A History of Australia's Immigrant Doctors, 1838-2021: Colonial Beginnings, Contemporary Challenges

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Doctor of Philosophy

July 2022

School of Historical and Philosophical Studies
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Submitted in partial fulfilment for the degree of Doctor of Philosophy at the University of Melbourne

Abstract

Since colonisation in 1788, Australia has been populated by immigrants. Among them, for all this period, there have been practitioners of Western medicine who qualified overseas. This thesis is about them, now termed International Medical Graduates (IMGs). Starting in 1838, when the first colonial medical Acts were promulgated, it explores who those graduates were, from where they came, why they migrated at specific times in response to geopolitical and other events, how were they received and what were their experiences. Their history is integral to the history of medical practice and medical politics in Australia. It has not previously been examined across the *longue durée* researched here; the purpose has been to better understand the *evolving* and continuous process of medical immigration, rather than the fragments that constitute the current historiography.

The methodology is quantitative and qualitative. First, a prosopography was constructed comprising all IMGs registered in each colony, state, and territory from 1838 to 1984, supplemented by data from a random sample of contemporary IMGs to bridge to the present. From this, the time course, profile of donor countries, and characteristics of successive waves of IMGs has been documented, then linked to causal historical events, including the changing and frequently obstructive medical legislation. Throughout the colonial period and the first half of the twentieth century, nearly all immigrant doctors had trained in Great Britain and Ireland, often motivated by difficulties establishing practice at home and attracted by opportunities in a new land, but with source countries restricted by the Medical Acts. Then, as Australia opened to migrants from the rest of the world in the second half of the twentieth century, so the spectrum of IMGs expanded immensely—approximately, but not completely matching that of the immigrant populations overall. Currently, about 30 percent of the Australian medical workforce was born and trained overseas.

A second aim was to understand and learn from the experiences of living IMGs. For this, 87 oral histories were recorded—using criterion-referenced, random, and snowball sampling. Many were negotiating the pathways to medical registration, under the now national regulator, the Australian Health Practitioner Regulation Agency (AHPRA). The thesis gives them a voice, and illustrates their difficulties and crises—sometimes at the hands of what seems to have been a Kafkaesque bureaucracy. The other pathway for some has been to persuade a specialist college that their overseas qualification is comparable to that of the Australian college. Interviews with college and AHPRA representatives confirm the author's impression that much has been done

recently to improve the fairness of those processes; but the thesis also provides evidence in the oral histories of what appear to be historical and recent injustices.

Australia owes much to its IMGs. The thesis allows us to learn from their history during almost two centuries. It concludes with recommendations for how we can still assure the paramount need to protect Australian patients, yet also improve the effectiveness and fairness of our current processes for registering and supporting those who received their medical training overseas.

Declaration

This is to certify that:

• the thesis comprises only my original work towards the PhD except where indicated in the preface,

• 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, figures, bibliographies, and appendices.

_____

Signed: Neville D Yeomans
Date: 1 July 2022

Preface

The work presented in this thesis (except for some interviews mentioned below) was performed during my PhD candidature under the supervision of the late Laureate Professor Emeritus Stuart Macintyre AO, Professor Sean Scalmer, Redmond Barry Distinguished Professor Emerita Janet McCalman AC, and Dr James Bradley.

The work is my own, except for part of the material in the publication in Appendix C2 which contributes to Chapter 9, and some ideas developed with the co-authors of the publication in Appendix C3. My contribution to the first paper was 85 per cent; my co-authors were Mr Philip Pigou (CEO of the Australian Medical Council (AMC)), Associate Professor Jill Sewell (former President of AMC), and Professor Macintyre. Mr Pigou provided access to the AMC's extensive database on its examinations since their inception, and the programming to extract the raw deidentified material was performed by Mr Kevin Ng (Senior Computer Programmer) and Ms Prathyusha Sama (Software Developer) at the AMC. My co-authors for the paper in Appendix C3 were Dr Ayaz Chowdhury and Mr Alan Roberts. Dr Chowdhury is an International Medical Graduate (IMG) who has been active via his role in the federation of associations of Bangladeshi medical immigrants. Mr Roberts has for many years mentored IMGs as they try to negotiate our systems. The ideas we workshopped for improvements in the way the Australian Health Practitioner Regulation Agency handles those who are in limbo after passing AMC examinations have contributed to some of my recommendations in the Conclusion chapter. We estimate that my contribution to that second paper was 75 per cent.

In the year prior to commencing this candidature, I recorded 38 interviews which are included with the 87 oral histories in Chapter 10. Six of those oral histories (nos. 1, 2, 4, 23, 28 and 29) formed part of my thesis for the degree of Bachelor of Arts (Hons.) in 2018, as did a demographic tabulation of the other 32. Also included in my BA (Hons.) thesis was a preliminary analysis of an earlier 5 per cent sample of the Medical Directory of Australia database; a larger and later sample is examined more fully in Chapter 8.

I was the sole contributor to the other publications and conference presentations listed on the next page. Unless otherwise noted, all translations from Latin, French, German and Italian are my own. My candidature was supported by an Australian Government Research Training Program fee-offset scholarship and a Graduate Research in Arts travel scholarship.

Publications and Presentations

The following publications and presentations have been generated during the candidature for this degree:

Refereed Journal articles

1. Yeomans, Neville D. "A Dangerous Migration: Early Mortality in Immigrant Doctors in Colonial Victoria." *Health and History* 22, no. 2 (2020): 67-84.
2. Yeomans, Neville D, Jill Sewell, Philip Pigou, and Stuart Macintyre. "Demographics and Performance of Candidates in the Examinations of the Australian Medical Council, 1978-2019." *Medical Journal of Australia* 214, no. 2 (2021): 54-58.
3. Yeomans, Neville D, Ayaz Chowdhury, and Alan Roberts. "IMGs in Cul-de-sacs: 'Lost in the Labyrinth' Revisited?" *Medical Journal of Australia* 216, no. 11 (2022): 553-55.
4. Yeomans, Neville D. "Demographics and Distribution of Australia's Medical Immigrant Workforce." *Journal of Migration and Health* 5 (2022): 1-6, https://doi.org/10.1016/j.jmh.2022.100109

Published, refereed blog from coursework unit required as part of this degree[1]

5. Yeomans, Neville D. "Sir Peter MacCallum: The Man behind the Monument." University of Melbourne Archives, May 2020. Available at https://blogs.unimelb.edu.au/archives/sir-peter-maccallum-the-man-behind-the-monument/

Conference and other presentations

6. Yeomans, Neville D. "Oral Histories from Medical Immigrants: Some Issues of Objectivity." Oral History Society of Victoria, Melbourne, 16 June 2019.
7. Yeomans, Neville D. "A History of Australia's Overseas-Trained Doctors, 1960-2017: Hoops and Hurdles." Oral presentation at biennial conference of Australian and New Zealand Society for the History of Medicine, Auckland, New Zealand, 4-7 December 2019.
8. Yeomans, Neville D. "Pandemic phthisis and other maladies in nineteenth century medical emigrants to the antipodes." Accepted for oral presentation (*but deferred* because of Australian government's pandemic travel ban), biennial conference of British Society for the History of Medicine, Sheffield, UK, 15-18 September 2021.
9. Yeomans, Neville D. "*Phthisis pulmonales* and other misadventures: early mortality of immigrant doctors in colonial Victoria." Oral video presentation at biennial conference of Australian and New Zealand Society for History of Medicine, Newcastle, Australia, 1-4 December 2021.
10. Yeomans, Neville. "Licensing Australia's Immigrant Doctors: A Sixty-Year Narrative through Oral Histories." Oral presentation at annual conference of Australian Historical Association, Geelong, Australia, 27-30 June 2022.
11. Yeomans, Neville. Contribution to "Who do you think you are? (Simon Baker: Dr Andrew Sexton Gray, founder of a nineteenth century hospital)", SBS Television (Australia), broadcast 21 June 2022, available at https://www.sbs.com.au/ondemand.

Refereed historical essay, published during candidature but not directly related to it

12. Yeomans, Neville. "A Short History of Time (with apologies to Stephen Hawking)." *Academia Letters* (2021): available at https://www.academia.edu/50859195/A_short_history_of_time_with_apologies_to_Stephen_Hawking

[1] "Digital Humanities: Working with Archives" (Semester 2, 2019).

Acknowledgments

This thesis is dedicated to the memory of Laureate Professor Stuart Macintyre AO, who guided me with his vast knowledge of Australian political and social history, his endlessly insightful and challenging comments, and his untiring generosity with the commodity of time until his death on 22 November 2021. He is immensely missed, by me and so many others.

I owe a very large debt also to Professor Sean Scalmer, Redmond Barry Distinguished Professor Emerita Janet McCalman AC, and Dr James Bradley—distinguished historians whose encouragement and advice was invaluable, even more so after Stuart's death.

The other academic mentor I want to acknowledge is Professor Antonia Finnane, who persuaded me that an honours degree in history is a prerequisite foundation for an Australian historian.

Many others contributed to this work by facilitating my access to their materials, and are gratefully acknowledged here:

Alan Roberts, principal of ARIMGSAS, who arranged introductions for me to the 'criterion-sample' of the IMGs whose oral histories are included in Chapter 10;

Laura Sherwood and Nick Miller (archivists) at the State Records Office of South Australia; Kate Musgrave, Rachel Hollis and Elizabeth Hicks at the State Archives of NSW; other helpful archivists in the State Archives of Queensland and Tasmania;

Deborah Brown and the Research Evaluation Committee of AHPRA for facilitating access to restricted historical Medical Board material;

Professor Con Michael and Tracey Annear of the WA Medical Board;

Helen Egan, Manager of the Northern Territory Medical Board;

Anthony McEachran, Manager of the Australian Capital Territory Medical Board;

Ian Frank, former CEO of the AMC, for sharing his knowledge and passion about the history of his organisation and facilitating access to its data;

The many, mostly anonymised, IMGs who gave their oral histories, their insights, and sometimes bared their emotions for this thesis;

The officers of institutions tasked with the evaluation of IMGs for Australian registration or otherwise supporting them who were interviewed for Chapter 11;

Helpful librarians in each Australian State;

My daughter, Roxane Horton, for introducing me to the historical and present consequences of the political process;

And finally, my wife Margot—the first to show me that history is the science of past and future possibilities, and who has always been my muse.

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Glossary of Abbreviations

ACCC	Australian Competition and Consumer Commission
ACD	Australian College of Dermatologists
ACEM	Australian College for Emergency Medicine
ACRRM	Australian College of Rural and Remote Medicine
AFPHM	Australasian Faculty of Public Health Medicine
AGPS	Australian Government Publishing Service
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
AMC	Australian Medical Council
AMEC	Australian Medical Examining Council
ANOVA	Analysis of Variance (statistics)
ANZCA	Australian and New Zealand College of Anaesthetists
ARIMGSAS	Alan Roberts International Medical Graduates Support and Advisory Services
BMA	British Medical Association
BMDV	Office of Births, Marriages and Deaths, Victoria
COAG	Council of Australian Governments
Cth.	Commonwealth (especially for Commonwealth Acts and Ministers)
ECFMG	Educational Commission for Foreign Medical Graduates (USA)
Edin	Edinburgh (in medical corporations/colleges)
Eng	England (in medical college)
F	F in front of initials of a medical college indicates Fellowship
FPQC	Foreign Practitioners Qualification Committee (Victoria)
FPS	Faculty of Physicians and Surgeons, Glasgow (later Royal Faculty)
Glasg	Glasgow (in medical corporations/colleges)
GMC	General Medical Council (of United Kingdom)
GP	General Practice or General Practitioner
HMO	Hospital Medical Officer
ICU	Intensive Care Unit
IMG	International medical graduate
IQR	Interquartile range (statistics)[2]
IRO	International Refugee Organisation (of United Nations)
Lond	London (in medical corporations/colleges)
L	L in front of initials of a medical college indicates Licentiateship
LAH	Licentiate of Apothecaries Hall, Dublin
LMSSA	Licentiate in Medicine and Surgery of the Society of Apothecaries (more recent version of the qualification LSA)
LSA	Licentiate of Society of Apothecaries, London
M	M in front of initials of a medical college indicates Membership
MBA	Medical Board of Australia
MCQ	Multiple Choice Question(s)
MDA	Medical Directory of Australia
Mini-CEX	Mini-Clinical Evaluation Exercise (used for assessment of trainees)

[2] Interquartile range—appropriately used to indicate the spread around a median as distinct from a mean—is the range from the lower to the upper quartile of values in the sample (i.e., 50 percent of values lie within its limits).

NAA	National Archives of Australia
NHS	National Health Service (UK)
NR	Not recorded (when no data in a field in archival record)
NSWSA	New South Wales State Archives and Records
OSCE	Objective Structured Clinical Examination
p	Probability that a difference (e.g., between means, medians or proportions) is due to chance (in statistical significance tests)
PESCI	Pre-employment Structured Clinical Interview (RACGP)
QSA	Queensland State Archives
RACGP	Royal Australian College of General Practitioners
RACMA	Royal Australasian College of Medical Administrators
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RANZCR	Royal Australian and New Zealand College of Radiologists
RCOG	Royal College of Obstetricians and Gynaecologists (UK)
RCP	Royal College of Physicians of England
RCPA	Royal College of Pathologists of Australasia
RCS	Royal College of Surgeons of England
SD	Standard Deviation (statistics)[3]
SMH	Sydney Morning Herald (newspaper)
SRSA	State Records of South Australia
TA	Tasmanian Archives
USMLE	United States Medical Licensing Examinations
VPRO	Victorian Public Records Office
WBA	Workforce-Based Assessment (pathway to registration for IMGs)

Abbreviations for Australian Colonies, States and Territories

ACT	Australian Capital Territory
NSW	New South Wales
NT	Northern Territory
QLD	Queensland
SA	South Australia
TAS	Tasmania
VIC	Victoria
VDL	Van Diemen's Land
WA	Western Australia

Glossary of most frequent medical degrees conferred by universities

BCh	Baccalaureus Chirurgiae (Bachelor of Surgery)
BM or BMed	Bachelor of Medicine
BS	Bachelor of Surgery
ChB	Chirurgiae Baccalaureus
MB	Medicinae Baccalaureus (Bachelor of Medicine)

[3] Standard Deviation (SD) is a statistical measure indicating how widely the values for a parameter (e.g. height, age, income, etc.) are spread in a population; in a normally-distributed population, 68% of individual values for the parameter lie within ± 1 SD of its mean.

MCh	Magister Chirurgiae (Master of Surgery)
MD	Medicinae Doctor (Doctor of Medicine)

INTRODUCTION

> Sogliono dire gli uomini prudenti, e non a caso né immeritamente, che chi vuole vedere quello che ha a essere, consideri quello che è stato; ...
> [Wise men are wont to say, and not by chance nor without reason, that whoever wants to see the future must consider what has been; ...][1]

Australia has been home to people who practised their traditional skills of healing for many thousands of years.[2] But after its colonisation by Europeans, the paradigm for Australian healthcare shifted to what we will call Western Medicine. The first Western doctors were all trained overseas, only to eventually become the minority as the profession was enlarged by graduates from the Australian medical schools. Even today, about 30 percent of the Australian medical workforce—now usually known as International Medical Graduates (IMGs)[3]—has been trained overseas. Brendan Murphy, Secretary of Health, recently acknowledged their importance thus:

> IMGs … are incredibly valuable in the Australian health workforce, and we would not be in the situation we are now, with a very good health system and very good health outcomes, without the extraordinary support that we've had from overseas-trained doctors.[4]

This thesis is about those overseas-trained doctors. It will trace who they were, from where they came, what they experienced, and what lessons can be learned to improve the processes for IMGs in the future. The genesis of the idea to research this topic had its roots in the author's practice in medicine in Australia and overseas, where he has worked alongside IMGs, and also assessed them for licensing via the examinations of both the Australian Medical Council and his specialty college. This led in turn to a desire to be formally trained as a historian, after completing a late-in-life humanities degree.

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[1] Niccolò Machiavelli, *Discorsi sopra la prima Deca di Tito Livio*, (1531), Book 3, Ch. 43, para 1. [Translation my own].

[2] AP Elkin, *Aboriginal Men of High Degree*, 2nd ed. (St Lucia, Qld: University of Queensland Press, 1977), xx,7-9; T Theodor Webb, "Aboriginal Medical Practice in East Arnhem Land," *Oceania* 4 (1933): 95-8; Marcia Langton, "Traditional Aboriginal Healing Practice," in *The Art of Healing: Australian Indigenous Bush Medicine*, ed. Jacqueline Healy (The University of Melbourne: Medical History Museum, 2018), 2.

[3] Graduates from New Zealand universities are not classified as IMGs since, as will become clear in Chapters 3 and 4, they have usually been treated as identical to graduates from Australian medical schools for the purpose of licensing in Australia.

[4] Brendan Murphy, "Introduction", presentation at Australian Medical Association National Conference, Canberra (video-meeting), 29 July 2021. Professor Murphy is Secretary, Commonwealth Department of Health, and previously was Australia's Chief Medical Officer.

The thesis begins in 1838 when the first Medical Board was created in New South Wales; it ends, at the present time, by exploring the lived experience of current immigrants through their oral histories. While other scholars have examined segments of this period, my purpose in tackling this '*longue durée*'[5] has been to analyse, synthesise and critique the information about the changing patterns of migration of doctors to every jurisdiction across Australia from about the time responsible government began, ca. 1850. This has not been attempted before, and one contribution of the thesis is to identify global and local events that have influenced Australian medical migration at different times and places.

The methodologies I have used are both quantitative and qualitative. One approach is the construction of a prosopography with details of every IMG registered in an Australian colony, state or territory from the creation of medical registers in each jurisdiction, supplemented by extracting data for currently living and registered IMGs up till 2020. This has been a central tool for charting the fluctuations in medical migration, and hypothesizing and testing evidence for their causes. The prosopography has then been used to link to other databases and sources to examine in qualitative terms the history of two groups of IMGs during the colonial period—members of the colonial parliaments, and immigrant doctors who died soon after arriving. The final chapters of the thesis use a qualitative methodology, based on a unique set of oral histories of IMGs who migrated during the last half a century. Their experiences and reflections give novel and valuable insights into the history of the challenges IMGs faced and still face, counterpoised with the problems our regulatory systems face in dealing with them fairly as well as effectively.

The aims of this Introduction are to outline how migration as a whole has shaped Australia, briefly refer to the historiography of medical migration as a global phenomenon, and give a synopsis of the work of other scholars on specifically medical migration to Australia. The placement of the thesis in the wider scholarship is not dealt with here in detail. Instead, because that scholarship is fragmented across the different areas the thesis addresses, it is inserted into the relevant chapters as the data are analysed and discussed. Finally, the purpose of each chapter is described.

[5] Fernand Braudel introduced the idea of a historiography that examines a long sweep of time. Braudel contrasted this unkindly with some short-term historiography, which he characterised as addressing *les médiocres accidents de la vie ordinaire:* Fernand Braudel, "La Longue Durée," *Annales: Histoire et Sciences Sociales* 13, no. 4 (1958): 727-9.

Overall Migration to Australia

Australia's original inhabitants, according to the archaeological record, arrived here between at least 45,000 and 65,000 years ago.[6] The lack of a written history casts a veil over the movements of people that may have occurred during those intervening millennia. Starting with the arrival of the First Fleet in 1788, the first major influx of immigrants was British and Irish, but with some a little later from Germany.[7] The founding European population consisted mainly of large numbers of people (convicts) transported to a new colony against their will. And in the space of less than one hundred years, because of introduced diseases, frontier wars, and particularly the arrival of waves of new immigrants, the original inhabitants became outnumbered almost ten to one.[8]

Throughout the nineteenth century, the immigrants continued to be mainly British and Irish. In 1901, the year of Australian Federation, McCalman and Kippen calculated that, as a result of natural increase, just over three quarters of the population was born in Australia; the immigrants came from Britain (60%), Ireland (22%), elsewhere in Europe (9%), and Asia (6%).[9] Eric Richards said that 'Australia, in reality, was more homogeneous than the homeland.'[10] While some of the British migrants were agricultural workers, Timothy Hatton calculates that, in contrast to Canada and USA, most of the adult males who came between 1880 and 1910 were from skilled occupations.[11]

Although Asians were in the minority, an important group throughout the second half of the nineteenth century was the Chinese, estimated by John Fitzgerald to total 60,000 to 90,000, more than 30,000 of whom were on the Victorian and New South Wales goldfields between 1855 and 1861.[12] Those on the goldfields were met with settler unease, anger, and at times violence, and this contributed to resistance to Asian

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[6] Chris Clarkson et al., "Human Occupation of Northern Australia by 65,000 Years Ago," *Nature* 547, no. 7663 (2017): 309; Peter Hiscock, *Archeology of Ancient Australia* (London: Routledge, 2008), 84.

[7] James Belich, *Replenishing the Earth: The Settler Revolution and the Rise of the Anglo-Celtic World, 1783-1939* (Oxford: Oxford University Press, 2009), 265.

[8] Ibid., 272-5; Stuart Macintyre and Sean Scalmer, "Colonial States and Civil Society, 1860-90," in *The Cambridge History of Australia*, eds. Alison Bashford and Stuart Macintyre (New York: Cambridge University Press, 2013), 189; Janet McCalman and Rebecca Kippen, "Population and Health," ibid., 294-6.

[9] Ibid., 301; they compiled these data from several sources; another three per cent of the 1901 population came from elsewhere.

[10] Eric Richards, *Destination Australia: Migration to Australia since 1901* (Sydney: UNSW Press, 2008), 2.

[11] Timothy J Hatton, "Emigration from the United Kingdom to the United States, Canada and Australia/New Zealand, 1870-1913: Quantity and Quality," *Australian Economic History Review* 61, no. 2 (2021): 148.

[12] John Fitzgerald, *Big White Lie: Chinese Australians in White Australia* (Sydney: University of NSW Press, 2006), 62; David Goodman, "The Goldrushes of the 1850s," in *The Cambridge History of Australia*, eds. Alison Bashford and Stuart Macintyre (New York: Cambridge University Press, 2013), 182.

immigration (including medical immigration) for more than a century.[13] By the 1890s, regulations to restrict Chinese migration had been introduced in every Australian colony.[14] The barrier to the entry of most non-British 'foreigners' was then codified in 1901 in the Immigration Restriction Act—one of the first pieces of legislation to be passed by the new Australian Parliament, which became the basis of what was widely known as the 'White Australia Policy'.[15] In introducing the second reading of the Bill, the Prime Minister (Edward Barton) described it as 'a measure of definite and high policy' and referred specifically to 'the Chinese question'.[16]

Thus, for the first half of the twentieth century, those who came to live in Australia continued to be predominantly emigrants from Britain and Ireland, with much smaller contributions from elsewhere in Europe. In the 1947 census, the population was 7,579,358, of whom 744,187 were born outside Australia. Of these, 73 percent were born in Britain or Ireland, 14 percent elsewhere in Europe (more than half from Italy, Germany and Greece) and only 3 percent from Asia.[17]

In the twenty years after WWII, successive Australian governments set about stimulating immigration, and the mix of source countries began to change. In the immediate postwar years, around 200,000 immigrants were European refugees—many of them professionals but forced to work in nonprofessional occupations; more will be said about them in Chapter 6. Their legacy through their children was a huge contribution to Australia's intellectual life.[18]

Between 1961 and 1966, 55 percent of the immigrants were British, 30 percent came from Southern Europe, and a further 7 percent from Eastern Europe.[19] Then, beginning in 1966, there was a progressive dismantling of the 'White Australia' policy, starting with the *Migration Act 1966* which allowed non-Europeans with professional and academic qualifications to apply for entry.[20] Gwenda Tavan has comprehensively

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[13] Myra Wyllard, *History of the White Australia Policy to 1920*, 2nd ed. (Melbourne: Melbourne University Press, 1967), 17-32; Gwenda Tavan, *The Long, Slow Death of White Australia* (Carlton North, Vic.: Scribe Publications, 2005), 176-80.

[14] Alison Bashford and Stuart Macintyre, *The Cambridge History of Australia* (Cambridge: Cambridge University Press, 2013), 11.

[15] *Immigration Restriction Act 1901, No. 17* (Cth.); Wyllard, *History of the White Australia Policy*, 99.

[16] Edward Barton, *Commonwealth Parliamentary Debates, House of Representatives* (7 August 1901).

[17] "Census of the Commonwealth of Australia, 1947," accessed 18 December 2021, https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2109.01947?OpenDocument. At that time, full blood Aboriginals were not included in Australian censuses.

[18] Ruth Balint and Zora Simic, "Histories of Migrants and Refugees in Australia," *Australian Historical Studies* 49, no. 3 (2018): 393-403; Jacques Vernant, *The Refugee in the Post-War World* (New Haven: Yale University Press, 1953), 57-90.

[19] WD Borrie, *The European Peopling of Australasia: A Demographic History, 1788-1988* (Canberra: Australian National University, 1994), 221-35, 42.

[20] *Migration Act 1966 No. 10* (Cth.).

analysed the political forces and events that drove these changes.[21] The effect of the dismantling was almost immediate: in the years 1971–73, 21 percent of net immigration was from Asia, and by 1990 it was 33 percent of an influx of 121,560.[22]

Now, Australia has become a thoroughly multicultural and polyglot country. The most recent data from the Australian Bureau of Statistics (2020) show that 29.8 percent of resident Australians were born overseas, and nearly every country in the world is represented. The principal source countries (percent of resident immigrants) are England (13%), India (9.5%) and China (8.6%).[23]

Medical Migration: A Global Phenomenon

A socially important subset of medical migrants move, usually from the global North to underprivileged countries, to deliver humanitarian health care for generally a limited time. Examples are those who travel under the umbrellas of bodies such as Médecins sans Frontières and the International Red Cross. These are transient migrants, not immigrants.

Almost a century ago, in his classic work on the transborder movement of people, Henry Fairchild argued that migration could be classified under four broad headings: conquest, invasion, colonisation and immigration.[24] The first two involved violence, and the part played by doctors was usually confined to caring for the health of the troops.[25] He classified the latter two as being largely peaceful (though whether this was true of colonisation can be contested). The nineteenth century waves of colonisation across the world inevitably brought doctors with them as part of the process, which Laurence Monnais and David Wright described as 'an important but complicated circulation of physicians and surgeons … predicated along imperial and linguistic lines.'[26]

Fairchild's theories probably bear some relevance to the nineteenth century migration examined in Chapter 5 of the thesis. But he did not envisage one quite common motive for doctors to now migrate: to take up a job or training opportunity in

[21] Gwenda Tavan, *The Long, Slow Death of White Australia* (Carlton North, Vic.: Scribe Publications, 2005), 176-80.

[22] Ian Castles, *Year Book Australia 1994* (Canberra: Australian Bureau of Statistics, 1994), 141-2.

[23] Australian Bureau of Statistics, "Migration, Australia, 2020," accessed 18 December 2021, https://www.abs.gov.au/statistics/people/population/migration-australia/latest-release.

[24] Henry Pratt Fairchild, *Immigration: A World Movement and Its American Significance* (New York: Macmillan, 1925), 13, 17, 19-23.

[25] Martin R Howard, *Napoleon's Doctors: The Medical Services of the Grande Armée* (Stroud (England): Spellmount, 2006), 97-127.

[26] Laurence Monnais and David Wright, "Introduction," in *Doctors Beyond Borders: The Transnational Migration of Physicians in the Twentieth Century*, eds. Laurence Monnais and David Wright (Toronto: University of Toronto Press, 2016), 5.

a similar country to their own.[27] Modern migration theories are much more complex and sometimes highly mathematical. Bodvarsson and Van den Berg summed up some recent theory, saying: 'there is still no … convergence to a single model … Sociologists and economists have different views about why people migrate, and politicians and policymakers seem to have yet another set of views.'[28] Elements of all these reasons for migrating abound in the oral histories in Chapter 10 of this thesis.

The last of Fairchild's propositions was that 'true immigration' is between countries with similar economic standing (his word was 'civilization'). This is not true for the bulk of medical migration in more recent years, where the net movement of doctors has been from poorer countries to richer ones. Just over 40 years ago Alfonso Mejia, as lead author of a large review for the World Health Organisation, summarised by saying:

> Countries which produce far more physicians and nurses than they can economically afford [the global South] become donors of such manpower and those that produce fewer than they can afford [the global North] become recipients.[29]

Around 1972, there were at least 140,000 doctors living in countries where they had not been trained, and three quarters of them were in just three countries: USA, UK and Canada.[30] The situation is much the same today. In the decade after 2006, the number of foreign-trained doctors in the 38 member nations of the Organisation for Economic Development (OECD) increased by half, to reach nearly 500,000. The US is still the major destination, followed by the UK, Germany, and Australia.[31] But immigrant doctors have contributed significantly to the medical workforce in most OECD countries; In Ireland, for example, foreign doctors accounted for 80 percent of the increase in workforce in the first five years of the twenty-first century.[32] There is strong evidence that the recipient countries benefit by acquiring medical practitioners for whose education they have not had to pay, at the same time reducing the pool of doctors in the often lower-income source countries.[33] Labonté and Schrecker describe this as

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[27] OECD, Recent Trends in International Migration of Doctors, Nurses and Medical Students, (Paris: OECD Publishing, 2019), 32-3, 41-7, https://doi.org/10.1787/5571ef48-en.

[28] Örn B Bodvarsson and Hendrik Van den Berg, *The Economics of Migration: Theory and Policy*, 2nd ed. (New York: Springer, 2013), 27.

[29] Alfonso Mejía, "Migration of Physicians and Nurses: A World Wide Picture," *International Journal of Epidemiology* 7, no. 3 (1978): 207.

[30] Ibid., 208.

[31] OECD, *Recent Trends,* 23.

[32] Yasser Moullan, "What Fundamentals Drive the Immigration of Medical Doctors?," in *High-Skilled Migration: Drivers and Policies*, ed. Mathias Czaika (Oxford: Oxford University Press, 2018)., 301.

[33] Fitzhugh Mullan, "The Metrics of the Physician Brain Drain," *New England Journal of Medicine* 353, no. 17 (2005): 1817.

reflecting 'a [global] bidding contest for the services of health professionals.'[34] This depletion of professional capital from poorer nations for the benefit of richer ones, often called 'brain drain', has prompted calls by a number of authors for international solutions.[35] However, I argue that it highlights a philosophical conundrum: how to counterpoise the responsibilities of citizens to the country that paid for their medical training with the human right of individuals to cross borders of nation states if they wish. Elements of this dilemma will be seen in some of the oral histories in Chapter 10.

Medical Migration to Australia: A Brief Literature Overview

The scholarship of Australia's medical migrants falls broadly into two categories. One part of that historiography has focused on individual migrant doctors, particularly those who came during the colonial period, when nearly all the medical practitioners had been trained overseas. Notable works in this genre were published by Brian Gandevia, whose works often focused on the diseases they combated as much as the doctors themselves.[36] Others who made valuable contributions include John Pearn, JM Last and Milton Lewis.[37] Still others wrote biographies of individual IMGs or groups of IMGs, which set them in the context of their new place and social roles.[38] Some of their work is discussed later when it becomes relevant to material that emerges from the research in Chapters 5 and 6. These works are representative of the style of medical historiography that Warwick Anderson and Linda Bryder refer to as 'white male doctors documenting the progress of medical ideas and practices' and 'heroic and progressive medical history.'[39] This thesis dabbles in that 'heroic' historiography in places in

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[34] Ronald Labonté and Ted Schrecker, "Globalization and Social Determinants of Health: The Role of the Global Marketplace (Part 2 of 3)," *Globalization and Health* 3, no. 6 (2007).

[35] Tikki Pang, Mary Ann Lansang, and Andy Haines, "Brain Drain and Health Professionals: A Global Problem Needs Global Solutions," *British Medical Journal* 324, no. 7336 (2002): 499; Lincoln Chen et al., "Human Resources for Health: Overcoming the Crisis," *Lancet* 364, no. 9449 (2004): 1986-88; Nir Eyal and Samia A Hurst, "Physician Brain Drain: Can Nothing Be Done?," *Public Health Ethics* 1, no. 2 (2008): 181-9; Alex Sager, "Reframing the Brain Drain," *Critical Review of International Social and Political Philosophy* 17, no. 5 (2014): 561-4.

[36] Bryan Gandevia, *An Annotated Bibliography of the History of Medicine in Australia* (Sydney: Australian Medical Publishing Co., 1955); "The Pattern of Australian Medical History," *Proceedings of the Royal Society of Medicine* 50 (1957).

[37] John Pearn, "Surgeon-Superintendants on Convict Ships," *Australian and New Zealand Journal of Surgery* 66 (1996); "Forced Emigration, Favourable Outcomes," *Australian and New Zealand Journal of Public Health* 25, no. 5 (2001); JM Last, "Migration of British Doctors to Australia," *British Medical Journal* 2, no. 5359 (1963); Milton Lewis, "Medicine in Colonial Australia, 1788–1900," *Medical Journal of Australia* 201, no. 1 (Suppl.) (2014).

[38] John Poynter, *The Audacious Adventures of Dr Louis Lawrence Smith: 1830-1910*, vol. 1 (North Melbourne, Vic.: Australian Scholarly Publishing, 2014); Richard Travers, "Dr David Hastings Young (1863–1926): A Peripatetic Practitioner," *Health and History* 19, no. 2 (2017).

