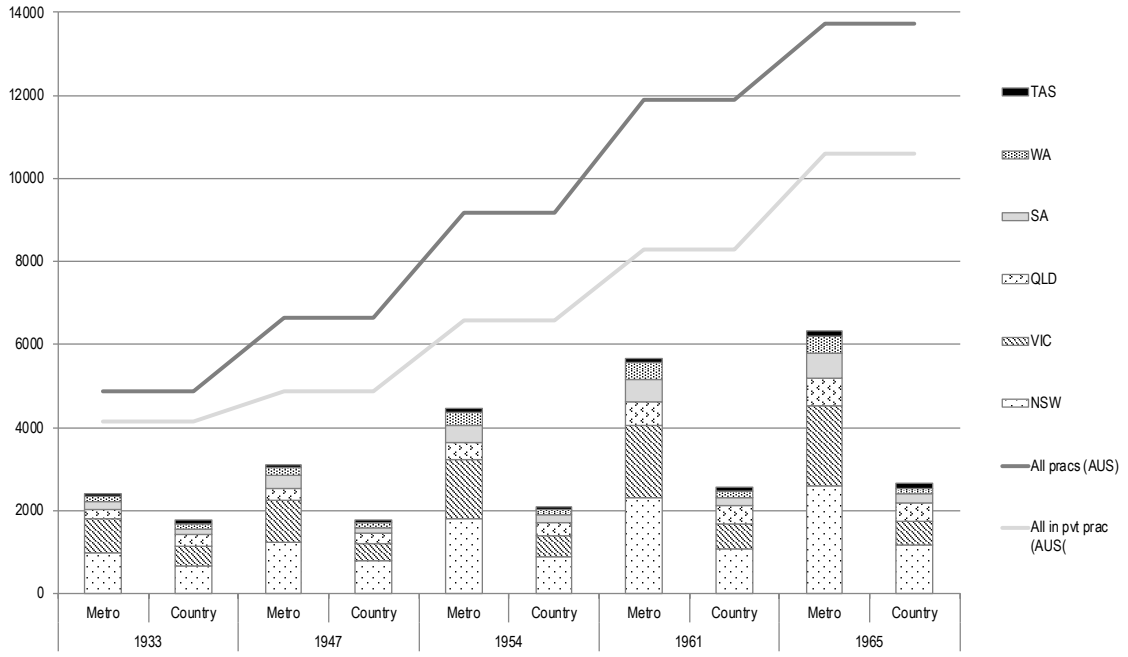
334 Ibid., See also, Crichton, *Slowly Taking Control?*; 35-38.

335 Blackburn, 'The Growth of Specialism in Australia During Fifty Years', 20-24.

336 For an overview, see: Digby, *The Evolution of British General Practice*; Weisz, *Divide and Conquer.*

Australian states were no exception. However, the dominance of private practice as the primary mode of medical practice complicated the goal of achieving full-time specialist status, which increasingly required private practitioners to maintain a connection with hospitals.

Figure 4 Distribution of medical practitioners in Australia, 1933-66.



Source: Adaptation of data reported in Scotton, 'Medical Manpower in Australia'.

This type of practice afforded greater incomes and simultaneously a diverse, more stimulating work environment. Significant in-roads into the makeup of Australia's ratio of GPs and specialists came from a combination of the international influence of increasing medical specialisation, but also significant government intervention following the introduction of the Page scheme in 1953. It became increasingly difficult to connect the quality of care afforded the Australian public with the continued prevalence of the hybrid GP-specialist. There was also growing number of specialists supporting tighter controls on the right to claim and practice in specialist branches of medicine.[337] This resulted in a gradual change in how Australian practitioners self-identified away from GPs to specialists from the 1960s.[338] As Deborah Saltman and Michael Bollen went on to observe:

> … The emergence of the range and number of general practitioner organisations may be seen to reflect the concerns of GPs and their

337 Pensabene, *Rise of the Victorian Medical Practitioner,* 115-19.

338 Ibid.

perceptions of the attitude of the major medical organisations toward change.[339]

Richard Scotton's analysis of the trends in distribution and organisation of Australia's medical manpower (summarised in Figure 4) highlights the similarities in how doctors organised themselves in each state – by type of work, and geographical location.[340] Scotton's study demonstrated the predominance of private practitioners, and the significant change as salaried positions particularly in hospitals increased in the later decades (seen in the widening gap between the two lines in Figure 4). In contrast, the distribution of practitioners between the metropolitan and country areas across each state sharpened.

Scotton also found that the ratio of GPs to specialists began to even out: in 1961 it was estimated there were 2,758 specialists compared to 5,805 GPs. By 1971, the specialist figure had almost doubled to 5,007 compared to the GP figure that modestly increased to 7,376.[341] By 1976, the same source was reporting almost equal numbers of GPs and specialists practising in Australia.[342] However, a study of medical manpower suggests that the introduction of national recognition of specialists, linked to problems with the 1953 Page health scheme, significantly influenced how practitioners self-reported.[343] The viability of Page's health scheme was also slowly eroded by a combination of exploitation of the system for commercial gain by doctors acting unethically, and the induced demand for medical services by the free pensioner scheme, creating a healthcare bill that was increasingly unaffordable.

A landmark study in 1960 by Australian Dr Clifford Jungfer noted that the free pensioner service, for example, was inducing unnecessary demand for medical services.[344] The official statistics for 1961-62 shows that, on average, each pensioner or dependent received 9.3 general practitioner services, compared to 2.11 for insured persons.[345] There was also no incentive for GPs to engage in preventive medicine.[346] Sir Theodore Fox's more diplomatic assessment of the scheme in 1963 suggested that it was not only costing the government increasingly large amounts of money, but that it was bordering on exploitation in the worst cases. One doctor he interviewed remarked that in Australia, 'an indication for a hysterectomy is any woman over 40 who still has her uterus'.[347] Finally, a third of the population could not

339 Bollen and Saltman, 'A History of General Practice in Australia', 3.

340 Scotton, 'Medical Manpower in Victoria'.

341 Ibid. Scotton used a combination of a medical advertising agency data from Permail.

342 Ibid., 986-7.

343 Scotton, 'Keynote address', 17.

344 Jungfer, 'General Practice in Australia'.

345 Ibid.

346 Incidentally, this was a key criticism from sections of the profession of the 1938 health insurance bill.

347 Fox, 'Private Practice Publicly Supported'.

afford private health insurance, but even those who were insured were still paying up to a third of their medical expenses themselves.[348]

Reform of the Australian health scheme became a major election issue for Gough Whitlam's Labor campaign in 1969, as he argued that the 'ramshackle' scheme introduced in 1953 was 'unwieldy, unjust, enormously costly, inherently costly'.[349] Anne Marie-Boxall and James Gillespie assess that the 1953 scheme fitted Australia's private practice healthcare service model of the 1950s and 1960s,[350] but as a government inquiry into health insurance (the Nimmo report) found in 1969, it was increasingly expensive and delivering questionable quality to Australia's citizens. The Nimmo report recommended controversial changes to the health scheme, which resulted in a further split between the newly formed Australian Medical Association (AMA) and its GP members.[351]

Figure 5 Cartoon by Stewart McCrae, ca.1970. Title: " - G.P.s' society urges Doctors to withdraw from pensioned service - ". Handwritten caption: 'This isn't good enough Nurse / I had him practically cured before I found out he was a pensioner'.



Source: National Library of Australia, © Stewart McCrae, 1919-2008.

348 Dewdney, *Australian Health Services*.

349 Gough Whitlam 1969 Election policy speech, Sydney Town Hall, available online, http://whitlamdismissal.com/1969/10/01/whitlam-1969-election-policy-speech.html.

350 Boxall and Gillespie, *Making Medicare,* 34-35.

351 State branches of the British Medical Association in Australia formerly merged to form the Australian Medical Association in 1962.

The formation of the Australian College of General Practitioners in 1958 was a formalisation of a growing band of the AMA special interest group for GPs. AMA membership now covered GPs as one of three main member types, the others being a growing group of full-time specialists and salaried hospital staff – and its policy positions subsequently changed to accommodate this changing membership demographic.[352] The fact that Australian-based GPs also formed a further two national GP associations: the General Practitioners' Society in Australia (1968) and the National Association of General Practitioners in Australia (1972) – and a fourth general group, the Doctors' Reform Society (1973) – hints at the division and debate surrounding general practice and universal healthcare in Australia. The latter three groups were formed in direct response to the recommendations of the Nimmo report and the federal election.[353] Healthcare was a central election issue, and political cartoonist Stewart McCrae's sketch (Figure 5) reflects changing public sentiment towards medical practitioners as, once again, internal medical politics played out in public fora.

The AMA supported revisions proposed to the *National Health Act* following the Nimmo report which included a fee schedule for services with higher fees chargeable by specialists for the same service; the concept of a 'common fee' to reduce the gap between insurance cover and the government rebate; and establishing a national committee to evaluate and recognise specialists,[354] so only officially accredited practitioners could claim the higher rebate proposed for referred specialist services. The Royal Australian College of General Practitioners – apolitical, until then – argued that it effectively devalued GP services in the eyes of patients in favour of specialist services,[355] and the common fee was a subversive step towards mandating what fee a practitioner could charge his patient.

The General Practitioners' Society of Australia formed explicitly to oppose the common fee. The GPs lobbied unsuccessfully, and the act passed in 1970. However, this episode demonstrates the tension of increasing formal demarcation between a GP and specialist in Australia; and the sense of professional inadequacy as they collectively struggled to re-define their *raison être.* This was most succinctly summarised in 1972 by the AMA study group on medical planning which concluded that, 'Today's general practitioner [in Australia] has been trained for a task, much of which now properly belongs to the specialist in one or other fields.'[356]

That same year, sociology PhD student Ione Fett surveyed over three thousand Australian medical graduates who had graduated from a local university between 1920-1972.[357] One question asked respondents to rank the prestige of medical specialisations.[358] The outcomes summarised in Table 2 shows that practitioners ranked surgery, internal medicine and obstetrics

352 AMA, *More Than Just a Union*.

353 Boxall and Gillespie, *Making Medicare*.

354 The established National Specialist Qualification Advisory Committee ran from 1972-2001.

355 Winton, *A Body's Body*.

356 AMA Study Group on Medical Planning, 'General Practice and its Future', 21.

357 Fett, PhD diss.. 121.

358 Ibid.

as the most prestigious medical specialisations, and typically salaried roles in anaesthetics and public health as the least prestigious. The position of general practice in this table reflects the complicated position of the GP in Australia, with one third of respondents reporting that they were self-declared specialists (623 women and 713 men).[359] It was only in 1978 that Australia's National Specialist Qualification Advisory Committee recognised general practice as a specialist branch of medicine.

Table 2 Rank of medical specialisations by perceived prestige, survey of Australian medical graduates in 1970.

	Rank by medical men (n=1414)	Rank by medical women (n=1632)	No. of self-declared specialists
Surgery	1	1	183
Internal medicine	2	2	155
Obstetrics & gynaecology	3	3	116
Other	4	5	Not reported
Research	5	4	Not reported
General Practice	6	8	-
Paediatrics	7	6	91
Psychiatry	8	7	159
Pathology	9	10	109
Orthopaedics	10	9	Not reported
Anaesthetics	11	11	160
Public Health	12	12	49

Source: Adapted from Fett, 'Australian Medical Graduates', Tables 4.15 and 4.16, 121-22.

Summary

This chapter unpicked the oft-repeated characterisation of Australian medical practitioners as a homogeneous group enjoying 'high status and income' in the period 1930-75. It is undeniable that medical practitioners – like many tertiary-qualified professionals – enjoyed a relatively higher status and income compared to the general population. However, this generalisation is insufficient when interrogating motivations and attitudes that shaped the local profession's responses to groups of European medical migrants; as well as to frame the resettlement of medical migrants. Such an examination requires a more sensitive development of the structure, practice and politics that characterised Australian medicine, and framed the arrival of groups of medical migrants.

This chapter drew on a wide range of secondary literature to provide an overview of these topics, and provides essential background to the case studies that follow in subsequent chapters. The key points that emerged from examining this history include: the consolidation of a predominantly locally-trained medical workforce; the growing fragmentation between GPs and aspiring full-time specialists that remained politically contentious for much of the period

359 Ibid., 123.

1937-72; and the fractious relationship between the main medical lobby, the BMA in Australia, and the federal Coalition and Labor governments who were in power between 1937-41 and 1941-49 respectively over the introduction of state-funded health services. Finally, this chapter introduced and discussed the interrelated dominance of fee-for-service private practice as the mode of medical service for the period under investigation.

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Part II – Privileged & Invisible: Two Case Studies of British and Irish Medical Migrants

Introduction to Part II – Case studies of British and Irish Medical Migrants in Context

Between 1930-60, a total of 743 medical migrants were registered in the state of Victoria.[360] Of these, the largest majority – almost ninety percent – were graduates from British and Irish medical schools, mainly from England (Table 3). As illustrated in Table 3, a smaller sample of these migrants – 86 men and 55 women were drawn for further study.[361] Part II of this thesis comprises two case studies exploring the migration and resettlement of two distinct groups of British and Irish medical migrants among this arriving cohort – a group of post-war Bristol graduates and a group of British and Irish medical women. These case studies begin to redress the distinct type of 'collective amnesia' that characterises how rank-and-file groups of British medical migrants are represented in the historiography – their privileged position has rendered them largely invisible as a group.[362]

The groups who are the subjects of the subsequent two case studies were chosen owing to their relative rank-and-file position within established medical hierarchies – as inexperienced recent medical graduates and as women in a male-dominated profession respectively. As such, both these case studies enable a reflection of the contours that comprised different categories of medical migrant – or what Laurence Monnais and David Wright have described as an 'interstice' between the local medical elite and the general population – in the Australian context.[363] As historians of Australian migration have demonstrated, despite the shared cultural base, British settlers in Australia also experienced a process of transition and adjustment.[364] For each of the two case studies, I explore this process. One outcome of doing so, as will be seen, is that it is demonstrates how groups of medical migrants leveraged the Commonwealth medical market to further their career aspirations.[365] In exploring the patterns of medical work they undertook, I also reflect on the 'special types of labour' each group of British/Irish medical migrants occupied.[366]

Each case study includes further discussion of the methodological and analytical approaches adopted to analyse these two groups, therefore I will not repeat it here. It is however important to contextualise these case studies in two ways – both of which outline the embedded privileges that differentiated British and Irish medical migrants from their continental European

360 See Appendix 1-2 for a detailed discussion of method; and Appendix 4 for a full list of medical migrants.

361 Ibid.

362 See Chapter 1. Quote: Simpson et al., 'Writing Migrants Back into NHS History', 392.

363 Monnais and Wright, *Doctors Beyond Borders*, 10.

364 Hammerton and Thomson, *Ten Pound Poms*.

365 NB: The term Commonwealth medical market is used here to conceptualise the opportunities available to British medical graduates within former British-controlled territories; ones which were consciously cultivated by the British-based medical profession on the basis of Britain's imperial power. For a discussion of the changing boundaries of British medicine and the politics of reciprocal recognition, see: Haynes, *Fit to Practise,* particularly 36-104.

366 Simpson et al., 'Providing "Special" Types of Labour', 208.

counterparts. First, I outline the available migration pathways for white British and Irish settlers to provide background on the arrival and registration of 456 men and 113 women holding British and Irish degrees against the broader trends describing British and Irish immigration to Australia for the period 1930-60. Second, I outline how this freedom of movement between the UK, Ireland and Australia constituted one of the cornerstones upon which the Commonwealth medical market was built. A second cornerstone included reciprocal recognition. I conclude this section by reflecting on how this dual privilege is reflected in the pathways of the British and Irish medical migrants in this study.

Contextualising British and Irish medical migration to Australia, 1930-60

Until the introduction of Australian citizenship in 1948, Australians were British subjects, which blurred the distinction between British and Irish settlers and the locally-born population.[367] However, officially, twentieth-century Australian immigration policy distinguished between two broad categories of migrant – 'aliens' and British (and later Irish) subjects.[368] Only non-British subjects required landing permits to be issued prior to their arrival. White British and Irish subjects could freely travel to Australia until 1983. Once there, they were afforded almost all the rights of Australian-born citizens, including the right to vote. The patterns described below were underpinned by the political and socially popular ideal that Australia's future was as a white, culturally British nation.[369]

There are demonstrable general patterns of migration of British and Irish settlers to Australian states and territories, with peaks broadly reflecting a combination of the comparative health of national economies and instituted migration programs. Figure 6 illustrates patterns of net migration to Australia, with the peak in 1919 reflecting the failed interwar scheme to settle British migrants in rural Australia.[370] The Depression years saw a dramatic decline in migration to Australia and was marked by an end to assisted passage schemes to Australia, as well as a high volume of return migration of British subjects from all parts of the world.[371] The end of the Second World War saw a sharp increase in migration. Australia's post-war migration policies underpinned by the mantra of 'populate or perish' included an advertised aim to recruit almost half the total number of migrants from Britain and Ireland. Figure 6 and Table 4 reflects the result of this population drive on the composition of the Australian population which saw over one million settlers arrive in the early post-war decades.

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367 NB: Indigenous Australians were included in this category because they were born in Australia. However, Indigenous Australians were denied many of the rights of white Australians. For example, the *Commonwealth Franchise Act 1902* gave women the right to vote in Australia, but denied Indigenous Australians from doing so. For a full discussion of citizenship as an 'empty category' for Indigenous Australians in twentieth-century Australia, see: Chesterman and Galligan, *Citizens Without Rights.*

368 Jupp, *From White Australia to Woomera,* 5-20.

369 Bridge and Fedorowich, *The British World*; Mann, '"Leavening British Traditions".

370 For a discussion, see: Richards, *Destination Australia,* 80-112.

371 Baines, *Emigration from Europe 1815 – 1930*, see Table 2.

Table 3 Summary of British medical migrants registered in Victoria by country and place of primary medical qualification (n=569).

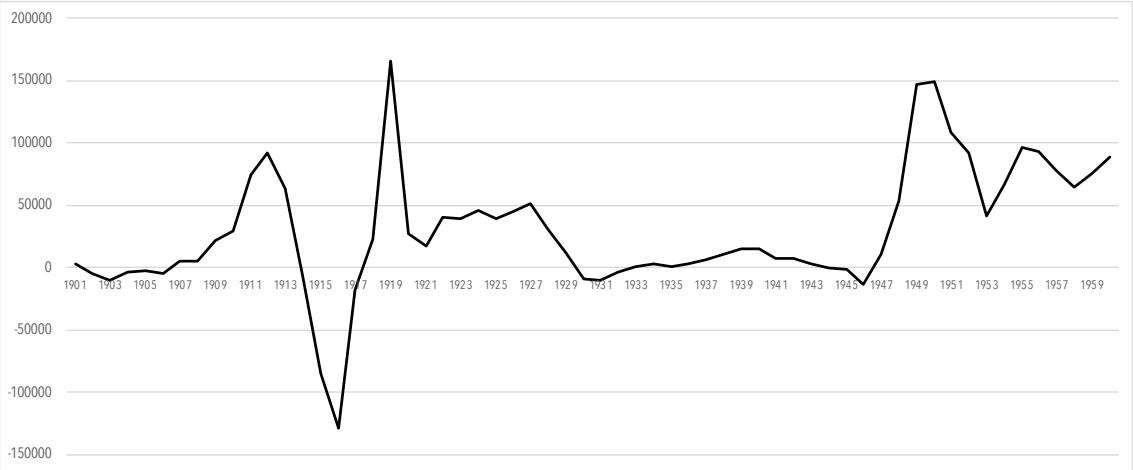
	Total	Total Men	Total Women	Interwar & war arrivals	Post-war arrivals	Sample Men	Sample Women
Total	**569**	**456**	**113**	**102**	**467**	**86**	**55**
Scotland	**159**	**131**	**28**	**50**	**109**	**23**	**15**
Aberdeen	17	12	5	3	14	2	4
Edinburgh	95	83	12	36	59	16	7
Glasgow	31	27	4	4	27	5	1
St Andrews	16	9	7	4	12	0	3
England	**333**	**261**	**72**	**42**	**291**	**52**	**30**
English conjoint*	135	116	19	21	114	24	9
London total	84	64	20	10	74	14	7
London MBBS	66	50	16	-	-	-	-
LMSSA/LSA	18	14	4	-	-	-	-
Birmingham	12	9	3	1	11	-	-
Bristol	14	10	4	0	14	2	3
Cambridge	15	12	3	1	14	2	1
Durham	24	16	8	3	21	3	2
Leeds	7	6	1	0	7	4	1
Liverpool	16	14	2	0	16	-	1
Manchester	13	6	7	3	10	-	5
Oxford	9	5	4	0	9	3	0
Sheffield	4	3	1	0	4	-	1
N. Ireland	19	12	7	3	16	2	4
Belfast (inc. Queens)	19	12	7	2	17	2	4
Ireland	**54**	**49**	**5**	**7**	**47**	**9**	**2**
Dublin	21	18	3	1	20	-	1
Ireland (nec)	33	31	2	6	27	9	1
Wales	**4**	**1**	**3**	**0**	**4**	**-**	**2**
Cardiff	4	1	3	0	4	-	2

Source: Victorian medical registers, 1931-60.

The bid to attract as many British settlers as possible in the post-war era included a free passage scheme for ex-servicemen. (This was later extended from just British ex-servicemen to include citizens of Belgium, Denmark, France, Holland and Norway.) British settlers were eligible for a number of other schemes, most popularly the revival of an assisted passage scheme, nicknamed the 'Ten Pound Pom' scheme in reference to the cost of

passage for successful applicants. By the early 1950s, the assisted passage scheme was still operational. However, the British government changed its financing of the scheme, as priorities shifted within the UK.[372] This prompted a number of additional initiatives to encourage British settlement to Australia, including the 'Bring out a Briton' campaign.[373] As historians James Hammerton and Alistair Thomson summarised, for twenty years, starting from 1946, 'Australia House in London sold a potent image of Australia'.[374] The success of these post-war campaigns can be seen in the total number of settlers from the UK, both assisted and unassisted summarised in Table 5.

Figure 6 Net migration to Australia, 1901-60.



Source: ABS, Historical Migration Statistics.

At no point in Australia's federal immigration program for the period under investigation was there explicit preference given to selecting medical graduates (or highly-skilled migrants) for general migration.[375] In the interwar period, public immigration initiatives were dramatically reduced in the wake of the Depression, with the notable exception of assisted passage schemes for female domestic workers and farm boys.[376] In the wake of anti-Semitic legislation in Poland, Germany and Italy, Australia was among those countries that accepted applications for refuge from European Jews.[377] However, the BMA in Australia successfully lobbied the federal government to reject, not accept, applications from Jewish refugees who

372 Of particular concern was that the UK was losing too many skilled workers. A secondary shift was political as the British renegotiated their place in Europe. See: Salter, *Immigration of the Highly Skilled* 32-41.

373 Jupp, *English in Australia,* 131-155.

374 Hammerton and Thomson, *Ten Pound Poms*, 36.

375 NB: There was a brief period in 1946-7 when immigration officers in refugee camps in Europe erroneously promoted applications from continental European doctors. For a discussion, see: Kunz, *The Intruders,* 7-20.

376 For a full chronology of interwar immigration, see: Richards, *Destination Australia,* 10-140.

377 Markus, 'Jewish Migration to Australia'.

were doctors, dentists and pharmacists.[378] During the war, all recorded immigration was largely war-related.[379] In the post-war era of reconstruction, Australia's immediate labour needs were for unskilled and semi-skilled workers – there was a shortage of housing and public infrastructure, for example.[380] Additionally, the main source of Australia's intended migrant pool – the UK – was particularly insistent that Australian recruitment efforts did not focus solely on highly skilled workers or apprentices.[381] Instead, the UK Oversea Migrant Board, established in 1953 to monitor emigration, routinely reported that Australia was recruiting 'a reasonable cross-section' of British citizens.[382] Historian Reginald Appleyard rightly concluded, however, that these negotiations only applied to official federal immigration efforts, including the assisted passage schemes which required interested migrants to apply for the scheme.[383]

Table 4 Summary of top ten overseas-born residents in Australia as a percentage of total population (n=recorded population), Census results for 1921-61. *India included the territories of British India before independence in 1947.

	1921 (n=5,455,136)	1933 (n=6,629,836)	1947 (n=7,579,358)	1954 (n=8,986,530)	1961 (n=10,508,186)
United Kingdom	67.7	70.2	66.7	47.9	40.4
Ireland	12.5	8.7	6	3.5	2.1
New Zealand	4.6	5.1	5.9	3.4	2.6
Italy	1	3	4.5	9.3	12.8
Germany	2.7	1.9	1.7	4	6.1
China	1.8	0.9	0.8	0	0
India*	0.8	0.7	0.9	0	0
South Africa	0.6	0.7	0	0	0
USA	0.8	0.7	0.8	0	0
Denmark	0.7	0	0	0	0
Greece	0	0.9	1.1	2	4.3
Poland	0	0	0.9	4.4	3.4
Netherlands	0	0	0	4	5.7
Yugoslavia	0	0	0	1.8	2.8
Malta	0	0	0	1.6	2.2
% Top ten total	**93.2**	**92.8**	**90.4**	**81.8**	**82.6**
% Total of overseas born	**15.4**	**13.6**	**9.8**	**14.3**	**16.9**

Source: ABS, Historical Migration Statistics.

378 This will be discussed further in Chapter 5.

379 Richards, *Destination Australia,* 141-65.

380 Macintyre, *Australia's Boldest Experiment,* 175-184, 287-293.

381 For a discussion, see: Salter, *Immigration of the Highly Skilled,* 32-41.

382 Salter, *Immigration of the Highly Skilled*, 35.

383 Appleyard, *British Emigration to Australia*.

Table 5 Summary of post-war British migration to Australia.

	Total settlers	Total UK and Irish settlers (% of total)	Unassisted UK and Irish settlers	Assisted UK and Irish settlers
1945-49/50	379,560	175,138 (46.1%)	92,287	82,851
1950/51-1959/60	1,174,084	405,946 (34.5%)	118,146	287,800
Total	1,553,644	581,084	210,433	370,651

Source: Adapted from Thomson and Hammerton, Ten Pound Poms, Table 1.

Throughout the period 1930-60, British and Irish subjects could freely travel to and settle in Australia if they had the means to do so. Additionally, Australian-based employers were free to recruit and sponsor British subjects for specific jobs. In the post-war period, Australian employers could also take advantage of the existing federal free and assisted passage schemes to recruit British and Irish settlers, since the cost of passage to Australia was otherwise often prohibitive.[384]

The discoverable evidence for the sample of British medical migrants in this study reflects the myriad pathways and opportunities created by federal migration policy, as well as state and private efforts that enabled British and Irish medical migrants to consider and choose Australia as a destination.[385] For example, medical couple Peter and Denise Sherwood – both Bristol graduates – arrived under the Ten Pound scheme. Denise Sherwood recalls that:

> Because we wanted to take advantage of the 'cheap' travel we had to be ready to travel on the boat at 10 days' notice (quite a feat with 2 small kids!).[386]

The Sherwoods were 'sponsored' by the Victorian Mental Hygiene Authority following Peter Sherwood's appointment to the Ararat mental sanatorium.[387] Geoffrey Alfred Silley and his wife also came under an assisted passage scheme in July 1958. Their nominee was Roger van Assche – a partner in a well-known medical recruitment agency based in Melbourne.[388] Silley's registration was to a private practice in the suburb of Moonee Ponds.[389] A final example is Arthur McHaffie, who arrived in 1957 with his wife and three children having been sponsored by a fellow British medical migrant, Gordon Guthrie.[390] It is likely the pair knew each other from medical school – they both graduated from Glasgow in 1938. What these examples emphasise is the freedom of travel afforded British and Irish subjects, as well as concerted effort

384 Ibid.

385 For a further discussion, see: Hammerton and Thomson, *Ten Pound Poms,* particularly the chapter on 'Imagining Australia', 28-47.

386 Denise Sherwood, e-mail to author, 14 January 2016 and 21 March 2016.

387 Ibid.

388 PROV: VPRS 5978, Sponsor-Applicant Schedules.

389 Victorian Medical Register 1959.

390 PROV: VPRS 5978, Sponsor-Applicant Schedules.

to recruit them as post-war settlers. Both of these points form important background context to understanding the journeys of the groups of medical migrants discussed in the two case studies.

Between 1930-45, just over one hundred British medical migrants were registered in Victoria; in the next 15 years, this figure more than quadrupled to 467 (Table 3). These trends were not restricted to Victoria, John Seale estimated that between the same period, the number of British and Irish doctors registered in Australia increased from 404 in the interwar period to 1891 for the period between 1946-63.[391] Although Seale did not account for double-counting between state medical registers, the sharp increase in post-war British medical migration to Australia is apparent. In the wider context of Australia's post-war migration, however, medical migrants, and tertiary-qualified migrants generally, comprised a small proportion of both pre- and post-war migration. For example, Moira Salter estimated that between 1950-1960, professional workers averaged a mere 2.4 per cent of all migrants entering Australia via assisted passage schemes.[392] This included UK schemes, European schemes, and other schemes including the Irish Scheme, the Empire and Allied Ex-Servicemen Programme and the General Assisted Passage Scheme.[393] What studies including Salter's confirm is that Australia's pattern of migration over the period between 1930-60 did not explicitly set out to recruit medical practitioners, and from the perspective of Australian migration history, professionals, however broadly defined, comprised a small subset of its migrant intake.[394] The multitude of available pathways for migration described above, however, underpinned the arrival of British and Irish medical migrants who are the subjects of this study.

The Commonwealth medical market and British and Irish medical migrants in Australia

The freedom to travel described above comprised one cornerstone of the interconnected Commonwealth medical market consciously cultivated by the British to expand the scope of opportunities available to British medical men and, to a lesser extent, women.[395] This medical market was sustained through a transnational network, of which reciprocal recognition formed another integral part.[396] Degrees issued by British and Irish medical training institutions – including the extramural qualifications issued by the Royal Colleges – were among the few foreign medical degrees continuously recognised in all Australian states for the first half of the

391 Seale, 'Medical Emigration from Great Britain and Ireland'.

392 There is a very diverse set of secondary sources documenting the skills and spread of migrant labour arriving in post-war Australia. The varying research questions these studies represent means that the definitions and categories employed are not comparable. Salter used a wide definition of professional worker – as an occupation where 'lengthy preparatory training' is required. See: Salter, *Immigration of the Highly Skilled,* Appendix I, 178-79. Other studies documenting skilled migration in the post-war period includes: Appleyard, *British Emigration to Australia;* Collins, *Migrant Hands.*

393 Ibid.

394 An important exception appears to be the early DP scheme, when migration officials mistakenly encouraged DPs to apply for migration to fill shortages in medical manpower in Australia. See: Kunz, *The Intruders,* 7-20.

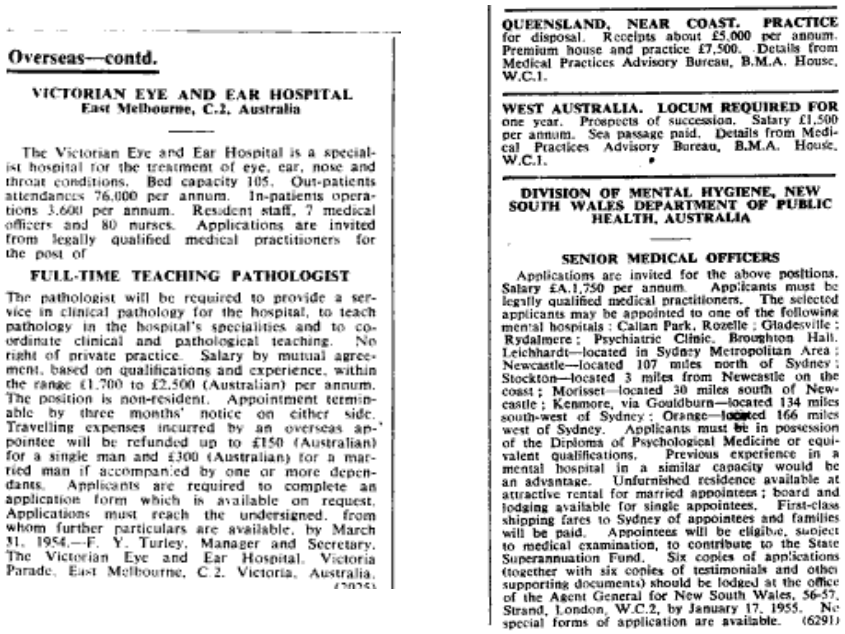
395 Haynes, *Fit to Practise*, 36-55.

396 Ibid.; Armstrong, PhD diss., 67-94.

twentieth century. This reciprocal recognition was individually brokered with Australian states in the early years of the twentieth-century, following the Federation of Australian states in 1901.[397] Migration controls that finally restricted the entry of British and Irish medical graduates to Australia were only implemented in 1978-9 following a two-decade-long expansion in the output of Australian medical schools and an unprecedented spike in medical migrants, now including those from the sub-continent.

Apart from reciprocal recognition, the Commonwealth medical network was maintained between the UK and Australia in a number of ways in an era of increasing autonomy of former British colonies and dominions.[398] This included through: the British Medical Association (BMA), whose Australian branches were individually affiliated with the parent organisation in London; interchangeable eligibility for national military service; numerous medical congresses and conferences; and a growing trend to travel for postgraduate research and training.[399] Finally, and perhaps most notably, the network enabled formal and informal recruitment of medical practitioners to fill vacancies in each medical market.

Figure 7 Examples of advertisements recruiting British medical graduates in the *BMJ,* 1953 and 1955.



Overseas—contd.

VICTORIAN EYE AND EAR HOSPITAL
East Melbourne, C.2, Australia

The Victorian Eye and Ear Hospital is a specialist hospital for the treatment of eye, ear, nose and throat conditions. Bed capacity 105. Out-patients attendances 76,000 per annum. In-patients operations 3,600 per annum. Resident staff, 7 medical officers and 80 nurses. Applications are invited from legally qualified medical practitioners for the post of

FULL-TIME TEACHING PATHOLOGIST

The pathologist will be required to provide a service in clinical pathology for the hospital, to teach pathology in the hospital's specialities and to co-ordinate clinical and pathological teaching. No right of private practice. Salary by mutual agreement, based on qualifications and experience, within the range £1,700 to £2,500 (Australian) per annum. The position is non-resident. Appointment terminable by three months' notice on either side. Travelling expenses incurred by an overseas appointee will be refunded up to £150 (Australian) for a single man and £300 (Australian) for a married man if accompanied by one or more dependants. Applicants are required to complete an application form which is available on request. Applications must reach the undersigned, from whom further particulars are available, by March 31, 1954.—F. Y. Turley, Manager and Secretary, The Victorian Eye and Ear Hospital, Victoria Parade, East Melbourne, C.2, Victoria, Australia.

QUEENSLAND, NEAR COAST. PRACTICE for disposal. Receipts about £5,000 per annum. Premium house and practice £7,500. Details from Medical Practices Advisory Bureau, B.M.A. House, W.C.1.

WEST AUSTRALIA. LOCUM REQUIRED FOR one year. Prospects of succession. Salary £1,500 per annum. Sea passage paid. Details from Medical Practices Advisory Bureau, B.M.A. House, W.C.1.

DIVISION OF MENTAL HYGIENE, NEW SOUTH WALES DEPARTMENT OF PUBLIC HEALTH, AUSTRALIA

SENIOR MEDICAL OFFICERS

Applications are invited for the above positions. Salary £A.1,750 per annum. Applicants must be legally qualified medical practitioners. The selected applicants may be appointed to one of the following mental hospitals: Callan Park, Rozelle; Gladesville; Rydalmere; Psychiatric Clinic, Broughton Hall, Leichhardt—located in Sydney Metropolitan Area; Newcastle—located 107 miles north of Sydney; Stockton—located 3 miles from Newcastle on the coast; Morisset—located 30 miles south of Newcastle; Kenmore, via Goulburn—located 134 miles south-west of Sydney; Orange—located 166 miles west of Sydney. Applicants must be in possession of the Diploma of Psychological Medicine or equivalent qualifications. Previous experience in a mental hospital in a similar capacity would be an advantage. Unfurnished residence available at attractive rental for married appointees; board and lodging available for single appointees. First-class shipping fares to Sydney of appointees and families will be paid. Appointees will be eligible, subject to medical examination, to contribute to the State Superannuation Fund. Six copies of applications (together with six copies of testimonials and other supporting documents) should be lodged at the office of the Agent General for New South Wales, 56-57, Strand, London, W.C.2, by January 17, 1955. No special forms of application are available. (6291)

Source: *BMJ*, 'Appointments', 5 December 1953, 53 and *BMJ*, 'Appointments', 25 June 1955, 46.

For example, the classified sections of well-subscribed British medical journals including the BMA's *British Medical Journal* and the *Lancet* were traditional channels through which medical vacancies in Australia were advertised. These opportunities ranged from prestigious university and hospital positions, to locums (Figure 7). It was only in the early 1960s that the UK Oversea Migrant Board began to fully appreciate what came to be known

397 Salter, 'Prejudice in the Professions'.

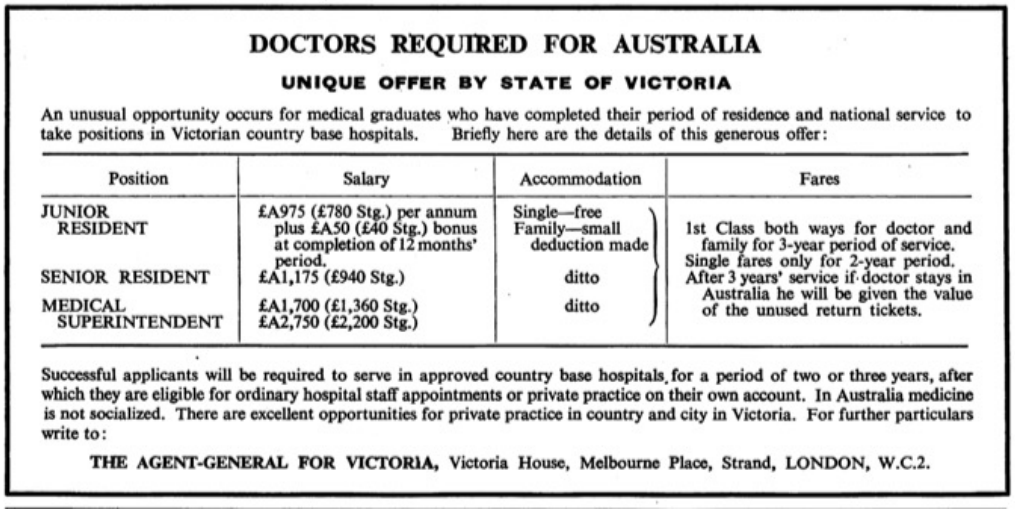
398 John Armstrong has described a similar network, which he calls the 'Common-Health'. See, Armstrong, PhD diss, 67-94.

399 Ibid.; Haynes, *Fit to Practise*, 80-101.

as the British 'brain drain', noting that Commonwealth countries including Australia, Canada, New Zealand and Rhodesia had traditionally targeted the UK when recruiting immigrants to professional and highly skilled occupations, and continued to do so following the Second World War.[400] In this study, this continuity is seen in the recruitment of, for example, John Ferguson as Victoria's director of tuberculosis (1930); John Colquhuon as superintendent of the Children Hospital's new orthopaedic hospital in Frankston (1930), and in the post-war period with the dual appointments of Maurice Ewing and Richard Lovell as the University of Melbourne's first chairs in surgery and medicine respectively in 1955.[401]

This transnational job market extended to more junior and less prestigious positions as well. A number of state-based initiatives saw doctors specifically recruited through either the free ex-serviceman scheme or through employment offers that included a funded passage. The Royal Australian Navy, for example, enlisted a number of British doctors in the post-war years to facilitate the demobilisation of Australian doctors to resume private practice.[402] Three of the sample of 86 male post-war arrivals – Nickel Crombie, William Gibson and John Little arrived under this offer. In 1955, the Royal Australian Air Force sought to employ at least ten British doctors as flight lieutenants owing to local shortages. George Duncan arrived in 1957 under a similar offer, and worked in the RAAF base in Laverton. As inducement, volunteers for the military posts were offered first class passages for themselves and their families, and paid wages commencing on embarkation, in exchange for a minimum term of service.[403]

Figure 8 Advertisement recruiting British medical graduates for country hospitals in Victoria.



DOCTORS REQUIRED FOR AUSTRALIA

UNIQUE OFFER BY STATE OF VICTORIA

An unusual opportunity occurs for medical graduates who have completed their period of residence and national service to take positions in Victorian country base hospitals. Briefly here are the details of this generous offer:

Position	Salary	Accommodation	Fares
JUNIOR RESIDENT	£A975 (£780 Stg.) per annum plus £A50 (£40 Stg.) bonus at completion of 12 months' period.	Single—free Family—small deduction made	1st Class both ways for doctor and family for 3-year period of service. Single fares only for 2-year period. After 3 years' service if doctor stays in Australia he will be given the value of the unused return tickets.
SENIOR RESIDENT	£A1,175 (£940 Stg.)	ditto	
MEDICAL SUPERINTENDENT	£A1,700 (£1,360 Stg.) £A2,750 (£2,200 Stg.)	ditto	

Successful applicants will be required to serve in approved country base hospitals for a period of two or three years, after which they are eligible for ordinary hospital staff appointments or private practice on their own account. In Australia medicine is not socialized. There are excellent opportunities for private practice in country and city in Victoria. For further particulars write to:

THE AGENT-GENERAL FOR VICTORIA, Victoria House, Melbourne Place, Strand, LONDON, W.C.2.

Source: *BMJ*, 6 September 1958, 57.

400 Gish and Godfrey, 'A Reappraisal of the "Brain Drain"', 1-11.

401 Harper, *Plaster and Paint*; Russell, *Melbourne Medical School*.

402 'British Doctors for Aust. Navy', *The Daily Telegraph*, 12 February 1949, 5.

403 'British doctors for R.A.A.F.', *Advocate*, 30 September 1954, 5.

The state of Victoria sought to alleviate shortages of doctors for country base hospitals using similar inducements to the RAAF scheme in the late 1950s (Figure 8). John Garner (MBBChir Cambridge 1956) recalled his experience of learning about the scheme while completing his compulsory military service in England. He recalled:

> …one day, on my desk … there was a letter from Victoria House in London, inviting me to apply, if I wished to an internship in a country hospital in Victoria … they must have circulated a lot to medical people in the services … I don't know. They offered me, they said, Sale, Geelong, Ballarat, Bendigo, Mildura. And, so on. And so I contacted them and said, what exactly are these places like.
>
> I'm afraid I lost the letter, but they said we can tell you Mildura is hot, Ballarat is cold, and Geelong is a port area of Melbourne. So with that, we got in touch with a relative of mine down in Bairnsdale and she asked her doctor. And he said, look tell him to go to either Geelong, Bendigo or Ballarat. So I thought, well Ballarat, because, … they offered you two years, they paid your passage out, two years employment, and then after three years your passage back to England if you wanted to.[404]

John Garner arrived in Victoria is 1959 and worked as a resident medical officer at the Ballarat Base Hospital, as did Kathleen Blott (MB ChB Bristol 1946) as an anaesthetist. Other such arrivals included Robert Cameron (MB ChB Edinburgh 1946, Wonthaggi District Hospital); David McDonald (MB ChB Aberdeen 1951, Mildura Base Hospital); Glyn Priddle (MBBS London 1956, Glenelg Base Hospital) and John Reid (MB ChB Edinburgh 1933, Warrnambool Base Hospital).

Summary

To summarise, the discoverable evidence highlights the myriad ways in which the embedded privileges of the Commonwealth medical market, as well as the freedom with which British and Irish subjects could travel and settle to Australia, formed the framework within which British and Irish medical migrants arrived and registered to practise medicine in Victoria throughout the period under study. This discussion backgrounds the two case studies that comprise the remainder of this part of the thesis. Both of these case studies are reproduced in their published format. Chapter 3 comprises a case study published in *Social History of Medicine* in 2018; and Chapter 4 comprises a case study published in *Women's History Review*, also in 2018.

***

404 John Fairfax Garner, interview with the author, 13 October 2017.

Chapter 03: Revisiting Post-war British Migration: A Case Study of Bristol Medical Graduates in Australia [publication]

As discussed in the Introduction, this is a thesis *with* publication. **This chapter is a pre-copyedited, author-produced version of an article accepted for publication in *Social History of Medicine* following peer review.** The version of record,

> Mody, Fallon. "Revisiting Post-war British Medical Migration: A Case Study of Bristol Medical Graduates in Australia." *Social History of Medicine* 31, no. 3, (2018):485-509

is available online at: https://academic.oup.com/shm/article-abstract/31/3/485/3862109, or https://doi.org/10.1093/shm/hkx009.

Errata

This article was accepted by the journal in 2016 and was available as an advanced publication from 7 June 2017. Since then the total number of medical migrants discovered in the Victorian medical registers changed from that quoted in the publication – from 735 to 743; and the number of British medical migrants from 563 to 569.[405] Therefore '**Table 1 Overseas medical graduates registered in Victoria, 1930-60'** on pp.489 of the publication should now be updated to include the additional nine medical migrants. This update is summarised in Table 6 below.

Table 6 Updated 'Table 1 Overseas medical graduates registered in Victoria, 1930-60'.

	Brit & Irish women		Brit & Irish men		Other European		Rest of World	
	ALL	Sample	ALL	Sample	Women	Men	Women	Men
1930-45	26	14	70	13	2	27	3	15
1946-60	87	41	386	73	17	42	8	61
Total (% in sample)	113	55 (47%)	456	86 (19%)	19 (100%)	68 (100%)	11	76

Source: Victorian medical registers, 1931-60.

405 See Appendix 2 for further discussion.

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Chapter 04: Migrant Medical Women: A Case Study of British Medical Graduates in Twentieth-century Australia [publication]

As discussed in the Introduction, this is a thesis *with* publication. **This chapter is a reproduction of the Accepted Manuscript of an article published by Taylor & Francis in *Women's History Review* on 01 September 2018, available online: https://www.tandfonline.com/doi/full/10.1080/09612025.2018.1513828**.

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Part III – Alien & Marginalised: Three Case Studies of Continental European Medical Migrants

Introduction to Part III – Case Studies of Continental European Medical Migrants in Context

Out of the 743 medical practitioners registered in Victoria between 1930-60, only 87 gained registration on the basis of a continental European degree – 68 men and 19 women (Table 1).[406] In the first two case studies in this next Part, I revisit the 'administrative' or gatekeeper response to their arrival.[407] That is, the mechanics of a complex set of medical registration protocols deployed and sustained by the local profession, notably the BMA in Australia, to prevent the registration of continental European medical migrants, many of whom were European Jews seeking refuge.[408] As discussed in Chapter 1, analysis of the gatekeeper response in Australia has been a central focus in the historiography documenting this group of medical migrants. A consequence of this almost exclusive focus is that continental medical migrants have largely been frozen as 'marginalised' in the historiography.[409]

Despite historians' focus on the Australian gatekeeper response to groups of continental medical migrants, in Chapter 1 I also outlined two important limitations of this historiography: the extent to which medical politics has been ignored in examining this gatekeeper response; as well as the lack of scholarship exploring or describing the agency of this group of medical migrants. It is these two limitations that are respectively addressed in the following two case studies. In Chapter 5, I revisit the role of racial prejudice – specifically anti-Semitism – in understanding the gatekeeper response to Jewish medical migrants in interwar Australia. Between 1935-39, a notable number of medical practitioners were among the Jewish refugees Australia accepted for resettlement.[410] By late 1938, the medical profession in most states and territories had mobilised to prevent the creation of a pathway by which these men and women might legally practise medicine.[411] Historians Suzanne Rutland and John Weaver position prevalent anti-Semitic attitudes among influential medical practitioners as central to understanding the restrictive and protectionist response(s) introduced in Australian states in the mid-1930s.[412] In Chapter 5, I weave in what I argue is an essential thread in understanding the Australian gatekeeper response: the implications of the ongoing debates over the introduction of medical benefits to the proposed National Health Insurance scheme in Australia in the mid-1930s. In this context, the perception of continental medical migrants as 'overspecialised' in a medical market dominated by general practitioners becomes more significant.[413] This chapter is

406 See Appendix 2 for further discussion of who was included in this group, as well as for the full list of names.

407 Weindling, 'Medical Refugees in Britain and the Wider World'.

408 Ibid.

409 See Chapter 1 for a more detailed discussion.

410 Rutland, *Take Heart Again*.

411 See, Rutland, 'An "Example of Intellectual Barbarism"'; Weaver, 'A Glut in the Market'.

412 Ibid.

413 See Chapter 2 for a detailed discussion of the structure and practice of medicine in Australia.

a revision of an earlier article published as peer-reviewed conference proceedings. The original publication is reproduced in Appendix 6.

In Chapter 6, I continue the exploration of the gatekeeper response, but from the perspective of a group of post-war continental medical migrants who were affected by the restrictive medical legislation in place. The Unregistered Doctors Association (UDA) in Victoria was formed by a group of medically-qualified Displaced Persons (DPs) in 1951.[414] A key goal for the UDA was to lobby for the introduction of a fairer pathway for the recognition of medical qualifications in Australia for individuals who qualified from non-reciprocating countries.[415] Through an exploration of the activity of the UDA, I highlight an important example of the depth and extent of the agency exerted by these medical migrants in the face of prolonged and sustained barriers to liberalising state medical acts. The existing historiography, as discussed in Chapter 1, has represented medical migrants as largely passive actors in this process: they are the victims of the BMA in Australia exerting its considerable influence over state and federal governments in this matter.[416] Therefore, this case study serves as an important corrective by highlighting some of the ways in which groups of continental medical migrants went about reconstructing their professional identity in Victoria. This chapter is a reproduction of an article published in *Health & History* in 2015.

In the final case study, I continue the exploration of the interplay of medical politics and Victoria's medical needs in contextualising the work of continental medical migrants, a large majority of whom worked as GPs. In doing so, I provide a fuller examination of the professional lives of these medical migrants – further fracturing and complicating the popular representation of them as victims – of professional prejudice and protectionism.[417] Instead, I demonstrate the vital role(s), and occasionally pioneering work, collectively and quietly displayed by a group of men and women engaged in private practice. That is, the 'special type of labour' undertaken by this group of medical migrants.[418] Their collective professional lives reveal in fragments the dynamics of numerous local contexts that, when combined, can deepen our understanding of the experiences of continental European medical migrants in twentieth-century Australia. It highlights that the collective biography of these medical migrants need not solely emphasise their marginalisation.

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414 NB: Displaced Persons or DPs were a specific category of non-British migrant in Australia. DPs typically refer to the group of European refugees recruited from camps across post-war Europe under Australia's Displaced Persons Scheme. The Scheme comprised a part of Australia's commitment to the International Refugee Organisation to facilitate the resettlement of European refugees who could not or did not wish to be repatriated. For further discussion, see: Persian, PhD thesis.

415 As discussed in Chapter 2, the principle of reciprocity in the recognition of foreign medical qualification was introduced in state medical acts at the turn of the century.

416 See: Kunz, *The Intruders;* Rutland, 'An "Example of Intellectual Barbarism"'; Weaver, 'A Glut in the Market'.

417 Ibid. A notable exception includes: Winterton, 'Alien Doctors', 77-82.

418 Simpson et al., 'Providing "Special Types of Labour"'.

As with Part II of this thesis, it is necessary to provide important background context for these three case studies. First, the pathways that described the arrival of British and Irish medical migrants (see introduction to Part II of this thesis) are vastly different to their continental medical migrant counterparts. Therefore, to contextualise the arrival of the 87 continental European medical migrants in this study I will provide a brief overview of the displacement of medical practitioners in continental Europe, as well as the Australian migration policies that facilitated the resettlement of so-called 'alien' or non-British settlers to Australia for the period 1930-60. Finally, as indicated in the discussion above, until 1956, most continental European medical qualifications were not recognised in Victoria (or many other Australian states). However, this was not a static condition. The medical registration rules in Victoria changed a number of times between 1930-1956, in specific response to the arrival and local response to these medical migrants. This process and the implications of these changes will be discussed in the subsequent three chapters. However, for clarity, I briefly summarise the high-level changes that enabled the registration of continental medical migrants in Victoria over the period under investigation.

The displacement of medical practitioners in continental Europe, 1930-60

Figure 9 maps the years of arrival of continental medical migrants registered in Victoria between 1930-60, highlighting two distinct periods of arrival for the 87 continental medical migrants registered in Victoria: between 1938-39 and 1949-50. The place and year of graduation for these men and women highlight the heterogeneity of the group in medical training terms (Table 14). As can be seen, the single most represented medical school was Vienna with 14 out of 87. What is more noticeable, and is unsurprising, is that the majority of these practitioners graduated before 1939, and arrived in Australia just before the outbreak of the Second World War (Figure 9 and Table 14). Medical practitioners were among the earliest groups of Jewish, mixed heritage, and anti-regime European nationals who were expelled or sought to migrate in the wake of growing anti-Semitism in Europe.[419] The patterns that describe their training and the timing of their arrival to Australia both reflect what historian Michael Kater has described as the 'progressive disenfranchisement' of Jewish (including mixed heritage) medical practitioners across continental Europe.[420]

In Germany, this disenfranchisement began shortly after the election of Adolf Hitler's National Socialist regime in 1933. Jewish university students – including in medicine – were among the earliest group to face discrimination and were forced to drop out or were restricted from university places.[421] The amendments to the German civil service act in 1933, for example, excluded an estimated 2,600 Jewish GPs from providing services under the German National Health Insurance scheme, although Jewish doctors who had served in World War I and/or had been practising prior to August 1914 were originally exempt.[422] By 1934, the admission of

419 Sanders, *Shores of Refuge,* 428-435.

420 Kater, *Doctors Under Hitler*, 192.

421 Ibid.

422 Ibid.

non-Aryan students to medical degrees was restricted almost completely.[423] Established Jewish practitioners were allowed to practice in severely limited conditions, including in universities and other teaching positions; many were left unemployed.[424] The Nuremberg Laws introduced in 1935 marked a more radical set of anti-Jewish legislation. These laws extended the exclusion of Jewish doctors to private practice and university positions.[425] It is estimated that between 4,500-6,000 German Jewish medical practitioners were stripped of their professional status. Medical practitioners were among the earliest groups to seek refuge (they were also more likely to have had the wealth and networks to facilitate this exit).[426] However, prior to 1938 many more – as with German Jewry more generally – were reluctant to leave, and those who did thought their emigration was temporary.[427]

Beginning from 1938, however, the urgency to leave was compounded by growing violence and an increasingly uncertain future.[428] On 25 July 1938, an ordinance was issued which declared that all but a few Jewish doctors would be delicensed, and could no longer lease spaces to run medical practices. The exceptions were those whose services were retained to treat Jewish patients, but under severely limited circumstances.[429] Following Hitler's annexation of Austria in early 1938, Austrian medical practitioners – estimated to be almost half the total medical workforce – shared a similar, yet harsher fate. First because they were assumed to be of Eastern Europe Jewry, and second because their expulsion from the medical profession occurred over a much quicker timeframe compared to their German counterparts.[430]

Wide-ranging discriminatory measures (both formal and informal) on Jews in Poland predated measures in Germany and Austria, and by 1935 followed the German example.[431] Growing unrest lead to wide-scale emigration of Polish Jews in the interwar period.[432] Although estimated to be over half of Poland's medical profession in the early 1930s, it is unclear how many Polish-Jewish doctors were among the emigrants.[433] The fate of Polish-Jewish medical students is easier to trace. A 1923 campaign to introduce quotas on Jewish university admissions (*numerus clausus)* failed, the principle of quotas was introduced in Poland around that time.[434]

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423 Collins, 'European Refugee Physicians'.

424 For a discussion of the regional differences in the treatment of Jewish medical practitioners in 1930s Germany, see: Kater, *Doctors Under Hitler*; Grossman, 'German Women Doctors from Berlin to New York'; and von Villiez., 'Emigration of Women Doctors from Germany'.

425 Ibid.

426 Weindling, 'Medical Refugees in Britain and the Wider World'.

427 Sanders, *Shores of Refuge,* 428-435; Strauss, 'Jewish Emigration from Germany'.

428 For a detailed overview, see: Sanders, *Shores of Refuge,* 436-458.

429 Kater, *Doctors Under Hitler,* 192-99.

430 Ibid.

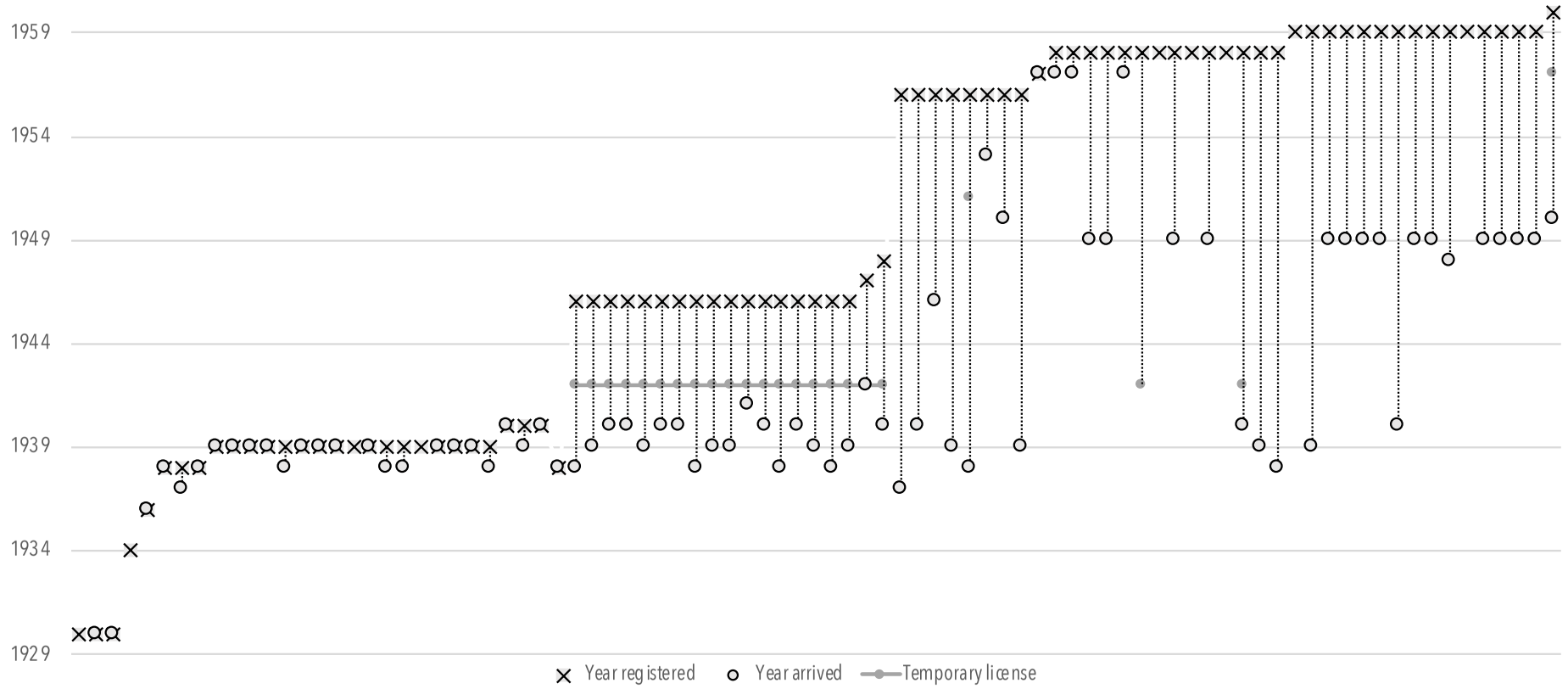
431 Rudnicki, 'Anti-Jewish Legislation in Interwar Poland', 148-170; Hagen, 'A Comparative Analysis of Political Anti-Semitism in Interwar Germany and Poland', 351-381.

432 Ibid. See also, Sanders, *Shores of Refuge,* 399-415.

433 Ibid. NB: Weindling notes that the emigration of Polish-Jewish doctors is an understudied area. See: Weindling, 'Medical Refugees in Britain and the Wider World'.

434 Rudnicki, 'Anti-Jewish Legislation in Interwar Poland', 156.

Figure 9 Year of arrival and registration of continental medical migrants (n=87).



Source: Victorian medical registers and passenger arrival data (Appendix 3).

Table 14 Summary of country and year of graduation from primary medical degree (n=87).

		Year of graduation					
Country	**Place of graduation**	**Before 1930**	**1930-39**	**1940-45**	**After 1945**	**Not known**	**Total**
Austria	Vienna	8	6	0	0	0	14
Former C'Slovakia	Bratislava	0	1	0	0	0	1
	Prague	0	1	0	0	0	1
Former Yugoslavia	Belgrade	0	1	0	0	0	1
Germany	Basle	0	2	0	0	0	2
	Berlin	2	1	0	0	0	3
	Bonn	1	0	0	0	0	1
	Frankfurt	0	1	0	0	0	1
	Freiburg-Breisgau	4	0	0	0	0	4
	Graz	1	0	0	1	0	2
	Hamburg	0	1	0	0	0	1
	Leipzig	0	1	0	0	0	1
	Munich	0	0	0	1	0	1
	Strasburg	1	0	0	0	0	1
Hungary	Budapest	2	1	2	1	0	6
	Hungary	1	0	0	0	0	1
	Pecs	1	0	0	0	0	1
	Szeged	0	0	0	1	0	1
Italy	Bologna	0	4	0	0	0	4
	Florence	0	1	0	0	0	1
	Genoa	2	2	0	0	0	4
	Italy	1	0	0	0	0	1
	Messina	1	0	0	0	0	1
	Milan	0	2	0	0	0	2
	Naples	0	2	0	0	0	2
	Padua	1	3	0	0	0	4
	Parma	0	1	0	0	0	1
	Pisa	0	1	0	0	0	1
	Rome	1	5	0	0	0	6
	Siena	1	0	0	0	0	1
	Turin	0	1	0	0	0	1

		Year of graduation					
Country	**Place of graduation**	**Before 1930**	**1930-39**	**1940-45**	**After 1945**	**Not known**	**Total**
Latvia	Latvia	2	3	0	0	0	5
Lithuania	Lithuania	1	1	0	0	0	2
Malta	Malta	0	0	0	1	0	1
Poland	Lodz	0	0	0	1	0	1
	Poland	0	0	0	0	1	1
	Vilno	1	1	0	0	0	2
	Warsaw	1	0	0	0	0	1
Russia	Kharkov	0	0	0	0	0	0
	Moscow	1	0	0	0	0	1
Switzerland	Zurich	1	0	0	1	0	2
Total		35	42	2	7	1	87

Source: Victorian medical registers and medical directories, 1931-60.

This is reflected in the numbers of Jewish university students, which fell from 25% of the student body in 1925 to 10% in 1937/38.[435] Polish Jews sought university places, including in medicine, outside of Poland. Italy, notably, continued to admit non-Italian Jewish students to medical school, as well as permitting medical students who had not taken their final exams to do so instead from an Italian institution. This is reflected in the group of 87 continental medical migrants registered in Victoria. The Polish nationals showed a mosaic of graduations, including in Austria, Germany, Switzerland and Russia. Remarkably, only four of the 28 Italian medical graduates registered were Italian-born, compared to 15 Polish-born. This statistic alone highlights how Italy was an effective refuge for medical students and practitioners, until 1938 when racial laws were introduced under Italy's fascist regime and Jewish residents were forced to leave.[436]

The discussion above does not cover all the places from where the group of 87 continental medical migrants had graduated, or, indeed, where they had been working before they were impelled to leave (Table 14). However, it does provide an overarching context for the specific ways in which medical practitioners were stripped of their professional status, or were living in precarious circumstances prior to the outbreak of the Second World War. After the annexation of Austria and the pogroms that followed in 1938, including *Kristallnacht* (or night of broken glass, 10 November 1938), Jewish medical practitioners were at risk of incarceration if found treating patients.[437] Historians have described the varied and stepped nature of the journeys Jewish medical practitioners undertook as anti-Semitic legislation was adopted in continental Europe from the early 1930s.[438] In Germany, this included mandatory surrender of passports introduced in October 1938, further limiting their ability to leave. The United States of America took the largest number, followed by France and British-controlled Palestine.[439] England and Scotland were close intermediary destinations, particularly for those who sought to retrain before relocating within the Commonwealth network.[440] Historian John Weaver also notes the importance of Shanghai (often via Russia) as a place of refuge because passports and visas were not required by Chinese authorities until 1940.[441] For the interwar arrivals in this study, Cuba, Hong Kong, Japan, Palestine, Switzerland and the United States of America are just a few places from which continental medical migrants applied and received a landing permit for Australia.[442]

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435 Weiss, 'Polish and German Jews Between Hitler's Rise to Power and the Outbreak of the Second World War', 205-223.

436 Livingston, *The Fascists and the Jews of Italy*.

437 Kater, *Doctors Under Hitler,* 192-206.

438 Ibid. See also, von Villez, 'The Emigration of Women Doctors from Germany'; Weaver, 'Pathways of Perseverance'.

439 Kater, *Doctors Under Hitler,* 206-20.

440 Collins, 'European Refugee Physicians'.

441 Weaver, 'Pathways of Perseverance'. See also, and Edele and Fitzpatrick, 'Displaced Persons from the Soviet Union to Australia.

442 Based on analysis of prosopographic database constructed for this PhD. See Appendix 3 for a discussion of sources.

The second largest wave of arrivals came between 1949-51 (Figure 9). This latter group of men and women had survived the Second World War whilst living in Europe, and had spent their war years in hiding, imprisoned (including in concentration camps), working in military hospitals, or under direction from occupying forces.[443] A handful had graduated during the war (Table 14). For the post-war arrivals, with the exception of those who sought refuge following the Hungarian revolution, many were recruited or assisted to leave refugee or DP camps established by the United Nations Relief and Rehabilitation Administration (later the International Refugee Organisation) in liberated European cities.[444] Among them were the smaller percentage of Jewish medical practitioners who had remained in Europe and survived the Holocaust.[445] Among the non-Jewish arrivals were those who had worked as forced labourers and as guest workers in Germany and Poland in particular, or had simply not worked owing to their displacement. For example, Polish-born, Roman Catholic Sergiusz Chrapowicki graduated from Russia's Kharkov medical school in 1927. He worked as a GP in Poland from 1934-42, then as an ENT Surgeon based in the Lodz Town Hospital (1942-44). From 1944 until the end of the war he reported that he worked as a doctor in a German 'Foreign Workers Camp'. Chrapowicki continued to work in DP camps run by the International Refugee Organisation until he was selected for migration to Australia.[446] Similarly, Eugenie Cikalov was born in Ukraine and was of Greek Orthodox faith. She graduated from medicine in Belgrade where she also worked until 1941 – presumably until the German invasion of Yugoslavia and subsequent resistance to its occupation, which resulted in widespread civilian displacement.[447] She resumed medical work in 1946 as a medical officer in a DP camp.[448] Eugenie, her husband and two children were recruited for Australia's DP scheme, and arrived in 1949.

Alien migration to Australia, 1930-60

For much of the twentieth-century Australians imagined themselves part of a wider British world.[449] The 'unravelling of British race patriotism' in Australia happened gradually.[450] Expressions of this included the dismantling of race-based immigration policies in the 1960s, which for the better part of 150 years rested on what historian James Jupp describes as 'the maintenance of British hegemony and white domination'.[451] As you would expect, this unravelling was episodic – there are key periods in Australia's post-Federation history when these imaginings were disturbed and challenged. In these moments, Australians were forced to

443 Kunz, *The Intruders*, 8. For an overview, see: Gatrell, *Making of the Modern Refugee,* 85-117; and Sanders, *Shores of Refuge,* 591-608.

444 For a discussion of Australian recruitment of DPs, see: Persian, *Beautiful Balts,* 59-66.

445 For a discussion of the fate of Jewish doctors who remained in Germany and Austria, in particular, see: Kater, *Doctors Under Hitler,* 206-20.

446 IRO, *Professional Medical Register,* 230.

447 St Pavlović and Pavlowitch, *Hitler's New Disorder*.

448 IRO, *Professional Medical Register*, 12.

449 Bridge and Fedorowich, *The British World*.

450 Mann, '"Leavening British Traditions"', 47.

451 Jupp, *From White Australia to Woomera*, 7.

consciously and collectively engage with and unpick the assumptions and implications upon which their society, politics and culture were based. The early 1930s mark the beginning of one such moment in Australian history when during the throes of the depression, German Jews and later Austrian, Czech and Polish Jews began to look for refuge as discussed above. Australia's response to this humanitarian crisis disturbed an otherwise almost universally held ideal that only white, assimilable settlers were acceptable.[452] Jewish settlers, as will be discussed in the next chapter, were seen as highly *un*assimilable.

The twin ideals of Britishness and whiteness were encapsulated in Australia's earliest immigration policy – the 1901 *Immigration Restriction Act*. The Act created a filtration system, restricting unwanted or undesired permanent settlement by means of a dictation test. The dictation test was often set in a language that would likely not be known to the undesirable migrant, forming the basis for denying entry into Australia.[453] Non-white settlers were thus effectively discouraged, although not completely deterred, from permanently settling in Australia. The impact of 'White Australia Policy' is demonstrable. For example, the 1933 Census reported a non-European population of 0.99 per cent (this included half-caste, but not full-blood Indigenous Australians).[454] White Australia policy only began to be dismantled in the late 1950s, notably with the introduction of the *Migration Act 1958*, which removed references to race, as well as the dictation test. However, only in 1972, with the election of Gough Whitlam, was immigration policy changed to explicitly state that Australia would no longer discriminate on the basis of race or ethnicity. In contrast, as discussed in the introduction to Part II of this thesis, white British subjects continued, until 1983, to have the unrestricted ability to settle in Australia. In the intervening years, there was a two-class immigration system in operation, which distinguished between white British and Irish subjects, and everyone else who was deemed 'alien'.

However, by the 1930s, Australia's need to 'populate or perish' had bi-partisan support.[455] The effects of the Great Depression had a marked effect on the local birth rate, for example, in 1931 Australia's annual population growth was 0.8 per cent.[456] Australia's population for much of the 1930s hovered under seven million, which was considered too low to achieve economic growth.[457] Plans to grow Australia's population became secondary following the outbreak of the Second World War, with one notable exception. Between 1935-39, roughly 8,000 European Jews were issued landing permits.[458] This was Australia's formal humanitarian response to the displacement of continental European Jews, which in 1938 was capped at accepting 15,000 Jewish refugees over three years.[459] As will be discussed further in the next

452 This is discussed further in Part III of this thesis, in particular Chapters 5-6.

453 For a further discussion, see: Jupp, *From White Australia to Woomera,* 5-20.

454 ABS, 1933 Census.

455 The term 'populate or perish' was popularised by Arthur Calwell.

456 ABS, Historical Migration Statistics.

457 For a discussion, see: Richards, *Destination Australia* 113-40.

458 Markus, 'Jewish Migration to Australia'.

459 Ibid.

chapter, this was a concession in the face of the unpopularity of admitting 'aliens' in large numbers.

With the outbreak of the Second World War, migration was effectively halted for all but war-related efforts. However, one notable set of arrivals were mostly German nationals – Jewish and non-Jewish – captured as 'enemy aliens' in Britain and transported to Australia for internment.[460] The most infamous of these arrivals were those aboard the *HMS Dunera* (or the 'Dunera Boys').[461] These men were interned in camps, the largest ones being in NSW and Victoria, along with German-, Italian- and Japanese-born men who had been resident in Australia when the war broke. By 1942, the British government recognised many of the internees were not dangerous, and the overseas internees sent to Australia (and Canada) were offered return passage to Europe by the British government.[462] However, quite a few opted instead to stay in Australia. This included three medical practitioners in the group of 87 continental medical migrants in this study: Paul Schatzi, Georg Rechelmann and Friedrich Landaeur. Their pathways will be discussed further in Chapter 7.

Australia's defensive vulnerability and economic need, highlighted by the events of the War, added urgency to post-war reconstruction plans to increase its population.[463] The stated post-war aim was to grow Australia's population by two per cent a year – half of that contribution was to come via immigration. This period of post-war immigration is widely considered a watershed moment.[464] Arthur Calwell was appointed Australia's first minister for immigration in 1945. Calwell's proposals were radical in comparison to Australia's prior efforts to attract settlers, particularly as it became clear the quota he established could not be met by Britain and Ireland alone. As early as 1944, Cabinet reports recommended 'an education campaign' to ensure general support for the planned increase in population, particularly in light of the mixed reception Jewish refugees had experienced in the late 1930s.[465] This task also fell to Calwell's department, which set about reassuring the Australian public that British settlers would always be preferred with an advertised mandate that 90 per cent of the post-war growth was to come from the UK and Ireland. Additionally, the campaign sought to reassure Australians that all other migrants would create, not take Australian jobs, and that they would assimilate into an imagined 'Australian Way of Life'.[466] The chief guiding principles that governed the

460 Approximately 8,000 people were sent to Australia for internment. See: NAA, 'Wartime Internment Camps in Australia', http://www.naa.gov.au/collection/snapshots/internment-camps/introduction.aspx, last accessed 31 October 2018.

461 Saunders, '"The Stranger in Our Gates"', 22-43.

462 Ibid.

463 For a discussion, see: Richards, *Destination Australia,* 166-203.

464 Ibid. See also, Jupp, *From White Australia to Woomera,* 5-20.

465 Zubrzycki, *Arthur Calwell and the Origin of Post-war Immigration*.

466 For a discussion, see: Meaney, 'Britishness and Australian Identity'; Stanner, 'The Australian Way of Life'; and White, 'The Australian Way of Life'.

recruitment of non-British settlers was that they were white, likely to assimilate and able to work.[467]

The earliest recruitment of non-British Europeans as part of a mass migration scheme came in the form of the DP scheme. Under this scheme, 170,000 DPs arrived in Australia between 1947-54, on two-year labour contracts.[468] Continental Europeans recruited for the DP Scheme were among the earliest non-British migrant cohorts. Therefore, migration officials were directed to recruit with a deliberate eye to placating Australian fears. They were to be, in Calwell's words, 'beautiful Balts': blonde, blue-eyed, young families.[469] The DP scheme was one facet of Australia's expansive post-war immigration program, which comprised a series of individual schemes and deals. The schemes available to British and Irish settlers was discussed in the introduction to Part II of this thesis and will not be repeated here. Calwell also oversaw the introduction of migration agreements with the Netherlands and Italy (1951), Austria, Belgium, West Germany, Greece and Spain (1952), and the United States, Switzerland, Denmark, Norway, Sweden and Finland (1954). It should be noted that Calwell also specifically set-out to limit the number of Jews – particularly Sephardic Jews – admitted under Australia's post-war schemes.[470] Finally, one relatively smaller group of post-war arrivals – in the mid-late 1950s – were Hungarian or resident in Hungary during the revolution in 1956.[471]

Overall, the proportion of British settlers to Australia reduced from 46 per cent between 1945-1950, to 34 per cent in the following five years (Table 5). By the 1961 Census, a much more nuanced European population can be seen in Australia compared to 1933 (Table 4). In the top ten countries of birth for the overseas-born population, Italy, Germany, Netherlands, Greece, Poland, Yugoslavia and Malta were now included; and the proportion of UK-born had dropped to 40.4 per cent. Australia's population was transformed in the wake of its post-war immigration program. It is against this general legislative framework and general migration backdrop that the 87 continental medical migrants arrived in Australia between 1930-60.

The recognition of overseas medical degrees in Victoria and the registration of continental European medical migrants, 1930-60

The patterns of registration of the 87 continental medical migrants registered in the state of Victoria between 1930-60 reflects the changing recognition afforded foreign medical degrees (Figure 9). As discussed in Chapter 2, in the first decade of the twentieth-century, most Australian states had introduced a reciprocity clause in their medical acts, effectively shutting out local medical markets from unwanted or unexpected competition.[472] Therefore, with the exception of British, Irish and New Zealand qualifications which were afforded automatic recognition, all other foreign degree holders had to demonstrate reciprocal recognition of

467 Richards, *Destination Australia,* 166-203; Jupp, *From White Australia to Woomera,* 5-20.

468 Persian, *Beautiful Balts,* 59-66.

469 Ibid., 50-75.

470 Rutland, 'Postwar Anti-Jewish Refugee Hysteria, 69-79.

471 Urmenyhazi, 'Hungarian Immigration in Australia'.

472 Salter, 'Prejudice in the Professions'.

Australian medical degrees in their country of qualification. As you can imagine, such reciprocity was almost exclusively negotiated at a governmental level.[473]

Between 1930-56, there were three windows of opportunity for medical migrants holding unrecognised degrees to gain registration in Victoria. The first was an existing reciprocity agreement with Italy (by virtue of British foreign policy being applicable in Australian states).[474] However, that was nullified by 1940 when Italy entered the war as an axis power.[475] The second was the temporary federal licensing scheme introduced in 1942 to alleviate civilian shortages of doctors. This scheme marks the beginning of a softening towards 'alien doctors'.[476] At the end of the war, state medical boards around Australia endorsed full registration of these licensees only.[477] In Victoria, this latter legislation was passed in 1946.[478] Finally, a temporary licensing scheme was passed in Victoria in 1951 that allowed two-year restricted licenses for foreign medical graduates who were sponsored by an Australian medical institution.[479] This legislation was introduced to facilitate short-term research appointments as the available funding for medical research increased, prompting research institutes and large teaching hospitals to expand their post-war recruitment.[480] The main Victorian medical act, however, was only fully amended in 1956-57 to provide a standard, more objective pathway for the recognition of foreign medical degrees. This will be discussed further in Chapter 6.

In the intervening years, it is estimated that there were over 100 continental medical migrants resident in Victoria alone – both interwar and post-war arrivals – holding unrecognised degrees.[481] Table 14 above documents the diversity of European medical schools represented in the group of 87 continental medical migrants being studied in this thesis. Given the history of forced migration and persecution represented among this group of medical migrants, it is unsurprising that almost all but ten of these doctors graduated before 1939, meaning that many of these medical migrants were likely established practitioners before they were forced to leave Europe. In Victoria, their retraining options included completing the full six-year medical degree at the University of Melbourne; or moving to another state to complete a shorter three-year course. However, for those post-war settlers who arrived in Australia under the DP scheme, even these options were closed off to them until they had fulfilled their two-year labour

473 For a discussion, see Haynes, *Fit to Practice,* 36-55.

474 Weaver, 'A Glut in the Market'.

475 Ibid.

476 The *National Security (Alien Doctors) Regulations Act* was passed in 1942.

477 PROV, VPRS 16389/P1 unit 6.

478 The *Medical Practitioners' Registration Act* was passed on 19 November 1946.

479 As the *Medical (Temporary Registration) Act* 1951.

480 NB: The impetus for this act was to attract overseas medical researchers in an expanding post-war funding environment. Registrants were not entitled to private practice. Without the provisions of the introduced act, the employment of overseas medical graduates contravened existing legislation introduced in 1938. See: Victorian Parliamentary Hansard, Vol CCXXXVI 1154/52, 21 August 1951, 3933-41; and PROV: VPRS 16389/P1 unit 7.

481 Kunz, *The Intruders*.

contract with the federal government.[482] I will discuss both these points further in the next two case studies. Thus, the patterns of registration seen in Figure 9 reflects the changing recognition afforded continental European medical graduates. It also highlights that the average number of gap or unregistered years for the 87 continental medical migrants documented in this study was nine – as seen in the horizontal lines connecting year of arrival to year of registration in Figure 9. I will discuss this further in Chapter 7.

Summary

In this introduction, I have outlined how Australia's federal and state policies formed the basis upon which a two-class system of immigration and recognition of medical qualifications was in operation for the better part of the twentieth-century. As discussed in the Introduction to this thesis, the differential rights and recognition afforded so-called 'alien' settlers (and medical practitioners) compared to British and Irish counterparts requires careful reflection. This introduction to the next three case studies serves to highlight the basis upon which these differences were built, as well as the contrasting pathways that brought medical migrants to Australia between 1930-60. The next three case studies document the resettlement, transitions and medical work of the 87 continental medical migrants registered in the state of Victoria between 1930-60. Chapter 5 is a revision of an earlier publication (Appendix 6), and Chapter 6 is reproduced here in its publication format.

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482 Ibid., in particular 93-120.

Chapter 05: 'Are These Men Trained to Our Standard of General Medical Work … I Am Sure Not'[483] – Re-examining the Social and Professional Responses to Jewish Refugee Doctors in Victoria, 1930-45[484]

On 1 September 1937, the members of the Medical Board of Victoria spent a portion of their meeting reflecting on the 'obscurity of the provisions' of the current *Medical Act 1928*.[485] These reflections were prompted by the Board's highly-publicised, unsuccessful bid to defend its decision to refuse registration to a German-Jewish doctor, Moritz Meyer.[486] Meyer held an extramural British degree recognised by the Board – the 'Scottish Triple' as it was commonly referred to, was an amalgamated entry-level qualification offered by the three Scottish medical colleges.[487] Meyer had successfully passed the Scottish examinations in 1937, and was a Licentiate of the Royal College of Physicians in Edinburgh, Licentiate of the Royal College of Surgeons Edinburgh, and a Member of the Royal Faculty of Physicians and Surgeons of Glasgow.

Meyer's full eligibility to be registered in Victoria hinged, however, on the legality of using a combination of unrecognised medical qualifications together with recognised medical qualifications to meet the required minimum of five years of medical training. Meyer had completed the full medical course and graduated in 1919 from the University of Leipzig in Germany, while he had spent between 10-15 months only retraining in Scotland.[488] On their own, neither of the two qualifications met the requirements of the Victorian act.[489] The Act did not explicitly stipulate that *all* the required medical training had to be obtained solely from recognised (reciprocating) institutions. However, when Moritz Meyer and another German doctor, Kurt Aarons, applied for registration in Victoria, the Board refused their application on these grounds. This was contrary to the written assurance Meyer and Aarons had received from the Board prior to migrating to Australia that their Scottish degrees would be recognised.[490]

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483 W. Maxwell, 'The Refugee Doctors', *MJA,* 16 December 1939, 919.

484 This case study is based on an early publication which has been reproduced in full in Appendix 6.

485 PROV, VPRS 16389/P1, BM, 1 September 1937.

486 The case was reported on by all major newspapers between June-September 1937. See for example, 'High Court Equally Divided Over Meyer Case', *The Telegraph*, 27 August 1937, 2; 'DR. MEYER CASE', *The Age,* 28 August 28 1937, 20; 'DOCTOR'S QUALIFICATIONS – Judgement Given in His Favour', *The West Australian*, 30 June 1937, 19.

487 For an overview, see: Dingwall, 'The Triple Qualification Examination'.

488 PROV, VPRS 16389/P1.

489 Foreign medical qualifications were only registrable in Victoria if the applicant could demonstrate that the country from which they graduated offered reciprocal recognition to graduates of the University of Melbourne – such an agreement did not exist between Germany and the state of Victoria. See Introduction to Part III for a full discussion.

490 PROV, VPRS 16389/P1.

Meyer subsequently lodged and won a formal appeal against the Victorian Board's ruling in the Supreme Court of Victoria (June 1937).[491] The Board unsuccessfully sought to overturn this decision and rushed to submit a counter appeal at their own expense for consideration in the High Court of Australia.[492] Meyer was registered as a legally qualified practitioner on 1 September 1937 – the same day the Board reflected on the urgent need to correct the 'obscure provisions' of the Act.[493] His case set a precedent that contradicted the Board's intentions – it enabled not curbed the potential for an 'influx of continental practitioners' to be registered in Victoria.[494]

The official responses to the growing number of Jewish doctors seeking to retrain in the UK prompted considerable and conflicting debate across the Commonwealth countries.[495] The UK Home Office issued these doctors permits to retrain in Britain; the Scottish licensing bodies insisted on its liberal approach to retraining these doctors; and on successful completion of this training the General Medical Council (GMC) registered them. However, the Home Office eventually bowed to the pressure from the British Medical Association and refused all but a select few individuals from permanently practising in the UK.[496] The main argument forwarded by the BMA was that the interests of the local profession ought to be protected from unwanted competition, as potentially thousands of doctors might seek refuge in the UK.[497] Instead, the British authorities encouraged these individuals to use their British qualification and GMC registration to seek positions within the Commonwealth network, where this combination was often sufficient to gain immediate registration.

In 1937, South Africa responded by removing its automatic recognition of British degrees.[498] As one correspondent in Australia explained in 1938:

> New legislation has been made imperative by the inexplicable action taken by British authorities. Britain would not permit these refugees to practise in Britain but agreed to register them… The effect of this action was to make possible the migration of these doctors to Australia, where, having British

491 'Law Courts – GERMAN DOCTOR MUST BE REGISTERED', *The Argus*, 30 June 1937, 14.

492 The Victorian Premier refused to use public money to fund the expense of counter appealing. See, PROV VPRS 16389/P1, and Meyer v The Medical Board of Victoria [1937] VicLawRp 48; [1937] VLR 237 (29 June 1937).

493 PROV, VPRS 16389/P1.

494 This phrase was used repeatedly in the popular press, minutes of meetings, and reports in the *Medical Journal of Australia* by official spokespeople, typically the BMA of Australia.

495 Collins, 'European Refugee Physicians in Scotland'.

496 Ibid.

497 Ibid.

498 Ibid.

> registration, there was no legal barrier to their establishment as qualified practitioners.[499]

The various medical regulatory bodies of former British dominions including Australia, Canada, New Zealand and South Africa formally registered their disapproval over the actions of the British authorities – typically to a combination of the BMA and the GMC.[500]

Moritz Meyer's win whilst a personal victory for him, was a short-lived guarantee for other Jewish doctors requalifying in Scotland in the hopes of re-emigrating to an Australian state. By December 1938, less than a year from Meyer's High Court victory, the medical act in Victoria was amended to prevent other alien doctors from using what was represented as a backdoor route to gaining registration.[501] Most Australian states followed Victoria's example, or had been in the process of doing so already.[502] Between Meyer's victory in September 1937 and December 1938, only ten more German doctors were registered in Victoria on the combined basis of a British extramural qualification and a German degree.[503] These numbers were possibly further stemmed since in mid-1938 – at the peak of anti-Semitic violence in the lead-up to the Second World War – the BMA in Australia persuaded the federal government to reject applications for resettlement from Jewish refugee doctors, dentists, and pharmacists.[504] Finally, the University of Melbourne required foreign degree holders to repeat its full six-year medical degree – this was the most restrictive response in the country.[505]

As discussed in Chapter 1, historians have largely examined the social responses that resulted in the marginalisation of continental medical migrants in Australia in the interwar period. These studies have invoked Moritz Meyer's case as one of many examples of a particular type of hostility directed towards Jewish refugee doctors.[506] Historian Suzanne Rutland concludes that the negative reception by the medical profession towards Jewish practitioners can be understood 'in light of the general xenophobia of the Australian public,

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499 'Alien Doctors', *Gippsland Times*, 21 July 1938, 2.

500 Collins, 'European Refugee Physicians'; Haynes, *Fit to Practice*.

501 This perception is particularly prominent in the parliamentary debates in 1938 with respect to the proposed changes to the Victorian Medical Act to restrict the registration of continental European medical migrants. See, Victorian Parliamentary Hansard, 29 November 1938 3226-9 and 6 December 1938, 3692-7.

502 Tasmania changed its legislation earlier in 1938 to restrict registration of medical practitioners to British subjects only. In New South Wales, an amendment was passed to its medical registration bill restricting registration of unrecognised practitioners to eight per annum.

503 It is likely that one further doctor, Hans Goldmann, registered in 1938 on the basis of a Scottish Triple also held a German degree. However, he never formally declared it unlike his peers. Goldmann was 39-years-old when he gained the Scottish Triple in 1937, and was married with two children on arrival in Australia. It is unlikely that he completed five years of retraining in the UK after he fled Germany in the 1930s, however, I have not been able to trace his German degree.

504 Rutland, 'An Example of "Intellectual Barbarism"'.

505 The other three medical schools in Queensland, New South Wales and South Australia followed the English path, and offered a three-year period of retraining.

506 Rutland, 'An Example of "Intellectual Barbarism"'; Weaver, 'Pathways of Perseverance'.

further influenced by anti-Semitism, [that] was particularly strong in the period'.[507] Rutland argues that there was 'an element of anti-Semitism' that describes in particular the 'exclusive attitudes of upper class Australians', to which the Australian medical profession belonged.[508] Similarly, historian John Weaver examined the implementation of the Italian reciprocity agreement, with particular reference to the states of Queensland and New South Wales. Weaver argues that while 'most hostility towards refugees in Australia seems to have had an economic character … diligence could also be predicated on a group slur that revealed insecurity and parochialism'.[509]

The basis of both Rutland's and Weaver's argument relies upon the strength of prevalent anti-Semitism in Australia. In this chapter, I will revisit the question of the role, extent and utility of racial prejudice in fully understanding the Australian medical profession's response to Jewish medical migrants arriving in the interwar period. The first section in this chapter is a critical exploration of the political and general reception of Jewish refugees in the wider Australian community (the social response). Drawing on the large historiography documenting interwar Jewish migration to Australia, I highlight the complexity of attributing anti-Semitism alone to the social response to these refugees.

In the last section of this chapter, I re-examine the professional response. Drawing on the case of the state of Victoria, and the medical migrants registered there between 1930-45, I further develop the economic argument for understanding the profession's official response, an aspect that is regularly invoked but poorly-considered in the literature to date.[510] In particular, I will consider the significance of the medical profession's negotiations over the proposed National Health Insurance scheme in the 1930s, which was perceived by a large number of Australian practitioners as a threat to their hard-won professional autonomy. The growing fracture between GPs and aspiring full-time specialists in Australia was revealed in the debates over National Health Insurance in the 1930s.[511] As I will demonstrate, the publicised perceptions about continental European medical education and practice, particularly that practitioners specialised too early (another aspect that has been ill-considered in the existing literature) becomes more relevant in this context.

In 1936-37, rank-and-file GPs in all Australian states uncharacteristically mobilised against the proposed National Health Insurance scheme. I argue that endorsement of uncontrolled entry of continental European medical migrants in an urban market that appeared overcrowded would have been impolitic. In the face of what was considered to be an unmitigated threat to their livelihoods and autonomy, the gatekeepers of the Australian medical profession forsook compassion for these men and women in favour of the interests of their

507 Rutland, 'Intellectual Barbarism', 256-7.

508 Ibid., 237.

509 Weaver, 'Pathways of Perseverance', 54. In an earlier paper, John Weaver made a more explicit argument for the role anti-Semitic members of state medical boards had on processing applicants through the Italian reciprocity. See: Weaver, "A Glut on the Market'.

510 As discussed in Chapter 1.

511 Gillespie, *Price of Health,* 87-110.

colleagues. Their actions were undeniably prejudiced against this group of perceived outsiders. However, I argue that it was as much the perceived economic and medico-political implications of registering Jewish doctors, as their race, that drove the negative professional response to them.

Throughout this chapter, I will draw on the experiences of medical migrants from the sample drawn for this study (Appendix 4) – both registered and unregistered to illustrate key points. Several other primary sources will be drawn upon to supplement this analysis, including: articles published in the popular press; the minutes of the Medical Board of Victoria; and the archives held at the National Archives of Australia documenting the 1942 wartime temporary licensing scheme.

Forced departures and contested arrivals: Australian responses to Jewish refugees, 1930-45

The Great Depression of the 1930s affected Australia particularly deeply, with unemployment peaking in 1932 at an estimated 29 per cent of the workforce.[512] Although by 1936 there were signs of recovery, the Australian economy remained flat.[513] Among the observed effects of the Depression was a falling birth rate and an almost complete standstill of assisted and voluntary immigration.[514] Both these factors impacted upon population debates, with politicians remaining divided during the interwar years over what number constituted Australia's future optimum population and the proportion and source of future immigrant numbers that would contribute to this growth.[515] There was bipartisan support, however, to increase Australia's population which was just over 6.6 million at the last Census count in 1933.[516]

Despite this commitment to increasing its population, Australia issued only a small number of landing permits for Jewish refugees in the interwar period. Between 1930-35, very few Jewish settlers arrived in Australia, although there was growing unrest in Germany marked by Hitler's assumption of power. In 1935, it is estimated that less than 100 Jewish refugees arrived from Europe; in 1936, this number increased to over 150, and in 1937 to 500.[517] In the wake of *Anschluss* (the annexation of Austria by Nazi Germany) in March 1938 and *Kristallnacht* (9-10 November 1938), the impetus for Jews to flee their homes was paramount, and necessitated a global response.[518] The number of Jewish refugees who arrived more than doubled to 1,556 settlers in 1938 as the persecution of Jews intensified and spread from Germany and Poland to Austria and Czechoslovakia. In 1939, a further 5,058 settlers arrived before the outbreak of the Second World War once again stilled all but war-related migration

512 Richards, *Destination Australia,* 113-40.

513 Gregory and Butlin, *Recovery from the Depression.*

514 Richards, *Destination Australia*, in particular 113-140.

515 Ibid.

516 ABS, 1933 Census.

517 Markus, 'Jewish Migration to Australia', 18-31.

518 Ibid.

to Australia. The number of arrivals for 1938-39 represents a fraction of the total number of applications received at Australia House in London, estimated to be roughly 300 per week.[519]

The development of an Australian response to the resettlement of European Jews in the interwar period, as historian Eric Richards observed, 'raised the racial issue and aroused strong passions: the most newsworthy was the claim that the Jews were a "non-assimilable" people'.[520] Australia's immigration policy – or 'White Australia' policy – was an example of operationalised racial prejudice – designed to preserve a majority British population and culture, achieved by excluding settlers perceived as least likely to be able to or want to integrate. This included Asian, non-white, and non-British settlers.[521] Political commitment to the White Australia policy remained strong across the major political parties.[522] European Jewish settlers, although white, were seen as highly non-assimilable. Additionally, the majority of established Australian Jewry feared that large-scale migration of European Jews would prompt an anti-Semitic backlash from the Australian public that would compromise their position.[523]

Australia's delegate at the Evian conference, organised in 1938 to coordinate a global response to Jewish refugees seeking resettlement, only committed Australia to taking limited numbers, infamously reasoning that 'as we have no racial problem we are not desirous of importing one'.[524] Prior to the conference, the Australian cabinet had already secretly agreed a quota of 15,000 Jewish refugees over a period of three years.[525] Australia, however, eventually resettled the second largest cohort of Jewish refugees. Several historians have argued that Australia's humanitarian effort with regards to interwar Jewish resettlement appears generous in world-terms, yet Australia's capacity to absorb more Jewish refugees far outstripped the quotas imposed on Jewish migration.[526] At the core of this political response was the belief that large-scale resettlement of Jewish settlers would contradict Australia's immigration policy: owing to 'their religious beliefs and strict rules as regards marriage, they remain a separate race and this failure to become properly assimilated in the country of adoption appears to create difficulties'.[527]

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519 Ibid.

520 Richards, *Destination Australia*, 140.

521 For a succinct overview, see: Jupp, *From White Australia to Woomera*, 7-11. See also, Langfield, 'Australian Population Debates in the 1930s', 408-19.

522 Ibid.

523 Rutland, *Edge of the Diaspora*, 174-223; Markus, 'Jewish Migration to Australia'.

524 Australia's delegate was Colonel Thomas White and this is a well-known quote. For a further discussion of Australia's response at the Evian Conference, see: Ibid.

525 Markus, 'Jewish Migration to Australia'.

526 Ibid. See also, Bartrop, *Australia and the Holocaust, 1933-1945*; and Blakeney, *Australia and the Jewish refugees, 1933-1948*. For a contradicting view of the extent to which anti-Semitic racial policies influenced departmental and federal government policy, see: Rubinstein, 'Australia and the Refugees of Europe, 1933-54: A Dissenting View'.

527 An internal federal government memorandum dated 7 April 1938, as quoted in Markus, 'Jewish migration', 20.

Historian Konrad Kwiet argues that Jewish refugees arriving in Australia, particularly German-Jews, were subject to a 'four-fold stigma … as foreigners, as Germans, as refugees, and as Jews'.[528] Australians during this time generally displayed a suspicion of foreigners or white aliens.[529] Publicly expressed hostility towards non-British settlers was particularly apparent when they were found in large groups. This is demonstrated, for example, by the marked hostility towards the community of Japanese pearl divers in Broome and the larger community of cane cutters from southern Italy who also settled in Queensland in the 1920s.[530] The latter even resulted in a restriction of white Italian migration to Australia.[531]

As the number of Jewish refugees arriving increased, stereotypical portrayals of Jews as ambitious, wealthy, cut-throat and clannish, who as migrants would take away Australian businesses, houses and jobs, whilst simultaneously diluting what it meant to be 'Australian', found regular expression in the mainstream media via known anti-Semitic magazines including *The Bulletin* and *Truth*.[532] Often anti-Semitic sentiment was couched in expressions of economic competition. For example, in May 1939, the president of the Victorian Legislative Council described Jewish immigrants as 'slinking rat-faced men … who worked in backyard factories in Carlton … for 2/- or 3/- a week pocket money and their keep'.[533] A Western Australian wrote a letter titled 'Refujews' asking:

> Where will our wealth be in the years to come? – in the hands of the Jews. These Jews and foreigners have the best positions while our Australian youths are tramping the street. Run them out![534]

However, Australian immigration historians and historians of the Jewish diaspora largely agree that marked, virulent anti-Semitism was a fringe response in the interwar years – with respect to both Australian and arriving European Jewry.[535] Historian Rodney Benjamin argues there was no 'structural anti-Semitism' operating in Australia that excluded Jews from education, parliament, professions or the armed forces.[536] Similarly, historian Suzanne Rutland emphasises that the

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528 Kwiet, 'Re-acculturation of German-Jewish Refugees in Australia', 39.

529 For an overview of attitudes to non-British migration, see: Richards, *Destination Australia,* 141-165.

530 For a discussion of Japanese migrant experiences in Australia, see: Oliver, *Japanese Presence and Australian Reactions 1860s to 1942*. For Italians in the 1920s, Cresciani, *The Italians in Australia*, 51-72.

531 Richards, *Destination Australia,* 80-110.

532 This has been detailed in a number of studies on European Jewish refugees in Australia, see: H. Rubinstein, *The Jews in Australia*; Kamenka, 'The Making of a Russian-German-Jewish Australia'; Rutland, *Edge of the Diaspora,* 184-193.

533 'MENACE OF THE REFUGEE', *The Age,* 9 May 1939, 11.

534 'Refujews', *The Daily News*, 1 April 1939, 7.

535 See for example, Rutland, *Edge of the Diaspora,* 184-193, 196-201*;* Kwiet, 'The Internment of German-Jewish Refugees in Australia', Kwiet, 'Reacculturation of German-Jewish Refugees in Australia'.

536 Benjamin, *A Serious Influx of Jews*, 14. The position of Australian Jewry and the presence of anti-Semitism in Australia is also discussed by both Hilary Rubinstein and Suzanne Rutland

hostility of Australians towards refugees in the 1930s arose from the perception of the 'refugees not as Jews, but as foreigners'.[537]

To Australians, groups of non-British migrants represented unwelcome social implications of migration: change, different languages, customs, appearance, religion and perceived competition for scarce jobs. Sydney University anthropologist Caroline Kelly was commissioned to research a series of reports for the Australian federal Ministry of Post War Reconstruction (1945) and the Immigration Advisory Council (1947). She found that 'the antipathy to foreigners is expressed mostly in economic and religious terms. It does not occur to the average Australian to consider the non-British migrant socially at all'.[538] Caroline Kelly noted what later studies also would: hostility towards migrants took the form of generalised views, and varied depending on state and individual preferences from a dislike of 'dago' work ethics to unfamiliar forms of religious expression.[539]

In 1939 Dr Isaac Steinberg of the Freeland League arrived in Australia to canvas support to resettle approximately 75,000 Jews in the remote Western Australian Kimberleys region. Isaac Steinberg found the negativity he encountered towards large-scale Jewish immigration to be more an expression of economic anxiety and fear of competition rather than a deep-seated hatred of the Jewish race and people, contrasting sharply to the anti-Semitism in parts of Europe.[540] Remarkably, Steinberg gained support for his scheme from a number of highly influential figures and bodies, including the Western Australian government, the Australian Council of Trade Unions, newspapers including *The Sydney Morning Herald, The Argus, The West Australian,* and a number of high-profile academics and politicians.[541]

Historians who have documented the resettlement experiences of interwar Jewish refugees largely mirror Kelly's findings of a mixed response, and extend it to include the conservatism that characterised early responses of Australian Jewry to their European

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in their wider histories of the Jewish diaspora in Australia, see: Rutland, *Edge of the Diaspora*; and Rubinstein, *The Jews in Australia*.

537 Rutland, *Edge of the Diaspora,* 184. Suzanne Rutland's assessment of the Australian responses to pre-war European Jewish migration is supported by a number of other scholars, including Rodney Benjamin and William Rubinstein. Other examples include migrant biography and autobiography, see for example, Kamenka, 'The Making of a Russian-German-Jewish Australia'.

538 NAA: A2169, 1947 Commonwealth Immigration Advisory Council.

539 The term 'dago' was and continues to be a derogatory term to describe persons believed to be of Italian and/or Spanish descent.

540 Steinberg, *Australia: The Unpromised Land*, 172. Steinberg was one of the founders of the Freeland League for Jewish Territorial Colonization, an organization that aimed to resettle Jews in new, welcoming countries. Steinberg's book was published as a final attempt to persuade the federal government to change its decision to deny the Kimberley plan, so Steinberg's recollections must be read in that light. Steinberg documents the mixed response to his proposal, including the overt racism he experienced and heard whilst in Australia, so the subsequent support he gained for his plan highlights that many Australians were sympathetic to the plight of European Jews.

541 NB: This scheme was eventually abandoned. For a discussion of the scheme, see: Rutland, *Edge of the Diaspora*.

counterparts. The conservative attitudes of Australian Jewry towards Jewish refugee settlers were particularly prominent in the interwar years, before the full extent of the horrors of the Holocaust was revealed.[542] Australia's small Jewish community, who were mostly Australian-born and entrenched in its Anglo-British culture,[543] feared their position would be compromised by the mass migration of European Jews. These views were vocalised by senior Australian Jewish religious, political and business leaders, many of whom publicly worked towards carefully controlling the numbers of European Jews issued landing permits, as well as the policies governing who was accepted.

The Australian Jewish Welfare Society established in 1938 – replacing the German Jewish Relief Fund – was led by members of the Australian Jewry who supported a conservative approach towards resettling European Jewish refugees: in small numbers, preferably sponsored by British subjects, with every effort made to encourage rapid assimilation. Representatives of the Society met every boat of arrivals, and issued these newly arrived men and women with a set of instructions. A well-known example from 1939 included directives to:

> Not speak German in the streets and in the trams … Do not make yourself conspicuous anywhere by walking with a group of persons all of whom are loudly speaking in a foreign language … Remember that the welfare of the old-established Jewish community in Australia as well as of every migrant depends on your behaviour.[544]

Very few Australian Jews were vocal opponents of these adopted attitudes by their community.[545] Few, in common with the majority population, publicly expressed support for widening of Australia's policy on Jewish immigration.

The Australian Jewish Welfare Society worked tirelessly to facilitate the resettlement of European Jews, including raising thousands of dollars to guarantee the required capital to be issued a landing permit, sponsoring applicants, helping them find work, and providing temporary housing.[546] However, it also operationalised its own set of biases that strove to minimise any negative impact on local Jewry. Sir Samuel Cohen, who was the founding president of the Society, exemplified this form of response by the local Jewry. His son recalls that Sir Samuel 'wanted to help refugees but not mix with them. He would do anything on an

542 These include large historical studies by Suzanne Rutland and W.D. Rubinstein, but also autobiographical work. See for example, Kamenka, 'The Making of a Russian-German-Jewish Australia'; Freadman, *Australian Jewish Autobiography*.

543 There is some debate amongst historians as to the extent of the Anglo-Jewish roots of Australia's Jewry prior to 1930, in particular the dominance of British Jewish descendants compared to German, Russian and eastern European Jews. For a discussion, see: Benjamin, *A Serious Influx of Jews*, in particular 9-20.

544 As quoted in Rutland, 'Australian Responses to Jewish Refugee Migration', 38.

545 Suzanne Rutland notes Russian-born Dr Fanny Reading as 'one of the few community leaders who criticized these approaches'. See: Rutland, MA thesis, 131-32.

546 Andgel, *The History of the Australian Jewish Welfare Society, 1936-1986*.

official basis but little on a personal basis'.[547] In this respect, the established élite of the Jewish community shared the wider attitudes of Australians towards migration and migrants.

The Australian Jewish Welfare Society was the most prominent institution established during the interwar period to help European refugees. The Society was originally mainly concerned with the migration of German and Austrian Jews. As a result, a number of Australians mobilised to assist the growing number of Polish Jews seeking refuge, as well as the smaller number of non-Jewish Europeans. These religious and non-religious groups were established around Australia, particularly in the eastern states. These included the United Emergency Committee for European Jewry, the Australian Federation of Polish Jewry, state-based chapters of the International Refugee Emergency Councils, the Inter-Church Committee for non-Aryan Christian Refugees, the Australian German Migration Association, the Jewish People's Fund, the Jewish People's Clothing Fund, the United Jewish Overseas Relief Fund, and the Australian Open Door Council. These organisations worked to facilitate the migration and subsequent resettlement of refugees – both Jewish and non-Jewish; and during the war, to help fund relief work in Europe.

The outbreak of war stilled large-scale migration, and with it the further resettlement of large numbers of Jewish refugees. The lens of a looming war fuelled local suspicions towards Germans and other 'enemy aliens', including long-term local residents. Additionally, there was widespread expression of resentment, as thousands of Australian men enlisted, while these aliens and 'reffos' were ineligible to do so.[548] A forceful expression of this wartime paranoia was seen in the internment of 'enemy aliens' including in Hay (New South Wales) and Tatura (Victoria).[549] In total, 9,000 enemy aliens were interned in such camps during the war, including over 4,000 Italian nationals, almost 2,000 German nationals, and almost 500 Japanese nationals.[550] Internees included long-term residents, and those sent to Australia as POWs from Britain and British territories, beginning in 1940 with the now infamous *HMT Dunera* carrying over 2,500 mostly male, Jewish 'enemy aliens' from Britain.[551]

The experiences of the *Dunera* and other internees illustrates the distinction between the more complex nature of the social response to Jewish refugees, compared to the conservatism and naiveté reflected in official policies adopted not just by the Australian but British

547 As quoted in Rutland, 'Australian Responses to Jewish Migration', 38-9.

548 NB: By 1940, 'friendly' aliens were eligible to enlist in the Australian Imperial Force, and by October 1941 enacted National Security regulations allowed aliens to enlist in home defence.

549 Neumann & NAA, *Civilian Internment in Australia during World War II*.

550 Ibid.

551 Saunders, '"The Stranger in Our Gates"'. To date, the literature documenting the experiences of the Dunera internees is scattered. See for example, Patkin, *The Dunera Internees;* and Pearl, *The Dunera Scandal: Deported By Mistake*. Others include partial accounts, including Kwiet, 'Be Patient and Reasonable' and autobiographical accounts. Two official histories of or related to the 'Dunera boys' are forthcoming. Historians Ken Inglis, Seumas Spark and Jay Winter are due to publish a two-volume history in scheduled to be published on 30 July 2018 as *Dunera Lives: A Visual History*. Historian June Factor is also currently writing a history of the Eighth Labour Company military unit formed during the war to release internees into non-combat military service.

government too. This is seen, for example, in the undifferentiated grouping of 'enemy aliens', which included Jewish internees being co-located with Nazi sympathisers.[552] As the British and Australian governments realised the unwarranted extremity of this forcible internment, many were released and/or offered repatriation. A commonly accepted form of release offered to internees, which many accepted, was into the specially-formed Eighth Labour Company of the Australian Imperial Force.

The members of this company collectively recall the friendliness and respect Australian military officers afforded them, but also members of the public.[553] For example, historian June Factor observed that:

> In interviews with Employment Company members, I have found most of the men emphasise the kindness of those Australian families who welcomed them into their homes, and the pleasures of dances and other congenial entertainments provided for the troops; some recall the delights of assignations with local girls. In these interviews, they rarely volunteer examples of prejudice or overt hostility.[554]

A former *Dunera* internee, Klaus Loewald, who served in the specially-formed Labour Company in Melbourne, wrote of instances of 'warm friendship' intermingled with instances of 'xenophobia … most easily directed at people whose English was not fluent'.[555] Biographies and autobiographies of the interwar Jewish arrivals mirror this mixture of warmth and hostility, and of 'gratitude and resentment' when describing and reflecting on their experiences in Australian communities.[556]

To summarise, the overall political and administrative responses to the mass migration of European Jewish refugees was conservative, conceived within a framework that was committed to maintaining a white, British Australia. The social responses to newly-arrived Jewish refugees too was complicated, as they arrived in an economic climate that was recovering from the Depression, which intensified the mixed reception afforded them by a generally xenophobic Australian public. The established Australian Jewish community, although active in facilitating the migration and resettlement of European Jews, were cautious of doing so within the boundaries that did not compromise their own position.

Anti-Semitic attitudes were expressed by individuals, advanced by social and political organisations, and disseminated through popular print media.[557] However, to date the influence

552 Kwiet, '"Be Patient and Reasonable"'.

553 Factor, 'Forgotten Soldiers, Aliens in The Australian Army's Employment Companies During World War II', abstract from forthcoming book available here, http://www.yosselbirstein.org/pdf/eng/other/Forgotten_Soldiers.pdf (quoted with permission from the author); Loewald, 'The Eighth Australian Employment Company, 82.

554 Factor, 'Forgotten Soldiers'.

555 Ibid. See also, Loewld, 'The Eighth Australian Employment Company', 82-3.

556 Freadman, *This Crazy Thing A Life,* 41-44.

557 Rutland, *Edge of the Diaspora,* 188-192.

and pervasiveness of anti-Semitic attitudes or the adoption of anti-Semitism as a political ideology in interwar Australia was not so marked as to encompass a total explanation. Historians who have examined this period in Australia's immigration history and the resettlement experiences of interwar Jewish refugees have instead focussed on unpacking the implications of the prevailing political conservatism that prevented the resettlement of more Jewish refugees, and the myriad of experiences that describe these refugees' lives and their contribution to the Jewish diaspora, and to Australia.

Professional responses to 'alien doctors' and the medical context

The gatekeeper bodies of the medical profession – the medical boards, the BMA in Australia, and the university medical faculties – adopted a conservative policy based on mitigating the *potential* influx of immigration of continental medical migrants. This response was formulated in direct reaction to the debates over the position of these men and women requalifying in Britain, as discussed in this chapter introduction.[558] In February 1934 during a regular meeting of the BMA's Federal Council in Australia, it was resolved that there was an 'adequate supply of medical practitioners who are graduates of British Universities', and that 'it is undesirable to admit graduates of alien countries unless reciprocity … exists'.[559] It is clear that from as early as 1934 the BMA in Australia decided to reinforce its commitment to what was in practice the essentially unattainable principal of reciprocal recognition because these agreements were brokered at the government-level.[560]

In seeking to understand the nature of the Victorian medical profession's response to this group of doctors, it appears that timing was paramount. In 1930, several years before the retraining of refugee Jewish doctors became a political concern, Moses Sternfeld, a Lithuanian national, applied for registration in Victoria on the basis of an English conjoint qualification which he had gained in 1929 (he was a Licentiate of the Royal College of Physicians in London, and a Member of the Royal College of Surgeons in England). Prior to arriving in England, Sternfeld spent seven years in Germany, which included completing a medical degree from the Albert Ludwigs University of Freiburg. He had spent three years and six months requalifying in England before he was forced to leave.[561] While studying in London, Sternfeld married a Polish-born British subject who was the daughter of a Jewish rabbi. Despite his marriage, the UK Home Office refused his application to remain in London and practise medicine there. The Sternfelds left for Australia in 1930.[562] Once in Melbourne, Sternfeld's application to register was processed by the Victorian board as a matter of course, despite his recognised English training only accounting for a maximum of three and a half years (of the required five years),[563]

558 Collins, 'European Refugee Physicians'.

559 INFLUX OF DOCTORS FEARED, *The Telegraph*, 10 February 1934, 20.

560 See: Weaver, 'A Glut in the Market'.

561 NAA: A1, 1932/7063 M Sternfeld naturalization certificate.

562 Ibid.

563 PROV: VPRS 16389/PI unit 4, Medical Board Minutes 1906 - 1934.

the same right Moritz Meyer had to fight for doggedly seven years later. The Board's scrutiny of such applications had clearly intensified by 1937.

The Victorian Board originally adopted a wait-and-see attitude towards continental Europeans retraining in Scotland who might seek to resettle in Victoria.[564] However, in January 1937 a letter from the secretary of the British Medical Association in London seeking clarification on the eligibility of such doctors to be registered in Victoria was minuted and necessitated a formal response.[565] It appears that it was during this meeting that the Board consolidated its intentions towards continental medical migrants. The minutes read:

> It was decided to reply that the provisions of the Medical Acts of this state render a person who has obtained a recognised qualification after a course of study of less than five years' duration ineligible for registration in Victoria.[566]

In their next monthly meeting in February 1937, the Board also refused registration to a German Anna Lewin who had requalified via the Scottish Triple, and the Board deferred decisions on pending applications from other continental medical migrants in a similar situation.[567] In March 1937, the Crown Solicitor informed the Board that 'there is no reason at common law contained in Part I of the Medical Act why an alien holding a requisite qualification should be disqualified from registration'.[568] In that same meeting, the Board also minuted a reply from the Commonwealth Director General of Health, and member of the Medical Board in Canberra, John Cumpston who 'expressed doubt as to the interpretation placed on the provisions of the Victorian Medical Act' as proposed by the Board.[569] The Board, however, did not reverse its refusal in the case of Lewin, despite her solicitor requesting an appeal. In June 1937, the Board subsequently refused Meyer and Aarons on the same grounds, as discussed.[570]

It is clear that by early 1937 the majority of the Board chose a conservative interpretation of the medical act, mirroring the overtly protectionist policy adopted by the BMA in Australia. Historian John Weaver observed a similar trend in the states he examined, noting that the period around 1938 marks a 'shift from ad hoc rejection to broader policies', and an 'intensification of gatekeepers' efforts' with respect to continental European medical migrants.[571] The Board in Victoria comprised nine senior medical practitioners, all of whom were not just members of the BMA, but were intimately involved with the association's affairs.[572] For

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564 These were minuted as 'potential influx of continental practitioners', and such variations. See: Ibid; and VPRS 16389/P1 unit 5, Medical Board Minutes 1934 – 1945.

565 VPRS 16389/P1 unit 5.

566 Ibid., 'Registration of German Jewish doctors', Minutes of meeting on January 7th 1937.

567 Ibid., Minutes of meeting on February 3rd 1937.

568 Ibid., Minutes of meeting on March 3rd 1937.

569 Ibid.

570 Ibid., Minutes of meeting on June 2nd 1937.

571 Weaver, 'Pathways of Perseverance', 44.

572 The nine Board members for the years 1931-39 included Alexander Joske (President of Board to 1939; consulting physician); George James Hodgson (surgeon); Crawford Mollison

example, several long-standing boards members – Augustus Kenny, Basil Kilvington, John Newman-Morris, and Bernhard Zwar – had served as presidents of the Victorian branch of the BMA. Historian Tony Pensabene's analysis of the medical profession in Victoria notes the Board's membership consistently included past presidents of first the Medical Society of Victoria, which later merged to form the Victorian branch of the BMA in Australia.[573]

The BMA in Australia overtly espoused protectionist policies, repeatedly privileging the protection of Australian-trained doctors and Australian medical students over Australia's humanitarian obligation.[574] This prerogative was openly invoked by Victorian MPs discussing the proposed changed to the medical act in 1938, the majority of whom eventually voted for the restrictions.[575] In the context of the Depression, and slow economic recovery, this attitude was not controversial to urban and suburban doctors, and arguably to many Australians. Only country towns in Victoria, and other Australian states, where doctors were in short supply, publicly expressed interest in a more liberal attitude towards continental medical migrants.[576]

The early years of the Depression had a particularly strong impact on the incomes of medical practitioners, in a market that was almost entirely based on fee-for-service private practice.[577] The BMA in Australia reported that the number of Victorians accessing the means-tested, free out-patients services offered by urban public hospitals almost doubled compared to the previous decade, from 103,760 in 1924 to 213,098 in 1934.[578] Additionally, as historian James Gillespie observed, the 'financial strength of the friendly societies cushioned medical practitioners from the worst effects of the depression'.[579] Membership of friendly societies, however, was also strictly means-tested, and the number of eligible medical services that could be accessed through society membership had been severely limited by the profession in the previous decade.[580]

In the absence of any form of national uniform subsidies for health services, the Australian middle classes represented the group most affected by the Depression. These citizens

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(consulting pathologist, coroner's surgeon); Professor Colin MacKenzie (orthopaedic surgeon), George Thomas Howard (retired GP); Clarence George Godfrey (consulting psychiatrist); Augustus Leo Kenny (ophthalmologist, BMA Vic president 1899 and 1914); and Leslie Scott Latham (consulting physician, BMA Vic president 1923). Basil Kilvington (consulting surgeon) and Bernhard Zwar (consulting surgeon) were appointed in 1932, John Arthur Sherwin (consulting gynaecologist) in 1933 replacing Howard and Latham. John Newman Morris (consulting surgeon) was appointed in 1934, and Sir Hugh Devine (consulting surgeon) replaced Hodgson in 1936.

573 Pensabene, *Rise of the Victorian Medical Practitioner,* 99-119.

574 This was mirrored, for example, in the arguments made by Victorian parliamentarians when debating the proposed changes to the medical act in 1938.

575 Victorian Hansard, 29 November 1938 3226-9 and 6 December 1938, 3692-7.

576 Ibid., See for example, 'COUNTRY DOCTORS', *The Age*, 3 December, 1938, 36.

577 See Chapter 2.

578 'SHORTAGE OF DOCTORS', *The Age*, 21 November 1935, 8.

579 Gillespie, *Price of Health*, 11.

580 Ibid., 7-11.

had to be able to afford a standard consultation with a GP which ranged from 11 shillings to £2. For those who were members of friendly societies, services that were not subsidised by lodge practice also represented an out-of-pocket expense. Therefore, instead of reaping the benefits of a hard-won and strictly guarded monopoly, doctors in the 1930s faced a looming economic crisis: a growing proportion of the population could not afford their services. This affected private practitioners differently, but was particularly severe for recent graduates who needed to recover costs of medical school early, and older doctors closer to retirement, many of whom had also had their incomes depleted during World War I service.[581]

Amidst increasing political pressure to widen the net of eligibility to access the public hospital system, the most serious threat to private practice re-emerged in the form of the conservative federal government proposals to nationalise hospital governance and introduce National Health Insurance (NHI). When NHI was first debated in the 1920s, the BMA in Australia originally opposed it because none of the proposed models would achieve the aims of the scheme and still protect the private fee-for-service model of medical practice.[582] By 1937, however, the Federal Council of the BMA capitulated. As discussed in Chapter 2, the Federal Council of the BMA, comprised predominantly of prominent specialists, miscalculated the reception of the BMA membership. State-based members of the BMA in Australia saw the NHI as the government's step towards abolishing private practice in favour of a salaried nationalised medical service.[583]

The revolt over NHI appeared to be income-driven and for the large part it was. However, several other factors contributed to the internal politics over NHI. Firstly, in the 1920s there was a marked increase in professional hostility between surgeons and the larger proportion of referring GPs over the issue of fee-splitting.[584] This surfaced in the growing tension felt by the majority GPs that the minority full-time surgeons and other private specialists were trying to distinguish themselves as an élite group within the profession.[585] Secondly, the idea of capitation fees underpinning NHI recalled the historically fraught relationship between friendly societies and the BMA in Australia.[586] Technically the profession would not be party to any panel systems or fee-setting outside of their control, but doctors' dependence on friendly societies meant that the profession had to continue negotiating with them.[587] Finally, until the proposal to include medical services in national insurance, the Federal Council of the BMA mainly dealt with issues that did directly affect members' incomes to the same extent. The National Health Insurance bill became the catalyst for the surfacing of all of these issues, and the official voice for the BMA in Australia, its Federal Council, was clearly no longer representative of its membership base. The

581 Pensabene, *Rise of the Victorian Medical Practitioner,* 82-3.

582 Gillespie, *Price of Health,* 57-110; Crichton, *Slowly Taking Control?,* 35-40.

583 Ibid.

584 Ibid., Newton, Phd diss., 19-21.

585 Ibid.

586 Ibid., 147-158; and Gillespie, 'Medical Markets and Australian Medical Politics 1920-1945', 30-46.

587 Gillespie, *Price of Health,* 7-14; Crichton, *Slowly Taking Control?*, 19, 24-5.

overall solidarity of the profession was at its weakest and the eventual defeat of the NHI bill in early 1939 came at a considerable cost to the internal unity of the BMA.[588] In Victoria, historian James Gillespie argues the opposition was most vocal from rank-and-file private practitioners, most of whom were GPs who had endured the most bitter relationship with friendly societies.[589]

It was in this unsettled cultural and medico-political milieu that European doctors found themselves trying to resurrect their medical careers: communities varyingly suspicious of cultures they did not understand and professional peers suspicious of their ability and fit. Members of the Australian profession, notably the BMA in Australia, maintained a consistent portrayal of the limitations of continental medical migrants, including the argument that Europeans – with no regard to the real regional differences in medical education – specialised much earlier than doctors in Australia. Full-time medical practice as a specialist was uncommon in Australia compared to continental Europe.[590] As discussed in Chapter 2, GPs performed procedures that in most European countries were exclusively performed by full-time specialists, particularly surgery, midwifery and anaesthesia. It was argued that the average continental European's professional experience, together with their variable English-language proficiency, made them ill-equipped to practise as GPs, particularly in country areas.