[39] Warwick Anderson, "Disease, Culture and History," ibid.1, no. 1 (1998): 30; Linda Bryder, "History of Medicine in Australia and New Zealand," ed. Mark Jackson, *The Oxford Handbook of the History of Medicine* (Oxford: Oxford University Press, 2012 (online version)),

Chapters 9 and 10, but mostly takes the broader analytical approach through Chapters 5 to 8.

The latter was the methodology used by Fallon Mody in a recent dissertation for which she used, as the starting point, a prosopography of a thirty-year period of IMGs registering in Victoria.[40] Her work is discussed in the context of some of my findings about British immigrants in Chapter 6. Similarly, Egon Kunz and Gabrielle Wolf published important critiques of the adversity and hostility that refugee IMGs experienced when they came to Australia in the years circa WWII. Their observations and conclusions are discussed in relation to data for that period from my prosopography in Chapter 6.[41]

In about the last thirty years, there has been a resurgence of interest by scholars in the processes of assessing and supporting IMGs when they first come to Australia and try to practise. Most of their work will be acknowledged and discussed along with the information presented in Chapters 10 and 11, based on the oral histories of contemporary IMGs. But three scholars to recognise here are Laurie Geffen, who compiled the comprehensive history of the Australian Medical Council in 2010, and Bob Birrell and Lesleyanne Hawthorne, who wrote extensively between 1997 and 2014 about the difficulties IMGs experience as they transition to Australian practice.[42] Their work is referred to in context in Chapters 8 and 10.

Chapter Contents

The thesis provides novel information and insights into the overseas-trained doctors who migrated to Australia over a period of almost two centuries.

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http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199546497.001.0001/oxfordhb-9780199546497-e-017, 1.

[40] Fallon Mody, "Doctors Down Under: European Migrants in Victoria (Australia), 1930-60 (PhD, University of Melbourne, 2018).

[41] Egon F. Kunz, *The Intruders : Refugee Doctors in Australia* (Canberra: Australian National University Press, 1975); Gabrielle Wolf, "The Law and Politics of Registering Doctors: Lessons from New South Wales, 1937-42," *UNSW Law Journal* 43, no. 4 (2020).

[42] Laurence Geffen, *Assuring Medical Standards: The Australian Medical Council 1985-2010* (Kingston, ACT: Australian Medical Council, 2010); Robert J. Birrell, "Australian Policy on Overseas-Trained Doctors," *Medical Journal of Australia* 181, no. 11-12 (2004); Bob Birrell and Andrew Schwartz, "Accreditation of Overseas Trained Doctors: The Continuing Crisis," *People and Place* 14, no. 3 (2006); Bob Birrell and Lesleyanne Hawthorne, "Medicare Plus and Overseas-Trained Medical Doctors," ibid.12, no. 2 (2004); L. Hawthorne, "The Question of Discrimination: Skilled Migrants' Access to Australian Employment," *International Migration (Geneva, Switzerland)* 35, no. 3 (1997); Lesleyanne Hawthorne, "International Medical Migration: What Is the Future for Australia?," *Medical Journal of Australia Open* 1, no. Suppl. 3 (2012); "The Scale and Nature in Recent Years of the Foreign-Born and Foreign-Trained Medical and Health Workforce Developed in Australia," in *Migration of Health Workers: WHO Code of Practice and the Global Economic Crisis*, eds. Amani Siyam and Mario R. Dal Poz (Geneva: World Health Organization, 2014).

PART 1: CONTEXT (Chapters 1-4). This section aims to provide the background—a context—into which the research data in Parts 2 and 3 can be positioned and understood.

Chapter 1 outlines the historiography of medical education over the period during which IMGs arrived in Australia, with a strong focus on the countries that have been the main source of IMGs for most of that period. Its relevance to the later chapters is that regulatory bodies have usually made their judgments about whether to allow an IMG to practise in Australia according to the nature of the training they had received. I will argue that the data in this chapter show those assessments were not always well founded.

Chapter 2 describes the Australian health care system and its historical evolution. Its relevance is to us being able to understand the changing framework into which the IMGs needed to fit at different times during the nearly 200-year span the thesis addresses.

Chapter 3 embarks on a forensic dissection of the changes in the medical Acts in Britain, the Australian colonies, then the Australian states. Its relevance becomes clear in Chapters 5 to 8 as the data on who was admitted to practice and who was not are discussed. I argue that many of the changes to legislation were based on prevailing views of the nature of Australian society at each time, and often were motivated by xenophobic or protectionist sentiments.

Chapter 4 also provides context to the journeys of IMGs through the various processes they need and needed to pass for licensing, by describing the assessment methods used in Australia at different times. As well as necessary context, it provides evidence for arguments I make at the end of the thesis for procedural improvements in these processes.

PART 2: THE MEDICAL IMMIGRANTS: 1838-1984 (Chapters 5-7). This section examines the data on IMGs who have come to Australia since the first medical boards were created in the late 1830s, up to the year the Australian Medical Council was created.

Chapters 5 and 7 present and discuss what can be learned from the comprehensive prosopography compiled for the thesis. They provide details about every IMG registered in the Australian colonies, states, and territories between 1838 (when the New South Wales Medical Board was formed) and 1984. The complete database of the prosopography will be hosted on https:figshare.com and made available to other researchers. The information in these chapters is rich and novel, and provides a basis for arguments I develop about causes of the historical changes in countries of origin of

the IMGs, as well as the locations within Australia to which different groups chose to come at different times.

Chapter 6 asks questions, helped by using the prosopography to create linkages with existing databases, about two select groups of IMGs who practised in the colonies in the nineteenth century: those who played important roles in politics, and a group that met an untimely end soon after arriving.

PART 3: THE MEDICAL IMMIGRANTS: ca. 1984-2021 (Chapters 8-12). This section examines the history of medical migrants who arrived during the last half century.

Chapter 8 bridges the gap between the last date of the prosopography and the current time, to explore the characteristics of the IMGs who are currently registered to practise in Australia, some of whom have been practising in the country for more than 50 years. It too forms the basis for conclusions about when source countries changed in importance and why.

Chapter 9 examines the characteristics and performance of IMGs assessed for licensing via the examinations of the Australian Medical Council (and its precursor) between 1978 and 2018. It also explores the countries from which they came at various times and looks for likely geopolitical drivers for some of those immigration patterns. Other hypotheses explored in this chapter concern the predictors of success in the examinations at different periods in the time span studied.

Chapters 10 and 11 seek to put a human face on what are essentially demographic and numerical data in most of the earlier chapters. The core approach in these two chapters is qualitative—to get an understanding of what medical migration means and has meant to individual human beings, taking advantage of what Michael Patton calls 'the value of in-depth, open-ended inquiry into people's perspectives and experiences.'[43]

Chapter 10 makes a novel contribution to the historiography of medical migration to Australia by presenting and analysing the oral histories of many contemporary IMGs. It examines their reasons for migrating, their experiences during the process, and dissects the widely varying difficulties they have had in obtaining (sometimes failing to obtain) medical registration to practise. Their stories indicate that Australia's regulation of licensing has sometimes been excessively and punitively bureaucratic; and it will be argued that protectionist sentiments in particularly some of the specialist colleges have led to unfair infringements on specialist IMGs' rights.

[43] Michael Q Patton, *Qualitative Research and Evaluation Methods* (Thousand Oaks, Calif.: Sage Publications, 2002), 203.

Chapter 11 provides a counterpoint to the difficulties some IMGs experienced, by analysing interviews with those who have shouldered the important responsibility of judging IMGs' credentials, as well as others who have contributed by helping to support IMGs in their journey.

Chapter 12 evaluates how well recommendations of a major Parliamentary report on IMG migration and registration have been implemented, concludes that some have not been addressed, and makes recommendations for further change.

The concluding chapter pulls together the arguments and evidence examined throughout the thesis. It reviews the idea that Australia's approaches to IMGs were for a long time centred on a belief in the supremacy of British heritage, that sequential steps were made to open the country up to medical migrants from the rest of the world, but that more work is needed to improve the performance of the current national regulator of medical licensing and the accountability of some of the specialist medical colleges.

PART 1

CONTEXT

Chapter 1

The Training of Medical Doctors

The overseas trained doctors who populate this thesis arrived first from the United Kingdom of Great Britain and Ireland. But by 2020, they had come (or at least applied to come) from more than 150 countries.[1] The purpose of this chapter is to provide an overview of the different systems under which they had been trained, since these were yardsticks used by the medical boards when deciding whether to license IMGs from particular countries. The other frame of reference the medical Acts and Boards applied was the nature of the training undergone by *local* graduates and specialists, hence a synopsis of that is provided at the chapter end.[2]

Most relevant to the IMGs who came to Australia since 1838 is the history of medical education in nineteenth and twentieth century Great Britain. Although there were eight university medical schools in Britain and Ireland in the nineteenth century, fewer than one in five IMGs who were registered in the Australian colonies up to 1850 had a university degree.[3] The majority had a qualification from one of the medical or surgical colleges, or from the London or Dublin corporations of apothecaries.

The Worshipful Society of Apothecaries of London received its charter from James I in 1617. Hugh Sinclair wrote that James accepted the advice to separate the apothecaries from the grocers on the grounds that 'grocers are but merchants [whereas] the business of an Apothecary is a Mistery, whereby I think it fitting they be a Corporation of themselves.'[4] WSC Copeman wrote that the apothecaries were originally dispensers of drugs but, by the nineteenth century, especially after the passing of the *Apothecaries Act* of 1815, they became the 'general practitioners of medicine'.[5] The philosopher and political economist, Adam Smith, said of the apothecary: 'He is the physician of the poor in all cases, and of the rich when the distress or danger is not very great.'[6]

A consequence of the Apothecaries Act was that a curriculum was drawn up requiring 'a competent knowledge of Latin', attendance at lectures on anatomy, physiology, theory and practice of medicine, chemistry, and materia medica. An

[1] Evidence is presented in Chapter 7.

[2] Commonwealth Department of Health, "Assessment of Overseas Trained Specialists," accessed 2 November 2021, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-pubs-mtrp-13-toc~work-pubs-mtrp-13-5~work-pubs-mtrp-13-5-req.

[3] See prosopography (Chapter 5) for NSW, Tas., Vic., and SA. The Qld. and WA registers commenced after 1850.

[4] Hugh Sinclair, "Foreword," in *The Worshipful Society of Apothecaries of London: A History 1617-1967*, ed. WSC Copeman (Oxford: Pergamon Press, 1967), ix. James presumably used 'mistery' in the sense of 'a highly skillful or technical operation in a trade or art' [Oxford English Dictionary].

[5] WSC Copeman, *The Worshipful Society of Apothecaries of London: A History 1617-1967* (Oxford: Pergamon Press, 1967), 20.

[6] Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations* (Edinburgh: Adam and Charles Black, 1863), 51.

apprenticeship of five years was mandated, including six months' attendance at a public hospital. At the end, the apprentice had to pass oral examinations, and in 1839 written examinations were added. However, Susan Lawrence criticised the Society for only specifying a curriculum, without monitoring course content or inspecting hospitals and infirmaries.[7]

After 1800, it became usual for apothecaries in general practice to also take the licence of the Royal College of Surgeons.[8] Copeman noted that the teaching functions of the Society were gradually taken over by the University of London (founded 1828), and relinquished when King's College and University College hospitals were built.[9] Less attention has been paid to the earlier 1791 Irish Apothecary's Act, which Susan Mullaney suggests was 'The first nationwide regulation of Apothecaries in the British Isles.' They made up the largest segment of the Irish medical profession at the start of the nineteenth century, and the Act established Apothecary's Hall in Dublin, which awarded the qualification of Licentiate (LAH *Dublin*).[10] By 1900, 38 of the IMGs registered in New South Wales had this qualification.[11]

The other important players in nineteenth century medical education in Britain and Ireland were the Royal Colleges of Surgeons and Physicians. Candidates for the diploma of the Royal College of Surgeons of London (MRCS) were required to be at least 22 years old, have 'been engaged six years, at least, in the acquisition of professional knowledge', have attended lectures in anatomy and surgery, and spent at least a year in surgical practice in a hospital before they could take the College examinations.[12] In Ireland, George IV amended the charter of the Irish College of Surgeons in 1828, saying: 'the regulation of the Profession of Surgery was of the utmost importance to the public, and highly necessary for the welfare of mankind.' Under the new charter, registered apprentices had to submit proof, before taking the examinations, that they had attended in the dissection rooms, at hospital, and at lectures on anatomy, physiology, surgery, medicine, materia medica and midwifery. A further revision in

[7] Susan C Lawrence, "Private Enterprise and Public Interests: Medical Education and the Apothecaries' Act, 1780-1825," in *British Medicine in an Age of Reform*, eds. Roger French and Andrew Wear (London: Routledge, 1991), 51.

[8] SWF Holloway, "The Apothecaries' Act, 1815: A Reinterpretation," *Medical History* 10, no. 3 (1966): 108.

[9] Copeman, *The Worshipful Society*, 52-69; Charles Newman, *The Evolution of Medical Education in the Nineteenth Century* (London: Oxford University Press, 1957), 74, 107-8.

[10] Susan Mullaney, "The 1791 Irish Apothecary's Act: The First Nationwide Registration of Apothecaries in the British Isles," *Eighteenth-Century Ireland* 25 (2010): 177.

[11] My prosopography (Chapter 5).

[12] Royal College of Surgeons in London, "Regulations of the College of Surgeons, and Apothecaries' Company, Relative to the Admission of Members and Licentiates," *Lancet* 5, no. 108 (1825): 17-18. The college was renamed the RCS *England* in 1843.

1843 required candidates to pass an exam in Latin or Greek.[13] In Scotland, surgical and medical qualifications could be obtained in either Edinburgh or Glasgow. Glasgow combined both medicine and surgery in the diploma of its Faculty of Physicians and Surgeons (LFPS *Glasg*). By 1852, its curriculum required attendance in a general hospital for 24 months, and passes in examinations in anatomy, physiology, surgery, chemistry, pharmacy, and botany.[14] The Royal College of Surgeons of Edinburgh, founded in 1505, awarded a licentiateship as its basic qualification (LRCS *Edin.*), and had similar curriculum requirements to the other surgical colleges. One development during the 1800s was the development of extramural teaching, where individuals offered paid lectures to students, outside the domain of the college or the universities.[15]

The London College of Physicians has a long history, dating from the sixteenth century. It never engaged in undergraduate education, but had an important role in England as an examining body. By the late nineteenth century, many had obtained its basic physician's qualification of LRCP *Lond.*[16] The Royal College of Physicians of Edinburgh played a similar role in Scotland.[17]

Throughout the nineteenth century, the universities in Britain steadily increased their contribution to medical training. As they created medical schools, they took on hospitals as partners, and bedside teaching eventually became the centrepiece of medical education. Newman argues that an important driver for this was that major surgery occurred only in hospitals.[18] The rise of the university medical schools created a challenge for the medical and surgical colleges, which feared being supplanted. The Scottish colleges responded by creating in 1884 the so-called 'Scottish triple qualification': LRCP LRCS *Edin* LFPS *Glasg*; with a jointly planned curriculum and jointly managed examinations.[19]

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[13] Charles A Cameron, *History of the Royal College of Surgeons in Ireland and the Irish Schools of Medicine*, 2nd ed. (Dublin: Fannin & Company, 1916), 181, 93, 238-9.

[14] Johanna Geyer-Kordesch and Fiona Macdonald, *Physicians and Surgeons in Glasgow: The History of the Royal College of Physicians and Surgeons of Glasgow, 1599-1858* (London: Hambledon Press, 1999), 341-4. The Faculty was given a royal charter in 1909 so the qualification became LRFPS (*Glasg*).

[15] Helen Dingwall, *'A Famous and Flourishing Society': The History of the Royal College of Surgeons of Edinburgh 1505-2005* (Edinburgh: Edinburgh University Press, 2005), 160.

[16] George Clark, "History of the Royal College of Physicians of London," *British Medical Journal* 1, no. 5427 (1965): 79, 82.

[17] Ronald H Girdwood, "Three Hundred Years of the Royal College of Physicians of Edinburgh," *British Medical Journal* 283 (1981): 654; Clarendon Hyde Creswell, *The Royal College of Surgeons of Edinburgh: Historical Notes from 1505 to 1905* (Edinburgh: Oliver and Boyd, 1926), 4.

[18] Charles Newman, "The Hospital as a Teaching Centre," in *The Evolution of Hospitals in Britain*, ed. FNL Poynter (London: Pitman Medical Publishing, 1964), 200-2; Arthur Thomson, "History and Development of Teaching Hospitals in England," *British Medical Journal* 2, no. 5201 (1960): 749-51.

[19] HM Dingwall, "The Triple Qualification Examination of the Scottish Medical and Surgical Colleges, 1884-1993," *Journal of the Royal College of Physicians of Edinburgh* 40, no. 3 (2010): 270-3.

Despite the rise of the university medical schools, most practitioners by the end of the nineteenth century still had only college or apothecary's qualifications. For instance, in New South Wales between 1891 and 1900, just 33 percent of the British/Irish IMGs newly registered in the colony had a degree from a UK university.[20] However, a university degree was not necessarily a guarantee of a superior education in the nineteenth century. Barry Smith noted that graduates from Oxford and Cambridge received no experience at all in obstetrics during their course.[21]

This was in stark contrast to those IMGs allowed to register in Australia from countries other than Britain, who nearly all had a university qualification. Medical practice in France, while suffering a setback during the revolution, returned to pre-eminence in its aftermath.[22] John Warner wrote that, at the start of the nineteenth century, 'Paris became a centre unmatched in its medical vitality.' The French had developed the science of physical examination of the patient, based on the systematic study of pathology at autopsy, and many British students went to France for a part of their training.[23]

Michel Foucault quotes a message sent from the Directoire to the Council of Five Hundred (Cinq-Cents), denouncing the many charlatans who practised medicine before the revolution:

> Le publie est victim d'une foule d'invidus peu instruits ... qui distribuent des remèdes au hazard, et compromettent l'existence de plusieurs milliers de citoyens.[24]

The Directoire was concerned that the Cinq-Cents needed to make progress, and proposed a law that would compel anyone who claimed to practise one of the arts of healing to undergo 'de longues études, à l'examen d'un jury sévère [long studies and examination by strict adjudicators] ... to prevent crimes that are little short of murder.'[25] The resulting law, *14 Primaire III*, was based on a proposal by Antoine Fourcroy to create three teaching hospitals, in Paris, Montpellier and Strasbourg, where:

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[20] Even as late as 1971-80, 20 percent of UK-trained IMGs registering in New South Wales had only a college or apothecary's qualification (my prosopography).

[21] FB Smith, *The People's Health, 1830-1910* (London: Croom Helm, 1979), 24.

[22] Guenter B Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York: Oxford University Press, 1999), 309-17.

[23] John Harley Warner, "The Idea of Science in English Medicine: The 'Decline of Science' and the Rhetoric of Reform, 1815-45," in *British Medicine in an Age of Reform*, eds. Roger French and Andrew Wear (London: Routledge, 1991), 137-8; Stephen Jacyna, "Robert Carswell and William Thomson at the Hôtel-Dieu of Lyons: Scottish Views of French Medicine," in *British Medicine in an Age of Reform* [London: Routledge, 1991), 110-1.

[24] 'The public is victim to a throng of poorly educated people, who distribute remedies at random, compromising the lives of many thousands of citizens': Michel Foucault, *Naissance de la Clinique* (Paris: Presses Universitaires de France, 1963), 64.

[25] Ibid., 77.

> Les élèves pratiqueront les opérations anatomiques, chirurgicales et chimiques; ils observeront la nature des maladies au lit des malades, et on suivront le traitement dans les hospices voisins de l'École.[26]

Thus, much more than in nineteenth century Britain, the core of medical training was in the clinic—the medical student did ward work in the hospitals of Paris, and the special clinics it had elsewhere, 'from his first to his last day in medical school, even when he had not yet acquired any knowledge of anatomy and physiology.'[27]

A few of the overseas-trained doctors who came to Australia in the nineteenth century had trained in Germany—some born there, but others were British citizens who travelled there to study. The oldest school was at Halle, followed by Göttingen and Berlin. By the 1900s, to be licensed to practise in Germany candidates had to graduate from a medical school with a doctorate (MD) but also pass the national medical licensing examination, the Staatsexamen.[28] Charles Singer and SWF Holloway comment that the University of Leyden was another medical centre with a formidable reputation, and 'English, Scottish and Irish students … flocked there.' Some of the northern Italian medical schools were also highly regarded.[29] As will be seen in Chapter 5, small numbers of IMGs succeeded in being registered in Australia on the basis of those European qualifications; and some of the British and Irish, who were registerable by virtue of their college or apothecary's qualifications, had also acquired an MD from a European university, sometimes as their first step.[30]

In Part 2 of the thesis, it will be seen that many of Australia's IMGs since about the 1980s were trained in India or South Africa. A brief commentary on medical education in each country will provide some useful background.

Both countries owe their medical education system to their colonial beginnings. The first British medical school in India was the Calcutta Medical College, founded in 1835. Currently there are 555 accredited medical colleges in the country, with a combined annual intake of just over 80,000 students. With more than 1.5 million applicants each year, places are fiercely contested with only slightly more than one in

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[26] 'The pupils will practise anatomical, surgical and chemical procedures; they will observe the nature of illnesses at the bedside of the patients, and follow their treatment in the hospices near the school': Antoine-François Fourcroy, "Décret des Comités d'Instruction Publique et de Salut Public sur l'Établissement d'une École Centrale de Médecine à Paris, Montpellier et Strasbourg," *Archives Parlementaires de la Révolution Française* 102 (2012, reprint of 1794), no. 1 (1794).

[27] Erwin H Ackerknecht, "Medical Education in Nineteenth Century France," *Journal of Medical Education* 32, no. 2 (1957): 149.

[28] Hans-Heinz Eulner, "Historische Aspekte zu Aktuellen Fragen des Medizinstudiums," *Medizinhistorisches Journal* 3, no. 3 (1968): 181-6.

[29] Charles Singer and SWF Holloway, "Early Medical Education in England in Relation to the Pre-History of London University," *Medical History* 4, no. 1 (1960): 1-2.

[30] Prosopography, chapter 5.

twenty being successful. Most courses are five and a half years long, with the final year an internship, ending with the award of dual bachelor degrees (MB BS) in medicine and surgery. The courses are still traditional in structure, with basic sciences taught first as stand-alone subjects followed by the clinical years in hospital settings. Solanki and Kashyap point out that there is little in the way of vertical and horizontal integration—now a feature of medical courses in many wealthier countries.[31] Daneen Muthalaly noted in her oral history (Chapter 10) that there was also much more rote than active learning in Indian compared with modern Australian medical schools.[32] Entry to specialist training programs in India is very competitive, with most structured as three-year MD postgraduate programs in universities.[33]

Medical Education in South Africa has been well regarded, and their graduates are sought after internationally. Most schools have a six-year curriculum, awarding MB BCh at graduation. Originally traditional and didactic, they have recently modernised to include more integrated and problem-based educational methods. Its hospitals have high caseloads, so the graduates gain a great deal of clinical experience in a short period.[34]

Finally, it will be useful to give a brief outline of basic medical education and specialty training in Australia. This gives some necessary context, since medical Acts in five states in the 1940s and 50s required their medical boards to judge the comparability of medical education in non-British countries against that in an Australian medical

[31] Vertical integration in a medical course encourages students to see relevance of basic sciences to clinical problems, and vice versa. Horizontal integration aims to break down the often artificial barriers between subjects learned at the same year level.

[32] Daneen Muthalaly, interviewed by author, Canberra (video), 3 August 2020.

[33] Samita Sen and Anirban Das, "A History of the Calcutta Medical College and Hospital, 1835-1936," in *Science and Modern India: An Institutional History, C.1784-1947*, ed. Uma Das Gupta (Delhi: Pearson Education, 2011), 477; National Medical Commission (India), "List of Colleges Teaching MBBS," accessed 6 November 2021, https://www.nmc.org.in/information-desk/for-students-to-study-in-india/list-of-college-teaching-mbbs/; Careers 360, "MBBS Admission in India," accessed 6 November 2021, https://medicine.careers360.com/articles/mbbs-admission-in-india; Anjali Solanki and Surender Kashyap, "Medical Education in India: Current Challenges and the Way Forward," *Medical Teacher* 36, no. 12 (2014): 1029; Marjo Wijnen-Meijer et al., "Vertical Integration in Medical Education: The Broader Perspective," *BMC Medical Education* 20, no. 509 (2020): 1-4; Anusuya Bhattacharyya et al., "Doctor of Medicine and Diplomate of National Board Courses in India—Issues and Equivalence: A Comparative Analysis," *Innovare Journal of Medical Sciences* 8, no. 1 (2020): 1-4.

[34] Athol Kent and Marietjie De Villiers, "Medical Education in South Africa—Exciting Times," *Journal of Continuing Education in the Health Professions* 29 (2007): 908; Mignonne Breier and Angelique Wildschut, *Doctors in a Divided Society: The Profession and Education of Medical Practitioners in South Africa* (Cape Town: HSRC Press, 2006), 32-36; Janet L Seggie, "MB ChB Curriculum Modernisation in South Africa: Growing Doctors for Africa," *African Journal of Health Professions Education* 2, no. 1 (2010): 8-13; JH Louw, "A Brief History of the Medical Faculty, University of Cape Town," *South African Medical Journal* 56, no. 22 (1979): 868-70; oral histories of Livia Morecroft (19 July 2019) and Hansie Le Grange (23 June 2020) (Chapter 10).

school. An outline of current training programs for Australian specialists will also be useful for when we examine the experiences of IMG specialists in Chapter 10.[35]

The original medical schools in colonial Australia were in Melbourne, Sydney and Adelaide, producing their first graduates in respectively 1867, 1888 and 1889.[36] The courses were based on those in England and Scotland but, unlike Britain, all were run by universities.[37] Laurence Geary wrote that the standard demanded of students at Melbourne in the 1880s was set so high that many failed and went to the UK, mainly to Scotland, to complete their degree.[38] Medical schools appeared later in Queensland and Western Australia, and the last state to have a medical school was Tasmania, graduating its first class in 1970.[39] In the last 20 years, the Australian schools have amended their curricula to promote active rather than passive learning.[40] By 2021, there were 21 accredited medical schools, most by then following the model that had been in place for over a century in North America: a four-year graduate program in medicine (MD), preceded by an undergraduate degree in science or another discipline of at least three years.[41]

During the last 50 years, most specialists have been trained under programs designed, monitored, and examined by specialist colleges, with Fellowship of the college awarded at the end. With a few exceptions, they are joint Australian and New Zealand (Australasian) bodies. The first was the Royal Australasian College of Surgeons, in 1927. The Royal Australasian College of Physicians followed in 1938, and its overarching specialty (following North American terminology) is now called Internal Medicine. Originally, it was common for these specialists to practise quite widely over the various subdisciplines within their broad specialty; now, most focus on a particular subspecialty in the later years of their training, and then practise mainly or exclusively in a subdiscipline. Examples of these in surgery are neurosurgery, cardiothoracic surgery, and orthopaedics; corresponding examples in internal medicine are neurology,

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[35] *Medical Practitioners (amendment) Act 1945 No. 11* (NSW); *Medical Practitioners Act Amendment Act 1955 No. 41* (SA); *The Medical Acts Amendment Act of 1955 (4 Eliz. II No. 27)* (Qld.); *Medical Act Amendment Act 1956 (5 Eliz. II No. 35)* (WA); *Medical Act 1959 No. 80* (Tas.); Commonwealth Department of Health, "Assessment of Overseas Trained Specialists".

[36] Prosopography, chapter 5.

[37] Harold R. Dew, "Developments in Undergraduate Medical Education in Australia," *Medical Journal of Australia* 1, no. 1 (1951): 35-6.

[38] Laurence M Geary, "The Scottish-Australian Connection 1850-1900," in *The History of Medical Education in Britain*, eds. Vivian Nutton and Roy Porter (Amsterdam: Rodopi, 1995), 55-6.

[39] Prosopography, Chapter 7.

[40] SJ Elliott and ND Yeomans, "Future Directions of Medical Education in Australia," *Internal Medicine Journal* 33, no. 8 (2003): 360.

[41] Australian Medical Council Limited, "Accredited Medical Schools," accessed 7 November 2021, https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-primary-medical-programs/accredited-medical-schools/.

cardiology, and rheumatology. Their training programs are long—six years for both FRACS and FRACP, starting after two or three years of hospital medical officer (HMO) experience—and, because of quite high failure rates in the demanding examinations, it is nine or more years after graduation before most start to practise independently in their specialty.[42]

Subsequently, almost every other specialty group has formed itself into a college, with responsibility for training, examinations, and continuing education. Nearly all their training occurs in teaching hospitals, with the principal exception of general practice. This is now regarded as a specialty in Australia and many countries (where it is sometimes called Family Medicine). The Australian College of General Practitioners (now Royal Australian College) was founded in 1958. Its training is carried out partly in hospitals but mainly in teaching general practices, with a minimum duration of three years after the intern year. A sister college, the Australian College of Rural and Remote Medicine, caters more specifically for GPs who intend to practise in rural areas. Both colleges play important roles in assessing and eventually supporting the many IMGs who try to achieve general registration in Australia.[43]

As mentioned at the outset, the purpose of this chapter has been to give context to the IMGs who populate the prosopography (Chapters 5 and 6). It also provides background for understanding the journeys of those IMGs whose oral histories make up Chapter 10, and the frameworks under which those who were interviewed for Chapter 11 needed to work.

[42] Julian O Smith, "The History of the Royal Australasian College of Surgeons, 1920-1935," *Australian and New Zealand Journal of Surgery* 41, no. 1 (1971): 2-10; Ronald Winton, *Why the Pomegranate? A History of the Royal Australasian College of Physicians* (Sydney: The Royal Australasian College of Physicians, 1988), 3; Royal Australasian College of Surgeons, "Guide to SET 2022: A Comparative Guide of Surgical Specialties and an Overview of Surgical Education and Training," accessed 8 November 2021, https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/guide-to-set.pdf?rev=ee91981c30e5449fa0ace0cc299676ff&hash=7BBE2898A51BDBE4213E5187C8DB3F92; Royal Australasian College of Physicians, "RACP Fellowship Training Pathways," accessed 8 November 2021, https://www.racp.edu.au/become-a-physician/training-pathways.

[43] Mark F Harris and Nicholas A Zwar, "Reflections on the History of General Practice in Australia," *Medical Journal of Australia* 201, Suppl. 1 (2014): S37,40; RACGP, "The Pathway to Fellowship," accessed 8 November 2021, https://www.racgp.org.au/education/students/starting-the-gp-journey/the-pathway-to-fellowship.

Chapter 2

Structure of the Profession and Health Care in Australia

This chapter provides context for the empirical material presented in Parts 2 and 3 of the thesis by examining the structure of the medical profession in Australia and its changes over the years. It is against this background that I will later examine how the IMGs have been integrated into the Australian health system and the changes over time in how or whether the medical boards would register them for practice.

The first European medical practitioners in colonial Australia were nearly all British migrants, who often served as ship's surgeons then stayed to practise their profession. In the early years they were unregulated. But this began to change with the creation of medical Acts in each colony: in 1837 in Van Diemen's Land and a year later in New South Wales.[1] That legislative structure is the topic of the next chapter.

Several authors have written accounts of the early surgeons and of health care in the first fifty years of Australian settlement. For example, David Richards wrote about the 24 convicts who were medically trained and practised in Sydney or Hobart before 1818.[2] One of the more notable was D'Arcy Wentworth, who arrived as a free man but had left England hurriedly to escape a pending court case. He had been charged with highway robbery previously but acquitted, was romantically (though perhaps fancifully) linked with Jane Austen, and 'as a public figure, he stood large in the tiny colony.'[3] Others who have contributed to the historiography of these earliest doctors and hospitals are Keith Brown, Cyril Bryan, CJ Cummins, Bryan Gandevia, Milton Lewis, W. Nichol, John Pearn and Fiona Starr.[4] The list is not intended to be exhaustive but gives an indication of some of those whose scholarship focused on individual doctors of that period.

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[1] *An Act to Provide for the Attendance of Medical Witnesses at Inquests 1837 [1 Vict. No. 14)* (VDL); *Medical Witnesses at Inquests Act 1838 (1 Vict. No. 3)* (NSW).

[2] David Richards, "Medical Convicts to New South Wales and Van Diemen's Land, 1788-1818," *Medical Journal of Australia* 161 (1994): 73-77.

[3] Ibid., 74; Wal Walker, *Jane and D'Arcy: Folly Is Not Always Folly*, vol. 1 (Sydney: Arcana Trust, 2017), 139-58.

[4] Keith Brown, "Surgeons in Exile at Botany Bay, 1770-1816," *Bulletin of the Postgraduate Committee in Medicine University of Sydney* 7, no. 1 (1951); Cyril Bryan, "The Earliest Medical History of Australia," *Journal and Proceedings of the Western Australian Historical Society* 2 (1933); CJ Cummins, *A History of Medical Administration in New South Wales, 1788-1983* (North Sydney: New South Wales Health, 1979); Bryan Gandevia, "The Pattern of Australian Medical History," *Proceedings of the Royal Society of Medicine* 50 (1957); Bryan Gandevia, *An Annotated Bibliography of the History of Medicine in Australia* (Sydney: Australian Medical Publishing Co., 1955); Brian Gandevia, "The Contribution of Doctors to Early Australiana," *Journal of the American Medical Association* 196, no. 1 (1966); Milton Lewis, "Medicine in Colonial Australia, 1788–1900," *Medical Journal of Australia* 201, no. 1 (Suppl.) (2014); W Nichol, "The Medical Profession in New South Wales, 1788-1850," *Australian Economic History Review* 24, no. 2 (1984); John Pearn, "Forced Emigration, Favourable Outcomes," *Australian and New Zealand Journal of Public Health* 25, no. 5 (2001); Fiona Starr, "The 'Sydney Slaughter House': Convict Experience of Medical Care at the General 'Rum' Hospital, Sydney, 1816-1848," *Health and History* 19, no. 2 (2017).