For example, one correspondent in the *Medical Journal of Australia* suggested the profession was duty-bound to protect the sick from the services of European doctors who 'have surprising faith in a foreign accent and exotic manner, even when these may not be accompanied by most desirable professional and ethical attributes'.[591] Another asked, 'are these men trained to our standard of general medical work … I am sure not'.[592] Victorian-based Dr McRae Russell wrote to *The Age* in 1939 citing confidential assessments of 12 continental medical migrants who filled locum tenens appointments that found 'they are untrained in surgery; some know little, if anything, about the giving of anaesthetics, and most are untrained or inadequately trained in obstetrics'.[593]

The most vocalised argument in favour of licensing continental European medical migrants was that they could alleviate shortages in country areas. In 1938, the British Medical Agency which offered a locum tenens relief service for registered doctors, reported they were 'inundated' with applications.[594] The BMA in Australia, however, maintained that many of these positions were temporary and insufficient to sustain the livelihood of a practitioner. The Victorian branch of the BMA reported that their investigation 'revealed that the abandonment of practices was entirely a question of economics'.[595] Additionally, the branch reported that of

588 Ibid.

589 Gillespie, *Price of Health,* 7-14.

590 Weisz, *Divide and Conquer*.

591 "A Graduate of Sydney", 'Influx of European Practitioners', *MJA* 3 March 1934, 322-23.

592 Maxwell, 'The Refugee Doctors', 919.

593 W. McRae Russell, 'Refugee Doctors', *The Age*, 17 August 1939, 2.

594 'Not Enough Doctors in Australia – Agency Inundated with Applications', *Evening News*, 4 May 1938, 7.

595 'Doctors's Basic Wage – Aliens No Help', *The Argus*, 25 August 1939, 2.

the 25 Italian graduates registered in Victoria via reciprocal recognition, only four had moved to country towns, demonstrating the likely attitudes of other continental European medical migrants should registration be extended to include them.[596]

One Italian graduate, Polish-born Daniel Wajcberg (MD Pisa 1934) – who anglicised his family name to Wise – spent six months as a resident medical officer in the Victorian country town of Warrnambool after being registered in 1939. On completion of this residency, the medical superintendent Dr Cecil Berryman wrote of Daniel Wise that:

> I have seen his work and had many discussions with him and have formed the opinion that he is a very sound and reliable medical man and one who will do credit not only to himself but to his medical school. He has a very sound knowledge of medicine; is careful and detailed in his examination of patients; is a good diagnostician; and has the ability to apply his knowledge.[597]

Berryman's explicit reference to Wise's medical school appears to be aimed at counteracting the general views publicly espoused by the medical community with regards to the standard of continental European medical education around that time.[598]

Two of the most outspoken proponents for liberalising state medical legislation in Victoria were both academics. One was the controversial figure of Sir James Barrett, former chancellor of the University of Melbourne, former president of the BMA and a founding member of the Bush Nursing Association. The latter association aimed to address shortages of access to health services in country areas. Barrett was a prominent but divisive figure in the medical profession.[599] The other was Professor Harold Woodruff, who was then director of the Department of Bacteriology. Woodruff also chaired the Victorian chapter of the International Refugee Emergency Council, established to help non-Jewish and non-Catholic refugees in Australia.[600] Professor Woodruff publicly criticised the BMA's stance on continental European

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596 Ibid.

597 Letter reproduced with permission from the Wise family.

598 As discussed above, Moritz Meyer's case was a prominent example of public comparisons of Australian medical degrees with continental European ones. For other examples, see: 'Practice By Foreign Doctors', *Maryborough Chronicle, Wide Bay and Burnett Advertiser*, 26 July 1937, 5; and 'The Country Is Entitled to Fully Qualified Doctors', *Weekly Times*, 10 May 1941, 26.

599 Barrett's views on medical politics – notably on country health policies and on alien doctors – was directly opposed to the popular gatekeeper view. Barrett was a frequent, vocal and influential critic of the BMA in Australia. (See, for example, 'B.M.A. Secretary on Doctors' Problems', *The Herald,* 25 August 1939: 9.) Barrett's biographer contextualises his divisiveness, despite his illustrious career as a medical professional, to his openly-expressed attitudes. For example, Barrett was 'bitterly unpopular' with academic staff whilst chancellor of the University of Melbourne because he 'regarded [them] as employees to be kept in their place'; and was 'never popular in the medical profession', owing perhaps to his 'reputation for busybodiness and over-reaching himself'. See: Murray-Smith, 'Barrett, Sir James William (1862-1945)'.

600 Woodruff and other humanitarians in Australia have been credited as central advocates for 'broadening Australia's refugee intake'. See: Damousi, 'Australian League of Nations Union

medical migrants, arguing that while these doctors might be 'bad for the BMA', they 'would benefit medicine and science'.[601]

The official response by the BMA to Woodruff reveals the intersection of the politics of registering this group of medical migrants with the politics of national health insurance and the provision of medical services. The President of the Victorian branch, Dr Davies observed that

> Professor Woodruff is in a sheltered position. It does not matter to him how many doctors come to Australia; for he has a position with a fixed salary and it does not affect him at all.[602]

Davies's comments reflect a key point of contention. If registered, these doctors were free to enter private practice. If registered, there was no guarantee or control under current legislation to ensure these doctors would stay in positions local doctors found unattractive. Practically, restricting the work of doctors to a specific position would require them to be salaried or under contract. This would amount to a form of salaried general practice.

The medical profession's agitation over NHI was underpinned by a fear of nationalisation of medicine. The report by the special committee of the BMA appointed to assess the shortages of doctors in Victorian country towns concluded in 1939 that although a viable solution,

> it has not been the policy of the British Medical Association to encourage a free service by medical men paid by Government, and the establishment of such a system, even in an isolated area, would lead to demands for its extension, with the final result of nationalization [sic] of the profession and the wrecking of the present not unsatisfactory system of medical practice.[603]

Davies's remarks coincide with the profession's struggle over the proposed NHI. There was no appetite within the BMA in Australia to antagonise GPs who had mobilised against a perceived attack on their livelihood. As he went on to observe, 'it is not the great doctors from Germany … who are wanting to come here, but only the rank and file'.[604] Indeed, the BMA in Australia did not object to continental European medical migrants being employed in salaried teaching or research positions, which usually restricted rights to private practice entirely.[605]

A further example of the fear of competition in a depressed economy can be seen in the response of enrolled students at the University of Melbourne in 1938 and 1939. In 1938, 379 out of 700 medical students at the University of Melbourne signed a petition against registering

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and War Refugees', 72-79.

601 'B.M.A. Criticised', *The Argus,* 22 June 1939*,* 3.

602 'Refugee Doctors', *Riverine Herald*, 18 July 1939, 3.

603 A report prepared by a special subcommittee of the Council of Victorian Branch of the British Medical Association, 'Medical Services in Country Districts in Victoria', *MJA*, 7 January 1939, 42-44.

604 'Refugee Doctors', *Riverine Herald*.

605 Ibid.

foreign doctors. The students' petition stressed they had no objection to foreign settlers 'so long as they were prevented from entering the medical profession'.[606] The Victorian branch of the BMA presented this petition to the Victorian legislative assembly to forward the passage of the proposed amendments to the medical bill prompted by Moritz Meyer's high court success. In 1939, the University's medical student journal, *Speculum*, deplored the 'criminal waste' of continental Europeans being forced to duplicate their undergraduate training.[607] However, in August 1939 the Melbourne Medical Students Society once again gathered 500 signatures in support of a petition ahead of a gathering of the country's Vice Chancellors to maintain the University's requirement for unrecognised doctors to complete its full medical degree, which was the most stringent measure in Australia. The divided views within the medical student body over unrecognised doctors in many ways reflects the tensions seen in the wider medical community.

Australia's entry into the Second World War marked a subtle shift in the BMA's response to refugee doctors, as the federal government proposed to employ unrecognised doctors to compensate for civilian medical shortages. As historian James Gillespie summarised, the initial attitude of the BMA in Australia helped 'develop the general air of threat around even the most trivial of government proposals'.[608] The BMA forwarded its protest through the newly established State Coordination Committee, a consultative body to advise the federal government on military and civilian medical affairs. The president of the South Australian BMA chapter, Dr Erichsen, outlined plans to protect South Australian medical men enlisting in the forces, arguing that unrecognised doctors ineligible for military service should not be allowed to take over the practices of Australian men who could and did.[609] This emotionally-charged portrayal was echoed by many other states in a surge of nationalistic sentiment.[610] Fear of Fifth Columnists was equally rife, the independent member for Gregory in Queensland declared that one such doctor was a known member of the Fascist party, and another was in possession of a diathermy machine – a high-frequency oscillator commonly used by doctors for localised application of heat – which the 'enemy alien' instead 'could use to send wireless messages'.[611]

By early 1942, however, the War Cabinet agreed there was a shortage of civilian practitioners.[612] It was estimated that over 2,500 doctors were serving in the Australian Army Medical Corps.[613] The federal government outlined plans to use its emergency powers to alleviate the shortage of doctors by utilising resident unrecognised doctors. Similar measures

606 'FOR JEWISH MIGRANTS', *The Argus*, 27 July 1938, 13.

607 'Editorial', *Speculum*, 1939, 142, 15-16.

608 Gillespie, *Price of Health,* 238.

609 'Alien Doctors and Practises', *The Advertiser*, 10 October 1939, 18.

610 Leach, 'Enlistment of "Friendly Aliens" in the Australian Armed Forces', 26-48.

611 Alien Doctors, 7 November 1940, *Wellington Times,* 1.

612 NAA: A472, W5733 National Security (Alien Doctors) Regulations.

613 McWhae, 'The Medical Profession of Australia and the War'; Jacobson, 'World War II – Medicine and Medical Services', 481-5.

had already been passed in the UK.[614] The *National Security (Alien Doctors Registration) Act* passed in 1942 despite the protest from the BMA in Australia.[615] After a brief period of manoeuvring, the federal Department of Health was to administer examining boards in each state to license continental European medical migrants, but state authorities would place and monitor the licensees via state medical co-ordination committees. Additionally, an umbrella body – the Emergency Medical Service – was established in 1942, and it was empowered to monitor and control the distribution of civilian medical practitioners, as well as their hours and services. The latter was aimed at restricting time-consuming home visits by civilian GPs.

The Emergency Medical Service was eventually administered by a BMA-appointed medical co-ordination committee at its request – the BMA in Australia saw the powers bestowed on the Service as akin to compulsion, which resonated too closely with the recent debates over National Health Insurance.[616] Historian James Gillespie suggests in his analysis of these wartime measures that the BMA sought control of the Emergency Medical Service to prevent Australian doctors on active duty from losing their practices to licensed continental European medical migrants, and they only actively exercised their powers to do so.[617]A total of nineteen doctors were licensed under the emergency scheme to practise in Victoria, out of 40 applications.[618] In Victoria, their placement was overseen by Victorian Board member John Newman-Morris.

The examining processes of the state-based committees were far from standardised or objective, and many experienced applicants were denied temporary licenses.[619] However, this represented a significant step towards the assessment and recognition of continental European medical degrees in Australia on a case-by-case basis. The examining process that senior members of the profession had to engage in to license these doctors in 1942-43 was the first systematic test of the equivalency of Australian entry-level medical qualifications with a number of continental medical schools. German and Austrian graduates were most successful at passing these examinations, accounting for 12 out of the 19 temporary licenses granted in Victoria.

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614 In 1941 Professor Giblin, chairman of the Commonwealth Financial and Economic Committee, proposed mirroring the British scheme of temporarily registering refugee doctors. See: NAA: MP508/1 65/710/123.

615 The protest came via the BMA-controlled Central Medical Coordinating Committee formed in 1941, on behalf of enlisted medical practitioners. The President of the South Australian chapter of the BMA, however, approved the scheme. See: 'B.M.A. President Approves Refugee Doctor Plan', *The Advertiser*, 28 January, 1942, 9.

616 For a discussion of the politics of the EMS in Australia, see Gillespie, *Price of Health,* 127-28.

617 Ibid.

618 NAA: A1928, 652/17/4 SECTION 2 and A1928, 652/17/5 SECTION 3.

619 In 1946 AJ Metcalfe, Commonwealth Director-General of Health, replied to leader of the Labor opposite Tom Tunnecliffe defending the assessment methods employed by the Commonwealth Alien Doctors board saying that "among the factors which contributed to the failure of candidates to pass the examination was the narrow specialisation early in the medical course which still prevails in some European countries". See: NAA: A1928, 652/17/5 Section 1 Medical Practitioners (Registration in Australia of Persons who have qualified elsewhere). National Security (Alien Doctors) Regns. 1942 Licences under Applications and Correspondence Queensland: South Australia: Western Australia and Tasmania. Section 1, 157.

The success rate of applicants for this license, examined against the standards of undergraduate finals, belied the BMA's rhetoric of the general unsuitability of non-British medical education.

The assessments of the wartime licensees whose performances were evaluated annually by the state medical co-ordination committee demonstrates a largely positive peer assessment of their work. For example, the report from 1943 noted that the committee had received letters of commendation from several patients of Manfred Süss (MD Vienna 1935) who was working under the direction of the Emergency Medical Service in Tongala; that Robert Gruenfield (MD Vienna 1923) had 'fitted in excellently' in all his locums over the last year; and that the only complaint of Paul Schatzki (MD Frankfurt 1934), a former *Dunera* internee, was that he 'examines his patients so carefully he is able to see a much smaller number than is usually recorded as efficient'.[620] The work of these doctors will be discussed further in Chapter 7.

The BMA in Australia and state medical boards did not oppose a change in legislation following the end of the war to grant full licenses to these doctors, since all emergency legislation would soon be repealed, nullifying these doctors' temporary licenses.[621] In Victoria, 19 European medical migrants were registered in 1946 under the specially-passed amendment to the medical act. This did not represent a change in official policy (as will be discussed in the next chapter), instead it represented a softening of official attitudes towards this particular group. As one report on the parliamentary debate noted, the Bill would 'not open Victoria to a flow of outside medical men', but would prevent 'hardships' towards the temporary licensees themselves.[622]

Summary

Between 1930-45, over 10,000 refugees, most of whom were Jewish arrived in Australia. The arrival of qualified doctors among this cohort stirred a vehement and coordinated response by the medical profession. Historians have documented this response as an expression of a mix of anti-Semitic attitudes and xenophobia, further fuelled by a parochial profession protective of their high income and status.[623] This chapter presented a case study of the political, social and professional responses to continental medical migrants in Victoria between 1930-45, and in doing so, argues for a more nuanced interpretation of the profession's response.

The first part of this chapter outlined the reception of Jewish refugees in Australian communities, exploring the attitudes of both Australian Jewry and Australians more largely, demonstrating that the responses to Jewish refugees politically and socially had elements of anti-Semitism, but was equally driven by broader social and economic considerations that non-British migration represented during the Depression years. Therefore, the correlation between prevalent anti-Semitic attitudes reflected in the medical profession's responses to refugee doctors must also be nuanced to account for the contested social response to Jewish refugees.

620 NAA: A1928, 652/17/4 SECTION 2, Schedule enclosed in correspondence from H. Boyd Graham to JHL Cumpston, 13 October 1943.

621 PROV: VPRS 16389/PI unit 6, Minutes of Medical Board of Victoria 1945-49.

622 'Registration of Refugee Doctors', *The Argus*, 3 October 1946, 24.

623 Rutland, 'An Example of "Intellectual Barbarism"'; Weaver, 'A Glut on the Market'.

Second was to consider the gatekeeper response by the Victorian medical profession and to weave in the significance of both the Depression of the 1930s and the medical profession grappling with the contentious National Health Insurance bill in the mid-late 1930s, which appeared to many members of the medical profession as a first-step towards a nationalised medical service. Many Australian private practitioners viewed their agitation over this Bill as a fight for their livelihood, and the rift between aspiring full-time specialists and GPs deepened. In this context, liberal attitudes by the BMA in Australia and the Victorian Medical Board would have been impolitic, particularly when there was a deliberate projection that continental European medical migrants were overspecialised, and would increase competition in urban areas perceived to be already overcrowded relative to demand.

Taken together, what emerges were members of the medical profession who were as concerned with the intra-professional and medico-political implications of registering refugee doctors in interwar Australia as the race of these medical men and women. Historians have interpreted the responses of Melbourne's medical elite – its medical board, the committee of the medical faculty, and the committee members of the state and federal branches of the BMA – as reflecting widely-held racial prejudice towards Jewish refugees. This case study offers an extension to the historiography of 'alien doctors' in interwar Australia which to date has emphasised the role of racial prejudice and anti-Semitism in understanding the marginalisation of these doctors at the hands of the profession. I argue that a *fuller* understanding of this historical episode must include a more robust explication of the implication of a perceived 'flood' of continental European medical migrants in a depressed economy, heightened by debates over national health insurance in the late interwar period.

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Chapter 06: The Intellectual Boys are the Ones in a Mess: The Unregistered Doctors Association in Victoria, 1951-56* [publication]

> * The title of this paper is a quote from Dr Adam Redler, president of the Italo-Australian Welfare centre in "Entry to Most Professions Still Difficult for Migrants," *Sydney Morning Herald*, 4 June 1954, 2.

As discussed in the Introduction, this is a thesis *with* publication. **This chapter is a reproduction of the Accepted Manuscript of an article published by Australian and New Zealand Society of the History of Medicine, Inc. in *Health and History* in 2015, available online: https://www.jstor.org/stable/10.5401/healthhist.17.1.0017**.

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Abstract

Australia accepted over 170,000 Displaced Persons (DPs) after World War II, the majority of whom were unskilled or semi-skilled workers. However, professionally qualified DPs faced particularly challenging resettlement terms because their qualifications were often not recognised by local authorities. With the exception of Egon Kunz's The Intruders: Refugee Doctors in Australia (1975), very little has been written about DPs with medical qualifications. Among these were individuals who mobilised to form the Unregistered Doctors Association (UDA) in Victoria—a cross-cultural migrant group that lobbied to liberalise state medical legislation in the early 1950s. The story of the UDA highlights the active role highly skilled migrants adopted in the complex renegotiation of their professional status in postwar Australia.

Introduction

On 10 April 1975, author and historian Egon Kunz sent a copy of his forthcoming monograph to his friend, Stan, enclosing the note:

> Well, here it is. That there is no acknowledgement in it for your help is not due to my ungratefulness – but simply I did not want to cause you trouble, by doing so. Thanks for everything. And congratulations to you and your erstwhile UDA colleagues, for a fight nobly, and in your case, truly unselfishly done.[1]

Kunz's monograph, *The Intruders: Refugee Doctors in Australia,* was published eight days later. By that time, the Unregistered Doctors Association (UDA) that Stan helped found in 1951 had long since disbanded, yet this signed copy had been annotated by him, marking all instances where Kunz had used information or material linked to the UDA. Of equal interest is the last page of the monograph where Stan added to the final line of Kunz's biography, introducing the book as an offshoot of Kunz's long-term project researching the occupational adjustment of displaced persons in Australia: Stan wrote 'and one for which he was sacked'.[2]

Regardless of the actual circumstances of Kunz's employment at the Australian National University following publication of *The Intruders*, Stan's annotation is a reflection of the controversy and circumstances alive in his framing of and acute interest in the fate of all non-British immigrant doctors in Australia.[3] Stan, or more fully, Dr Stanislaw Weiner—born in

1 Letter, E.F. Kunz to S. Weiner, 10 April 1975, Author's private collection, Melbourne.

2 This controversial suggestion was arguably deliberately inserted to incite and to remind: Stan kept a list of people to whom he lent or possibly showed the book on the inside back cover. Source: annotated copy in author's private collection of Egon Kunz, *The Intruders: Refugee Doctors in Australia* (Canberra: Australian National University Press, 1975).

3 The distinction of being a 'non-British' immigrant is important. There were two major types of immigrant doctors arriving in Australia: British and Irish doctors who were technically immigrants, but practically were afforded the same rights and recognition as Australian-trained doctors in medical legislation across Australia. These doctors were free immigrants, often leaving Great Britain and Ireland for economic or political reasons. See for example, Brian Abel-Smith and Kathleen Gale, *British Doctors at Home and Abroad* (London: LSE Social Administration Occasional Papers, 1964); Oscar Gish, *Doctor Migration and World Health* (London: LSE Social Administration Occasional Papers, 1971). The other type of immigrant

Poland in 1920—was a founding member of the UDA along with his fellow immigrant doctors Dr Valteris (Walter) Didzys from Lithuania, Dr Elemer Paulikovics (Paul) from Hungary, and Dr Emil Miglic (officially listed as stateless), born in Yugoslavia. They were among the approximately 370 known displaced persons or DPs with medical qualifications resettled in Australia from refugee camps across Europe in the aftermath of World War II. The UDA was their response to what they saw as the sustained, unfair, unethical treatment of qualified doctors by the Australian state medical boards and the Australian branches of the British Medical Association (BMA);[4] these bodies resisted liberalising medical regulations so immigrant doctors could legally practise medicine. It was not until 1956–57 that medical legislation in the more populous states of Australia—New South Wales, Queensland, and Victoria—was amended so that qualifications outside of the Australian and British traditions could be assessed. For some, this ended an almost ten-year wait.[5]

The BMA during the period in question was by then a powerful organisation that exercised its influence over all aspects of health policy and medical legislation in Australia. There is a vast body of literature that documents the rise of the organised profession in Australia, including analysis of the BMA's protracted campaign against state-subsidised health care provision during the 1940s and 1950s.[6]

There have been several pieces of work to date which have discussed various aspects of DP and migrant doctors in Australia; Kunz's *The Intruders*, however, is the only extensive examination of the DP doctors' experiences,[7] the strength of his arguments only slightly

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doctor was the refugee doctor—including Jewish refugees and DPs—who were fleeing racial and/or political persecution in Europe before and after World War II.

4 The state branches of the British Medical Association in Australia only formally merged to form the Australian Medical Association (AMA) in 1962. During the period covered in the article, the Australian chapters of the BMA operated autonomously to the BMA Parent council in England, with an elected federal council that had representatives from all state branches. Therefore, all references to the BMA in this article refer to the Australian branches of the BMA and not the parent body in England. Where necessary, a distinction will be made between the federal and state councils of the BMA in Australia.

5 The waiting period was longer for some refugee doctors—mostly Jewish—who arrived in Australia in the 1930s and early '40s.

6 Ann Crichton's *Slowly Taking Control? Australian Governments and Health Care Provision 1788–1988* (Sydney: Allen & Unwin, 1990) critically outlines the evolution of health care provision in Australia in what she calls a 'system of negotiated compromises' between the government and the AMA. James Gillespie's more recent *The Price of Health: Australian Governments and Medical Politics 1910–1960* (Cambridge: Cambridge University Press, 2002) offers an equally comprehensive analysis of state influence in health care policy over the period 1900–1950.
Other works analysing this period of medical history in Australia, with a focus on the profession and its political activity include, but are not limited to: Tony S. Pensabene, *The Rise of the Medical Practitioner in Victoria* (Canberra: Australian National University, 1980); Evan Willis, *Medical Dominance: The Division of Labour in Australian Health Care* (George Allen & Unwin, 1983); Kevin White, "The State, the Market, and General Practice: The Australian Case", *International Journal of Health Services* 30, no. 2 (2000):285−308; Milton J. Lewis, *The People's Health. Vol I: Public Health in Australia, 1788—1950* and *Vol II: Public Health in Australia: 1950 to the Present* (Westport, CT, and London: Praeger, 2003).

7 Suzanne Rutland wrote of the experiences of Jewish doctors who started arriving from

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hampered by his open sympathy towards his fellow DPs. In his review of *The Intruders*, David Maddison, foundation dean of Medicine at the University of Newcastle, acknowledged the importance of Kunz's monograph as a 'timely reminder that the activities of organised medicine require to be monitored with constant, unprejudiced vigilance.[8] Later studies by Peter Winterton and John Weaver on the historical attitudes to immigrant doctors in Australia have largely focused on what Paul Weindling has called the 'professional administrative responses': the complex, high-level, renegotiation of medical legislation.[9] It is perhaps then unsurprising that the work of the Unregistered Doctors Association, active for only five years between 1951–56, has been somewhat overlooked. Not even Kunz—constrained perhaps out of concern for UDA members' professional reputations in 1975—provided a comprehensive or prominent analysis of the work the UDA undertook.

In this article, I will argue that the UDA, a small, under-funded, but passionate group of doctors mobilised by a shared belief that they were being denied a 'fair go', made creditable in-roads in the fight for liberalisation of Australian state medical legislation. Telling its story also shifts the focus away from the administrative response, to illustrate the active role this group of highly skilled migrants adopted in the process of re-establishing themselves in Australia. This research draws on sources including Kunz's papers—one of the sole surviving deposits of UDA archives, material held at the National Archives of Australia, newspaper accounts, personal correspondence with surviving family members, and other sources including Stan Weiner's annotated copies of *The Intruders*, acquired from his estate. To contextualise the role the UDA played in this story, it is necessary to revisit in turn some familiar themes in postwar Australian history, including general attitudes towards immigrants and the professional environment in which they found themselves. Because the UDA operated out of Victoria, this paper will focus

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the 1930s, relating the anti-Semitism she argued as being prevalent in Australia at the time, to why the medical elite hampered efforts to allow Jewish doctors the right to practise. See: Suzanne Rutland, "An example of 'Intellectual Barbarism': The story of 'Alien' Jewish Medical Practitioners in Australia, 1933–56", *Yad Vashem Studies* XVIII (1987): 233−57. By contrast, Moira Salter's exploration of prejudice in the Australian professions focussed specifically on the medical profession, where she argued they were more tolerant of migrants than most. See: Moira Salter, "Prejudice in the Professions", in *Racism: The Australian Experience,* edited by F.S. Stevens (NSW: Hobgin Poole, 1974), 67−75.
It is important to note two deficits in both of these studies: only an estimated 2 percent of later Displaced Persons doctors were Jewish, and yet DPs faced exactly the same hostility; and Salter's measure of tolerance is arguably overestimated because she counts British and Irish doctors as immigrants—which for the purposes of medical registration, they were not. For a full discussion, see Fallon Mody, "Racial Prejudice in the Medical Profession? The Case of Refugee Doctors in Australia, 1930–1945" (paper presented at the 1st Melbourne University Research Conference on the History and Philosophy of Science, Melbourne, Australia, 21 February 2013).

8 David Maddison, "Book Review of The Intruders: Refugee Doctors in Australia*,* by Egon Kunz", *Social Science and Medicine* 11, no. 1 (1975): 58−9.

9 Paul Weindling, "Medical Refugees in Britain and the Wider World, 1930–1960", *Social History of Medicine* 22, no. 3 (2009) 489–511; John Weaver, "A Glut on the Market: Medical Practice Laws and Treatment of Refugee Doctors in Australia and New Zealand, 1933–42" (paper presented at 28th Annual Australian and New Zealand Law and History conference, Wellington, New Zealand, 11−13 December 2009): 1–32; and Peter Winterton, "Alien Doctors: The Western Australian Medical Fraternity's Reaction to European events 1930–50", *Health and History* 7, no. 1 (2005): 67–85.

on this state with reference to national policies, and other state policies and activities, where relevant.

Growing Australia and the Displaced Persons Scheme

Increasing Australia's population was a vital part of the Curtin and Chifley government's plan to consolidate Australia's postwar position. Growth by immigration had been on the political agenda for much of the 1930s—with a focus on attracting the preferred British and Irish migrants.[10] Following the Great Depression of the 1930s and World War II, Australia's population growth had fallen from an annual rate of 2.1 percent in 1927 to 1.2 percent at the end of the war.[11] This decreased growth rate coupled with the realisation of Australia's vulnerability—exposed by the threat of invasion and the bombing of Darwin during the war—brought home the inadequacy of seven million people to defend such a vast landmass, let alone realise the economic potential of the country.

Arthur Calwell, appointed Australia's first immigration minister in 1945, soon outlined plans to attract migrants beyond the traditional source of Great Britain and Ireland within the constraints of the *Immigration Restriction Act of 1901*. Half of Australia's projected population growth was to come from immigration, with a slew of new agreements with countries including Greece, Italy, Malta, and Turkey. It was amidst this aggressive immigration drive that Australia eventually expanded its humanitarian *Displaced Persons Resettlement Scheme* quota in 1948 from 12,000 to 200,000 Displaced Persons (or DPs).[12]

DPs were offered resettlement in Australia if they were under forty years old (later expanded to fifty); passed a health check; and agreed to a two-year employment contract with the Department of Labour and National Service, which would negotiate job placements for them according to labour shortages in Australia. These contracts included a five to six week orientation and English language program at migrant reception centres around the country,

10 Plans to expand Australia's population through immigration were revisited at meetings of the ministry of postwar reconstruction as early as 1943. There was bipartisan support for an increase through immigration to secure Australia's future safety and progress, with political acknowledgement that this would be unpopular. For further literature on Australia's population growth and debate, see Michele Langfield, "To Restore British Migration: Australian Population Debates in the 1930s", *Australian Journal of Politics & History* 41, no. 3 (1995): 408–19; Kerzy Zubrzycki, *Arthur Calwell and the Origin of Post-War Immigration* (Canberra: Bureau of Immigration, Multicultural and Population Research, 1995); Freda Hawkins, *Critical Years in Immigration: Canada and Australia Compared*. Vol. 2 (McGill-Queen's Press-MQUP, 1991); Kenneth Douglas Cocks, *People Policy: Australia's Population Choices* (Sydney: UNSW Press, 1996).

11 Australian historical population statistics, annual population growth by sex, states and territories, year ended 31 December 1789 onwards, Australian Bureau of Statistics, 2004.

12 This matched a similar commitment from the United States of America, and was announced in July 1948 by Arthur Calwell.

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most notably Bonegilla in Victoria.[13] Eventually 170,700 DPs took up the offer and arrived in Australia between 1947–54, approximately 370 of whom were doctors.[14]

At times, immigrants during this period arrived faster than Australia could house or hire them—by November 1955 Australia had welcomed its one millionth postwar immigrant. The DPs, however, were among the earliest non-British arrivals. As a result, the operational and societal implications of the DP migrant in Australia received ample coverage in the popular press. The urgent need to house DPs when houses were scarce in postwar Victoria,[15] led Victorian premier Mr Holloway to accuse army minister Cyril Chambers as being 'intent on moving displaced Australians to make room for displaced Europeans', in response to Chambers' suggestion that Balcombe and Camp Pell military barracks be used to house DPs.[16]

Accounts in Victorian newspapers provide an insight into the varied attitudes Australians adopted towards migrants. Clive Turnbull's column in *The Argus* regularly contained anti-'New Australian' sentiment ('New Australian' being the term Calwell coined in December 1947). Turnbull maintained that Australia was importing Europe's 'quarrels and unsavoury types',[17] and cautioned DPs that they were here 'on sufferance' and not worthy of Australian citizenship until they had proved their right to it.[18] Gordon Birch, by contrast, also writing for *The Argus* reminded Victorians of the great benefit DPs brought to Australia's economy, especially to those areas where Australian workers were loathe to go.[19] In 1950, the *Singleton Argus* reported that non-British migrants did not want to be in Australia because they were made to feel like second-class citizens. Migration experts quoted in the article suggested that DPs felt like they were being tolerated as long as they did not take an Australian's job or

13 These migrant hostels and the conditions imposed on DPs, especially families, have been the subject of some academic analysis, notably Glenda Sluga, *Bonegilla: A Place of No Hope* (Parkville: Victoria 1988); and Jayne Persian, "Bonegilla: A Failed Narrative", *History Australia* 9, no. 1 (2011): 64–83.

14 These DPs—out of a group of about one million still living in refugee camps—comprised mainly non-Jews from Czechoslovakia, Hungary, Poland, Ukraine, and former Baltic states, who feared persecution if repatriated; and some Jewish DPs largely liberated from concentration camps. See Angelika Königseder and Juliane Wetzel, "Displaced Persons, 1945–1950: The Social and Cultural Perspective", in *Post-War Europe: Refugees, Exile and Resettlement*, *1945–1950* (Reading: Cengage Learning EMEA Ltd, 2007); Statistical bulletin, Australia Department of Immigration, October 1954

15 There was an acute housing shortage in Australia following the war. See for example, Migration policy in regards to housing shortage, National Archives of Australia (hereafter NAA): A445, 202/1/1.

16 "Own Homeless Come before DP Migrants", *Argus,* 18 March 1949, 3.

17 Clive Turnbull, "Why Such Carelessness in Europe about Migrants?", *Argus*, 29 October 1949, 2.

18 Clive Turnbull, "Beans in Boots, Cats in Meat Safes", *Argus*, 12 November 1949, 2.

19 Gordon Birch, "A DP Looks at his New Country", *Argus*, 9 July 1949. For an analysis on the type of work and employment opportunities offered to DPs, see Andrew Markus, "Labour and Immigration 1946–9: The Displaced Persons Program", *Labour History* (1984): 73−90.

home.[20] Jean Martin supported this impression based on interviews with thirty-one DPs in 1953, noting that DPs felt unwelcome, inferior, exploited as labour, and pressured to assimilate.[21]

Historian Geoffrey Sherrington argues that the success of individual refugees is related to how well their former lives prepared them for Australian conditions, both socially and professionally.[22] Although initial conditions for DPs (and migrants) were tough—unions, notably those lead by communist bosses, initially refused to let migrants work in their industries—most ended up finding on-going employment at the end of their two-year contracts. After a peak in the unemployment rate in 1952–53 of 2.9 percent, the Australian labour market was buoyant with lower unemployment rates going into the 1960s.[23] These strong employment opportunities, however, did not extend to the smaller group of DPs with tertiary qualifications, whose situation eventually drew the most attention from sympathetic political figures, journalists and the general public.

The Situation for DP Doctors

When DPs were recruited by Australian officials, they were told that every effort would be made to match allocated jobs to their skills, but that Australia's labour needs would take priority. Kunz puts forward a compelling case for how some DPs doctors were verbally assured by immigration officials that they would be able to practise medicine if not during their contract, then afterwards, because Australia had a shortage of doctors.[24] It is unclear how many DP doctors chose a contract to Australia on the basis of such unofficial guarantees,[25] but it is undeniable that on arrival in Australia many professionally qualified DPs were forcibly reclassified as unskilled or semi-skilled labourers (men) or 'domestics' (women). As late as 1954, the *Sydney Morning Herald* ran a section on how difficult entry into some professional circles including dentists, doctors, and veterinarians in NSW was compared to others, notably engineers and accountants.[26]

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20 "D.P. Migrants 'Feel Like Second-class Citizens': Many Band Together in Racial Groups", *Singleton Argus*, 1 March 1950.

21 Jean I. Martin, "Refugee Settlers, A Study of Displaced Persons in Australia" (PhD thesis, Australian National University, 1965).

22 Geoffrey Sherrington, *Australia's Immigrants, 1788–1978* (Sydney: George, Allen & Unwin, 1980).

23 Reserve Bank of Australia, "Australian Economic Statistics 1949–50 to 1996–1997", Occasional Paper No. 8, http://www.rba.gov.au/statistics/frequency/occ-paper-8.html (accessed 10 August 2014), 1998.

24 See chapter 1 on the recruitment of DP doctors in Kunz, 7−20.

25 International Refugee Organization (IRO) records show that there was general difficulty in resettling highly skilled refugees. The IRO set up an advisory committee for the resettlement of specialists and intellectuals, and on 7 January 1948 a health sub-committee met for the first time to tackle the problem of resettling medical personnel in particular. See for example, Gale Cengage Archives Unbound collection – Post-war Europe: refugees, exile and resettlement, 1945–50, http://gdc.gale.com/archivesunbound/. Some letters to the press also indicate that later DPs were aware of the difficulty of gaining registration in Australia, but came anyway. See for example, Eugene Arminski, "Migrant doctors aren't dupes", *Argus*, 29 June 1954, 4.

26 "Entry to Most Professions Still Difficult for Migrants", *Sydney Morning Herald*, 4 June 1954, 2−3; For a comparison across the professions, see Egon Kunz, *Displaced Persons:*

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The situation DP doctors found themselves in is illustrated by Hungarian-born UDA member Dr Karoly Dobos' account of his time in Australia. He was recruited in Regensburg (postwar United States Zone) in Germany where he had been managing three doctors and seventy beds in the male ward of the Department of Central Disease at the International Refugee Organisation's central hospital. He recalls the visit to his ward in 1948 where an Australian immigration mission member, through an official interpreter, encouraged him to apply for the DP scheme because Australia had a 'marked shortage of doctors'. The current laws preventing foreign doctors from registering in Australian states would be changed shortly, and as DPs, European doctors would be placed 'as near their profession as possible'. Dobos was even given a preference card to expedite his application, and four months later he and his wife were en route to Melbourne.

On arrival at the Bonegilla Migrant Reception Centre, however, Dobos recalls district controller Dr Redshaw telling new arrivals that their professional degrees were not recognised in Australia, because they could have been purchased on the black market.[27] Dobos was placed as a medical orderly at Bonegilla, despite having a six-year medical degree from Semmelweis University in Budapest, and having a total of ten years' experience—six as an army doctor, and another four years at the IRO hospital.[28] Dobos describes the situation as humiliating: he was working in the capacity of a doctor, but without the respect or authority to do his job. By day his medical diagnoses were subject to the opinion of the female nurse he worked with, and by nightfall she ordered him to scrub floors and clean crockery.[29]

On 24 February 1953, Charles, UDA member number thirty-one, dictated a six-page statement witnessed by his UDA colleague Dr Weiner outlining his experiences as a DP doctor in Australia. Dobos had been an active member of the UDA, and he ends his statement by saying that he didn't believe 'any other country in the free world would treat a foreign doctor in this manner'.[30] Two days later he left for Germany and never returned.

Dobos took one of the easier options out: he had fulfilled his DP contract, and had the freedom and flexibility to leave. Kunz estimates that almost 20 percent of all DP doctors left Australia before the changes in medical legislation occurred.[31] However, many older DPs and those with families were unable or reluctant to uproot themselves once more. Like Dobos, it was during their contracts that DP doctors realised through a combination of the nature of their employment as medical orderlies or manual labourers, word-of-mouth, and official replies from state medical boards and universities that their futures as legal, registered doctors in Australia

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Calwell's New Australians (Sydney: Australian National University Press, 1988).

27 Statement by Charles Dobos MD, 24 February 1953, held in UDA documents, Egon. F. Kunz papers - Box 20 Doctors of Medicine (The Intruders files), Noel Butlin Archives (hereafter NBA) ANUA 497, Australian National University, Canberra.

28 Schedule of Displaced Persons with Professional and Semi-professional Qualifications, 1949. NAA: MP1722/1, Canberra.

29 Statement by Charles Dobos, NBA ANUA 97.

30 *Ibid.*

31 See Table 6: 'Departure of D.P. doctors from Australia', in Kunz, 113.

was far from assured. Between 1947 and 1956, five DP doctors took their own lives—a most tragic reflection of the toll exacted by the existing system.

The situation for new arrivals, especially for those with limited English would have appeared not just unfair, but convoluted. Each state had its own medical act, with a state-appointed medical board governing registration and regulation of medical practitioners. However, the federal government controlled territories (including Antarctica and Papua New Guinea), as well as appointments to federal departments. Each state act adopted different responses to the DP and migrant doctor question—at a minimum, practicing medicine required another move or expensive requalification (see Table 1 for state-by-state summary). All ineligible inquirers were told to seek requalification if they wished to practice medicine in those states with a medical school. The University of Melbourne required foreign doctors to complete its full six-year course, unlike both the Universities of New South Wales and Queensland that allowed foreign graduates entry into the fourth year of their medical degree.[32]

Table 1 Summary of conditions for non-British migrant doctors.

State	Conditions for non-British doctors	Re-qualification	Year Medical Act liberalised
New South Wales	No foreign qualifications apart from British & Irish qualifications	Complete last 3 years of medical school. But registration quota of 8 foreign doctors to be registered each year who undertake University of Sydney course	1955
Queensland	No foreign qualifications apart from British & Irish qualifications	Complete last 3 years of medical school	1955
South Australia	No foreign qualifications apart from British & Irish qualifications	Complete last 3.5 years of medical school	1966
Tasmania	One year hospital internship introduced in 1950	No medical school in state	1950
Victoria	No foreign qualifications apart from British & Irish qualifications	Complete full 6-year degree	1956
Western Australia	Regional placements available	No medical school in state	1946

Only doctors holding qualifications from Australia, Great Britain, or Ireland had guaranteed registration. Graduates from other foreign medical schools had to demonstrate that their countries offered Australian doctors reciprocal recognition.[33] Whilst state medical acts did not specifically name countries excluded from registration, most maintained a blanket policy of deferring to the medical board on the subject of foreign doctors. State medical boards judiciously applied this reciprocity clause; so all enquiring DP doctors were refused an assessment of their qualifications because none of the European countries (except Italy) had reciprocal agreements in place. Following Italy's entry into World War II, this last remaining

32 The Universities of Queensland and New South Wales required these migrants to pass third year examinations to gain entry into the fourth year of their medical degrees.

33 Salter's analysis on prejudice in the professions (see Salter, 1974) outlines the origination of the reciprocity clause in the early1900s.

loophole was closed in 1940. John Weaver concludes his account of prewar changes to Australian medical legislation (mostly affecting Jewish refugee or alien doctors) by saying that continued insistence on exercising this reciprocity clause—complicated to negotiate, made impossible by the political turmoil in Europe—was wilfully petty.[34]

There remains only one instance until legislation changed in the late 1950s where any significant proportion of refugee or DP doctors had their qualifications peer-reviewed. Australia's war cabinet recommended licensing alien doctors to fill the shortage of doctors in country areas and other institutions for the period of the war, with or without the consent of state medical boards.[35] The *National Security (Alien Doctors) Registration Act* was passed in 1942 despite strong resistance from the profession. The concession made to state medical boards was that temporary registrants could not establish any private practice, and could only work jobs assigned to them by the state boards. The Commonwealth Alien Doctors Board was established to administer the Act, and potential applicants had to first pass a written and oral exam. In the end Victoria granted 27 temporary licenses (out of 40 applications); New South Wales 25 of 47.[36] Following the repeal of the emergency acts after the war, these doctors were granted unrestricted right to practise.

The UDA fights back

Despite the success of war-time temporary registration, there was little will to change state legislation following the war. Whilst Western Australia kept its war-time measure of offering foreign doctors limited registration to practice in rural areas, and Tasmania introduced a one-year probationary hospital internship in 1950, elsewhere effectively returned to its prewar status.[37] By the time fellow European doctors met on 21 July 1951 to form a club for unregistered doctors (which became the UDA), the rhetoric surrounding 'alien doctors', 'DP doctors', and 'refugee doctors' was firmly established. The BMA and other prominent members of the profession across Australia ran a coordinated campaign against liberalising medical legislation. Foreign doctors, they argued, were not up to Australia's high standard of medical education, had questionable professional ethics, could not speak English properly, were unfit for the GP-dominated Australian market because most were specialists, and finally, Australia, it was argued, had enough locally-trained doctors to supply each state. There is little evidence in the

34 Weaver, 32−8. Where Weaver draws attention to the pettiness of the arguments put forward by the profession, in restricting himself to the treatment of Jewish doctors during the war, he does not draw out the similarity between those arguments and the ones put forward by the medical profession five years later in response to DP doctors. The key difference being that anti-Semitic sentiment alone could no longer explain the negative attitudes to the non-Jewish group of arrivals.

35 See Weaver, 25−9.

36 *Ibid.*

37 In Western Australia, these changes were passed as the *Medical Act Amendment Act 1940*, which stipulated that once an alien doctor had served for seven years in a region, they were eligible for unrestricted right to practise (this was later revised down to five years). See: Table of Acts, http://www.comlaw.gov.au/Details/C2004Q00200 (last accessed May 2015). For Tasmania, see *Medical Act 1951,* http://www5.austlii.edu.au/au/legis/tas/num_act/ma195126o1951107/ (last accessed May 2015).

available primary sources to suggest that these claims were evidence-based.[38] The latter question of the absorptive capacity of the Australian medical profession dominated the dialogue between the Department of Immigration's Immigration Planning Council and the BMA.

The Immigration Planning Council was quick to support liberalising state acts, and facilitated the recruitment of DP doctors for posts as medical officers in federal departments, Papua New Guinea and Antarctica: posts and places Australian doctors were reluctant to go. The documented dialogue between the council and the BMA highlights the apathy towards DP doctors from the BMA. A council report on medical manpower published in December 1950 concluded that the numbers of doctors in Victoria and NSW were comparable, both with worryingly low numbers of doctors in rural areas. The report also concluded that once projected growth in the population and the anticipated rate of retirement, death, and outflow of doctors had been accounted for, the number of Australian graduates for the years 1952 and beyond would be insufficient to maintain healthy doctor-patient ratios, so the profession could absorb more doctors without detriment.[39]

On 13 June 1951, the BMA federal council eventually responded to the council, outlining the conclusions of its own Migrant Doctor sub-committee. It opposed liberalisation, recycling all the old arguments from lack of reciprocity to maintaining standards.[40] The committee also suggested the government could address its responsibility to DPs by funding their three years of study in Australia. The terms of reference for the Migrant Doctor committee published in the Medical Journal of Australia in April 1951 highlight the detached attitude towards DP doctors implicit in the language and tone used. The committee was to examine: the number of medical practitioners likely to be required for the population in the next ten years; the capacity of Australian universities to fill those needs; the number of British migrant medical practitioners that could be attracted to Australia; and "what gap, if any, there would remain for the absorption of foreign medical practitioners [emphasis mine]".[41]

The BMA demonstrated that it would sooner concern itself with attracting British doctors than consider the value of DP doctors already in the country. In a personal interview years later, Calwell's reflection echoes this attitude from the former president of the Victorian Medical Board:

38 The BMA commissioned Sir Peter MacCallum to investigate medical education in Australia in 1952, and only in 1960 did the BMA commission an inquiry into specialisation of doctors. Kunz argued that fear of competition from specialised doctors was a key reason that the profession lobbied against allowing migrant doctors from being registered. For a wider discussion of the Australian medical market, see: Kevin N White, "The State, the Market, and General Practice: The Australian case", *International Journal of Health Services* 30, no. 2 (2000): 285–308.

39 Meetings of immigration planning council - minutes, agenda, notes etc., NAA: A987 E1191 (1950), Canberra.

40 Commonwealth Immigration Planning Council - Agenda, notes and minutes of 7th, 8th and 9th meetings held during 1951, NAA: A10875 1951 (1951), Canberra.

41 "The Registration of Alien ('New Australian') Medical Practitioners", *Medical Journal of Australia* 2, 21 April 1951, 597.

> Sir John Newman-Morris said that … medical standards in Europe had fallen since the First World War, especially since 1940. But even if this was true, why not assess each individual migrant doctor as to his present qualifications? Sir John quickly made it obvious that the provision was designed to protect not the community, but only Australian doctors. He said … 'We are registering 150 of our own young doctors to-day. They had to do a six year course, alien doctors have to do only three years'. Sir John overlooked that the alien doctors were doctors before their three years of further studies. And if the nearly absurd statement that one doctor in 1,100 people was adequate, why freely grant recognition to doctors from other foreign sources [British and Irish migrants] without limitation as to numbers?[42]

In fact, Hugh Poate reported in the Medical Journal of Australia that 507 British doctors had been admitted to practise in Australia between 1948 and 1952.[43]

In 1951, the UDA issued a pamphlet calling all unregistered doctors to unite to 'fight for registration under the same conditions as exist for our European Colleagues in England, U.S.A and Canada'.[44] By March the following year, over 200 European doctors across Australia had joined. Several members also volunteered their time to help with association activities: particularly Zygmunt Gizycki—a 42-year-old Polish DP requalifying at the University of Melbourne—who acted as treasurer, and a female Latvian doctor Alma Draska-Starks who later became vice-president. The UDA seemed to have received little encouragement or support from prewar migrants who gained registration, doctors they referred to as 'Italian-pre-war-popular-edition' who had 'turned' on them.[45] At its peak, the UDA had 205 members, mainly from Hungary, Latvia, Lithuania, Czechoslovakia, Ukraine, Poland, Romania, and Estonia.

One of their first tasks was to survey all UDA members to build an evidence-base, to refute with fact what they saw as arbitrary statements about European doctors' ability and standards.[46] The results of this exercise, which included examining university certificates, résumés, research, publications, and allied war service, were used to compile a report addressing each one of the standard statements used by the BMA and opponents of liberalising state medical acts. This key publication presents a passionate but reasonable argument for their case, which the UDA used to highlight their situation to relevant local and international authorities and to leverage the local press. One goal was in mind throughout: to put forward a convincing, logical case for amending state legislation.

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42 Quote from Arthur Calwell, in Lindsay R. Smith, "A study of European Immigration and Australia, 1942 and 1949" (Masters thesis, University of Queensland, 1970).

43 Hugh Poate, "The Capacity of the Medical Profession in Australia to Absorb New Members", *Medical Journal of Australia* 16, no. 2 (1953): 616−21.

44 Alien Doctors – Conditions of Practice in Australia, 1942–1955, NAA: A446 1958/66376 Part I, Canberra.

45 UDA bulletin no 2 – November 1952, E.F. Kunz papers, NBA: ANUA 497.

46 UDA bulletin no 1, March 1952, 1, Kunz papers, NBA.

The UDA approached both the federal council and the Victorian branch of the BMA, the medical board of Victoria, the Victorian minister for Health, W.P. Barry, the minister for Immigration, the prime minister, and even Catholic archbishop David Mannix. The federal council of the BMA responded to the UDA in October 1952 advising that they wished to remain 'neutral' on the matter of registration—contrary to their own report to the Immigration Planning Council the year before, and suggested the UDA contact the state medical board. The Victorian medical board took nine weeks to respond, and refused a meeting stating that since it:

> is responsible for the administration of the Medical Acts, and has no power to vary in any way the limitations imposed by the Victorian parliament on the registration of medical practitioners, it is not considered that any useful purpose would be served by granting the interview as requested.[47]

The UDA were not easily discouraged. Between May 1952 and November 1953, they reported sending no fewer than fifteen letters chasing follow-up meetings with federal, state, and international officials. Apart from their constant lobbying, they also set about sourcing and connecting their members to opportunities overseas, particularly in North America. Although they received sympathy from international organisations including the National Committee for Resettlement of Foreign Physicians and the World Health Organization,[48] little came of their efforts to establish a steady stream of resettlement out of Australia for those members wishing to relocate.

The lack of progress saw president Dr Miglic admit in 1953 that after three years of 'a struggle for the elementary human rights [*sic*]', the UDA had considered disbanding. Blaming authorities for creating a situation where new Australians were humiliated, disincentivising naturalisation and assimilation into a society denying them an equal start, Miglic said:

> For the time being our hands are bound. All we can do is counter the decaying feeling of frustration, to try to prevent formation of hate. Which is not easy as we have been denied years of service, denied for the sake of men who sold their ethics and forgot the words [of the Hippocratic Oath] 'I will use my power to help the sick to the best of my ability and judgment; I will abstain from harming or wronging any men by it'.[49]

Miglic went on to speak about the ongoing work of the UDA, writing that:

> the task is great, but our organisation consists of people who went through camps and prisons and did not give up their way of thinking … We are not asking for pity, but for justice, aware of the fact, that this country is crying out for skilled men, is definitely in need of doctors, and has no gain at all

47 UDA bulletin no 2, 1952, 1–2. , Kunz papers, NBA.

48 For example, Letter, Laura G. Rubin to UDA, 5 January 1952, E.F. Kunz papers, NBA: ANUA 497; Letter, Louis H. Bauer to UDA, 29 October 1953, E.F. Kunz papers, NBA: ANUA 497.

49 UDA bulletin no 3, November 1953, 1–2, Kunz papers, NBA.

This chapter is a pre-copyedited, author-produced version of an article accepted for publication in *Health and History* following peer review.

> in dissatisfied settler families, humiliated for the sake of a little group of influential traders. We have nothing to lose.[50]

One of the most important outcomes of the UDA's five years of active operation was that it succeeded in keeping the issue of medical registration alive in the media and in public forums.[51] They won the ear of sympathetic journalists including Norman Dunbar who published an article in the *Argus* calling for relevant authorities to give migrant doctors a 'fair go' in 1951.[52] In the same year, the *Argus* led with the headline 'Sick patients can't be treated, but - MIGRANT DOCTORS IN NURSING JOBS'.[53] The deputy-editor of the *Argus* and supporter of the UDA, John Hetherington led with a front-page headline 'THIS IS A CRIME!'.[54] In a letter to Dr Weiner, Hetherington wrote, 'I hope the article … will help to get at least a measure of justice, not only for alien doctors, but for alien intellectuals at large'.[55]

Between 1951 and 1957, members of the UDA secretariat were quoted in articles published in a range of metropolitan and rural newspapers, including *The Sydney Morning Herald* (New South Wales), *The Advertiser* (South Australia), *Barrier Miner* (New South Wales) and the *Goulburn Evening Post* (Victoria).[56] Another significant public forum the UDA influenced was the 1953 Citizenship Convention—federally-sponsored conventions to promote Australian citizenship and the government's wider assimilation and integration agenda,[57] and also used to discuss all aspects of citizenship. Sympathetic members of the Good Neighbour Council nominated Dr Stan Weiner and another UDA colleague to attend the 1953 convention—incidentally the first time immigrants were invited to attend, and where Dr Weiner tabled a UDA paper on the prospects for migrant doctors which was again widely reported in the press.[58]

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50 *Ibid.*

51 The UDA actively leveraging the mainstream press to garner public sympathy is remarkable because for early postwar migrants from non-English speaking backgrounds, the foreign language press—where they could communicate in their native tongue—was the preferred route. See for example, Miriam Gilson and Jerzy Zubrzycki, *The Foreign-Language Press in Australia, 1848–1964* (Canberra: Australian National University Press, 1967). The most frequently immigrant-initiated press grievances in mainstream press came from British immigrants—or the ten-pound Poms—over hostel conditions. See for example, Andrew Hassam, "From Heroes to Whingers: Changing Attitudes to British Migrants, 1947 to 1977", *Australian Journal of Politics and History* 5, no. 1 (2005): 79–93.

52 Norman Dunbar, "Let us Give these Skilled Professional Men a Straight—and Early—Answer. Migrant Doctors Plead for a 'Fair-Go'", *Argus*, 19 November 1951, 2.

53 "Sick Patients can't be Treated, but – MIGRANT DOCTORS IN NURSING JOBS", *Argus*, 25 October 1951, 7.

54 John Hetherington, "THIS IS A CRIME!", *Argus*, 17 Dec 1953, 1–2.

55 Letter, John Hetherington to Dr Stanley Weiner, 22 December 1953.

56 See for example, "Migrant Doctors Want Inquiry", *Sydney Morning Herald,* 4 January 1952, 2; "'Spurned,' Say Doctors", *The Argus,* 25 June 1954*,* 4; "Eye on Alien Doctors", *Argus,* 14 December 1956, 6.

57 Citizenship conventions were held from 1950 to 1968, initially annually and later biannually.

58 UDA bulletin no 3, November 1953 – Secretary's report, 1–3, E.F. Kunz papers, NBA: ANUA 497; and Kunz, 84–7.

The second key activity the UDA undertook was to create and facilitate a community, especially for those doctors in metropolitan Melbourne.[59] They initially ran monthly meetings that later reduced in frequency, owing in part to the dispersed nature of their members, including those still on DP contracts. The committee organised pot luck Christmas parties for members and their families, and generally through their bulletins and private letters maintained a stream of correspondence. They also ran professional development in the form of lectures researched and delivered by members, with ongoing call for contributions. Lectures were topical and useful to new settlers, for example, treasurer Dr Gizycki delivered a lecture titled 'Australian Snakes and Spiders Focusing on Identification, Diagnosis and Treatment'; and Czech Dr Novak presented on the diagnosis, aftercare and late prognosis of poliomyelitis.

In May 1956, the *Medical Act of Victoria* was amended to remove the requirement for reciprocity and allowed the medical board to register suitably qualified alien doctors—almost seven years after then Victorian minister for Health, J. Gartside had announced a potential change in legislation.[60] However, it was actually the Immigration Planning Council that initiated state-level discussions five years earlier. Frustrated with its stalemate with the BMA, an internal council brief concluded that while the BMA would never openly budge on their stance, neither would they hinder a full-scale inquiry at the state level.[61] The council organised a meeting of relevant state authorities resulting in each state committing to a full review of their medical legislation.[62] By the time the *Victorian Medical Act* was relaxed in 1956, all the other states had formally or informally liberalised registration.

With what ought to have been the cue for the natural disbanding of the UDA, whose existence was technically rendered obsolete following national liberalisation of medical legislation, came possibly the hollowest of victories. The *Argus* reported in November 1956 that of the 96 applications made to the Victorian Medical Board since May that year, one was approved, 22 were still being processed and 73 were rejected—the latter without any assessment other than looking over their paper qualifications. The single approved applicant being a pathologist who had a personal reference from Sir Peter McCallum.[63] It was in the wake of heavy negative press coverage on the actions of the Victorian medical board that the final formal statements and comments from the UDA are recorded in the national press. It was only in the late 1950s, after the introduction of qualifying examinations, that more European doctors were finally registered in Victoria.[64] In 1959 the last of the founding members of the UDA

59 For example, original president and founder Dr Walter Didzys stepped down due to a conflict between his work in rural Victoria and the work required running the UDA.

60 "Alien Doctors Maybe Allowed to Practise here", *Argus,* 5 March 1949, 5.

61 NAA: A10875 1951.

62 "Inquiry Ordered on Doctors: Aliens' Rights", *Argus,* 25 Oct 1951, 7.

63 "Dr Salk Couldn't Hang up his Plate Here – Nor Could these Men", *Argus*, 1 November 1956, 4.

64 During the latter years, there is no direct evidence of UDA activity. However, they might have leveraged their European doctor network to put members in need of a refresher or help with English medical jargon in touch with the St Thomas More Society and the Prince Henry Hospital—both organisations ran 3-month refresher courses to help DP doctors pass qualifying

gained registration, and by 1963 there were eighty-nine foreign doctors on the Victorian medical register—including those from parts of Asia and South Africa.[65]

Image 1 Inaugural meeting of the Lithuanian doctors association in 1964 at the residence of Dr I. Kaunas.



From left: Drs Walter Didzys (former president of UDA), J Juozapavicius (former UDA member), Elvira Petrikaitè, Jurgis Mikolajunas, K Bredikytè, Izidorius Kaunas (former UDA member) and Stasys Statkus. Underlined doctors were all previously unregistered; the others requalified in Australia.

Photo source: *Australijos lietuviu metrastis*, Sydney, 1961, p. 320. Additional information provided by Eva Aras, daughter of Dr Walter Didzys.

The final and arguably lasting contribution of the UDA brings us back where we began—their former work and research was instrumental in helping Egon Kunz with his own research on professionally qualified DPs, which resulted in the offshoot monograph *The Intruders: Refugee Doctors in Australia*. Kunz contacted members of the UDA secretariat in the early 1970s, long after they had stopped being an active body, and long since Australian medical legislation had been changed. The UDA loaned him copies of correspondence with politicians and members of the medical profession, their bulletins, survey documents, and member lists. As a case in point, the second chapter of Kunz's monograph on background and demographic data is an almost complete reproduction of the UDA provisory report based on their survey results from 1953. In total, Dr Stan Weiner marked thirty-two instances where Kunz had made use of facts, quotes, or interviews facilitated by the UDA in his annotated copy of *The Intruders*. In Kunz's research, the work of the UDA found a second life.

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examinations.

65 Medical Board of Victoria, "Register of Medical Practitioners for 1963", *Victorian Government Gazette* 12 (1963): 357–465; Dr Stan Weiner was registered earlier in 1956.

Conclusion

What started as a club for unregistered doctors in Victoria, turned into an association that for its short lifespan and given its limited budget had a wide reach. Perhaps what spurred DP doctors to mobilise was the rapid acknowledgement of the lack of collegiality extended to them by members of the profession; members of the UDA openly expressed their disbelief in how the BMA failed in its moral obligation to recognise and help fellow medical colleagues, rendering the BMA the villains again and again.[66]

Can we directly attribute any change in attitudes or policy to the passionate work of the UDA? Probably not. That does not, however, lessen its role in the fight for formal recognition of European qualifications in Australia. Nor does it preclude the UDA from earning its place in Australia's complex but rich migrant history. Firstly, the experiences of this group of doctors serve as a case study in how professionally qualified migrants (then the minority migrant type) were forced to struggle against their peers for a right to a 'fair go', to use the Australian vernacular. Finally, by sustaining their association through the tireless activity of four or five individuals, the UDA brought hope to their colleagues. More importantly they became the voice for European and other migrant doctors in Australia during the period. Consciously or not, the UDA understood and leveraged the popular press. They built lasting relationships directly with journalists or indirectly through their networking, and were approached for comment over the life of the issue, and incidentally the life of their organisation. For a small, under-financed group of displaced people in a new country, the UDA's efforts emerge meritorious.

Acknowledgement

The author records her thanks to Dr James Bradley and Dr Simon Sleight for their advice and encouragement.

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66 In many of the returned surveys Egon Kunz collected, former migrant doctors placed direct blame on the BMA for their situation. See E.F. Kunz papers, NBA: ANUA 497.

Chapter 07: 'Lost Years and Wasted Lives'?[624] A Case Study of European Medical Migrants in Victoria, 1930 – ca. 1966

Jacob Schwarzbrod arrived in Australia aboard the *SS Oronsay* on 3 October 1938. He was an Austrian-Jew, had completed a medical degree in Vienna in 1921, and had been practising there as a GP before he was impelled to leave.[625] Twenty years later, after two attempts at the newly-introduced qualifying examination for 'alien doctors' in Victoria, having anglicised his name, 58-year-old Jacob Shaw was registered as a medical practitioner.[626] The eventual liberalisation of Victoria's medical act in 1956 came at a considerable collective cost for those continental medical migrants whose degrees were not recognised, but were resident in Victoria from 1930 onwards. As discussed in the Introduction to Part III, for some practitioners the gap between their arrival and eventual registration was in the most extreme cases between 17-20 years (Figure 9). Shaw was one of the 87 continental medical migrants registered in Victoria between 1930-60. He applied for a temporary war license, but was unsuccessful, and spent the interim years practising as a dietitian.[627] He chaired an informal association of 'alien unregistered doctors and dentists' in Victoria in the post-war years, which similar to the Unregistered Doctors Association (see Chapter 6), sought fairer assessment for foreign medical qualifications.[628]

For historian Egon Kunz, the gap years experienced by practitioners like Jacob Shaw represented 'lost years and wasted lives'.[629] Kunz mapped the career trajectories for a sample of DP doctors for the 20-years since their arrival in Australia.[630] His analysis showed that almost half of these men and a smaller number of women took between nine to ten years to work in a professional capacity again. On the basis of these findings, Kunz concluded that the BMA in Australia, through its influence and adopted policies, achieved 'the elimination and repulsion, or at least neutralisation, of just over half of the available talents and skills which the Displaced Persons (DP) doctors brought with them to Australia'.[631] The major aim for Kunz was to expose the protectionist activities of the BMA in Australia, state medical boards and the university medical schools, as a lesson in the consequences of misused power by elements of the medical profession, and the resulting human tragedy of the migrants who were victims of a poorly implemented immigration program.[632] As historian Jayne Persian observes of his other

624 Kunz, *The Intruders*, 93.

625 PROV: VPRS 16389/P1 unit 5.

626 Ibid. NB. Anglicisation of names was very common (see Figure 11 below). The name changes are particularly prevalent among former Polish nationals. For example, the *Sunday Mail* reported in 1939 that Charles Walker who changed his name from Chaim Simche Zygmunt Wachs did so 'as his patients and friends had difficulty with his Polish name' ('Patriotic Efforts', *Sunday Mail*, 8 October 1939, 4).

627 PROV: VPRS 16389/P1 unit 7.

628 'Law Is Harsh, Aliens Claim', *The Argus*, 16 August 1950, 7.

629 Kunz, *The Intruders*, 93.

630 Ibid.

631 Ibid., 115.

632 Ibid., 133-34.

work, Kunz sacrifices exploring more nuanced themes to highlight this main thesis.[633] Writing as he was in mid-1970s, at the height of a radical rethinking of the role and sources of power of established professions, Kunz's focus also reflected the contemporary sensitivity of the topic.[634] Anecdotally the BMA in Australia tried to prevent the publication of *The Intruders*, and the Department of Immigration demanded thorough fact-checking of Kunz's monograph prior to its publication.[635]

With the exception of *The Intruders,* very few studies map the collective professional lives of these doctors.[636] As discussed in Chapter 1, the histories of this group of medical migrants are focussed on the gatekeeper response. These studies often conclude at the point 'alien doctors' gain registration, often concluding with a sense of these doctors' subsequent success. Historian Suzanne Rutland, for example, concludes her account of Jewish refugee doctors in NSW noting that, 'despite the many obstacles … most succeeded in re-establishing themselves in medical practice, and many made a positive contribution to both the general and Jewish communities'.[637] The individuals Rutland singles out follow another common trend in these accounts: the perpetuation of internal medical hierarchies of prestige.[638] Historians typically connect success and 'positive contribution' to those who eventually regained (consultant) specialist status.[639] At the other end, histories of medical migrants focus on their interrupted careers, which are evoked to illustrate the human cost of protectionist attitudes adopted by the local profession, as well as to portray the impact of denying continental medical migrants registration earlier.[640] Kunz, for example, accentuated the narrative of national loss by highlighting the critical role DP doctors – denied registration in Australian states – played as federal civil servants in shaping Papua New Guinea's fledgling medical system.[641]

Therefore, two key gaps in the history of the continental medical migrants in Australia includes a wider exploration of these doctors' unregistered or gap years from a biographical perspective; how we might understand their work over the course of their working lives in Australia, including in their unregistered capacities. The latter must surely include a focus on the most common career outcome in Australia – and not just for medical migrants – that of a

633 Persian, PhD diss., 15-18 and 235-242.

634 Freidson, *Professional Dominance*. NB: Kunz does not reference sociological work explicitly, however, he draws heavily on the work of his colleague, Thelma Hunter, whose thesis included analysis of the role of ideology and power in the medical profession. See: Thelma Hunter, 'The Politics of National Health', PhD diss., ANU, 1969).

635 Persian, PhD diss., 235-242.

636 See also, Winterton, 'Alien Doctors', 77-81.

637 Rutland, 'An Example of "Intellectual Barbarism"', 256.

638 See Chapter 2.

639 Success stories Rutland includes are: Henryk Frant (OBGYN), Salec Minc (cardiologist), Henry Price (orthopaedic surgeon), and Oscar Schmalzbach (psychiatrist). Rutland, 'An Example of "Intellectual Barbarism"', see footnote 77. See also, Winterton, 'Alien Doctors', 77-81.

640 For a detailed discussion, see: Chapter 1.

641 Kunz, *The Intruders,* in particular, 8-9 and 52-9.

rank-and-file private practitioner.[642] In this chapter, I address these gaps by focussing on the continental medical migrants in my sample who worked as private practitioners. In total, 50 of the 87 continental medical migrants ended their Australian careers as private practitioners; 41 of them as GPs (Table 16).[643] This chapter begins by contextualising the arrival and registration of the wider cohort of 87 continental medical migrants, exploring what Kunz has described as 'lost years'. In this section I highlight the breadth of work undertaken by unregistered doctors, and demonstrate the particular sustained impact protectionist policies had on unregistered doctors formerly engaged in private practice. I also highlight how the combination of the medical profession's restrictive policies, as well as the circumstances under which these men and women arrived, meant that the professional resettlement experiences of this group are more heterogeneous than existing studies suggest.

The next section addresses the extrapolation that these gap years resulted in what Kunz saw as 'wasted lives' for both continental medical migrants and the nation, 'even if the doctor was registered at a later date'.[644] Through a thematic exploration of the collective work patterns of the cohort of private practitioners, including their unregistered years, it is clear that formal and informal structures relegated medical migrants – of which the continental European graduates formed a large part – to less prestigious medical work. The Victorian medical profession repeatedly refused to register these doctors on the grounds that their *qualifications* were not 'of special value to the people of Victoria'.[645] However, as the head of the Victorian Blood Bank, Lucy Bryce, argued to the Victorian medical board in the case of the pathologists under her employ, it was the nature of their *work* not their qualifications that was of special value.[646] This argument can be extended to describe much of the work these doctors undertook willingly or not, often as a result of low demand from their locally-trained counterparts. In the interwar years, this was doctoring in country areas. In the post-war years, this included the extent to which these doctors' multilingualism and shared cultural base resulted in them servicing their own migrant communities. This is particularly apparent as the post-war population expansion in Australia extended to including large numbers of non-English speaking settlers. Of course, these doctors 'lost years' owing to the prejudices and protectionism deployed by the profession's gatekeepers, however, I argue that in the collective patterns that describe their resettlement, these were not lives that should only be remembered as 'wasted'.[647] Continental medical migrants too fulfilled 'special types of labour' in Victoria.[648]

642 As discussed in Chapter 2.

643 The work of 16 of the 87 doctors cannot be definitively classified in the traceable records. For a discussion, see Appendix 3.

644 Kunz, *The Intruders,* 115.

645 This was the principal amendment introduced to modify the 1956 *Victorian Medical Act* to enable the recognition of foreign (non-reciprocating) medical qualifications. See, *Medical (Registration) Act* 1956, 90.

646 Klugman, *Blood Matters*, 69-86.

647 Kunz, *The Intruders,* 115.

648 Simpson et al., 'Providing "Special" Types of Labour', 208.

Table 16 Summary of first and last known medical roles in Australia (n=total number of continental medical migrants).

	First known medical role	Last known medical role
General practice (inc. locum tenens)	32	41
Specialist practice	7	19
Anaesthesia	-	1
Dermatology	-	4
Cardiology	-	1
Neurology	1	1
OBGYN	-	1
Pathology	2	5
Paediatrics	1	1
Psychiatry	-	2
Psychoanalysis	1	1
Radiology	1	1
Surgery (nec)	1	1
Venerology	-	1
Hospital general, inc lab work	15	4
Public Health, inc. mental health sanatoria	13	9
Blood bank	7	4
Mental Health	3	3
School medical service	3	1
Tuberculosis	-	1
Research/Teaching	4	5
Other – medical, inc. dentistry and nursing	9	3
Not working	1	-
Unknown	8	16
Total	**89 (n=87)**	**81 (n=87)**

Source: Author's analysis. See Appendix 3.

Table 17 Summary of Last known primary medical role prior to arriving in Australia.

Last known primary medical role prior to Australia*	**Total**
General practice (inc. ship's surgeon)	22
Specialist practice	21
- ENT (1)	
- Cardiology (1)	
- Dermatology (1)	
- Neurology (2)	
- Obstetrics and gynaecology (3)	
- Ophthalmology (1)	
- Pathology (2)	
- Paediatrics (1)	
- Psychoanalysis (1)	
- Physician (all branches) (3)	
- Radiology (1)	
- Sports medicine (1)	
- Surgeon (all branches) (1)	
- Tuberculosis (1)	
- Urology (1)	
Hospital	6
- General, inc lab work (5)	
- Medical administration (1)	
Research/Teaching	6
Other – medical, inc. military, dentistry and nursing	4
Not working	6
Unknown	25
Total	**90 (n=87)**

Source: Author's analysis. See Appendix 3.

Table 18 Summary of work undertaken during gap (unregistered) years (n=54). **Italians medical graduates and those who were granted temporary licenses to practice almost immediately after arrival were excluded from this table.

	Interwar arrivals (n=30)	Post-war arrivals (n=24)	Total
Medical/Health (inc. military)			20
- Chiropody	1	-	1
- Dietitian	1	-	1
- Hospital (general)	1	-	1
- Orthopaedics	1	-	1
- Pathologist	4	-	4
- Physiotherapy	1	-	1
- Psychology, Psychoanalysis	2	1	3
- Research/Teaching	3	1	4
- Radiologist	1	-	1
- Student (requalifying)	2	1	3
Assistant medical/health roles			27
- Medical orderly	1	8	9
- Pathology technician	2	6	8
- Radiographer/x-ray technician	0	5	5
- Technician - other	2	3	5
Other			12
- Labourer	3	4	7
- Sales/clerical	2	1	3
- Translator/language services	2	-	2
Not working (interned)	4	-	4
Unknown	4	5	9
Total	33	21	54
Not applicable**	29	4	33

Source: Author's own analysis. See Appendix 3.

'Lost years' – transitions and mapping the gap years

Fifty two of the 87 continental medical migrants registered in Victoria experienced a gap between their arrival and eventual registration (Figure 9). For the wartime licensees, the average gap was three years until they gained their temporary license; for the rest of the interwar and early post-war arrivals, the gap extends to 9-10 years. Table 17 details the last known work for these 87 men and women prior to arriving in Australia, and Table 18 their gap years in Australia. Before discussing these gap years, it is important to contextualise the data in these two tables. First, Table 17 does not represent the complexity of the pathways that describe this

group. As discussed earlier, on departing for Australia, the professional aspirations of many of these doctors had already been interrupted or completely dismantled owing to National Socialism, anti-Semitic legislation, and the disruption and aftermath of the Second World War.[649] Second, the work histories for this group – including for their gap years – have been difficult to reconstruct for two reasons, each of which I discuss in turn below.

The last known work for this group prior to arriving in Australia has been the most difficult to reconstruct, with very limited data available for 25 of these 87 medical migrants (Table 17). One reason for this is the conflation of issues of language and reasonable access in undertaking historical research: many relevant archival records are published in a language I am not fluent in, and even for those that are, the diversity of the group, and their mobility across borders, means these records are not digitised, and are scattered across national archives and institutions across continental Europe.[650] The records I have used to document the prior work histories of the remaining 63 of these men and women have predominantly been drawn from the following five main sources: self-reported medical directory entries, although very few of these doctors reported detailed career histories prior to registering in Australia; applications for the 1942 temporary wartime license available in the National Archives of Australia; applications for registration with the Medical Board of Victoria from 1956 onwards; and the International Refugee Organisation (IRO) professional register developed to assist DPs being resettled from refugee camps in post-war Europe. Finally, a small number of these doctors had detailed obituaries written by their colleagues, which though less reliable, provided valuable detail of their lives prior to arriving in Australia. As you can see, a large number of these sources were created by government bodies in response to registering foreign practitioners. Therefore, somewhat ironically, 19 of the 26 least documented individuals are from the group of Italian medical graduates registered under the existing reciprocal arrangement.

The work histories detailed in Table 17 can be contrasted with Table 18 which provides a summary of the discoverable work patterns for this group's gap years. Reconstructing these was similarly challenging since these doctors rarely left records of the work they undertook in their unregistered years, particularly if it was unskilled. The data in this table have also primarily been drawn from the records listed above.[651] Therefore, these data are limited in revealing, for example, those who worked as informal (illegal) medical practitioners, since these men and women would not disclose that information to federal and state authorities. It was well-known that a number of doctors stretched the limits of allowable unregistered practise.[652] Occasionally, as in the case of German graduate Johannes Heinrich Becker in Adelaide in 1936, and Italian graduate Iszo Van der Hope in Melbourne in 1950, the work and employment of

649 Weaver, 'Pathways of Perseverance', 44-49, 53-60.

650 Weindling also noted this particular challenge to telling fuller histories for European refugee doctors. See: Weindling, 'Medical Refugees in Britain and the Wider World'.

651 NAA: 1928, 652/17/4; PROV: VPRS 16389/P1 unit 7; VPRS 16389/P2 unit 1; VPRS 16392/P1 unit 1.

652 See: Martin *The Migrant Presence,* 173; Rutland, *Take Heart Again.*

unregistered doctors resulted in formal prosecution.[653] In Van der Hope's case, he was a legally registered practitioner who was struck off for employing an unregistered Viennese doctor in a registered capacity.[654] The gap years of 12 of the 55 doctors who spent three or more months unregistered is untraceable, or cannot be reliably determined. It is likely that some of these doctors found sympathetic pharmacists willing to dispense drugs to their patients, and were able to practise illegally. However, this may be impossible to ever reliably recover.

Table 18 illustrates the notable differences between the interwar and post-war arrivals, particularly in the numbers of medical orderlies and technicians, which reflects the two-year labour contract under the DP scheme. The latter were typically placed in hospitals and/or the state health department, or in unrelated work altogether.[655] By comparison, the interwar arrivals were freer to seek out work through a variety of mechanisms, within the constraints of existing legislation.[656] The interwar arrivals pursued and utilised numerous avenues to seek out meaningful work. For example, the following advertisement appeared in *The Sydney Morning Herald* in December 1941:

> REFUGEE DOCTOR. 12 years' experience in Biochemistry, Pathology, Physiotherapy. Wants suitable employment.[657]

Earlier, in 1940, another wanted advertisement in Brisbane was placed by a group of medical students seeking a 'refugee doctor teacher'.[658] Austrian Kora Singer was free to follow a lead, and wrote to a fellow refugee psychiatrist Anita Muhl seeking work:

> Mr Penhalluriack, the Passport and Control Officer was kind enough to mention your name and to tell me you might be looking for a part-time assistant. Therefore, I beg to offer my services. I am a Viennese lady-doctor and passed my medical degree in Vienna in 1932. After that, I was working for four years as a resident medical officer in the General Hospital in Vienna where I spent almost a year on the Clinic for Psychiatry.[659]

Kora Singer eventually found part-time work in two Melbourne hospitals as a biochemist and physiotherapist, before successfully applying for a wartime license in 1942.[660]

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653 'Unregistered Doctor Fined', *The Argus*, 18 January 1936, 18; 'Doctor's Deregistration', *The Age*, 17 June 1950, 5.

654 Wolf, 'Regulating Unconventional Doctors', 331-356.

655 For a discussion, see: Kunz, *The Intruders,* 93-106.

656 NB: The federal *Aliens Registration Act* 1939 required all non-British subjects to notify federal authorities of a change of address. During the war, enemy aliens that were not interned were subject to varying restrictions of movement.

657 Advertising, *The Sydney Morning Herald*, 3 December 1941, 17.

658 Advertising, *The Telegraph*, 23 August 1940, 12.

659 State Library of Victoria: Letter from Kora Singer to Anita Muhl, 19 March 1939.

660 NAA: 1928, 652/17/4 Section 1.

Some practitioners reinvented themselves entirely in their gap years. For example, Friedrich Landauer (MD Strasburg 1914) stated he had been working as a 'chiropodist and health consultant' since his arrival in 1939.[661] There is no surviving record of Landauer's practice as a chiropodist in Melbourne, or membership of the local association. He did have over a decade of experience as a GP in Berlin and five years' hospital experience as an assistant to surgeon Professor Richard Müsham.[662] If Landauer did practice chiropody, nothing in his discoverable prior career reflects experience in this particular field of foot and ankle conditions, so it is likely that this was a reinvention forced by his inability to work openly as a medical practitioner in Victoria. Similarly, German Hans Heydemann, an orthopaedic surgeon, set up 'The Establishment for Modern Orthopaedics' in the working-class suburb of Fitzroy in Melbourne where, prevented from performing surgery, he ran a business making 'orthopaedic appliances' instead.[663]

The applications for the wartime license reveal that the most disadvantaged group were those whose former careers had been in private practice, particularly solely in general practice prior to arriving in Australia. These doctors were less likely to have sufficient experience in teaching, research, or laboratory-based diagnostic roles – three common forms of employment unregistered doctors found in Australia since they were outside the jurisdiction of the medical act. The experiences and pathway of Polish-born Isidore Huppert highlights this point. Huppert arrived in Australia in 1940 via London. He was by then a Czechoslovakian national having graduated from medical school in Prague in 1924. Huppert spent three years gaining postgraduate hospital experience in Prague and Vítkovice (in modern day Czech Republic), after which he entered general practice in 1927 in Novy Jičín, Moravia. Huppert moved to Moravia shortly before it merged to form Moravian-Silesian Land, one of five lands that comprised Czechoslovakia.[664] Huppert was 43-years-old when he arrived in Melbourne in July 1940 with his wife and children.[665] He worked five months as a first aid officer for the Victorian State Rivers and Water Supply Commission, and then spent six months as a factory hand at Australian Bobbins Pty Ltd. In 1942, he was among the first applicants for the national security license.

Another applicant, Manfred Süss, was born in Linz, Austria in 1910, and graduated from the University of Vienna in 1935. As a graduate, Süss's career demonstrates a typical trajectory – he gained a year of hospital experience in Vienna's general hospital, St Elisabeth's Hospital and finally at Rothschild Hospital. The Rothschild was the hospital for the *Israelitische Kultusgemeinde Wien* or the Orthodox Jewish community in Vienna. In 1936 Süss registered as

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661 Chiropody or podiatry was a growing para-medical field in Australia. For a discussion, see: Schnock, *Annotations to the History of Chiropody-podiatry in Victoria*.

662 Professor Richard Müsham today is remembered for performing some of the earliest and wholly experimental gender reassignment surgeries in Berlin in a bid to 'induce' heterosexuality. See: Volker Weiß, Transsexualität im Geschlechtsdispositiv", Part III of „Eine Weibliche Seele Im Männlichen Körper" – Archäologie Einer Metapher Als Kritik Der Medizinischen Konstruktion Der Transsexualität (PhD diss., Freien Universität Berlin, 2007).

663 Advertising, *The Argus*, 18 August 1956, 26; NAA: A1928 652/17/A Alien Doctors, Section 3, 91.

664 NB: The 1938 Munich Agreement resulted in parts of Moravia being annexed by Germany.

665 NAA: 1928, 652/17/4 Section 1.

a private practitioner and also undertook contract practice with the Union of Health Insurance Companies. He married in 1939 and left Vienna with his wife shortly afterwards. On arriving in Australia that same year, he worked briefly as a waiter. From January 1940 to the date he applied for a wartime license, he had been working as a carpet weaver for Baldwin and Grant Carpet Manufacturers, in the western industrial suburb of Footscray. Süss concluded his cover letter to the Commonwealth Alien Doctors Board by saying, 'may I be permitted to thank you for offering this opportunity, which may possibly help me to return to my own profession'.[666]

These doctors' gap years contrast sharply with those whose specialisations and past experience enabled them to find work in professional and semi-professional capacities in Australia. Several of these used the wartime scheme introduced in 1942 to formalise this status. For example, in his history of the Blood Bank, historian Matthew Klugman recounts how in 1938 German Rachel Jakobowicz

> was rescued from a life as a cosmetics demonstrator when Lucy Bryce [head of the Blood Bank] heard of this young woman of "great scientific ability" and sent a research assistant off on a search of Melbourne's cosmetic outlets.[667]

Jakobowicz had graduated in Berlin, and previously worked with celebrated doctor Karl Landsteiner who first described the ABO blood group system, before she was forced to flee Germany with her family.[668] Rachel Jakobowicz became the Victorian Blood Bank's first salaried serologist. Other such applicants included Hans Bettinger who was employed as the first Director of Pathology at the Royal Women's Hospital;[669] Jakobowicz's colleague, Margaret Karoly, was also working as a serology technician at the Blood Bank; Professor Arthur Schüller whose international reputation and prior Australian networks facilitated his appointment as a consultant radiologist at St Vincent's Hospital in Melbourne since his arrival in 1938;[670] and Alfred Gottschalk who had been employed as a researcher at the Walter and Eliza Hall Institute since 1939.[671]

The resettlement of several of these doctors had been facilitated by members of the Australian profession. For example, German-born Hans Bettinger was originally recruited in Hong Kong to teach pathology at the University of Sydney in 1938. However, he was shortly transferred to Melbourne (his biographer describes it as a 'belated summons'), where he became the first director of the new pathology unit at the Women's Hospital in April 1939.[672]

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666 NAA: A1928, 652/17/A, 275.

667 Klugman, *Blood Matters,* 76.

668 Ibid.; NAA: 1928, 652/17/4 Section 1.

669 McCalman, *Sex and Suffering*, 225-6.

670 "Your Lovely Free Country" Says Viennese Professor of Medicine, *Telegraph*, 11 August 1939, 11; and Schindler, 'Arthur Schüller: Pioneer of Neuroradiology'.

671 Fenner, 'Gottschalk, Alfred (1894–1973)'.

672 'Bettinger, Hans Frederick', entry in Biographical Compendium of Royal Women's Hospital, last accessed 29 October 2018, https://thewomens.r.worldssl.net/images/uploads/

His appointment at the Women's Hospital required some delicacy; the consulting and resident doctors had snubbed the two women bacteriologists appointed between 1937-38 on the grounds that they 'were not real doctors'.[673] Hans Bettinger met the criteria of being a medical man and could be legally appointed under Victorian law as long as he was not allowed to set-up a private practice.[674] Fritz Duras (MD Freiburg 1927) arrived in Melbourne in March 1937 to develop a one-year course designed to train school teachers on physical education. [675.] A landing permit for Fritz Duras was secured on the basis of his appointment at the University of Melbourne, following an interview in London.[676] Duras had been forced to flee Germany because his father was Jewish. Prior to this, he had established and run the first Institute of Sports Medicine at the University of Freiburg.[677]

Finally, Clara Geroe's migration to Melbourne had been facilitated by a group of Australian practitioners – doctors Reginald Ellery, Roy Winn, Paul Dane and (Sir) Charles Moses – all of whom wished to establish an institute for psychoanalysis.[678] Geroe (MD Pecs 1924) recalled that hers was the only successful application from a group of six Hungarian psychoanalysts seeking to migrate to either Australia or New Zealand.[679] Psychoanalysis along with psychology and physiotherapy were further examples of medical practice outside the purview of the medical act. Geroe originally applied for a wartime temporary license and withdrew on discovering she had to sit the equivalent of undergraduate final medical exams.[680] She later described her unregistered status as a 'fly in the ointment' as the newly established Melbourne Institute for Psychoanalysis flourished.[681] Geroe and Duras were registered in Victoria in 1956 when the medical act was amended to recognise qualifications from non-reciprocating countries.

Three men offer a sharp contrast to the pathways of Bettinger, Duras and Geroe. They arrived in Australia as captured 'enemy aliens' and were originally interned. Georg Rechelmann (MD Freiburg 1924) and Paul Schatzki (MD Frankfurt 1934) were both aboard the infamous *HMS Dunera*, which arrived in Australia overfull of overseas 'enemy aliens' captured in Britain and its territories and transported under appalling conditions. On arrival, Rechelmann was 42-years-old and Schatzki was 38. Rechelmann had ten years' experience as a GP in Germany when he left in 1938. Schatzki was on course to becoming a cardiologist after a career-change

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general-downloads/about-us/Biographical-Compendium-web.pdf.

673 McCalman, *Sex and Suffering*, 226.

674 PROV: VPRS 16389/P1 unit 5, Minutes, of meeting on 17 February 1939.

675 Kentish, 'Duras, Fritz (1896–1965)'.

676 Ibid.

677 Ibid.

678 Brett, 'Geroe, Clara Lazar (1900–1980)'.

679 Brett, 'The Reluctant Immigrant', 3.

680 NAA: 1928, 652/17/4 Section 1.

681 Brett, 'The Reluctant Immigrant', 3; Damousi, *Freud in the Antipodes*.

at age 26.[682] Both Schatzki and Rechelmann were transferred from Camp Hay (NSW) to Tatura Internment Camp in Victoria, where they took up the opportunity offered to internees in 1941 to be released if they enlisted in the specially-created 8th Employment Company in the Australian Imperial Forces.[683] Schatzki was subsequently employed as a medical orderly, while another former internee turned draftee, Robert Gruenfeld (MD Vienna 1923), was picking fruit. It is unclear what work Rechelmann undertook in the Labor company, however, it was most likely manual work.[684] All three of these doctors were successful licensees under the 1942 scheme, prior to which their freedom of movement was forcibly curtailed.

The majority of the continental medical migrants known to have arrived after the Second World War came under the DP scheme.[685] Therefore, the first two years of their Australian lives were determined by the work assigned to them by the federal Department of Labour and National Service.[686] As discussed in Chapter 6, the majority of these doctors were stripped of their professional status under prevailing *state* law, and were placed as medical orderlies and technicians in hospitals and state health departments. Some DP doctors avoided this by qualifying for positions in Papua New Guinea and Antarctica where they were granted full recognition as doctors, since these were federally-controlled territories.[687] The work of the Unregistered Doctors Association highlights the extent to which this group of unregistered doctors in Victoria were united by their negative experiences under the DP scheme and mobilised to agitate for legislative change.

The obituary for one of the DP doctors, Austra Elvira Grinfelds (MD Latvia 1937), offers a typical and poignant summary of the early DP experience, characterised by paramedical work and manual labour.

> The [Grinfelds] migrated to Australia in 1949. They were bonded to work determined by the government for two years, and lived first at Bonegilla migrant camp, then Rushworth, and finally Cowra migrant camp. At Cowra, Austra was technically Female Senior Medical Orderly, supervised by a medical practitioner … Austra too worked in a factory for a while, hated it and would never discuss this subsequently. She was happier working as a medical record clerk at the Queen Victoria Memorial Hospital.[688]

Austra Grinfeld passed the Victorian licensing examination on her first sitting in September 1959. Ten years after her arrival in Australia she restarted her medical career.

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682 Mathew, 'Obituary – Paul Schatzki'.

683 Loewald, 'The Eighth Australian Company'.

684 NAA: A1928, 652/17/A.

685 NB: It was estimated by the Department of Immigration that in 1950 there were approximately 256 male and 61 female DP doctors resident in Australia. See: NAA: A2169, 1947 Commonwealth Immigration Advisory Council.

686 Kunz, *Displaced Persons,* 139-144.

687 Kunz, *The Intruders,* 89-92.

688 Newton and Ellims, 'Obituary - Austra Elvira Grinfelds', 156.

It is important to reiterate here that not all post-war arrivals fell under the DP scheme. For example, the Department of Immigration implemented a number of initiatives to limit Jewish applicants for the DP scheme.[689] Jewish Holocaust survivors arrived under privately-funded schemes, commonly facilitated by the Australian Jewish Welfare Society.[690] Similarly, a number of landing permits were issued to Hungarians following the uprising against communism there in November 1956. Although these settlers were given assisted passage, they were not required to work under a labour contract.[691] A number of Hungarian doctors arrived in time to sit the newly-introduced licensing examinations in Victoria in 1957. These two groups of practitioners were freer than their counterparts under the DP scheme to seek out meaningful work.

In Victoria, a number of these doctors not bound by the DP scheme were sponsored by university and hospital research and teaching units, under the 1951 temporary license act.[692] By 1960, of the 34 temporary registrations granted, eight were for alien doctors already resident in Victoria.[693] The Victorian Blood Bank was a prominent sponsor in this capacity. Four of these licenses were for alien doctors working there: Adam Chojnowski, George Lakos, Herta Lowy, and Edith Phillips.[694] A few more of them, including Georg Berci (Department of Surgery, University of Melbourne) and Magda Gergely (Victorian Eye and Ear Hospital), were also able to take advantage of the temporary licensing scheme.

The patterns observed in this study suggests that the wider group of continental medical migrants holding unrecognised degrees were variably affected by the protectionist attitudes deployed by the medical profession. Those arriving as internees, under the DP scheme, and those who were formerly working in private practice were amongst the worst affected by the combination of prevailing federal and state legislation. Of course, the sampling strategy adopted for this study ensured a form of success since it was based on medical migrants legally registered in Victoria.[695] A limitation of this approach is that the resulting analysis might overstate the success of those migrants who came under the DP scheme, for example. Kunz suggests many DP doctors failed to regain this legal status.[696] Therefore, the representativeness of this group of 87 continental medical migrants is not totalising, that is, it does not reflect the career trajectories of those individuals whose circumstances, age and available support precluded them from ever practising medicine legally again.[697] However, I do not believe this limitation diminishes the importance of recovering the processes through which continental medical migrants went about re-establishing their professional status, as well as making a living

689 Rutland, 'Postwar Anti-Jewish Refugee Hysteria', 69-79.

690 Ibid.

691 Urmenyhazi, 'Hungarian Immigration in Australia'.

692 See: Introduction to Part III.

693 PROV: VPRS 16392/P1 Registry Book, T1098 - T2535.

694 Ibid.

695 See Appendix 2.

696 Kunz, *The Intruders,* see Figure 1, 114.

697 For a further discussion, see: Introduction.

in their new setting. Historian John Weaver described the migrations of European refugee doctors in reaching Australia as 'pathways of perseverance'.[698] This section reveals that this description can be extended to characterise their early resettlement too.

'…Wasted lives'?: European medical migrants in private practice, 1930-ca. 1966

This final section turns to the work of these doctors – in both their registered and unregistered capacities. The previous section highlighted how this group began occupying particular niches in medical and health work, even in their unregistered capacities. Some, including Clara Geroe and Fritz Duras, carved out successful and prominent careers on the fringes of medical work; as did others, notably as pathologists.[699] The remainder of this chapter describes the work of continental medical migrants in private practice, particularly as GPs. In exploring the processes through which these migrants went about re-establishing themselves and seeking meaningful work, their collective biography also revealed two ways in which their work comprised 'special types of labour' in the Victorian context.[700] This final section considers this work in two sub-sections organised thematically and chronologically – first, as interwar country practitioners, and as post-war doctors to 'New Australians'.

Interwar & wartime country practice

This sub-section focuses on the interwar and war years, and explores the relocation of a group of continental medical migrants to country towns. In this section I discuss how the BMA's lobby to minimise state control over internal medical affairs necessitated micro-level management of this issue by individual towns, and macro-level intervention by the federal government, which resulted in a number of continental medical migrants filling shortages of medical services in country areas.

As discussed in Chapters 2-3, the question of adequate medical manpower in country towns represented a contested area in medical politics. The BMA in Australia consistently challenged that there was shortage of country doctors.[701] In contrast, the state government, local councils, and invested third party organisations, notably the Victorian Bush Nursing Association and the Country Women's Association were in constant negotiation over the adequacy and availability of medical care in Victorian country towns and bush settings.[702] In the late interwar years, the latter groups argued this shortage was heightened because practitioners had abandoned several country towns (as local unemployment spiked) during the depths of the Great Depression, and despite improving economies, these vacancies remained unfilled.[703]

698 Weaver, 'Pathways of Perseverance', 42.

699 Klugman, *Blood Matters,* 69-86.

700 Simpson et al., 'Providing "Special Types of Labour"', 209.

701 See Chapter 5 for a discussion.

702 Thames, PhD diss., 360-4; Priestley, *Bush Nursing in Victoria: 1910-1985*.

703 Thame, PhD diss., 360-4; Pensabene, *Rise of the Victorian Medical Practitioner,* 90-91.

Unsurprisingly, rural communities and supporters of the bush nursing hospitals were the most vocal advocates of licensing continental medical migrants.[704]

The state chapter of the BMA, however, supported the evidence of free market economics in demonstrating shortages, countering that if a private practitioner left a country town, it was likely indicative that this town did not have sufficient wealth or population to induce a private practitioner to give up the more rewarding and intellectually stimulating environment offered in suburban Melbourne. In 1938, a BMA committee investigating the issue for Victoria concluded that a country practitioner should be certain of an income of £1000 per annum, a minimum of half of which should be guaranteed by the town.[705] Additionally, the BMA state branch concluded that a country town only needed a private practitioner if it had a population no smaller than 200 families, and there was no other doctor available within 30 miles (approximately 48km) from the centre of the town.[706]

Victorian government authorities could do little by way of easing these shortages in the interwar period as much of the distribution of medical manpower depended on the appetite of practitioners to relocate to the country. The majority of the profession repeatedly rebuffed any attempts at normalising salaried private practice under state-control, as discussed in Chapter 2. The state branch insisted that continental medical graduates if registered would not practise in country towns of their own free will.[707] Amidst fresh calls to license 'alien doctors' to practise in country towns in late 1939, a year after the medical act had been amended, the Victorian state branch of the BMA reported they had made 'extensive inquiries' and found only four of the 25 Italian graduates licensed were working in country towns.[708] The report declared that:

> Many of them admitted that their training in Europe, unlike that of students here, had not fitted them to cope with the responsibilities of medical practice in country districts remote from the assistance of specialists.[709]

This account was undoubtedly tailored to fit the BMA's policy of protection for local doctors, invoking the routinely deployed image of the heroic, hybrid Australian GP-specialist, trained to the 'highest standards'.[710]

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704 See, for example, 'Country Women Urge Refugee Doctors for Vacant Practices', *Weekly Times,* 1 July 1939, 48. For a full discussion, see Chapter 5.

705 A report prepared by a special subcommittee of the Council of Victorian Branch of the British Medical Association, 'Medical Services in Country Districts in Victoria', *MJA*, 1939, 42-44.

706 Ibid.

707 'Country Doctors', *The Age,* 25 August 1939, 8.

708 Ibid.

709 Ibid.

710 See for example, 'Australian Medicine', *The Armidale Express and New England General Advertiser*, 16 July 1930, 1; 'Famous Surgeon's Visit', *The Courier-Mail*, 18 February 1935, 18; 'Australian Doctors Earn High Reputation', *The Daily New*, (19 January 1937, 7. For a discussion, see: Gandevia, *History of General Practice in Australia*.

Figure 11 Map of continental medical migrants in country towns, 1930-1970. Legend: ^Population numbers are based on Census data, and is reported for the town (and not the greater shire).


NEW SOUTH WALES
SOUTH AUSTRALIA
VICTORIA.
TASMAN SEA
BASS STRAIT
Wentworth
Mildura
Euston
Hattah
Ouyen
Pinaroo
Kow Plains
From Adelaide
Swan Hill
Ultima
Sea Lake
Koondrook
Kerang
Deniliquin
Hopetoun
Rainbow
Nhill
Serviceton
Dimboola
Warracknabeal
Donald
Wycheproof
Charlton
Korong Vale
Pyramid Hill
Inglewood
Rupanyup
Murtoa
Goroke
Horsham
St Arnaud
Dunolly
Maryborough
Avoca
Stawell
Noradjuha
Naracoorte
Edenhope
Harrow
From Kingston
From Beachport
Ararat
Beaufort
Castlemaine
Clunes
Creswick
BENDIGO
Heathcote
Redesdale
Shelbourne
Daylesford
Kyneton
Kilmore
Macedon
BALLARAT
Sunbury
Smythesdale
Buninyong
Pitfield
Bacchus Marsh
Werribee
MELBOURNE
Wallan
Seymour
Alexandra
Yea
Mansfield
Jamieson
Whitfield
Euroa
Benalla
Rushworth
Shepparton
Echuca
Nathalia
Strathmerton
Cobram
Katamatite
Wahgunyah
Wangaratta
Rochester
Miriamo
Albury
Wodonga
Tallangatta
Corryong
Yackandandah
Beechworth
Jingellic
Milta Milta
Bright
Omeo
Deddick
Eden
Bendoc
Orbost
Bruthen
Bairnsdale
Woods Pt
Healesville
Warburton
Walhalla
Briagolong
Maffra
Sale
Moe
Warragul
Traralgon
Dandenong
Frankston
GEELONG
Queenscliff
Sorrento
Cape Schanck
Portland
Nelson
Mt Gambier
Branxholme
Hamilton
Casterton
Coleraine
Willaura
Mortlake
Camperdown
Terang
Koroit
Port Fairy
Warrnambool
C Bridgewater
Timboon
Beach Forest
Apollo Bay
Cape Otway
Colac
Forrest
Lorne
Otway
Loch
Korumburra
Foster
Outtrim
Port Albert
C Liptrap
Wilsons Promontory
Corner Inlet
Gippsland Lakes
C Everard
Cape Howe
Gabo I
Green Cape
Mallacoota Inlet
Murray River
Murrumbidgee
Loddon R
Avoca R
Wimmera R
Glenelg R
Hopkins R
Barwon R
Goulburn R
Ovens R
Kiewa R
Mitta Mitta R
Snowy R
Tambo R
Brodribb R
Bemm R
Cann R
Thurra R
Genoa R
Towamba R
Tooma R
Indi R
Murray R
Darling R
Lake Albacutya
L Hindmarsh
L Bael Bael
L Boga
L Tyrrell
L Buloke
L Charm
L Wallawalla
L Timboon
L Corangamite
L Colac
L Purrumbete
L Bullen Merri
L Gnotuk
L Terang
L Keilambete
L Elingamite
L Wellington
L Victoria
L Reeve
L Tyers
L Glenmaggie
L Wellington
Port Phillip
Western Port
French I
Phillip I
Cape Schanck
Mt Kosciusko
To Sydney
From Adelaide
From Kingston
From Beachport
Renmark
Albury
Ballarat
Bendigo
Geelong
Melbourne
Wentworth
Mildura
Swan Hill
Echuca
Shepparton
Wangaratta
Wodonga
Bairnsdale
Sale
Traralgon
Warragul
Moe
Morwell
Maffra
Dandenong
Frankston
Warrnambool
Portland
Hamilton
Ararat
Horsham
Stawell
Castlemaine
Kyneton
Seymour
Benalla
Euroa
Whitfield
Bright
Omeo
Bendoc
Orbost
Eden
Bruthen
Briagolong
Healesville
Warburton
Woods Pt
Jamieson
Alexandra
Yea
Mansfield
Deddick
Tallangatta
Corryong
Yackandandah
Beechworth
Milta Milta
Rushworth
Rochester
Miriamo
Pyramid Hill
Inglewood
Charlton
Korong Vale
Wycheproof
Kerang
Koondrook
Deniliquin
Strathmerton
Cobram
Katamatite
Wahgunyah
Nathalia
Echuca
Rainbow
Nhill
Serviceton
Dimboola
Warracknabeal
Donald
Hopetoun
Murtoa
Rupanyup
Goroke
Horsham
St Arnaud
Dunolly
Maryborough
Avoca
Stawell
Noradjuha
Naracoorte
Edenhope
Harrow
Ararat
Beaufort
Clunes
Creswick
Daylesford
Macedon
Sunbury
Smythesdale
Buninyong
Pitfield
Bacchus Marsh
Werribee
Wallan
Shelbourne
Heathcote
Redesdale
Castlemaine
Kilmore
Casterton
Coleraine
Willaura
Mortlake
Camperdown
Terang
Koroit
Port Fairy
Timboon
Beach Forest
Apollo Bay
Cape Otway
Colac
Forrest
Lorne
Otway
Loch
Korumburra
Foster
Outtrim
Port Albert
C Liptrap
Wilsons Promontory
Nelson
Mt Gambier
Branxholme
Hamilton
Portland
C Bridgewater
Queenscliff
Sorrento
Cape Schanck
Frankston
Dandenong
Maffra
Sale
Moe
Traralgon
Warragul
Briagolong
Bairnsdale
Bruthen
Orbost
Bendoc
Eden
Omeo
Deddick
Tallangatta
Corryong
Yackandandah
Beechworth
Milta Milta
Bright
Whitfield
Euroa
Benalla
Rushworth
Shepparton
Echuca
Nathalia
Strathmerton
Cobram
Katamatite
Wahgunyah
Wangaratta
Albury
Wodonga
Jingellic
Deniliquin
Koondrook
Kerang
Swan Hill
Ultima
Sea Lake
Hopetoun
Rainbow
Nhill
Serviceton
Dimboola
Warracknabeal
Donald
Wycheproof
Charlton
Korong Vale
Pyramid Hill
Inglewood
Rupanyup
Murtoa
Goroke
Horsham
St Arnaud
Dunolly
Maryborough
Avoca
Stawell
Noradjuha
Naracoorte
Edenhope
Harrow
Ararat
Beaufort
Clunes
Creswick
Daylesford
Macedon
Sunbury
Smythesdale
Buninyong
Pitfield
Bacchus Marsh
Werribee
Wallan
Shelbourne
Heathcote
Redesdale
Castlemaine
Kilmore
Seymour
Alexandra
Yea
Mansfield
Jamieson

Number on map	Country town	Year*	Population^		
Italian medical graduates			**1933**	**1947**	**1954**
1. Adrian, Joseph (anglicised from Adorjan)	Murrayville	1939, 1940	603	NA	452
2. Curzon, Maurice (Izrael Czerchowski)	Bendigo Base Hospital (RMO)	1939	NA	26,739	39, 928 (greater Bendigo)
	Yallourn Hospital (RMO)	1940	2520	4119	5580
3. Fox, Eric (Erich Fuchs)	Murrayville	1939	603	NA	452
	Broadford	Ca. 1944-54	1153	1101	1598
4. Deery, Arthur (Deutsch)	Quambatook	1940	503	424	534
	Toora	1941-48	463	698	764
	Healesville	1948-ca. 1970	2035	NA	3566
	Mooroolbark	1970-retirement	403	NA	NA
5. Kiel, Robert (Mojzen Zelman Kokiel)	Manangatang	1939	509	406	498
6. Marshall, Samuel (Marszalkowizc)	Mildura Base Hospital (RMO)	1938-9	6617	9527	NA
	Sale Hospital (RMO)	1939-40	4262	5119	6537
7. Martin, Martin (Margulius)	Beulah	1939-44	474	389	471
	Garfield	1944-52	397	530	652
8. Snow, Moses & Gisella (Schneebaum)	Natimuk	1939-41	793	NA	665
	Horsham	1941-ca. 43	5273	6388	7767
	Stawell	ca. 1943-45	4747	4840	5463
9. Van der Hope, Iszo Hartmayer	Beech Forest	Ca. 1930-32	419	NA	NA
10. Walker, Charles (Chaim Wachs)	Mitiamo	1939	333	NA	NA
11. Winthrope, Leopold (Weintraub)	Tongala	1941-2	NA	848	NA
12. Wise, Daniel (Wacjberg)	Murrayville	1939	603	NA	452
	Warrnambool Base Hospital (RMO)	1939	8906	9993	10,850
	Nyah West	1939	NA	829	NA
	Stawell	1945-49	4747	4840	5463
13. Szaja Baumatz^^	Ararat (State mental health hospital)	1947			

Number on map	Country town	Year*	Population^		
Wartime licensees			1933	1947	1954
14. Landaeur, Friedrich	Murrayville	1942-45	603	NA	452
15. Rechelmann, Georg	Moe	1942-45	898	2811	NA
	Lakes Entrance	1946-69	882	NA	1252
16. Schatzki, Paul	Ballarat Base Hospital	1942-45	35,638	38,140	39,945
	Warragul & West Gippsland Hospital		5809	6727	8605
17. Süss, Manfred	Tongala	1942-45	NA	848	NA
18. Zieher, Roman	Omeo	1944-ca. 1946	439	NA	45
	Walwa	ca. 1946	NA	208	NA
	Werrimull	1942-44	590	294	227

Source: State Library of Victoria. Postcard map of Victoria (out of copyright).

In fact, it appears that thirteen of the 25 Italian graduates – most of whom were not Italian-born – registered between 1930-40 who lived in Victoria, began their Australian careers in country towns (Figure 11).[711] Almost all of these positions were in private practice, often under an income guarantee generated from public fundraising.[712] Additionally, another five continental medical migrants licensed under the wartime scheme were deployed to country towns. The average period of service these doctors gave to country towns varied considerably (Figure 11). Polish-born, Italian graduate Eric Fox, for example, spent only three months in Murrayville before he left for South Australia. However, he later set up practice in the town of Broadford where he practised for almost a decade.[713] At the other end, Polish-born Daniel Wise started his medical career in Murrayville before taking up a resident medical officer vacancy at the base hospital in Warrnambool. Wise went on to spend almost a decade in country towns. Arthur Deery spent over thirty years in country towns.

The resettlement patterns of these medical migrants reflect those country towns that placed high value on having a resident doctor, but equally the difficulty they faced without one. The remote border town of Murrayville serves as an example of how these towns privileged their community needs over possible reservations of having an alien doctor. In early 1939, the resident doctor at Murrayville was due to leave after eleven years of practising there.[714] In March, a Viennese graduate Dr Schmidt proposed moving there if he could obtain a landing

711 See: Introduction to Part III for a discussion of anti-Semitic legislation in Poland which resulted in a large number of Polish Jews training in Italy.

712 See for example, 'Italian Doctor for Beulah', *The Age*, 18 August 1939, 14; 'Resident Doctor for Natimuk', *The Horsham Times*, 5 July 1938, 10.

713 Advertising, *The Argus* 30 October 1945, 18; 'Fine for Medical Scheme Fraud', *The Age,* 10 February 1954: 5.

714 'Medical Trust at Murrayville', *The Mail*, 4 November 1939, 7.

permit, and recognition of his degree. In response, the Murrayville hospital committee resolved to ask the state branch of the BMA and the secretary of the Bush Nursing Association, Sir James Barrett, 'to do their utmost to obtain an Australian resident doctor, or, if one were not available, to obtain a refugee doctor'.[715]

Schmidt's application could not be accepted because his Austrian qualifications were not recognised. However, in May, Polish-born Italian graduate Daniel Wise arrived in Murrayville. Wise worked six weeks there before he obtained a six-month hospital position in Warrnambool. His replacement was another Italian graduate, Joseph Adrian originally from Hungary. These latter two locum positions were funded for five months by the local bush hospital before the cost made the arrangement untenable. In November 1939, the newly formed Murrayville Medical Trust called a public meeting and appointed its third Italian graduate, Eric Fox, for three months with a guarantee of £750 per annum.[716] When Fox left for Adelaide, Joseph Adrian (accompanied by his wife) returned to Murrayville as a locum in early 1940.[717] In November that year, the Murrayville Medical Trust asked its local shire to send a deputation to the Victorian Premier to seek a grant to match the £600 raised locally to maintain a doctor on a more permanent basis.[718]

The outbreak of the Second World War exacerbated the problems facing country towns. By April 1941, the towns of Beulah, Murrayville and Werrimull were reporting problems recruiting a doctor despite having a state subsidy arrangement that would match locally-raised funds.[719] The available pool of recruits shrank as Australian doctors enlisted in the armed forces. In Werrimull, it was reported that 'hundreds of families were separated by 45 miles of bad roads from the nearest medical aid, and with insufficient petrol … to ensure' help could arrive in time.[720] By December that year, the bush hospitals in Quambatook, Werrimull, and Murrayville were among those that had closed due to lack of staff.[721] The latter two towns were amongst the first recipients of temporary wartime licensees in 1942, receiving Roman Zeeher and Friedrich Landaeur respectively.

The 1942 wartime licensing scheme is the most prominent example of the targeted use of medical migrants to fill gaps in country medical manpower. The Emergency Medical Service (discussed in Chapter 5) was set-up in each state to direct temporarily licensed refugee doctors to areas with an identified need. Figure 11 illustrates the traceable movement of five of the doctors registered under this scheme in Victoria who spent six or more months, but often longer, undertaking GP-work in country towns. The exact details of these appointments have been lost in the archival material preserved, however the assessment reports for the years 1942-44

715 Ibid.

716 'Country News', *The Argus*, 21 November, 1939, 4.

717 'Change of Doctors At Murraville', *The Mail*, 24 February 1940, 7.

718 'Murrayville Hospital', *Chronicle*, 14 November 1940, 13.

719 'Doctor Shortage,' *The Argus,* 29 April 1941, 7.

720 'No Doctor Available', *Recorder*, 22 August 1941, 3.

721 'Plight of Country Hospitals', *The Argus*, 31 December 1941, 4.

noted that two of these doctors were despatched to a number of country towns – via the British Medical Agency that placed locum tenens as well as acting as a broker for selling practices.[722]

The competence of continental medical migrants to adapt to the demands of Victorian country practice – which as discussed in Chapter 5 was the subject of considerable debate – as well to providing quality medical care is reflected in a number of ways. These doctors were subject to intense scrutiny, particularly by committee members of the BMA, as well as by the more xenophobic sections of the local communities they lived in. Any form of personal or professional (mis)conduct, or suggestion of it, was noticed, reported, and sometimes even newsworthy[723] For example, residents of Toora reported Arthur Deery to local authorities as a potential spy during the war.[724] The police report filed following an investigation into Deery's activities noted that:

> Deery [is] the centre of a hotbed of small town gossip … [involving] the religious question, professional etiquette and medical ability, coupled with a certain amount of suspicion, which at these times is directed towards all foreigners.[725]

Therefore, the lack of widespread public and professional criticism or formal deregistration suggests these doctors were no more or less competent or professional in comparison to their local colleagues, including in coping with the conditions of medical practice in Australia. The latter includes the particular demands of country practice.

Three Italian medical graduates – Zygmunt Epstein, Iszo van der Hope, and Eric Fox – were struck off the medical register, two temporarily. However, only one of those charges relating to Zygmunt Epstein's use of an unconventional surgical technique was due to suspected professional error.[726] Van der Hope was struck off for employing an unregistered doctor in a registered capacity; Eric Fox was charged after the war for defrauding the National Insurance Scheme.[727] Perhaps equally telling are the assessments of the BMA-run Emergency Medical Services who undertook annual assessments of the temporary wartime licensees. Max Süss and Friedrich Landauer were assessed as 'giving entirely satisfactory service' in Tongala and Murrayville respectively; Roman Zieher as having shown 'praiseworthy ability' in Werrimull; and Paul Schatzki as 'one of the best', including having given 'an excellent term of service' at the Ballarat hospital.[728].

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722 NAA: A1928 652/17/5 SECTION 2 and 3.

723 See, for example: W. McRae Russell, 'Refugee Doctors', *The Age*, 17 August 1939, 2; 'Doctors' Basic Wage – Aliens No Help', *The Argus*, 25 August 1939, 2; W. Maxwell, 'The Refugee Doctors', *MJA,* 1939, 919; 'REFUGEE DOCTORS PRAISED', *The Argus*, 30 December 1942, 6.

724 NAA: A6119, 5461 DEERY.

725 Ibid.

726 Wolf, 'Regulating Unconventional Doctors'.

727 Ibid; and PROV: VPRS 16389/ P1 unit 7.

728 NAA: A1928, 652/17/4 SECTION 2. Notably, of the wartime licensees, it was two (of five) women placed in Melbourne hospitals whose work was considered unsatisfactory – Romanian-

It is apparent that the status of doctors in these communities was high. Undoubtedly it is through the work medical migrants undertook, including daily and intimate contact with their patients, that this status was built.[729] This is particularly exemplified in the biographies of those doctors who spent longer periods in country towns. For example, Roman Zieher, who was placed in Omeo under the wartime scheme, is recorded to have 'soon warmed the hearts and opened the homes of the people of Omeo'.[730] His obituary goes on to note that Zieher maintained a close contact with Omeo's community long after he moved back to metropolitan Melbourne.[731] The Wises spent close to four years in the old mining town, Stawell. In 1949, they left for Melbourne in part so Daniel Wise could pursue postgraduate medical education. The Mayor of Stawell hosted a civic reception in their honour that was attended by nearly one hundred residents.[732] The *Stawell News* reported the occasion with a heading titled, 'Popular Citizens Farewelled'.[733]

Hungarian Arthur Deery divorced his first wife, Perla, and moved from one country town, Toora, to another, Healesville, in 1948. In 1961, *The Age* reported that the Healesville District Hospital had removed Arthur Deery from the list of honorary medical staff which meant he could no longer treat public patients there.[734] All the local doctors – as was common practice – were honorary medical staff at the district hospital. However, Deery was the only one dismissed without reason (although the newspaper alleged that he 'was ousted for slander' since Deery had condemned alleged 'illegal operations' being performed at the Hospital).[735] The residents of Healesville were reported to be 'split … into two camps'.[736] Deery's supporters – mainly mothers and pensioners – organised two separate protest marches through Healesville's main street. Their placards insisted, 'reinstate our doctor' (Figure 12).[737] Over 500 Healesville residents also signed a petition against Deery's dismissal.[738] Their actions were successful in instigating a public inquiry into the matter. By December 1962, the public inquiry exposed a web of corruption surrounding the hospital's governance, and no further grounds to prevent Deery's reinstatement.[739] Arthur Deery continued to practise in Healesville for almost a decade

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born, Swiss graduate Freda Pose (owing to 'temperamental difficulties') and German born and trained Charlotte Wolffe (because she was 'slow and has a lot to learn', and who was also heavily pregnant at the time). both women had their temporary licenses revoked, but both gained full registration after 1956.

729 McCalman, *Sex and Suffering.*

730 Webb, 'Obituary – Roman Zeeher', 260.

731 Ibid.

732 'Popular Citizens Farewelled', *Stawell News*, 9 February 1949.

733 Ibid.

734 'Removal of Doctor From List Causes Stir – Healesville Dispute', *The Age,* 27 January 1961, 3.

735 Ibid.; NAA: A6119, 5461 DEERY.

736 Ibid.

737 'Fifty Mothers March on Hospital', *The Sun*, 28 January 1961, 5.

738 '500 Vote: "Put Doctor Back", *The Sun,* 7 February 1961.

739 'Hospital Inquiry Reveals Sinister Activity of NCC', *Tribune,* 5 December 1962. Copy

afterwards. The mobilisation of Healesville residents highlights the value they placed in their doctor, despite his divisive public persona which included his foreignness, and his suspected ties to the Communist Party of Australia.[740]

To conclude, although not numerically significant, the collective work of these continental medical migrants deserves recovery in Australian medical history because of what the pattern revealed in their collective biography symbolises. First, across Australian states, continental medical migrants re-established their professional lives in country towns, or were deployed to do so.[741] In doing so, these continental medical migrants were the vanguard to the post-war relocation of British/Irish medical migrants to country towns, as discussed in Chapter 3. Thus, in service to country Victorians – the 'special type of labour' undertaken by continental medical migrants is apparent.

Figure 12 One mile march to protest Arthur Deery's dismissal from the Healesville Hospital.



FIFTY MOTHERS MARCH ON HOSPITAL

"Reinstate our doctor"

IN blistering, near-century heat yesterday, 50 mothers and mothers-to-be marched through Healesville, protesting at the local hospital's dismissal of one of its honorary doctors.

The dismissed doctor is Dr Arthur Deery, 53, who has lived in the district.

Prams were there, too

Source: NAA: A6119, 5461 DEERY. Photostat copy of *The Sun,* 28 January 1961.

preserved in: NAA: A6119, 5461 DEERY.

740 Ibid.

741 For NSW, see: Rutland, *Take Heart Again*. For WA, see: Winterton, 'Alien Doctors'.

Doctors for 'New Australians'[742]

This final sub-section focuses on a second trend revealed in the post-war work of continental medical migrants: as migrant doctors for migrant patients. As the interwar registrants became more firmly established, a drift towards central Melbourne is seen. This drift, together with the post-war arrival of more medical migrants, and the subsequent liberalisation of the state medical act, resulted in the largest number of continental medical migrants practising in twentieth-century Victoria. In this section, I describe the development of this trend, beginning in the interwar years, of continental medical migrants providing official and unofficial medical services to their fellow migrants. This is most notable in Melbourne suburbs settled by large numbers of non-English speaking post-war migrants (or 'New Australians'). The role medical migrants played doctoring within their own communities has been under-explored, including in the mainly social scientific literature documenting post-war immigrant health outcomes and ethnic health policy. As I will demonstrate, the patterns seen in the career paths of this group of continental medical migrants reveals clustering according to shared cultural bases and developing migrant networks. Political histories of the state medical board and profession's repeated deployment of protectionist measures highlight the general loss of medical labour to Australian states and territories. This observed pattern of migrant doctors servicing migrant patients, I suggest, is a poignant reminder that this protectionism also deprived meaningful health care services to some of Australia's newest and more vulnerable communities – their fellow migrants.[743]

Australia's migrant intake of Italians in the 1920s and Jewish refugees in the 1930s represent a comparatively small number compared to the post-war migration programme.[744] An estimated 1.6 million migrants arrived in Australia between 1945-60 under free and assisted passage schemes. This included over 170,000 DPs recruited from IRO camps in Europe under a two-year labour contract; and another half a million from other European (non-English speaking) countries, notably Germany, Greece, Hungary, Italy and Malta.[745] Writing in 1990, medical practitioners and health administrators Pam Garrett and Vivian Lin observed that 'it was the newly-arrived ethnic groups, much in need of primary health care, who suffered most because of the non-recognition of overseas health and medical qualifications'.[746] The authors argue that the non-British migrants were invisible in state and federal health policy beyond their

742 NB: 'New Australians' was a term coined by Arthur Calwell to describe non-British post-war settlers.

743 Indigenous Australians are unequivocally the most vulnerable communities; they have been the victims of systematic and deliberate racial marginalisation since white settlement of Australia in 1788, that has led to the observed gaps in their contemporary health outcomes. For further discussion, see: Special Issue: Aboriginal Health and History*, Health & History* (2007).

744 See Introduction to Part III.

745 Jupp, *From White Australia to Woomera*. See Introduction to Part III for further discussion of Australia's non-British migrant intake.