Nichol examined the structure of the profession in those earliest years in New South Wales, noting that opportunities for private practice were limited and that nearly all were government employees (colonial surgeons)—originally appointed by the Secretary of State for the colonies, but subsequently by the colonial governments themselves. The budget from Whitehall was parsimonious, with the result that in 1820 there were only 0.25 surgeons per thousand population, though by 1841 the ratio had more than quadrupled due to an influx of settler doctors.[5]

This thesis picks up the narrative from 1838 onwards, when the first immigrant doctors were 'legitimised' by being registered with the new Medical Boards. Not all chose or managed to be legitimised, however: the 1846 New South Wales census recorded 343 'medical men' in the colony, only 286 of whom were on the medical register.[6] By this time, the early practitioners were a mix of government employees and free-market entrepreneurs. CJ Cummins has written a comprehensive account of the colonial surgeons in New South Wales. Being salaried, they provided services to convicts, the military, public servants, and free settlers alike without charge.[7] But from about 1850 onwards, the rapidly enlarging medical workforce was increasingly engaged in private practice as general practitioners, caring for the enlarging population.[8] In Victoria, in the 1850s, many came to the gold fields in search of patients, and some to try their luck as prospectors.[9]

Colonial Hospitals

While many of the colonial doctors were sole practitioners in the community, working from their office and visiting patients in their homes, others divided their time between caring for patients in the colonial hospitals and their private practice. The early convict hospitals were being replaced with public hospitals in each city, and the immigrant doctors, not surprisingly, were influential in their development. The following examples illustrate some common themes but different solutions.

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[5] Nichol, "The Medical Profession," 116-24. Robert Hughes, *The Fatal Shore: The Epic of Australia's Founding* (New York: Vintage Books, 1988), 362; James K Fowler, "The Colonial Medical Service as a Career," *Lancet* 194, no. 5009 (1921): 729; W Younghusband, "Appointment of Colonial Surgeon," *South Australian Register*, 11 November 1858, 3.

[6] Nichol, "The Medical Profession," 128; prosopography (chapter 5).

[7] Cummins, *History of Medical Administration*, 14-20. Cummins says they had a limited right of private practice but few opportunities to use it.

[8] Lewis, "Medicine in Colonial Australia," S5.

[9] Keith Bowden, *Doctors and Diggers on the Mount Alexander Goldfields* (Maryborough, Vic.: Hedges and Bell, 1974), 2-12.

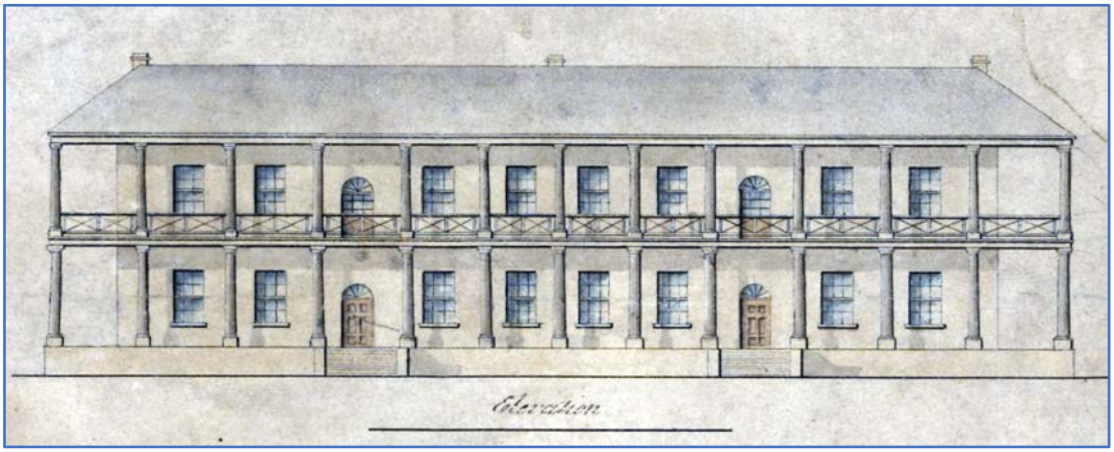

Figure 2.1: Sydney Hospital. Plan, section and elevation of the South Wing of the Convict Hospital Sydney, 1854. NSWSR, NRS-4335-9 [plan 2342]-[92]

The first was Sydney Hospital (Figure 2.1). Catering mainly for convicts and known colloquially as the 'Rum Hospital', Fiona Starr quotes a ward assistant as calling it the 'Sidney [*sic*] Slaughter House.'[10] But by the 1850s, it had evolved to have the structure and function of a major general hospital—elements of which continued for the next hundred years in Australian metropolitan hospitals. One that persisted was the medical staffing model. Whereas the early hospital had been staffed by salaried colonial surgeons, from mid nineteenth century the doctors were nearly all honorary, divided into the broad specialties of physician or surgeon to care for the inpatients.[11] J Frederick Watson, who graduated in 1903 as one of the early students of the Sydney medical school, wrote that in 1866 there were just two salaried resident staff, one physician and one surgeon; the rest were honorary, except for doctors in the outpatient department who were paid.[12] By the end of the nineteenth century, some doctors were becoming more specialised. George Weisz suggests that one driver may have been 'a new collective desire to expand medical knowledge'.[13] And it seems logical that could be better achieved if the practitioner focused on a small number of related problems—a feature of other developments in science more generally. Thus, specialty departments—among them ophthalmology, dermatology and gynaecology—began to appear in the Sydney Hospital in the 1880s and 90s.[14]

[10] Starr, "Sydney Slaughter House," 70.

[11] More explanation is provided about the honorary system later in the chapter.

[12] J Frederick Watson, *The History of the Sydney Hospital from 1811 to 1911* (Sydney: WA Gullick, 1911), 103-5; Ann M Mitchell, *Watson, James Frederick (Fred) (1878-1945)*, Australian Dictionary of Biography (National Centre of Biography, Australian National University), https://adb.anu.edu.au/biography/watson-james-frederick-fred-9001/text15847, published first in hardcopy 1990, accessed online 14 November 2021).

[13] George Weisz, "The Emergence of Medical Specialization in the Nineteenth Century," *Bulletin of the History of Medicine* 77, no. 3 (2003): 539.

[14] Watson, *Sydney Hospital*, 161-4.

However, if a satirical illustration in *Sydney Punch* were to be believed, the Sydney hospital may not always have welcomed those with an infectious disease (Figure 2.2).

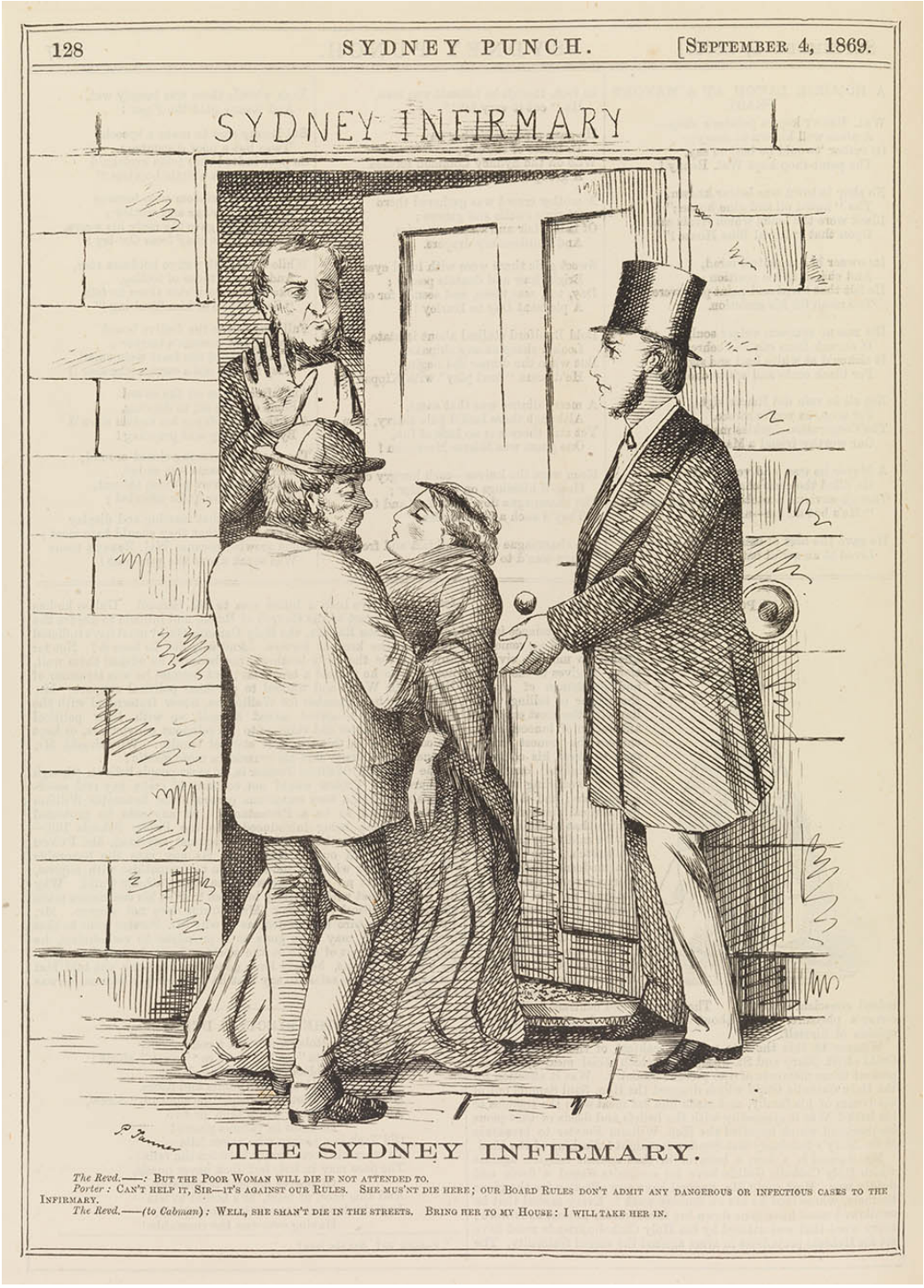

Figure 2.2: Satirical depiction of alleged discrimination by Sydney Infirmary against infectious patients, 1869; from the collections of the State Library of New South Wales [QA827/S]

The early years of the Hobart Hospital paralleled those of its Sydney counterpart. It was a hospital for convicts, destitute free settlers and the military, and was staffed by paid government surgeons. But after the transportation of convicts to Van Diemen's Land ended in 1853, it made the transition to a public hospital. Unlike the Sydney Hospital, which had been governed since 1848 by a board of directors elected by the public subscribers,[15] the Hobart Hospital board was run by a board of management appointed by the colonial Parliament. This was vigorously opposed by the doctors, who feared a loss of their autonomy in a hospital run by 'public servants'. However, their protests about the board were in vain. The Colonial Secretary had also planned to appoint a full-time colonial surgeon, without right of private practice, to act as superintendent. The doctors opposed that too, for a similar reason, and this time they succeeded. From 1860 to 1900, nearly all the staff were honorary, and even by 1970 the honoraries were still in the majority.[16]

The Adelaide Hospital (Figure 2.3) took a slightly different route. It began in 1837 in a shed as the Colonial Infirmary, but soon moved to a new site in 1841. It's first medical staff were honorary surgeons, then three years later the Board was dispensed with and put in the charge of the colonial surgeon.[17] The *Hospitals Act 1867* recreated a Board of Management, one third of whom would be elected by the community 'contributors' to the hospital, and could contain 'any number of duly qualified medical practitioners and other persons as the Governor … may determine'.[18] From that time until 1972, when the hospital moved to having paid specialists, the senior medical staff were all honorary.[19] In his history of the Royal Adelaide Hospital, J Estcourt Hughes lists all the 125 honorary medical staff in 1966. Only eight (6.4 percent) of them had been trained outside Australia; two of them were professors who were recruited from UK.[20] By contrast, 510 of the 2772 practitioners registered in the state between 1920 and 1966 were IMGs—a threefold higher proportion than on the hospital honorary staff.[21] It is plausible that medical school and other social networks in Adelaide society discriminated against the IMGs gaining senior positions at Adelaide's premier hospital during those years. Diana Dyason wrote that, as early as the 1890s, the Australian

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[15] Ibid., 91-5.

[16] William G Rimmer, *Portrait of a Hospital, the Royal Hobart* (Hobart: Royal Hobart Hospital, 1981), 4-7, 89-92, 321-2.

[17] J Estcourt Hughes, *A History of the Royal Adelaide Hospital* (Netley, SA: Board of Management of the Royal Adelaide Hospital, 1967), 2-22.

[18] *The Hospitals Act 1838 No. 7* (SA), s. 4.

[19] South Australian Branch Australian Medical Association, *The South Australian Branch of the Australian Medical Association: A Centenary History* (Adelaide: SA Branch of AMA, 1979), 4; Reece Jennings, "The Medical Profession and the State in South Australia, 1836-1975" (MD, University of Adelaide, 1998), 326.

[20] Hughes, *Royal Adelaide Hospital*, 2-22.

[21] Prosopography, chapter 7.

medical profession prided itself on a certain superiority to its British counterparts: 'Colonial it might have been; whinge it did; but cringe it manifestly did not.'[22]

Melbourne acquired three important hospitals in just over three decades after the birth of the city. The first was the Melbourne Hospital (Figure 2.4), founded in 1846 to serve the young and growing population. Alan Gregory wrote that a key event in securing it 'was a public meeting called by fourteen leading men of the settlement on 1 March 1841.' It was to cater for both 'contributing' (i.e., subscribing) and 'non-contributing' (the poor) patients, and the running costs were later promised by the colonial government (then in Sydney) on the condition that matching funds were met by public subscription. The hospital was completed in the northwest corner of what is now the central business district, and there it remained until rebuilt in 1941 (then Royal Melbourne Hospital) to cater for the American and Australian casualties in WWII.[23]

The Lying-in Hospital, later to be renamed the Royal Women's Hospital, began in 1856 in a nine-room house on the fringe of the CBD. A crucial impetus to its naissance was the lobbying and fund-raising by a group of determined women in the young colony, prominent among whom was Frances Perry, the wife of the Bishop of Melbourne. Their efforts secured a grant of land from the government in 1857, on which the second hospital (Figure 2.5) was built and opened 18 months later.[24] Janet McCalman, in her history of the lying-in hospital, provides this picture of its importance to the women in the young city:

> On 22 January 1866 at two o'clock in the morning, Miss Bridget Kelly, aged twenty-two and born in Ireland, delivered herself of a baby daughter in the Melbourne suburb of Prahran. She knew she needed help and she also knew that somewhere in the city of Melbourne there was a hospital, but the only way to get there was to walk. We don't know how long it took her to walk the four miles to the city. It was dark and the roads unlit, and between Prahran and the river lay bushland and swamps. Once over the river she faced a long, unrelieved climb up Swanston Street, past St Paul's church and the Town Hall. On the corner of Lonsdale Street she found the Melbourne Hospital, now eighteen years old and the first general hospital in the colony. But it was the wrong place they told her: she needed the Lying-in Hospital further up the hill in Madeline Street, opposite the university. The hill became steeper and it was a brisk twenty-minute walk for the fit. But this time she was taken in, and when her clothes were drawn aside it was discovered that she 'had the infant in her arms with the *funis* and placenta attached' ... If this book is about that Lying-in Hospital which is today Melbourne's Royal Women's Hospital, it is

[22] Diana Dyason, "The Medical Profession in Colonial Victoria, 1834-1901," in *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, eds. Roy Macleod and Milton Lewis (London: Routledge, 1988), 209.

[23] Alan Gregory, *The Ever Open Door: A History of the Royal Melbourne Hospital 1848-1998* (South Melbourne: Hyland House, 1998), 1, 5-8, 254-63.

[24] Janet McCalman, *Sex and Suffering: Women's Health and a Women's Hospital: The Royal Women's Hospital, Melbourne 1856-1996* (Carlton, Vic.: Melbourne University Press, 1998), 8-13.

> also about all the Bridget Kellys, married and unmarried, who have passed through its wards and clinics in the past one hundred and forty years.[25]

The third hospital, now a leading international centre for paediatric research and patient care, was the Melbourne Hospital for Sick Children (now Royal Children's Hospital). It began in 1870 in a small cottage on the east side of Melbourne's CBD, run by two philanthropic doctors: John Singleton and William John Smith.[26] Singleton (MD *Glasg*) had been in the colony for almost twenty years, working in the city's poorer areas. Smith (MRCS *Eng*; MD *Lond*) was a young graduate who had arrived in Melbourne the year before.[27] As with most of these early colonial hospitals, the funding was via government grants and charitable funds from benefactors and subscribers. Frances Perry and a group of other charitable women were again the drivers for the creation of the first hospital, its move shortly after to rented larger premises nearby, then by 1876 to a substantial building in Carlton in the city's near north.[28] There it remained for 80 years before moving in two stages to its present large site in the near-north suburb of Parkville close to The University of Melbourne and the current Royal Melbourne and Royal Women's Hospitals.

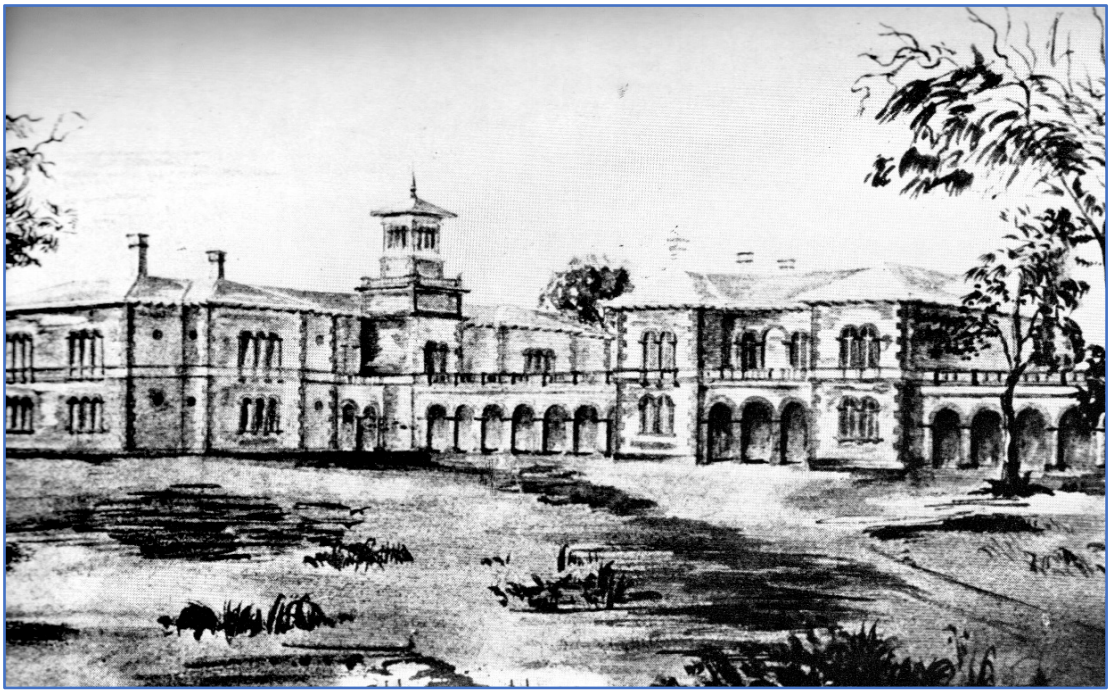

Figure 2.3: The Adelaide Hospital in 1860, from a drawing presented to the Royal Adelaide Hospital by Sir Trent de Crespigny (from Hughes, 1967, facing p. 46).

[25] Ibid., vii. *Funis* (latin) is the umbilical cord.
[26] Lyndsay Gardner, *Royal Children's Hospital, Melbourne, 1870-1970* (Parkville, Vic.: The Hospital, 1970), 2.
[27] Prosopography, Medical Register certificates 192 and 635.
[28] Gardner, *Royal Children's Hospital, Melbourne, 1870-1970*, 4-7.

Figure 2.4: The Melbourne Hospital, 1848. https://www.thermh.org.au/about/about-rmh/our-history/history-city-campus

Figure 2.5: The second Melbourne Lying-In Hospital, 1858. https://www.thewomens.org.au/ about/our-history/history-overview

It is worth digressing for a moment to say more about the honorary system in public hospitals. It was abolished in Queensland in 1944, when that state moved to pay its senior hospital doctors directly. But it persisted in all other states until the 1970s.[29] Robert Evans argues that the main motivations for the profession (and the BMA) clinging to it were that it preserved their independence from government and hospital administration. Furthermore, the honorary system:

> advanced their careers in private practice by demonstrating their clinical prowess to their colleagues and medical students, thereby attracting patient referrals. An ethical system of self-promotion was valuable for specialists in Australia because they were consultants: they treated only patients referred by other doctors.[30]

Reece Jennings, who himself worked in the public hospital system, said that appointment as an honorary 'heralded the start of the ascent of the eminent consultant to his [*sic*] pinnacle of professional prestige.'[31]

John Hirst asserts that the Australian approach to the poor was partly shaped by the desire to avoid the punitive nature of the new British poor laws of 1834.[32] Janet McCalman argues that hospitals and benevolent asylums that sprang up in the Australian colonies were essentially a recreation of the Old Poor Law, based on voluntary contributions by registered subscribers, and with colonial government oversight.'[33] And so, the medical profession in Australia, from colonial times until the second half of the twentieth century, cared for them mainly by charity—providing their services without charge to inpatients in public hospitals through the honorary system,

[29] George Rupert Palmer and Stephanie Short, *Health Care and Public Policy: An Australian Analysis*, 3rd ed. (South Yarra, Vic.: Palgrave Macmillan, 2014), 70.
[30] Robert G Evans, "The Transformation of Australian Hospitals between the 1940s and the 1970s," *Health and History* 7, no. 2 (2005): 106-8.
[31] Jennings, "The Medical Profession," 181.
[32] John Hirst, *Sense and Nonsense in Australian History* (Melbourne: Black Inc. Agenda, 2009), 125.
[33] Janet McCalman, *Vandemonians: The Repressed History of Colonial Victoria* (Carlton, Vic.: Miegunyah Press, 2021), 146.

or from hospital outpatient departments with their salary subsidised by charities or governments. Only the very poor were entitled to attend the outpatients.

Medical Practice and the Friendly Societies

A large segment of the population, though, had its medical care provided by doctors employed by the friendly societies. Roland Wettenhall offers a useful definition. Friendly societies were:

> mutually operated, community-based, benefit societies that encouraged financial prudence and social conviviality within the umbrella of recognised institutions that lent social respectability to their members … [which provided] sickness benefit payments, funeral benefits, and ultimately medical benefits – all at a time when no State social security systems existed.[34]

John Murphy more concisely summarised their major function as 'to provide welfare without charity.'[35] Nevertheless, there is good evidence that the friendly societies had a wider function, with mutuality at its core—essentially to amortise risk. Based on their inclusive membership practices, which usually did not discriminate on the basis of social class, and their requirement that the members should regularly meet together as well as support those who were in difficulty,[36] it can be argued that they also played an important role in promoting social cohesion.

The Australian friendly societies were based on their predecessors in Britain, but their membership covered a wider cross-section of society. Though mainly focussed on the upper working class and lower section of the middle class, Hirst stressed that even when they had done well, members usually remained subscribers and 'continued to associate at the weekly Lodge meetings with those who had been less fortunate.'[37] Nancy Renfree, in her treatise on the friendly societies in Australia, calculated that they had about 50,000 members in 1873, representing about a quarter of the male population older than twenty. Roland Wettenhall broke the membership down by occupation: in 1871–74 in Victoria, 49 percent were factory workers, 38 percent fabric or transport workers, but 21 percent were government employees and a significant 14 percent worked in 'learned professions'.[38]

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[34] Roland Seton Wettenhall, "The Influence of the Friendly Society Movement in Victoria, 1835-1920" (PhD, University of Melbourne, 2019), ii.

[35] John Murphy, *A Decent Provision: Australian Welfare Policy, 1870-1949* (Farnham, Surrey: Ashgate, 2011), 5.

[36] Nancy Swinburne Renfree, "Migrants and Cultural Transference: English Friendly Societies in a Victorian Goldfield Town" (PhD, Latrobe University, 1983), 93-7,148-9; Wettenhall, "The Influence," 197-228.

[37] Hirst, *Sense and Nonsense*, 141.

[38] Wettenhall, "The Influence," 69.

Since important among their functions was protecting the members against the financial dangers of unemployment due to sickness and costs of medical treatment, nearly all societies limited the upper age at which someone could first join; they also required medical evidence of initial good health. In Renfree's survey, the upper age limit was usually 36, though older people could sometimes join if they paid a preloaded subscription.[39]

To begin with, before the colonial medical schools were created, the doctors employed by the friendly society Lodges were necessarily all IMGs, but increasingly included local graduates as the Australian medical schools began to augment the workforce. The relations between the doctors and the societies gradually changed as the power balance between them shifted. Evan Willis, in *Medical Dominance*, argues that the division of labour in health care is 'a process based upon conflict; a struggle between occupations … not so much over occupational roles but over occupational territory or task domains.'[40] We will see more of this theme, and the related theme addressed by Tony Pensabene in his *The Rise of the Medical Practitioner,*[41] in later chapters. The foundations of conflict began to emerge, though, in the second half of the nineteenth century.

The friendly societies employed doctors on a capitation basis to provide health care to their members. There were some advantages for the doctors, the main one being a partly guaranteed income. Geoffrey Blainey calculated that by about 1900 it was common for a doctor to derive about half his income from the Lodge to which he was attached. A Lodge appointment was more attractive for those doctors starting in practice—either recently arrived from overseas or graduating from the local medical schools—than for those already well established and with a steady stream of private patients.[42] When Lodges needed a doctor they would advertise for tenders, encourage doctors to bid against each other and, in the event there was competition, Renfree's example suggested they usually chose the doctor with the lowest tender; little thought seems to have been given to the relative skills of the tenderers.[43] An example of an 1898 tender request is in Figure 2.6.

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[39] Renfree, "Migrants," 158-60.

[40] Evan Willis, *Medical Dominance: The Division of Labour in Australian Health Care*, 2nd ed. (Sydney: Allen & Unwin, 1989), 4.

[41] TS Pensabene, *The Rise of the Medical Practitioner in Victoria* (Canberra: Australian National University, 1980).

[42] Geoffrey Blainey, *Odd Fellows: A History of IOOF Australia* (North Sydney: Allen & Unwin, 1991), 73; Wettenhall, "Friendly Society," 236-8.

[43] Dan Weinbren and Bob James, "Getting a Grip: The Roles of Friendly Societies in Australia and Britain Reappraised," *Labour History*, no. 1 (2005): 96; Renfree, "Migrants," 174.

MEDICAL MAN.—TENDERS are invited for a July qualified Medical Man, for the United Ancient Order of Druids Lodge, Medical Attendance and Medicine. Tenders close SATURDAY, September 10th, 1898. Full particulars from E. W. ORTH, High-street, Penrith.

Figure 2.6: Advertisement for doctors to tender for a Lodge position. Sydney Morning Herald 5 September 1898, p. 2.

The disadvantage for the doctors, though, was that their relationship with the Lodge was essentially a servant-master one. They were fined and could be dismissed for failings such as delaying attendance on a patient, and the amount they earned for looking after a Lodge patient was substantially less than they could bill privately.[44] When one doctor sued for non-payment by a Lodge, the Judge, in upholding the doctor's case in 1870, said:

> The club regards its medical officer as its servant, treats him as its servant, fines him, suspends him, censures him, bullies him, worries him, and at its sweet will dismisses him.[45]

As a result, it was sometimes difficult for a Lodge to engage a doctor. Renfree gives the example of two Manchester Unity lodges in Castlemaine, Victoria, who banded together to appoint the same doctor. Dissatisfied with his services, they tendered without success for a replacement every year from 1875, forcing them to reappoint him each time until he died in 1885.[46] Blainey mentions attempts to form an IOOF Lodge in Sunbury, near Melbourne, which failed because the town's only doctor refused to contribute.[47]

One source of grievance for the doctors was having to provide services, without additional payment, for wealthy members of lodges. In 1880, the British Medical Association (BMA) established branches in New South Wales, Victoria and South Australia, as an early step in medical trade union power.[48] It was not till 1962 that the Australian state branches of the BMA finally morphed into the Australian Medical Association (AMA), a formidable pressure group to this day.[49] In the 1890s, the BMA campaigned for a fee-for-service approach so the doctors could set their own fees and relate them to the complexity of the service provided.[50] Then, at the intercolonial conference of the medical profession in 1898, delegates supported a proposal that

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[44] Renfree, "Migrants," 175.
[45] Editorial, "Professional Self Respect," *Australian Medical Journal*, no. 3 (1870): 82.
[46] Renfree, "Migrants," 229-30.
[47] Blainey, *Odd Fellows*, 72.
[48] Terence J Johnson and Marjorie Caygill, "The British Medical Association and Its Overseas Branches: A Short History," *The Journal of Imperial and Commonwealth History* 1, no. 3 (1973): 313.
[49] Thelma Hunter, "Pressure Groups and the Australian Political Process: The Case of the Australian Medical Association," *Journal of Commonwealth & Comparative Politics* 18, no. 2 (1980): 194.
[50] Weinbren and James, "Getting a Grip," 97-8.

friendly society members with an income greater than 200 pounds annually should not be eligible for medical benefits via their lodge.[51] Not surprisingly, the lodges refused, and a state of armed neutrality continued until 1918. Things came to a head when the Victorian branch of the BMA withdrew its services from all the Victorian lodges, demanding better remuneration and a more respectful relationship.[52] Not to be outdone, a past president of the Friendly Societies Association was reported to be travelling to Canada to secure a thousand Canadian doctors to fill the breach. This led to Stanton Crouch, the BMA secretary, writing to the Journal of the American Medical Association to warn the North American profession.[53] The plan to recruit Canadian 'scabs' clearly failed since there was only a single Canadian graduate registered in Victoria between 1915 and 1930.[54]

It was not until 1923 that the last of the friendly societies, Manchester Unity, finally came to an agreement with the BMA. Members would be charged a fixed fee for each medical attendance. David Green summed up thus:

> The doctors' victory was complete … The profession had successfully adopted trade union tactics to impose their demands on a significant proportion of their patients – those intermediate between the very poor who relied on charity, and the better-off wage and salary earners who could afford private fees. Henceforth medical care was to be a producer-dominated market. And when, in later years, governments attempted to collectivise medical care, the doctors were sufficiently powerful to insist that the collectivisation took place on their terms.[55]

Nevertheless, the friendly societies did not disappear. In 1938, although their membership had fallen sharply because of the depression, almost 30 percent of the population were still benefiting from their services.[56] But this left many who could not afford to belong to a lodge without cover. Doctors often waived their fees for the poorest, and hospital treatment was free for those who met a stringent means test, but this left many others for whom illness could be a financial disaster.[57] So in the late 1930s, there were moves to create a national insurance scheme for all wage-earners. It received the endorsement of the federal council of the BMA, but the state councils and rank and file

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[51] "Conference re Friendly Societies and the Medical Profession," *Intercolonial Medical Journal of Australasia* 3, no. 11 (1898): 679.

[52] David G Green, "The 1918 Strike of the Medical Profession against the Friendly Societies in Victoria," *Labour History* 46, no. 1 (1984): 83. Green notes, though, that the doctors were far from unanimous about attacking the friendly societies, since they sympathised with their social purpose.

[53] C Stanton Crouch, "Friendly Societies and the Australian Profession," *Journal of the American Medical Association* 71, no. 15 (1918): 1241.

[54] Prosopography, chapter 7.

[55] Green, "The 1918 Strike," 87.

[56] David G Green and Lawrence G Cromwell, *Mutual Aid or Welfare State: Australia's Friendly Societies* (Sydney: Allen & Unwin, 1984), 14.