746 Garrett and Lin, 'Ethnic Health Policy and Service Development', 339-380.

initial health screening during the migration selection process, the latter they argue created the 'illusory sense of universal health' of incoming migrants.[747]

One overarching theme in much of the literature on migrant health and migrant health policy in the early post-war decades is that migrant communities were denied doctors who shared their language and culture, and some migrants were 'exploited' by unregistered and sometimes unqualified practitioners who took advantage of patients 'desperate for medical advice they could understand'.[748] Monolingualism and the lack of cultural awareness formed a core, recurring problem for English-speaking doctors faced with migrant patients – not least in general practice and psychiatric settings. It is worth noting that this historiography draws heavily on the work of Egon Kunz.[749] Citing Kunz's *The Intruders,* Pam Garrett and Vivian Lin, for example, connect the poor experiences of groups of migrants needing medical care to the restrictive actions of the profession (and particularly the BMA in Australia), which they argue had 'a profound and enduring effect on the ethnic composition' of Australia's medical workforce.[750]

The lack of culturally appropriate health care, particularly the basic need to be understood, for non-English speaking migrants also reflects the impact of Australia's agenda of assimilation which the federal government aggressively pursued. Migrants faced enormous pressure to learn English.[751] Although large numbers of migrants attempted to do so, a significant gap in health care access existed for several decades before it surfaced at a policy-making level. The address by Minister for Health in Victoria, Tom Roper, to a committee on medical manpower as late as 1983 highlights this. Minister Roper outlined plans to

> address a small, but none-the-less significant, problem and that is to ensure that we do have medical practitioners who are able to communicate with our migrant communities. We have not always had appropriately qualified people from the migrant communities itself, nor have we had medical practitioners who are able to communicate with some of our major non-English language groups … a desire to ensure that in the psychiatric areas, and I name one where language is crucial, we do have skills that we traditionally do not have in this State.[752]

The interim, documented efforts by the local profession to respond to the complications of the language barriers between them and their migrant patients ranges from misguided to

747 Ibid., 341.

748 Martin, *The Migrant Presence,* 173.

749 Ibid.

750 Garret and Lin, 342.

751 Haebich, *Assimilation in Australia 1950-1970*.

752 Address by Minister Tom Roper, in Victorian Medical Postgraduate Federation, *Medical Manpower and Training in Victoria*, Proceedings of a seminar held on 16th April, 1983 (VMPF, 1983), 9.

patchy.[753] Examples of the latter include the Commonwealth Bank's Migrant Information Service which collaborated with the BMA in Australia in 1960 to produce a booklet of common questions in multiple languages as a diagnostic aid for GPs.[754] A second aid for maternity ward nursing staff was produced by request from several hospitals.[755] The Women's Hospital in Melbourne whose admissions doubled between 1945-55 employed their first interpreter in 1955 in response to the large volumes of migrant women being admitted.[756] As Janet McCalman's history of the Women's Hospital illustrates, the experiences of migrants in large institutions were often of isolation, incomprehension and occasionally outright callousness at the hands of medical and nursing staff.[757] The first national effort to address the problems encountered by non-English speaking migrants came in 1973 with the establishment of a free Telephone Interpreter Service offering twenty-four hour services in 20 languages.[758]

The insufficiency of multilingual and culturally sensitive medical care available to migrants in the early post-war decades is also not in dispute. Nor do I contest the impact of the BMA's 20-year campaign in Australia to restrict the migration and registration of continental medical migrants on the ethnic diversity of Australia's interwar and post-war medical workforce. The medical profession was clearly ill-equipped to deal with the post-war influx of non-English speaking migrants.[759] However, the foci of the existing literature, some of which I have briefly summarised above, has obscured the work already undertaken by resident groups of multilingual continental European medical graduates both in their unregistered and registered capacities, beginning in the interwar period.

Table 16 summarises the first and last known primary occupation for the 87 European medical migrants registered in Victoria, demonstrating that a large proportion of these doctors, like their local counterparts, were in private practice (50 in total). By 1946, there were 48 continental medical migrants legally practising in Victoria (not counting those who retrained in the UK, or those who retrained at the University of Melbourne). A decade later, Victorian state law had been amended to introduce a standard licensing examination, and between 1956-60, a further 39 doctors were registered. In this section, I will demonstrate how many of these doctors, by the early post-war period responded to or were already practising as GPs and GP-specialists in known migrant-dominated suburbs, or with strong professional links to their respective migrant communities. In doing so, I argue that already resident continental medical migrants in Victoria (and possibly Australia) quietly filled an important medical role, that of doctoring 'New Australians'.

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753 Martin recorded 118 articles published between 1956-77 on migrant health, see: Martin, *The Migrant Presence,* 150.

754 'A Hospital Breaks the Word Barrier', *The Australian Women's Weekly*, 29 November 1961, 15.

755 Ibid.

756 McCalman, *Sex and Suffering*, 255-70.

757 Ibid.

758 'Telephone aid for migrants', *The Canberra Times*, 19 February 1973, 7.

759 These campaigns are discussed in Chapters 5 and 6.

The trend for continental medical migrants to service migrant communities – including by practising in migrant-dominated suburbs – began with the arrival of large numbers of Italians from the late 1920s. On a national-level, this is illustrated by the career of one of the few Italian medical graduates who was also Italian by birth, Pietro Bianchi. Bianchi was registered in Victoria in 1930, however, by 1933, Bianchi had moved to Innisfail, in northern Queensland.[760] The community of Italians and their predominance in the Queensland sugar cane industry as canecutters is well-documented.[761] Between 1921-33, almost seven thousand Italians settled in Queensland, where they worked in cane-cutting gangs mostly in Innisfail, Ingham, Ayr and Cairns.[762] Another Italian doctor, Giovanni Merlino also lived in Innisfail in the early 1930s; and in the 1940s Bianchi was one of five Italian doctors there.[763] This was emblematic of a process that is observable in Victoria, especially in Melbourne as I will outline below.

Bianchi's peer and fellow Italian Santoro Soccorso (MD Genoa 1926) was registered on the same day as him. Soccorso remained in Melbourne, renting professional rooms at 110 Collins street in Melbourne. During a time when house calls by doctors were still common,[764] Soccorso's 1934/35 tax return noted that his "practice consists of mainly Italians . . . scattered in all suburbs of Melbourne . . . , [his] average monthly mileage is 1200".[765] The following financial year Soccorso declared a gross income of £761, which was on par with estimated average salaries for general practitioners at the time.[766] His son George Soccorso, also a medical practitioner, remembers that his father immersed himself in the Australian-based Italian community, was president of the Dante Alighieri Society from 1931-59, and enjoyed a high status among the predominantly working-class group. George also recalls that his father 'spent a great deal of time translating for patients and accompanying them to specialists', and that it 'was unusual for him to complete a home call in under an hour'.[767]

The Italian-speaking doctors capitalised on their appeal to their fellow countrymen. Giovanni Merlino, for example, moved from Innisfail to Melbourne. In May 1934, Merlino rather cleverly circumvented the advertising restrictions on registered practitioners publicly soliciting patients. The Italian language newspaper *Il Giornale Italiano* published an 'article' informing their readers that Merlino 'ha deciso di fermarsi definitivamente a Melbourne, ove intende esercitare la sua professione' [has decided to permanently settle and practise his profession in Melbourne].[768] The article notes that his new practice was at Harley House on 71

760 'Innisfail Inquest', *Cairns Post*, 4 August 1933, 11.

761 Richards, *Destination Austrailia,* 86-108.

762 Evans, *A History of Queensland*, 175-77.

763 Choat, et al., (eds.), *Italian pioneers in the Innisfail District.*

764 NB: in Australian states, the practise of doctors paying house calls remained common until the early post-war decades. See: AMA Study Group on Medical Planning, *General Practice and Its Future*, 21-29.

765 Soccorso, 'Across Two Continents and a Century', 600-602.

766 Ibid. See also, Pensabene, *Rise of the Victorian Practitioner,* 82-98.

767 Ibid

768 'Il Dott. Merlino Si Stabilisce a Melbourne', *Il Giornale Italiano*, 30 May 1934, 6.

Collins Street, where his 'connazionali' [fellow countrymen] can find him. Merlino had also provided the newspaper additional background on his experience in 'nelle migliori cliniche italiane' [the best Italian clinics], and that in addition to general practice, he specialises in venereal diseases, and obstetrics and gynaecology.

The interwar migrant and refugee arrivals established small cultural bases in metropolitan Melbourne, along shared linguistic, religious and cultural grounds. For example, one Jewish interwar arrival recalled that:

> Carlton is full of Jews, the Kadimah is round the corner. There's Yiddish theatre with some of the best actors from Warsaw, a Yiddish school, a secular Hebrew school, *shules*, *cheders*. There are Communists and Zionists of all political shades fighting each other and here we can finally be full Bundists …[769]

Along with Carlton, the cities of St Kilda and Caulfield, followed by Prahran, Moorabbin and Kew – all of which were already highly-populated by established Australian Jewry – were boosted by European Jewish settlement.[770] Other existing organisations, for example, the Bialystock Lending Society run by early Polish Jewish migrants was recast as the Bialystock Centre, a *landsmanschaft* or a base of support and mutual aid for fellow migrants.[771] The establishment of migrant-led organisations intensified in the post-war years.[772] The pre-and post-war migrants largely defied the political and social pressures to assimilate, although many invested in learning English.[773]

Large numbers of post-war settlers who came under assisted passage schemes, including those on the DP scheme, were housed temporarily in migrant reception centres.[774] One of the larger centres in regional Victoria was Bonegilla Migrant Reception Centre, estimated to have processed and housed over 300,000 migrants between 1946-71.[775] Migrant hostels were also established in Victorian suburbs including Altona, Broadmeadows, Nunawading and Preston.[776] These suburbs, together with many inner North and Western suburbs ended up being the new homes for a high proportion of 'New Australians' in the early post-war decades.

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769 Meadows, 'Pesach in My Parents' Home', 44.

770 Rutland, *Edge of the Diaspora*, 146-52.

771 Wajsenberg, '*Landsmanschaft* Postscript: The Bialystoker Centre in Melbourne, Australia', 57-78.

772 Ibid.

773 Clyne and Kipp, 'Language Concentrations in Metropolitan Areas', 50-60.

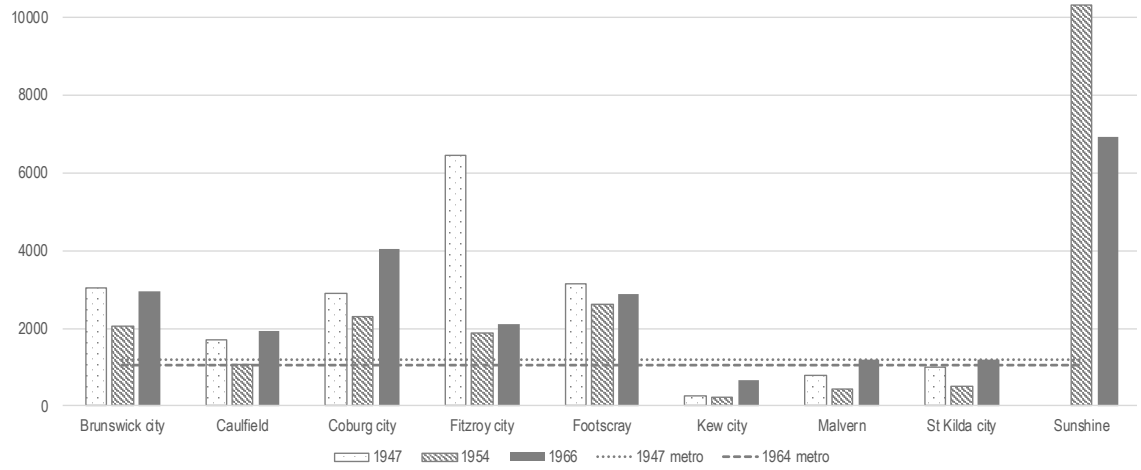
774 The time spent in these migrant reception centres varied considerably. For a discussion, see: Dellios, *Histories of Controversy: The Bonegilla Migrant Centre;* and Sluga, *Bonegilla, 'A Place of No Hope'*.

775 Ibid.

776 Stimson, 'Patterns of Immigrant Settlement in Melbourne, 1947-66', 114-126.

The patterns of settlement in these suburbs corresponded to distinct ethnic groups.[777] The Polish community, for example, settled along the south-eastern suburbs, particularly in Caulfield, Bentleigh, Carnegie and Gardenvale.[778] Whereas Italians and former Yugoslav nationals settled in inner northern and western suburbs including Brunswick, Collingwood, Fitzroy, Footscray, Keilor and Whittlesea.[779] The suburb of Sunshine and its nearby suburbs were heavily populated by former DPs from the Baltic region – Estonia, Latvia and Lithuania.[780] By 1971, the percentage of migrants alone, excluding their children, in some of these inner Melbourne suburbs accounted for almost half the total population. For example, Fitzroy had an overseas-born population of 50.6%, Collingwood 45.1%, Richmond 42.2%, Brunswick 43.3%, Northcote 35.0% and Prahran 34.5%.[781]

Figure 13 Summary of doctor:population ratios for 1947, 1954 and 1966.



Source: Census data, 1947-64, Medical Directories of Australia, and Scotton, 'Medical Manpower in Australia'.

These suburbs – many of which were semi-industrial or industrial, lacked essential services, and were often developed by owner-builders – consistently reported low numbers of doctors compared to the average metropolitan ratios.[782] Figure 13 provides a snapshot of the vastly different doctor:population ratios for growing post-war suburbs, including Brunswick city and Footscray compared to the more affluent suburbs of Malvern and Kew for the years 1947, 1954 and 1966. The differential distribution within metropolitan Melbourne continued to be

777 In 1981, these suburbs were estimated to have over 30% of its population as non-English speaking, this included later immigrants from Lebanon, Malta, Turkey and Vietnam. See, Jock Collins, *Migrant Hands,* 38-41.

778 Stimson, 'Patterns of Immigrant Settlement in Melbourne', 114-126.

779 Collins, *Migrant Hands,* 41.

780 Ford, *The Making of Multicultural Sunshine 1939-1975*.

781 Burnley, 'Southern European Populations in the Residential Structure of Melbourne, 1947-71', see Table III.

782 Burnley, "Immigration: the Postwar Transformation of Sydney and Melbourne", 119-34; Morrow, 'Ardeer: A Postwar Ukranian Suburban Village', 390-403.

proportional to affluence rather than community need.[783] As historian Tony Pensabene observed, 'the choice of practice affected the [doctor's] quality of life … he hardly desired to house, clothe and educate his children in a working-class community'.[784] In 1946 the *Australian Blue Book* described Malvern as where 'the homes of many of Melbourne's leading citizens are located', which compares starkly with Brunswick described as 'very closely populated … with an important Technical School … and many industries… a considerable number of them providing for brick-making and pottery'.[785] Therefore, the trend illustrated in Figure 14 for migrant private practitioners to either rent rooms in centrally-accessible consulting rooms, or to purchase practices in immigrant-heavy suburban practices is noteworthy.

The importance of growing, clustered migrant communities in understanding these patterns cannot be underestimated. Continental medical migrants varyingly shared in common with their fellow migrants experiences of displacement, forced migration, persecution, survival, survival guilt, shared nationalism for their home country and shared experiences of resettlement. For example, the Wises moved from Stawell in part for Daniel Wise to pursue a specialist interest, but also to provide a Jewish education for his children.[786] Wise purchased a practise in Sunshine (Figure 14), and was remembered by some of his former migrant patients, many of whom could not afford their visits to the doctors, for returning their payment under a pillow or to one of the children during a house call.[787] Figure 14 marks all the practice locations of known private practitioners (GPs and GP-specialists) in 1957 and 1966, showing their increased presence in migrant suburbs. It is noteworthy that over half of the practitioners who rented rooms on Collins Street commonly also practised out of a second location, typically in the south-eastern suburbs. For example, the Polish medical couple Irwin and Sura Weyman rented professional rooms at 111 Collins Street, as well as running a practice out of 274 Orrong Road in Caulfield for much of the 1950s and 1960s.

The patterns of practice for the registered doctors was supplemented by the work of these medical migrants in their unregistered capacity. Many DP doctors bound by the two-year labour contract were placed as medical orderlies and low-level technicians in migrant camps, hospitals and within the state Department of Health between 1947-51. For example, Latvian Austra Grinfelds worked as a medical orderly at the centre in Cowra, where

> in practice she was a doctor to non-English speaking migrants from Eastern Europe, using the knowledge of Slavic languages she had acquired in refugee camps …[788]

Grinfeld's experience would have mirrored that of Izidorius Kaunas (MD Lithuania 1930) who was placed as a medical orderly at the migrant hostel in Maribyrnong in 1949 before being

783 Pensabene, *Rise of the Victorian Medical Practitioner,* 78-81.

784 Ibid, 81.

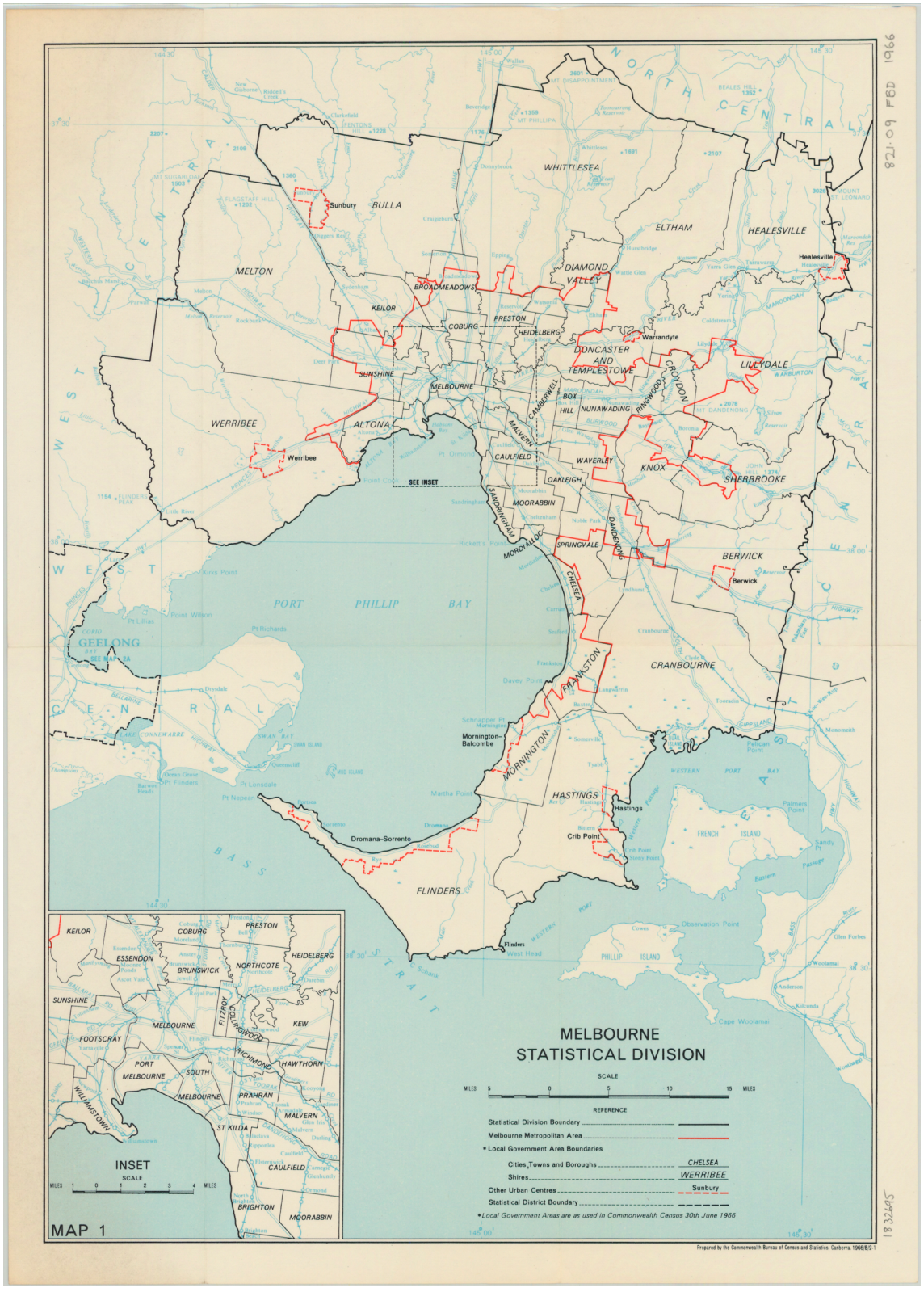
785 Beckett (ed.), *The Australian Blue Book*, 2nd edition.

786 Colin Wise, interview with the author, 5 July 2017.

787 Ibid.

788 Newton and Ellims, 'Obituary – Austra Grinfelds'.

Figure 14 Map of Metropolitan Melbourne ca. 1964, with table describing the distribution of registered continental medical graduates in private practice, 1957 (n=28) and 1966 (n=42). *Marks medical migrant practicising in more than one location. ^Marks Peter MacCallum clinic in Melbourne. **Marks population quoted for 1954 and 1961 inter Census collections.



Legend	1957		1966		
Melbourne suburb	**Popu-lation****	**No. of cont. med migrants (n=28)**	**Popu-lation****	**No. of cont. med migrants (n=42)**	**Notes on migrant communities**
CBD (city centre) and East Melbourne	93, 172	3 + 10*	76, 002	1 + 12* + 2^	By 1971, % overseas-born population is 34.8%
Altona/Newport	-	1	25,020	1	Altona was a destination for many post-war European migrants, and temporary and hostel accommodation was provided there. Stimson found between 50-100% increase in European-born population in Altona between 1947-61.
Brighton/ Gardenvale	-	1	41,302	-	-
Brunswick/ Brunswick West	53, 630	-	53, 093	2	By 1971, 43.3% of Brunswick's population is overseas-born.
Camberwell	90, 397	-	99, 353	1 + 1*	-
Carlton		1 + 1*		1	Emigrants found employment and affordable housing there, and two main groups were Jews and Italians. By 1919 increasing numbers of Jews in Carlton brought about a synagogue in Pitt Street. Jewish population peak in south Carlton during the inter-war years.
Caulfield/ Caulfield North	75,217	1 + 4*	76,119	2 + 3*	Jewish community, including synagogue and kidergarten.
Coburg	62, 077	-	68, 557	1*	By 1981, 12.6% of Coburg's population were Italian-born, 4.2% (Greek), 1.3% (Yugoslav) and 1% Maltese.
Essendon/ Pascoe Vale/ Ascot Vale	57, 873	-	58, 258	3	-
Fitzroy	30,312	1	27,277	-	Between 1947-91 Fitzroy's population fell by 44%. The non-Australian born component, however, moved from 42% in 1947, to a high of 49% in 1966. By 1954 about 12% of Fitzroy's population was Italian-born; in 1966 33% were Italian or Greek-born.
Footscray/ Yarraville	57,915	4+ 1*	58, 832	3	Footscray's manufacturing industries and relatively low house prices attracted migrants, English and European after the war. In 1976 residents born in Yugoslavia, Greece or Italy were 22.5% of Footscray's population. In 1986 they were about 17%.
Hawthorn	37,188	1 + 1*	36, 728	2	-
Heidelberg	60,007	1	86,430	-	-
Kew	-	1	33, 341	3 + 1*	-
Malvern/ Burnley	46,910	1*	50,051	3*	-

Legend	1957		1966		
Melbourne suburb	**Popu-lation****	**No. of cont. med migrants (n=28)**	**Popu-lation****	**No. of cont. med migrants (n=42)**	**Notes on migrant communities**
North Melbourne	-	1	-	1	By the 1980s, because of its proximity to central Melbourne, North Melbourne was affected relatively early in the gentrification process as younger, usually better-off people displaced the postwar migrants.
Oakleigh/ Chadstone/ Murrumbeena	24,305	2	52,769	2	Greek and Turkish families in the post-war years
Parkville	-	1	-	-	By the late 1950s, Camp Pell slums were resettled into commmission estates at Heidelberg West, Doveton, Preston, Maidstone and Broadmeadows.
Prahran/ Armadale	54,409	2	54,658	1*	Prahran became home to migrants from Britain and Europe. The two largest groups were Greeks and Britons and in 1966, 16,000 of Prahran's 55,000 residents were born overseas. By 1971, 34.5% of Prahran's population is overseas-born.
Preston/ Thornbury/ Reservoir	63, 868	2	84,146	3	In 1966 11% of Preston municipality's population was in Commission dwellings. In 1986 about 30% of the residents of Preston municipality were born overseas, slightly more than for metropolitan Melbourne.
Sandringham	-	1	37,701	-	-
St Kilda/Elwood	53,301	1*	58,138	1 + 1*	The community has a landmark synagogue at the corner of St Kilda and Toorak Roads. By 1971, 43.2% of St Kilda's population is overseas-born.
Sunshine	41,332	-	69,264	2	During the 1920s substantial numbers of British and Maltese migrants settled in Sunshine.. Housing was built by cooperatives, the Housing Commission and building societies, and prefabricated units came with British migrants under the 'Operation Snail' (that is, carry your own house) scheme.
Toorak	-	1*	-	1+ 1*	-

Source: Image © State Library of Victoria. Data drawn from Monash University and University of Queensland project, Victorian Places 2015, https://www.victorianplaces.com.au/; Burnley, 'Immigrant Absorption in Australian Cities', Tables 2 and 3; and Stimson, 'Patterns of Immigrant Settlement', Figures 1-4.

transferred to the Department of Health as an X-ray technician; and Klavs Kepars (MD Latvia 1930) who worked as a medical orderly at the immigration reception centre in Bathurst (NSW).

The work of these unregistered doctors placed as orderlies, but who often were tasked to work in a full professional capacity, highlights the lack of social justice for these men and women. However, this should not overwrite the early services they were able to render their fellow migrants, particularly in the government-run reception centres. Several unregistered and registered doctors not bound by the labour contract worked as psychologists, psychiatrists, psychoanalysts or offered counselling services to their fellow migrants. Former German national Charlotte Wells and Russian-born Jacob Mackiewicz both worked as psychologists in Melbourne before their official registration in 1956. In an interview following his registration, Russian-born former neuropathologist Jacob Mackiewicz (MD Moscow 1911) – who spoke five languages fluently – noted that he 'had filled in his three years in Australia by assisting with the psychological problems of European migrants'.[789] It may never be possible to recover the full extent to which registered and unregistered continental medical migrants provided their fellow migrants with primary health care services. This study suggests they played a vital part.

Writing in November 1953, the president of the Unregistered Doctors Association in Victoria argued that the validity of their lobby for registration was reflected 'in a patient who insists on seeing a European doctor or dentist. A physician who is not registered, not allowed to prescribe nor certify, yet to him the sufferer is not an account'.[790] One of the long-standing objections of the gatekeepers of the medical profession against the registration of continental European doctors included their lack of working knowledge of English. The arrival of hundreds of thousands of 'New Australians' who spoke no English created a new legitimacy for continental medical migrants representing the numerous ethnic and language groups that formed Australia's post-war demographic.[791]

Latvian-born and trained paediatrician Grinfelds concluded her medical career working in the Victorian School Medical Service after she gained formal registration in 1959. Her colleagues wrote that:

> Austra enjoyed … the diversity of work in inner suburbs, in some of which practically all children were from non-English speaking homes. There was the opportunity to use her rich experience of paediatrics and knowledge of

789 'The Happy Doctor', *Argus*, 16 November 1956, 8; Alan Stoller, 'Obituary – Jacob Mackiewicz', *MJA*, 1966, 120.

790 Noel Butlin Archives, Egon Kunz papers.

791 See Table 14 (Introduction to Part III) for a summary of place of graduation which provides a rough indication of the languages spoken by this group of doctors, notably German (including Austrian-German), Czech, French, Hungarian, Italian, Latvian, Lithuanian, Maltese, Polish, Russian, and Slovak.

> languages in communities with very restricted access to both interpreters and paediatricians for many years.[792]

Austra spoke her native Latvian, as well as having formally studied English, French, German and Latin. She also gained working knowledge of Slavic languages over the three years she spent working in refugee camps, undoubtedly improved in the four years she spent as a medical orderly in Cowra Migrant Centre (NSW). The register produced by the IRO to help DPs establish their professional status noted that 'most refugees speak three of four languages'.[793] The biographies of men and women like Austra Grinfelds, who served large numbers of fellow 'New Australians', further highlights the important community roles these medical migrants assumed in Australia's transforming post-war demographic.

Summary

In this case study, the work of continental medical migrants has been unpacked to reveal two ways in which these medical practitioners undertook 'special types of labour' in Victorian communities.[794] This chapter focussed on two distinct, low-prestige roles – country doctoring in interwar Australia, and doctoring in 'New Australian' communities – to highlight aspects of the participation of continental medical migrants that has been obscured by the more dominant narrative of their marginalisation at the hands of a prejudiced local profession. Most famously in 1975, Kunz labelled these 'lost years, and wasted lives' – an evocative summary that has largely shaped the literature on alien doctors in Australia. This case study explored the collective work patterns of medical migrants who faced directed structural barriers to re-establishing themselves as medical professionals; making the recovery and contextualisation of their work in Australian communities doubly-important. These migrants, more than the British and Irish medical migrants that settled in Australia alongside them, contributed to making the Australian medical profession more open to foreign practitioners and more multicultural. The individual and collective agency of these doctors is apparent in the pathways through which they forged new careers in their adopted home. As historian Paul Weindling observed, an outcome of recovering a collective biography of medical migrants on the outside of the mainstream demographic, including marginalised groups, is that it can complicate narratives of marginalisation suggested by political histories of the gatekeeper response.[795]

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792 Newton and Ellims, 'Obituary – Austra Grinfelds', 156.

793 IRO, *Professional Medical Register*, 7.

794 Simpson et al., 'Providing "Special Types of Labour"'.

795 Weindling, 'Medical Refugees in Britain and the Wider World'.

Conclusions

In the opening paragraph of this thesis I quoted Richard Scotton, one of the architects of Australia's second health insurance scheme, who reflected in 1967 that:

> A decline in immigration … could seriously affect … particular areas which are already dangerously dependent on immigrant doctors for the maintenance of their present strengths.[796]

Scotton did not elaborate. However, historians exploring medical migrants in the twentieth-century have repeatedly demonstrated that medical migrants undertake specific types of medical work, often reflecting the hierarchies and politics of local medical practice.[797] Historian Julian Simpson and his colleagues have labelled these roles as constituting 'special types of labour'.[798] In this thesis, I aimed to write medical migrants into Australian histories of medicine and migration; to illuminate and extend our understanding of medical migrants in Australia as more than groups of passive actors in the political, social and professional debates and processes that shaped their journeys, experiences and professional trajectories. In doing so, I have recovered the special types of labour medical migrants in mid-twentieth century Australia undertook in the process of navigating professional life in a new land.

Each of the case studies in this thesis, underpinned by a prosopographical database documenting over two hundred reconstructed professional lives, has explored distinct themes that characterised the process of migration and resettlement in Australia for groups of these men and women. In doing so, each case study has addressed a particular, identified gap or limitation in the existing historiography documenting medical migrants in Australia, drawing on a wider body of work by historians, in Canada and the UK in particular, who have led the way in examining twentieth-century medical migrations and recovering its implications for both home and host nations.[799] Taken together, what emerges from these five case studies is a bittersweet account depending on the perspective from which the sum total of these lives is viewed.

Medical practice in twentieth-century Australia was relatively free of state or federal control apart from a carefully and highly regulated means of entry – the ability for a medical migrant to re-establish themselves was, in the majority of cases, contingent on gaining registration as a legally-qualified practitioner. This portal was outside lay control in almost every Australian state. State medical boards were dominated by Australia's medical elite, often those directly aligned with its key professional association, the British Medical Association in Australia. The latter body fought against the nationalisation of medical care, rejecting contract practice models premised on the type of practice environment created by friendly societies,

796 Scotton, 'Medical Manpower in Australia', 986.

797 For example, Simpson et al., 'Providing "Special Types of Labour"'.

798 Ibid.

799 Ibid., See also, Haynes, *Fit to Practise*; Monnais and Wright, *Doctors Beyond* Borders; Zamet, 'Aliens or Colleagues?'; Wright et al., 'Worse Than Being Married'; Weindling, 'Impact of German Medical Scientists on British Medicine', 86–114; Weindling, 'Medical Refugees in Britain and the Wider World'.

as well as any form of salaried practice – both of which threatened loss of professional autonomy.[800] At first implicitly, but later explicitly, the majority of the profession strove to maintain the individualistic nature of medical practice dominated by fee-for-service private practice.[801] Therefore, established cultures of practice and hierarchy created specific gaps in medical domains and the distribution of medical manpower.[802] Importantly, as I have shown in this thesis, gaps that newly-arrived migrants could most easily access and occupy.[803]

This was, however, contingent on gaining registration. Europeans graduating from continental medical schools across Austria, former Czechoslovakia, Germany, Hungary, Lithuania, Poland and Switzerland to name a few, found on arrival that their qualifications were not recognised, and a thirty-year-old clause requiring reciprocal recognition was invoked to protect the local profession from claims of overcrowding.[804] In Victoria, between 1930 and 1956, with the brief exception of Italian degrees (to 1940), these medical migrants were largely unrecognised and were forced either to retrain at great expense, or practise illegally, or even give up their profession entirely. These men and women, many of whom were Jewish, arrived on humanitarian grounds as refugees and later Displaced Persons. They had few options, and often mouths to feed. Their plight, however, was deemed insufficient cause for the profession to support liberalisation of medical registration; instead its gatekeepers mobilised to restrict a feared 'influx' of continental practitioners.

Two case studies – Chapters 5 and 6 – re-examine what historian Paul Weindling calls the gatekeeper response to Australia's so-called 'alien doctors'.[805] In Chapter 5, I consider the significance of the Depression on doctors' incomes which intertwined with the profession's vehement debates over the introduction of medical benefits in a proposed national health insurance scheme. In this chapter, I connect these latter circumstances, to the specific ways in which the gatekeepers of the local profession imagined and portrayed continental medical migrants as 'overspecialised' and unfit for private practice in Australia. In Chapter 6, this gatekeeper response is analysed from the perspective of the medical migrants, who mobilised in the form of the Unregistered Doctors Association in 1951 to lobby for case-by-case recognition of foreign medical degrees. These two case studies offer fresh perspectives to the existing historiography. First, by challenging how historians have interpreted the profession's response in the interwar period as mostly reflecting prevalent xenophobia interspersed with anti-Semitism. Second by examining how medical migrants exerted agency in the face of this protectionist response. Both these aspects have been ill-considered in the historiography to date.

Successful registration as a legally-qualified practitioner was one step in re-establishing professional status in Australian states. A second was making a medical living. Three case

800 Gillespie, *Price of Health*.

801 Ibid.

802 Fett, PhD diss., 121-23.

803 See also, Klugman, *Blood Matters*.

804 Weaver, 'A Glut in the Market'; Rutland, 'An Example of "Intellectual Barbarism"'.

805 Weindling, 'Medical Refugees in Britain and the Wider World'.

studies – Chapters 3, 4 and 7 – examined the work undertaken by groups of medical migrants, highlighting distinct patterns in the way that these men and women went about re-establishing themselves as medical professionals – that is, three 'special types of labour' specific to Victorian (and often Australian) orthodox medical practice.[806] The first 'special types of labour' was doctoring in country towns which, to varying degrees, suffered shortages throughout the interwar and early post-war decades.[807] Filling these vacancies required these towns to recruit, entice and/or incentivise practitioners to move there since the distribution of practitioners was not mandated by identified need, and largely outside state and/or federal government control. Instead, many of these towns raised funds to provide a minimum income guarantee to attract a private practitioner, and often these advertised vacancies included a house and surgery for the doctor's use. In the interwar and war years, half of the Italian medical graduates who were resident in Victoria practised in a country town, as discussed in Chapter 7. They were subsequently supported by temporary licensees during the Second World War, who were assessed and deployed to country towns to mitigate urgent gaps in medical care as shortages of medical services country towns faced were exacerbated by the enlistment of Australian doctors. In the post-war years, continental medical migrants moved to metropolitan Melbourne. However, Chapter 3 outlines the extent to which recently-graduated British medical migrants in particular – who were arriving in unprecedented numbers compared to the interwar years – filled these gaps instead.

The case study of a group of Bristol graduates (Chapter 3) highlights the contours of the particular space British medical migrants occupied in post-war Australia. The Bristol group were recent medical graduates, though not necessarily young in years. This case study reveals the interplay between the group's dissatisfaction with their prospects in post-war Britain and their professional networks in motivating them to leave Britain; as well as determining their choice of Australia as a migrant destination. As relatively inexperienced rank-and-file medical migrants, the Bristol group's resettlement processes that I have recovered begins to challenge the myth that British medical migrants were synonymous with their local counterparts. (A myth, as I discussed in Chapter 1, that historians have largely perpetuated, in part by not seeking to explicitly challenge it.) Similar to interwar continental medical migrants, the patterns of work displayed by this Bristol group reflect a wider, national trend for British and Irish medical migrants to occupy this particular gap in Australian rural and outback medical manpower in the post-war period.

A second unique role medical migrants occupied is seen in the examination of the role of gender in shaping the privileged space occupied by British medical migrants in their professional setting. British medical women were registered and worked in numbers that closely-matched their local counterparts in the state of Victoria. In Chapter 4, the transitions and work of migrant medical women highlighted how these women navigated particular gendered barriers in Australia, including marriage bars and informal male-dominated networks within metropolitan practice. In search of work, these women were recruited by and drawn to

806 Simpson et al., 'Providing "Special" Types of Labour'.

807 Scotton, 'Medical Manpower in Australia'.

core women's networks, including the Queen Victoria Memorial Hospital, which for the bulk of its existence was a separatist hospital: it was run by women, for women; and the Victorian Medical Women's Federation. Chapter 4 highlights how migrant medical women leveraged these networks to establish themselves, as well as participate and influence medical politics – occupying gaps created by the lack of interest and support from local medical women.

Finally, Chapter 7 highlights particular settlement patterns of continental medical migrants who worked as private practitioners, which suggests they sought to capture the medical market in their own ethnic or 'New Australian' communities. This is the third 'special type of labour' medical migrants undertook. The barriers to medical care faced by the large numbers of non-English speaking migrants or 'New Australians' only surfaced as a critical service gap in the 1970s, when state and national efforts to address the specific healthcare needs of over half a million of these settlers were formulated. The last half of Chapter 7 examines how the multilingualism of both registered and unregistered continental medical migrants, as well as their shared culture and experiences (many as war survivors), provided migrant groups with access to meaningful medical care throughout the interwar and post-war decades. This was often in practices that were located in growing migrant dominated suburbs, where the local medical élite were less likely to practise. Therefore, it is clear that Australia's comparative appeal for medical migrants – as a place of refuge, as a migrant destination, as an alternate system of medical care – resulted in distinct forms of gain for local communities. In seeking to sustain themselves and their families, medical migrants also sustained specific parts of Victoria's (and Australia's) medical system. Apart from the deliberate deployment of continental medical migrants during the war, this was largely inadvertent.

This narrative of gain – that is, the ways in which the state of Victoria benefited from the work medical migrants undertook – is not, however, the sole contribution these case studies make to the historiography. In contextualising the collective lives of these doctors, I have also tried to recover the loss, change, frustrations and modes of adaptation that have described these migrant journeys. That is, the patterns that describe their collective biography. In doing so, the development of self-made networks are also revealed, including: the Unregistered Doctors Association; the deployment of existing transnational networks, seen in the chain migration of Bristol graduates to Australia; and the utility of available networks, seen in the Queen Vic and Victorian Medical Women's Federation. The collective biographies of these medical migrants also disrupt perpetuated notions of privilege (or lack of it) based on ethnicity alone, which has characterised previous studies. Taken together, what these case studies also highlight is the layered experiences of being a medical migrant – or a professional outsider – in Victoria, and that medical reciprocity helped but did not guarantee an easy transition. By focussing on groups of rank-and-file medical migrants, these case studies also reveal the particularities of medical regulation, practice and politics in Victoria (and Australia) that created and shaped the ever-changing contours of categories of 'other' in mid-twentieth century Australian medicine.

Future research

The major limitations of my research project were imposed by the necessity of limiting its scope, as well as in the choice of method, which I discussed in the Introduction to this thesis. Appendix 1-4 contains further elaboration on these points. Therefore, I will not repeat them here. The adopted methodology, which was to examine the patterns revealed by the prosopographical database through a series of case studies, necessarily meant that not all aspects revealed by the analysis of the subsequent database I constructed has been exhausted; neither have all possible groups of medical migrants been thoroughly examined. This provides ample scope for future research, particularly as it is my intention to publish the full database on an open source platform in the near future. Therefore, instead of reiterating the limitations of the methodological approach adopted in this thesis, I will focus on emergent themes that I believe immediately suggest valuable avenues for further study.

Refugee medical women

In this thesis, I did not examine the pathways and experiences of the 19 continental European medical women to include consideration of the role of gender in understanding their resettlement experiences. This decision was based upon the small number of women registered in the state of Victoria, as well as the limited data available for them. A future research project that focusses on the resettlement of these women in all Australian states suggests a stronger basis from which such a study could be made. Historians Atina Grossman and Anna von Villiez both wrote accounts of German women doctors who fled as refugees to the United States of America.[808] Atina Grossman explored a group of German medical women from Berlin and observed a phenomenon that is today a well-recognised feature of migration and resettlement of *married* refugee women. Grossman wrote that:

> … married refugee women doctors; the wives worked initially as cooks, housekeepers, and nurse-maids while their husbands slowly re-established their practices, circles of colleagues, and professional identities. There was little support for women doing the same …[809]

Anna von Villiez also examined the migration of German women doctors from Hamburg between 1933-45. Von Villiez's work highlights another pattern seen in the migration and resettlement experiences of professional couples, where women were more likely to forfeit re-establishing their professional status in favour of their husbands, if such a choice was required.[810] The Australian medical profession's response to 'alien doctors' was not unique – European refugees in the interwar and post-war periods were regularly faced with lengthy and costly pathways to re-establishing themselves as medical professionals (and many other

808 Grossman, 'German Women Doctors from Berlin to New York', 65-88; von Villez, 'Emigration of Women Doctors from Germany', 553–67.

809 Grossman, 'German Women Doctors from Berlin to New York', 84.

810 von Villiez, 'Emigration of Women Doctors from Germany'.

professions) in their countries of resettlement.[811] Given that medical women were more likely to be married to a fellow practitioner or another tertiary-qualified professional,[812] Grossman and von Villiez's work suggests that the resettlement experiences of refugee medical women can and should be nuanced to account for gender relations within an already marginalised group.

The existing historiography documenting 'alien doctors' in Australia notes but does not offer much insight into the experiences of the medical women amongst this cohort. Women appear in these narratives as vital support for their husbands, but this pattern is not interrogated. For example, in *The Intruders*, Egon Kunz notes that many of the post-war DP doctors who chose to retrain at an Australian university were dependent on the earnings of their wives.[813] Similarly, Suzanne Rutland's study of the early experiences of Jewish refugee doctors in Sydney noted that 'in order to make ends meet, most of the wives worked' as their husbands retrained in medicine.[814]

Von Villiez noted that many of refugee medical women eventually returned to medicine. However, they were slower to do so. They appeared to eschew their own ambitions in favour of their husbands', or because they prioritised their family commitments. Von Villiez also cautiously favours the finding that the migrant medical women in her study resettled more easily than men – supporting a broader argument made by Marion Beghahn, in 1984, and more recently in Sybil Quack's edited volume on women refugees, *Between Sorrow and Strength* published in 1995, that refugee women adapted better to the difficult and often discriminatory reception in their country of resettlement.[815] However, it appears that this resettlement came at the cost of their professional work, with many women in both studies returning to traditionally accepted labour for women, as nurses, physiotherapists and social workers.[816] In von Villiez's sample, of 50 Hamburg medical women, one third never worked in medicine again; in Grossman's study this figure was higher – two thirds of those women did not return to medicine.[817] Grossman observed of the Berlin medical women, their resettlement as refugees also necessitated considerable shifts in these women's attitudes and expectations, away from the open, liberal Weimar ideal. Grossman concluded that for these women, 'the collapse of the Weimar republic marked the end of a brief and precarious experiment in the negotiation of maternity and modernity'.[818]

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811 See Chapters 5-6.

812 This is a well-known phenomenon, and the reverse pattern did not hold i.e. medical men were not more likely to marry tertiary-qualified professional women. For a discussion of the patterns in Australia, see: Fett, PhD diss., 166-83.

813 Kunz, *The Intruders*.

814 Rutland, *Take Heart Again,* 11.

815 See, for example, Miller, 'England. An Eyewitness Report', 87-88; Berghahn, *German-Jewish Refugees in England,* 118-126.

816 Mann, PhD diss.

817 von Villiez, 'Emigration of Women Doctors from Germany', 563-4; Grossman, 'German Women Doctors from Berlin to New York', 85-6.

818 Grossman, 'German Women Doctors from Berlin to New York', 86.

Creating and shaping medical knowledge and domains of practice

The specific recruitment of medical migrants to university and hospital teaching and research positions is apparent from the biographies I reconstructed. For example, Edinburgh graduate John Boyd Colquhoun was hired to head the newly-created paediatric orthopaedic section of the Royal Children's Hospital in Melbourne in 1930; Scotsman John Bell Ferguson headed the state department of Victoria's tuberculosis arm; and the first chairs in medicine and surgery at the University of Melbourne were two Englishmen: Maurice Ewing and Richard Lovell. This pattern of recruitment was not restricted to British medical migrants either. Australian-based practitioners also sought to recruit continental European practitioners displaced by the early rise of National Socialism, including the recruitment of Hans Bettinger to teach pathology at the University of Melbourne, Fritz Duras to introduce a physical education course for school teachers, and Clara Geroe to establish an Institute of Psychoanalysis.[819]

Of the biographies reconstructed for this thesis, the lack of qualified pathologists in hospitals and medical faculties appears to have resulted in several medical migrants occupying these roles. Matthew Klugman's history of the Victorian Blood Bank highlights the role of continental medical migrants, including Rachel Jakobowicz and Herta Lowy, in maintaining and driving the work of the Blood Bank.[820] However, he does not examine the wider implications and transfer of particular medical practice into Australian settings.[821] Pathologists from continental Europe including Maurice Berah, Hans Bettinger, Rachel Jakobowicz, and Stanley Weiner went on to occupy clinical teaching positions at the University of Melbourne. Jacob Mackiewicz, a Russian neuropathologist remembered for describing 'the Mackiewicz sign' (a physical examination that can reveal a femoral nerve injury) continued his research in Melbourne, studying the experimental effects of antidepressant drugs, tranquilisers, and the pathology of senility.[822] Similarly, British graduates Frederick Moran, Michael Wilson, Courtenay Greer, Donald Menzies and John Reid also lectured, published scholarly articles, and were directors of pathology departments, particularly in Victoria and Tasmania.

Taken together, theirs is one example of potentially many domains of medical practice in which the flow of knowledge and novel modes of practice was disseminated and facilitated by medical migrants. Historians in the UK, notably Paul Weindling and John Zamet, have done considerable work on cultures of medical research and practice, and the particular impact of the displacement of Austrian and German doctors and dentists had in shaping particular medical domains.[823] A recent special issue in the *Journal of the History of Neurosciences* also documented the role of refugee doctors on the practice of psychiatry and neurology in Britain and the United States of America.[824] These studies highlight the potential for future research

819 For a discussion, see Chapter 7.

820 Klugman, *Blood Matters,* 69-87.

821 Ibid.

822 Eadie, *The Flowering of the Waratah,* 118.

823 See for example, Weindling, 'Impact of German Medical Scientists on British Medicine'; Zamet, 'Aliens or Colleagues?'.

824 Special issue of *Journal of The History of The Neurosciences*, 2016, 25 (3). This has since

to focus on medical specialisms and the role(s) medical migrants have played in shaping the development of these specialisms in the Australian context.

Return, re-emigration, and circular migration

In this thesis, I also did not explore the subsequent transnational mobility of these medical migrants in great detail. The vast majority of the medical migrants identified for this study settled in Australia permanently for the bulk of their working lives. However, clear patterns of migration emerge highlighting the continued mobility of medical practitioners in a globalising market for medical labour. In the 1970s and 1980s, for example, as temporary migration for research, postgraduate study, or work became normalised by changes to national migration schemes, the flow of medical practitioners between nations was radically altered. The medical migrants in this study not only brought with them training and experiences from a wide array of nations and settings – from Cuba to West Africa – they continued to travel in their capacity as practising doctors and medical researchers.

These patterns of travel, and their meaning for understanding the more global implications of medical migration, have not been fully explored in this thesis. However, this would be an interesting and valuable field of further study. In particular, it would help situate Australia in a transnational conceptualisation of a global medical marketplace, and transnational networks that were established and developed. Hungarian refugee Georg Berci, for example, arrived in Australia in 1957 and started experimental surgical research at the University of Melbourne having secured a Rockefeller scholarship. Whilst there, Berci developed novel techniques and technologies to improve endoscopy. In 1963, Berci visited Cedars-Sinai Medical Centre as a visiting professor, a visit which resulted in his permanent relocation to Los Angeles. Berci clearly maintained his Australian networks: the foreword for his edited volume *Endoscopy* (1976) was written by British migrant Maurice Ewing, still Professor of Surgery at the University of Melbourne.[825]

Other medical migrants demonstrated circular migration.[826] John Ward Little, for example, enlisted in the Australian Navy as a medical officer in 1958 and subsequently joined the Queen Victoria Hospital in 1960 as a Senior House Officer. In 1961, he left to Buckinghamshire in England where he spent two years as a Senior House Officer before returning to Manly in Sydney in 1963, where he proceeded to practise until 1985. Italian graduate Piero (Peter) Guastalla arrived in Surat (Queensland) from Trieste in Italy in 1940, where he practised for a decade before leaving for Belfast, Northern Ireland, for three years to gain postgraduate hospital experience in obstetrics and gynaecology. He returned to Queensland with postgraduate qualifications and proceeded to obtain a consultant post in Toowoomba. The role of further migration and travel for medical practitioners and Australia's role as a destination for medical migration and travel, has yet to be fully unpacked. Historian John Armstrong's

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been published as an edited volume. See: Stahnisch and Russell (eds.) *Forced Migration in the History of Twentieth-Century Neuroscience*.

825 Berci (ed), *Endoscopy*.

826 Migration historians, of course, have studied this phenomenon in greater detail. See, for example, King, 'Generalizations from the History of Return Migration', 7-55.

analysis of the role of sponsored travel opportunities for hospital-based aspiring specialists in New Zealand highlighted the link between such opportunities and gendered barriers to accessing those opportunities, which shaped the distribution of medical women in medical specialities in New Zealand.[827] Australia was simultaneously a destination for medical migrants as it was reliant on overseas travel opportunities for local practitioners to gain postgraduate qualifications. Therefore, examining the patterns of mobility of medical migrants could extend our understanding of informal networks that characterised postgraduate education and experience, as well as structural barriers that may or may not have shaped these migrations.

Reflecting on the present: Final summary

These identified gaps do not detract from the achievements of this PhD project, which is the first of its kind in the Australian context. The importance of meaningfully writing medical migrants into Australian history finds its justification in the position occupied by medical migrants in contemporary Australia, whose national medical system depends on these men and women. Richard Scotton's reflections in 1967 of the 'dangerous dependence' on medical migrants is not only echoed but amplified in contemporary Australia.[828] A report published in 2017 documents Australia's 'extraordinary reliance' on medical migrants, where for example, forty per cent of its general practitioners are overseas-trained.[829] Today, legally practising medicine as a migrant in Australia involves a stringent national accreditation process to demonstrate equivalency to local educational standards and often a commitment to a minimum period of work in areas of shortage and need.[830] These policies are underpinned by near-universal agreement of the privilege owed to locally-trained medical practitioners – medical migrants are welcome, but not as source of competition for local doctors.[831] Unsurprisingly then, mainstream representations of medical migrants are still polarised: they are victims or economic opportunists; they are pioneers or grossly-incompetent.[832] Australians have no framework within which to appreciate that medical migrants continued to shape its medical systems beyond the early decades of pioneering colonials following white settlement of Australia in 1788. Perhaps a result of this collective amnesia is that Australia's relationship with and modes of deployment of medical migrants today is transactional, commodified and often exploitative.[833] This jars with the importance Australians place on health and healthcare, reflected most recently in the primacy

827 Armstrong, PhD diss., 215-254.

828 Scotton, 'Medical Manpower in Australia'.

829 Hawthorne, 'International Medical Migration', 18.

830 NB: In 1973, the *Health Insurance Act* set the minimum period to ten years, and is often referred to as the '10-year moratorium'. In 2013, this period was reduced to five years for migrant general practitioners in rural areas with long-term shortages.

831 Iredale, 'Luring Overseas Trained Doctors to Australia', 31-65.

832 For a discussion, see: Sullivan, 'Foreign-trained versus British-trained: Exploring the Identity of Non-Australian Trained Medical professionals, 48-58.

833 Iredale, 'Luring Overseas Trained Doctors to Australia'.

the future of *Medicare* – Australia's universal healthcare system – took in the 2016 federal elections.[834]

In this thesis, I have reconstructed the scattered professional lives of European medical migrants to highlight the ways in which medical migrants sustained aspects of medical practice in Australia. Through a series of case studies, I have aimed to develop a fuller picture of the journeys, resettlement experiences and work of groups of medical migrants in interwar and post-war Australia, redressing the obscurity of medical migrants in Australian histories of medicine and migration. It is a truism to say that Australia is a nation built on the back of immigrant labour. Historians have played an important role in recovering and complicating this representation, highlighting the ways, means, experiences and legacies of groups of immigrants on the emerging social, cultural and political fabric of the nation. The contribution of this thesis is that it adds one more thread to this narrative. In this thesis, I highlight that migrant labour did not just build Australian cities and roads, it helped care for the health and well-being of the people that lived in and travelled on them. The European medical migrants who arrived in the interwar and immediate post-war years transformed the make-up of the nation's medical workforce. They were the vanguard and the basis upon which future political imaginings for the role of medical migrants in Australia were conceived – as country doctors, as stop-gaps, as transient labour. This thesis begins to redress the silences that characterises the historiography on twentieth-century medical migration to Australia. In doing so, I have demonstrated that medical migrants today represent part of an unbroken and sometimes hard-won legacy of refuge, second chances and fresh starts inherited from the medical migrants who arrived before them.

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834 Johnson, 'Government Had to Reassure Australians about Medicare', 17.

Appendices

Appendix 1: Prosopography as a Methodological Approach to Writing Histories of Medical Migrants

The five case studies that comprise the bulk of this PhD project are underpinned by a prosopographic database documenting the professional lives of over 228 European medical migrants registered in the state of Victoria between 1930-60. In Chapter 1, I highlighted the lack of studies documenting both the resettlement experiences and medical work of *groups* of medical migrants in Australia. In this study, I have aimed to meaningfully write European medical migrants into Australian medical and migration histories by studying their collective professional lives. As previously discussed, this aim together with the existing gap in the historiography, lead directly to the choice of prosopography as the methodological approach adopted for this thesis.[835] In this Appendix, I outline the limitations and strengths of prosopography as a methodological approach to exploring historical questions. In doing so, I highlight key considerations I grappled with in choosing prosopography as the underpinning methodological approach for my own project, as well in considering how I went about constructed the prosopographic database. The detail for the latter comprises Appendices 2-4.

Background: Prosopography and historical scholarship

Prosopography in its modern form is a methodological tool used by a wide array of historians as one of the many approaches through which we might seek to understand the past.[836] At its core, prosopography is a source-critical biographical method used to explore a closely-defined group of individuals; and it is distinct from, but related to collective or group biography, as well as biography.[837] Each of these approaches are clearly concerned with studying the life course of an individual or groups of individuals. The key distinction between each approach is the varying emphasis placed on recovering the personality or individuality – that is, internal features – of the person or people under investigation. In turn, this emphasis dictates the *type* of historical findings that each method can elicit.

The definition of internal versus external features broadly distinguishes between characteristics that are 'susceptible to an unequivocal description', that is, are not psychological and/or personal.[838] Taking the example of the subjects of this thesis, medical migrants, a biography of a medical migrant would focus on both the internal and external features of an individual. For example, the entry for English medical migrant Doris Lyne Officer in the *Australian Dictionary of Biography* describes discoverable external features: her heritage (English-born), her social status (daughter of a master mariner), her educational attainment

835 See the Introduction and Chapter 1.

836 Prosopography has been used by classicists to describe the compilation of biographical lexicons; and its use by historians as early as 1743. However, it was re-popularised in the 1920s and 1930s as a historical method by scholars including Ronald Syme and Lewis Namier. For a discussion of the development of modern prosopography, see: Stone, 'Prosopography'; and Keats-Rohan (ed.), *Prosopography Approaches and Application*, particularly 71-94.

837 Keats-Rohan (ed.), *Prosopography Approaches and Applications*.

838 Ibid., 65.

(medical degree from the London School of Medicine), but the author also provides an impression of Officer's personality.[839] She 'enjoyed hiking', and 'showed little interest in fashion'. Throughout the entry, we gain an understanding of Officer's achievements as a medical practitioner – including an illustrious thirty-year career in women's and children's health, recognised by an Order of the British Empire in 1959, but also an insight into the values that drove her professionally: of 'tireless' effort, and that she believed 'prevention is better than cure'.[840]

The extent to which a biographical approach is concerned with recovering the 'private life' or 'inner person', as historian Paul Magdalino frames it, also separates collective or group biography from prosopography.[841] Doris Officer's biography is one of many entries in both the *Australian Dictionary of Biography* and *Encyclopaedia of Women and Leadership in Twentieth-Century Australia.* Both these projects, and particularly the former, are classic examples of collective or group biography. These collections contain a number of individual biographies, where the primary source material discoverable for each individual is leveraged to best explore the characteristics and experiences of the *individual*. What binds the individual to the group under study is often thematic – in the case of the *Australian Dictionary of Biography,* it is Officer's contribution to the development of a facet of Australian cultural and social heritage; in the *Encyclopaedia of Women and Leadership in Twentieth-Century Australia*, it is that she was a woman identified as having displayed leadership in her chosen profession in Australia.

Essentially, in collective biography, the core unit of analysis is still the individual, although there is scope to draw out patterns and additional themes that bind individuals together. The *Encylopaedia of Women*, for example, is a repository of biographies documenting women identified as demonstrating leadership in multiple aspects of Australian life – civil, professional, cultural. However, additional themes that binds smaller groups of these women are also explored. For example, the shared experience of being a woman in medicine in Australia, which identifies that the type of leadership these women displayed was contingent on mitigating the structured disadvantages of being a contested minority in a hierarchical and traditionally male-dominated field.[842] Although often used interchangeably, a collective or group biography is distinct from prosopography in its intended outcome although both are methods designed to study groups.

A prosopography is a collection of uniform or systematic information about a group of individuals, an analysis of which can reveal patterns that do (or don't) describe the group. A prosopography of medical migrants, for example, might reveal hitherto unknown patterns that connect these migrants together, including patterns in career outcomes; particular professional achievement linked to their medical school; or a shared political ideology that underpinned their decision to migrate.[843] A uniform collective biography is a step in the process of creating

839 Crockett, 'Officer, Doris Lyne (1898–1967)'.

840 Ibid.

841 Magdalino, 'The Contribution of Prosopography', 41-55.

842 Rasmussen, 'Medicine'.

843 Verboven et al., 'A Short Manual to the Art of Prosopography'.

a prosopography. However, the distinction between prosopography and collective biography is that the former is characterised by the objective of collecting data that 'transcends individual lives'.[844]

How then is prosopography defined? A leading prosopographer, historian Katharine Keats-Rohan, observes that the meaning of prosopography as used in historical research is 'plural', making definitions of prosopography 'more descriptive than prescriptive'.[845] However, other historians argue for a greater degree of prescriptiveness in defining the parameters of prosopography.[846] There is, however, broad agreement as to the main features of a prosopography. This is aptly summarised by historian Hilde de Ridder-Symoens as compiling

> a collective biography, describing the external features of a population group that has something in common (profession, social origins, geographic origins, etc.). Starting from a questionnaire, biographical data are collected about a well-defined group of people. On the basis of these data answers may be found to historical questions. [847]

Despite eluding firm definition, historians and practitioners of prosopography generally also agree that there are four main components or stages to prosopography. They are: determining a group to be studied, and compiling a list of names or identifying these individuals; developing a questionnaire that captures the uniform set of information to be collected to describe the group; compiling that information into biographical dossiers which together comprise a type of collective biography. Finally, these dossiers can be analysed and explored according to the research questions. In his now seminal paper on prosopography as a historical tool, Lawrence Stone argues that the potential of prosopography to reveal new interpretations to historical questions cannot be denied providing its limitations are properly understood, and the techniques correctly deployed.[848] In the remainder of this Appendix, I explore some of the strengths and limitations of prosopography, as relevant to this study.

Strengths of prosopography

The potential of prosopography principally lies with how the method meets the challenge that underpins all historical work, that is the need to make generalisations based on the surviving, often fragmentary material and relics of the period of interest. It is the triangulation of a wide variety of primary sources for each individual selected for study, and the systematic collection of the same information about each individual in the group, that lends prosopography its credibility as a research tool. For if the number of individuals in the group to be studied is large enough, emerging patterns (or the lack of them) suggests a shared experience, or

844 Ibid., 47.

845 Keats-Rohan, 'Chameleon or Chimera? Understanding Prosopography', 20.

846 See for example, Oldfield, 'Narrative, Biography and Prosopography', 35-60. 2; Coles et al., 'Using Prosopography to Raise the Voice of Those Erased in Social Work History', 85-97.

847 de Ridder-Symoens, 'Prosopografie en middeleeuwse geschiedenis', as translated and cited in: Verboven at al., 'Short Manual to the Art of Prosopography', 39.