[57] Stuart Macintyre, *Australia's Boldest Experiment: War and Reconstruction in the 1940s* (Sydney: New South, 2015), 209-10.

of the doctors had not been consulted and this early attempt at a national scheme folded in 1938 without being proclaimed.[58]

In 1953, Earle Page, Minister for Health in a conservative Commonwealth Government,[59] introduced a national voluntary health insurance scheme which lasted for a little more than twenty years. In essence, the Commonwealth provided subsidies to registered health insurance providers, many of which were still friendly societies, as well as providing free medical and hospital care for pensioners. Medical benefits, sourced from both the patients' and the Commonwealth's contributions to the insurance provider, were paid to patients after they had paid the doctor. The Medical benefit was a fixed amount for each item, according to a schedule of medical services. Hospital benefits were paid as a fixed amount per inpatient hospital day.[60] TS Pensabene wrote that Page's status within the medical profession (he was a member of the BMA and founder of the Royal Australasian College of Surgeons) helped him broker the scheme, which the doctors supported because it allowed them to continue to control their fees.[61] A visiting Englishman, Theodore Fox, said that his country's system was 'geared more to the patient's satisfaction', but the Australian one favoured the profession.[62] Evan Willis declared that this period 'marked the heyday of medical dominance' in the politics of Australian health care.[63]

The Evolution of National Health Insurance

During the 1960s, community and government dissatisfaction with the voluntary health insurance scheme grew. One response was a Commonwealth Committee of Enquiry, chaired by John Nimmo.[64] Key findings of its 1969 report were: (i) the operation of the health insurance scheme was unnecessarily complex; (ii) benefits received by contributors were often much less than the cost of hospital and medical treatment; (iii) contributions had increased so much that they were beyond the capacity of some and involved considerable hardship for others; and (iv) the rules of many registered

[58] James A Gillespie, *The Price of Health: Australian Governments and Medical Politics 1910-1960* (Cambridge: Cambridge University Press, 1991), 90-5; PR Hart and CJ Lloyd, *Lyons, Joseph Aloysius (Joe)(1879-1939)*, Australian Dictionary of Biography (Canberra: Australian National University, 1986).
[59] Page was Australia's eleventh Prime Minister (1939).
[60] Gillespie, *Price of Health*, 264-76; RB Scotton and CR Macdonald, *The Making of Medibank* (Kensington, NSW: University of NSW, 1993), 11-12.
[61] Pensabene, *Rise of the Medical Practitioner*, 171-2.
[62] Theodore Fox, "The Antipodes: Private Practice Publicly Supported," *Lancet* 281, no. 7286 (1963): 875.
[63] Willis, *Medical Dominance*, 201.
[64] Scotton and Macdonald, *Making of Medibank*, 19-29.

organisations allowed them to disallow or reduce claims for particular conditions, causing serious and widespread hardship.[65]

The Whitlam Labour government came into power at the end of 1972 and set about creating the first universal national health insurance program: Medibank, which commenced operation in 1975.[66] RB Scotton wrote that 'it was introduced in the face of bitter opposition from organised medicine and private health insurers, whose position was supported by the opposition parties.'[67] Medibank provided free treatment for public patients in public hospitals, and subsidies to private hospitals to allow them to reduce their fees. It reimbursed patients 85 percent of the scheduled fee for medical services and guaranteed they would not be out of pocket by more than $5 for any one item.[68] The funding mechanism proposed was a levy on taxable incomes, but since part of the enabling legislation was defeated, the scheme was initially funded out of general revenue.[69] As an aside, for patients to be eligible to get the rebate on fees charged by a specialist, their doctor had to be registered as such by the Commonwealth Department of Health. The oral history of Dr Jana Rao in Chapter 10 illustrates how the introduction of Medibank could suddenly impact the livelihood of IMG specialists after 1975, if they had not become a member of one of the Australasian specialist colleges.

By December 1975, the Whitlam government had been defeated by the conservative Fraser government, which immediately set about reviewing Medibank. The resulting changes to the legislation, leading to what became known as Medibank Mk II, increased the levy on taxable income to fund the new scheme to 2.5 percent (with exemptions for low-income earners), and gave citizens the right to opt out if they took out private health insurance for both hospital and medical benefits.[70] The *Sydney Morning Herald* declared that the changes had created confusion and 'must be considered the most notable political and administrative ineptitude of the present Federal Government's first year in office.'[71]

When the Hawke Labour government came into power in 1983, one of its priorities was to restore a universal health-care system, and with this Medicare was born. Anne-Marie Boxall and James Gillespie wrote that 'the AMA, for the moment, barely

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[65] JA Nimmo, *Health Insurance: Report of the Commonwealth Committee of Enquiry into Health Insurance* (Canberra: AGPS, 1969), 9.

[66] Gillespie, *Price of Health*, 132-51; Amanda Biggs, *Medicare—Background Brief* (Canberra: Parliament of Australia, 2004); the enabling legislation for Medibank was the *Health Insurance Act 1973* (Cth.)

[67] RB Scotton, "Medibank 1976," *Australian Economic Review* 10, no. 1 (1977): 23.

[68] SJ Duckett, "Chopping and Changing Medibank," *Australian Journal of Social Issues* 14, no. 3 (1977): 233.

[69] Scotton and Macdonald, *Making of Medibank*, 133.

[70] Ibid., 241-2.

[71] Editorial, "Medibank Mark II," *SMH*, 29 September 1976, 6.

put up a fight.'[72] Medicare was compulsory and tax funded. The private health funds, some of which were still derived from friendly societies, could no longer offer insurance for GP services—they were confined to offering insurance for accommodation in private hospitals, or for patients who elected to be admitted to public hospitals as private patients. There remained a market for the latter, because 'private patients' were guaranteed to be looked after by their own private specialist rather than the hospital-appointed doctors.[73] A feature that was retained from the earlier Medibank schemes was that patients who were bulk-billed for medical services at the scheduled fee, by their GPs or specialists, would not be out of pocket.[74]

Since that time, Medicare has changed little. Public hospital care remains free, unless a patient chooses to use their private health insurance to be admitted as a private patient. Many insured patients choose, though, to be treated by their private doctor in a private hospital.[75] At the time of writing, there were 35 registered health insurers in Australia.[76] Even today, one of the first of the colonial friendly societies, Manchester Unity Independent Order of Oddfellows, survives as Australian Unity to provide private health insurance cover for its members.[77]

Medical services may be bulk-billed under Medicare, if the doctor chooses to accept just the Medicare-schedule rebate for the service.[78] Otherwise, the patient pays the doctor for whatever they charge, and receives the difference between that and the schedule rebate as a partial refund.[79]

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[72] Anne-Marie Boxall and James Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia* (Sydney: UNSW Press, 2013), 115.

[73] Ibid., 133-45.

[74] Scotton and Macdonald, *Making of Medibank*, 268; Boxall and Gillespie, *Making Medicare*, 168.

[75] Australian Government Department of Health, "The Australian Health System," accessed 8 December 2021, https://www.health.gov.au/about-us/the-australian-health-system.

[76] Australian Prudential Regulation Authority, "Register of Private Health Insurers," accessed 8 December 2021, https://www.apra.gov.au/register-of-private-health-insurers.

[77] "Australian Unity: Our Story," accessed 2 December 2021, https://www.australianunity.com.au/about-us/our-story.

[78] This is obligatory if the patient is a pensioner.

[79] Stephen Duckett and Sharon Willcox, *Australian Health Care System*, 5th ed. (Sydney: Oxford University Press, 2015), 75-7; Australian Government Department of Health, "Medicare Provider Number Restrictions," accessed 8 December 2021, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-pubs-mtrp-16-toc~work-pubs-mtrp-16-chapter-5~work-pubs-mtrp-16-chapter-5-medicare-provider-number-restrictions.

Where do Doctors Currently Work and How Are They Paid?

This short section serves to summarise some of what is written above, and to highlight an important current restriction for payment of IMGs for medical services, especially for IMGs.

When they graduate from Australian or New Zealand medical schools, doctors start their career as a hospital intern, then spend a variable number of years getting further experience as Hospital Medical Officers (HMOs), most often in years 2 and 3 postgraduation, and many will progress to work as Registrars (trainee specialists). All the specialty training programs except general practice have a major or total hospital experience requirement. Trainee general practitioners spend some time as an HMO and the rest in teaching general practices in the community.[80] These are salaried positions. IMGs who have passed the Australian Medical Council (AMC) examinations or are following the AMC Specialist Pathway (Chapter 4) are usually required to spend a period of mentorship in an HMO or specialist training position before they are given full Australian medical registration.[81]

Once their postgraduate training is over, most doctors in Australia (as it was for much of the history recounted above) run small businesses—either billing their patients directly for their services, or directly bulk-billing Medicare. Since 1997, in order for the doctor to bulk-bill, or for their patients to get a Medicare refund if they are billed directly, the doctor must have a Provider Number. Since 2010, IMGs have been unable to get a Provider Number for generally ten years unless they work in a District of Workforce Shortage. They could bill patients, but the patient would not be able to get the Medicare rebate. In effect, this means that IMGs who do not get a provider number are restricted for a period to salaried practice in hospitals or larger general practices.[82]

Specialists, both local graduates and IMGs who have obtained specialist registration by a state Board or the Medical Board of Australia, generally work in both the public and private sectors. Most senior specialists (except specialist GPs) spend at least part of their week in salaried work in government hospitals, and the rest of their time with patients in their private rooms. Some specialists, particularly those in

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[80] Neville D Yeomans, GP Thompson, and Napier M Thomson, *Medical Careers in Australia*, 2nd ed. (Surrey Hills, Vic.: Victorian Medical Postgraduate Foundation Inc., 1987), 41-117.

[81] Medical Board of Australia, "Provisional Registration," accessed 14 December 2021, https://www.medicalboard.gov.au/Registration/Types/Provisional-Registration.aspx; Medical Board of Australia (AHPRA), "Guide to the Specialist Pathway: Information for International Medical Graduates," accessed 29 November 2021, https://www.ahpra.gov.au/documents/default.aspx?record=WD20%2F30478&dbid=AP&chksum=VjXVXsLaw%2FAQ%2FgGuHMqI0g%3D%3D.

[82] Department of Health, "Medicare Provider Number Restrictions".

administrative or academic roles, are fully salaried – though they often have the right of private practice for perhaps a day a week.

It has been into this evolving structure of Australian health care that the IMGs who appear in Part 2 of the thesis, and those who gave their oral histories in Chapter 10, have needed to insert themselves and function.

Chapter 3

Regulation of the Medical Profession in Australia

This chapter examines the many historical changes in the legislative framework that has regulated access to the medical profession. It provides necessary context for evaluating the empirical material in the following chapters.

In her recent essay on self-regulating professions, Tracey Adams describes two historical frameworks for the regulation of a profession such as medicine. One, which she and others describe as neo-Weberian, 'was the product of campaigns by (male) professionals who organised, and mobilised economic, social, and cultural resources to lobby governments for regulatory privileges.' In this scenario, she suggests states are largely at arm's length, and simply grant the privileges on request. The other framework, which sociologists such as she have labelled Foucauldian, portrays 'the state as much more active in profession creation', wanting to regulate the profession for the benefit of its citizens.[1]

British Legislation

The dynamics of the regulation of the medical profession in Britain and Australia shows elements of both these frameworks and motivations. Perhaps the earliest instance in Britain was the *Act for Appointing Physicians and Surgeons 1511*. Its preamble refers to physick and surgery being practised by 'a great Multitude of ignorant Persons, of whom the greater Part have no Manner of Insight in the same [physick and surgery] nor in any other Kind of Learning.' The body of the Act stated in part:

> That no Person within the City of *London* , nor within Seven Miles of the same, take upon him to exercise and occupy as a Physician or Surgeon, except he be first examined, approved, and admitted by the Bishop of *London*, or by the Dean of *Pauls* for the time being, calling to him or them Four Doctors of Physick, and for Surgery other expert Persons in that Faculty ...[2]

This early medical Act may have provided protection for the British public from untrained practitioners but was probably also driven by self-interest of the practitioners who likely lobbied for it. Another early example of British royal regulation was the charter issued by Elizabeth I in 1577, which united the barbers and surgeons in Ireland into the one corporation—the 'Master, Wardens, and Fraternity of Barbers and Surgeons of the Guild of the Blessed Mary Magdalene.' It explicitly prohibited anyone practising in Dublin without having been admitted to the guild.[3]

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[1] Tracey L Adams, "Self-Regulating Professions: Past, Present, Future," *Journal of Professions and Organization* 4, no. 1 (2017): 72-3.

[2] *An Act for the Appointing of Physicians and Surgeons 1511 (3 Hen. VIII c. 11)* (Imperial).

[3] Mary Ann Lyons, "The Role of Graduate Physicians in Professionalising Medical Practice in Ireland, c. 1619-54," in *Ireland and Medicine in the Seventeenth and Eighteenth Centuries*, eds. James Kelly and Fiona Clark (London: Routledge, 2010), 19.

In the early nineteenth century, moves were afoot to legislate for the training of British medical practitioners. Prominent in this was Edward Harrison who, in an address to the Lincolnshire Benevolent Medical Society in 1809, said that 'pretenders exceeded the regular Faculty, in the proportion of nine to one.' His thrust was that quacks should be discouraged, and the profession of medicine should be regulated. He began his speech:

> Among the various inquiries which have lately excited public attention, and the various abuses that have been in consequence removed, it seems not a little extraordinary that the medical profession should have remained so totally neglected.[4]

Harrison produced a draft of a Bill titled: *An Act for the Appointing of Physicians and Surgeons.* Its preamble reads:

> Forasmuch as the science and cunning of Physic and Surgery (to the perfect knowledge whereof be requisite both great learning and ripe experience) is daily within this realm exercised by a great multitude of ignorant persons, of whom the greater part have no manner of insight in the same, nor in any other kind of learning:[5]

It went on to specify that the practitioner's competence must be established by examination, with some of Harrison's wording taken from the 300-year-old 1511 Act. He further specified that surgeons and apothecaries must have 'served a regular apprenticeship of five years'.[6]

Despite Harrison's efforts, Charles Newman reported that the Bill did not succeed.[7] Harrison had started something in motion, though, and six years later a pivotal piece of legislation for the practice of medicine in Britain was passed: the *Apothecaries Act 1815*.[8] SWF Holloway wrote that the Bill was 'prepared by the Society of Apothecaries, under the patronage of the College of Physicians … [and] after much revision … was finally rushed through a depleted House of Commons in the closing phases of a particularly active session.'[9] The Apothecaries Act essentially defined who could be a general practitioner in England and Wales, how they must be trained, how their

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[4] Edward Harrison, *An Address Delivered to the Lincolnshire Benevolent Medical Society at Their Anniversary Meeting in 1809, Containing an Account of the Proceedings Lately Adopted to Improve Medical Science, and an Exposition of the Intended Act for Regulating Medical Education and Practice*, (London: R. Bickerstaff, 1810), 1, available at https://play.google.com/books/reader?id=Rah9HNz6FogC&hl=en_US&pg=GBS.PP5.

[5] Ibid., Appendix A, 1-3.

[6] Ibid., Appendix C, 31.

[7] Charles Newman, *The Evolution of Medical Education in the Nineteenth Century*, (London: Oxford University Press, 1957), 65.

[8] *An Act for Better Regulating the Practice of Apothecaries Throughout England and Wales 1815 (55 Geo. III c. 194)* (Imperial).

[9] SWF Holloway, "The Apothecaries' Act, 1815: A Reinterpretation," *Medical History* 10, no. 2 (1966): 107.

competence must be assessed, and what penalties applied if its requirements were breached. It was the forerunner of essentially all the Medical Acts to be introduced later in Australia. It was not without its critics, though. The most prominent was Thomas Wakley, founding editor of *The Lancet*, a surgeon, social reformer, and radical member of Parliament. In an editorial in 1831, he thundered:

> After what we have stated, is it not the grossest insult that can be offered to common sense, to say that the Apothecaries' Act is a proper measure of protection for the medical profession? Founded upon a trading principle, and its powers carried into execution by a trading Company, it is as ill calculated for the wants and the respectability of the profession, and to give a proper security to the public against the lawless pretensions of unqualified practitioners, as would be the most miserable that human imbecility could fabricate.[10]

Wakley did have a point: the Apothecaries had carved a market share for themselves, and did generate income from examining candidates desirous of joining their ranks.

There were others who were as concerned about incompetence within the ranks of the doctors as outside them and called for better education and assessment of professional competence. One was the Glasgow surgeon, George Watt, who wrote in 1831:

> Ignorance and charlatanism are not, however, confined to individuals out of the profession. In every one of its ranks, medical, surgical or obstetrical, numerous and melancholy examples of the utter incompetence of *licensed* charlatans present themselves daily [my emphasis] … the Government and the profession ought equally to combine in bringing about a thorough, and an effectual reform.[11]

Before leaving imperial laws, one other British Act must be mentioned, because it was a powerful influencer of subsequent Australian legislation, and a response in part to voices such as those of George Watt. The *Medical Act 1858* created the General Council of the United Kingdom—known thereafter simply as the General Medical Council (GMC). Its powers were extensive: not only must every person who wished to be a *legally qualified medical practitioner* be registered by the Council, after providing their credentials, it listed all the universities and medical corporations whose qualifications could be recognised; furthermore, it had the power to ask the Privy Council to de-register any medical school or corporation whose curriculum and/or examinations were judged inadequate by the Council.[12] When the Australian medical schools were formed, the GMC had similar powers over them, only to eventually be replaced as late as 1984 by the Australian Medical Council (AMC). The GMC's functions

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[10] Thomas Wakley, "The Infamous Apothecaries' Act," *Lancet* 15, no. 383 (1831): 469.

[11] George Watt, "Remarks on Medical Education," *Glasgow Medical Journal* 4, no. 14 (1831): 151.

[12] *An Act to Regulate the Qualifications of Practitioners in Medicine and Surgery 1858 (21&21 Vict. c. 90)* (Imperial).

also included enquiring into allegations of misconduct by practitioners, with the power to remove their registration if found guilty. That function became a responsibility of the various Medical Boards in the Australian colonies and states. MJD Roberts points out that revisionist historians have downplayed the importance of the 1858 Act,[13] but the information in this and later chapters does not support the revisionists' view.

Australian Legislation

For the first 50 years in colonial Australia, medical practitioners did not have to be registered to ply their trade. But things began to change. In 1838, two linked pieces of legislation were passed by the Legislative Council in New South Wales: the first empowered coroners, through the *Medical Witnesses at Inquests Act 1838,* to require a 'legally qualified Medical Practitioner' to give evidence at coronial inquests and/or to perform an autopsy.[14] This mirrored the English Act two years earlier, the *Medical Witnesses Act 1836.*[15] However, the first of these NSW Acts begged the question of who was a 'legally qualified Medical Practitioner', so its companion Act four months later set that into law. The *Medical Witnesses at Inquests 1838 (2)* required the formation of 'The New South Wales Medical Board,' and mandated that to be 'deemed a legally qualified Medical Practitioner', a person must:

> have proved to the satisfaction of the President or any other Member [of the Board] …that he is a Doctor or Bachelor of Medicine of some University or a Physician or Surgeon licensed or admitted as such by some College of Physicians or Surgeons in Great Britain or Ireland or a Member of the Company of Apothecaries of London or who is or has been a Medical Officer duly appointed and confirmed of Her Majesty's sea or land service.[16]

And so the New South Wales Medical Board was born, with a somewhat ambiguous charter about which university degrees it could recognise, but an unambiguous mandate to recognise only British and Irish qualifications from the medical corporations.[17] Its first President was John Thompson, Deputy Inspector General of Hospitals, and not medically qualified. The members were Charles Nicholson MD *Edin*

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[13] MJD Roberts, "The Politics of Professionalization: MPs, Medical Men, and the 1858 Medical Act," *Medical History* 53, no. 1 (2009): 37-8.

[14] *An Act to Provide for the Attendance of Medical Witnesses at Coroner's Inquests and Inquiries Held by Justices of the Peace 1838 (1 Vict. No.3)* (NSW).

[15] *An Act to Provide for the Attendance and Remuneration of Medical Witnesses at Coroners' Inquests 1836 (6 & 7 Wm. IV, c. 89)* (Imperial).

[16] *An Act to Define the Qualifications of Medical Witnesses at Coroner's Inquests and Inquiries Held by Justices of the Peace in the Colony of New South Wales 1838 (2 Vic. No.22)* (NSW).

[17] 'Some University' might be read as meaning only British or Irish ones (as were the colleges), and the practice of the Board made it clear they took that view. However, there is a structural ambiguity in the syntax, which in the 1840s handling of applications by Jean dit Fattorini led to a NSW Supreme Court case, discussed in Chapter 4.

(1833); Francis Lascalles Wallace MD *Edin* (1831); Kinnear Robertson, *Colonial Surgeon*; and John Dobie, *Surgeon RN*.[18]

This started the process of defining who in Australia could be registered as a medical practitioner, and clearly pushed some of the unqualified into the shadows, as suggested in this satirical nineteenth century ditty:

> I'll leave for England with my hoard,
> In the colony I'll not abide;
> They're forming now a medical board,
> To discover who're not qualified.
> So all you quacks just take a warning,
> Like poachers run you down they will;
> And they'll slew you some fine morning,
> If you've no certificate to kill.[19]

The initial Acts foreshadowed a multitude of Acts and amendments in the colonies, states and territories for the next 170 years—a total of 219. Often, as we will see later, they had to do with which countries could or could not have their graduates registered to practise in Australia. The description, here, of the evolution of these laws will provide context to the findings about the changing patterns of IMG source countries in the prosopography (Chapter 5 and 7), and to the more recent demographic changes that are discussed in Chapters 8 and 9.

Many of the amendments were of a minor procedural nature, and not relevant to the arguments developed in the thesis. Hence, only those that particularly impacted on which practitioners (and from where) could be registered are discussed here—especially those that either caused or were in reaction to changes in IMG immigrant flows. For completeness, a full list of acts and ordinances annotated with their implications for IMG registration is provided in Appendix A, Supplementary Table 1.[20]

[18] NSW Government Gazette, 27 February 1839, 259; NSWSA: Register of Medical Practitioners for New South Wales, 1838-1980, NRS-15581.

[19] Charles Thatcher, *Thatcher's Colonial Songster* (Melbourne: Charlwood & Son, 1865), 29.

[20] Since all the Acts are referenced in the Bibliography, they are footnoted only when it appears more convenient for the reader to immediately see the full citation for an Act.

Table 3.1: First medical Acts or ordinances in each colony and territory

Colony /Territory	Year	Name of Act
Van Diemen's Land	1837	An Act to Provide for the Attendance of Medical Witnesses at Inquests 1837 (1 Vict. No. 14)
NSW	1838	Medical Witnesses at Inquests Act (1 Vict. No. 3)
VIC (NSW governing Act)	1844	Medical Witnesses at Inquests Amendment Act (8 Vict. No. 8)
SA	1844	An Ordinance to Define the Qualifications of Medical Practitioners in this Province for Certain Purposes 1844 (8 & 9 Vict. No. 17)
QLD*	1867	Medical Act 1867 (31 Vict. No. 33)
WA	1869	Medical Ordinance 1869 (33 Vict. No. 8)
ACT	1930	Medical Practitioners Registration Ordinance 1930 No. 13
NT	1935	Medical Practitioners Registration Ordinance 1935 No. 1

*Prior to 1867, medical practitioners in Queensland were registered under NSW Acts.

As had occurred in New South Wales, the first medical Act in each of the other colonies and territories created a medical board or council, responsible for maintaining a medical register for their locale, and deciding who should be entered on it. Those foundation Acts and when they were created are listed in Table 3.1. I will first describe the sequential changes to the medical laws for the two oldest jurisdictions, New South Wales and Tasmania. Then, at the chapter's end, I will examine the common themes in the legislation that can be identified across all jurisdictions.

New South Wales

In 1844, with the growth of the new settlement in what was to become Victoria, the New South Wales Legislative Council passed an amendment to the second of the *Medical Witnesses at Inquests Acts 1838*. This created a parallel medical board with the same charter as the parent one in Sydney—the Medical Board for the District of Port Phillip.[21] Another amendment to the 1838 Act was passed in the following year. It added Licentiate or Membership of the Apothecaries Hall of Dublin to the list of eligible qualifications.[22]

The New South Wales *Medical Practitioners Act 1855* marked a significant change in who could be registered as a doctor in the colony. It first defined the minimum

[21] *Medical Witnesses Act Amendment Act 1844 (8 Vict. No.8)* (NSW).
[22] Ibid.

length of study for registration, then where that needed to have occurred. It is worth quoting the requirements in Section 1:

> Any person who shall prove… that he has passed through a regular course of medical study of not less than three years' duration in a School of Medicine and that he has received after due examination from the University of Sydney or from some University College or other body duly recognized for that purpose in the country to which such University College or other body may belong a diploma degree or license entitling him to practice medicine in that country shall be deemed to be a legally qualified Medical Practitioner within the meaning of the Acts passed in the second and ninth years of the reign of Her present Majesty and … shall be entitled to a certificate as such from the said [NSW Medical] Board.[23]

This began to open the door for IMGs to come from countries other than mother Britain, and they did so in small numbers for the rest of that century as we will see in Chapter 5. The 1855 Act mentions the University of Sydney, but it did not have a medical school when the Act was gazetted, and produced no graduates of its own for a further thirty years.

Three more medical Acts were gazetted in the colony before federation: the *Medical Practitioners Act 1898*, which simply consolidated the earlier Acts into one, without making substantive changes; the *Medical Practitioners Amendment Act 1900;* and the *Medical Practitioners Acts further Amendment Act 1900.* [24]

The first of the 1900 Acts made one substantive change: it declared that only practitioners entitled to be registered under the 1898 Act could describe themselves as or imply they were a 'legally qualified practitioner'; a substantial penalty, including possible imprisonment, was prescribed. This finally put to rest the campaign by New South Wales doctors against the homeopaths and other 'irregular practitioners'—a narrative developed further in Chapter 6. The second of the 1900 Acts provided for the removal from the register of practitioners found 'guilty of infamous conduct in any professional respect'. Another important change was that the minimum period of study at a medical school must be five instead of three years. [25]

In 1915, with Australia at war with Germany and Austria, the New South Wales Act was amended to prevent citizens of either country being registered. That prohibition was never repealed, although it was superseded in a new Act 23 years later. For the first time, the 1915 New South Wales Act specifically mentioned graduates from Australian

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[23] *An Act to Provide for the Registration of Legally Qualified Medical Practitioners 1855 (19 Vic. No. 17)* (NSW).

[24] *Medical Practitioners Act 1898 No. 26* (NSW); *Medical Practitioners Act Amendment Act 1900 No. 33* (NSW); *Medical Practitioners Acts Further Amendment Act 1900 No. 70* (NSW).

[25] The previous (1900 No. 33) Act had already made it possible for those convicted of 'a felony or misdemeanour' to be removed from the register.

medical schools as eligible for registration.[26] This was also the first New South Wales legislation to specify countries whose medical graduates could *not* be registered, as distinct from mentioning only those from whom they *could* (Britain and Ireland) in the 1830s and 1840s Acts.

The *Medical Practitioners Act 1938* ran to 38 pages and made many changes. Some related to the composition of the Medical Board and how it was to function. More relevant to arguments developed later in this thesis were substantially revised stipulations about who could be registered. Graduates in medicine or surgery from any university in the Commonwealth of Australia or the Dominion of New Zealand were specified for the first time in a new Section 17(1)(a). The other major changes in who was eligible for registration were set out in Sections 17(1)(b) and (c):

- s17(1)(b) allowed registration of graduates from a school of medicine in 'some part of the British Empire', provided the course was recognised by the Board as 'not lower in standard than that required … by the University of Sydney [for its medical degree]' and who were entitled to practise medicine in that country;
- s17(1)(c) referred to graduates from a five year or longer course in a school of medicine in a country *not* part of the British Empire. They could be considered if their degree or diploma entitled them to practise medicine in their parent country, but to be registered in New South Wales they must then attend and pass the fourth, fifth and sixth years of the MBBS course at the University of Sydney;
- s18(6) specified that not more than eight who were 'not natural-born British subjects' could be registered each year. [27]

Sections 17(1)(c) and 18(6) thus raised the bar immensely for IMGs from a country outside the British Empire, since available places in the Sydney course were few and, even if the IMGs graduated, they were subject to a ballot by the Board if their number exceeded the annual limit. More will be said about this in Chapter 7 as data in the prosopography are analysed.

The 1938 Act added a further element, missing from earlier ones, that of reciprocity. Qualifications from other countries would not be accepted unless University of Sydney graduates could be registered 'without further examination' in that country. The Act did, however, provide for the registration of those with three or more years' engagement in postgraduate teaching or research—presumably a necessary waiver for recruiting medical academics. The Minister for Health also had the power to approve

[26] *Medical Practitioners Act 1915 No. 33* (NSW). Graduates from Australian medical schools prior to this amendment were eligible under one of the general provisions of the earlier Acts.
[27] *Medical Practitioners Act 1938 No. 37* (NSW).

registration of those with 'such special qualifications … and special experience in the practice of medicine or surgery … as would justify waiving compliance' with the criteria in Section 17(1).[28]

The following year, the 1938 Act was amended to allow the Governor and Minister to declare a region of the state an area 'not adequately provided for in respect of medical and/or surgical services'. It gave the Board power to provide 'regional registration' for an IMG who would otherwise be restricted by section 17(1)(c) above, with a test administered by the Board (or examiners approved by it) if it wished. The 1939 amendment further provided that the IMG could be fully registered after serving with a regional certificate for five years.[29] This was a forerunner of later restrictions of practice in Australia (including for local and New Zealand graduates) to designated Areas of Need for defined periods.

Three years after the outbreak of WWII, restrictions were placed on IMGs from countries with which Australia was at war. This was via a regulation—the *Medical Practitioners, National Security (Alien Doctors) Regulations 1942*—under the Commonwealth *National Security Act 1939.*[30] However, the Prime Minister (John Curtin) wrote to Premiers in January that year to advise them of an exception which allowed the Commonwealth to register some alien doctors to fill areas of need, bypassing the state medical boards.[31] The broader restrictions were removed by an amendment in 1945, once the National Security Regulations ceased to have effect.[32]

The 1950 amendment made life slightly easier for IMGs who qualified outside the British Empire, by deleting s18(6) that had imposed the cap of eight per annum who could be registered.[33]

There was a minor procedural amendment in 1953 but the next substantive amendment that affected IMGs was in the *Medical Practitioners (Amendment) Act 1955.*[34] This added a new section (s21B) directed at IMGs given a limited or regional registration to practise under supervision in an area or hospital with a workforce shortage. The new requirement was that they must pass an oral or clinical examination[35]

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[28] Section 17(2)(b and c) of the 1938 Act.

[29] *Medical Practitioners (Amendment) Act 1939 No. 5* (NSW).

[30] "Medical Practitioners National Security (Alien Doctors) Regulations 1942," (NAA: 652/17/1); *National Security Act 1939* (Cth.).

[31] NAA: W5733, item 100850, 1942, 168-9.

[32] *Medical Practitioners (Amendment) Act 1945 No. 11* (NSW).

[33] *Medical Practitioners (Amendment) Act 1950 No. 29* (NSW).

[34] *Medical Practitioners (Amendment) Act 1953 No. 22* (NSW); *Medical Practitioners (Amendment) Act 1955 No. 23* (NSW).

[35] Clinical examinations assess directly the performance of a candidate in taking a history from and examining an actual or simulated patient, then synthesising the information obtained.

or both, by an 'Examining Medical Committee' established by the Minister. Thus, for IMGs who had been allowed to bypass some of the earlier registration requirements, this amendment introduced a process to directly assess their knowledge and skills. The Examining Committee was required to report to the Board that the candidate had: (i) English language skills adequate for medical practice; and (ii) 'requisite knowledge and skill … according to the standards in force at the University of Sydney'. The successful applicants would then be placed on a list, from which the Board would later choose who it considered most appropriate when the Minister notified it a hospital or other institution was in need. Chapter 7 explores some IMGs who came under the s21B provisions.

The flood of amendments to the Medical Act 1938 continued, with revisions in each of 1956, '57 and '58. The first made mainly administrative changes that did not greatly affect overseas-trained doctors. One provision in the 1957 Act, though, allowed the Minister to bypass the Board and directly issue a regional licence if the Board refused to do so. Presumably there had been some friction between Minister and Board, and perhaps lobbying by a rejected candidate with political clout.[36]

The 1958 amendment was notable because it evidenced a lack of geopolitical awareness on the part of the Board or the Department of Health. Section 17(1)(b) of the consolidated 1938 Acts had continue to advantage medical graduates from a university or college in the British Empire, including Ireland. It was not until 1958 that the New South Wales legislature caught up with the fact that the Republic of Ireland had left the Empire in 1949.[37] The revised Act dealt with this, effectively by declaring Ireland an honorary member—'to be included within the British Empire for the purposes of this Act.'[38]

The 1963 amendment deleted any reference to the British Empire and moved the registerable qualifications into two appended schedules: the first listed all the Australian medical schools, plus universities and colleges by name in New Zealand, UK, Ireland, South Africa, Hong Kong, Ceylon and Malta, plus Manitoba in Canada and Bombay in India; the second schedule listed colleges whose membership or fellowship denoted specialist status in medicine or surgery.[39] Manitoba was singled out in Canada since it was the only medical school that offered reciprocity to New South Wales graduates.[40]

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[36] *Medical Practitioners (Amendment) Act 1956 No. 14* (NSW); *Medical Practitioners (Amendment) Act 1957 No. 20* (NSW).

[37] *Republic of Ireland Act 1948 No. 22* (Éire).

[38] *Medical Practitioners (Amendment) Act 1958 No. 12* (NSW).

[39] *Medical Practitioners (Amendment) Act 1963 No. 22* (NSW). The Act also listed higher degrees in Australian, UK and Irish universities that denoted specialist status.

[40] *NSW Parliamentary Debates, Legislative Assembly*, (26 March 1973), 3720.

An amendment in 1964 made mainly syntactical changes to several sections, but added Universities of Singapore and Malaysia, and the Polish School of Medicine at the University of Edinburgh.[41]

An amendment in 1972 had little relevance to IMGs, but the 1981 amendment did: IMGs from the non-Commonwealth countries who succeeded in being registered could have their registration cancelled if they were not living or practising in New South Wales six months after being placed on the medical register. The motivation for this amendment will be addressed in Chapter 7, when marked surges in inflows from certain countries are discussed. The 1987 amendment marked a change to a more national approach to evaluating IMGs, requiring those whose medical school was not on the Schedule to pass the new AMC examinations.[42]

After 54 years of frenetic legislative activity with continual amendments of the 1938 Medical Act, New South Wales finally got a new Act, the *Medical Practice Act 1992*, which stipulated who could be registered much more concisely. Those eligible were: (i) graduates of a medical school accredited by the AMC (i.e., all Australian and New Zealand schools), or (ii) foreign graduates who had passed the AMC examinations, or (iii) those with medical registration in another Australian state or territory. The Board also had power to register practitioners not covered above if it considered there was a special need. Overseas specialists were registerable if their qualifications and experience were recognised by one of the Australian specialist colleges.[43]

Thus, the New South Wales 1992 Act removed the privileged position graduates from UK and Ireland had enjoyed since the Medical Board was first created, and from many current or former Commonwealth countries since the 1930s. Unless they were registered as a specialist or admitted to a specialist training program by a college, they had to pass the AMC exams if they wanted general registration.

Finally, the long procession of New South Wales medical Acts was replaced by the Health *Practitioner Regulation National Law Act 2009*, mirroring the Queensland Act which all the states and territories agreed to use as the template to create for the first time a truly national process for registering medical practitioners.[44] More is said about that in Chapter 4.

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[41] *Medical Practitioners (Amendment) Act 1964 No. 13* (NSW).

[42] *Medical Practitioners (Amendment) Act 1972 No. 52* (NSW); *Medical Practitioners (Amendment) Act 1981 No. 55* (NSW); *Medical Practitioners (Amendment) Act 1982 No. 51* (NSW); *Medical Practitioners (Amendment) Act 1983 No. 41* (NSW); *Medical Practitioners (Further Amendment) Act 1983 No. 177* (NSW); *Medical Practitioners (Amendment) Act 1987 No. 127* (NSW).

[43] *Medical Practice Act 1992 No. 94* (NSW).

[44] *Health Practitioner Regulation National Law Act 2009 No. 86* (NSW).

The evolution of the New South Wales medical Acts has been described in detail, since it was one of the first two colonies to develop medical legislation, and in sufficient detail to show the many convolutions the legislation went through—at times to exclude, and at other times to facilitate the licensing of overseas-trained doctors.

Van Diemen's Land/Tasmania[45]

Many of the Tasmanian Acts evolved in response to similar issues (and prejudices) as those described above in more detail for New South Wales. Thus, only the changes that had important impacts on the ability of IMGs to register will be discussed here. All the Tasmanian medical Acts, as for the other jurisdictions, are summarised in Appendix A, Supplementary Table 1.

The first Van Diemen's Land Act, like the New South Wales one, was closely modelled on the Imperial *Medical Witnesses Act 1836*, but it is interesting that it was assented to eight months earlier in the junior colony.[46] As was the case in New South Wales, it became necessary to indicate who was a 'legally qualified medical practitioner', so this was the purpose of the 1838 Act, 1 Vict. No. 17. It replicated the New South Wales Act by allowing registration of anyone with a British or Irish degree or medical licentiateship but was more liberal by allowing for licensing with 'letters testimonial' of those already practising in the colony. It also provided for local apprenticeship of would-be doctors, then their assessment by the Court of Examiners created by the second 1837 Act. There were very few of these (Chapter 5), but they are of historical interest since this local training of doctors in Tasmania preceded the establishment of its medical school by 125 years.[47]

After Federation, Tasmania passed medical Acts in 1908 and 1918 that set the tone for the next fifty years. The core registerable qualifications were Australian, British or Irish, or from a university 'within the British dominions'. The 1937 Act essentially restricted registration to British subjects but gave the Board some discretion. By the 1950s, Council was able to award limited registration to a small, capped number of non-British graduates, with the requirement they practise in a hospital under supervision then pass an examination at another Australian medical school. Those who were successful were given the parochial qualification: Tasmanian Licentiate in Medicine or Surgery (TLMS). The 1973 amendment specified that IMGs with limited registration

[45] Citations for all the Van Diemen's Land/Tasmanian medical Acts referred to in this section are listed in the Bibliography under Government Acts and Regulations.

[46] *An Act to Provide for the Attendance of Medical Witnesses at Coroner's Inquests 1837 (1 Vict. No. 14)* (VDL).

[47] *An Act to Regulate the Practice of Medicine in This Colony 1837 (1 Vict. No. 17)* (VDL); Laurence Geffen, "A Brief History of Medical Education and Training in Australia," *Medical Journal of Australia* 201, no. 1 (2014): S20.

must pass an exam 'equivalent to the final examinations … [in medicine and surgery] at the University of Tasmania.'[48] That amendment also allowed the Governor to designate other qualifications if the Council recommended them.

The *Medical Act 1977,* depending on one's viewpoint, either made opaque or flexible the qualifications that would allow the Council to register practitioners in the state. It abolished the Schedule, which had listed the qualifying degrees, licentiateships and memberships, stating instead:

> the recognized primary qualifications are those declared by the Governor, by order made on the recommendation of the Council, to be recognized primary qualifications for those purposes.[49]

As we will see in Chapter 7, the consequence was a gradual increase in registration of IMGs from countries outside the British Commonwealth.

The next change to Acts affecting IMGs was the *Medical Practitioners Registration Act 1996*, which belatedly responded to the creation of the AMC twelve years earlier, changing those who could be newly registered in Tasmania to graduates of an AMC accredited medical school or those (all would have been IMGs) who passed the AMC examinations.[50]

Finally, the 2010 Act mirroring the Queensland principal Act brought Tasmania into the national medical accreditation scheme.[51]

Victoria

As noted above for Tasmania, many of the changes in the Victorian medical legislation followed similar themes to those in New South Wales, as the exemplar, but there were some differences to note here.

The first Act that governed registration in Victoria was the 1844 New South Wales Act, which created a medical board for the District of Port Phillip before Victoria became self-governing. One notable difference from New South Wales was that, as early as 1862, a Victorian Act made it illegal for someone to pass themselves off as medically qualified.[52] New South Wales took much longer to do that, and the political intrigues and community attitudes that played a part in the different approaches of the two colonies is discussed in Chapter 6.

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[48] The Tasmanian medical school produced its first graduates in 1970 (prosopography).
[49] *Medical Act 1977 No. 98* (Tas.), s. 14(2).
[50] *Medical Practitioners Registration Act 1996 No. 2* (Tas.).
[51] *Health Practitioner Regulation National Law Act 2009 No. 45* (Qld.); *Health Practitioner Regulation National Law Act 2010 No. 2* (Tas.).
[52] *Medical Practitioners Act 1862 (25 Vict. No. 158)* (Vic.)

One other notable point of difference between the Victorian legislation and that in the other states was a clause, in the 1915 Act, that specifically allowed doctors with a homeopathic qualification—from either the Boston Homeopathic Hospital or the New York Homeopathic College—to be registered, but limited to one person per year, and provided they worked at the Melbourne Homeopathic Hospital.[53]

The Other States

For the most part, similar themes to those described in some detail for New South Wales and Tasmania can be discerned in the medical legislation in the other states. For reasons of space, a detailed analysis of how IMGs were affected by each of the numerous medical Acts, in every jurisdiction, is provided in Supplementary Table 1 (Appendix A) rather than here. To my knowledge, this has not been published before. The next section examines the common themes, plus some points of difference, as the legislative framework evolved across the country.

Common Themes in the Medical Acts across the Australian Jurisdictions

The earliest Acts in every colony except South Australia specified that only those who were qualified to practise in UK or Ireland were registerable in that colony.[54] Even the first ACT and Northern Territory ordinances (1930 and 1935) stated that they could register only IMGs who were registered in UK (or had qualifications entitling them to be registered there).

South Australia's 1844 Act allowed that colony right from the start to consider registering a 'regular Graduate in Medicine of some foreign University which shall appear to the said Medical Board to be of sufficient credit and authority.'[55] The other jurisdictions subsequently opened the door to non-British or Irish graduates at differing times and to differing degrees: New South Wales in 1855, Victoria in 1865 and Queensland in 1867 began to accept some IMGs with non-British qualifications.[56] Western Australia only accepted British or Irish degrees until 1894, then broadened eligibility to anyone who was *registered* in the UK.[57] The 1894 Western Australian Act also allowed the registration of those with a medical diploma awarded after 'Three years' study in a British or Foreign School of Medicine.' The amendment that added this clause

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[53] *Medical Act 1915 (6 Geo. V No. 2753* (Vic.). The Melbourne Homeopathic Hospital later renounced practice of homeopathy and became Prince Henry Hospital.

[54] British Naval and Army surgeons were also registerable.

[55] *An Ordinance to Define the Qualifications of Medical Practitioners in this Province for certain purposes 1844* (8 & 9 Vict. No. 17) (SA).

[56] *Medical Practitioners Act 1855 (19 Vict. No. 17)* (NSW)*; Medical Practitioners Statute 1865 (28 Vict. No. 262)* (Vic.)*; Medical Act 1867 (31 Vict. No. 33)* (Qld.).

[57] *Medical Act 1894 (58 Vict. No. 36)* (WA).

to the draft Bill was not without controversy—as the Legislative Assembly debated it, Walter James pointed out that: 'An expert medical man, as a rule, did not travel to a colony where the language was different from his own', and John Richardson cautioned that 'American diplomas were obtained too easily to be of value.'[58] The amendment passed, nonetheless. But just one year later, the 1895 amendment to the Western Australian Act deleted the clause allowing recognition of 'foreign medical schools.'[59] Tasmania accepted only British qualifications until the 1908 Act extended eligibility to 'any university within the British dominions' then discretion to consider graduates from elsewhere in 1937.[60]

At differing times, every jurisdiction except Tasmania and Western Australia required non-British practitioners to have trained in a country that gave reciprocity to Australian-registered doctors. Victoria was the first, in 1906, to specify that graduates from a non-British country could only be considered if doctors registered in Victoria could practise in that third country without being required to pass any examination. Between 1915 and 1957, New South Wales, Queensland, South Australia, the ACT and NT followed suit, though the Victorian Act was softened in 1953 to allow the third country to require a period of hospital experience in it (provided it did not require examinations).[61]

Three states, starting with New South Wales in 1939, moved to give limited registration to IMGs from non-British countries so they could practise in an area of health workforce need. Western Australia, having the pressing problem of getting doctors to practise in its very remote regions, introduced regional registration certificates in 1940; after seven years' service, those IMGs were eligible for full registration. Victoria introduced an area of need pathway for IMGs in 1983.[62]

In obvious attempts to ensure the competence of IMGs who had trained in countries where the health system was less well understood, South Australia and Western Australia added clauses requiring their Boards to decide that the standard of the non-British degree was 'not lower than' that of the medical school in their own

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[58] Walter James, *Western Australia Parliamentary Debates, Legislative Assembly* (15 November 1894), 1434.; John Richardson, *Western Australia Parliamentary Debates, Legislative Assembly* (15 November 1894).

[59] *Medical Act Amendment Act 1895 (59 Vict. No. 17)* (WA).

[60] *The Medical Act 1908 (8 Edw. VII No. 32)* (Tas.); *Medical Act 1937 (1 Geo. VI No. 53)* (Tas.).

[61] *Medical Act 1906 (7 Edw. No. 2069)* (Vic.); *Medical Practitioners (amendment) Act 1915 No. 33* (NSW); *The Medical Act of 1925 (16 Geo. V No. 24)* (Qld.); *Medical Practitioners Act Amendment Act 1955 No. 41* (SA); *Medical Practitioners Registration Ordinance 1939 No. 2* (ACT); *Medical Practitioners Registration Ordinance 1957 No. 4* (NT).

[62] *Medical Practitioners (amendment) Act 1939 No. 5* (NSW); *Medical Act Amendment Act 1940 (4 & 5 Geo. VI No. 51)* (WA); *Medical Practitioners (Conditional Registration) Act 1983 No. 9948* (Vic.).

state.[63] Then, to further ensure comparability, New South Wales, Victoria, Tasmania and Queensland introduced their own examining committees, with examiners drawn from their medical schools.[64]

Finally, starting in the 1980s, every state but South Australia required all IMGs who desired general registration to pass the examinations held by the AMC. South Australia used those exams too, but the opaque and all-encompassing wording of their Acts between 1983 and 2010—i.e., applicants must have 'prescribed qualifications and experience' without specifying what they were in the Act—meant it did not need to be legislated.[65]

One provision that was added to medical Acts in the 1970s and 80s was the introduction of residency requirements by all jurisdictions except Tasmania, Victoria and the ACT.[66] It was clearly provoked by marked contemporaneous changes in IMG fluxes. The motivation for these amendments might be interpreted as racist, and the evidence will be discussed with the data in Chapter 7.

In summary, the legislation that determined which overseas-trained doctors could be registered in Australia has evolved in three main phases: (1) an initial one in the colonial period, which in most jurisdictions made it virtually mandatory for an applicant to have a British or Irish qualification, or to be otherwise registerable under the *Medical Act 1858* of the UK; (2) a second phase where there were ebbs and flows in the generosity of the jurisdictions to recognise non-British qualifications, sometimes for the purpose of encouraging doctors to practise in under-served locations; and (3) a final phase from the mid-1980s when nearly all IMGs (except some specialists, university academics and postgraduate trainees) were required to pass the AMC examinations. How these regulatory oscillations played out in practice will be seen Parts 2 and 3 of

[63] *Medical Practitioners Act 1919 (10 Geo. V No. 1372) (SA)*; *Medical Act Amendment Act 1956 (5 Eliz. II No. 35)* (WA).

[64] *Medical Practitioners (amendment) Act 1955 No. 23* (NSW); *Medical (Registration) Act 1957 No. 6084* (Vic.); *Medical Act 1959 No. 80* (Tas.); *Medical Act Amendment Act 1973 No. 30* (Qld.). Tasmania's school had not yet begun so they used examiners from other medical schools.

[65] *Medical Practitioners (Further Amendment) Act 1984 No. 10132* (Vic.); *Medical Amendment Act 1985 No. 70* (WA); *Medical Practitioners (amendment) Act 1987 No. 127* (NSW); *Medical Practitioners Registration (Amendment) Act 1993 No. 21* (ACT); *Medical Practitioners Registration Amendment Act 1985 No. 3* (NT); *Medical Practitioners Registration Act 1996 No. 2* (Tas.); *Medical Practitioners Registration Act 2001 No. 7* (Qld.).

[66] *Medical Act Amendment Act 1976 No. 70* (WA); *Medical Practitioners Registration Ordinance 1976 No. 67* (NT); *Medical Act Amendment Act 1979 No. 34* (Qld.); *Medical Practitioners Act 1983 No. 25* (SA); *Medical Practitioners (further amendment) Act 1983 No. 177* (NSW).

the thesis. The history of the examinations and other assessments IMGs were required to undergo is the topic of the next chapter.

Chapter 4

The Assessment of IMGs for Medical Registration

This chapter examines the historical development of processes used to judge whether IMGs could practise in Australia. It provides context to the material in all the remaining chapters, especially to the data and issues discussed in Chapters 10 and 11—the oral histories and interviews with assessors and employers of IMGs. It draws also on the evolution of the medical legislation dealt with in Chapter 3.

Period 1838 to ca. 1950

From the time when medical boards were created in each colony and territory until the 1950s, the boards made decisions about who to register without requiring any additional evaluation of their knowledge and skills (e.g., by an examination). They did this by demanding to see authentic certificates of qualifications, often some evidence that the applicant was 'of good character', and then deciding whether the qualification fitted the lists of eligible qualifications in the medical Acts which governed them.

As discussed in the previous chapter, the first medical Acts in all colonies except South Australia restricted the eligible qualifications to those obtained in Britain and Ireland, until some flexibility to consider other countries crept into Acts in most of the other colonies from the 1860s. This thesis (at least until the oral histories of contemporary IMGs in Chapter 10) is nearly all about those who managed to *achieve* registration. But it is instructive to look at the early minutes of the New South Wales Board to explore a few of those who did not.

At the last meeting of the New South Wales Board in 1838, two applications were declined (unsurprisingly) because they were 'unsupported by any Diploma or other Testimonial.' Early the next year, a William Howell was not registered because his diploma of LAH Dublin was 'not sufficiently agreeable to the terms of the Act'.[1] At an 1845 meeting, the Board showed leniency for two doctors whose testamur had been lost, on the basis of affidavits from colleagues who knew them: William Houston lost his on the *Indiana* when it caught fire; Barry Copper was on the *Isabella* when it was shipwrecked.[2]

Much more interesting was the case of Dr Jean Baptiste Charles Lammonerie dit Fattorini, and it is worth describing his battles with the New South Wales Board in a little detail. According to JCH Gill, Fattorini arrived in the colony about 1829.[3] Reports in Sydney newspapers suggest he was attached as a surgeon to the Sydney Dispensary

[1] NSWSA, Minutes of Proceedings of the NSW Medical Board, NRS9871-[7/5151]-3, 31 December 1838, 21 January 1839. An Amendment six years later added LAH Dublin to the registerable qualifications (Appendix A, Supplementary Table 1).
[2] NSWSA, ibid., 25 January 1845.
[3] JCH Gill, "Jean Baptiste Charles Lamonnerie Dit Fattorini, Late of Port Macquarie, NSW," *Royal Historical Society of Queensland* 9, no. 2 (1971): 141.

and the Benevolent Society between at least 1830 and 1834, though whether he was still practising after that is unclear.[4] Gill ascertained that he was involved in some agricultural activities and may have provided medical services to the Port Macquarie (NSW) convict hospital up to about the early 1840s.[5] But Fattorini must have decided about then that he should regularise his medical activities by being licensed by the new Medical Board. He first applied via his solicitor in 1843, but the application was denied. His next application was considered by the Board in April 1846. Their minute was brief, stating only that they had examined the Diploma he submitted, and could not register him because the Board could certify only those 'who produce the Diploma of some British or Irish University College or Hall.'[6] Although the Board minutes do not state what the diploma they rejected was, Fattorini later went public and published it in the Sydney Morning Herald: it was an MD, awarded in 1828 by the University of Göttingen, Germany.[7]

Fattorini was a persistent man. He tried again in 1847, this time submitting to the Medical Board 'an opinion of the [NSW] Attorney General that the Act … does entitle Dr Fattorini to the usual [medical licence] certificate.' The Board felt it understood the Act better than the chief government law officer, and disagreed. It reiterated that it was:

> of opinion that the obvious intention of the Act of the [Legislative] Council, and the wording of it distinctly expressed that no person shall be deemed a legally qualified Medical practitioner unless he be a Doctor or Bachelor of Medicine of some university, or a Physician or Surgeon licensed by some College of Physicians or Surgeons in Great Britain or Ireland – and that Dr Fattorini not holding the Diploma of a British or Irish University or College is not entitled to the usual Certificate of being a Licensed Medical Practitioner in New South Wales.[8]

The semantic ambiguity of that part of the Act was noted in Chapter 3. However, the Board appeared oblivious to it, despite having made it more obvious by erroneously inserting a comma after 'university'— a comma which was not present in the Act.

Dr Fattorini tried a fourth time in 1849 and his application was again denied.[9] That was not quite the end of the matter. His final attempt was to ask the New South Wales Supreme Court for a *rule nisi* against the Board. Fattorini's counsel drew the Court's attention to the ambiguity in the drafting of the Act and argued that 'university' could apply to a university in any country: that the words 'Great Britain or Ireland'

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[4] "Sydney Dispensary," *Sydney Gazette*, 7 August 1830, 3; "Annual Meeting of the Benevolent Society," *Sydney Gazette*, 3 June 1830, 2; "Benevolent Society: Account of the Late Anniversary Meeting," *Sydney Monitor*, 18 June 1834, 4.
[5] Gill, "Fattorini," 143-4.
[6] NSWSA, Board Minutes, 14 October 1843, 6 April 1846.
[7] "Appendix A: Diploma of the University of Göttingen," *SMH*, 4 August 1849.
[8] NSWSA, Board Minutes, 4 October 1847.
[9] Ibid., 2 April 1849.

referred only to the head of the phrase in which they were constituents.[10] The case was heard by three justices. The Solicitor-General appeared for the Board but said that he felt 'the construction of the Act … admitted of great doubt.' From the transcript, it appears that two of the judges substantially agreed with Fattorini and his counsel, but the Chief Justice eventually had his way and Fattorini's plea was defeated in a 2:1 majority judgment.[11] He never was registered in Australia and died 'after a long and painful illness' on 24 October 1853.[12]

Two years later, the New South Wales Act was amended to allow the possibility of registering practitioners who qualified in a country outside the hub of the Empire, and Victoria and Queensland followed suit in the 1860s. For most of the next hundred years, the medical boards registered those IMGs whose qualifications were listed in their evolving medical Acts, without requiring them to undergo examinations.

As mentioned in Chapter 3, the periods surrounding the two world wars saw amendments to many of the medical Acts to prevent the registration of IMGs regarded as enemy combatants. There were also moves by some boards to impede or prevent the registration of refugee doctors, particularly those who were Jewish and/or from Eastern Europe. The historiography of that issue has been elegantly and extensively dealt with by Egan Kunz and Gabrielle Wolf, and will be examined again in Chapter 7.[13]

Period 1950 to the present

Starting in the 1950s, New South Wales, Victoria, Western Australia, and Tasmania began to mandate examinations for IMGs who qualified outside the British system. An example was the Foreign Practitioners Qualification Committee (FPQC) created by the Victorian 1957 Act.[14] The University of Melbourne was consulted when the Act was drafted, and it provided the medical members of the committee. Others were ex officio from the university's teaching hospitals. The committee held examinations biannually for non-British IMGs, consisting of written papers and clinical examinations in medicine, surgery, paediatrics, and obstetrics/gynaecology, plus an assessment of English language competence. In the first ten years, 94 IMGs were examined and 65

[10] Counsel did not say the 'head of the phrase' but that is what he meant. Linguistically, the head of a phrase is the nucleus that determines the syntactic category of the whole phrase.

[11] Supreme Court, "Re Parte Dr Fattorini," *SMH*, 20 April 1849, 2.

[12] "Deaths," *Illustrated Sydney News*, 5 November 1853, 6.

[13] Egon F Kunz, *The Intruders : Refugee Doctors in Australia* (Canberra: Australian National University Press, 1975); Gabrielle Wolf, "Machinations of the British Medical Association: Excluding Refugee Doctors from Queensland's Medical Profession, 1937-1942," *American Journal of Legal History* 59 (2019); "The Law and Politics of Registering Doctors: Lessons from New South Wales, 1937-42," *UNSW Law Journal* 43, no. 4 (2020).

[14] See Chapter 3.

passed, whereupon they were entered in a separate medical register.[15] In a similar vein, the 1955 Act in New South Wales created a Medical Examining Committee, to conduct examinations and assess the English skills of non-British IMGs who were given regional or area-of-need registration. The failure rate for those examined in NSW was high.[16]

For a reader not familiar with how clinical skills are assessed in medical schools, specialist colleges, or for assessing IMGs, a brief description may be useful. Some clinical skills—particularly judgment in assessing scenarios listing patients' symptoms, physical examination findings, and laboratory results—can be assessed in paper examinations. These may be in multiple choice format, where the distractors are designed to put forward plausible diagnoses or courses of action, and the right answer is the one considered 'best'. Clinical reasoning and judgment can also be assessed in short answer or even essay formats. But most universities, colleges, and now the Australian Medical Council put most reliance on a Clinical Examination where the candidate is asked to interact with real patients and/or actors simulating patients, and is usually also given relevant investigations for that patient (e.g., X-Rays and/or blood tests). In the last 10-20 years, a commonly used format is the Objective Structured Clinical Examination (OSCE), in which candidates move from room to room to respond to different scenarios or patients. The advantages are that all candidates are tested on similar 'cases' and are assessed by a different examiner at each station. A disadvantage is that in real life a doctor may need much more time to complete a comprehensive assessment and discussion with a patient than the eight minutes typically allowed in a station.

In 1969, a more national approach to assessing and registering IMGs began to emerge. The Committee on Overseas Professional Qualifications was created, whose first term of reference was: 'To seek out, assemble and collate information relative to the recognition of overseas professional qualifications'.[17] When tabling the committee's 1978 report in Parliament, the Minister reported proudly that a national examination for assessing IMGs had been developed. It was to be administered by the new Australian Medical Examining Council (AMEC), which adopted the format of the Victorian FPQC

[15] VPRO: Medical Act, Foreign Practitioners Qualification Committee General Correspondence Files, VPRS 6345/P0000/300, 1960-1998; ibid., Letters 26 April 1967 and 14 April 1975, Secretary of Medical Board to Department of Health; Foreign Register, Medical Board of Victoria; VPRS 16392/P0001, 1, 1957-1981.

[16] NSWSA: Medical Board, Registration files of medical practitioners registered under Section 21c of the Medical Practitioners Act, NRS9875/1, 19/7573.

[17] Editorial, "A Committee on Overseas Professional Qualifications," *Medical Journal of Australia* 1 (1969): 863.

examinations. All IMGs who had graduated from medical schools not approved by the GMC, Ireland or New Zealand were required to pass the AMEC exam.[18]

In 1984, the Health Ministers in all states and territories agreed to the creation of a national body—the Australian Medical Council (AMC) —to oversee standards of medical education for Australians, as well as take responsibility for assessing IMGs. They were responding to the decision by the GMC to cease accrediting Australian and New Zealand medical schools—a delayed consequence of the United Kingdom joining the European Union.[19] Richard Smallwood wrote: 'The AMC's troubled birth is testimony to the difficulty of creating a national organisation in our federation of powerful jurisdictional interests.'[20] Thus, in 1986, the AMC took over the examinations, started by AMEC, for almost all IMGs desiring general registration in Australia.[21]

These days, the AMC accredits all medical schools in Australia and New Zealand, on a cycle that is rarely longer than ten years, and sometimes much shorter if issues of concern are identified. It accredits the training programs of the specialist medical colleges. And it functions as the first point of contact for all IMGs applying for registration in Australia, as well as running the examinations for those who seek general registration.[22]

Smallwood was writing at a time when those 'powerful jurisdictional interests' had also agreed to give up their autonomy to allow the formation of a single national medical board. The Medical Practice Acts that allowed this were mentioned in the previous chapter. The outcome, commencing on 1 July 2010, was the Australian Health Practitioner Regulation Agency (AHPRA), which now oversees national boards covering 15 health professions. The one responsible for registration of local and overseas-trained medical practitioners is the Medical Board of Australia (MBA).[23] The Medical Board has

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[18] Michael MacKellar, *Commonwealth Parliamentary Debates, House of Representatives* (3 April 1979), 1400; RB Blacket, "Foreign Medical Graduates. The Experience of the Australian Medical Examining Council and the Australian Medical Council, 1978-1989: Implications for Medical Immigration and the Medical Workforce," *Medical Journal of Australia* 153, no. 3 (1990): 125.

[19] Laurence Geffen, *Assuring Medical Standards: The Australian Medical Council 1985-2010* (Kingston, ACT: Australian Medical Council, 2010), ix. The New Zealand Medical Council invited the AMC to also accredit their medical schools, which has been done jointly since 1994 (Geffen p. 44).

[20] Richard Smallwood, "Foreword," in *Assuring Medical Standards*, vii.

[21] Ian Frank, personal communication, 14 March 2018.

[22] Australian Medical Council Limited, "Accredited Medical Schools," accessed 7 November 2021, https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-primary-medical-programs/accredited-medical-schools/; "Assessment and Accreditation of Specialist Medical Programs," accessed 24 November 2021, https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-specialist-medical-programs/; "Overview of Assessment Pathways," accessed 15 September 2021, https://www.amc.org.au/assessment/pathways/overview/.

[23] Medical Board of Australia, "Regulating Australia's Medical Practitioners," accessed 20 September 2021, http://www.medicalboard.gov.au/.

the final role in determining registration to practise medicine anywhere in Australia, receives advice and recommendations from the AMC and the specialist medical colleges, and exerts its own policies, procedures, and additional requirements at varying stages, but always at a final step.

For those coming via the Standard Pathway (passing the two stages of the AMC examinations), AHPRA requires that one year be spent under supervision after the AMC certificate is awarded, with a Provisional Registration until that is complete. It is also possible for an IMG to work in a supervised post (if they can find one), after passing the first AMC exam and while preparing for the second. The latter group is given Limited Registration.

AHPRA's performance at various levels has attracted criticism; one of the more vocal critics is Kerry Breen, a former President of the Medical Board of Victoria.[24] This thesis will give examples in the oral histories in Chapter 10 where AHPRA's performance has raised concern.

The Board's other important function is to monitor and regulate standards of practice for those already registered. The investigation of complaints against practitioners is delegated to an AHPRA local office and Medical Board in every state and territory, but final decisions are made by the national board after receiving that local advice.[25]

AMC Examinations

Table 4.1 sets out a timeline of the evolution of the AMC written and clinical examinations, which provides a necessary background for: (i) my analysis in Chapter 9 of the raw data from the AMC on its examinations, (ii) the discussion of the oral histories of those who took or were trying to pass the examinations (Chapter 10), and (iii) some of the matters discussed with those who assess or support IMGs (Chapter 11). It is based on an annotated timeline provided to me as personal communication by Ian Frank on 14 March 2018, when he was CEO of the AMC, together with the other sources as footnoted.[26]

[24] Kerry J Breen, "National Registration Scheme at 5 Years: Not What It Promised," *Australian Health Review* 40, no. 6 (2016): 675-7; Kerry Breen and Kym Jenkins, 10 June 2019, https://blogs.bmj.com/bmj/2019/06/10/australias-health-ministers-ignore-concerns-about-mandatory-reporting-of-unwell-doctors/.

[25] AHPRA, "Concerned About a Health Practitioner?" accessed 29 November 2021, https://www.ahpra.gov.au/Notifications/Concerned-about-a-health-practitioner.aspx.

[26] Ian Frank was AMC Chief Executive from 1991 to 2018.

Table 4.1: Timeline of significant events in evolution of AMC examinations

Period	Main events and changes
1986-1990	All IMGs must pass English test (exemptions if English is national language), then Multiple Choice Questions (MCQ) examination; after passing MCQ, clinical examinations must be passed in medicine, paediatrics, surgery and obstetrics/gynaecology.
1990	NSW no longer required overseas-trained specialists to take AMC examinations, unless they desired general registration. Their credentials were assessed by the relevant specialist medical college, and registration limited to their specialty field.
1992	New Zealand agreed for its medical schools to be accredited by AMC; their graduates were therefore registerable automatically in each Australian state. In response to the Macklin report, raising concerns about numbers of IMGs wishing to be registered in Australia,[27] quota of 200 per year sitting clinical exams introduced.
1993	The assessment process for overseas-trained specialists that was instituted in NSW in 1990 now applied nationally. Access to the 200 annual places in clinical examinations determined by rank order of marks in the MCQ exam.
1995	Full bench of Human Rights and Equal Opportunity Commission (HREOC) finds AMC in breach of Act, since the quota cut off was higher than the pass mark in the MCQ exam.[28]
1996	AMC appeals HREOC judgment to full bench of Federal Court and wins.[29] However, AMC voluntarily removes the quota and establishes calibration process with participating medical schools to validate standard of MCQ exam as comparable to standard of Australian medical graduate.
1997	IMGs stage hunger strikes in NSW and Victoria, protesting 'overly stringent registration tests'. Health Minister promised 100 extra places in universities (for last three years of courses), based on order of marks in a test run by the Australian Council for Educational Research—provided they worked in rural areas after graduation.[30]
1997	AMC launches publication *Annotated Multiple Choice Questions* to provide examples of questions from the MCQ banks, with annotations about expected answers.
1998	Following legal advice that the objective of AMC examination was to assess IMGs for purpose of registration and not as an immigration control, requirement for resident status to sit the AMC exams or apply for specialist registration was removed.
1999	AMC establishes Joint Standing Committee on Overseas Trained Specialists with the Committee of Presidents of Medical Colleges, to streamline processes for assessing overseas trained specialists.
2003	AMC publishes *Anthology of Medical Conditions*—a list of presenting conditions and key aspects for assessing each—to assist candidates preparing for examination.
2004	AMC clinical examination format changed to a 16 station Objective Structured Clinical Examination,[31] similar to examinations used in most Australian medical schools at that time.
2005	AMC implements computer-administered MCQ exam in Australia and internationally.
2006	State and territory medical boards agree to hand over to the AMC the task of Primary Source Verification of medical qualifications of all IMGs seeking registration in Australia.

[27] *The Future of General Practice (Issues Paper No. 3)*, (Melbourne: National Health Strategy, 1992), 5.

[28] *Dr Siddiqui v. Australian Medical Council and Commonwealth Minister for Health*, (1995) EOC 92-730.

[29] *Australian Medical Council v. Sir Ronald Wilson, Elizabeth Hastings and Jenny Morgan (Constituting the Human Rights and Equal Opportunities Commission) and Dr B Siddiqui and Commonwealth Minister for Health*, (1996) 68 FCR 46.

[30] Christopher Zinn, "Doctors Stage Hunger Strike in Australia," *British Medical Journal* 315, no. 7122 (1997): 1559; Bob Birrell, "Hunger Strikes and the Accreditation of Overseas Trained Doctors in Australia," *People and Place* 5, no. 4 (1997): 54.

[31] Used because of its high reliability: CPM Van der Vleuten, "The Assessment of Professional Competence: Developments, Research and Practical Implications," *Advances in Health Sciences Education* 1, no. 1 (1996): 47.