848 Stone, 'Prosopography'.

representativeness that can be related to the social, cultural or political context these individuals found themselves in. This strength is amplified in research that seeks to reconstruct the lives, experiences and activity of individuals who are often hidden or marginalised in the surviving record. As a group of historians of social work recently observed, 'the method allows for the voices of the unheard to be brought to the forefront'.[849] However, prosopography is not restricted to the study of marginal or disenfranchised groups. It has been, and continues to be, routinely deployed to study elite lives.[850] However, as Stone observed, the group under study tends to shape the type of analysis of the collected data – as well as the balance between quantitative and qualitative analytical techniques, and varies substantially between studies. As a result, several historians distinguish between types of prosopography.[851]

A second key strength of prosopography is in the ability for historians to make sense of multiple primary sources in a uniform manner. Through the development of a questionnaire, data from a wide-ranging number of diverse sources can be collated, including archival records, material artefacts, published secondary sources and articles in the popular press, and oral histories. The multi-source nature of prosopographical research means the biographical profiles developed for the group under investigation is often rich in detail. This in turn enables a researcher to craft 'a more vivid portrait of the historical, social and political context' being explored.[852]

Another strength of prosopography is the ability for historians to deploy computational techniques to storing and structuring data; as well as to apply multiple analytical techniques – including multiple software packages – to analysing the data. This includes, qualitative, quantitative, and mixed-methods analytical techniques. However, mixed-methods approaches in history, including in analysing prosopographies is relatively rare since it requires sophisticated statistical analysis which is often outside the historian's traditional skillset.[853] The high volume of data typically collected when creating a prosopography has resulted in prosopographers being early adopters of emerging computational techniques to collect, structure and analyse their data. For example, many contemporary prosopographies – especially ones undertaken by teams of researchers – are relational databases. This in turn has led to increasingly sophisticated reflections on the implications of doing so, and the production of a strong best-practice basis for using prosopography in historical research.[854]

Finally, prosopography is particularly suited to career analysis; to revealing hidden networks, decisions, motivations and relationships shared between individuals; to exploring

849 Coles, Coles et al., 'Using Prosopography to Raise the Voice of Those Erased in Social Work History', 87.

850 Stone, 'Prosopography'.

851 Ibid., Oldfield, 'Narrative, Biography and Prosopography'; and Verboven et al., 'Short Manual to the Art of Prosopography'.

852 Jones, 'Prosopography and Discursive Protest', 72.

853 Cohen et al., 'Towards A Mixed Method Social History', 211-229.

854 See, for example, Pasin and Bradley, 'Factoid-based Prosopography and Computer Ontologies', 86-97.

social mobility; and to exploring the work and function of institutions, as well as the individuals who shaped it. This is evidenced in a number of past studies that have deployed prosopography to explore such questions. For example, in *Medical Lives in the Age of Surgical Revolution,* historians Anne Crowther and Maguerite Dupree are able to show through a prosopography of Lister's students' careers that 'it was noticeable that Listerism was established firmly wherever there was a critical mass of former students'.[855] They attribute the extent of the spread of Lister's antiseptic method to his access to large cohorts of students at the prime of Scotland's position as a medical hub. More recently, Jacqueline Jenkinson's study of the careers of Scottish medical practitioners who were also shop-keepers in the late nineteenth and early twentieth century challenges the common representation of the homogeneous modes of practice seen in the historiography by demonstrating that owning a dispensary or a shop was more common than previously thought for the period under study. That is, the practice of shopkeeping was not restricted to medical practitioners on the outer fringes of intra-professional prestige.[856] Essentially, prosopography shares in common with other historical methods the strengths of producing novel insights, if deployed correctly, if the strengths of the method are matched to the aims of the research project.

Limitations of prosopography

The limitations of prosopography are principally related to core features of the approach, which as discussed above typically begins with defining the group to be studied, and the external features of the group to be described by populating a uniform questionnaire for each individual. Such an objective has drawn criticism that prosopographic studies are reductionist, that is, individual voices are erased. This is, of course, a valid criticism – particularly for the future utility of prosopographic databases to inform *future* research. However, I would argue that the historian who seeks to write a biography, or histories that champion individual voices, has perhaps erred in their choice of method. For research questions more suited to prosopography, there are more pressing limitations that require careful navigation. I will discuss some of these below.

The first concerns the question of defining the group to be studied. If loosely-defined, or too widely cast, a prosopographic study is compromised from the beginning because the group under study cannot yield robust or reliable answers to historical questions. Historians Christine MacLeod and Alessandro Nuvolari argued this was the case in Zorina Khan and Kenneth Sokoloff's study of 'great inventors' in the United States of America, where the criteria for who counted as an inventor was, in their opinion, too loose.[857]

855 Crowther and Dupree, *Medical Lives in the Age of Surgical Revolution,* 367.

856 Jenkinson, 'Prosopography of Scottish Shop-keeping Doctors', 89-111.

857 MacLeod and Nuvolari, 'Pitfalls of Prosopography', 757-776. For the study under discussion, see: B. Zorina Khan and Kenneth L. Sokoloff, '"Schemes of Practical Utility": Entrepreneurship and Innovation among the 'Great Inventors' in the United States, 1790– 1865', *Journal of Economic History,* 1993, 53, 289–307; and B. Zorina Khan and Kenneth L. Sokoloff, 'Institutions and Democratic Invention in 19th-Century America: Evidence from 'Great Inventors,' 1790–1930', *American Economic Review*, 2004, 94, 395– 401.

A second interrelated set of criticisms of prosopography is that it is time-consuming, relies upon a strong *prior* understanding of the wider area of study, as well as the available primary sources that can be drawn upon to compile a prosopography. It also relies upon collecting data from a wide array of sources that can be difficult to access. To summarise, deploying this method is only possible for groups of individuals who can be identified, about whom sufficient volumes of existing documentation exists, and can be accessed. For these reasons, it is common for existing collective biographies, for example, national dictionaries of biography, to be mined by historians using this method.[858] While this practise is valid, it relies upon a strong understanding of the development of the sources being used. Returning to the MacLeod and Nuvolari's critique, they go on to argue that Khan and Sokoloff's prosopographic study of American inventors used American biographical dictionaries with little critical reflection, which risked 'the perpetuation of their sources', particularly established notions about inventors and inventions'.[859] MacLeod and Nuvolari go on to demonstrate how inventors in the equivalent British dictionary of biography 'starkly encapsulates various Victorian assumptions of who inventors were and what constituted an invention'.[860]

As discussed above, the first part of prosopography is 'when a biographical dictionary or lexicon is compiled, providing a set of biographical profiles of each individual in the group under investigation'.[861] The compilation of biographical profiles is typically based on the uniform population of a questionnaire. Therefore, similar to MacLeod and Nuvolari's criticism of perpetuating bias when using existing collective biographies, the sources used by historians to define a population and collect data is vulnerable to introduced bias by the researcher(s). That is, the selection of individuals and the scope of the questionnaire can tacitly embed the researcher's own world views on the research question(s). This is not wholly invalid, and feminist historians have used prosopography to great effect.[862] This vulnerability becomes problematic only if the researcher does not reflect on the rationale that underpinned the selection of their population, and the development of their questionnaire.

Another common criticism of the questionnaire is that it is too rigid, that in strictly populating only that information determined in the questionnaire, important evidence can be wholly discarded. Recently, some historians have responded to this limitation by promoting a more flexible approach to populating the prosopographic questionnaire: one that is source-led, and aims for posterity.[863] As historians Gidon Cohen, Andrew Flinn and Kevin Morgan argue for their work:

> At the outset of our [prosopographic] project [we] were alert to the concern that the structuring of data would leave us unable to record all the

858 See, for example, Namier, *England in the Age of the American Revolution.*

859 MacLeod and Nuvolari, 'Pitfalls of Prosopography', 761.

860 Ibid.

861 Keats-Rohan, 'Understanding the Pursuit of the Individual in Prosopography', 146.

862 See, for example, Cross and Flinn., 'Biography Meets History', 11-21; and Coles et al., ''Using Prosopography to Raise the Voice of Those Erased in Social Work History', 85-97.

863 Cohen et al., 'Towards A Mixed Method Social History', 211-229.

> information that the historian, interested in the development of narratives of an individual's life, would wish to record. At each stage we regarded the structuring of information as a useful supplement to, rather than a replacement of, recording the individual's life story. We aimed to record the information that would be most useful to understanding the individual's life rather than that which would be most useful in making generalisations. … As far as possible the database structure was led by the sources.[864]

Such an approach to prosopography, also mitigates an earlier criticism that prosopography cannot lead to research that champions individual(s) voices.

Finally, criticisms and limitations levelled at prosopography extends to the creation of the databases, and the subsequent analysis of the data. One such limitation of prosopography is highlighted by historian Maurice Crosland in his study of the French Academy of Sciences. Crosland argues that:

> A basic problem with the prosopographical approach is that it focuses far too much attention on the members of an institution and then tends to assume that the history of the institution is little more than the combined history of the individual members… Most prosopographical studies tend to treat individuals, whether politicians or scientists, as equal units.[865]

While Crosland is specifically addressing the study of institutions, his assessment can be broadened to highlight the potential for prosopographers to flatten or ignore important social, cultural, professional and political contexts, not only in shaping the development and membership of institutions, but those that create differences between individuals in a group. As historian of science David Sturdy argues in his more recent prosopographic study of members of the French Academy, 'the stature and achievement of scientists vary immensely', and these differences must be accounted for in the analysis undertaken.[866]

Other analytical limitations include that prosopographers often gloss over missing and/or unrepresentative data in their prosopographies when disseminating their findings.[867] As historian Gidon Cohen reflects, many prosopographers make 'the strong assumption that information is missing completely at random across most of our data'.[868] This assumption, Cohen argues, is more problematic for historians looking to use quantitative analytical techniques to explore their prosopographic databases. However, digital humanists John Bradley and Harold Short observe that even those prosopographers undertaking qualitative and/or mixed-methods approaches to analysing their prosopography have to grapple with the implications of gaps in their data during the analytical phase. As Bradley and Short reflect:

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864 Ibid., 215.

865 Crosland, *Science Under Control*, 175-6.

866 Sturdy, *Science and Social Status*, xii.

867 Cohen, 'Missing, Biased, and Unrepresentative', 166-176.

868 Ibid., 175.

> Categorization has always been an issue in prosopography. The prosopographer has always not only tried to fit limited, often biased, inaccurate, and inconsistent data found in texts into a sets of persons *[sic]*, but also trying to do this for other things such as offices, status titles, ethnic communities, religion, etc. However, it is the task of the prosopographer … to make these kind of decisions…[869]

Again, as Bradley and Short allude to, these are not insurmountable limitations. But, they are ones that a historian undertaking a prosopographic analysis needs to be aware of, and should seek to transparently document in his or her analysis.

Summary

Prosopography is an important methodological tool for historians. Among its key strengths is that it requires intensive source criticism, and provides an alternative biographical approach to studying groups of individuals – particularly when those individuals are marginal or hidden in traditional textual sources, and/or not available for interview. For the aim of my PhD project, prosopography is particularly suited to exploring the journeys, resettlement and careers of groups of European medical migrants. Medical practitioners – as a social group with often high status, working in a highly-regulated environment – are often well-documented.[870] Those medical practitioners working in Australian states in the twentieth-century are no exception, including so-called 'alien' or non-British doctors, many of whom were unable to legally practise medicine until the early 1950s.[871] In Appendix 2, I discuss how I went about the first stages of prosopography – defining the group under study, identifying them to create a list of names, and the development of the questionnaire. In Appendix 3, I discuss the subsequent stage of prosopography: the sources used to populate the questionnaire for each individual, as well as how the database was structured and analysed. Appendix 4 comprises the complete list of 743 medical migrants registered in Victoria between 1930-60. Appendix 5 comprises an example of a complete biographical dossier from the prosopographic database. Together, Appendices 1-5 detail the considerations that informed the construction and analysis of the prosopographic database that underpins the case studies present in the main body of this PhD thesis, as well as the processes through which it was created and populated.

869 Bradley and Short, 'Texts into Databases', 17.

870 See: Weisz, 'Medical Directories and Medical Specialization ', 23-68; Dupree and Crowther, 'The 'Medical Directory' As a Historical Source', 209–33.

871 See Introduction to Part III for a further discussion.

Appendix 2: Defining and Creating a List of European Medical Migrants Registered in Victoria, 1930-1960

This PhD project explores the journeys, resettlement experiences and work of European medical migrants arriving in interwar and post-war Australia. It draws on data collected for a subset of the 743 medical migrants registered in the state of Victoria between 1930-60 (Table 1; see Appendix 4 for a full list), and captured in a prosopographical database. The core trait these 743 individuals share in common is that they were registered as legally-qualifed medical practitioners in the state of Victoria between 1930-1960 on the basis of a primary medical qualification obtained *outside of Australia*. That is, they are what I label 'medical migrants'. As discussed in Appendix 1, the parameters that defined the population to be studied in a prosopography, as well as the sources used to identify and describe these individuals, needs to be well-understood. This ensures the subjectivities and biases of the sources drawn upon, as well as my own interpretations, are understood and accounted for. Therefore, in this Appendix, I detail how I went about finding 'medical migrants', defining the scope of who would count as a 'medical migrant' in this study.

Finding European medical migrants: The medical registers of Victoria as a primary source for identifying overseas medical graduates

The Medical Board of Victoria was established as a statutory authority in 1862 after the passage of the *Medical Practitioners Act 1862*.[872] The Board's authority from that time included overseeing the registration of men (and later women) seeking legal status as a medical practitioner. The Board had the authority to evaluate all applicants against the conditions for registration set out in the relevant medical act. Every individual wishing to practise medicine in the state of Victoria was obliged to apply to the Board for registration, typically supplying a completed application one month before the next scheduled Board meeting.[873] The cost of registration was a sum of £3, 3d, and additional qualifications could be added for a cost of 10s, 6d. Once approved, the name, full date of registration, nominated address, and qualifications of the applicant was then included as a new entry in the next medical register published.

Throughout the period of interest in this project, the Board were obliged by law to maintain and publish a register of practitioners in the *Victoria Government Gazette*.[874] For example, the *Medical Act 1933,* clause 10 states that:

872 Previously there had been a Port Phillip Medical Board which was replaced by the Medical Board of Victoria. See, Dyason, 'Medical Profession in Colonial Victoria'.

873 This was introduced in *Medical Act 1933*, amending the 1928 Act. The *Medical Act 1935* changed this requirement to 'not less than one month'. NB: In 1951 this was amended to allow research and/or teaching institutions to apply for registration on behalf of overseas-based applicants on temporary appointment. This was under the *Medical (Temporary Registration) Act 1951*.

874 *Medical Act 1933*.

> The Board shall in the month of January every year in which the Minister so directs cause a copy of the register corrected to the thirty first day of December then last past to be published in the *Government Gazette*.[875]

These published medical registers are, therefore, a reliable record of when practitioners were *first* registered to practise in Victoria.[876] From 1931-54, registers were published in January every year, with the exception of the 1942 register (see Table A1). For these registers, the latest registrants included were those who were registered by 31 December of the previous year. From 1955-1960, the registers were published toward the middle or the latter half of the year. It was common for these latter registers to sometimes include individuals registered in that year, as well as the previous year. For example, the 1960 register published on 02 May 1960, included individuals registered in 1959 and the first half of 1960. For this project, a manual search of annually published medical registers could be systematically mined for all the names of registrants who were licensed to practice based on an overseas medical qualification for the period 1930-60.

Table A1 List of medical registers published in the *Victoria Government Gazette*, 1931-60.

Year	Date of publication	Period of new registrants captured	Features of the register/notes
1931	27 Jan	To 31 Dec1930	-
	11 Feb	-	Supplementary list.
	11 Mar	-	Supplementary list.
1932	30 Jan	To 31 Dec 1931	None observed
1933	31 Jan	To 31 Dec 1932	-
1934	31 Jan	To 31 Dec 1933	-
1935	31 Jan	To 31 Dec 1934	Additional or 'supplementary' list of only. Full list not published.
1936	31 Jan	To 31 Dec 1935	-
1937	27 Jan	To 31 Dec 1936	Additional or 'supplementary' list of only. Full list not published.
1938	31 Jan	To 31 Dec 1937	Full list published this year.
1939	31 Jan	To 31 Dec 1938	-
1940	31 Jan	To 31 Dec1939	-
1941	31 Jan	To 31 Dec 1940	-
1942	18 Mar	To 08 Jan 1942	Additional or 'supplementary' list of only. Full list not published.
1943	29 Jan	Between 09 Jan 1942 - 31 Dec 1942	Additional or 'supplementary' list of registrants only. Full list not published.

875 Ibid.

876 NB: They are not a reliable record of the manpower or active manpower for the state at any given period. For example, the registers were only nominally updated to reflect departures, deaths and retirements.

Year	Date of publication	Period of new registrants captured	Features of the register/notes
1944	29 Jan	To 31 Dec 1943	Additional or 'supplementary' list of registrants only. Full list not published.
1945	31 Jan	To 31 Dec 1944	Additional or 'supplementary' list of registrants only. Full list not published.
1946	31 Jan	To 31 Dec 1945	Full list published this year.
1947	31 Jan	To 31 Dec 1946	-
1948	30 Jan	To 31 Dec 1947	Additional or 'supplementary' list of only. Full list not published.
1949	28 Jan	To 31 Dec 1948	Full list published this year.
1950	31 Jan	To 31 Dec 1949	-
1951	31 Jan	To 31 Dec 1950	-
1952	31 Jan	To 31 Dec 1951	-
1953	30 Jan	To 31 December 1952	-
1954	29 Jan	To 31 Dec 1953	-
1955	3 Jun	To 31 Dec 1954	Not published in January.
1956	5 Jun	To 31 Dec 1955	Not published in January. Additional or 'supplementary' list of registrants only.
1957	2 Aug	To 31 Dec 1956 - 12 Feb 1957	Full list published this year.
1958	7 Jul	Between 13 Feb 1957 – 31 Dec 1957	Additional or 'supplementary' list of registrants only.
1959	4 Feb	-	List of temporary licensees only.
	31 Jul	To 10 Feb 1959	Full list published this year.
1960	2 May	To 12 Jan 1960	Additional or 'supplementary' list of registrants only.

The implications of using Victorian medical registers to draw the population of medical migrants for this study are three-fold. First, it limits the study to those individuals who practised within the parameters of orthodox medicine. Those medical practitioners, including those from overseas, who did not need or never sought registration would not be captured. Additionally, historians have well-established that the local medical profession sought to restrict the registration of medical practitioners from continental Europe whose degrees were not recognised.[877] It is well known that some members of this group experienced long waits before they were able to register and legally practise medicine; and some never re-established themselves in this manner.[878] Therefore, mining the Victorian medical register alone for names of medical migrants would certainly be overrepresented by those overseas medical graduates from recognised countries, notably the UK and Ireland. This approach also risks over-

877 Rutland, *Take Heart Again.*

878 Ibid.; See also, Kunz, *The Intruders*.

representing the subsequent 'success' of continental European medical migrants.[879] Similarly, owing to the contested entry of women into orthodox medicine at the turn of the century, women were also less likely to be represented among these registers. Finally, the focus on the place of qualification risked including Australian-born individuals who qualified overseas. However, the latter consideration was less common by the 1930s, when the majority of the profession was known to be locally-born and locally-trained.[880] The principal means by which the first two implications were addressed was by drawing stratified cohorts for this study, where the 569 graduates from schools in Britain, Ireland and continental Europe were stratified by broad place of graduation, and by gender (Table A2). This was discussed in the Introduction to this thesis, therefore, I will only briefly discuss this below. However, it is necessary to discuss who was included as a 'medical migrant' in the primary list collated for, as you will see, there were exceptions to the stratified groups of medical migrants created by the sampling strategy adopted in this thesis.

Table A2 Summary of final count of medical migrants, by cohort, registered in Victoria, 1930-59/60.

	Final count, at as 31 Oct 2017	As a percentage of total number	Cohorts (rounded up)
UK – Males	456	61%	77%
UK – Females	113	15%	
EU – Males	68	9%	12%
EU – Females	19	3%	
ROW – Males	75	10%	12%
ROW – Females	12	2%	
Total	743	100%	

Source: Victorian medical registers, 1931-60.

Selection criteria: Who was included as a medical migrant?

All medical practitioners with a *primary* qualification from a medical school outside of Australia, who were registered between 1930-1959/60 were recorded.[881] A primary qualification here was taken to be the degree(s) that qualified a graduate for registration as a medical practitioner under the conditions of the medical act in force at the time of registration i.e. the degree listed recognised or entitled to be recognised in the medical register. The broad basis of recognition was as outlined in Clause 14 (1) and (12) of the *Medical Act 1928*:

> (1) No person whosoever shall be entitled to be registered as a legally qualified medical practitioner or to receive a certificate of qualification

879 See Introduction to this thesis and Chapter 7 for further discussion.

880 Pensabene, *Rise of the Victorian Medical Practitioner.*

881 It is worth noting that two medical registers proved elusive to find – the 1936 register was only found much later, and has been included in the final count for completion. The register for 1960 although published in May that year, only contains new registrants up to January 1960 (Table A1), therefore the count for 1960 is incomplete.

> unless he has passed through a regular course of medical and surgical study of five or more years' duration.
>
> (2) No school of medicine or university or college or other body for any country other than Great Britain Ireland or any British possession shall be recognised by the Board for the purposes of this Act unless it appears to the Board that registered legally qualified medical practitioners of Victoria are by virtue of being so registered and without further examination entitled to practise their profession in such country either on registration or otherwise.[882]

Between 1930-60, the scope of the eligibility described above changed, particularly with respect to qualifications obtained outside the former Commonwealth.[883] However, no postgraduate qualification(s) alone would have qualified an individual for registration. Therefore, an applicant with an MBBS Melbourne 1930, and a Fellowship from the Royal College of Surgeons in London (FRCS England 1939) would not be included in this list, since their *primary qualifying degree* was from the University of Melbourne.

The final list of medical migrants included practitioners who qualified under three additional pieces of legislation that enabled a 'special' form of registration, and modified the eligibility described in the *Medical Act 1928*. In 1946, the Victorian legislature voted to allow those individuals granted a temporary license during the Second World War to be registered as fully licensed practitioners in Victoria. This was passed as the *Medical Practitioners' Registration Act 1946* as an amendment to the principal medical act. These men and women were formally registered to practise in Victoria, and appeared as a special list of practitioners in the 1947 register, published separate to the main register. Similarly, in 1951, the Victorian legislature voted – with the support of the local medical profession – to introduce a temporary licensing scheme specific to the state, to temporarily register individuals who did not qualify under the principal act to work in a research and/or teaching capacity. This was passed as the *Medical (Temporary Registration) Act 1951*. These registrants were granted a restricted, two-year registration license, and their registrations were also recorded separately to the main register.

Finally, between 1956-8, a series of amendments were passed and consolidated in the *Medical Act 1958* which established recognition of foreign qualifications which were previously unrecognised. This clause, commonly referred to as 'Section 21', was first introduced in 1956 and authorised the Board to register at their discretion foreign medical graduates deemed to have qualifications and experience of 'special value' to the state of Victoria. In 1958 this was amended to include the establishment of a standard examination for foreign applicants who did not otherwise qualify for automatic or standard registration.

Individuals registered having both a primary degree from an Australian university *and* a foreign university were not included if it was their Australian qualification that formed the basis

882 *Medical Act 1928,* Division 3.

883 See Introduction to Part III for a detailed discussion.

for their registration. These instances were rarely found, and their inclusion was determined on a case-by-case basis, based on the eligibility for registration in force at the time. Two individuals – Igor Balabin (MBBS Melbourne 1957, MD Bonn 1950) and Franz Coco (MBBS Melbourne 1958, MD Vienna 1950) – were not included in the final count.

Igor Balabin was registered in 1957, and was listed as graduating from the University of Melbourne that year.[884] Franz Coco was registered in 1958, and was also listed as graduating from the University of Melbourne that year.[885] Under the registration rules in effect from 1956, both Igor Balabin and Franz Coco could have applied for registration under Section 21 which allowed consideration of applicants holding foreign qualifications where some or all of the required minimum of five years' medical training had been gained from a university outside of Australia or an unrecognised university (outside the former British empire).[886] However, the available records including the minutes of the Medical Board of Victoria documenting the basis upon which applicants were entered into the register shows they were registered on the basis of their Melbourne degree.[887]

Additionally, the University of Melbourne's entrance rules with respect to medical graduates holding unrecognised degrees who sought requalification was for them to complete the full six-year medical degree, with the maximum exemption granted for the first year of studies only.[888] For both Igor Balabin and Franz Coco to graduate with an MBBS from the University of Melbourne, they would have completed *at least* five years of study at the University of Melbourne. This requirement effectively meant there was less differentiation between these requalifiers and local students on paper, unlike the specific shortened three-year pathways offered at the Universities of Adelaide, Queensland and Sydney for unrecognised practitioners. The University of Sydney, for example, did not grant requalifying practitioners the degree title 'MBBS Sydney' until early 1970.[889]

Finally, Igor Balabin and Franz Coco appear to have been rare in declaring both their Melbourne and continental European qualifications. Historians Suzanne Rutland and Egon Kunz who have documented the requalification of cohorts of continental European medical migrants in Australia noted that dozens of such requalifications were undertaken[890]. There was no reliable way to single out these individuals from the broader graduating cohorts of Australian universities without spending considerable effort to access archival records at the Universities of Adelaide, Melbourne, Queensland, and Sydney (to capture interstate registrants as well). Therefore, for consistency, these two individuals were removed from the final list of medical migrants detailed below.

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884 Russell, *Melbourne Medical School*, See Appendix 'Graduates 1862-1962' entry for 1957, 251.

885 Ibid., 252.

886 *Medical Registration Act 1956.*

887 PROV – VPRS Minutes of the Medical Board of Victoria,

888 Kunz, *The Intruders*.

889 Rutland, *Take Heart Again* and Kunz, *The Intruders*.

890 Ibid.

Table A2 is a summary of the final stratification of the 743 individuals registered in Victoria on the basis of a primary qualification obtained overseas. Appendix 4 provides the full list of names of these 743 individuals. It is important to note that this list of 743 individuals was drawn *based solely on the registrations published in the medical registers of Victoria* to ensure a consistently-applied sampling technique. Therefore, those classified as a medical migrant and thus included in this list was based only on the degrees they had declared on registration. Further data collected on the sample of 228 of these individuals in this subsequent phase (which I discuss in Appendix 3), demonstrated that there were two cases where the individual also held an Australian degree, but had applied and were registered on the basis of a foreign degree. For example, the medical register entry for Karl Schubert (MD Vienna 1924), registered in Victoria in 1958, only listed his degree from Vienna. His medical directory entry, however, revealed that he had also completed the shortened three-year course for refugee practitioners at the University of Queensland in 1942. He was not removed in the final list because he was registered on the basis of his degree from Vienna.

Similarly, two other individuals – Frederick Harold Moran and Robert Phillip Strang – were selected for the smaller sample cohorts to be studied, were later found to be Australian, and have declared Australian degrees in their medical directory entries. Moran's was a Bachelor of Science from the University of Melbourne obtained in 1914. Strang declared a MBBS from the University of Melbourne obtained in 1939. Moran's inclusion is not problematic as his British qualification formed the basis of his registration. However, Strang's entry has been left in solely because it has not been possible to verify his Melbourne degree. For example, there is a 'Roderick Frank Arthur Strang' among the graduates listed in Kenneth Russell's lists of Melbourne medical graduates for 1939, but not a Robert Philip Strang.[891] Roderick Strang can be traced as a separate individual; and Robert Strang as far as could be traced never changed his name. Therefore, his name was left in the list because it was not fruitful to go through the full list of 456 men and 113 women with British/Irish medical degrees to identify other such cases. Strang remains an enigmatic case in more ways than one. His possible return to Australia was facilitated by his release from English prison having been charged with attempted murder; and he was struck off the General Medical Council register for infamous conduct.[892] Owing to the case study approach adopted in this thesis, Strang's continuing inclusion is jarring but does not confound the conclusions drawn. However, in the future, it is possible that his name will need to be removed from this list if his Melbourne degree can be verified.

Stratifying the sample of European medical migrants

In total, 743 medical migrants were identified in the medical registers published in the *Government Gazettes* of the state of Victoria (Table A2; full list in Appendix 4). These individuals were all registered on the basis of an overseas medical degree i.e. the qualification which they used as the basis for being licensed to practice in the state was not Australian. Table A2 demonstrates that, as expected, the majority of these practitioners – almost 77 per cent – held British and Irish degrees. In total, another approximately twelve per cent of the graduates

891 Russell, *Melbourne Medical School*.

892 'Ex-criminal Now Doctor in Australia', *Canberra Times*, 1 June 1957, 3.

held continental European degrees demonstrating that the majority medical migrant registered to practise in Victoria held European qualifications (broadly defined).[893] The graduates from the rest of the world were determined to be out of scope for this thesis, however, represent an area for further research.

The disparity in numbers between the cohorts of men and women, and British/Irish and other European necessitated that a smaller, representative sample be drawn for further study. The sample sizes were calculated using open source statistical software to determine sample sizes that had statistical significance – resulting in needing 55 British/Irish women and 86 British/Irish men.[894] As discussed in the Introduction to this thesis, the aim of this thesis was to explore the legacies and experiences of the full range of 'European medical migrants', despite the proportional differences in their absolute numbers and eligibility to practise medicine over the period 1930-60. Therefore, in consultation with the University of Melbourne's Statistical Consulting Centre, as well as historical demographer Rebecca Kippen who at the time was working on the *Founders and Survivors* project, a stratified sampling approach was adopted to identify and select individuals for the development of a prosopographical database.

Table A3 Final sample of European medical migrants used to construct the prosopographical database.

	Final count, as at 31 Oct 2017	Final sample drawn, as at 31 Oct 2017	Initial sample drawn, June 2013	Sample as a percentage of final count
UK – Males	456	86	86	19%
UK – Females	113	55	55	49%
EU – Males	68	68	67	100%
EU – Females	19	19	19	100%
ROW – Males	75	Out of scope		N/A
ROW – Females	12			
Total	**743**	**228**	**227**	-

Source: Victorian medical registers, 1931-60.

A further open source piece of software Research Randomizer was used to generate 55 unique numbers out of 113 for the British female cohort, and 86 unique numbers out of 456 for the male cohort. Since these individuals were given unique identifiers that preserved the chronology in which they were identified, starting from 1930, this ensured that any patterns in arrival over time would also be captured. Table A3 summarises the final result of this stratified sampling strategy – with a total of 228 individuals identified for creating a prosopographic database. The final smaller sample sizes are expressed against the original full cohort, and as you can see, the sample drawn reflects the arrival trends of the full cohort. Since these individuals were picked randomly, the sampled cohorts should also reasonably reflect trends

893 The breakdown of the 87 'Rest of the World' medical migrants are as follows: from New Zealand (69), South Africa (5), India (5), Pakistan (2), USA (2), Canada (1), Ceylon/Sri Lanka (1), Hong Kong (1) and Singapore (1). See Appendix 4.

894 The parameters used was a 0.08 degree of accuracy/margin of error, at 90 per cent confidence.

seen in all other variables of the full group, for example, country and place of education. These features are discussed in each case study of this thesis.

Changes to the sample

Appendix 4 lists a total of 743 overseas medical graduates. This number has changed over the life of the project. Since the sample was originally drawn in June 2013, there has been an overall change of +11 individuals from an original figure of 732 names identified as overseas medical graduates in Victoria (Table A4). On 31 October 2017, it was decided that no further additions or changes would be made. Table A4 documents these changes to the overall count, noting the changes for each stratification in the cohort, showing that the final count of overseas medical graduates is 743.

In total, thirteen new names were added (+7 to British/Irish males, +2 to females; +2 to Continental European males; +2 to Rest of World males). Two names – Igor Balabin and Franz Coco – were removed as discussed above, and one individual – Louie Myfanwy Beadnell – originally classified as 'British/Irish male' was discovered to be female and subsequently reclassified. Only three of these changes affected the sample drawn for the prosopographical database. Louie Myfanwy Beadnell's reclassification to the British female cohort added an individual. A randomly generated number was used to replace Beadnell in the sample of British/Irish men. This addition to replace the reclassification of Beadnell, together with two continental European males found, were the only two additions made to the sample drawn to construct the prosopographical database. Therefore, while the overall count changed from 732 to 743 identified medical migrants, the number of individuals drawn to construct the prosopography – 228 individuals (Table A3) – has remained relatively stable.

Table A4 Summary of changes to count of European medical migrants in Victoria, 1930-60.

Cohort	Final count, at as 31 Oct 2017	Count when sample drawn in Jun 2013	Notes on changes made, Jun 2013 - Oct 2017
UK – Males	456	450	Oct 2017 – two names added from 1936 register; two names added from 1939 register; one name added from 1942 register. Sep 2015 – two names added from 1960 register Jun 2013 – one name reclassified from 'male' to 'female
UK – Females	113	110	Oct 2017 – two names added from 1936 register Jun 2013 – one name added from reclassification of male to female
EU – Males	68	67	Jul 2017 – two names added from 1939 register Oct 2017 – one name removed from 1959 register
EU – Females	19	19	No changes
ROW – ALL	87	86	Oct 2017 – two names added from 1936 register; one name incorrectly classified as ROW, and subsequently removed from final count
Total	**743**	**732**	**Change of +11**

***

Appendix 3: The Prosopographic Database – Sources and Structure

In the previous appendix I outlined the process through which 228 individuals were identified for further analysis (Table A3). This appendix outlines the steps taken to construct, populate and use a prosopographical approach to studying the collective lives of these 228 individuals in order to address the primary aim of this study. In doing so, this appendix details the underlying sources and the manner in which the utilised sources were interpreted and used to construct the database. This appendix, therefore, provides a transparent account of the way in which the available data was collected and deployed, and forms the basis from which the case studies were developed. It is important to repeat here that the prosopographic database constructed to house this data is not complete. That is, as further sources of data are revealed, there is potential to add new information to any number of the 228 individual's records. However, a critical mass of information was deemed to have been collected so that analysis of each of the three identified cohorts – British/Irish men, British/Irish women, and continental European men and women – could be developed into case studies.

The prosopographical questionnaire

In Appendix 2, I outlined the stratified sampling strategy adopted for this project. The next stage in constructing a prosopographical database was to determine what biographical data was to be collected for these 228 individuals. The principal data to be collected was determined by the development and refinement of the questionnaire detailed in Table A5. This was originally based on typical prosopographical questionnaire's identified by Verboven et al, in 'The Short Manual to the Art of Prosopography', and modified to address the specific questions to be explored in this study.[895]

One major change that is worth noting is that I took a more liberal approach to data collection – one advocated by historian Gidon Cohen and his colleagues as discussed in Appendix 1 – compared to older, traditional prosopographies.[896] I decided from the start of the project that I would record all sources found for the individual, including those that did not strictly fit with the proposed questionnaire. My reasons for doing this were two-fold: first, the time-consuming nature of the data collection process, as well as the difficulty of accessing some archival material, meant that if I discovered I had discarded information that later proved to be important or relevant, I may not have the opportunity to go back and retrieve it. Second, my PhD project – as all Australian PhDs – is funded by the Australian federal government, and includes a mandate to disseminate research findings to wider audiences, including non-academic audiences. Therefore, I envisioned a future that would include a public engagement project, and potentially the publication of my database online for family members, and other interested audiences to engage with, as well as the possibility my data could comprise the starting point of a future research project. This is captured in the last row of Table A5 labelled 'Other/emergent data'.

895 Verboven et al., 'A Short Manual to the Art of Prosopography, 55-56.

896 Cohen et al., 'Towards A Mixed Method Social History', 211-229.

Table A5 Prosopographic questionnaire.

Type of information	Specific fields	Typical sources used	Rationale for collecting this data
Basic biographical information	Names, and all aliases	Medical registers, medical directories, immigration forms	Provides an indication of age on graduation, migration, and retirement.
	Dates and places of birth, death and marriage	Registers of births, deaths and marriage held in UK and Australia	Provides indication of social status, including changes in status.
	Father's occupation	Interviews, obituaries, (auto)biographies	Describes family units.
	Names of spouse and children (if applicable); spouse career (if available)	Passenger arrival and departure lists	Place of death also provides indication of permanent settlement in Australia, by state or territory.
Education	Name and place of secondary school	University records (where available); Interviews, obituaries, (auto) biographies	Provides information on medical education, and career progression.
	Name, place and year of graduation from all tertiary qualifications	General Medical Council lists; Victorian medical registers; Medical Directory entries; University records, BMJ published lists	University entrance records often provides information on social status and secondary schooling, which are both indication of social status of the individual on entrance to university.
	Name, place and year of attainment of all postgraduate qualifications		Postgraduate training is a strong indication of medical career aspirations and attainment.
Mobility and Migration	Places and/or countries worked	Medical directory entries, obituaries, Applications held in National Archives of Australia; Minutes of Medical Board of Victoria held in Public Records Office of Victoria	Provides insights into length of stay in Australia, the international and interstate mobility of medical migrants, including patterns of return migration or re-emigration.
	Arrival (and if applicable) departure from Australia	Passenger arrival and departure lists	

Type of information	Specific fields	Typical sources used	Rationale for collecting this data
Career information	All known occupations held, including locations	Medical directory entries; obituaries; (auto) biographies, interviews with surviving medical migrants in the sample; applications held in National Archives of Australia; Minutes of Medical Board of Victoria held in Public Records Office of Victoria; Archives held at the State Library of Victoria; published works, including histories of hospitals and medical institutions; International Refugee Organisation medical register and archives.	Self-explanatory.
	Career gaps (if applicable)		
	Memberships of professional associations		
	Committee and professional memberships		
	Publications in medical journals		
	Awards		
	Military service	Above; also National Archives, secondary sources that record lists of military service	
Other/emergent data	Captured in open-text fields	Source-led: Interviews, (auto)biographies, obituaries, diaries, letters and other primary sources; mentions in popular press	Enables reconstruction of individual lives (if required).

Reconstructing migrant medical lives: An evaluation of key sources and their limitations

Anne Crowther and Marguerite Dupree observed of their prosopography of nineteenth-century Scottish medical students, that

> from the historian's point of view, the perfect medical man was one who conscientiously filled in his annual entry in the *Medical Directory*, including his address and major activities … and who was finally accorded lengthy obituaries in several medical journals.[897]

To this can be added that the perfect medical woman would, in addition to the above, have consistently updated her entries in medical registers and medical directories to reflect name changes adopted after marriage. Medical directories are, however, an important primary source for medical histories.[898]

Having drawn a sample of 228 individuals (Table A3), and developed a prosopographic questionnaire (Table A5), the next major task – and the one that is destined to remain incomplete – was to find, verify, and capture the information outlined in the database for every

897 Crowther and Dupree, *Medical Lives in the Age of Surgical Revolution*, 122.

898 Ibid.; See also, Weisz, 'Medical Directories and Medical Specialization', 23-68; and Dupree and Crowther, 'The "Medical Directory" as a Historical Source', 209–33.

individual sampled. The starting point for each individual was the information provided in their registration with the Medical Board of Victoria: family name, given names, an address, a date of registration and a list of qualifications which included place and year of qualification as outlined in Appendix 4.

As discussed, published medical directories are established, important primary sources for medical historians. However, medical directory entries alone could not populate all the fields identified in the prosopographic questionnaire. A central part of this stage of the research was identifying other primary sources from which data could be drawn to develop the database. The third column of the questionnaire detailed in Table A5 provided examples of the sources I expected to drawn on to populate each individual's database entry. In this section I briefly evaluate only the *key* primary sources used to populate each individual's database entry, against the questionnaire developed and outlined above. Each source proved to have a different set of limitations that had implications for the interpretation of results derived from analysing the subsequent database for patterns of participation, and these will be highlighted. Table A6 below summarises the full list of all primary sources used to populate the biographical dossiers of the 228 individuals.

Table A6 Summary of additional primary sources used to populate biographical dossiers.

Primary source	**Location, and/or description**
Schedules of Displaced Persons surveyed	National Archives of Australia (Canberra and Melbourne)
Applications for 1942 wartime license	
Naturalisation records	
Australian Military Personnel records	
Individual records, typically if they were investigated by ASIO	
International Refugee Organisation, Professional Medical Register (1949)	Copy held by National Archives of Australia (North Melbourne)
Egon Kunz working papers on *The Intruders: Refugee Doctors in Australia*	Noel Butlin Archives, Australian National University (Canberra)
British Medical Women's Federation archives	Wellcome Library (London)
British Medical Association archives	BMA House (London)
Victorian Medical Women's Federation Archives	State Library of Victoria (Melbourne)
Biographical cuttings and recorded interviews	National Library of Australia (Canberra)
Medical Board of Victoria - minutes, foreign register and working papers	Public Records Office of Victoria (North Melbourne)
Wills and probates	
Sponsor/Applicant schedules for post-war emigration schemes	
Passenger arrivals and departures	Ancestry.com (paid digital resource)
UNRRA archives	Archives Unbound (paid digital resource)

Primary source	Location, and/or description
Obituaries and biographies	Medical journals; newspapers (inc. Trove); websites; Ancestry.com (paid digital resource); *Australian Dictionary of Biography;* interviews and e-mail correspondence
Research publications	
Plarr's Lives	Royal College of Surgeons (digital resource)
Munk's roll	Royal College of Physicians (digital resource)
Membership records	Royal Australian College of General Practitioners
Matriculation records	Multiple universities in Europe, inc. UK and Ireland

Despite spending close to four years (part-time) searching sources located in a number of states and countries, some individuals simply disappear in the accessible records. Therefore, the database is necessarily a mosaic, where the most complete records include verification from interviews with the surviving practitioner, to individuals who never updated their medical directory entries, or whose names are such a popular combination that tracing them across space and time is virtually impossible. For example, the English graduate Mary King whose name is the combination of two common first and last names. Two limitations of my data collection efforts were, however, imposed by financial and linguistic constraints. First, the Victorian registry of Births, Deaths and Marriages holds a remarkable volume of information on individuals. However, it is behind a pay wall that was insurmountable for a PhD project. Second, the only European language I speak fluently is Spanish, which enables some engagement with published information in Italian. There is no doubt a vast amount of information available about the continental European medical migrants sampled for this study in repositories around Europe, however, I had neither the finances nor language competence to access these repositories.

The database as it currently stands contains a number of 'unknowns' in one or more fields for many of these 228 individuals. There are two reasons for this, the first is straightforward: the individual could not be found in the set of primary sources consulted. The second reason is, however, owing to the ambiguity of self-reported career information published in medical directories, especially when no other supporting evidence for the individual was found. 'Unknowns' were recorded in any given field for an individual if the information found not be confidently attributed to the individual. Triangulation was central to this process of searching and sifting through all available sources. Although key sources are listed and discussed discretely here, you will see that each field of information eventually retained and recorded against an individual was the result of an iterative process between myself as the researcher and the set of primary sources consulted.

Medical directories

The medical directories of Australia, together with the older, more regularly published British counterpart – *The Medical Directory*, were the two major primary sources around which this study was built. Medical directories contained entries for registered medical practitioners which included, at a minimum, their name and primary qualification. However, the typical medical directory entry would also include additional self-reported information returned by the practitioner. The *pro forma* circulated to practitioners included scope to add postgraduate

qualifications, practice address(es), professional memberships, a chronological list of current and/or past positions held, and publications.

Medical directories were used by members of the profession to 'advertise' themselves in a hierarchical professional environment that prohibited other forms of self-promotion.[899] As the editor of the *Medical Journal of Australia* observed, the reprisal of a national medical directory in 1935 'was welcomed by the medical profession of Australia as a valuable book of reference'.[900] In the UK, the directories were also regularly consulted by employers of medical practitioners when considering applicants for a post.[901]

Therefore, while the entries are highly subjective accounts, practitioners were incentivised to self-report honestly – if not sometimes fluffily. Editors of the medical directories also edited returns from practitioners to remove false content.[902] A large proportion of practitioners were further incentivised to update their entries regularly. As Anne Crowther and Marguerite Dupree observed in their evaluation of the 1911 UK medical directory:

> It would have been folly for them [practitioners] to conceal their accomplishments unless they were so well known or so secure as to make advertisement superfluous.[903]

For a historian, the value of medical directories as a primary source is that it enables a reconstruction of individual professional lives across time, within the bounds of its subjectivity and its other limitations. Analysis of a single individual's entries in chronological order reveals how they edited and omitted information about their careers over the years. A common pattern observed was for junior, less prestigious early roles, and temporary roles to be left off as the individual's career progressed. However, closer to retirement or following retirement, many practitioners provided more detailed summaries of their careers. Therefore, the subjectivity of a single entry can be mitigated in part by collating entries over time.

A key activity undertaken in this study was to create a sketch of career patterns for each of the cohorts being studied by attributing a primary type of medical work that each individual undertook, at a particular point in time. The first limitation of the medical directory entries in this respect is that general practitioners – the most common practitioner type – were not explicitly named as such, owing to editorial policy that prevented descriptive titles.[904] Only institutional appointments held in hospitals, research institutions, or public health departments, for example, were allowed for much of the period this study is interested in.

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899 Dupree and Crowther, 'The "Medical Directory" As A Historical Source', 209–33.

900 'An Australian Medical Directory', *MJA*, 1937, 140.

901 Dupree and Crowther, 'The "Medical Directory" as a Historical Source', 209–33.

902 Very limited information exists for the editorial policy of the medical directories of Australia, however, the directories were edited with the involvement of the editor of the *Medical Journal of Australia* and the chapters of the British Medical Association in Australia. See: 'An Australian Medical Directory', *MJA*, 1937, 140.

903 Crowther and Dupree, 'The "Medical Directory" as a Historical Source', 215.

904 Loudon, *Medical Care and the GP,* 213.

While the consistence absence of any other employment information could reasonably indicate that an individual was in private practice, and most likely as a general practitioner, it would be a dangerously false attribution to make in the absence of any other form of corroboration, particularly as editors often reproduced the last entry if no updates were received in time for publishing the next edition.[905] Within the directories, membership or fellowship of either the UK or Australian College of General Practitioners, founded in 1952 and 1958 respectively, was often the only indication in the medical directories that the individual was a general practitioner. In the 1990 Australian medical directory, 'GP' was introduced in the entries.

Second, locum positions, secondments or other informal promotions were also not printed. This former is particularly relevant when studying medical migrants since locum work would have been a particularly easy and obvious transitional work for migrants to access if they arrived in Australia without prior employment arranged. Throughout the period 1930-60, Australian practitioners regularly reported difficulties obtaining locum relief for their practices. As discussed in Chapters 3, 4, and 7, interviews with surviving practitioners, and occasionally detailed biographical accounts, have revealed the extent to which medical migrants undertook locum work on first arriving in Australia. Medical directory entries in no way can shed light on the extent to which medical migrants availed themselves of locum work. Out of the 228 practitioners studied, only one – Constance Napier – reported a period as a locum in the New South Wales country town of Newcastle when she first arrived in 1950.[906]

Constance Napier reported this in her entry in the 1990 *Medical Directory for Australia*. Changes in the editorial policy for that edition have also further helped mitigate identifying general practitioners – the first limitation discussed – to a certain extent. By 1990, general practice was long-established as a medical specialty in Australia.[907] Self-reported entries included the ability to describe themselves as a 'GP'. For example, Jane Caldwell's entry in this edition was as follows:

> **Jane Madilo Caldwell**, MBBCh Belfast (Qu) 1949, BAO Belfast 1949; INT Nth Ireland 1949-50; GP Salford 1950-55; GP Melbourne 1956-61; GP Melbourne 1968-85; Mem AMA, BMA; Address: 14 Sandy st, Nunawading, Vic 3131.[908]

Her previous entries in both the British and Australian directories only included her qualifications, memberships, and an address.

Additionally, the new form of gazette introduced in the 1990 edition did not just group practitioners by locality, it also grouped them by reported specialism (and for general practitioners, included specialist interests too). Therefore, for practitioners including Jane Caldwell who included timeframes across each reported role, and/or reported themselves as still practising GPs in 1990, it is possible to attribute the role of general practitioner to them, as well

905 Additionally, early editorial practice meant that if an individual did not return their entry, the previous entry was reproduced.

906 Entry for 'Napier, Constance', *Medical Directory of Australia*, 1990.

907 As discussed in Chapter 2.

908 Entry for 'Caldwell, Jane Madilo', *Medical Directory of Australia*, 1990.

as map their practice geographically. Once again, the reliance on self-reporting means the utility of this new editorial policy is limited to those practitioners who took advantage of it.

Finally, time fractions were not allotted to reported roles. It is well-known that a medical career for the greater part of the twentieth-century was characterised by its plurality, whether in private practice or as a salaried employee.[909] For example, general practitioners often worked as part-time Medical Officers of Health for local or state councils; hospital consultant specialists often had private practices; married women often worked part-time. For many practitioners, it is impossible to use their medical directory entries alone to determine any of these three features confidently.

Despite these limitations, the medical directory entries for individuals are valuable primary sources for historians, particularly when seeking to explore collective patterns, over time. Once digitised, this information can be used to build sophisticated albeit illustrative sketches of the career progression of medical migrants; the nature of that progression, for example, by eliciting patterns in the attainment of postgraduate education or membership of specialist societies; as well as the geographical distribution and mobility – both international and intra-national – of practitioners over time.[910]

With that general overview of the utility of medical directories as a historical source in this study, the following two sections will briefly outline the specific ways in which the two different publications – the *Medical Directory for Australia* and *The Medical Directory* (UK) – were used in populating individual entries in the prosopographic databases. Each directory was structured differently, and as such, the specificities that have ramifications for this study are briefly outlined.

Medical Directory for Australia

For each individual, entries in the *Medical Directory for Australia* was captured in the database verbatim. In total, six editions' worth of entries spanning from 1935-1990 was consistently captured, and where necessary in-between editions and the 2000 edition was consulted. The six editions used were chosen to be roughly evenly spaced, and were the 1935, 1948, 1957, 1966, 1978 and 1990 editions. The 1935 edition was the only starting point possible for the Australian directory for reasons discussed below.

The 1935 edition of the *Medical Directory for Australia* marked the culmination of plans to resurrect a national directory by Errol Galbraith Knox.[911] Previous, sporadic volumes of Australian medical directories had last been published by the Butterworth publishing company, as *Loxton's Medical Directory for Australia, Tasmania, New Zealand, Pacific Islands, Malay States, China, Japan, and Hong Kong* in 1914. In the preface to this first volume, Knox observed that this volume was compiled 'on the lines of the British Medical Directory', offering

909 Fett, PhD diss., in particular, 88-91, 127-30.

910 As discussed in, Dupree and Crowther, 'The "Medical Directory" as a Historical Source'; Weisz, 'Medical Directories and Medical Specialization'.

911 'An Australian Medical Directory', *Medical Journal of Australia,* 1934, *x,* 368.

entries for 'every traceable registered medical practitioner in Australia, and the Commonwealth territories in the Pacific'.[912]

This first edition was compiled in a two-stage process, first by creating individual entries based on 'all available sources', and secondly by sending these entries to each identified individual for them to correct and return. Therefore, the 1935 edition is by its own admission incomplete – for example, it relied on the addresses listed in the published government medical registers, and therefore many of these letters would never have been received since these registers were notoriously poorly updated.[913] Non-receipt of their entries did not appear to have affected the practitioners in the sample of this study. All practitioners registered between 1930-1934 in Victoria would be expected to have an entry in this inaugural 1935 directory, and they did, as illustrated in Table A7.

Table A7 Summary of entries in Australian medical directories, by cohort. The numbers in parentheses indicates the total number of entries expected based on year of registration in Australia (Appendix 4). NB: these expected entries have not been adjusted to reflect changes due to death, retirement, and departures from Australia. Therefore, the total numbers of entries expectedly decline over time.

	1935	1948	1957	1966	1978	1990
British/Irish – men (n=86)	4 (4)	11 (16)	38 (63)	53 (86)	45 (86)	29 (86)
British/Irish – women (n=55)	3 (3)	7 (16)	22 (40)	32 (55)	29 (55)	21 (55)
Continental European – ALL (n=87)	4 (4)	32 (47)	46 (59)	66 (87)	51 (87)	20 (87)

Source: Australian medical directories, 1935-90.

Errol Knox was to go on to edit annual volumes up to 1939 (published in 1940). After this edition, the next edition was published in 1948, under the editorial oversight of the Australasian Medical Publishing Company Ltd., an independent subsidiary of the British Medical Association in Australia that also published the *Medical Journal of Australia*.[914] The 1948 directory was chosen over the 1940 edition for inclusion because the number of registrations between 1935-39 were small, whereas the 1948 edition would capture early post-war arrivals and registrations, as well as wartime service for those already resident in Australia between 1930-47.

From 1948, the directories were published roughly every three years up to 1960, and then roughly every two-three years until 1980. Therefore, the 1957, 1966 and 1978 editions were chosen for systematic inclusion because the first two were each nine years apart. In the absence of a 1975 edition, the 1978 edition was chosen over the 1974 edition and the 1980

912 Knox, *Medical Directory for Australia*.

913 Ibid.

914 Michael Kelly, 'Medical Directory of Australia', *Archives of Internal Medicine,* 1962, 212.

edition for inclusion in the database to reduce the period between the subsequent edition chosen for inclusion. From the 1980 edition, there was then a hiatus of ten years before plans to reprint a directory were once again resurrected. The next edition printed was the 1990 directory, under the chairmanship of Professor Priscilla Kincaid-Smith and the editorial oversight of Dr Peter Arnold at the Australasian Medical Publishing company.[915] Both of whom were, incidentally, South African medical migrants to Australia.

The overall scope of the directories, including the structure of entries remained fairly stable between the 1935 and 1978 editions. They include: names; qualifications (including place and year when available); hospital appointments that are both resident and honorary; public health appointments, including with state and federal health departments (including mental health sanatoria and repatriation hospitals); committee membership of BMA and other professional membership associations; war service; awards and honorary titles – for example, Order of Australia; publications in the medical and scientific journals; and finally addresses and telephone numbers. As discussed above, the 1990 volume represented a significant revision in the structure and presentation of the entries, most notably, the latter included locum and general practice as specific descriptions, as well as medical specialism classifications and declared special interests of general practitioners.

The supplementary information to the main alphabetical directory has also provided additional information that has been used in this study, particularly the gazetteers which provide names of practitioners by state and geographic distribution – classified by urban and country areas; as well as the lists of appointments in the state and federal departments of health, public hospitals and the universities; and membership lists for specialist societies.

The Medical directory (UK)

All practitioners sampled that held a British and/or Irish medical qualification – including postgraduate qualifications obtained after registration – were searched for in the relevant entries in the British medical directory. Systematic data were captured every ten years starting from 1931 and ending in 2001. The periodic spacing of this data capture was owing to the high degree of reproduction between the annual editions of *The Medical Directory*; and the rapid tapering of entries as permanent migrants stopped updating their British entry. For example, the average number of entries for the British/Irish medical women cohort and the male cohort was 2.8 respectively.

General Medical Council registers

The General Medical Council (GMC) register was the equivalent national medical register to the Victorian medical register. All medical graduates from British schools were required to register with the GMC, first as students, and then as graduates. These registers contained names, addresses, and a date and place of registration. Therefore, in addition to the data available in *The Medical Directory*, where applicable, the date of registration and country of registration – England, Scotland, Northern Ireland or Wales – was captured for all British medical graduates in the sample. The GMC dates are as precise as the date of first registration in the medical

915 Dr Peter Arnold, e-mail message to author, 08 March 2016.

registers of Victoria (the latter was used to draw the population of medical migrants registered in that state). Therefore, recording the GMC entries served two purposes: first, it enabled cross-referencing year of graduation published in the directories and the medical registers of Victoria to be confirmed. Second, it enabled calculations of time between graduation and registration in Victoria, for example, to be determined to a high degree of accuracy.

National Archives of Australia

Passenger arrival lists

Fully digitised and searchable passenger arrival lists are available for Australia between 1898-1966. Name searches were conducted for all individuals in the sample to record date of arrival and the name of the vessel. Where stated, the scheme under which the passenger(s) arrived was also recorded. These passenger arrival lists were also used to record marital status on arrival, as well as the names, occupation and dates of birth of spouses and accompanying children (if applicable). Later arrival cards of medical migrants who travelled frequently also listed dates of birth and occupation more definitively, therefore, where not found elsewhere, these cards were used as a source of information for these two fields.

The arrival dates for 64 of the 228 individuals is unknown or uncertain, and for one individual not applicable.[916] For the British/Irish male cohort, the arrival details for 37 out of 86 practitioners could not be found (43%). Most commonly, arrival dates cannot be traced for individuals with very common family names, for example, Smith or Wilson. A limitation of the passenger arrival index is that there is a degree of variation with which initials and occupations are recorded. For example, John Egerton Williams might have been indexed as: 'Williams, John', 'Williams, J E', or 'Williams, John Egerton' or simply as 'Williams'. Only occasionally were some individuals indexed with the title 'Dr'. Therefore, some individuals including 'John Wilson' who registered by the Medical Board of Victoria in March 1958 cannot be distinguished from the 'John Wilson' who arrived aboard the *Strathnaver* in February 1958, or the 'J Wilson' who also arrived in December 1957, or either of the two 'John Wilsons' who arrived in June and November 1957.

For the British/Irish female cohort, arrival details for 12 out of 55 could not be found (22%). In addition to the complications encountered by common family names, the most common difficulty encountered in tracing women is if they were married. The ship records and immigration records often simply stated 'Mrs Smith', for example, and frequently recorded their occupation as 'housewife'. Finally, 15 out of 87 of the continental European doctors could not be traced (17%). Those who proved most difficult to trace were doctors who changed their names by deed poll, prior to registering with the Medical Board of Victoria. Therefore, their medical registration and their passenger arrival index would be recorded under different names. Additionally, there were a number of these practitioners whose names are simply misspelled. However, the comparatively high rate of success in tracing arrival records for these individuals

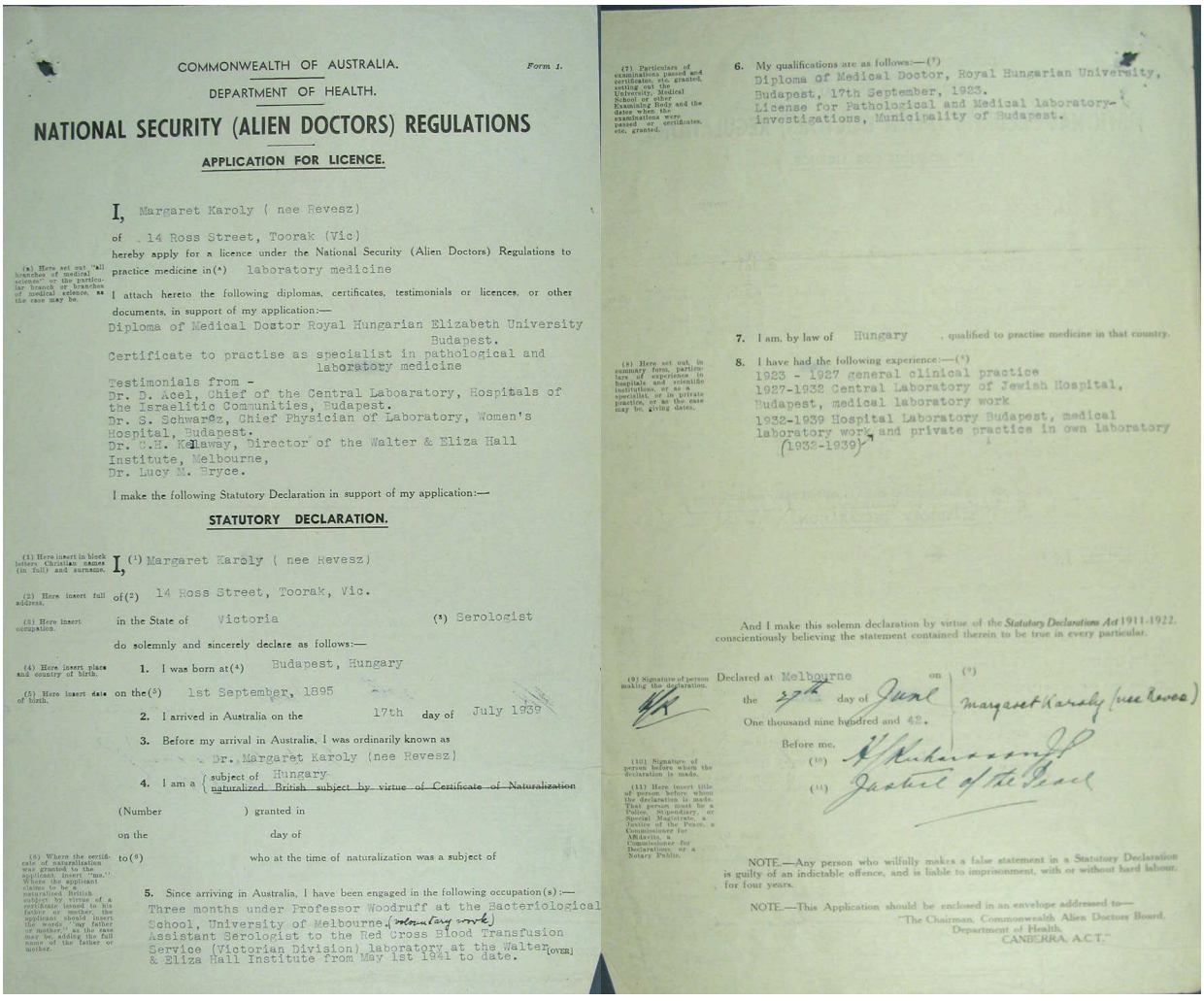
916 They are not applicable because there is a high degree of certainty that the practitioner never travelled to Australia, despite being registered in Victoria.

is owing to the uniqueness of their family names relative to the average passenger arriving in Australia during that time.