2007	Competent Authority model implemented—graduates from accredited medical courses in UK and Ireland, and IMGs who had passed the national licensing examinations in Canada and USA granted status towards the AMC certificate without having to take the examinations.[32]
2008	Council of Australian Governments[33] signs intergovernmental agreement to create a National Registration and Accreditation Scheme for the health professions.
2009-2010	Each state and territory gazettes its version of the *Health Practitioner Regulation National Law Act*, to create the Medical Board of Australia (MBA) as one of the boards of the Australian Health Practitioner Regulation Agency (AHPRA) from 1 July 2010.[34] The MBA now becomes the single body that registers all medical graduates for practice in Australia.
2011	AMC changes format of its MCQ examination to a computer-adaptive one, run via secure computer test facilities.[35]
2013	The National Test Centre for administering the AMC clinical examination was commissioned in Melbourne, to substantially increase the number of candidates who could be examined each year.
2014	AMC hands administrative responsibility for Overseas Specialist assessment and the Competent Authority pathway to AHPRA.
2015	AMC implements Electronic Portfolio of International Credentials (EPIC) process for primary source verification of medical credentials, outsourced to the US Educational Commission for Foreign Medical Graduates.[36]

Workplace-Based Assessment Pathway

A program for assessing the knowledge and skills of IMGs applying for general registration via the AMC standard pathway was developed by a team of medical academics led by Balakrishnan Nair at the University of Newcastle (NSW) and Hunter New England Health. In 2010, the AMC accredited it, as a pilot 6-month program, as an alternative to IMGs sitting the AMC clinical exam.[37] Candidates needed to have already passed the AMC's English language requirements and the MCQ exam, and be waiting for a place in the clinical exam. They were working in the Health Service's teaching hospitals in medicine, surgery, emergency, paediatrics, mental health, and obstetrics/gynaecology as junior medical officers. The assessments were by a combination of mini-clinical evaluation exercises (mini-CEX), case-based discussions, multi-source feedback (360º assessments), and end-of-term reports by supervisors. Those assessment methods are well validated, and currently used in many medical schools for

[32] Medical Board of Australia, "Competent Authority Pathway, 2019," accessed 12 January 2020, https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Competent-Authority-Pathway.aspx.

[33] COAG was comprised of the Prime Minister plus Premiers and Chief Ministers of the states and territories, plus other ministers for specific purposes. It was replaced in 2020, in response to the COVID-19 pandemic, by the National Cabinet.

[34] See Chapter 3.

[35] This examination format changes the difficulty of questions candidates are attempting according to their performance up to that point in the examination.

[36] ECFMG, "EPIC: Source Verified Physician Credentials," accessed 24 November 2021, https://www.ecfmgepic.org/index.html.

[37] Balakrishnan R Nair et al., "Workplace-Based Assessment for International Medical Graduates: At What Cost?," *Medical Journal of Australia* 200, no. 1 (2014): 41-2.

assessing their own students.[38] Candidates liked the program and felt it appropriate for judging their competence. Assessors noted that it was time consuming but in general considered it feasible and acceptable.[39]

Since the original pilot, the AMC has approved further sites. At the time of writing, there were eleven health services accredited to offer the program, at least one in each state but none in the territories.[40] An interview with the administrator of one of those programs is discussed in Chapter 11.

Specialist Pathway

Up till about 1990, state and territory boards made their own decisions about registering IMG specialists, guided by the wording of their medical Acts. As indicated in Table 4.1, after a short period when all IMGs (generalist or specialist) had to sit the AMC exams, the boards (since 1993) agreed to allow the AMC to refer specialists to the relevant Australian or Australasian specialist college. This process has been gradually refined, with the main changes being that the AMC *starts* the process by managing the verification of credentials—which it now outsources to the US Electronic Portfolio of International Credentials (EPIC) system. Once that is done, the candidate is passed on to the relevant specialist college. The colleges now regularly meet together with AHPRA to broadly coordinate their processes. The first step is to ask applicants to provide information about and verification of the training they underwent in their source country, together with details of any examinations they passed. In addition, they are queried about their subsequent experience and responsibilities in the practice of their specialty after they completed training. The college then makes a judgment about how comparable the IMG's training and experience in their specialty was to that of Australian-trained specialists. In 2005, when surveyed by the Australian Competition and Consumer Commission, this usually followed the schema set out in Table 4.2.

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[38] John J Norcini et al., "The Mini-CEX: A Method for Assessing Clinical Skills," *Annals of Internal Medicine* 138, no. 6 (2003): 477-9; Habiba Saedon, MHM Saedon, and SP Aggarwal, "Workplace-Based Assessment as an Educational Tool," *Medical Teacher* 32, no. 9 (2010): e369-71.

[39] Balakrishnan R Nair et al., "A Systematic Approach to Workplace-Based Assessment for International Medical Graduates," *Medical Journal of Australia* 196, no. 6 (2012): 399-401.

[40] Australian Medical Council Limited, "Workplace Based Assessment (Standard Pathway)," accessed 24 November 2021, https://www.amc.org.au/assessment/pathways/standard-pathway/workplace-based-assessment-standard-pathway/.

Table 4.2: Assessment framework colleges used to evaluate applications by IMG specialists (2005)[41]

College assessment	Likely outcome
1. Candidate does not have the experience, skills and experience required to be recognised as being a specialist practitioner.	Candidate is required to return to the AMC standard pathway and sit AMC exams for general registration.
2. Candidate has recognised qualifications, but requires additional training or orientation to be considered safe to provide medical services independently across the scope of practice expected of an Australian specialist in this area.	Candidate may be required to undertake formal training, examinations, and/or supervised practice for up to two years.
3. Candidate can be recognised as comparable to an Australian practitioner [in the specialty] and is recommended for registration to practise independently as a specialist.	Candidate is recommended to practise independently and has access to appropriate Medicare provider numbers.*

*See Chapter 2 for explanation of Medicare provider numbers.

Since the state and territory medical boards were supplanted by AHPRA and its national medical board, no IMG specialist is judged *fully* comparable to an Australian specialist. The three categories, corresponding approximately to categories 1 to 3 in Table 4.2 are *not comparable*, *partially comparable,* and *substantially comparable*. Even for those judged *substantially comparable*, AHPRA now requires that the applicant complete a period of 3 to 12 months practice under supervision, with a supervisor appointed by the college. The process is spelt out in some detail on the AHPRA website.[42]

One important recent change to procedures for licensing overseas-trained specialists to practise in a designated area of need is that AHPRA now requires them to apply directly to the relevant college. 'The college assesses the IMG's qualifications and relevant experience against the specified requirements of a position' and, if confirmed, the IMG can receive limited registration by AHPRA's Medical Board. Once working in that position, they can start the process of applying formally for specialist recognition if they wish.[43] It is very likely that these current processes for vetting specialists to practise in an area of need have been shaped by the Patel case, described in the last section of this chapter.

[41] ACCC and Australian Health Workforce Officials' Committee, *Review of Australian Specialist Medical Colleges: Report to Australian Health Ministers* (Canberra: Commonwealth of Australia, 2005), 30. Table slightly simplified from the original.

[42] Medical Board of Australia (AHPRA), "Guide to the Specialist Pathway: Information for International Medical Graduates," accessed 29 November 2021, https://www.ahpra.gov.au/documents/default.aspx?record=WD20%2F30478&dbid=AP&chksum=VjXVXsLaw%2FAQ%2FgGuHMqI0g%3D%3D.

[43] Ibid., 10-12.

The processes described above, which IMGs have needed to negotiate since the advent of the national framework under AHPRA, are summarised in Figure 4.1.

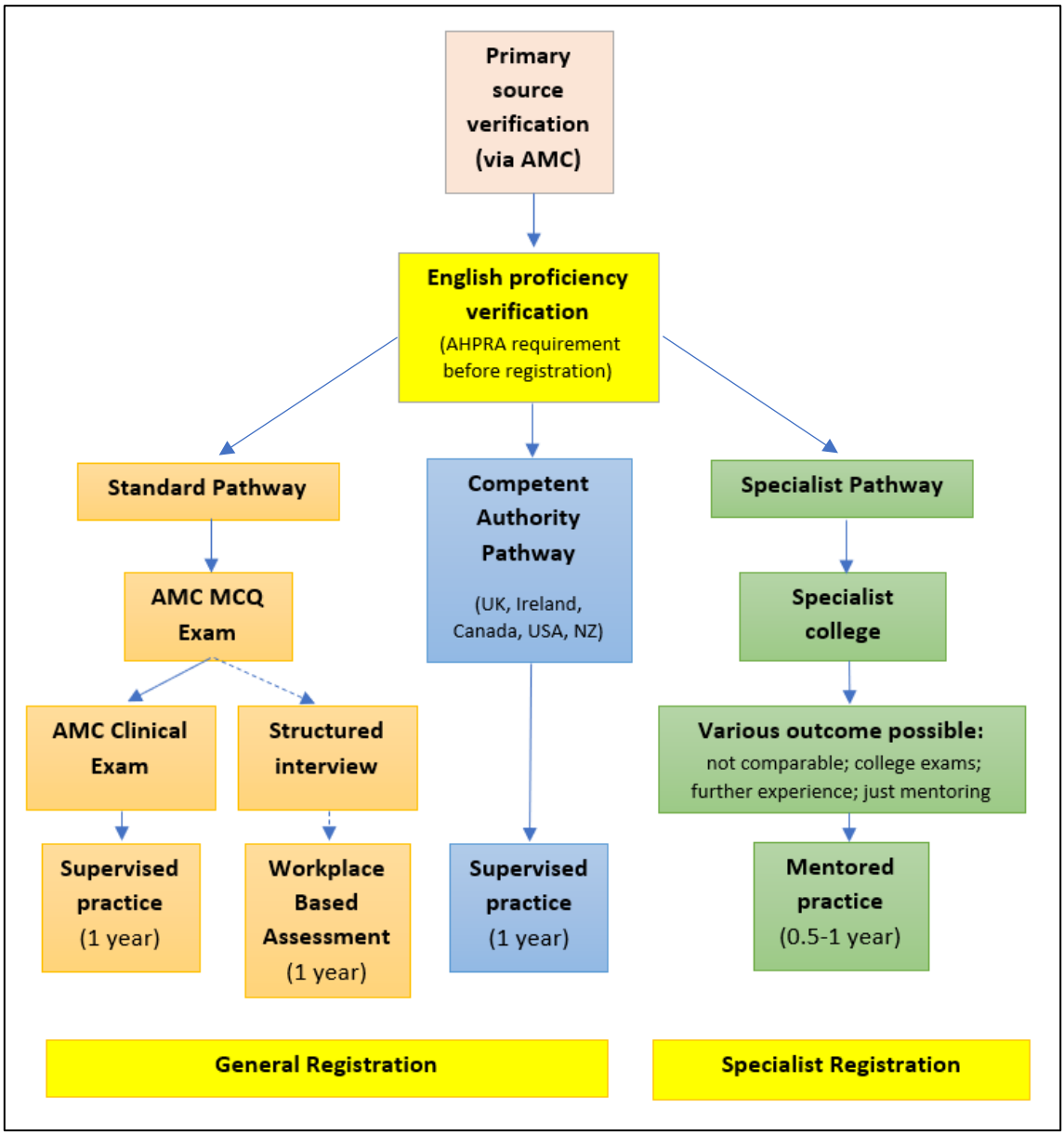

Figure 4.1: Current pathways to medical registration for IMGs (synthesised from descriptions on AMC and MBA websites cited previously). There are only a limited places in the Workplace Based Assessment pathway.

Recent Issues and Enquiries Concerning Registration and Support of IMGs

One event, perhaps more than any other in the last twenty years, focused regulators' attention on the need for rigorous assessment of the credentials of IMGs, especially those processed rapidly to fill a vacancy in an area of need. It developed between 2003

and 2005 in Queensland, and the reverberations echoed around the world. It was the case of Dr Jayant Patel. [44]

Jayant Patel qualified MBBS in 1973 from Saurashtra University in India, obtained his MS in surgery there, then practised as a surgeon in the US in New York State and Oregon. He was certified by the American Board of Surgery, and provided evidence he had been registered in Oregon in general surgery since 1989. Dr Patel was registered by the Queensland Medical Board on 11 February 2003, 'as a special purpose registrant to fill an area of need as a senior medical officer at Bundaberg Base Hospital.'[45] However, as a result of concerns raised by a nurse (Toni Hoffman) with the Shadow Minister for Health in March 2005, then with a Brisbane journalist (Hedley Thomas), two public enquiries were instituted in 2005. Ms Hoffman had told them that other staff were referring to Patel as 'Dr Death' behind his back, and that they believed he was responsible for numerous surgical complications and directly for several deaths. It was also claimed that nurses were hiding patients from him to avoid him recommending surgery.[46] A simple Google search had uncovered that Patel had been deregistered in New York, and censured and placed on restricted practice in Oregon.[47]

In fact, two enquiries were held on behalf of the Queensland government.[48] The first was terminated by an order of the Queensland Supreme Court on the grounds of apprehended bias by the original Commissioner. The second enquiry, headed by Geoffrey Davies AO, ended its work on 30 November 2005. Its first term of reference was to enquire into:

> The role and conduct of the Queensland Medical Board in relation to the assessment, registration and monitoring of overseas-trained medical practitioners,

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[44] Hedley Thomas, "Why Didn't They Check?," *The Courier-Mail*, 13 April 2005, 1; Sean Parnell and Tony Koch, "Coroner Probe in 'Dr Death' Scandal," *The Australian*, 15 April 2005, 6; Jo Chandler, "Dr Jayant Patel Is Being Investigated over the Deaths of 87 Patients in a Public Hospital in Country Queensland," *The Age*, 28 May 2005, 1,4; Chidanand Rajghatta, "Tale of Two Patels: One's a Lifesaver, the Other's Dr Death," *Times of India*, 21 April 2005, 15; Raymond Bonner, "Deaths and a Doctor's Past Transfix Australians," *The New York Times*, 19 June 2005, 19; "Surgeon Accused," *The Times (London)*, 6 August 2005, 50; "Australie: le 'Dr de la Mort' Condamné," *Le Figaro*, 1 July 2010; Meraiah Foley, "Inquiry into Australia's 'Dr Death'," *Irish Examiner*, 23 May 2005.

[45] Michael Steven Demy-Geroe, "Commission of Inquiry No. 1 of 2005, Medical Board of Queensland, Annexure Mdg-3," http://www.qphci.qld.gov.au/pdf/BHCI_Exhibit24-00.pdf.

[46] Hedley Thomas, "The Deadly Legacy of Dr Patel," *The Courier-Mail*, 13 April 2005, 13. Hedley Thomas received a Walkley Award for this investigative reporting.

[47] Ms Hoffman was the nurse in charge of the intensive care unit at the hospital. The shadow minister, Stuart Copeland, raised his concerns in question time, and the Minister replied that he would investigate: Stuart Copeland, *Queensland Parliamentary Debates* (22 March 2005); Oregon Medical Board, "Jayant M Patel, MD: Summary of Known Disciplinary Record," accessed 25 November 2021, http://www.oregon.gov/OMB/PDFforms/Patel.pdf; Thomas, "The Deadly Legacy," 13.

[48] Commissions of Inquiry Order (No. 1 and No. 2) 2005, under *Commissions of Inquiry Act 1950* (Qld.).

> with particular reference to Dr Jayant Patel and persons claiming to be overseas-trained medical practitioners.[49]

Briefly, the facts that emerged were that the Bundaberg Base Hospital suddenly found itself without any general surgeon. Evidence was presented that Queensland Health had systematically alienated the surgeons in the town, over a period of at least a decade, with the result that one by one they resigned to concentrate on private practice and instead used private hospitals for their patients. The commissioner summed up, saying: "It is clear at the very least that, by late 2002, the relationship between the Base and its medical staff had become a very unhappy one.'[50]

This would have created a crisis for the hospital, so the medical director engaged a recruiting agency to advertise overseas for the position of 'Senior Medical Officer–Surgery.' There was an almost immediate response from Dr Patel in Oregon, which one of the recruiting consultants followed up with a phone call, then reference-checking also by telephone. As a result, the agency reported that they considered Dr Patel was well qualified, and the Bundaberg Medical Director offered him the appointment for twelve months, subject to three conditions: (i) the Minister's delegate needed to determine that the position was in an area of need pursuant to s135 of the *Medical Practitioners Registration Act 2001*,[51] (ii) the Queensland Medical Board granted registration, and (iii) Dr Patel obtained a temporary working visa.[52]

The evidence that emerged from the Davies enquiry indicated that at least 13 deaths were directly attributable to lack of skill and care by Dr Patel, and another four were likely.[53] The recruiting agency was criticised for missing (based on the notes of their phone interviews to check references) probable warning signals in the referees' comments; Queensland Health was castigated for creating an unsafe environment in the Bundaberg Hospital; Queensland government was cited for concealing adverse information; and the hospital administration was criticised for not providing sufficient oversight of Dr Patel's work—especially after multiple concerns had been raised by his colleagues. Most relevant to the arguments of this thesis, though, the Queensland Medical Board was criticised for inadequate vetting of Dr Patel's credentials, and for not asking advice from the relevant specialty college, the RACS.[54] In partial defence of the Board, Patel had made a false declaration by answering in the negative the question:

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[49] Geoffrey Davies, "Queensland Public Hospitals Commission of Inquiry Report," (Brisbane: Queensland Government, 2005, available at http://www.qphci.qld.gov.au/final_report/Final_Report.pdf), preliminary page 3.
[50] Ibid., pp. 44-62.
[51] See Appendix A, Supplementary Table 1 (Qld.).
[52] Davies, "Commission of Inquiry Report," 64-70.
[53] Ibid., p. 184.
[54] Ibid., pp. 68-9, 135-40, 483, 537.

'Has your registration as a health practitioner ever been cancelled or suspended … in any State or Territory or in another country?'[55] It was for this falsehood that he was finally convicted in 2013, having pleaded guilty to fraud.[56] He had previously been convicted of manslaughter in the Queensland Supreme Court but had the conviction overthrown by the High Court.[57] The Medical Board of Australia irrevocably cancelled Dr Patel's registration, but only after his appeal was rejected by the Queensland Civil and Administrative Tribunal as late as 2015.[58]

One adverse consequence of the wide publicity about the Patel case was an immediate increase in 'doctors who appeared foreign being targeted for racial slurs and abuse'.[59] Nuwan Bandara, a Malaysian-trained paediatrician who was working in Townsville, Queensland in 2005 and whose oral history contributes to Chapter 10, said: "It was a bit of a stressful time" to be of Indian parentage.[60] However, a valuable consequence of the case was additional vetting of IMGs before they started work. The Queensland Medical Board immediately started 'double-checking the credentials of all the State's overseas-trained doctors'.[61] More important actions came from the meeting of the Council of Australian Governments (COAG) in early 2006. Following a recommendation about assessment of IMGs by the Productivity Commission the previous year (partly influenced by the Patel case), COAG agreed to establish nationally consistent assessment of IMGs, including off-shore screening exams, and assessment of competence against standardised position descriptions, interviews and supervision.[62]

Another process, which began in February 2003, was an investigation by the Australian Competition and Consumer Commission (ACCC) into the processes used by the RACS to control entry to the profession, including recognition of overseas-trained surgeons. For some time, there had been allegations that the college ran a 'closed shop', restricting numbers entering it for what many assumed were commercial reasons. The ACCC imposed several conditions on the college, requiring greater transparency in its training and assessment processes generally, and that 'the test for determining whether

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[55] Demy-Geroe, "Commission of Inquiry No. 1 of 2005, Medical Board of Queensland, Annexure Mdg-3". 1-2.

[56] David J Carter, "Correcting the Record: Australian Prosecutions for Manslaughter in the Medical Context," *Journal of Law and Medicine* 22 (2015): 589.

[57] *Patel v the Queen*, (2012) HCA 29.

[58] *Medical Board of Australia v Patel*, (2015) QCAT 133.

[59] Sanjiva Wijesinha, "Australians See Dr Death in Every Overseas-Trained Doctor," *The Age*, 14 June 2005, 13; Mukesh Haikerwal, "Observations from an Overseas Trained Doctor," (Australian Press Club, 20 July 2005).

[60] Nuwan Bandara, interviewed by author, Townsville (video), 19 June 2020.

[61] Mark Colvin, "Queensland to Review Overseas-Trained Doctors," (ABC Radio National, 13 April 2005).

[62] Productivity Commission, *Australia's Health Workforce: Research Report* (Canberra: Commonwealth of Australia, 2005), 127; Rick McLean and Jan Bennett, "Nationally Consistent Assessment of International Medical Graduates," *Medical Journal of Australia* 188, no. 8 (2008): 464.

overseas-trained surgeons should be able to practise in Australia should be redrafted to require that they be as competent as Australian-trained surgeons, rather than the ambiguous requirement of "equivalency".'[63] That latter recommendation (or the neglect of it) will be revisited when the oral histories of two contemporary IMG surgeons are examined in Chapter 10.

On receipt of the 2003 recommendations from the ACCC, COAG requested ACCC to conduct a wide-reaching examination of eleven other specialist colleges. The review was done jointly with the Australian Health Workforce Officials' Committee, and was reported to the Australian Health Ministers in July 2005. The Patel case was referred to obliquely in that report, and is likely to have triggered at least one of the recommendations. Another that related particularly to the assessment of IMGs was that:

> Further consideration should be given to the options for streamlining and making more accessible mutual recognition, advanced standing and access to training resources which would take into account the stage of the career of the overseas trained specialist and the nature of their practice and experience.[64]

How well colleges have responded to that recommendation will be interrogated in Chapters 10 and 11.

One more recent enquiry must be mentioned. Known as the *Lost in the Labyrinth* report, its origin was in a private member's motion in 2010 in the House of Representatives, by the National Party member for Maranoa (rural Qld.), the Hon. Bruce Scott.[65] It is instructive to reproduce a part of his speech to the motion, because it gives insight into community concerns about availability of medical care (particularly in rural areas), the awareness of the importance of IMGs, and the tribulations some were facing while trying to be registered. His remarks also provide context for historical and current issues that emerge in some of the oral histories discussed in Chapter 10.

> The reason I have brought this issue to the attention of the House is that it has been causing great distress for a number of doctors in my electorate of Maranoa and I know across many parts of Australia, particularly in Queensland. ... I will talk generally about the need to ensure that we provide our international medical graduates with the support they need to serve our rural communities. There is much concern that the current process to assess the competency of overseas trained doctors is discriminatory and that the process to approve registration for these doctors lacks transparency ... It has now been five years since ... [the ACCC] report was published and I think it is timely to conduct a parliamentary inquiry into the

[63] Australian Competition & Consumer Commission, "A.C.C.C. Proposes Surgical College Reform to Help Address Surgeons Shortage," news release, 2003, https://www.accc.gov.au/media-release/accc-proposes-surgical-college-reform-to-help-address-surgeons-shortage.

[64] Australian Competition & Consumer Commission and Australian Health Workforce Officials' Committee, *Review of Australian Specialist Medical Colleges: Report to Australian Health Ministers*, ix.

[65] 'Honorable' because he had been elected Deputy Speaker. The electorate is large, stretching to the Northern Territory and South Australian borders, and large parts of it are remote and underdoctored.

> assessment practices of Australia's medical colleges so that we can see what has been improved and what needs further improvement, particularly in relation to transparency. … Another complaint that has been brought to my attention is the inappropriate use of the pre-employment structured clinical interview, the PESCI, in assessing the competency of overseas trained doctors … there have been reports that some doctors are finding that they are passing their college clinical exams but failing the PESCI, which is administered by the Medical Board of Australia and a relatively new organisation, the Australian Health Practitioner Regulation Agency—AHPRA, which came into effect in July of this year.[66]

The motion was scheduled for a vote in November of 2010 but, in an unusually bi-partisan response, the Minister for Health and Ageing (Hon. Nicola Roxon MP, Labor) pre-empted it by referring the issues to the House Standing Committee on Health and Ageing: its purpose was to enquire into the 'registration processes and support for overseas trained doctors'.[67] The enquiry received 184 submissions and reported to the Parliament in March 2012. It made 45 far-reaching recommendations, which (in a slightly edited form) are reproduced in Appendix A, Supplementary Table 2. They recommended actions by all the specialist colleges, and six arms or agencies of government: specifically, the AMC, COAG, Medical Board of Australia/AHPRA, Australian Government Department of Health and Ageing, the Australian Health Ministers Council, and Health Workforce Australia. The largest number were directed at AHPRA's national Medical Board.[68] The report has led to significant improvements in some areas, which will be discussed in Chapters 10 and 11, but at least 15 of the recommendations are still unmet.

As mentioned at the start of this chapter, the material presented here provides context for the data in Parts 2 and 3 of the thesis. Issues highlighted in the *Lost in the Labyrinth* report, which at the time of writing remain unresolved, will be among those discussed in Chapter 12.

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[66] Bruce Scott, *Commonwealth Parliamentary Debates, House of Representatives* (18 October 2010), 615.

[67] Nicola Roxon, "Registration, Accreditation and Support Processes for Overseas Doctors ", news release, 25 November 2010, https://parlinfo.aph.gov.au/parlInfo/download/media/pressrel/398250/upload_binary/398250.pdf;fileType=application/pdf#search=%22registration%20processes%20and%20support%20for%20overseas%20trained%20doctors%22. 'Bipartisan' because the originator, Mr Scott, was from a party in opposition to that of the Minister at the time.

[68] House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the Inquiry into Registration Processes and Support for Overseas Trained Doctors* (Canberra: Commonwealth of Australia, 2012), xx-xxxiii.

PART 2

THE MEDICAL IMMIGRANTS: 1838-1984

Chapter 5

The Prosopography: IMGs in Australia, 1838–1900

One of the main tasks of this thesis has been to construct, then interrogate, a prosopography of Australia's medical immigrants—beginning in 1838 when the first colonial medical registers were instituted and ending at a cut-off date of 1984, the year the Australian Medical Council (AMC) was founded. This chapter presents the methodology, and the main quantitative findings in the colonial period. The period from 1901 to 1984 is the subject of Chapter 7.

Prosopography, or group biography, is described by Matthäus Heil as a discipline to collect and organise evidence relating to a group of historical individuals, and an analytical approach to make use of the collected data.[1] My intention has been to use it as a tool in this and the next chapter for a 'bottom up' approach to describing the history of medical immigration. While narratives of interesting or informative individuals are explored in later chapters, the prosopography is an attempt to avoid the danger referred to by Douglas Guthrie, when he wrote about the historiography of medicine:

> The writer ... may be tempted to exaggerate the importance of great discoveries and to lay great stress on the lives of famous men. It should be remembered that this is only one aspect of history, a survey of the peaks and not the valleys, a study of the milestones rather than of the miles between.[2]

Prosopography has been applied in many settings. Some have used it to compile profiles of individuals from antiquity: for instance, Roman citizens who appeared in Juvenal's poems, or who were mentioned in catalogues and documents in Roman-occupied Athens.[3] A classic work using this approach was Ronald Symes' book in 1939, *The Roman Revolution*.[4] More recently, the development of desktop computing and relational databases have provided historians with powerful tools to assemble and interrogate large quantities of data, greatly assisting prosopographical research.[5] Lawrence Stone, while recognising its weaknesses, describes prosopography as 'a tool with which to attack two of the most basic problems in history', one of which, relevant to this thesis, concerns social structure and social mobility.[6]

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[1] Matthäus Heil, Prosopography, (New York: Oxford University Press, 2011), Introduction, para 1.
[2] Douglas Guthrie, "On Writing a History of Medicine," *International Record of Medicine and General Practice Clinics* 169, no. 11 (1956): 700.
[3] John Ferguson, *A Prosopography to the Poems of Juvenal* (Bruxelles: Latomus, 1987); Geoffrey CR Schmalz, *Augustan and Julio-Claudian Athens: A New Epigraphy and Prosopography* (Leiden: Brill, 2009).
[4] Ronald Symes, *The Roman Revolution* (Oxford: Oxford University Press, 1939).
[5] KSB Keats-Rohan, "Prosopography and Computing: A Marriage Made in Heaven," *History and Computing* 12, no. 1 (2000): 7.
[6] Lawrence Stone, "Prosopography," *Daedalus* 100, no. 1 (1971): 46.

In the historiography of medicine, Michèle Stokes used this methodology to construct a group biography of Harley Street medical practitioners in London, and then to analyse characteristics of the doctors who established a practice at an address that, for many, 'represented the pinnacle of their career.'[7] Another to use prosopography to explore collective properties of a medical group is Georgeta Nazarska, who studied female medical graduates in Bulgaria in the years after the nation's formation.[8] Closer to home, Fallon Mody recently constructed a prosopography of international medical graduates (IMGs) who migrated to Victoria between 1930 and 1960.[9] I will draw on some of her findings when I write about this period in that state. Another database—effectively a prosopography—is the Australian Medical Pioneers Index (AMPI). This began with the work of the late David Richards, an English epidemiologist and social historian, who created a card file of colonial IMGs who practised in Australia up till 1863. The sources of information were numerous, including shipping records, newspapers, books and monographs. It was taken over and is now edited by Stephen Due and hosted as a publicly available website via VICNET and the State Library of Victoria.[10] I have consulted it to check details for some IMGs, during the period AMPI covers, especially when handwriting in the primary sources was difficult to make out.

The contributions of these other scholars to a prosopography of Australia's medical immigrants were intentionally focused on particular periods and particular groups of immigrants. What the present prosopography aims to create is a complete listing of every overseas-trained doctor, in every colony, state and territory over the entire period since records were systematically collected until the birth of the AMC. When Stone spoke about weaknesses of the methodology, he referred to 'collectors of butterflies' and 'quarries from which to dig out information about particular individuals.'[11] Indeed, the present compilation has been used (in chapter 6) to dig from the 'quarry', and it could be used similarly by other scholars of medical migrants in the future. But the greater value of this prosopography is for discerning sociological and geopolitical trends and patterns in the medical component of what John Mathew and

[7] MIchèle Stokes, "A Measure of the Elite: A History of Medical Practitioners in Harley Street, 1845-1914." (PhD, University of London, 2004),

[8] Georgeta Nazarska, "Bulgarian Women Medical Doctors in the Social Modernization of the Bulgarian Nation State (1878-1944)," *Historical Social Research* 33, no. 2 (2008).

[9] Fallon Mody, "Doctors Down Under: European Medical Migrants in Victoria (Australia), 1930-60" (PhD, University of Melbourne, 2018).

[10] Australian Medical Pioneers Index, "About AMPI," accessed 10 February 2019, http://www.medicalpioneers.com/about.htm. Stephen Due extended AMPI's coverage to 1875.

[11] Stone, "Prosopography," 49.

WD Borrie called 'the peopling' of Australia.[12] This can only really be done when every individual in a group is counted.

Methodology and Sources

The core information collected for the IMGs registered in each colony, state or territory was their name, up to three of their medical qualifications,[13] when and where these were conferred, and the year the IMG was first registered in the Australian jurisdiction. The data were extracted into Microsoft Excel spreadsheets then transferred to the relational database, Microsoft Access. The first qualification listed was the earliest one that allowed that individual to be registerable as a medical practitioner. Other key information obtained was the year of Australian registration, registration certificate number (when listed), and country of each qualification. Additional information, such as dates and places of birth and death, was also recorded in some instances but was usually not available from the principal sources noted below. A sample of a fragment of the prosopography database is shown in Figure 5.1.

[12] John Mathew, "The Peopling of Australia," *Nature* 62, no. 1614 (1900), 549; WD Borrie, *The European Peopling of Australasia: A Demographic History, 1788-1988* (Canberra: ANU, 1994).

[13] Focusing on those that allowed them general medical licensure, usually omitting later specialist qualifications.

Year registered	Last name	Other names	Qualification 1	University qual 1	Country qual 1	Year qual 1	Qual 2	University qual 2	Country qual 2	Year qual 2
1889	Birchall	Thomas Barrow	MB ChM	Glasgow	Scotland	1879				
1889	Wheeler	Edward Henry	LKQCP Ireland		Ireland	1887				
1889	Kenny	Frederick Hamilton	LSA Lond		England	1881	MRCS Eng		England	1882
1889	Reid	Robert George	LRCP LRCS Edin LFPS Glasg		Scotland	1888	MD	Durham	England	1908
1889	Johnson	Frederick Miller	MB ChM	Edinburgh	Scotland	1886	MD	Edinburgh	Scotland	1888
1889	Macdonald	George Bothwell Douglas	MB ChM	Aberdeen	Scotland	1887				
1889	Bagshaw	Thomas Washington	MD	Cambridge	England	1885				
1889	Swindells	John Adam	MRCS Eng		England	1879				
1889	Moreton	Charles Peyton	MRCS Eng		England	1864	LSA Lond		England	1867
1889	Adams	John	LRCP LRCS Edin LFPS Glasg		Scotland	1888				
1889	Pacey	Frederick John	LRCP LRCS Edin LFPS Glasg		Scotland	1888				
1889	Laycock	George Lockwood	MB ChM	Edinburgh	Scotland	1876				
1889	Warren	Thomas	LRCP LRCS Edin LFPS Glasg		Scotland	1888				
1889	Lawrence	Henry	MRCS Eng		England	1850	LSA Lond		England	1850
1889	Lawrence	Arthur Septimus	MB ChM	Edinburgh	Scotland	1888				
1889	Corry	Alexander	MD MAO	Royal U	Ireland	1885				
1889	Willmot	Robert	MRCS Eng		England	1863	LSA Lond		England	1865
1889	Anderson	Thomas Cochrane	MB ChM	Aberdeen	Scotland	1882				
1889	Harkin	Charles Fitzmaurice	MB ChB	Dublin	Ireland	1888				
1889	Keogh	Eustace Julian	MB ChM	Edinburgh	Scotland	1888				
1889	Massey	Harry Massey	MRCS Eng		England	1882	LRCP Lond		England	1882
1889	Macnutt	George Augustus	MRCS Eng		England	1881	MD	Brussells	Belgium	1885

Figure 5.1: Screenshot of left side of a segment of the Victorian prosopography database (certificate nos. 1530-56) showing some of the IMGs registered during 1889. Columns to the right of this field (not able to fit on this page) contain data on a third qualification, if any, and other fields for notes and data on birth and death when available.