The 1942 temporary wartime licensing scheme

In 1942, as discussed, the federal government overwrote state medical acts to temporarily license resident continental medical migrants to provide relief from the shortages of civilian practitioners. Applications were invited from these practitioners from all across Australia. The National Archives of Australia has retained all correspondence, applications, assessment for this scheme, as well as partially-retained records of the work and subsequent evaluations of successfully licensed doctors. The application forms, supporting documentation, and the reports of successfully-placed licensees provided significant information on a group of 20 continental European medical migrants who applied for the scheme, and are in my sample. See Figure A1 for an example of the application forms preserved in the National Archives of Australia.

Figure A1 Sample of application form for temporary wartime license from Hungarian Margaret Karoly.



COMMONWEALTH OF AUSTRALIA. Form 1.

DEPARTMENT OF HEALTH.

NATIONAL SECURITY (ALIEN DOCTORS) REGULATIONS

APPLICATION FOR LICENCE.

I, Margaret Karoly (nee Revesz)

of 14 Ross Street, Toorak (Vic)

hereby apply for a licence under the National Security (Alien Doctors) Regulations to practice medicine in(*) laboratory medicine

I attach hereto the following diplomas, certificates, testimonials or licences, or other documents, in support of my application:—

Diploma of Medical Doctor Royal Hungarian Elizabeth University Budapest.
Certificate to practise as specialist in pathological and laboratory medicine

Testimonials from -
Dr. D. Acel, Chief of the Central Laboaratory, Hospitals of the Israelitic Communities, Budapest.
Dr. S. Schwarcz, Chief Physician of Laboratory, Women's Hospital, Budapest.
Dr. C.H. Kellaway, Director of the Walter & Eliza Hall Institute, Melbourne,
Dr. Lucy M. Bryce.

I make the following Statutory Declaration in support of my application:—

STATUTORY DECLARATION.

I,(1) Margaret Karoly (nee Revesz)

of(2) 14 Ross Street, Toorak, Vic.

in the State of Victoria (3) Serologist

do solemnly and sincerely declare as follows:—

1. I was born at(4) Budapest, Hungary on the(5) 1st September, 1895
2. I arrived in Australia on the 17th day of July 1939
3. Before my arrival in Australia, I was ordinarily known as Dr. Margaret Karoly (nee Revesz)
4. I am a { subject of Hungary / ~~naturalized British subject by virtue of Certificate of Naturalization~~ (Number) granted in on the day of to(6) who at the time of naturalization was a subject of
5. Since arriving in Australia, I have been engaged in the following occupation(s):— Three months under Professor Woodruff at the Bacteriological School, University of Melbourne. (voluntary work) Assistant Serologist to the Red Cross Blood Transfusion Service (Victorian Division) laboratory at the Walter & Eliza Hall Institute from May 1st 1941 to date. [OVER]

6. My qualifications are as follows:—(7)
Diploma of Medical Doctor, Royal Hungarian University, Budapest, 17th September, 1923.
License for Pathological and Medical laboratory-investigations, Municipality of Budapest.

7. I am, by law of Hungary , qualified to practise medicine in that country.

8. I have had the following experience:—(8)
1923 - 1927 general clinical practice
1927-1932 Central Laboratory of Jewish Hospital, Budapest, medical laboratory work
1932-1939 Hospital Laboratory Budapest, medical laboratory work and private practice in own laboratory (1932-1939)

And I make this solemn declaration by virtue of the *Statutory Declarations Act* 1911-1922, conscientiously believing the statement contained therein to be true in every particular.

Declared at Melbourne on the 27th day of June (9) Margaret Karoly (nee Revesz)
One thousand nine hundred and 42.

Before me, (10) (11) Justice of the Peace

NOTE.—Any person who wilfully makes a false statement in a Statutory Declaration is guilty of an indictable offence, and is liable to imprisonment, with or without hard labour, for four years.

NOTE.—This Application should be enclosed in an envelope addressed to—
"The Chairman, Commonwealth Alien Doctors Board,
Department of Health,
CANBERRA, A.C.T."

Source: NAA: A1982 652/17/A.

A large proportion of evidence gathered to describe the 'gap years' of these doctors who were otherwise ineligible for registration until 1956 in Victoria is drawn from these applications. Applicants were required to describe their medical education in detail, as well as outline *all*

their work experience since graduation, both medical and non-medical. Additionally, for those applicants who were successful, records were kept outlining the nature of their placements, as well as frank evaluations of their performance since licenses were issued for a period of two-years, after which they could be renewed. Some successful applicants also had their original license modified to relax restrictions placed on the terms of the license by the examining board that assessed him or her. Occasionally, the licenses were further restricted. A large volume of correspondence and internal documentation with respect to this wartime scheme has been retained. A large portion of the documentation supplied by the applicants appears to have been retained, with the exception of copies of qualifications (testamurs), and copies of journal publications which some of these doctors appended to support their claim to specialist work.

Similar to the medical directory entries themselves, the completed application forms are a subjective account of these doctors' prior medical experience – typically in Austria, Germany and Italy, since they were filled out by the doctors themselves. Although they provided support of their qualifications, many of these doctors did not have written references, or further documentation, to support their claims. Therefore, similar care needs to be taken when using this archival source to reconstruct these doctors' lives, as discussed for medical directory entries. It is important to note that this archival source also represents the most complete record available of the 'gap year' work of unregistered doctors for many of the individuals in the Victorian sample. These men and women, particularly those who went on to re-establish themselves as practising medical professionals, often were reluctant to discuss or disclose further details.[917]

These applications are also for many of these doctors a more complete English-language source that documents their work in continental Europe. As discussed, early in the life of this project it was decided not to pursue the medical directories or equivalent publications published in the various countries from which these doctors studied and worked in Europe. The most common locations include Austria, Germany, Hungary, Italy, Lithuania, Poland as well as the Slavic states. The two key considerations that determined this was the complications of accessing these records, but equally importantly, being able to accurately translate these sources to analyse them. This is a limitation of this study. However, a large amount of effort was directed at sourcing and locating other primary sources that could corroborate and/or reveal the medical lives of these doctors prior to arriving in Australia.

Sources held by Public Records Office of Victoria (PROV)

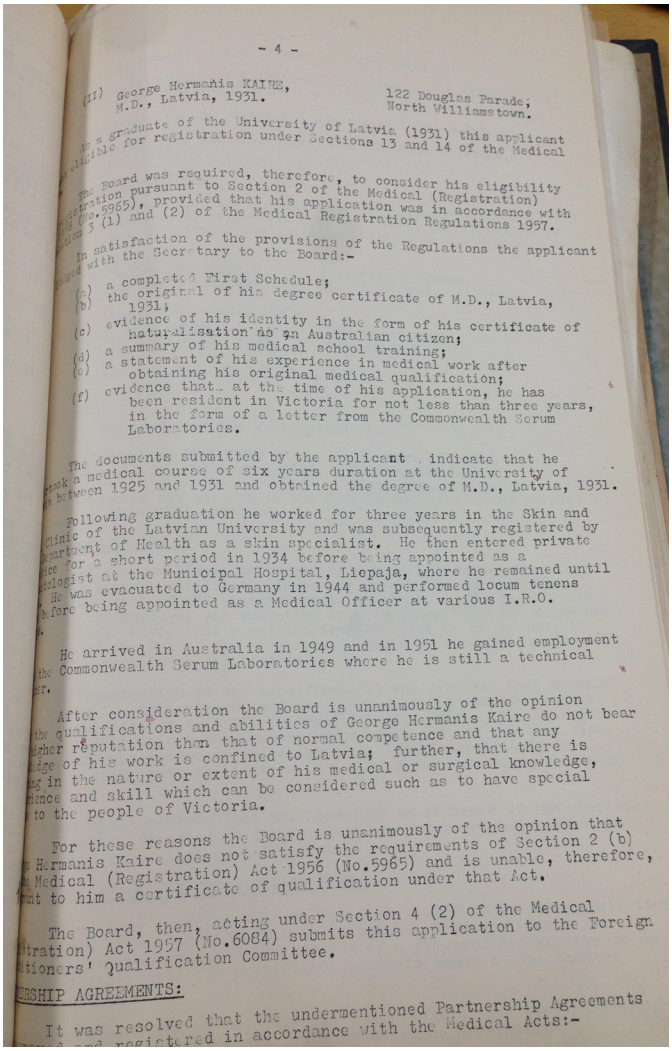
Minutes of the Medical Board of Victoria, 1930-60

Similar to the applications for the 1942 temporary licensing scheme discussed above, the minutes of the Medical Board of Victoria held in the Public Records Office of Victoria represents an equally rich record of prior work experience and gap year work for continental European medical migrants who applied for registration following the liberalisation of the state medical act in 1956, and subsequently the introduction of the foreign licensing examination. Unlike the records held in the National Archives of Australia – which are complete

917 Kunz, *The Intruders,* 93-115. See Chapter 7 for further discussion.

reproductions of the applications of these men and women – the Minutes are summaries of applications recorded by the secretary of the Board during each meeting. Figure A2 provides a snapshot of one such summary.

Figure A2 An example of Medical Board of Victoria minutes documenting continental European medical migrant applications – summary for George Hermanis Kaire.



- 4 -

(11) George Hermanis KAIRE, M.D., Latvia, 1931. 122 Douglas Parade, North Williamstown.

As a graduate of the University of Latvia (1931) this applicant is eligible for registration under Sections 13 and 14 of the Medical

The Board was required, therefore, to consider his eligibility for registration pursuant to Section 2 of the Medical (Registration) Act 1956 (No.5965), provided that his application was in accordance with Section 3 (1) and (2) of the Medical Registration Regulations 1957.

In satisfaction of the provisions of the Regulations the applicant has lodged with the Secretary to the Board:-

(a) a completed First Schedule;
(b) the original of his degree certificate of M.D., Latvia, 1931;
(c) evidence of his identity in the form of his certificate of naturalisation as an Australian citizen;
(d) a summary of his medical school training;
(e) a statement of his experience in medical work after obtaining his original medical qualification;
(f) evidence that at the time of his application, he has been resident in Victoria for not less than three years, in the form of a letter from the Commonwealth Serum Laboratories.

The documents submitted by the applicant indicate that he took a medical course of six years duration at the University of Latvia between 1925 and 1931 and obtained the degree of M.D., Latvia, 1931.

Following graduation he worked for three years in the Skin and Clinic of the Latvian University and was subsequently registered by Department of Health as a skin specialist. He then entered private practice for a short period in 1934 before being appointed as a dermatologist at the Municipal Hospital, Liepaja, where he remained until 1944. He was evacuated to Germany in 1944 and performed locum tenens before being appointed as a Medical Officer at various I.R.O.

He arrived in Australia in 1949 and in 1951 he gained employment with the Commonwealth Serum Laboratories where he is still a technical officer.

After consideration the Board is unanimously of the opinion that the qualifications and abilities of George Hermanis Kaire do not bear a higher reputation than that of normal competence and that any knowledge of his work is confined to Latvia; further, that there is nothing in the nature or extent of his medical or surgical knowledge, experience and skill which can be considered such as to have special benefit to the people of Victoria.

For these reasons the Board is unanimously of the opinion that George Hermanis Kaire does not satisfy the requirements of Section 2 (b) of the Medical (Registration) Act 1956 (No.5965) and is unable, therefore, to grant to him a certificate of qualification under that Act.

The Board, then, acting under Section 4 (2) of the Medical (Registration) Act 1957 (No.6084) submits this application to the Foreign Practitioners' Qualification Committee.

PARTNERSHIP AGREEMENTS:

It was resolved that the undermentioned Partnership Agreements be signed and registered in accordance with the Medical Acts:-

Source: PROV: VPRS 16389/P2 unit 1 – minutes of Medical Board of Victoria, 1958.

The minutes of the Medical Board of Victoria also proved useful in tracing relevant correspondence recorded for particular individuals, including contested applications for registration (notably Moritz Meyer, as discussed in Chapter 5), and records of complaints made against registered medical migrants (British, Irish and continental European). However, this source is limited in documenting British and Irish medical migrants, generally, since they were treated as being synonymous with locally-trained practitioners for the purpose of medical registration. Given the political sensitivity of registering continental European medical migrants – particularly in the interwar years – it appears that great care was taken to document (albeit in formal, summary fashion) correspondence and final resolutions with respect to these individuals.

Newspaper and print media (Trove)

The National Library of Australia's digital search engine, Trove, brings together a wide array of resources relating to Australia, ranging from archival sources held across public and private institutions in Australia, to archived websites, to print, audio and video content.[918]A key use of Trove for this project was its full text-searchable collection of digitised Australian newspapers and magazines published from 1800 onwards. Trove is a dynamic platform, and new content is being regularly added. The largest volume of print media that has been digitised covers a period up to 1980. All searches can be filtered by place of publication, the title of the publication, type of article, and by time (filters automatically enable sorting by decade, year, and month).

Variations of every single name in the prosopographic database were entered in Trove. The most common matches were one of three pre-categorised newspaper items: articles, family notices, and advertising. Advertising typically included notices submitted by practitioners regarding the establishment of a new practice or sale of a practice. For example, the following advertisement appeared on 12 March 1953:

> Dr PAUL SCHATZKI has ceased general practice at 88 Addison street, Elwood, but may be consulted at "Stanhill", 34 Queens road by appointment. Tel. Windsor 3538 (FW2181 if no reply).[919]

These advertisements nuance the content provided in medical directories, which often contain limited or no date qualifiers for the occupations or posts listed. Death notices often helped narrow subsequent searches in state registers of births, deaths and marriages.

Family notices typically recorded engagements, marriages, and death notices for the individual, and/or their extended family. For example, on 12 November 1948 a notice appeared announcing the engagement of Yvonne Capon – a British medical graduate in the sample, 'formerly of Teddington, England' to Thomas Hurley, 'third son of Mr and Mrs Victor Hurley', a prominent local medical family.[920] This was followed by a photograph of the married couple on 2 December 1948, outside the Melbourne Grammar School Chapel.[921] These notices were most useful in tracking and narrowing date ranges of marriages (and therefore name changes), divorces and deaths, particularly of the medical women who arrived unmarried. These notices often helped relocate these women in medical registers and medical directories, where women often disappeared following a change of name.

Finally, the most voluminous results were a wide range of articles covering aspects of the social and professional activity of these individuals, that reaffirm public interest in migrants broadly defined. The range of articles found included, but were not restricted to the announcements of the appointments of individuals prior to their arrival; coverage of their arrival in Australia as public interest in post-war migrants increased; mentions as part of coverage of

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918 See, https://trove.nla.gov.au.

919 'Advertising', *The Age*, 12 March 1953, 2.

920 'Family Notices', *The Argus,* 12 November 1948, 9.

921 'Engagements', *The Age*, 2 December 1948, 5.

prominent social events – from horse races to philanthropic events; political activity, including efforts to lobby for change; and social commentary on both wider social issues, as well as in their professional capacities; and professional activity. When analysed as a collective, these articles provided further insight into the numerous roles medical migrants were assigned and adopted, and how they leveraged their professional and social personas. The particular insights afforded by this aggregation should be particularly evident in Chapters 5-7.

Ancestry.com

The commercial organisation Ancestry.com is one of the largest single digital resources used by genealogists and family historians, however, it's value to historians who also draw on these resources cannot be understated. The single most important feature of Ancestry.com is that it provides access to digital copies to many of the original sources that underpins each set of it search results. Others are available behind a further paywall. Examples of digitised resources available with a basic subscription include fully-digitised, fully text-searchable copies of the 1911 Census of England and Wales. Similarly, it has digitised all General Medical Council lists making searches for hard-to-trace individuals particularly easier compared to hand-searching physical copies. The strength of Ancestry.com is in its English language collection, therefore, the most useful digitised resources were Australian, British, and Irish content.

Ancestry.com was a useful starting point for this study, enabling broad searches for individuals, and an aggregation of promising primary sources with specific results. If the content itself was not digitised, the source information provided for each result enables a much more efficient search of these sources. For example, passenger departure lists for Ireland and the UK were particularly helpful for narrowing subsequent searches in the National Archives of Australia.

Other registers and indexes

A number of other public registers and indexes were consulted, particularly for dates of birth, marriage and death. These included registers held in the Public Records Office of Victoria, and similar state-based offices in Australia. For much of this data, it was necessary to triangulate sources to adjust for human error in recording dates, particularly for dates of birth.

Ryerson Index (https://www.ryersonindex.org/)

The Ryerson Index is a free online resource run by volunteers to index death notices published in Australian newspapers from 1803 to date, with a particular, early focus on the *Sydney Morning Herald*. This index is dynamic and constantly being updated. This index proved to be a useful supplementary source since all searches provide a date of death, place of death, and the source newspaper from which the entry is based. Therefore, this index proved particularly valuable in discounting false leads, for example, the full newspaper death notices would often list occupations and names of family members that would help corroborate or invalidate the match between an individual and their correct date of death. This process proved particularly useful in funnelling subsequent searches of registers of death held by the various public records offices.

FreeBMD.org.uk

This index is a British project, and similar to the Ryerson Index, aims to scan and transcribe the 'Civil Registration index of births, marriages and deaths for England and Wales'. FreeBMD enables searches for births, marriages, and/or deaths by family name, given name(s), spouse/mother's family or given names, and by dates and/or date ranges. The project is also ongoing, and many transcribed entries include a link to a downloadable, scanned copy of the original page from the primary source from which it was derived.

This resource was used in a similar capacity to the Ryerson Index, to help triangulate information, and/or narrow subsequent searches in other physical primary sources. It proved particularly useful for discovering date and place of marriage for individuals who married in England, Wales, and Scotland to a lesser extent. It was also very useful for determining medical women's family names at birth for marriages after 1912 if the whole or part of their husband's given name(s) were known. For example, for medical couple Ian and Moira Palmer registered in Victoria in 1958, a search for marriages for 'Ian Palmer' with a spouse whose first name is 'Moira' revealed seven records starting from June 1958. This marriage record was to a 'Pratt'. A Moira Kathleen Margaret Pratt was found in the university entrance records for the medical school at the University of Aberdeen. The General Medical Council listed her as graduating from Aberdeen in 1951, this corresponded to the same year and place of graduation as the 'Moira Kathleen Margaret Palmer' registered in Victoria. Additionally, both Ian Palmer and Moira Palmer's medical directory entries listed Bournemouth as their last known place of work in England, further validating their date and place of marriage.

Biographical and autobiographical sources

Obituaries

There were three broad categories of published obituaries found on individuals. The first category is those published by family members, close friends as tributes typically in newspapers, or for recent deaths, on online dedicated memorial websites. The second were feature-obituaries of medical elites or individuals who were prominent figures. These obituaries were typically published in major popular print media, for example, *The Age*. The third were obituaries published by family members and/or close colleagues in general or specific medical journals, most commonly the *British Medical Journal* and the *Medical Journal of Australia*, as well as specialist medical journals. The more eminent end of the sample of individuals often had obituaries and dedications made to them that cut across all three of these categories.

The value of these obituaries as standalone sources of information for any of the fields of information identified in the prosopographic questionnaire is low. However, these sources proved particularly insightful for volunteering information on specific themes that in standard prosopography would be dismissed as being specific to the individual, and encroaching on the transition from individual to personality. However, as discussed, the decision was made to build a database that was 'source-led'.[922] This included capturing all available or discoverable sources

922 Cohen, 'Missing, Biased, and Unrepresentative'.

against individuals, and for the value of these sources to be considered based on the nature of the historical questions being explored.

With that in mind, obituaries proved particular useful sources in providing insights into individual's motivations to study medicine, to migrate, on the breadth of their career, and their contribution to medicine. These are all subjective observations, of course, and no attempt was made to standardise these observations to be incorporated into the database for collective analysis. Occasionally, however, obituaries proved fruitful for the core task of reconstructing medical lives by describing appointments or career moves in more detail than was available in medical directory entries.

The Australian Dictionary of Biography, and other collective biography projects

The most common sources of biographic accounts that, while still subjective with respect to the author, were more researched than the types of obituaries described above included the *Australian Dictionary of Biography*, the *Encyclopaedia of Women in Leadership in Twentieth-Century Australia*, and two medicine-specific collective biography projects, commonly known as Munk's Roll and Plarr's Lives. Munk's Roll or 'Lives of the Fellows' comprises entries for Fellows of the Royal College of Physicians (England), and Plarr's Lives is the equivalent project documenting the lives of Fellows of the Royal College of Surgeons (England). All these projects can be accessed online.[923] Both Munk's Roll and Plarr's Lives are aggregators, typically reproducing already published content on these individuals, including obituaries.

The utility of these accounts increased marginally compared to published obituaries, owing to the more transparent declaration of sources from which the entries have been compiled, particularly for the *Australian Dictionary of Biography* and the *Encyclopaedia*. When available, these sources added detail on career information and timelines that was particularly useful when attributing career categories for each individual. When available, these sources could also be used to corroborate other dates, and details about predeceased and surviving family members.

Interviews and correspondence

Occasionally, searches of Ancestry.com, as well as recent obituaries and other biographical sources reveal sufficient information about an individual's surviving family for me to be able to contact them – via phone, electronic mail or letter. More rarely, in broad searches for individuals, they have been found to still be alive. In total, I have made contact with dozens of family members and four surviving practitioners themselves. These interviews – both over the phone, and face-to-face, as well as ongoing correspondence have contributed greatly in developing the database entries for the respective individuals.

For the purpose of doing so, the data collection phase of this PhD included an active Human Ethics minimum risk application with the University of Melbourne.[924] All these

923 Australian Dictionary of Biography, http://adb.anu.edu.au/; Royal College of Physicians – Lives of the Fellows (Munk's Roll), http://munksroll.rcplondon.ac.uk/Biography/Search and Royal College of Surgeons – Plarr's Lives, https://livesonline.rcseng.ac.uk/.

924 University of Melbourne, Human Ethics Application ID 1339639.

interviewees and correspondents were supplied with a *Plain Language Statement* outlining the nature and aims of the research project, a sample of the prosopographic questionnaire, and a consent form detailing their right to privacy, and the manner in which I could use the information they provided me.

Only two extant interviews were found during the course of this study that related to individuals being researched. One for a member of the Bristol group documented in Chapter 3 conducted by historian Jill Tilley on behalf of the Carnarmah Historical Society in Western Australia. Jill Tilley very generously agreed to release the full transcript of this interview, and the surviving children of Dr Walker agreed to the reproduction of specified quotes of the interview. The other extant interview was for British medical woman, Muriel McPhillips (nee Rippin). Dr McPhillips was interviewed by historian Beryl Armstrong as part of an oral history project for the book *Australians 1938*.[925] The recording is currently available at the National Library of Australia.[926]

Other formally published sources

Although the biographies of medical migrants are scarce, biographical details of medical migrants were found in a number of histories of public hospitals, research institutions, and other providers of medical and health services. Each of these sources provided a combination of further biographical details and/or employment history for these individuals. In the database, these sources were captured against every individual found. It is not possible to discuss the interpretation of each of these sources individually. Throughout this study, when these sources have been used, they are cited as such, and evaluated critically then. For transparency, the bibliography of this study has listed these sources under 'Primary sources', and if also used as a secondary source, it has been reproduced in the 'Secondary sources' section as well.

A number of these sources have served this dual function, for example, Janet McCalman's history of the Royal Women's Hospital provides details of several individuals in this study, including pathologist Hans Bettinger.[927] It was also an important secondary source documenting the development of large public hospitals in metropolitan Melbourne. Similarly, Mathew Klugman's social history of the Victorian blood transfusion service provided detail on several refugee doctors who worked as pathologists and haematologists.[928] It was also referred to as an excellently researched account of wartime medical services in Melbourne, and the work and careers of pathologists.

925 Thomson, 'Biography of an Archive', 425-449.

926 National Library of Australia, McPhillips, Muriel. & Armstrong, Beryl. & Australia 1788-1988: A Bicentennial History. & Australia 1938 Oral History Project.

927 McCalman, *Sex and Suffering,* 226-7.

928 Klugman, *Blood Matters,* 69-87.

Database structure

The prosopographic database is in reality a series of three sub-databases, one for each cohort sampled, where all three sub-databases are structured identically. The first series of raw data was captured in a Microsoft Excel spreadsheet. The spreadsheets were set-up to be compatible with an eventual import into a relational database software package, for example SequelPro or Microsoft Access. Therefore, each unique identifier assigned to an individual in the full population was retained (Appendix 2), and all information was related to the unique identifier. The three spreadsheets had a field for each unique piece of information to be collected, and an open-text field to capture all sources used to compile fields for each individual. These three spreadsheets became the working documents for the life of the project, and captured all data transcribed from sources, usually verbatim. All subsequent analysis of these spreadsheets – both quantitative and qualitative – were conducted on duplicate spreadsheets if using Microsoft Excel, accurate to the date of final analysis.[929] Duplicate spreadsheets were also cleaned and prepared for import into other software packages, including mapping software. This was to ensure that the integrity of the raw data would not be altered during analysis conducted over the life of the project.

Individual biographical dossiers were generated based on the analysis of the raw data. An example, stylised dossier is reproduced in Appendix 4. These dossiers contained a mix of fields drawn from the raw, working data and standardised for consistency (marked as type 'Standardised' in Appendix 4); 'Assigned' values drawn from final analysis – both quantitative and qualitative; and collated entries which merged raw data fields. Typical data standardised including place names, country names, and place of qualification. For example, 'Edin', 'E'burgh' and 'Ed.' were all standardised to 'Edinburgh'. Assigned values include classifications of occupation and states in Australia. For example, in Appendix 4, individual M-UK-0358 John Garner was assigned occupational roles 'General Practitioner', 'Other – Military service' and 'Hospital – general'. Individual biographical dossiers retained a list of *all* sources used to create the individual entry in the working spreadsheets. These dossiers were also created in Microsoft Excel, to enable future export into a relational database for future public dissemination.

929 NB: In late 2015- early 2016, I trialled using the University of Melbourne's eScholarship Research Centre's software package, the Online Heritage Resource Manager (OHRM), for this project. However, I discontinued using the OHRM shortly after migrating my data into the platform. The primary reasons for doing so included the need to use licensed Microsoft Access to run the OHRM, as well as the additional time required to clean the migrated data for analysis.

Appendix 4: List of Medical Migrants Registered in Victoria, 1930-59/60

This Appendix provides a full list of the 743 medical migrants identified in the medical registers of Victoria for the years 1930-60. Table A8 is ordered by year of registration, and then by alphabetical order of their family name. Additionally, each individual was assigned a sex marker (male or female), and a geo-marker (UK for individuals registered on the basis of a British or Irish qualification; EU for all other continental European medical qualifications; ROW for 'rest of the world'). The names of the practitioners sampled for inclusion in the prosopographic database are highlighted in Table A8.

Table A8 List of 743 European medical migrants registered in Victoria, 1930-59/60. An '?' indicates information that is usually reported, but is missing for the individual in question. NB: Entries highlighted in light grey indicate those individuals sampled for the prosopographic database (Table 1). Entries highlighted in dark grey indicate individuals in the Bristol group (see Chapter 3), if not already included in the original sample.

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
1930 registrations											
Charles Henry Bruce	Adamson	MBChB	Edinburgh	1927							M UK
Pietro	Bianchi	MBChB	Italy	1926							M EU
Adam Gibson	Brydon	MBChB	Edinburgh	1900	MD	Edinburgh	1918				M UK
Henry Arthur Herbert	Claridge	MBBS	Durham	1892							M UK
John Boyd	Colquhoun	MBChB	Edinburgh	1925	FRCS	Edinburgh	1929				M UK
John Bell	Ferguson	MD	Edinburgh	1925	MRCP	London	1927				M UK
Vivian Hector	Leigh-Barlow	LRCP	Edinburgh	1927	FRFPS	Glasgow	1927				M UK
Doris Lyne	Officer	MBBS	London	1921	MRCS	England	1921	LRCP	London	1921	F UK
Soccorso	Santoro	MDChD	Italy	1926							M EU
Oswald Victor	Short	LRCP	Edinburgh	1930	LRFPS	Glasgow	1930				M UK
Moses	Sternfeld	MRCS	England	1929	LRCP	London	1929				M UK
Izso Hart-mayer	Van der Hoope	MDChD	Italy	1926							M EU
1931 registrations											
William John	Beveridge	LMRCP	Ireland	1896							M UK
Raymond Ponsonby	Carew-Smyth	LRCP	Edinburgh	1930	LRFPS	Glasgow	1930				M UK
William	McDermott	LMSSA	London	1929							M UK
James Thomas	Wilkin	MBBS	NZ	1906	FRCS	Edinburgh	?				ROW
1932 registrations											
Anthony Joseph	Parer	MRCS	England	1929	LRCP	London	1929				M UK
Robert Vivian	Storer	MRCS	England	1923	LRCP	London	1923				M UK
1933 registrations											
Olive Burton	Buckley	MRCS LRCP	London	1925	MBBS	Oxford	1925	MRCP	London	1928	F UK
1934 registrations											

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
Gilbert Maurice	Davis	MBChB	Aberdeen	1925							M UK
John	Egan	MBChB	Ireland	1923	DPH	London	1929				M UK
Joesph Patrick	Hennessy	MBChB	Ireland	1918	BAO	Ireland	1918				M UK
John	McPherson	MBChB	Aberdeen	1909	MD	Aberdeen	1918				M UK
Giovanni	Merlino	MD	Messina	1924							M EU
Basil Laun	Wilson	MBChB	NZ	1924							ROW
1935 registrations											
Gladys Ellen	Ainscow (now known as Bell Ferguson)	MBChB	Birmingham	1917	DPH	Birming-ham	1921				F UK
Charles William	Bruce	MRCS	England	1927	LRCP	London	1927				M UK
Janet Marcia	Moray-Law-rence (nee Fishe)	MBBS	London	1929							F UK
Geoffrey Buckland	Orbell	MBChB	New Zealand	1935							ROW
Robert Graeme	Orr	ChB	Cambridge	1931							M UK
Kenneth James	Talbot	MBChB	New Zealand	1933							ROW
1936 registrations											
Kathleen	Heyes	MRCS	England	1927	LRCP	London	1927	MBBS	London	1927	F UK
Norman Reynolds	James	LRCP	Edinburgh	1936	LRFPS	Glasgow	1936				M UK
Beryl Jessie	Lawrence	MBBS	NZ	1927							ROW
George Gordon	Milne	MRCS	England	1924	LRCP	London	1924				M UK
John Edward	Overstead	LRCP	Edinburgh	1922	LRFPS	Glasgow	1922				M UK
Thomas Sargent	Pearse	LRCP	Edinburgh	1904	LRFPS	Glasgow	1904				M UK
Peter William Stewart	Riley	MBChB	NZ	?							ROW
Muriel	Rippin	MRCS	England	1927	LRCP	London	1927	MBBS	London	1928	F UK
Arthur	Rose-Innes	LRCP	London	1917	MRCS	England	1917				M UK
Francis	Xipell	MD	Genoa	1935							M EU
1937 registrations											
Kurt	Aaron	LRCP	Edinburgh	1937	LRFPS	Glasgow	1937				M UK
William Lind-say Barnes	Burns	MBChB	NZ	1935							ROW
Alexander Hamilton	Dobbin	LRCP	Edinburgh	1935	LRFPS	Glasgow	1935				M UK
Anna Lydia	Hansen	MBChB	NZ	1931							ROW
Rupert Francis Leslie Victor	Harvey	LRCP	Edinburgh	1930	LRFPS	Glasgow	1930				M UK
William	Hawksworth	MBChB	NZ	1934							ROW

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
Margaret Isabel	Heron	MBChB	Belfast	1932	BAO	Belfast	1932				F UK
Raymond Frederick	Lomax	MRCS	England	1930	LROP	London	1930				M UK
Moritz	Meyer	LRCP	Edinburgh	1937	LRFPS	Glasgow	1937				M UK
Max	Michel	LRCP	Edinburgh	1936	LRFPS	Glasgow	1936				M UK
Mary Aletta	Saunders	LRCP	London	1931							F UK
Alan Keith	Tulloch	MBChB	NZ	1935							ROW
Minne Frances	Varley	LRCP	Edinburgh	1926	LRFPS	Glasgow	1926				F UK
Wilhelmina Johanna	Wagenmaker	MBChB	Edinburgh	1935							F UK
1938 registrations											
Oskar	Apelschnit (Alpins)	MD	Bologna	1936							M EU
Szaja	Baumatz	MD	Siena	`1926							M EU
Ernest	Colin	LRCP	Edinburgh	1938	LRFPS	Glasgow	1938				M UK
Alfred Adolf	Esser	LRCP	Edinburgh	?	LRFPS	Glasgow	?				M UK
Hans	Goldmann	LRCP	Edinburgh	1937	LRFPS	Glasgow	1937				M UK
Hermann	Jacks	LRCP	Edinburgh	1938	LRFPS	Glasgow	1938				M UK
Joachim	Lewin	LRCP	Edinburgh	1937	LRFPS	Glasgow	1937				M UK
Thomas Alastair	Macfarlane	MBChB	NZ	1936							ROW
Alfred Robert	Maclurkin	MBChB	Glasgow	1900	DPH	Edinburgh	1904	DTM	Liverpool	1904	M UK
Silvio	Pagliaro	MD	Rome	1924							M EU
Dolores	Predhomme	MDMCP	Manitoba	1934							ROW
Oscar	Rochlin	LMSSA	London	1938							M UK
Martin Wernen	Rosenthal	LRCP	Edinburgh	1937	LRFPS	Glasgow	1937				M UK
Moses	Schneebaum	MD	Rome	1935							M EU
David Uttley	Strang	MBBS	NZ	1937							ROW
1939 registrations											
Joseph	Adrian	MD	Bologna	1929							M EU
Geraldine Christein Wilhelmina	Amies	LRCP	Edinburgh	1938	LRFPS	Glasgow	1938				F UK
Maurice	Beraha	MD	Naples	1936							M EU
Thomas Enwright	Caffell	MBChB	NZ	1932							ROW
Peter David	Clein	LRCP	Ireland	1929							M UK
John Edwin Digby	Crozier	MRCS	England	1928	LRCP	London	1928	MBChB	Cam-bridge	1925	M UK
Maurice	Curzon	MD	Genoa	1936							M EU

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
Zygmunt	Epstein	MD	Rome	1937							M EU
Eric	Fox	MD	Bologna	1936							M EU
Bruce Walton	Grieve	MBChB	NZ	1936							ROW
Stanley	Hankin	MBBS	St Andrews	1930							M UK
James Alphonsus	Hennessy	MBChB	Edinburgh	1919							M UK
Robert Vivian	Kiel	MD	Milan	1937							M EU
Paul	Kinsbrunner	MD	Bologna	1935							M EU
Samson Seigfried	Kinsbrunner	MD	Florence	1932							M EU
Martin	Margulius	MD	Turin	1936							M EU
Samuel S	Marshall	MD	Rome	1937							M EU
Robert	McGladdery	MRCS	England	1937	LRCP	London	1937				M UK
Haralambos	Paroulakis	LMSSA	London	1934							M UK
George William	Patterson	MBBCh	Dublin	1936							M UK
Bernard	Rappaport	MD	Padua	1930							M EU
Silvio Gordon	Roberts	MBChB	Edinburgh	1934							M UK
Laurence Melville	Routh	MRCS	England	1909	LRCP	London	1909	MB	Cam-bridge	1911	M UK
Frederick Richard	Smale	MBChB	NZ	1925							ROW
Gisela	Snow	MD	Rome	1936							F EU
Maurice	Strauss	MD	Padua	1936							M EU
Carhles	Walker	MD	Parma	1935							M EU
Leopold	Weintraub	MD	Naples	1938							M EU
Irwin James	Weyman	MD	Genoa	1928							M EU
Sura	Weyman	MD	Milan	1932							F EU
Daniel	Wise	MD	Pisa	1936							M EU
1940 registrations											
Joseph Moses	Coplans	LRCP	Edinburgh	1912	LRFPS	Glasgow	1912				M UK
Arthur	Deery	MD	Padua	1933							M EU
Peter Brutus	Guastalla	MD	Rome	1936							M EU
Edward James Chipp	Hamp	MRCS	England	1939	LRCP	London	1939				M UK
Iver Douglas Macarthur Brodis	Maclurkin	LRCP	Edinburgh	1938	LRCS	Edinburgh	1938	LRFPS	Glasgow	1938	M UK
John Bell	McMiken	MBChB	NZ	1925							ROW
Ethel Eliza-beth Mary	Ogilvie	MBBS	London	1927							F UK

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
1941 registrations											
Roberto Alexandre de Castro	Basto	MRCS	England	1922	LRCP	London	1922				M UK
Alan Alfred	Crook	LRCP	Edinburgh	1934							M UK
Leo John	Gurry	MBChB	Edinburgh	1938							M UK
Mary	King	MBChB	St Andrews	1920							F UK
Daniel Henry	McDowell	LLM RCP	Ireland	1935	LLM RCS	Ireland	1935				M UK
John Bertram Gilchrist	Muir	FRCS	England	1924	MS	London	1937				M UK
Patrick John	Robinson	MRCS	England	1940	LRCP	England	1940				M UK
John Fisher	Williams	MRCS	England	1939	LRCP	London	1939				M UK
1942 registrations											
Anne Fergusson Crow	Burgess	MBChB	St Andrews	1927							F UK
Enid Margaret Obilvie	Campbell	MBChB	Aberdeen	1925							F UK
Winifred Harriet	Corke	MD	Manchester	1927							F UK
Henry William	Devlin	LMRCS	Ireland	1890	LMRCP	Ireland	1890				M UK
Ann Florence	Gibb	MBChB	Edinburgh	1934							F UK
William Hurst	Jeffery	MBChB	St Andrews	1929							M UK
Eva Gladys Le Messurner	Kneebone	MBChB	Manchester	1921							F UK
Ernest Victor	Luprian	MRCS	England	1922	LRCP	London	1922				M UK
Thomas Rhodes	Matson	MBChB	Edinburgh	1927							M UK
Frederick Harold	Moran	MD	London	1925	LRCP	London	1925				M UK
John	O'Rorke	LRCP	Edinburgh	1940	LRCS	Edinburgh	1940				M UK
John	Stewart	MBChB	Glasgow	1926							M UK
Rachel	Taylor	MBChB	Belfast	1923							F UK
Patience	Underwood	MBChB	Manchester	1932							F UK
Herbert Berkeley Deane	Vaughan	MRCS	England	1932	LRCP	London	1932				M UK
Stephen Empson	Williams	MBChB	NZ	?							ROW
Catherine McLean	Williamson	MBChB	Glasgow	1922							F UK
1943 registrations											
Margaret Wilkinson	Atkin	MBBS	London	1931							F UK
Phyllis Ellen	Bodley	MBBS	Durham	1939							F UK
James Hamilton	Kelly	LRCP	Edinburgh	1942	LRCS	Edinburgh	1942	LRFPS	Glasgow	1942	M UK
John William	Reid	LRCP	Edinburgh	1942	LRCS	Edinburgh	1942	LRFPS	Glasgow	1942	M UK
William John	Stevenson	LRCP	Edinburgh	1942	LRCS	Edinburgh	1942	LRFPS	Glasgow	1942	M UK

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
1944 registrations											
Anthony Bouchier	Bradford	MD	Durham	?	MRCS	England	1902	LRCP	London	1902	M UK
Caroline Mary	Kingsman	MRCS	England	1927	LRCP	London	1927	MBBS	London	1927	F UK
1945 registrations											
Conway Phillip	Allen	MBChB	Glasgow	1923	FRCS	Edinburgh	?				M UK
Pam	Macleod	MBBS	Queens	1930							F UK
Elizabeth	White	MBBS	London	1928							F UK
1946 registrations											
Franz	Bauer	MD	Vienna	?							M EU
Hans Frederich	Bettinger	MD	Breslau	1921	MCPA	Australia	1956	FRACP	Australia	1955	M EU
Mark George	Brunton	MD	Poland	1933							M EU
Lloyd Woodrow	Cox	MBChB	NZ	?							ROW
James Donald Hanson	Cran	MBChB	Manchester	1934							M UK
Clifford Francis	Evans	LRCP	London	1931	FRCS	England	?				M UK
Hugo	Goldberg	MD	Vienna	1899							M EU
Alfred	Gottschalk	MD	Bonn	1920							M EU
Robert	Greenfield	MD	Vienna	1923							M EU
Isidore	Huppert	MD	Poland	?							M EU
Thomas Henry	Jagusch	MBBS	NZ	?							ROW
Rachel	Jakobowicz	MD	Berlin	1934	MCPA	Australia	1956				F EU
Margaret	Karoly	MD	Budapest	1923							F EU
Friedrich Max	Lanadauer	MD	Strasburg	1914							M EU
Gordon Donald	McDonald	MBChB	Edinburgh	1944							M UK
Mervyn Edward	Morley	MD	Vilno	1930							M EU
John Frederick	Poolman	MRCS	England	1940	LRCP	London	1940				M UK
John Clark	Pyper	MBChB	Glasgow	1912	DTM DTH	London	?				M UK
Georg	Rechelmann	MD	Freiburg-Breisgau	1934							M EU
Martha	Renth	MD	Vienna	1937							F EU
Paul	Schatzki	MD	Frankfurt	1934	MD	Pisa	1934				M EU
Arthur	Schuller	MD	Vienna	1899							M EU
Cora Renata	Singer	MD	Vienna	1932							F EU
Manfred Max	Suss	MD	Vienna	1935							M EU
Arthur Newton	Talbot	MBChB	NZ	1941							ROW

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
Andrew Donald	Wilson	LRCP	Edinburgh	1930	LRCS	Edinburgh	1930	LRFPS	Glasgow	1930	M UK
1947 registratrations											
Horace Laurenson	Bowell	MBChB	NZ	1925							ROW
Arthur Graham	Brown	MRCS	England	1946							M UK
Melville Bryan	Bruce	MBChB	NZ	1944							ROW
Yvonne Brandon	Capon	MRCS	England	1946							F UK
Harold Hugh	Francis	MBChB	NZ	1944							ROW
Rachael Noeleen	Gillespie-Hill	LSA	London	1931							F UK
James Mulvihill	Horan	LRCP et S	Ireland	1912							M UK
Robert Glen-denning	Linton	BMChB	Edinburgh	1938	MRCS	England	1939	LRCP	London	1939	M UK
Norman William	Martin	MBChB	NZ	1932							ROW
John Ken-worthy	Ogden	MRCS	England	1943	LRCP	London	1943	?RCOG	?	1946	M UK
John Freder-ick Munton	Payne	MRCS	England	1915	LRCP	London	1915				M UK
Franklin Christian	Richards	LRCP	Edinburgh	1904	LRCS	Edinburgh	1904	LFPS	Glasgow	1904	M UK
Alfred John	Skinn	MBChB	Edinburgh	1935							M UK
Donald Moody	Sutherland	MBChB	Leeds	1924							M UK
Roman	Zeeher	MD	Vienna	1928							M EU
1948 registrations											
Muriel Grace Ellen	Clark	MRCS	England	1928	LRCP	London	1928				F UK
James Robertson	Colville	LRCP	London	1929	MRCS	England	1929				M UK
Brian Mor-rison	Corkill	MBChB	NZ	1946							ROW
John Francis Anning	Forster	MRCS	England	1934	LRCP	London	1934	MBBS	London	1935	M UK
George	Henderson	LRCP	Edinburgh	1930	LRCS	Edinburgh	1930	LRFPS	Glasgow	1930	M UK
Mary	Howson	MBChB	Edinburgh	1947							F UK
Alice Marion	Kaye	MRCS	England	1931	LRCP	London	1931	MBBS	London	1934	F UK
Phillip Langton	Langton-Loc-ton	MBBS	London	1943	MRCS	England	1943	LRCP	London	1943	M UK
Maurico	Leon	MBBCh	Dublin	1944							M UK
Francis Arthur Hatherall	Neate	MBChB	NZ	1935							ROW
William Joseph	Smith	MBChB	NZ	1941							ROW
Edward Michael	Trautner	MD	Berlin	1921							M EU

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Maurice Cecil	Warnock	MBBCh	Dublin	1938	DPH NU	Ireland	1942				M UK
Linsday Athol	Wilson	MBChB	Edinburgh	1943							M UK
Michael McColl	Wilson	MRCS	England	1938	LRCP	London	1938	MBBCh	Cam-bridge	1939	M UK
John	Woodley	MRCS	England	1940	LRCP	London	1940				M UK
1949 registrations											
Bernard Selwyn	Alderson	MBBS	Durham	1938	DLO RCP	England	1939				M UK
Joseph Frederick	Couch	LRCP	Edinburgh	1942	LRCS	Edinburgh	1942	LRFPS	Glasgow	1942	M UK
Edward John	Crowe	LLM	Ireland	1934	RCS	Ireland	1934	DPH	London	1948	M UK
Patrick Denis	Delany	LRCP	Ireland	1940	LRCS	Ireland	1940				M UK
Martin	Edwards	MBChB	St Andrews	1927							M UK
Richard Henry Lindo	Ferguson	MBChB	NZ	1947							ROW
Charles Clement	Geraghty	LLM	Ireland	1941	RCP	Ireland	1941	RCS	Ireland	1941	M UK
Susanna	Gordon	MBBS	London	1944							F UK
Howard Tobias	Halper	MRCS	England	1931	LRCP	London	1931	DMRE	Cam-bridge	1942	M UK
Harold Mar-cus Rhys	James	MBBS	London	1948							M UK
Patrick Raymond	Joyce	MBBCh	Ireland	1946							M UK
Richard	Kelvin	MRCS	England	1942	LRCP	London	1942	MBBS	London	1943	M UK
Kenneth Rodney	Kennedy	MBBCh	Belfast	1939	BAO	Belfast	1939				M UK
William Henry	MacKenzie	MBChB	Edinburgh	1940							M UK
William Alfred Noel	Marrow	MRCS	England	1928	LRCP	London	1928	FRCS	Edin-burgh	1939	M UK
Evelyn Ashley	Morgan	MBChB	Aberdeen	1945							F UK
Shiela Mary	Morphy	MBChB	St Andrews	1946							F UK
Albert Victor	Morse	LRCP	London	1945	MRCS	England	1945				M UK
Robert Miller	Munro	MBChB	Glasgow	1936							M UK
John James	O'Grady	LRCP	Edinburgh	1910	LRCS	Edinburgh	1910	LRFPS	Glasgow	1910	M UK
Stephen	Ormerod	MBBCh	Oxon	1941							M UK
Philip John	Orton	MBBS	NZ	1935							ROW
Colin Benja-min	Oxner	MBChB	NZ	1946							ROW
Basil Ainslie	Porritt	MBChB	NZ	1926	FRCS	Edinburgh	1933				ROW
David Shields	Prentice	MBBCh	Dublin	1918							M UK
Moses	Sendak	MRCS	London	1926	LRCP	England	1926	MBBS	London	1927	M UK
James	Sharkey	MBBS	London	1942	MRCP	London	1944				M UK
Carmen Myburgh Millott	Shepherd	LMSSA	London	1946							F UK

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Webster Graeme	Shepherd	LRCP	London	1945	MRCS	England	1945				M UK
Margaret	Sumpton	MBBS	Durham	1938							F UK
William McLaren	Thomson	MBBS	London	1945							M UK
Ian Archibald	Waldie	MBChB	Edinburgh	1945							M UK
Ronald Joseph Spencer	Walker	MRCS	England	1939	LRCP	London	1939	DMRD RCP	London	1949	M UK
Elisabeth Maud	Wann	MBBCh	Dublin	1947							F UK
John O'Ha-gan	Ward	LLM	Ireland	1937	RCP	Ireland	1937	RCS	Ireland	1937	M UK
John Bruce Russell	Wells	MBChB	NZ	1947							ROW
John Egerton	Williams	MRCS	England	1941	LRCP	London	1941				M UK
1950 registrations											
Betty Joan	Batt	MRCS	England	1948	LRCP	London	1948	MBBCh	Cam-bridge	1948	F UK
Eric Harrison	Batt	MBChB	Leeds	1940							M UK
Harold	Baytch	MBChB	Glasgow	1933	FRFPS	Glasgow	1948				M UK
Roland George	Chambers	BMBCh	Oxford	1948							M UK
George Bastian	Cliff	MBChB	Birmingham	1942	MRCS	England	1942	LRCP	London	1942	M UK
Vincent Harry	Cooper	MBChB	Birmingham	1937	DO RCOG		1950				M UK
Brian James	Doran	MRCS	England	1936	LRCP	London	1936				M UK
Andrew Alexander	Gray	MBChB	Edinburgh	1936							M UK
Agnes Lees	Hendrie	MBChB	Glasgow	1922							F UK
Matthew Lapsley	Hendrie	LRCP	Edinburgh	1925	LRCS	Edinburgh	1925	LRFPS	Glasgow	1925	M UK
George	Houseman	MRCS	London	1940	LRCP	London	1940	DA RCS	England	1946	M UK
Vincent	Hyslop	MRCS	England	1935	LRCP	London	1935				M UK
Felix Charles	Jobson	MRCS	England	1942	LRCP	London	1942				M UK
Robert Stewart	Kennedy	MBChB	Glasgow	1927	DPM	London	1933				M UK
John William	McCaw	MBBCh	Dublin	1948							M UK
Joseph Percy	McGladdery	MBBS	London	1936	MD	London	1939	DPH	London	1939	M UK
David Titter-ington	Methuen	MBBS	London	1946							M UK
David Cornelius	Morley	MBBCh	Cambridge	1947							M UK
Thomas Roy	Murphy	LRCP	Edinburgh	1935	LRCS	Edinburgh	1935	LRFPS	Glasgow	1935	M UK
Douglas Herbert	Mylechreest	MRCS	England	1926	LRCP	London	1926				M UK
William George	Richards	MBBS	London	1929	MRCS	England	1928	LRCP	London	1928	M UK

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
Ann Isabel Brighton	Ross	MRCS	England	1937	LRCP	London	1937				F UK
Sybil Joyce	Russell	MBBS	Durham	1939							F UK
Marcus Lionel	Sacks	MBBS	London	1946							M UK
Arthur Walter	Sonia	MRCS	England	1949	LRCP	London	1949				M UK
Victor Alexander Trevor	Spong	MRCS	England	1918	LRCP	London	1918	MBBS	London	1925	M UK
Werner	Stern	MBBS	London	1949	MRCS	England	1948	LRCP	London	1948	M UK
Alan	Stoller	MRCS	England	1935	LRCP	London	1935	DPM	England	1938	M UK
Angus Erskine	Stuart	MBChB	Glasgow	1948							M UK
Arthur Bernard	Sullivan	MRCS	England	1927	LRCP	London	1927	DMRE	Cambridge	1934	M UK
Laban Edwin	Vine	MBBS	London	1929	MRCS	England	1928	LRCP	London	1928	M UK
Norman Bryan	Walker	MBBS	Durham	1937							M UK
James Dermott	Willivers	MBChB	Manchester	1948	MRCS	England	1948	LRCP	London	1948	M UK
1951 registrations											
Trevor Cory	Beard	MBBCh	Cambridge	1945	MRCS	England	1944	LRCP	London	1944	M UK
Martin Desmon	Begley	MBBS	London	1948	MRCS	England	1948	LRCP	London	1948	M UK
John Anthony	Bloomfield	LMSSA	London	1949	MBBS	London	1950				M UK
David Byron	Brown	MBChB	NZ	1950							ROW
Norman James	Caldwell	LMSSA	London	1945	MRCS	England	1945	LRCP	London	1945	M UK
Alastair Simpson	Cameron	MBChB	Aberdeen	1937							M UK
Agnes Gillespie	Czulak	MBChB	St Andrews	1941							F UK
John Alexander	Dowds	MBBCh	Dublin	1930							M UK
Keith Douglas	Drayton	MBChB	NZ	1949							ROW
Coralie Leonora	Dummond	MBBS	Punjab	1937							ROW
John Scott	Elliot	MBChB	Edinburgh	1939							M UK
Norman Graham	Graham	LRCP	London	1943	MRCS	England	1943				M UK
Ian Robson	Gray	MBChB	Leeds	1937	MRCP	Edinburgh	?				M UK
Thomas Wishart	Harrison	MBChB	NZ	1937							ROW
Lawrence Ivan	Hatherley	MRCS	England	1944	LRCP	London	1944				M UK
Donald	Headley	LRCP	Edinburgh	1944	LRFPS	Glasgow	1944				M UK
Vera	Headley	MBBS	Durham	1943							F UK
John Rambaut	Healy	MBBCh	Dublin	1941	BAO	Dublin	1941				M UK

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Edwin Victor	Henton	MBChB	Edinburgh	1944							M UK
James Patrick Dermot	Higgins	LAH	Dublin	1949							M UK
Vera Merrick	Horwill	MBChB	Edinburgh	1928							F UK
William	Hutchinson	MBChB	Glasgow	1925							M UK
Eric David Glover	Kirkwood	MBChB	Liverpool	1942							M UK
Matthew	Laidlaw	MBChB	Glasgow	1922							M UK
William Cooper	Lees	MBChB	Birmingham	1947							M UK
Denys Hubert	Lloyd	MBChB	Liverpool	1949	MRCS	England	1949	LRCP	London	1949	M UK
James Nickie Atkinson	Lowson	MBChB	St Andrews	1924	MRCP	Edinburgh	1932	DTMH	Edinburgh	1932	M UK
Winifred Norah	Lowson	MBChB	St Andrews	1926							F UK
Kevin Joseph	MacGinty	LRCP	Ireland	1940	LRCS	Ireland	1940				M UK
Aileen Nada	Maxwell	MBChB	NZ	1943							ROW
Kevin	McCaul	LRCP	Ireland	1937	LRCS	Ireland	1937	DARCS	England	1945	M UK
Ian Anthony Jobson	McCready	MRCS	England	1942	LRCP	London	1942				M UK
Robert Campbell	Milne	MBChB	Edinburgh	1943							M UK
Duncan	Mitchell	MBBCh	Belfast	1939	BAO	Belfast	1939				M UK
Benjamin	Mushin	MRCS	England	1937	LRCP	London	1937				M UK
John Brendon Aloysius	Nally	LLM RCP	Ireland	1948	LLM RCS	Ireland	1948				M UK
Terence Willoughby Herdman	Porter	MRCS	England	1932	LRCP	London	1932	BMBCh	Oxon	1935	M UK
Luan Damian	Renouf	MBBCh	Ireland	1943	BAO	Ireland	1943				M UK
Leslie	Rosenbloom	MBChB	Liverpool	1945							M UK
Margaret Mary Patricia	Ryan	MBBS	Sheffield	1945							F UK
Eric Galton	Saint	MBBS	Durham	1942							M UK
Geoffrey Trickey	Salter	MBChB	Bristol	1949	DRCOC RCP		1949				M UK
Frederick John	Sharrod	MBBS	London	1945	MRCS	England	1947	LRCP	London	1947	M UK
George Birch	Smith	MBBS	London	1948							M UK
Joan Elizabeth Trevor	Spong	MBBS	London	1947	MRCS	England	1947	LRCP	London	1947	F UK
Alexander Maxwell Clark	Stephenson	LRCP	Edinburgh	1931	LRCS	Edinburgh	1931	LRFPS	Glasgow	1931	M UK
John Alexander Pollock	Stewart	MBChB	Glasgow	1944							M UK
Jeannie Eleanor	Stirrat	MBChB	Birmingham	1946	DPM	London	1948				F UK
Thomas Charles	Wall	MRCS	England	1951	LRCP	London	1951				M UK

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Wolfe Kildare Milton Colston	Watkins	MBChB	Liverpool	1948	MRCS	England	1948	LRCP	London	1948	M UK
Stewart Kennerly	Watson	MBChB	NZ	1942							ROW
John Eric Gaskin	Wright	LMSSA	London	1935							M UK
1952 registrations											
Margaret Grace	Ainslie	LAH	Dublin	1952							F UK
Keith I'Anson	Alexander	MBBS	Durham	1943	DRCOG		1952				M UK
Helen Margaret	Brailey	MBBCh	Cambridge	1943							F UK
James	Browne	MBBCh	Belfast	1938	MD	Belfast	1951				M UK
Robert Alexander	Cameron	MBChB	Edinburgh	1926							M UK
Paul Stephen	Clarke	MBBS	London	1946	LMSSA		1939				M UK
Eric Cunning-ham	Dax	MBBS	London	1934	LMSSA		1934				M UK
Edward James	Elkington	BMBCh	Oxon	1951							M UK
Robert	Evans	MBBCh	Ireland	1924	BAO	Ireland	1924				M UK
James Patrick Beaumont	Fitzgerald	MBChB	NZ	1950							ROW
Herbet Thomas	Foot	MRCS	England	1943	LRCP	London	1943				M UK
Edward Charles	Gawthorn	MBChB	Bristol	1952							M UK
Gordon Alfred	Guthrie	MBChB	Glasgow	1938							M UK
Arthur Montague	Gwynn	MBChB	Aberdeen	1942							M UK
Harry Taylor	Hardy	MBChB	Leeds	1938	MD	Leeds	1938	LRCPS	Edin-burgh	1939	M UK
Ronald Antony	Harrison	MRCS	England	1947	LRCP	London	1947	MBBS	London	1947	M UK
Robert Victor	Henderson	MBChB	Glasgow	1950							M UK
John	Hughes	Bchir	Cambridge	1932	FRCS	England	1936	MRCS	England	?	M UK
Colin Henri Gard	Kendall	MRCS	England	1948	LRCP	London	1948	MBBS	London	1950	M UK
Marjorie Amy Clara	Kuck	MBBS	London	1946	LRCP	London	1946	MRCS	England	1946	F UK
Ganz	Lazar	MBBCh	Belfast	1942	BAO	Belfast	1942	MRCP	Dub	1943	M UK
Colin Hill	MacGibbon	MBChB	NZ	1947							ROW
Richard George James	McCullagh	LRCPI LM	Ireland	1918	LRCSJ LM	Ireland	1918				M UK
Constance Beatrice Sarah	Napier	MRCS	England	1944	LRCP	London	1944	DLO	London	1948	F UK
George Henry	Oorloff	LMS	Singapore	1923							ROW

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John Thaddeus	Quinlan	MBBCh	London	1928	NUI	London	1928	DCP	London	1941	M UK
Keith Langdon	Robertson	MBChB	NZ	1947							ROW
Ian Leslie	Shepherd	MBChB	Aberdeen	1944							M UK
John Patrick Andrew MacDuff	Skene	MRCS	England	1946	LRCP	London	1946				M UK
Basil Arnold	Stoll	LRCP	England	1939	MRCS	London	1939	FFR	England	1952	M UK
Catherine Margaret	Sutherland	MBChB	Edinburgh	1939							F UK
Donald Kenneth Morley	Toye	MBBS	London	1945	DMRD	London	1949				M UK
Austin Francis	Tuohy	MBBS	London	1950							M UK
Derek Linsday	Walker	MBBS	London	1949	MRCS	England	1948	LRCP	London	1948	M UK
Thomas	Walsh	MBBCh	Ireland	1950	BAO	Ireland	1950				M UK
Joel	Wilbush	MBChB	Sheffield	1943	MRCOG		1956				M UK
Patricia	Wilson	MBChB	NZ	1949							ROW
1953 registrations											
Jean	Armstrong	MBBS	Durham	1950							F UK
Hazel Caroline	Blomfield	MBBS	London	1948	DCH	London	1951				F UK
James Douglas	Colonna	MBChB	NZ	1949							ROW
Cyril Walter	Crane	MBBS	London	1951							M UK
Eugene Donald	Doeherty	MBChB	Glasgow	1952							M UK
Samuel Robert Ambrose	Hogg	MBBCh	Belfast	1950							M UK
Claude	Langman	LRCS	Edinburgh	1950	LRCP	Edinburgh	1950	LRCPS	Glasgow	1950	M UK
Stephen John	LLoyd	MBChB	Bristol	1951							M UK
Allison Andrew	Maxwell	LRCP	Edinburgh	1937	LRCS	Edinburgh	1937	LRFPS	Glasgow	1937	M UK
Arnold Revell	Silcock	MRCS	England	1940	LRCP	London	1940				M UK
Mary Alice Theadore	Tolley	MBChB	NZ	1948							ROW
Philip Bertram Samuel	Willan	MRCS	England	1937	LRCP	London	1937				M UK
1954 registrations											
Frederick James	Appelbe	MBChB	Bristol	1952							M UK
Michael Francis	Bennett	MBChB	Ireland	1952							M UK
Kathleen	Blott	MBChB	Bristol	1946	DARCP	London	1951				F UK
William James	Carr	MRCS	England	1908	LRCP	London	1908	FRACP	Australia	1943	M UK
Ivo John	Carre	MRCS	England	1944	RCP	London	1945	MBBCh	Cambridge	1945	M UK