Primary Sources

The principal source in every colony, state, and territory was the medical register, which their Medical Practitioner Acts required them to maintain. The details of those sources are provided below, together with comments about their completeness and some conditions of access. Sometimes a register provided no more details than the practitioner's name, address, and when they were registered—in those circumstances, the primary source for their registrable qualifications and hence country of training became the medical board's minutes. Some details of the graduates of Australian medical schools were also extracted from the registers, so the contributions of the IMGs to the overall medical workforce in each year could be calculated.[14]

New South Wales

Volumes of the New South Wales medical register, from 1838 till 1980 are held in the New South Wales State Archives and Records (NSWSA) in series NRS-15581: on microfiche until 1901, then in bound handwritten volumes. However, after record #9565 in September 1954, the register stopped recording the qualifications of registrants and where they were obtained. To complete this portion of the prosopography, information on registrants' qualifications was therefore extracted from the Minutes and Proceedings of the New South Wales Medical Board, series NRS-9871, to 6 June 1984. The minutes from that date onwards are embargoed since they contain records of disciplinary hearings into potentially living practitioners.

Van Diemen's Land/Tasmania

The source material for this section of the prosopography is held in the Tasmanian State Library and Archives in several series: CB12/1 (1841-1901) and AE408/1/1-8 (1908-87), the Minutes of Meetings of the Medical Council of Tasmania; AE409, Register of Legally Qualified Medical Practitioners in Tasmania, annual printed lists from 1908; AE410, Register of Legally Qualified Medical Practitioners in Tasmania, 1930-92; AE411, Alphabetical Register of Legally Qualified Medical Practitioners in Tasmania, 1885-1984. The gap in information between 1901 and 1908 from those sources was completed using the lists published in the Hobart Gazette (1901-06) and Tasmanian Government Gazette (1907).[15] The gazettes were also used to clarify spelling and other details when the handwritten records in the archive could not be clearly made out.

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[14] For local (and New Zealand) graduates, just their years of graduation and registration and the university conferring the degree were extracted.

[15] Hobart Town Gazette (later Hobart Gazette, then Tasmanian Government Gazette), 1840-1984, accessed 3 January 2020, https://stors.tas.gov.au/TGG$tv.

Examples of material in the New South Wales and Tasmanian registers are in Figures 5.2 and 5.3.[16]

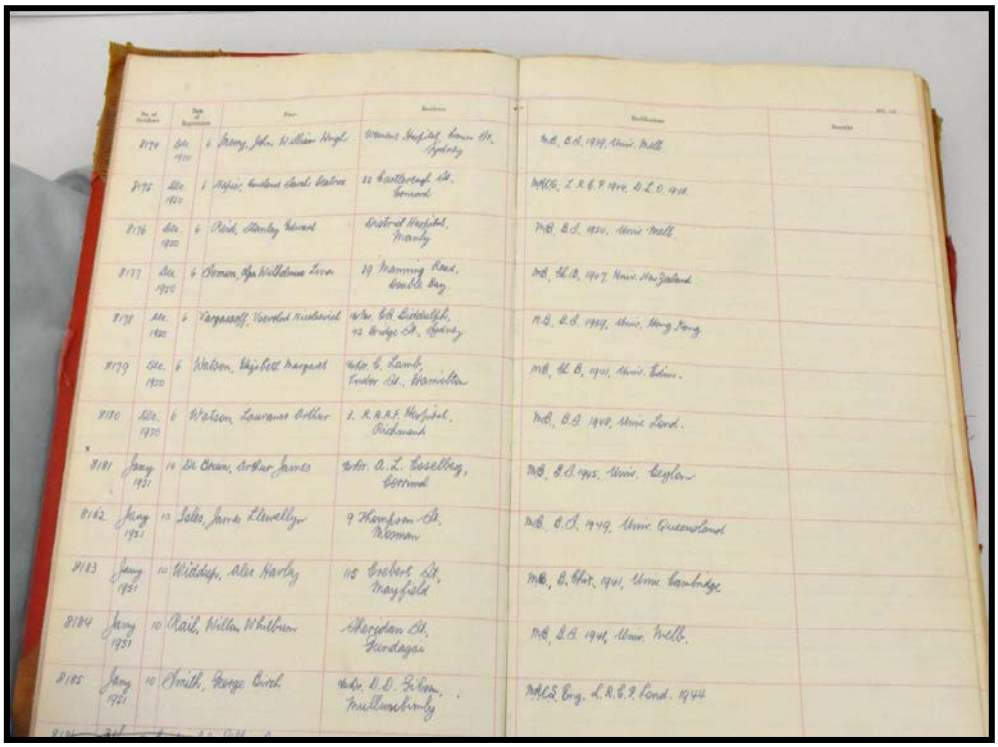
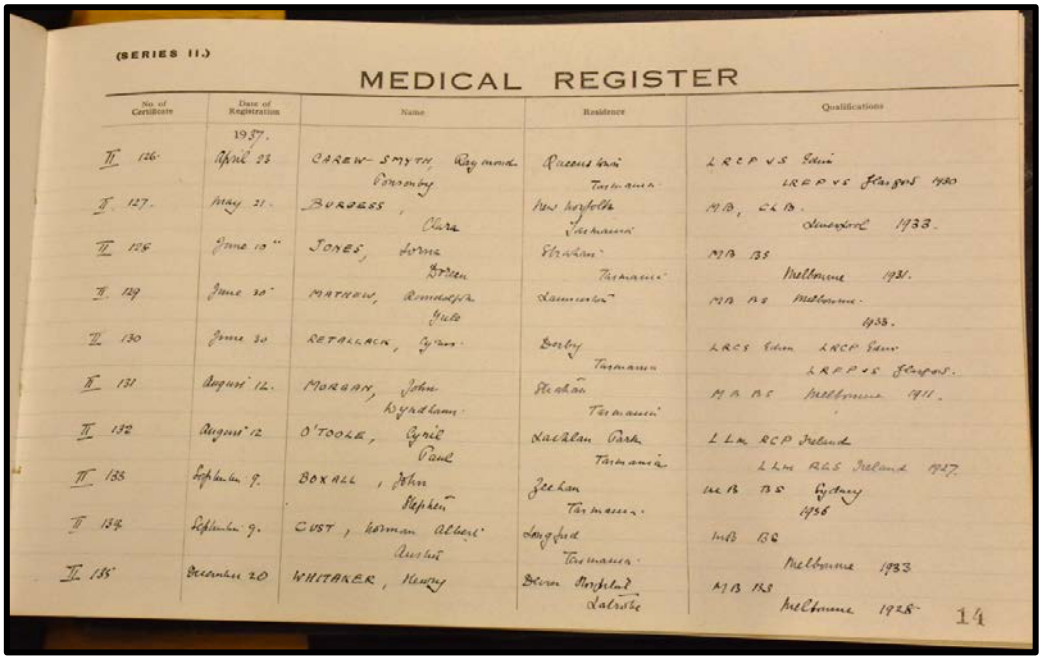


Figure 5.2: Sample of content in NSW Medical Register for 1950-51.



(SERIES II.)

MEDICAL REGISTER

No. of Certificate	Date of Registration	Name	Residence	Qualifications
	1937.			
II 126	April 23	CAREW-SMYTH, Raymond Cornamby	Queenstown Tasmania	L.R.C.P. V.S. Edin. L.R.F.P. V.S. Glasgows 1930
II 127	May 21	BURGESS, Clara	New Norfolk Tasmania	M.B., C.M. Aberdeen 1933.
II 128	June 15	JONES, Lorna Ellen	Evandale Tasmania	M.B. B.S. Melbourne 1931.
II 129	June 30	MATHEW, Rendelph Yule	Launceston	M.B. B.S. Melbourne 1935.
II 130	June 30	RETALLACK, Cyril	Derby Tasmania	L.R.C.S. Edin. L.R.C.P. Lond. L.R.F.P.S. Glasgows.
II 131	August 12.	MORGAN, John Wyndham	Sheffield Tasmania	M.B. B.S. Melbourne 1911.
II 132	August 12	O'TOOLE, Cyril Paul	Lalalan Park Tasmania	L.L.M. R.C.P. Ireland L.L.M. R.C.S. Ireland 1927.
II 133	September 9.	BOXALL, John Stephen	Zeehan Tasmania.	M.B. B.S. Sydney 1936
II 134	September 9.	CUST, Norman Albert Austin	Longford Tasmania.	M.B. B.S. Melbourne 1933
II 135	December 20	WHITAKER, Kenney	Devon Northland Latrobe	M.B. B.S. Melbourne 1928.

14

Figure 5.3: Page from the Tasmanian Medical Register for 1937

[16] New South Wales State Archives (hereafter NSWSA): NRS-15581-2-0-4; Tasmanian Archives (hereafter TA): AE409.

Figure 5.4 is an extract from the minutes of the Medical Council of Van Diemen's Land, used as the source material to compile the colonial years of the Tasmanian prosopography.[17]

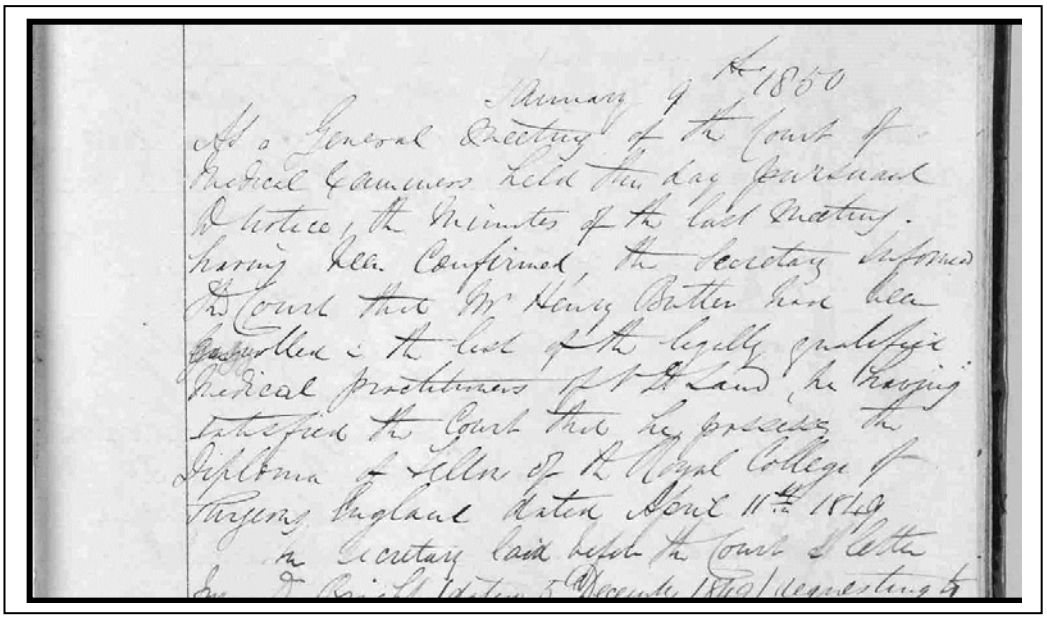


Figure 5.4: Extract from minutes of Medical Council of Van Diemen's Land, 9 January 1850 indicating that Henry Butler was admitted as a legally qualified practitioner in Van Diemen's Land on the basis of his Fellowship of the RCS England, conferred in 1849.

Victoria

The Victorian section of the prosopography was extracted from the handwritten volumes of the medical registers of the Port Phillip District, then Victoria, held in the Victorian Public Records Office (VPRO) from 1844 to 1986 as series VPRS16394, P1-5. When handwriting was unclear, details were checked using the digitised archives of the Victorian Government Gazette (Port Phillip Government Gazette between 1840 and 1849).[18]

South Australia

The South Australian medical register is held by State Records of South Australia (SRSA), starting from 1844 in series GRS/11897. This is available unrestricted to 1920, but thereafter was embargoed by the old Medical Board of South Australia. The likely reason is that the Board's minutes and the medical register were entered together in the same volumes. The Board's successor is the Australian Health Practitioner

[17] TA: CB12/1.
[18] State Library of Victoria, "Victoria Government Gazette: Online Archive 1836-1997," accessed 3 June 2021, http://gazette.slv.vic.gov.au/.

Regulation Agency (AHPRA), so the consent of its Research Evaluation Committee had to be sought. Access to the restricted register and minutes up to 1984 was obtained, subject to me not disclosing information recording disciplinary enquiries.[19] Other series made available to me were GRS/13215 (Index to foreign doctors, 1979-82) and GRS/13285 (Registers of medical practitioners, 1932-84).

Queensland

The Register of Medical Practitioners in Queensland is held by the Queensland State Archives (QSA), item IDs ITM/1101596 to /101603. It is freely available from its inception in 1860, but only until 1973. The minute books of the Queensland board are also available, series IDS9217 from 1860, again only till 1973. To complete the Queensland database for the remaining years to the prosopography end date of 1984, the annual lists of practitioners registered in Queensland, held in the National Library of Australia (NLA), were consulted.[20]

Western Australia

The records of the old Medical Board of Western Australia are not held in the state archives but by the Board's successor in Perth: the AHPRA WA State Board. Permission was obtained to access the registers (but not the minutes) from the Board's commencement in 1895 until 1984.[21] The first volume had the details of those registered under the preceding Medical Ordinance (1869) recorded in its initial pages.

Australian Capital Territory

The Medical Board of the Australian Capital Territory commenced its register in 1930, and the records are held by its successor, the AHPRA ACT Board. Application to access it was made to AHPRA's Research Evaluation Committee; permission was granted in July 2021.[22]

Northern Territory

The Northern Territory Medical Board maintained a medical register from 1935, which is now stored by its successor, the AHPRA NT Board. AHPRA gave me permission in December 2020 to access the register (but not the minutes).[23]

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[19] Email to N Yeomans from Deborah Brown, AHPRA, 9 April 2021.
[20] Medical Board of Queensland, *Register of Medical Practitioners, Queensland* (Brisbane: Medical Board of Queensland, 1975-1985), NLA bib. ID 2911442.
[21] Email from Karen Banks, AHPRA State Manager WA, 28 January 2020.
[22] Email from Bronwyn Schultz, Manager Records Management, AHPRA, 23 July 2021.
[23] Letter from Helen Egan, Territory Manager NT, 24 December 2020.

From all these sources, the records of 29,838 IMGs were retrieved and entered to the prosopography, starting with the first entry in a medical register in each jurisdiction and ending in 1984. It should be noted that the number of individuals in the prosopography is smaller than this total, since some were registered in more than one jurisdiction. Quantitation of this multiple registration in the colonial period is provided later in the chapter.

Terminology and Statistics

The evidence for the countries of origin of the IMGs in this chapter comes from the entries listing the place of degrees or other primary qualifications in the medical registers. Thus, I should correctly refer always to 'country of qualification'. This was not always the IMG's country of birth or even primary residence—some examples are seen in Chapter 10. However, I have taken the literary licence sometimes of referring to 'source countries', 'trained in', 'countries of training'[24] or simply 'countries'. In all instances, though, the data refer to country of primary registerable medical qualification. This caveat applies also to the data I present in Chapters 7 and 8.

In assessing the quantitative data in this chapter and throughout the thesis, a determination was often needed about the likelihood that observed differences occurred just by chance. The probabilities (p) of differences in frequencies were calculated using chi square testing, means were tested with Student's t test or Analysis of Variance, and differences between medians were assessed using the Mann-Whitney test.[25] Where the calculated p was equal to or less than 0.05, the difference was regarded as statistically significant; if the probability of a difference arising by chance was smaller than 1:1000, it was listed just as $p<0.001$ rather than an exact value.

[24] Even this is not always correct: some who qualified with the 'Scottish Triple' licentiates (see Chapter 1) actually did more of their training in a second country.

[25] Using Systat's *Sigmaplot* software.

The colonial IMGs

Between the start of formal licensing of practitioners in the Australian colonies (1838 in New South Wales) and Federation as a nation in 1901, the six colonies registered a total of 5766 who had obtained their medical qualification overseas.[26] About 1300 of these were registered in more than one colony, sometimes two or even more colonies in the same year.[27] Their movements between the colonies will be examined later.

Throughout the colonial period, most of the immigrants had made the decision to migrate while they were young, the majority registering in Australia between four and seven years after they qualified overseas (Figure 5.5). The exception was the decade 1846-55, when the median interval between qualification and registering in one of the colonies was more than ten years, and for a quarter of these IMGs it was more than 17 years. Perhaps the Australian goldrushes, discussed later, played a part in attracting older as well as young IMGs—at least in the 1850s.

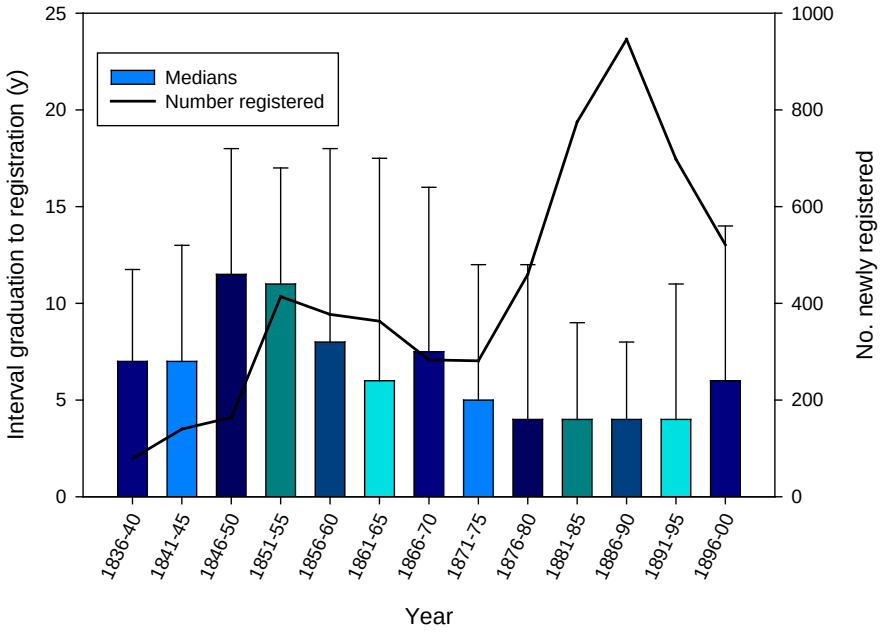

Figure 5.5: Time elapsed between obtaining first medical qualification and registration in an Australian colony. Date of qualification was not recorded in a register in 5% of all entries (mainly in Vic. and NSW prior to 1860). Medians and upper quartile. $p<0.001$ (ANOVA on ranks).

[26] Raw data in file: "Yeomans, ND-prosopography of Australian IMGs.xlsx", hosted at https://figshare.com, link in Appendix B (hereafter 'prosopography'); unless stated otherwise, numerical data in this chapter have been extracted from this source.

[27] I estimated that 1290 had registered in multiple colonies, but there was uncertainty about 27 whose entry in another colonial register was almost but not quite a match on names and years of their qualifications.

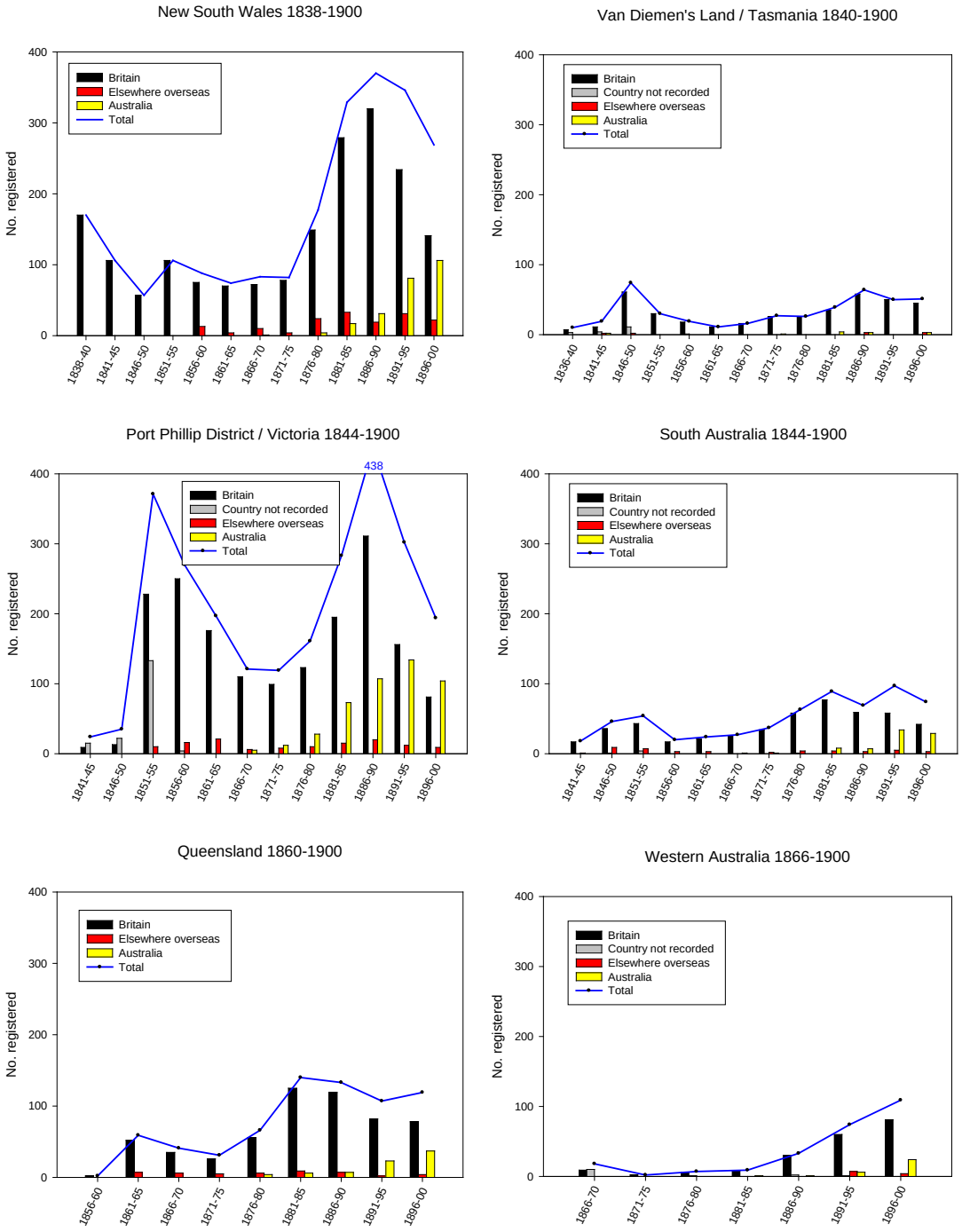

Figure 5.6: IMGs newly registered in each colony from the commencement of records by each Medical Board or Council, graphed to the same y-axis scale for comparison. In the earliest years of four of the colonies, only names of practitioners were recorded, not their qualifications and where obtained; however, nearly all (perhaps all) these would have qualified in Britain (evidence in Chapter 3). Between 1839 and 1860, 41 practitioners were registered in NSW as army, naval or government surgeons, without listing their qualifications or where conferred. They are deemed to have qualified in Britain, except for one who was in the French navy.

Figure 5.6 shows the numbers of newly registered practitioners in each colony during this period. It includes for comparison the registrants who had graduated from the young colonial medical schools, starting with Melbourne in the late 1860s, then followed more than 20 years later by graduates from Sydney and Adelaide. Until 1888, the local graduates who registered in every colony had trained at the University of Melbourne.[28] It is important to reiterate that the label IMG means that the practitioner's first licensable medical qualification was obtained overseas. Some will have been Australian residents who travelled abroad to qualify, either because they could not gain entry to one of the local medical schools, or for other reasons such as the perceived status of the local versus the British schools—especially in the colonial period. Some examples are found in Chapters 9 and 10.

The patterns of arrivals of the colonial medical immigrants, not surprisingly, show parallels with the arrivals and movement of the colonists overall. Most IMGs were registered in New South Wales and Victoria, the two most populous colonies, with only small numbers in the other four. For instance, the 1851 censuses recorded non-Indigenous populations of 268,344, 234,298, 63,700 and 70,130 for respectively New South Wales, Victoria, Van Diemen's Land (VDL) and South Australia.[29] Queensland had not at that time separated from NSW or acquired its own Medical Board, and the population of Western Australia was very small.

The next decade showed the effect of particularly the Victorian gold rush, with a tenfold increase (compared with 1846–50) in the number of doctors registered in that colony, about a halving of numbers in Tasmania/VDL and South Australia, and a more modest reduction in New South Wales despite its own gold rush. Some of the immigrant doctors were attracted to the goldfields as prospectors in search of their own fortune; others saw the opportunity to ply their trade caring for the health of the miners; some became pastoralists with or without combining it with medicine; still others would have simply followed the opportunities for practice in the expanding cities and rural communities.[30]

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[28] Dr Patrick Smith was registered in Queensland in 1878, with qualification listed as MD *Sydney*. It probably had been awarded *ad eundem gradum* since the Sydney medical school did not yet have students, but no medical qualification from elsewhere was listed.

[29] WD Borrie, *The European Peopling of Australasia: A Demographic History, 1788-1988* (Canberra: Australian National University, 1994), 16.

[30] Keith Bowden, *Doctors and Diggers on the Mount Alexander Goldfields* (Maryborough, Vic.: Hedges and Bell, 1974), 1, 4-12; E Alan Mackay, "Medical Practice During the Goldfields Era in Victoria," *Medical Journal of Australia* 2 (1936): 422.

Much has been written about the Australian gold rushes. David Goodman and Geoffrey Blainey are among many who have contributed.[31] Craufurd Goodwin said that the news of the 'new El Dorado' spread from Australia to Britain at lightning speed via pamphlets, newspapers, and word of mouth;[32] Stuart Macintyre described the impact thus:

> The gold rush transformed the Australian colonies. In just two years the number of new arrivals was greater than the number of convicts who had landed in the previous seventy years. The non-Aboriginal population trebled, from 430,000 in 1851 to 1,150,000 in 1861; that of Victoria grew sevenfold … giving it a numerical superiority over New South Wales that it retained to the end of the century.[33]

William Howitt arrived from England to try his luck at prospecting, and wrote on his return home:

> the Melbournians … have shown themselves from the beginning of their brief history a most mercurial race, – the maddest speculators in the world. At the slightest touch of prosperity, up they go beyond the clouds, and if they met the man-in-the-moon in their flight, he would never convince them that they must descend again – till they actually fell.[34]

And fall they did. There was a marked decrease in the number of newly registering IMGs in Victoria from the 1860s to 1880, then a substantial increase in both New South Wales and Victoria in the hyper-prosperous 1880s, only to fall again—most notably in those two colonies—as a result of the depression of the 1890s. Geoffrey Blainey said of Melbourne:

> It seemed, to those who read the signboards, that half the city was 'To Let'. There had been too much British capital entering Victoria, too many costly public works, too many people living in Melbourne compared to the country, too many imports, too few exports, and too much borrowing and speculating. Much of the standard of living depended on heavy borrowing but somebody would, some day, have to pay for it. The common belief was that Tomorrow would pay the debts, but suddenly Tomorrow became Today.[35]

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[31] David Goodman, "The Goldrushes of the 1850s," in *The Cambridge History of Australia*, eds. Alison Bashford and Stuart Macintyre (New York: Cambridge University Press, 2013), 170-87; Geoffrey Blainey, *The Rush That Never Ended: A History of Australian Mining* (Parkville, Vic.: Melbourne University Press, 1963), 28.

[32] Craufurd D Goodwin, "British Economists and Australian Gold," *Journal of Economic History* 30, no. 2 (1970): 405-6.

[33] Stuart Macintyre, *A Concise History of Australia* (Cambridge: Cambridge University Press, 1999), 87.

[34] William Howitt, *Land, Labour, and Gold: Two Years in Victoria with Visits to Sydney and Van Diemen's Land*, vol. 1 (London: Longman et al., 1858), 220.

[35] Geoffrey Blainey, *A History of Victoria* (Cambridge: Cambridge University Press, 2013), 147.

And just as Victoria and New South Wales saw a sharp decrease in newly arriving doctors (and Victoria experienced a net emigration of its population as a whole[36]), the fledgling colony of Western Australia began to acquire them. Blainey wrote:

> People poured from Melbourne—in steamships and on foot and in trains—to find work elsewhere. Many walked with their swags to the country. At least 60 000 went across the [Great Australian] bight to Albany and so to the new Western Australian goldfields, for Kalgoorlie was discovered just as Melbourne's banks were toppling.[37]

By searching the prosopography for duplicate names and dates of qualifications it was possible to track the movement of many of the IMGs between colonies. This is illustrated graphically in Figure 5.7. It is apparent that the major donor colonies were Victoria and New South Wales, and the largest recipient (late in the century) was Western Australia. In all, 21 percent of the 4475 colonial IMGs were registered in more than one colony and 4.9 percent in three or more—sometimes simultaneously, in which case they may have been keeping their options open about where they would eventually settle. Two of them were impressively mobile, registering in five of the six colonies. Frank Bingley Pullin qualified in Scotland in 1879 (LRCP *Edin* LFPS *Glasg*) and was first registered in Queensland in 1891.[38] He then appeared sequentially on the medical registers in New South Wales, Victoria, South Australia and finally Western Australia over the next five years. Robert Wright qualified in Ireland

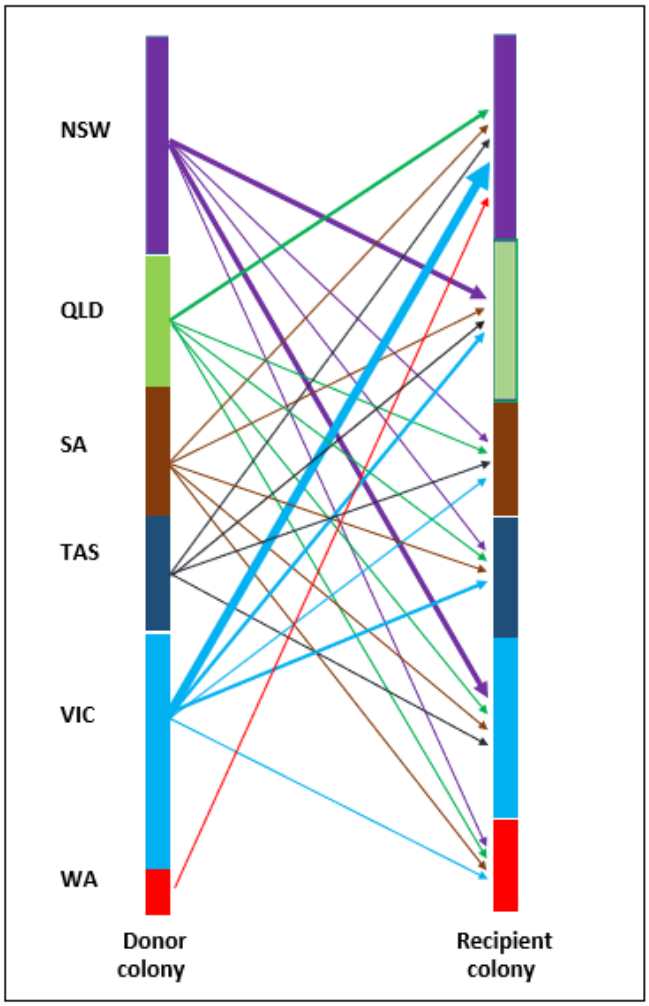

Figure 5.7: Movement of IMGs between colonies, 1838-1900 (movements of <5 IMGs omitted). The thickness of lines is proportional to numbers moving. Length of bars is proportional to square root of numbers donated and received by each colony.

[36] Borrie, *The European Peopling*, 123.
[37] Blainey, *A History of Victoria*, 149.
[38] Registration certificate #486.

(LRCS 1882, LKQCP 1883), was registered in Victoria in 1885,[39] then successively in Queensland, New South Wales, South Australia and Tasmania over the following six years. One can only speculate about what opportunities or difficulties made them so restless.

Table 5.1 gives more detail about these nineteenth century internal migrations. During the 1850s gold rush, the main inter-colony movements to Victoria (as distinct from new immigrants from overseas) were from New South Wales and South Australia. In the 1890s depression, most who transferred to Western Australia came from Victoria, New South Wales, and South Australia.

By the last decade of the nineteenth century, the contributions of the fledgling Australian medical schools began to make themselves felt (see Figure 5.6), with the number of local graduates comprising 48 percent of practitioners newly registered in Victoria, and about a third of those in New South Wales and South Australia—the three colonies with their own medical schools.

Throughout that century, the great majority of the arriving IMGs had qualified in Britain or Ireland. Indeed, as discussed in Chapter 3, the medical Acts in every colony except South Australia almost guaranteed that. However, small numbers of IMGs from other countries were allowed to practise since, toward the end of the century, amendments to the medical Acts gave the boards some flexibility. Table 5.2 lists the source countries that contributed at least one percent of the IMGs in a colony up till 1900. Supplementary Table 3 in Appendix A provides the data by decade for *all* countries in which the colonial IMGs had qualified.