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
Michael Francis	Cleary	LAH	Dublin	1950	MBBCh	Northern Ireland	1952				M UK
Matthew Scott	Crawford	BMChB	Glasgow	1945							M UK
Own William	Deacon	MBChB	Birmingham	1952							M UK
Margaret	Duncan	BMBCh	Oxford	1946							F UK
Michael Matthew Joseph	Enright	MBBCh	Ireland	1935	BAO	Ireland	1935	DOMS	London	1942	M UK
Richard Martin	Forsayeth	MRCS	England	1926	LRCP	London	1926				M UK
Leonard	Goodman	MRCS	England	1938	LRCP	London	1938	FRCS	Edin-burgh	1944	M UK
Michael	Hamilton	MBBS	London	1945	MRCP	London	1946	MD	London	1949	M UK
Alfred Erskine	Harley	LRCP	London	1933	MRCS	England	1933				M UK
Donald Amias Jenner	Hunwick	LRCP	London	1933	MRCS	England	1933				M UK
Helen Juliana	Jones	MBBS	London	1951	LRCP	England	1951	MRCS	England	1951	F UK
Owen	Lawrence	MBChB	NZ	1949							ROW
Ilija	Lopert	LRCP	Edinburgh	1944	LRCS	Edinburgh	1944	LRFPS	Glasgow	1944	M UK
Sheila Anne	Martyn	MBBS	Bristol	1952							F UK
William Dugald	McLellan	MBChB	Glasgow	1930							M UK
Cyril Francis	O'Reilly	MBChB	Belfast	1936	QC	Belfast	1936				M UK
Francis Owen Piers	Pearce	MRCS	England	1952	LRCP	London	1952				M UK
Stanley Frederick	Polley	MRCS	England	1937	LRCP	London	1937	DA RCPS	?	1942	M UK
Sheina Bryson Pendle	Potter	MBChB	Edinburgh	1942							M UK
Joseph Brian	Sheils	LLM RCP	Ireland	1950	LLM RCS	Ireland	1950				M UK
Frank Edward	Williams	MBBCh	Dublin	1947							M UK
1955 registrations											
Bernard George	Bennett	MBChB	Bristol	1952							M UK
James William	Bishop	MRCS	England	1942	LRCP	London	1942	MBChB	Leeds	1943	M UK
Mary	Bishop	MRCS	England	1942	LRCP	London	1942				F UK
Cyril Gavin	Burt	MBChB	NZ	1951							ROW
John Dunn	Campbell	MBChB	Edinburgh	1949							M UK
John Thomas	Cantwell	MBBCh	Ireland	1946	BAO	Ireland	1946	LM NU	Ireland	1946	M UK
John Arthur Basil	Cotsell	MRCS	England	1941	LRCP	London	1941				M UK
Laurence Frederick	Donnan	LMSSA	London	1931	LRCP	Edinburgh	1932	DPH QU	Belfast	1938	M UK

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George Alexander	Dunlop	MBChB	St Andrews	1924	DTM and Hyg	Liverpool	1927	MD	St Andrews	1931	M UK
Denis Roy	Elam	MRCS	England	1953	LRCP	London	1953	MBBS	London	1953	M UK
Donald	Emslie-Smith	MBChB	Aberdeen	1945	MRCP	London	1952				M UK
Elsa Ruth	Enright	MBChB	St Andrews	1942	DA RCS		1948				F UK
Maurice Rossie	Ewing	MBChB	Edinburgh	1935	FRCS	Edinburgh	1939	FRCS	England	1946	M UK
James Hamilton	Fairley	BMBCh	Oxford	1952							M UK
Alexander Melling	Fairlie	MBChB	Glasgow	1943							M UK
Clennell Cooke	Fenwick	MBBS	Durham	1923							M UK
Courtenay Hugh	Greer	MRCS	England	1941	LRCP	London	1941	MBBS	London	1941	M UK
Leslie Allen	Guile	MBChB	Liverpool	1952							M UK
Denis Michael	Hessle-grave-Jackson	LRCS	Edinburgh	1950	LRCP	Edinburgh	1950	LRFPS	Glasgow	1950	M UK
Noel Keith	Honey	MBChB	NZ	1950							ROW
John Edward	Howson	MBBS	Durham	1948	FRCS	England	?				M UK
Brenda Mary	James	MBBCh	Wales	1949							F UK
Douglas Terence Rhys	James	MBBS	London	1949							M UK
Rita	Jenkins	MBBS	Durham	1945							F UK
Robert Victor	Lea	MBBCh	Dublin	1950							M UK
Heather Jacqueline	Lopert	LRCP	Edinburgh	1952	LRCS	Edinburgh	1952	LRFPS	Glasgow	1952	F UK
Richard Robert Haynes	Lovell	MRCS	England	1941	LRCP	London	1941	MRCP	London	1947	M UK
Frederick John	Mayne	MRCS	England	1927	LRCP	London	1927				M UK
Norman Tate	McLaughlin	MBChB	Birmingham	1953							M UK
Patricia Gertrude	Moll	MBChB	Dublin	1951							F UK
Godfrey Thomas	Nelson	MBChB	Dublin	1951	BAO	Dublin	1951				M UK
John Henry	Nicholls	MBChB	Sheffield	1951							M UK
Noel Patrick	Orchard	MBBS	London	1940	MD	London	1952				M UK
Richard Ewart	Rawstron	MBChB	NZ	1941							ROW
Joan Marcia	Robinson	MBChB	Leeds	1944							F UK
Allan Bruce	Roy	MBChB	NZ	1920							ROW
Ralph Harold Bernard	Sacks	MBBS	London	1950							M UK
James Miller	Saunders	MBChB	NZ	1950							ROW
Dilys	Sawyer	MBChB	Edinburgh	1946							F UK
Gillian Esther	Sladden	MBBS	Durham	1949							F UK
Geoffrey William	Sprigge	MBBS	London	1952							M UK

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Doreen Guiness	St Davids	LMSSA	London	1951							F UK
Eric Hay	Stephenson	MRCS	England	1951	LRCP	London	1951				M UK
Margaret Laura	Ward	MRCS	England	1949	LRCP	London	1949	DRCOG	?	1951	F UK
William Bearn	Willder	LRCP	Edinburgh	1947	LRCS	Edinburgh	1947	LRFPS	Glasgow	1947	M UK
George Campbell	Young	MRCS	England	1925	LRCP	London	1925	DPM RCPS	?	1931	M UK
1956 registrations											
Edward Ambrose	Allcock	MBChB	Manchester	1949	FRCS	England	1955				M UK
John Heath	Apted	MBBS	London	1950							M UK
Anne Ridgway	Barlow	MBChB	Manchester	1949	DRCOG		1951				F UK
Thomas Frank	Barlow	MRCS	England	1925	LRCP	London	1925				M UK
Bruno	Blanckenberg	MBChB	Cape Town	1950	DA RCPS	London	1954	DA RCPS	Ireland	1954	ROW
Jane Madilo	Caldwell	MBBCh	Belfast	1949	BAO	Belfast	1949				F UK
Peter Henry	Caldwell	MBChB	NZ	1951							ROW
Andrew Moynihan	Claye	MRCS	England	1924	FRCS	England	1928	LRCP	London	1924	M UK
Aileen Forsyth	Connon	MBBCh	Belfast	1954	BAO	Belfast	1954				F UK
Brian Winfield	Cook	MBChB	NZ	1953							ROW
Joyce Margaretta	Daws	MRCS	England	1949	FRCS	England	1952	LRCP	London	1949	F UK
Constance Mauguerita	Dennehy	MBChB	NZ	1955							ROW
Alys Esther Patricia	Donnan	MBBCh	Belfast	1955	BAO	Belfast	1955				F UK
Graeme Ross	Duncan	MBChB	NZ	1953							ROW
Isabel Muriel	Dunlop	MBChB	St Andrews	1922	DPH	St Andrews	1924				F UK
Fritz	Duras	MD	Freiburg-Breisgau	1926							M EU
Kenneth William	Edmondson	MBChB	Bristol	1952							M UK
Clifton	Elliot	MBChB	NZ	1945							ROW
John Julius	Fryatt	MRCS	England	1955	LRCP	London	1955	MBBS	London	1955	M UK
Arnold	George	MBBS	London	1949							M UK
Clara Lazar	Geroe	MD	Pecs	1924							F EU
Paul Michael	Gill	MBChB	Bristol	1956							M UK
Teodozia	Goliborska-Golab	MD	Warsaw	1926							F EU
Robert Stanley	Hamilton	MBBCh	Belfast	1942							M UK
Hans	Heydemann	MD	Berlin	1923							M EU
Beverley John Herbert	Insull	MBChB	NZ	1953							ROW

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
George Pearson	Jeffery	MBChB	Edinburgh	1945							M UK
Henry Max	Johnson	MBChB	Liverpool	1950							M UK
Andrew	Kertesz	MBBS	London	1945	DTMH	England	1947	DCP	London	1959	M UK
Zygmunt	Kortus	MBBCh	Ireland	1956	BAO	Ireland	1956				M UK
Richard Henry	Lindsay	MBChB	Cape Town	1950							ROW
Thies Richard	Lubbe	MD	Hamburg	1937							M EU
Abe	Luntz	MBChB	Witwatersrand	1954							ROW
John Donald Campbell	Lyons	LRCP	Edinburgh	1948	LRCS	Edinburgh	1948	LRFPS	Glasgow	1948	M UK
Donald George Charles	MacDonald	MRCS	England	1940	LRCP	London	1949	MBBS	London	1949	M UK
Hugh Blyth Alexander	MacFie	MBChB	Edinburgh	1936	DTMH	Edinburgh	1940				M UK
Ian Ivor Maynad	MacGregor	LRCP	Edinburgh	1951	LRCS	Edinburgh	1951	LRFPS	Glasgow	1951	M UK
Jacob	Mackiewicz	MD	Moscow	1911							M EU
Hamish Alistair	Maclachlan	MBChB	Glasgow	1941							M UK
John Michael	Manners	MBChB	Leeds	1953							M UK
Henry Robert	McCoy	MBChB	NZ	1949	FRCS	England	1953				ROW
Ellison James	McInnes	MBChB	NZ	1949	DA RCP & S	London	1954				ROW
George Dunseith	Mulholland	MRCS	England	1952	LRCP	London	1952				M UK
Edward Joseph	Murphy	MBBCh	Ireland	1919	BAO	Ireland	1919				M UK
Patrick Aloysius	O'Brien	LRCP	Edinburgh	1950	LRCS	Edinburgh	1950	LRFPS	Glasgow	1950	M UK
Michael Earnan	O'Doherty	MBBS	Ireland	1947	BCh	Ireland	1947				M UK
James Patrick	O'Shea	MBBCh	Ireland	1951	BAO	Ireland	1951				M UK
Donal Barry	O'Sulli-van-Beare	MBBCh	Dublin	1927	BAO	Dublin	1927				M UK
Dina	Patuck	MRCS	England	1949	LRCP	London	1949	MBBS	London	1950	F UK
Constance Sophia	Pimm	MBChB	Aberdeen	1923							F UK
Leslie Ellis	Pimm	LMSSA	London	1914							M UK
Jack Ernest	Place	MBChB	Edinburgh	1935							M UK
David Glynne	Price	MBBS	London	1948							M UK
Joseph Henry	Scudamore	MBChB	Bristol	1951	DRCOG		1954				M UK
Joan Mar-garet	Scudamore	MBChB	Aberdeen	1948	DCH	London	1951				F UK
Denise Gordon	Sherwood	MBChB	Bristol	1952							F UK
Peter Henry	Sherwood	MBChB	Bristol	1952							M UK
Peter George	Todd	MBChB	Aberdeen	1953							M UK

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
James Reginalrd De Vos	Toussaint	MRCS	England	1936	LRCP	London	1936	DTMH	London	1937	M UK
Martin	Tows	MBBS	Durham	1935							M UK
Stanley	Weiner	MD	Zurich	1949							M EU
Charlotte Edith	Wells	MD	Berlin	1921							F EU
Margaret	Wilson	MBChB	Glasgow	1945	DCH	London	1949				F UK
1957 registrations											
James	Alexander	MBBCh	Belfast	1953	BAO						M UK
Douglas Barrie	Berryman	MBChB	NZ	1951							ROW
John Alex-ander	Black	MBChB	St Andrews	1948							M UK
Russell Claude	Brock	MRCS	London	1926	LRCP	London	1926	FRCS	England	1929	M UK
Percy Gordon	Burles	MBBS	London	1957	MRCS	England	1957	LRCP	London	1957	M UK
Norman Charles	Connell	MRCS	England	1945	LRCP	London	1945				M UK
George Desmond	Cribb	MRCS	England	1939	LRCP	London	1939	FRCS	England	1950	M UK
Ellis Thacker	Dick	MBChB	NZ	1941							ROW
Austin Eric	Doyle	MBBS	London	1946	MD	London	1951	MRCP	London	1950	M UK
George	Duncan	MBChB	Glasgow	1955							M UK
Richard Moreton	Ellison	MBChB	Edinburgh	1939	MD	Edinburgh	1951	DPM RCPS	Bristol	1950	M UK
Margaret Mary	Fitzgerald	MBBCh	Ireland	1950	BAO	Ireland	1950	FFA RCS	England	1955	F UK
Noel Russell	Freeman	MBChB	NZ	1942							ROW
Nesta	Gordon	MBBCh	Wales	1951							F UK
William Fleming	Gordon	MBChB	Glasgow	1948	FRCS	England	1955				M UK
Richard Henry	Griffith	MRCS	England	1947	LRCP	London	1947				M UK
Malachy	Heenan	MBBCh	Ireland	1950	BAO	Ireland	1950				M UK
Richard George	Hingston	MBBCh	Ireland	1956							M UK
Edwin Peter	Isacson	MD	Nebraska	1953							ROW
Cornelius Cummins	Kennedy	MRCS	England	1912	LRCP	London	1912				M UK
John Francis	Lees	MBBChir	Cambridge	1950							M UK
Mark John	Lindsey	MRCS	England	1933	LRCP	London	1933	MBBS	London	1935	M UK
Herta	Lowy	MD	Vienna	1938							F EU
George Mar-tin Anthony	Lynch	MBChB	Glasgow	1944							M UK
James Gillespie	Maclachlan	MBChB	Manchester	1953							M UK
Robert James	Marshall	MBBCh	Belfast	1948	BAO	Belfast	1948	MD	Belfast	1952	M UK

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
David Sande-man	McDonald	MBChB	Aberdeen	1951							M UK
Desmond Joseph	McGuigan	MBBChir	Cambridge	1955							M UK
Arthur William	McHaffie	MBChB	Glasgow	1938							M UK
Patrick	Melia	MBBCh	Ireland	1946	BAO	Ireland	1946				M UK
Colin William Angless	Murray	MBChB	Edinburgh	1947	DCH	London	1953	DRCOG	?	1956	M UK
Arthur Faquhar	Murray	MBChB	Aberdeen	1937							M UK
Hannah	Mushin	MRCS	England	1947	LRCP	London	1947	DOH RCPS	London	1951	F UK
Anne Theresa Amy	Myers	MRCS	England	1952	LRCP	London	1952	DCH RCPS	?	1954	F UK
John Androw	Owen	MBChB	Edinburgh	1949							M UK
Robert Alexander	Philp	MBChB	St Andrews	1939							M UK
Alastair Arnaud	Reid	MBBS	Durham	1947	MRCP		1951	DPM RCPS	?	1954	M UK
William Hanron	Reid	MBChB	NZ	1941							ROW
Brenda Elizabeth	Ridley	MBChB	Glasgow	1939							F UK
Paul	Roboz	MD	Budapest	1924							M EU
Yvonno Kerr	Russell	MBBS	London	1949	MRCS	England	1949	LRCP	London	1949	M UK
Ivor Philip Quintin	Scott	MRCS	England	1951	LRCP	London	1951	MBBS	London	1951	M UK
Mabel Margaret	Stevenson	MBBCh	Belfast	1952	BAO	Belfast	1952				F UK
John Michael	Stoner	MRCS	England	1951	LRCP	London	1951	MBBS	Mel-bourne	1957	M UK
Robert Philip	Strang	MRCS	England	1940	LRCP	London	1940	MRCP	?	1946	M UK
William Iain	Stuart	MBChB	Edinburgh	1950							M UK
Margaret Elizabeth	Thompson	MBChB	Edinburgh	1955							F UK
Arthur Trevor	Thompson	MBChB	Manchester	1953							M UK
Irena	Waga	MBChB	Edinburgh	1948							F UK
Geoffrey Norman	Wardle	MRCS	England	1933	LRCP	London	1933				M UK
Emanuel	Wilder	MBChB	Edinburgh	1947							M UK
1958 registrations											
David Paul	Adamson	MBBS	London	1953	LMSA	England	1952				M UK
John Gavin	Andrews	MBChB	NZ	1956							ROW
John Kenneth	Arkle	MBBS	Durham	1943	MRCS	London	1943	LRCP	London	1943	M UK
Geoffrey Lister	Asherson	BMBCh	Oxford	1953	MRCP	Edinburgh	1956	MRCP	London	1957	M UK
Louie Myfan-wy May	Beadnell	MRCS		1954	LRCP	England	1954				F UK

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
William Duncan	Bennett	MBChB	Edinburgh	1952							M UK
Georg	Berci	MD	Szeged	1950							M EU
Paul	Borg	MD	Malta	1949	DA	England	1956				M EU
John T	Boyer	MD	Harvard	1955							ROW
Frank Russell	Braithwaite	MBBS	Durham	1954	DRCOG	?	1958				M UK
Hugh Cameron	Butel	MBChB	NZ	1954							ROW
Gerald	Carn	LRCP	Edinburgh	1928	LRCS	Edinburgh	1928	LRFPS	Glasgow	1928	M UK
Adam	Chojnowaki	MD	Lodz	1949							M EU
Sergiusz	Chrapowicki	MB	Kharkov	1923							M EU
Eugenie	Cikalov	MD	Belgrade	1935							F EU
Helen Margaret	Connell	MBBS	London	1945	MRCS		1945	LRCP	?	1945	F UK
Peter	Cook	MBBS	London	1953							M UK
John Moir	Crombie	MBChB	Glasgow	1956							M UK
Nickel	Crombie	MRCS	England	1956	LRCP	London	1956	MBBS	London	1956	M UK
Peter	Crossley Meates	MBBS	London	1955							M UK
Augustine Joseph	Cunningham	MBChB	Liverpool	1949	DTMH	Liverpool	1956				M UK
John Russell	Dalton	MBBS	London	1955							M UK
Gareth Evans	Davies	MBChB	Wales	1948							M UK
Norman Anthony	Elvin	MBBS	Durham	1954	DRCOG		1958				M UK
David Keith	Fairweather	MBBChir	Cambridge	1954	MRCS		1954	LRCP	?	1954	M UK
Charles Dalby	Fisher	MBChB	Liverpool	1953	DRCOG		1957				M UK
Elizabeth Ann	Fisher	MBChB	Birmingham	1955							F UK
Kathleen Elspeth	Fleming	MBBS	London	1952							F UK
Patrick Ambrose	Fogarty	MBBS	London	1958							M UK
David	Freeman	MBBChir	Cambridge	1957	MRCS		1957	LRCP	?	1957	M UK
Roy Thomas Reynolds	Freshwater	MRCS	England	1937	LRCP	London	1937	MBChB	Birmingham	1937	M UK
Margaret Winifred Helen	Game	MRCS	England	1949	LRCP	London	1949				F UK
John Fairfax	Garner	MBBChir	Cambridge	1956	MRCS		1955	LRCP	?	1955	M UK
Magda	Gergely	MD	Budapest	1950							F EU
William Russell	Gibson	LMSSA	London	1956	BChir	Cambridge	1957				M UK
Charlotte	Golding	MD	Leipzig	1937							F EU
Ian James	Gordon	MBChB	Aberdeen	1946	FRCS	England	1954				M UK
Rita	Hackett	MBBS	Nagpur	1952							ROW
Gerald Lindsay	Hardman	DMRD	England	1950	MRCS	England	1933	LRCP	England	1933	M UK

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
Pamela Nonette	Harris-Wright	MRCS	England	1947	LRCP	London	1947	MBBS	London	1948	F UK
Jack Cyril	Heny	LRCP	London	1940	MRCS	England	1940				M UK
Paula	Holojad	MD	Graz	1949							F EU
Hugh Peter Harney	Ivens	LMSSA	London	1952	MBBS	London	1953				M UK
Gillian Frances	Jacob	MBBChir	Cambridge	1947	DTMH	London	1952	MD	Cam-bridge	1956	F UK
John Swift	Joly	MRCS	England	1937	LRCP	London	1937	MBBChir	Cam-bridge	1937	M UK
Anne Francis	Jones	MBBS	London	1953	DA	London	?				F UK
Montague Philip	Joyston-Be-chal	MBBCh	Oxford	1954							M UK
Mushtaq Ahmad	Khan	MBBS	Karachi	1958							ROW
Priscilla Sheath	Kincaid-Smith	MBBCh	Witwatersrand	1951	DCP	London	1954	MRCP	London	1956	ROW
Wilhelm	Knie	MD	Vienna	1925							M EU
George	Lakos	MD	Budapest	1935							M EU
Paul Garner	Large	MBBS	London	1943	FRCS	England	1948	MS	London	1952	M UK
James Gordon	Lindsay	MBChB	Glasgow	1953	DRCOG	?	1957				M UK
John Ward	Little	MBChB	Glasgow	1957							M UK
Gordon	Low	MBBS	Hong Kong	1956							ROW
Alastair	MacKellar	MBChB	Edinburgh	1944	FRCS	Edinburgh	1948				M UK
Iain	Macmillan	MBBS	London	1952							M UK
Rajindar Lal	Manchanda	MBBS	Lahore	1938	MS	Lahore	1943				ROW
Frederick Milward	Mansfield	MBBS	London	1951	DRCOG		1956				M UK
Andrew Guy	McComb	MBChB	Belfast	1955							M UK
Grace Alison	McCormack	MRCS	England	1946	LRCP	London	1946				F UK
Keith Grace	McKenzie	MBChB	NZ	1955							ROW
Reginald Shaw	McLatchy	MRCS	England	1924	LRCP	London	1924				M UK
Donald William	Menzies	MBChB	Glasgow	1946							M UK
Terence Thomas Eskine	Michael	MBBCh	Dublin	1949	MRCOG	?	1957				M UK
David Colin	Mintz	MBChB	Birmingham	1957							M UK
Samuel	Moore	MD	Freiburg-Bre-isgau	1909							M EU
John Stanley James	Morley	LRCP	London	1943	FRCS	England	1953				M UK
John Graham	Mortimer	MBChB	NZ	1956							ROW
Arthur Lewis Christopher	Packham	MBBS	London	1950							M UK
Ian William	Palmer	MBChB	Bristol	1952	DRCOG	London	?				M UK

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
Moira Kathleen Margaret	Palmer	MBChB	Aberdeen	1951							F UK
Joyce	Park	MBChB	Bristol	1942	DPH	London	1947				F UK
Ralph Desmond	Pearson	MRCS	England	1952	LRCP		1952				M UK
Edith	Phillips	MD	Vienna	1938							F EU
Victor Donald	Pippett	BMBCh	Oxon	1953	DRCOG		1955				M UK
Ronald William	Plowright	MBBS	London	1953							M UK
Freda Mary	Pose	MD	Basle	1934							F EU
Glyn	Priddle	MBBS	London	1956	DRCOG		1958				M UK
Peter Alfred	Reed	MRCS	England	1945	LRCP	London	1945	MBBS	London	1949	M UK
John Thursten	Roberts	MBChB	Liverpool	1955							M UK
Angus Reid	Robertson	MBChB	Manchester	1957	MRCS		1957	LRCP	?	1957	M UK
Georges Emile	Rousseaux	BMBCh	Oxford	1950	DLO	London	1952	FRCS	London	1958	M UK
Thomas Arthur	Sale	MBChB	Liverpool	1940	FRCS	Edinburgh	1949				M UK
Karl	Schubert	MD	Vienna	1924	MBBS	Queensland	1942				M EU
Jacob	Shaw	MD	Vienna	1921							M EU
George Alfred	Silley	MRCS	England	1942	LRCP	London	1942				M UK
Robin Owen Stroud	Sims	MBBChir	Cambridge	1957							M UK
Ian MacNicol	Smith	MBBChir	Cambridge	1943	FRCS	England	1954				M UK
Jennifer	Spurr	MBBS	London	1957							F UK
Thomas	Stevens	MBBS	Edinburgh	1949							M UK
Paul	Steward	MRCS	England	1951	LRCP	London	1951	DA	?	1956	M UK
Mary Agnes	Stott	MBChB	Manchester	1949							F UK
Kenneth	Talboys	LMSSA	London	1944							M UK
Dorothy	Taylor	MRCS	England	1927	LRCP	London	1927	MBBS	London	1927	M UK
Marjorie Paula	Thomas	MBChB	Manchester	1957							F UK
Jerrold William	Thomson	MBBS	London	1955							M UK
John Joseph	Valentine	MBChB	NZ	1950							ROW
Robert Frederick	Warnock	MBBChir	Cambridge	1952							M UK
Michael John	Waterfield	MBChB	Sheffield	1956							M UK
Bertram Calvin	Weerappah	LRCP	Edinburgh	1940	LRCS	Edinburgh	1940	LRFPS	Glasgow	1940	M UK
David Whatton	Wilkie	MBChB	NZ	1948							ROW
Alexander Scott	Wilson	MRCS	England	1956	LRCP	London	1956				M UK
John	Wilson	MBChB	Leeds	1940							M UK
Stuart Henry	Wydell	MBBS	London	1954	MRCS	England	1954	LRCP	London	1954	M UK

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
1959-60 registrations											
Charles Hill	Balmer	MBChB	Belfast	1956	BAO	Belfast	1956				M UK
Charles Lorenz	Bar-tholomeusz	LMS	Ceylon	1934							ROW
Allen Austin	Bartholomew	MRCS	England	1949	LRCP	London	1949	DPM RCS	London	1957	M UK
Henri Glenis-ter Shalcross	Battersby	MBChB	Edinburgh	1957							M UK
Sophie Hannah	Beecham	MBChB	NZ	1955							ROW
Veronica Vera	Bower	MD	Basle	1939							F EU
Jack William	Brooks	MRCS	England	1954	LRCP	London	1954				M UK
Patricia Mary	Bucknole	MBBCh	Wales	1955	D. Obst RCOG	?	1958				F UK
Margaret Ursula	Bullen	MBBChir	Cambridge	1958							F UK
Donald Charles	Caine	MBBCh	Witwatersrand	1940							ROW
David Joseph Edward	Cheshire	MRCS	England	1947	LRCP	London	1947	MBBS	London	1947	M UK
John Ray-mond	Cope	MBChB	Liverpool	1954							M UK
Barbara Phyllis	Coppen	MRCS	England	1953	LCRP	London	1953	MBBS	London	1953	F UK
Bryan Joseph	Cremin	MBBS	London	1952							M UK
John De Berri Johnston	Dade	LMSSA	London	1956	BS	London	1957	D.Obst RCOG	?	1958	M UK
Alexander Carle	Denholm	MBChB	Aberdeen	1957							M UK
Paramatma Sharan	Dhasmana	MBBS	Lucknow	1957							ROW
Walter	Didzys	MD	Berlin	1923							M EU
Dmytro	Dobrotwir	MD	Prague	1931	MD	Poznan	1934				M EU
Bernard	Ekert	MD	Vienna	1926							M EU
Brinley Lightfoot	Evans	MBChB	Liverpool	1950							M UK
Lois Rose-mary	Fenna	MBChB	Manchester	1955							F UK
Gerard Niall	Flaherty	MRCS	England	1957	LRCP	London	1957	MBBS	London	1957	M UK
Anthony Francis	Floyd	MBBS	London	1954	DRCOG		1957				M UK
Andrew Keith	Frazer	MBChB	Liverpool	1950							M UK
Eleanor Kay	Frazer	MBChB	Liverpool	1954							F UK
Clive Hough-ton	Garlick	MBChB	NZ	1942							ROW
Austra Elvira	Grinfields	MD	Latvia	1937							F EU
Edward Trevor	Hale	LRCS	Edinburgh	1923	LRCP	Edinburgh	1923	LRFPS	Glasgow	1923	M UK
Robin Bryant	Handscombe	MRCS	England	1952	LRCP	London	1952				M UK
Conelia	Henley	MD	Hungary	1922							F EU

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
Malcolm John	Hoare	MBChB	Birmingham	1958							M UK
John Alfred Gorton	Holt	MRCS	England	1947	LRCP	London	1947	FRCS	England	1953	M UK
Hedley Anthony	Hosking	MRCS	England	1952	LRCP	London	1952				M UK
Keith Nich-olson	Howson	MBBS	Durham	1957							M UK
Ian Pierce	James	MBBChir	Cambridge	1949	DPM	London	1957				M UK
Ronald Anthony	Johnson	MBChB	Liverpool	1954							M UK
David Ellis	Jones	MRCS	England	1921	LRCP	London	1921	DPM RCPS	?	1935	M UK
George Hermanis	Kaire	MD	Latvia	1931							M EU
Pard-hasaradhi	Kattula	MBBS	Andhra	1954							ROW
Izidorius Jurgis	Kaunas	MD	Lithuania	1930							M EU
Klavs	Kepars	MD	Latvia	1930							M EU
Manzoor Ahmad	Khan	MBBS	Punjab	1954							ROW
John Francis	Killick	MBChB	Edinburgh	1956							M UK
Arthur	King	MBBS	Durham	1956	DPM	Durham	1956				M UK
Edmund Joseph	King	MRCS	England	1943	LRCP	London	1943				M UK
Greta Mary	Langdon	MBBS	London	1926							F UK
Ramon Henry James	Laurence	MBBS	London	1954							M UK
Clive Denton	Levis	MBBCh	Dublin	1950	FRCS	London	1957				M UK
James Howells	Lewis	MBChB	Aberdeen	1952							M UK
Michael	Lieder-Mrazek	MD	Munich	1950							M EU
Victor St Clair Dudgeon	Logan	MRCS	England	1956	LRCP	London	1956	MBChB	Liverpool	1958	M UK
Robin Camp-bell Wilson	Lowe	MBChB	Edinburgh	1945	MRCP	Edinburgh	1950	FRCS	Edin-burgh	1952	M UK
Alan John	Lyne	MBChB	Birmingham	1956							M UK
Ernest Evans	Malone	MBBCh	Dublin	1926							M UK
John Hackett	McCarthy	MBBCh	Ireland	1954	BAO	Ireland	1954				M UK
Emil	Miglic	MD	Graz	1925							M EU
Eileen Margaret	Millward	MBChB	Liverpool	1956							F UK
Helen Mary Philomena	Moloney	MBBCh	Ireland	1954	DPM	London	1958				F UK
Michael	Murray-Alston	MBBCh	Dublin	1957							M UK
Verners	Nolle	MD	Latvia	1927							M EU
Elemer	Paulikovics	MD	Budapest	1940							M EU
John Arnold	Porritt	MRCS	England	1950	LRCP	London	1950	MBBS	London	1957	M UK

Given name(s)	Surname	Degree 1	Place of degree	Year	Degree 2	Place of degree	Year	Degree 3	Place of degree	Year	Field
Herbet Johnstone Granville	Redmond	MBBCh	Belfast	1948	BAO	Ireland	1948				M UK
John Dowie	Reid	MBChB	Edinburgh	1933	DPH RCPS	Edinburgh	1935	DPH RFPS	Glasgow	1935	M UK
George Arnold	Rundle	MRCS	England	1945	LRCP	London	1945				M UK
Eleanor Hilda	Russell	MBBS	Durham	1922	MD	Durham	1925	DA	London	1946	F UK
Thomas Fraser	Sandeman	MBChB	Edinburgh	1950	DMRT	Edinburgh	1958				M UK
Graham Hope	Scott	MBBS	Durham	1935	DPM	London	1957				M UK
William O'Neill	Shields	MBChB	Glasgow	1957							M UK
Henry Roy	Simpson	MBChB	St Andrews	1952	D. Obst RCOG	?	1954	DCH	London	1956	M UK
Miklos	Szigethy	MD	Budapest	1944							M EU
Amiela Anna	Szwede	MBChB	Edinburgh	1949							F UK
James William Wishart	Thomson	MBChB	St Andrews	1954	FRCS	Edinburgh	1958				M UK
Peter Alan	Thorpe	MRCS	England	1943	LRCP	London	1943	DLO	England	1944	M UK
Donald Harry	Wadelton	MBChB	Birmingham	1952	DCH	London	1955				M UK
George Alfred	Weaver	MBBCh	Dublin	1955							M UK
John Treharne	Wheeler	MRCS	England	1953	LRCP	London	1953	DA	London	1957	M UK
Francis David	Whittle	MBBS	London	1956							M UK
David Bowen Morgan	Williams	MBBS	London	1956							M UK
Ronald Stevenson	Wilson	MBChB	Edinburgh	1958							M UK

Source: Victorian Medical Registers, 1931-60.

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Appendix 5: Example Biographical Dossier

M-UK-0358		
Field	**Entry**	**Type**
Family name	Garner	
Given names(s)	John Fairfax	
Aliases	[Blank]	
Date of birth	01 September 1931	
Place of birth	Leicester	
Country of birth	England	
Secondary school	Boarding school, Sheffield Dean Close School, Cheltenham	Collated, Open text
Father's occupation	Leather factor	
Nationality on arrival	British	
Religion	[Blank]	
Year of departure	1959	
Date arrived in Australia	DD-MM-1959	
Scheme	Sponsored, Assisted passage – State of Victoria	Assigned
Left Australia	N	Assigned
Year of departure	N/A	
Naturalised/Aust citizenship	Y	
Marital status	Unmarried on arrival	Assigned
Year married	196X	
Spouse name		
Spouse occupation	Nurse	
Children	Y	
Date of Death	N/A	
Place, Country of Death	[Blank]	
Date registered in Victoria	10 March 1959	
Date first registered to practice medicine	4 December 1956	
Country of first registration	England	
Qualifications – primary	MBBChir Cambridge 1956	
Qualification – other *[name, place, year]*	MA Cantab 1952 MRCS England 1955 LRCP London 1955 FRACGP 1974	
Postgraduate qualifications on arrival	N	Assigned
Postgraduate qualifications in Australia	Y	Assigned

M-UK-0358		
Countries worked in	England, Australia	Assigned
States of Australia worked in	VIC – rural	Assigned
Professional memberships	British Medical Association Australian Medical Association Fellow, Royal Australian College of General Practitioners Australian Sports Medicine Fellow	Collated, Open text
Last known occupation before departure	Other – Military service	Assigned
First known occupation(s) in Australia	Hospital - general	Assigned
Last known occupation(s) in Australia	General practitioner	Assigned
Gap years	N/A	Open text
Military service	Y	Assigned
Occupations held	Hospital – general; Other – Military service; General Practitioner; Medical Administrator; Other – Visiting Medical Officer	Assigned
List of roles	House Surgeon and House Physician, Guy's Hospital, London, England, 1955-56 Royal Air Force, Flight Lieutenant Medical Services, Yorkshire, England, 1957-1959 Resident Medical Officer, Ballarat Base Hospital, Ballarat, Victoria, Australia 1959-61 General Practice, Ballarat, Victoria, Australia, 1961-1990 Visiting Medical Officer, Queen Elizabeth Geriatric Centre, Ballarat, Victoria, Australia, 1961 Medical Administrator, Ballarat & District Base Hospital, Ballarat, Victoria, Australia 1973-1988 Medical Administrator, Family Medicine Program – Ballarat & District Base Hospital, Royal Australian College of General Practitioners, Australia, 1975-1988	Collated, Open text
List of known addresses	c/o 176 Station road, Cropston, Leicester Ballarat & District Base Hospital, Ballarat, Australia 612 Sturt street, Ballarat, Victoria, Australia 17 Errard street, North Ballarat, Victoria, Australia 203 Landsborough street, Ballarat, Victoria 3350, Australia	Collated, Open text

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- Dr John Garner, interview with Fallon Mody, October 2017
- Monash University Calendars, 1977, 1978
- Photograph, *Dr Garner, Dr D O'Sullivan, Dr J Acherson- Medical Supervisor, Mr Murray Byrne - ? Sports Medicine*, http://trove.nla.gov.au/version/213137596

Appendix 6: Racial Prejudice in the Medical Profession? The Case of Refugee Jewish Doctors in Australia 1930-1945 [publication]

Chapter 5 of this thesis is a revision of the following publication reproduced in full in this appendix. The full citation for the publication is:

> Mody, Fallon. "Racial Prejudice in the Medical Profession? The Case of Jewish Refugee Doctors in Australia, 1930-45." *Proceedings of the 1st Melbourne University Research Conference on History and Philosophy of Science* (University of Melbourne, 2013), 21-30. University of Melbourne, 2013.

Racial prejudice in the medical profession? The case of refugee Jewish doctors in Australia 1930-1945

by Fallon Mody

Moritz Meyer arrived in Melbourne in 1937 as one of thousands of Jews fleeing Nazi persecution. Meyer was prepared to rebuild his medical career: he had fled Germany, retrained in Scotland and had written confirmation from the Victorian Medical Board that his new Scottish qualifications would allow him practice in Victoria.[1] Little did he know that despite having no less than four qualifications listed in the *Victorian Medical Act 1928*, it would take a court case that made it all the way to the High Court of Australia to force the medical board to acknowledge the legitimacy of his application.[2]

Medical practitioners like Moritz Meyer were amongst those who sought refuge in Australia in the wake of events leading up to and during World War II – it is estimated that over 200 refugee doctors arrived between 1930-1945 to a hostile reception from their local colleagues.[3] Existing studies of refugee doctors in Australia – mainly stemming from cultural and political studies of migration – have generally concluded that racial prejudice played an important part in the reception of these Jewish doctors. Suzanne Rutland has researched Jewish migration and settlement in Australia extensively, and she attributes the cold treatment of these doctors to the fear of competition and anti-Semitic attitudes prevalent in upper-class Australians at that time.[4] Weaver agrees, he argues that behind alleging "sly practices, deceit and false pretences, and culturally unsuitable medical arts",[5] the fact that most of these doctors were Jews provided for him sufficient reason to associate it with anti-Semitism.

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[1] The Sydney Morning Herald, 30 June 1936.

[2] Doctor Meyer's original five-year medical degree was from the University of Leipzig in Germany, but he also had four qualifications listed on the Victorian Medical Act 1928's schedule of acceptable qualifications for registration. The Victorian Medical Board argued that accepting his application for registration would breach the reciprocity clause outlined in the act because Germany did not have an existing reciprocal recognition arrangement with Australia, and Dr Meyer was fulfilling the necessary length of medical education stipulated in the act on the basis of a German degree. This case was widely reported in local newspapers and prompted medical boards around the country to amend their respective medical acts so very few refugee doctors could use this precedent to gain registration.

[3] John Weaver, "A glut on the market: medical practice laws and treatment of refugee doctors in Australia and New Zealand, 1933-1942," *ANZ Law & History E-Journal* (2009): 32-38.

[4] Suzanne Rutland, "An Example of "Intellectual Barbarism": The Story of "Alien" Jewish Medical Practitioners in Australia, 1933-1956," *Yad Vashem Studies* XVIII (1987): 233-57.

[5] Weaver, "A glut on the market, 31.

In the 1971 book *Racism: The Australian Experience*, Salter provides the only analysis of racial prejudice in the Australian professions around this period.[6] She concludes that not only is there insufficient evidence to charge the medical profession with racial prejudice, they showed a degree of tolerance and flexibility towards migrant doctors. However, Salter based her interpretation on the combined numbers of UK doctors and foreign doctors that were granted registration in Australia. I believe a distinction must be made between UK-trained doctors and other foreign doctors because the profession made that distinction, and there are also good cultural reasons for doing so.

In this paper I will revisit the story of refugee doctors who migrated to Australia leading up to and during World War II to discuss how the threat of change that jeopardised the hard-won status of Australian doctors might have contributed more to these attitudes than racially-motivated prejudice, as has been argued. There are two important elements to be considered and I will discuss each one in turn. The first is the question of the depth and spread of anti-Semitic sentiment in Australia, and the second is the medical context within which refugee doctors found themselves.

Australian attitudes to Jews

By 1950 Australia had accepted more migrants from more countries than it had ever done before, and their vanguard was Jewish refugees fleeing Nazism. In the late 1930s, embassies in the UK were flooded with applications from Jews requesting resettlement. Australia House reported between May-August 1938 they received 300-500 applications per week from Jews, prompting the Cabinet to impose a quota of accepting 15,000 Jews over three years in 1938. Australia's humanitarian effort with regards to Jewish resettlement appears generous in world-terms, yet Australia's capacity to absorb more Jewish refugees far outstripped the quotas imposed on Jewish migration.[7]

Apathy towards Jews was common, including from Australian Jews who saw Jewish refugees as threatening their hard won acceptance into Australian society.[8] Stereotypical portrayals of Jews as ambitious, wealthy, cut-throat and clannish people who would take away Australian businesses, houses and jobs, whilst simultaneously diluting what it meant to be "Australian" found popular expression in the mainstream media via known anti-Semitic magazines like *The Bulletin* (see Figure 1 below).

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[6] Moira Salter, "Prejudice in the professions," in *Racism: the Australian Experience,* ed. FS Stevens (NSW: Hobgin Poole, 1974), 67-75.
[7] Andrew Markus, "Jewish migration to Australia 1938-49," *Journal of Australian Studies* no7 13 (1983): 18-31.
[8] See for example, Rutland, "An example of intellectual barbarism," 233-57; Markus, "Jewish migration", 18-31; Suzanne Rutland, "Post-war anti-Jewish refugee hysteria: A case of racial or religious bigotry?," *Journal of Australian Studies* 23 no 77 (2003): 29-48
The Australian Jewish Welfare Society was tasked with helping Jewish refugees resettle in Australia, and there has been mixed analysis of its efforts. See for example, Anne Andgel, *Fifty years of caring: The history of the Australian Jewish Welfare Society, 1936-1986* (AJWS and AJHS, 1988) and Rodney Benjamin, *A serious influx of Jews* (Allen and Unwin Academic: 1998).

One outraged Queenslander wrote to the Minister of the Interior in 1938 condemning the proposal to accept more Jewish settlers:

> *These people [Jews], in spite of the praise they get from muck newspapers they own, are a real menace to any white nation if allowed much latitude especially if they exist in large numbers.*[9]

Another Western Australian wrote a letter titled "Refujews" asking:

> *where will our wealth be in the years to come? – in the hands of the Jews. These Jews and foreigners have the best positions while our Australian youths are tramping the street. Run them out!.*[10]



Figure 1 Published in the *Northern Times* (WA), reprinted with courtesy *The Bulletin,* Thursday, 6 February 1939.

However, in 1939 Isaac Steinberg, during his extensive tour of Australia to canvas support to resettle ~75,000 Jews in the Kimberleys (WA), found the negativity towards Jews to be more an expression of economic anxiety and fear of competition rather than any true, deep-seated hatred of the Jewish race and people, unlike in Europe.[11] In fact Steinberg gained support for his radical plan from a number of highly influential people and bodies, including the Western Australian government, the ACTU, newspapers including *The Sydney Morning Herald, The Argus, The West Australian,* and a number of high-profile academics and politicians.[12]

Furthermore, the Jews were not alone: Southern Italians, Baltic people and Greeks in particular faced similar problems as migrants. [13] By 1948 when the mass immigration scheme peaked, a study found the ranking of preferred migrants

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[9] NAA: A434 1949/3/3196 Admission of Jews to Australia, 19 May 1921- 09 March 1938.
[10] *Daily News* (Perth), Saturday 1 April 1939.
[11] Isaac Steinberg, *Australia: The unpromised land*, (London: Gollacnz, 1948), 172. Steinberg was one of the founders of the Freeland League for Jewish Territorial Colonization, an organization that aimed to resettle Jews in new, welcoming countries. Steinberg's book was published as a final attempt to persuade the Curtin government to change its decision to deny the Kimberley plan, so his recollections must be read in that light. However, Steinberg does not gloss over the mixed response to his radical proposal, or the overt racism he experienced and heard, so the subsequent support he gained for his plan from all classes of society demonstrates that many Australians were sympathetic to the Jews' situation.
[12] Beverley Hooper, "Steinberg, Isaac Nachman (1888-1957)," Australian Dictionary of Biography, National Centre of Biography, ANU, last accessed 22 April 2013 http://adb.anu.edu.au/biography/steinberg-isaac-nachman-11757.
[13] See for example, FS Stevens, ed., *Racism: The Australian experience* (NSW: Bigpin Pool, 1974); James Jupp, *From white Australia to Woomera: The story of Australian immigration* (Cambridge University Press: 2002).

starting from the most preferred as follows: English, Irish, Germans, Chinese, Greeks, Italians, Jews and negroes.[14] Australia prior to the late 1940s was a homogenous and isolated society with an identity that has been described as distinctly Australian, but one that retained strong ties to its imperial heritage reinforced by the predominance of the Australian-born.[15] The "Britishness" that Australians felt during the period has been demonstrated amply, strong examples include the tradition of swearing an Oath of Loyalty to the Empire in schools, to as late as 1947 when 65% of polled Australians said they would opt for British nationality over Australian,[16] despite the "great betrayal" of Australia and New Zealand by the British who failed to defend Singapore in 1942.[17]

To Australians, non-British migrants represented all of the unwelcome social implications of migration: change, different languages, customs, appearance, religion and unwanted competition for jobs.[18] In a series of reports Sydney University academic Caroline Kelly was commissioned to research for the Ministry of Post War Reconstruction (1945) and the Immigration Advisory Council (1947), she found that "the antipathy to foreigners is expressed mostly in economic and religious terms. It does not occur to the average Australian to consider the non-British migrant socially at all". Kelly noted what later studies also would: hostility towards migrants took the form of generalised views, and varied depending on state and individual preferences from a dislike of "dago" work ethics to unfamiliar forms of religious expression.[19]

The medical profession and national health insurance

From a predominantly British-educated profession before 1890, the number of locally trained doctors in Australia rose rapidly in the 1930s. However, the professional connection to the motherland had long been consolidated by the continuing tradition for Australian doctors to specialise in the UK, and the strength of the British Medical Association (BMA) membership

[14] Samuel B Hammond, and Oscar Adolf Oeser, eds., *Social structure and personality in a city*. (University of Melbourne, Office of Research, 1954). By 1954 when the study was conducted, despite the events of World War II that included internment of "enemy" Germans in Australia, German migrants were preferred over Jews.

[15] See for example, Sol Encel, "Nature of race prejudice in Australia," in *Racism the Australian experience 1,* ed. FS Stevens (NSW: 1971); Geoffrey Sherington, *Australia's immigrants: 1788-1988* (Allen & Unwin: 1990); Victor J Callan, "Anglo-Australian attitudes toward immigrants: A review of survey evidence," *International Migration Review* (1983):120-137; Jupp, "From White Australia",1-10.

[16] *Australian Gallup polls*, nos 470-7 (November-December 1947).

[17] For discussions on Australian identity and Australians' sense of Britishness, see for example, Neville Meaney, "Britishness and Australian identity: the problem of nationalism in Australian history and historiography," *Australian Historical Studies* 32 no 116 (2001): 76-90; William F. Mandle, *Going it alone: Australia's national identity in the 20th century* (Melbourne: Penguin, 1978); Stephen Alomes, *A national at last? The changing character of Australian nationalism, 1880-1988* (Sydney: Allen & Unwin, 1988).

The "great betrayal" refers to the fall of Singapore in 1942 when Japan invaded and captured Singapore despite British reassurances to Australia and New Zealand that they would defend Singapore. The fall of Singapore resulted in the capture of large numbers of Allied troops as POWs. For perspectives on the aftermath of the fall of Singapore, see for example: Malcom M Murfett, "An Enduring Theme: The Singapore Strategy." In *A Great Betrayal* eds. Brian P Farrell and Sandy Hunter (Singapore: Marshall Cavendish, 2010).

[18] See for example, Jupp, "From white Australia", 145-160.

[19] NAA: A2169, 1947 Commonwealth Immigration Advisory Council – agenda, notes and minutes of 1st. 2nd, 3rd, 4th & 5th meetings held during 1947; NAA: A9816, 1945/641 [Ministry of Post-War reconstruction] Full employment – white paper draft 'E' – for Cabinet sub-committee.

base in Australia.[20] The Australian medical profession fought hard to achieve its dominance at the turn of the century, and the profession set about consolidating itself to ensure "doctors never again suffered the frustration and humiliation experienced in the late nineteenth century".[21]

Instead of reaping the benefits of a hard-worn and strictly guarded monopoly – with exception given only to British doctors – doctors in the 1930s faced a looming economic crisis: a growing proportion of the population could not afford their services. The high costs of attending medical school, coupled with the costs of establishing themselves on graduating meant Australian doctors were dependent on friendly societies to supplement private fee-for-service practice.[22] Amidst increasing pressure to widen the net of eligibility to access the public hospital system, the most serious threat to private practice re-emerged in the form the Lyons' government proposals to nationalize hospital governance and introduce a National Health Insurance (NHI) scheme in the 1930s.[23]

When NHI was first debated in the 1920s, the BMA originally opposed it because none of the proposed models would achieve the aims of the scheme and still protect the private fee-for-service model of medical service. By roughly 1936, however, the *Federal Council* of the BMA capitulated. This distinction is important: the Federal Council of the BMA, comprised specialists and surgeons, were giving way to what they saw as the inevitable need to change in order to protect its members' financial interests. NHI would provide a scheme by which to broaden the pool of patients who could access medical services. *State boards* of the BMA saw the NHI as the government's step towards abolishing private practice, and there were internal revolts between the Federal Council and its state boards (who represented the "rank-and-file" GPs, their major member type) over the form the bill took – especially the proposed capitation fee. This resulted in the BMA Federal Council back-flipping from acceptance in 1937 to a publicly-aired revolt over NHI in 1938.[24]

The revolt over NHI appeared to be income-driven and for the large part it was, however, several other factors contributed to the internal politics over NHI. Firstly, in the 1920s there was a marked increase in professional hostility between surgeons and the larger proportion of GPs over the issue of fee-splitting.[25] This brought to the surface the growing tension felt by the majority

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[20] The Australian chapter of the BMA paid fees to the parent body, and had to have all policy decisions ratified by the parent body. There was a failed attempt to form an Australian Medical Association in the 1930s, and it was only in 1960 that this was successfully achieved. It has been estimated that during this period between 85 - 90% were members of the BMA (Hugh Poate, "The capacity of the medical profession in Australia to absorb new members," *Medical Journal of Australia* 2:16(1953), 616-621

[21] Tony Samuel Pensabene, "*The rise of the medical practitioner in Victoria,*" (ANU:1980), 159. The humiliation included competing with alternate practitioners, combating quackery, winning the right to self-determination, and establishing an uneasy, co-dependent working relationship with friendly societies.

[22] James A Gillespie, "Medical markets and the Australian medical politics 1920-1945," *Labour History* 54 (1988), 30-46.

[23] Britain introduced a similar scheme in 1911, and many contemporary commentators viewed the introduction of a similar scheme in Australia inevitable (Gillespie, "The price of health", 48).

[24] See for example, *The Canberra Times,* 6 June 1938; *The West Australian,* 26 May 1938; *Chronicle,* 2 June 1938.

[25] Fee-splitting generally refers to the practice of sharing fees for a procedure between a specialist/surgeon and the GP who referred a patient to them. Officially medical professions around the world were against the practice, but it is believed to have been widespread. Dr AJ Cronin's book *The Citadel* that explores issues of medical ethics was published in 1937, coinciding with NHI debates in Australia, and received a lot of press attention because of Cronin's description of Harley street doctors' practices as "guinea-chasing, fee-splitting, back-scratching, comical, heartless, exploitation of rich hypochondriacs".

GPs that the minority surgeons and specialists were trying to distinguish themselves as more elite.[26] Secondly, capitation fees touched a nerve. Technically the profession would not be party to any panel systems or fee-setting outside of their control, but doctors' dependence on friendly societies meant that GPs did have to negotiate with them.[27] Finally, until the proposal to include medical services in national insurance, the Federal Council of the BMA mainly dealt with issues that did not so directly affect members' incomes.

NHI became the catalyst for surfacing all of these issues, and the official voice for the BMA was clearly no longer representative of its membership base. Individual state councils of the BMA mobilised and threatened to boycott NHI. The state branch campaigns over national insurance in 1938 caused rare in-fighting over issues BMA members were usually happy to leave to the Federal Council. The overall solidarity of the profession was at its weakest, and the eventual defeat of the NHI bill in 1939 came at a considerable cost to the internal unity of the BMA.[28]

Refugee doctors

It is in this unsettled cultural and medico-political milieu that refugee doctors found themselves trying to resurrect their medical careers: communities predisposed to suspicion of that which they didn't understand, and professional peers suspicious of their ability and fit. The first stumbling block for refugee doctors was the issue of reciprocity. In 1906 most Australian state medical acts were amended to include a clause that disallowed recognition of foreign degrees unless practitioners from that state could practice in that country as well.[29] Thus the efforts in 1906 to introduce the principle of reciprocity in Australia unintentionally came to its fore in the 1930s.

Medical registration was controlled at the state-level, so state boards could refuse to register practitioners from other countries simply because there was no reciprocal arrangement. The only option left for refugee doctors was to retrain at considerable personal expense. University medical schools offered a minimum of three years retraining (SA, NSW and QLD) to no concessions (VIC) despite their prior qualifications and experience. Even after retraining, doctors were not assured a clear pathway to regaining their professional careers, for example, the NSW

[26] This culminated in the formation of a GP committee of the BMA and a new journal *The GP* later named *The General Practitioner*. The question of national health insurance was revisited in the late '40s and early '50s and eventually in 1953, there was a split from the BMA and the Royal College of General Practitioners formed.

[27] For graduate doctors, capitation fees from lodge practice formed a large proportion of their early income. Capitation fees varied across states according to state BMA chapters and the councils of friendly societies, for example, Victoria had the lowest capitation fees of all states at 20 shillings in metropolitan areas and 25s in regional areas.

[28] Gillespie, "The price of health," 38. There were political casualties of the scheme too: Menzies resigned in protest of the delays in introducing the bill, and shortly afterwards the Coalition government collapsed. The war temporarily shelved all plans for a National Health scheme, and the Chifley government's attempts to revive the scheme failed again28. It took the re-election of Menzies in 1949 with Sir Earle Page – a BMA member – as Minister of Health, and a heavily altered National Health Scheme before it was eventually passed in the 1950s.

[29] See for example: *Victorian Medical Act 1906*. This amendment was a direct consequence of certain countries refusing to register British doctors. For the BMA it became a matter of urgency to protect British interests above any other in the Empire, and the Colonial Committee of the BMA successfully lobbied Australian states into introducing the principle of reciprocity.

Medical Board restricted the number of foreign doctors who could register on graduating via the shortened pathway to eight per year.[30]

Reciprocity provided an initial legal shield for the profession, but it wasn't long before external pressures forced them to justify their reluctance to amend state legislation in the face of an humanitarian crisis in Europe, coupled with a shortage of doctors in rural areas.[31] The reasons proffered included: European doctors specialised too early and registering them would jeopardise Australia's medical standards; their English was poor which created a further barrier since much of the doctor's art relied upon clear communication between a doctor and his patient; and finally, there was no shortage of doctors in rural areas despite alarmist reports to the contrary.[32]

Running parallel to this was the larger debate over NHI with a single pressure point in common: specialisation. Medical specialisation was a rarity in Australia compared to continental Europe. Australia had a GP-dominated profession, for example, between 1938-9, there was an estimated 1200 GPs in Australia compared to 200 surgeons and 200 specialists amongst the BMA membership base.[33] GPs performed procedures that in most European countries were considered the domain of specialists. Refugee doctors' professional experience, therefore, represented a form of medical practice that was poorly understood and quite removed from Australian tradition. Only in 1960 did the BMA commission a study into specialisation that found Australia was considerably behind the times.[34]

Despite all claims of poor standards, there is proof these alien doctors were competent. The emergency *National Security (Alien Doctors) Registration Act* passed in 1942 forced the profession to examine them. The purpose of this act was so alien doctors could fill the gap created by Australian doctors called into service, especially in country areas.[35] Victoria and NSW granted 27 and 25 temporary licenses respectively, amounting to about a 60% success rate for doctors from countries including Germany, Czechoslovakia, Poland, Hungary and

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[30] NSW Medical Practitioners Act 1838-1938, section 17(C).

[31] World War II broke down all normal channels through which reciprocity could be established. Typically reciprocal arrangements that applied in Australia were driven by British relationships. For example, Weaver, "A glut on the market" describes the reciprocal arrangements for Italian qualifications that applied in Australia because Italian qualifications were recognized in Australia.

[32] Rural hospitals during this time were generally thought to be struggling for nurses, doctors and several hospitals were near closure (See for example, *The West Australian,* "Country Hospitals. Annual Conference. Shortage of nurses discussed," 18 July 1940; *The Argus,* "Hospital closes for want of doctor," 8 August 1941; *The Canberra Times,* "Medical service, Shortage of doctors problem in rural towns," 11 September 1941). Within and outside the profession, political commentators were open in their support for staffing these hospitals with refugee doctors. For example, James Barrett, former chancellor of the University of Melbourne and former president of the BMA, wrote in a 1940 article "Medicine in Australia and refugees" published in *The Australian Quarterly* arguing for medical registration rules to be relaxed to allow refugee doctors to practice in rural areas. In 1941 Professor Giblin who was the chairman of the Commonwealth Financial and Economic Committee also proposed mirroring the British scheme of allowing temporary registration of refugee doctors (NAA: MP508/1 65/710/123).

[33] Pensabene, "*The rise of the medical practitioner in Victoria,*" 159-176. And R Watts, "The light on the hill: The origins of the Australian welfare state," unpublished PhD thesis, University of Melbourne: 1983.

[34] Kevin White, "The state, the market, and general practice: the Australian case," *International Journal of Health Services* 30 no2 (2000): 285–308.

[35] During May-July 1941 the BMA opposed the idea painting an emotionally-charged picture of Australian doctors completing wartime service for their country returning home to practices taken over by foreign practitioners, and of Australian citizens receiving poor medical treatment because continental medical education was inferior to Australia's.

Romania.[36] Both Victoria and NSW modified their legislation in 1946 to allow these doctors to remain registered – an implicit acceptance of their ability to practise medicine competently in Australia.[37]

Conclusion

Australians were undeniably suspicious of and slow to welcome migrants, including Jewish refugees fleeing the horrors of Europe. Yet all non-British migrants, not just Jews, were seen as different; they were a threat. The arrival of refugee doctors coincided with the medical profession grappling with the contentious NHI. In the context of a debate over what most Australian doctors saw as a fight for their livelihood, the question of whether their reaction to Jewish refugees was racially motivated feels querulous – if prejudice existed, it was a question of whether or not they were British-educated as opposed to whether or not they were Jewish.

The employed attitude towards refugee doctors served the profession: it provided a platform on which to remind the Federal Government that it was united, and it would not be dictated to on issues that ought to be resolved within the profession. It also protected its current members from the threat of the unknown specialist European doctor at a time when the NHI bill was threatening to tip the balance of Australian medical practice in favour of specialists – a sensitive topic at the time. For the BMA and BMA-friendly state medical boards to endorse liberalisation of refugee doctors perceived as specialists would only have served to further agitate the already fragile internal unity of the profession. Here then, I argue, was a profession more concerned with the implications rather than race of these refugee medical men.

[36] Weaver, "A glut on the market," 28-9. In 1946 AJ Metcalfe, Commonwealth Director-General of Health, replied to leader of the Labor opposite Tom Tunnecliffe defending the assessment methods employed by the Commonwealth Alien Doctors board saying that "among the factors which contributed to the failure of candidates to pass the examination was the narrow specialisation early in the medical course which still prevails in some European countries" (NAA: A1928).

[37] There have been a few studies on the success of refugee doctors in Australia. Winterton's 2005 paper includes short biographical entries of such doctors in WA, Joan Clarke's biography of interned German specialist Dr Max Herz, and Kunz' brief exploration of Displaced People doctors who went to Papua New Guinea after World War II are a few examples.

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1 NB: This bibliography does not include the references for Chapters 3, 4 and 6 which are included in each chapter in their complete, publication format. This aligns with the University of Melbourne's guidelines for theses with publication. See: https://gradresearch.unimelb.edu.au/preparing-my-thesis/thesis-with-publication, last accessed 12 November 2018.

2 NB: This does not include individual passenger arrival lists for all 228 medical migrants sampled, nor does it include naturalisation records for these migrants (where applicable). These are easily searchable online using the following two platforms of the National Archives of Australia: https://recordsearch.naa.gov.au/SearchNRetrieve/Interface/SearchScreens/PassengerSearch.aspx and https://recordsearch.naa.gov.au/SearchNRetrieve/Interface/SearchScreens/NameSearch.aspx. See Appendix 3 for a detailed discussion.

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