[39] Certificate #1215.

Table 5.1: Numbers of colonial IMGs who moved to a second colony after their first registration in Australia

Donor colony	Recipient colony	1841-50	1851-60	1861-70	1871-80	1881-90	1891-00	Total
NSW	QLD	0	0	13	12	41	47	113
	SA	5	1	2	5	6	14	33
	TAS	8	2	1	6	9	11	37
	VIC	6	15	21	11	41	23	117
	WA	0	0	0	0	0	20	20
QLD	NSW	0	0	4	18	23	24	69
	SA	0	0	0	0	1	5	6
	TAS	0	0	1	0	2	1	4
	VIC	0	0	6	3	12	9	30
	WA	0	0	0	0	1	5	6
SA	NSW	0	1	-7	3	30	11	38
	QLD	0	0	0	0	4	3	7
	TAS	0	0	0	2	3	2	7
	VIC	0	16	4	3	15	6	44
	WA	0	0	0	0	1	11	12
TAS	NSW	4	2	2	7	3	13	31
	QLD	0	0	2	0	3	1	6
	SA	1	1	0	0	2	3	7
	VIC	0	6	4	4	14	12	40
	WA	0	0	0	0	0	2	2
VIC	NSW	1	5	18	33	65	49	171
	QLD	0	0	12	13	26	15	66
	SA	0	2	6	9	11	16	44
	TAS	0	2	5	13	9	27	56
	WA	0	0	0	0	0	21	21
WA	NSW	0	0	0	0	2	3	5
	QLD	0	0	0	0	0	2	2
	SA	0	0	0	1	1	0	2
	TAS	0	0	0	0	0	3	3
	VIC	0	0	0	0	1	1	2

Does not include 206 who registered in two or more colonies in the same year (may have been in the nature of 'insurance' or they may have actually moved their practice within the same year).

Table 5.2: IMGs registered in each colony to 1900

Country	QLD		NSW		SA		TAS*		VIC		WA		P†
	N	%	N	%	N	%	N	%	N	%	N	%	
Canada	7	1.1	20	1.0	3	0.6	2	0.5	21	1.1	2	0.9	0.808
England	251	41.1	833	42.0	164	31.3	201	49.9	733	39.7	94	44.3	<0.001
Germany	23	3.8	43	2.2	26	5.0	5	1.2	44	2.4	2	0.9	<0.001
Ireland	112	18.3	289	14.6	71	13.5	46	11.4	287	15.5	42	19.8	0.009
Scotland	212	34.7	743	37.4	253	48.3	147	36.5	732	39.6	69	32.5	<0.001
USA	6	1.0	57	2.9	7	1.3	2	0.5	31	1.7	3	1.4	<0.001
Totals	611		1985		524		403		1848		212		

Countries which contributed ≥1.0% of the IMGs registered in at least one colony during this period. Totals are IMGs from these major countries, not from *all* countries in each colony.

*Five were registered in Van Diemen's Land in 1840-48 with 'Letters Testimonial' – they may have been locally trained (see Chapter 3), in which case they were not IMGs.

†Chi square test.

In New South Wales, Queensland, Tasmania, and Western Australia, most had qualified in England, followed by Scotland and Ireland. South Australia was the exception, where almost half the colonial IMGs had trained in Scotland.[40] Why the Scottish trained doctors were more likely than the English or Irish to go to South Australia is not clear since, according to Peter Gibson, overall Scottish migration was fairly evenly distributed between the colonies in the late nineteenth century.[41] Although the number of German-trained doctors was small, they made up almost 5 percent of the IMGs registered in South Australia, significantly more than any other colony. This is explicable by the size of the diaspora in that colony: James Belich notes that Germans and their descendants comprised 8 percent of the South Australian population in 1891, almost three times that of Australia as a whole.[42] The only other countries outside Germany and the British Isles to contribute more than 1 percent of colonial IMGs were Canada and the USA; a larger proportion of the latter came to New South Wales.

What were the 'push factors' that contributed to the large immigration of particularly British and Irish doctors during this period? As mentioned above, the gold rush clearly was a 'pull factor' for many during those years. But conditions for doctors in the last half of the nineteenth century in Britain were not always easy. Medical litigation was increasing, and the inspectorate of the Poor Law had substantial powers to charge or discipline doctors accused of negligence, which reached a peak in the

[40] Seventy per cent arrived between 1871 and 1900 (Appendix A, Supplementary Table 3C).
[41] Peter Gibson, "Scottish Emigration to Australia, 1788-1939," *Descent* 30, no. 2 (2000): 83.
[42] James Belich, *Replenishing the Earth: The Settler Revolution and the Rise of the Anglo-Celtic World, 1783-1939* (Oxford: Oxford University Press, 2009), 63.

1870s.[43] Some of the immigrants may have been escaping such a situation, not necessarily to the benefit of their new patients in an Australian colony.

More importantly, it was often difficult for a doctor in Britain to earn a living, since by the second half of the century there was an oversupply, and competition with other established doctors nearby could be fierce.[44] Jeanne Peterson writes that many who could not establish themselves left the country temporarily or permanently—some to the military medical services or to the colonies. 'Prospects were thought to be good in colonial practice, but the price was high. Personal values of family, friendship and home were sacrificed for the sake of a career.'[45] Anne Digby quotes James (later Sir James) Paget as writing that in the first seven years of practice his largest annual income from medicine was only £23.[46]

Charles Keetley published a guide to medical practice for students and young doctors, in which he advised one option was: 'To settle in a small place where there is only one doctor on his last legs from old age, drunkenness or consumption.' Another he suggested was to migrate, writing:

> £500 a year can generally be made at once by one who is willing to emigrate and rough it in some useful settlement. … Many colonial districts advertise for a doctor and guarantee him a certain income …[47]

Conclusion

Australia in the nineteenth century was in word and deed a British colony. It is therefore unsurprising, since by late in the century only three regions had created their own medical schools, that the overwhelming proportion of doctors were imports from the medical colleges and universities in the United Kingdom of Great Britain and Ireland. Indeed, the medical acts in the individual colonies implied that these doctors were the best in the world—an assumption that sits badly with what should have been known about the standard of some of the European medical schools (see Chapter 1). In the

[43] Kim Price, *Medical Negligence in Victorian Britain: The Crisis of Care under the English Poor Law, C1834-1900* (London: Bloomsbury Academic, 2015), 94-5.

[44] ISL Loudon, "A Doctor's Cash Book: The Economy of General Practice in the 1830s," *Medical History* 27 (1983): 255; M Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley, CA: University of California Press, 1978), 91-2.

[45] *The Medical Profession in Mid-Victorian London, 124-6.*

[46] Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), 138.

[47] Charles Bell Keetley, The Student's and Junior Practitioner's Guide to the Medical Profession, (London: Baillière-Tindall, 1885), 46, https://wellcomecollection.org/works/wpcu2c2v.

event, small numbers of doctors with European qualifications, particularly from German universities, did manage to find a place later in the century.[48]

The pattern of arrivals to the various colonies of first convicts and their administrators, then free settlers, was largely mirrored by the pattern of arrival of the IMGs. New South Wales led the way together with Van Diemen's land, but was soon followed by IMGs arriving in Victoria, South Australia, and the newly separated Queensland. Western Australia, the last to be more extensively populated, was the last to acquire substantial numbers of IMGs—some as new immigrants, but others who fled from the Eastern States at the height of the depression of the 1890s. Economic factors were also behind the largest perturbations of all: the two major surges in registrations in Victoria in the 1850s and 1880s—the first due to the finding of vast amounts of gold, the second the building of what the English journalist George Sala dubbed 'Marvellous Melbourne'[49] as a consequence of gold-derived wealth (or a speculative bubble).

A limitation of the data presented here, that has no or minimal effect on the demographic findings but is relevant to the detail of the prosopography itself, is the difficulty at times of reading the handwriting of the clerks who compiled the medical registers. It is likely that I have sometimes misspelled names of doctors, and the place where qualifications were conferred was occasionally unclear. The material was also limited by the details provided in the registers: for instance, places of residence, dates of birth, and other biographical information would enrich the database further, and could be an area for future research.

[48] Supplementary Table 3, Appendix A.
[49] George Augustus Sala, "The Land of the Golden Fleece: Marvellous Melbourne," *The Argus*, 8 August 1885, 5.

Chapter 6

Illustrative Biographies of Some Early Immigrants

We can better understand some aspects of the history of colonial IMGs, by selectively tracing their activities and preoccupations in nineteenth century Australia. This chapter uses the prosopography to identify members of two markedly different groups of immigrant doctors in the colonial period: (i) those who were elected to the parliaments; (ii) doctors who met an untimely end soon after they arrived in Victoria and Queensland. The first group is used to examine the hypothesis that their medical expertise, and perhaps biases, impacted on their legislative activities—relevant to one of the aims of the thesis, which is an evaluation of the contributions of IMGs to the history of health care. The second group offered the opportunity to research, using individual examples, a historical affliction that motivated doctors to migrate to the antipodes, a medical controversy at the time, other diseases that were prevalent in nineteenth century Australia, and some instances where one outcome of migration was depression and despair.

Medical Members of the Colonial Parliaments

An advantage of a prosopography such as this is that there is a name attached to each entry. The opportunity was taken, therefore, to identify every IMG in the nineteenth century who was elected to parliament, with the broad aim to examine their contributions to colonial society but, more specifically, whether their parliamentary activities impacted the community's health. This was achieved by linking the prosopography to online databases listing previous members of the NSW, Queensland, South Australian, and Western Australian parliaments. For Tasmania and Victoria, the lists of former members compiled by McKay and Pickup, and by Thomson and Serle were consulted.[50]

From the more than four thousand doctors registered up till 1900 in the six colonies, 80 (just under two percent) served in a colonial parliament.[51] Table 6.1 lists their parliaments, year of registration in their colony, and medical qualifications.

[50] "Parliament of New South Wales, Former Members," accessed 23 July 2021, https://www.parliament.nsw.gov.au/members/formermembers/Pages/former-members.aspx; "Queensland Parliament, Former Members Register," accessed 25 July 2021, https://www.parliament.qld.gov.au/Members/Former-Members/Former-Members-Register; "Parliament of South Australia: All Former Members," accessed 23 July 2021, https://www.parliament.sa.gov.au/en/Members/All-Former-Members; Parliament of Western Australia, "Biographical Register of Members of the Parliament of Western Australia," accessed 23 July 2021, https://www.parliament.wa.gov.au/parliament/library/MPHistoricalData.nsf/screenMemberBios; PT McKay and E Pickup, *The Parliament of Tasmania, 1856-1973* (Hobart: Govt. Printer, 1973); Kathleen Thomson and Geoffrey Serle, *A Biographical Register of the Victorian Parliament, 1859-1900* (Canberra: ANU Press, 1972).

[51] I calculate that 4475 IMGs were registered in Australia to 1901, after accounting for those who were registered in more than one colony. However, there was uncertainty about 30 when common names

Table 6.1: Overseas-trained medical members of parliaments, registered in colonies prior to 1901*

Parliament	Year Reg. in Colony	Name	Qualifications	First elected to Parliament
NSW	1839	A'Beckett, Arthur Martin	MRCS *Lond*	1856
NSW	1858	Aldcorn, Andrew†	MRCS *Glasg,* MD *Glasg*	1858
NSW	1889	Arthur, Richard	MB ChM *Edin*	1904
NSW	1882	Beeston, Joseph Lievesley	LRCS LKQCP *Ire*	1908
NSW	1839	Bland, William	RN surgeon	1843
NSW	1842	Bowker, Richard Ryther S	LSA MRCS *Lond*, MD *St And*	1858
NSW	NR	Bowman, James	RN surgeon	1823
NSW	1871	Cortis, William Richard	LSA MRCP *Lond*, MRCS *Eng*	1887
NSW	1867	Creed, John Mildred	LRCP *Edin*, MRCS *Eng*	1872
NSW	1847	Docker, Joseph	LSA MRCS *Lond*	1856
NSW	1848	Douglass, Henry Grattan	MRCS *Lond*, MD *Dublin*, LKQCP *Ire*	1851
NSW	1891	Doyle, Henry Martin	LSA LRCP *Lond*, MRCS *Eng*	1925
NSW	1885	Graham, Sir James	MB ChM *Edin*	1894
NSW	1841	Jenkins, Richard Lewis	LSA MRCS *Lond*	1858
NSW	1839	MacFarlane, John	MD *Glasg*	1858
NSW	1869	MacLaurin, Sir Henry Normand	LRCS *Edin*, MD *Edin*	1889
NSW	1839	Mitchell, James	LRCS *Edin*	1855
NSW	1883	Nash, Lt.Col. John Brady	MRCS *Eng*, MB ChM *Edin*	1900
NSW	1839	Nicholson, Sir Charles	LRCS *Edin*, MD *Edin*	1843
NSW	1842	Palmer, Sir James Frederick	MRCS *Lond*	1848
NSW	1862	Renwick, Sir Arthur	MRCS *Edin*, MD *Edin*	1879
NSW	1857	Ross, Andrew	MD ChM *Glasg*	1880
NSW	NR	Smith, John	MD *Aberd*	1874
NSW	1868	Tarrant, Harman John	LRCP *Edin*, LRCS *Ire*	1880
NSW	1883	Wilkinson, William	MB *Lond*, LRCP *Lond*, MRCS *Eng*	1885
QLD	1866	Benson, John Robinson	MD *Queen's U Ontario*	1870
QLD	1880	Garde, Henry Croker	LAH *Dublin*	1902
QLD	1890	Hirschfeld, Eugen	Staats Examen, Germany	1914
QLD	1879	Marks, Charles Ferdinand	MD *Dublin*	1888
QLD	1862	Mullen, John Joseph	LRCS *Ire*	1872
QLD	1862	O'Doherty, Kevin Izod	FRCS *Ire*	1867
QLD	NR	Simpson, Stephen	Colonial surgeon	1860
QLD	1870	Taylor, William Frederick	LSA *Lond*	1886
SA	1845	Browne, William James	MRCS *Edin*	1860
SA	1867	Campbell, Allan	LRCP LRCS *Edin* LFPS *Glasg*	1878
SA	1876	Cockburn, Sir John Alexander	MRCS *Eng,* MD *Lond*	1884
SA	1844	Davies, Charles	MD *Univ. of France*	1857
SA	1850	Dean, Horace	MD *Missouri*	1857
SA	1845	Moorhouse, Mathew	MRCS London	1860
SA	1862	Spicer, Frederick	LSA *Lond*, MRCS Eng	1870
SA	1850	Wark, David	MD *Aberd*	1857
TAS	1846	Agnew, James William	MRCS *Eng*, MD *Glasg*	1877
TAS	1840	Bedford, Edward Samuel P	FRCS *Eng*	1856

(e.g., John Smith) appeared on more than one register but with slightly different dates recorded by the clerks for their qualifications.

TAS	1880	Butler, Gamaliel Henry	LRCP *Lond*, MRCS *Eng*	1896
TAS	1850	Butler, Henry	FRCS *Eng*	1856
TAS	1875	Crowther, Edward Lodewyk	MD ChM *Aberd*, LRCP *Edin*, MRCS *Eng*	1878
TAS	1846	Crowther, William Lodewyk	MRCS *Lond*	1866
TAS	1843	Huston, George Francis	Not recorded in minutes	1886
TAS	1881	McCall, Sir John	MB ChM *Glasg*	1888
TAS	1872	Young, Arthur	MRCS *Eng*	1886
VIC	NR†	Aldcorn, Andrew†	MD *Glasg*	1853
VIC	1857	Beaney, James George	FRCS *Edin*, MD *St And*	1883
VIC	1852	Embling, Thomas	LSA *Lond*, MRCS *Eng*	1855
VIC	1864	Embling, William Henry	MRCS *Glasg*, LRCP *Lond*	1892
VIC	1855	Findlay, John	MD (university NR)	1857
VIC	1854	Girdlestone, Tharp Mountain	FRCS *Eng*	1862
VIC	1844	Greeves, Augustus Frederick Adolphus	LRCS *Edin*, MRCS *Eng*	1853
VIC	NR	Haines, William Clark	'Practised surgery in England'	1853
VIC	1859	Heath, Richard	LSA *Lond*, MRCS *Eng*	1866
VIC	1851	Hedley, George Dixon	LSA *Lond*, MRCS *Eng*	1860
VIC	1848	Hope, Robert Culbertson	MD *Lond*	1856
VIC	1851	Hunter, Alexander	FRCS *Edin*	1859
VIC	1878	Le Fevre, George	LSA *Lond*, MB ChM *Edin*	1887
VIC	1888	Maloney, William Robert Nuttall‡	LSA *Lond*	1889
VIC	1853	Owens, John Downes	MRCS *Eng*	1855
VIC	NR	Palmer, Sir James Frederick	'Surgeon at Guy's Hospital'	1851
VIC	1882	Rose, James Marmaduke‡	MB ChM *Edin*	1883
VIC	1849	Russell, Alexander	LFPS *Glasg*	1859
VIC	1891	Salmon, Charles Carty‡	LRCP LRCS *Edin* LFPS *Glasg*	1894
VIC	1864	Scott, Thomas	LRCP *Edin* MRCS *Eng*	1892
VIC	1853	Smith, Louis Laurence	LSA *Lond*	1859
VIC	NR	Thomson, Alexander	Surgeon on convict ships	1843
VIC	1853	Tierney, Daniel Joseph	MD *Glasg*	1856
VIC	1845	Wilkie, David Elliot	MD *Edin*, LRCS *Edin*	1858
WA	1869	Birch, Edmund	Not recorded	1873
WA	1892	Hitch, Frederick Charles	LSA LRCP Lond, MRCS Eng	1901
WA	1884	Jameson, Adam	MBBS Edin	1900
WA	1890	O'Connor, Michael	MB ChB BAO Dublin	1901
WA	1895	Saw, Athelstan John Hornton	MB ChB Cantab	1915
WA	1877	Scott, Edward	LSA Lond, MRCS Eng	1886

*Several were medically qualified but never registered in the colony (NR); qualifications of all others taken from the prosopography.
†Andrew Aldcorn served first in the Victorian Parliament (1853–58), but was not registered there.
‡Born in Australia, but medical education in UK.

Western Australia had the highest proportion of medical MPs: almost 1 in 20 of the 151 who were appointed or elected up to 1900.[52] Not surprisingly, the colonies with

[52] Parliament of Western Australia, "Biographical Register of Members of the Parliament of Western Australia".

the largest populations, NSW and Victoria,[53] had the largest number of medical MPs—25 and 24 respectively. There were representatives in each chamber in every colony, though slightly more (43 vs 37) were in the Legislative Councils. The Councils, unlike the Assemblies, were elected on a restricted property-based franchise or appointed (mostly in NSW), which may have favoured some of the doctors.[54] We could speculate that those with influence with the Governor, perhaps by providing professional care to him or his family, may have been advantaged. In NSW, four of the 26 doctors were appointed to the Council before the proclamation of the Constitution Act in November 1855 marked the start of responsible government.[55] Therefore, they all would have been appointed rather than elected.[56]

Medically qualified members were nevertheless in the minority among the parliamentarians. Thomson and Serle catalogued the occupations of every colonial member of the Victorian parliaments and showed that the most common occupations were businessmen, pastoralists and lawyers.[57]

A few of these medical men rose to considerable prominence. Seven became chief secretary or colonial secretary. In New South Wales, Joseph Docker was appointed to the Legislative Council in 1856, then rose to briefly be Colonial Secretary in 1868.[58] He remained in the Parliament till his death in 1884, taking several portfolios. He appears to have been something of a polymath, with interests as diverse as composing, painting, sculpture, architecture, and photography.[59]

In South Australia, Sir John Alexander Cockburn was registered in 1876, two years after graduating MD, then elected MLA for Burra in 1884. It was not apparent that he practised medicine thereafter. He served as Chief Secretary and Premier from 1889–90.

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[53] WD Borrie, *The European Peopling of Australasia: A Demographic History, 1788-1988* (Canberra: Australian National University, 1994), 121.

[54] HS Chapman, *Parliamentary Government; or Responsible Ministries for the Australian Colonies* (Tasmania: Pratt and Son, 1854), 15; Sean Scalmer, "Containing Contention: A Reinterpretation of Democratic Change and Electoral Reform in the Australian Colonies," *Australian Historical Studies* 42, no. 3 (2011): 341.

[55] *The New South Wales Constitution Act (18 & 191 Vic. No. 54) 1855* (Imperial). They were Drs William Bland and James Bowman, Sir Charles Nicholson and Sir James Palmer.

[56] Chapman, *Parliamentary Government; or Responsible Ministries for the Australian Colonies*, 13-14; Hilary Golder, *Politics, Patronage and Public Works: The Administration of New South Wales, 1842-1900*, vol. 1 (Sydney: University of NSW Press, 2005), 108.

[57] Thomson and Serle, *A Biographical Register*.

[58] New South Wales State Archives: Register of Medical Practitioners for New South Wales, 1838-1980, NRS-15581 (hereafter NSWSA: Medical Register), no. 290; "Parliament of New South Wales, Former Members"; “Mr Joseph Docker (1802-1884)”

[59] Ibid.

The only Victorian Colonial Secretary who was medically qualified—William Clark Haines—was never medically registered in Australia.[60] He graduated in 1833 from Cambridge, then 'practised as a surgeon for some years … went to Australia … [and] farmed near Geelong' before his election to the Legislative Council in 1851.[61] He was premier twice, in 1854 and 1857. [62]

Van Diemen's Land and Tasmania had four Chief Secretaries who were registered as medical practitioners before federation, though two took office just after. The first was William Lodewyk Crowther, who obtained his MRCS in 1841 and was registered by the Van Diemen's Land Court of Medical Examiners in 1845.[63] In 1866, he was elected to the Tasmanian House of Assembly, moved to the Council in 1869, and became premier in 1878.[64] James William Agnew was registered the year after Crowther, and was Chief Secretary and Premier from 1886–87.[65]

Sir John McCall was born in Tasmania but travelled to Scotland to study medicine. There was no medical school in Tasmania at the time, and places in the Melbourne school were limited.[66] He graduated in Glasgow in 1881, returned to Tasmania and was elected to the House of Assembly in 1888, becoming Chief Secretary in 1903 and 1904.[67] The last of these Tasmanian colonial IMGs to become Chief Secretary was Gamaliel Henry Butler. Like McCall, he was born in Tasmania, but chose England for his medical training, returning immediately to be registered in 1880. He served in the Legislative Council from 1896 to 1914, was Chief Secretary from 1909 to 1914 and died in office.[68] Gamaliel Butler's medical father, Henry, was registered in the colony in 1850 and served in the Assembly from 1856–85.[69] He was elected speaker twice; James Fenton wrote that

[60] Author's prosopography.
[61] "A Cambridge Alumni Database: William Clark Haines," University of Cambridge, accessed 3 September 2021, https://venn.lib.cam.ac.uk/Documents/acad/2018/search-2018.html.
[62] Thomson and Serle, *A Biographical Register*, 83.
[63] WELH Crowther, *Crowther, William Lodewyk (1817-1885)*, Australian Dictionary of Biography (National Centre of Biography, Australian National University, https://adb.anu.edu.au/biography/crowther-william-lodewyk-3297, published first in hardcopy 1976, accessed online 3 September 2021; Tasmanian Archives (TA): Minutes of Meetings of the Court of Medical Examiners, 1841-1901, CB12/1, 29 November 1945.
[64] McKay and Pickup, *The Parliament of Tasmania*, 17.
[65] Ibid., 13.
[66] Editorial, "The Melbourne Medical School," *Australasian Medical Gazette* 1, no. 1 (1881): 23.
[67] Scott Bennett, *McCall, Sir John 1860-1919)*, Australian Dictionary of Biography (National Centre of Biography, Australian National University, https://adb.anu.edu.au/biography/mccall-sir-john-7299, published first in hardcopy 1986, accessed online 3 September 2021.
[68] Parliament of Tasmania, "The Parliament of Tasmania from 1856: Gamaliel Henry Butler," accessed 3 September 2021, https://www.parliament.tas.gov.au/history/members/butlerg269.html.
[69] McKay and Pickup, *The Parliament of Tasmania*, 15.

he 'had special claims upon the confidence of the House from his long Parliamentary career, his sound knowledge, and undoubted judgment.'[70]

The purpose of these brief biographies is to identify migrant doctors who rose to positions of particular prominence in the colonial parliaments: those who became Chief Secretaries, Premiers, or Speakers, since they were in privileged positions to influence the development of nineteenth century Australia using skills that were probably unrelated to medicine.

However, it is not surprising that the legislative activities of some of the medical members of colonial parliaments targeted issues that concerned their profession. One was the development of laws regulating who could be registered as a medical practitioner. This led to lively debates in both the NSW and Victorian parliaments. In both colonies, the legislators were petitioned by what would now be called 'alternative practitioners' to avoid legislation that would limit their privileges, standing and presumably income.

The alternative practitioners were rife, and Peter Phillips described the second half of the nineteenth century as 'the golden age of quackery ... in an age that enshrined free enterprise [especially in free trader New South Wales], lying and extravagant advertisements were accepted as normal.'[71] Most were British immigrants, and they plied their trade in patent medicines, and electrical and other devices, which they claimed as cures.[72]

In 1849, Dr John Dickson introduced a bill to the NSW Legislative Council with the intent to create a Board that would examine persons wishing to be registered as medical practitioners if they 'came to the colony without the proper vouchers'. Additionally, it would have given the Board power to enter the premises of druggists to examine the quality of the medicine sold there.'[73] The bill created a storm of petitions from druggists and segments of the medical profession as well, and disappeared in committee without returning to the Council.[74] This was a time in that colony when legislators resisted allowing a particular group to achieve a position of privilege. It was

[70] James Fenton, *A History of Tasmania from Its Discovery in 1642 to the Present Time* (Hobart: J Walch and Sons, 1884), 412.

[71] Peter J Phillips, *Kill or Cure? Lotions, Potions, Characters & Quacks of Early Australia* (Adelaide: Rigby, 1978), 7; Peter Lloyd, "The Evolution of Tariff Protection and Wage Protection in the Late Colonies and Early Federation," *Economic Papers* 36, no. 4 (2017): 462.

[72] Robert Crawford, "Ignoble but Lucrative: Quacks, Ads, & Regulation." *Journal of Australian Studies* 36, no. 1 (2012): 31-4.

[73] *NSW Legislative Council, Votes and Proceedings*, (3 July 1849).

[74] Petitions were tabled in the Council on 17, 20 and 24 July, 3, 8, 10 August, 11 September and 5 October (NSW Council Votes and Proceedings).

not till the *Medical Practitioners Amendment Act 1900* was passed that finally the NSW doctors were given exclusive right to call themselves medical practitioners (see Chapter 3).

In Victoria, an enabling bill had been first introduced to the Legislative Assembly in February 1858 by Dr Thomas Embling, 'to make more efficient provision for the registration of the Medical Practitioners in this colony ... as at present any person might practise as a medical man'.[75] Initially, it received enthusiastic support from two other medical members of the Assembly: Dr John Owens said it 'would protect the public against the actions of charletans [*sic*]', while Dr. Augustus Greeves agreed that 'those who were not duly qualified should not be allowed to practise, and so injure the public.'[76]

The 1858 bill ran into difficulties. Embling's key proposal was that any person using a title of legally qualified medical practitioner, and practising as such without a certificate from the Victorian Medical Board, would be guilty of a misdemeanor and be fined. He said that, at that time:

> There was no telling [recognising] a medical man ... and in case of sudden illness the husband or father might run to where he saw a light over the door. And that light might only be evidence of the destroyer within ... In one case 80 deaths occurred in the practice of one gentleman ... [who] had no diploma.[77]

The bill provoked several petitions against it, and Richard Heales (who became Premier in 1860) said he would instead move for the introduction of a clause to create a board of homeopathic physicians 'with all the powers and privileges of the medical board of Victoria.'[78] George Evans also argued against the bill, saying 'he might believe in homeopathy because it was the nearest approach to taking no medicine at.'[79] Both were indicating an aversion to the doctors claiming a special status in healthcare.

Homeopathy relied on the theories of Samuel Hahnemann, who held that diseases could be treated by finding a substance that produced side-effects similar to the symptoms of the disease, then diluting it by many orders of magnitude (often such that no molecules of the original substance remained). He wrote that if the treatment did not work, '*die Gabe nicht klein genug war* [the medicine dose was not small enough].'[80] A century later, historian Jacqueline Templeton wryly described

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[75] *Victorian Parliamentary Debates, Legislative Assembly*, (12 February 1858), 284.
[76] Ibid., (13 April 1858), 360.
[77] *Victorian Parliamentary Debates, Legislative Assembly*, 360.
[78] Ibid., (15 April 1858), 385.
[79] Ibid., (27 April 1858), 435.
[80] Samuel Hahnemann, *Organon der Heilkunst* (Dresden: Arnoldischen Buchhandlung, 1829), 277.

homeopathy as 'treatment by a hair of the dog that bit you.'[81] The medical politicians did not prevail, though, and in the face of sustained opposition in the Assembly, Embling's bill lapsed in Committee.

However, other attempts to regulate the practice of medicine in Victoria were made in the Second Parliament in 1860. Drs Louis L Smith and John Macadam separately proposed bills in January 1860. John Poynter remarked that Smith had a somewhat tempestuous relationship with others of his profession, and that is perhaps why Macadam took the main running on the bill, with Smith providing frequent commentary.[82] The House, however, was getting a little tired of attempts to pass a medical bill. Mr Mollison noted that the bill in the previous Parliament had "been most strenuously opposed by his hon. friend Mr Heales, who fought it clause by clause and line by line … as the advocate of allopathy and the advocate of homeopathy (laughter), and at last succeeded in rendering it so nauseous to the House, and so ridiculous, that it was, by common consent, thrown out."[83] Nevertheless, the bill with various amendments did make gradual progress. An attempt to have read a petition from homeopathic practitioners was summarily rejected by the Assembly—by now it was April 1861.[84] The bill moved back and forth between the two Houses, with frequent amendments. It did not do so, as Edmund Burke wrote: 'amidst the storm of such tempestuous passions, in the sharp conflict of so many wits, and tempers, and characters, in the agitation of such mighty questions'.[85] It was marked instead by endless carping about seemingly minor matters. But it finally became law as the *Medical Practitioners Act* of 1862. Some of its key provisions were: it was unlawful for anyone not registered by the board to 'pretend or use the name or title' in a list of qualifications specified in the act (e.g., doctor, physician, surgeon); persons obtaining a certificate under false representations were liable to imprisonment for up to three years (with or without hard labour); and foreign degrees, in addition to those from the UK, could be registered.[86]

Chapter three dissected the evolution of the Australian Medical Acts from the perspective of which *medically* qualified practitioners from which countries could be registered at different times. The activities described above show, by contrast, the

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[81] Jacqueline Templeton, *Prince Henry's: The Evolution of a Melbourne Hospital, 1869-1969* (Melbourne: Robertson & Mullens, 1969), 3.

[82] John Poynter, *The Audacious Adventures of Dr Louis Lawrence Smith: 1830-1910*, vol. 1 (North Melbourne, Vic.: Australian Scholarly Publishing, 2014), 66-7, 200-12.

[83] *Victorian Parliamentary Debates, Legislative Assembly*, (5 July 1860), 1477.

[84] *Ibid.*, (11 April 1861), 638.

[85] Edmund Burke, *Thoughts on the Cause of the Present Discontents* (London: printed for J. Dodsley, in Pall-Mall, 1770), 59.

[86] *An Act to Amend the Laws Relating to the Registration of Legally Qualified Medical Practitioners 1862* (Vic.).

attempts by medically-registered parliamentarians to limit the activities of quacks in the colony. And while their actions could be described as self-serving, a more generous interpretation is that they had the safety of their patients at heart.

The medical parliamentarians also used their medical knowledge and experience in attempts to legislate to improve public health. Thomas Embling was active on many issues other than those mentioned already. In the First Victorian Parliament (1856–57), he argued for the regulation of lunatic asylums (for the safety of the inmates) and the establishment of public baths in Melbourne for 'maintenance of the health of the city.'[87] In NSW, Henry Grattan Douglass moved a Bill in 1853 to make vaccination against smallpox mandatory.[88] Unlike similar Acts in Victoria and Tasmania, the NSW Bill was never enacted—Rebekah McWhirter notes that there was particularly strong anti-vaccination sentiment in that colony.[89]

Sir James Palmer was the first president of the Victorian Legislative Council and a former mayor of Melbourne.[90] He practised as a surgeon in London before migrating to Australia but was never registered by the Victorian Medical Board. His many legislative activities included supporting the British Pharmacopoeia Bill and scholarships to support talented students in schools.[91] John Downes Owens was registered by the Victorian Medical Board in 1853, then served in the Legislative Council 1855–63. He was prolific in the debates of both chambers. Bills that he sponsored, which drew at least partly on his medical expertise, were the Seaman's Hospital, the Poisons, and the Safety of Marine Navigation Bills.[92]

Thus, while the number of these overseas trained medical politicians in the Australian colonies was small, their legislative activities probably had an impact on some aspects of colonial health—most notably by providing a degree of protection against charlatans late in the century, and by the enactment of several measures promoting public health.

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[87] *Victorian Parliamentary Debates,* Ibid., (2 and 9 December 1856), 47, 79.
[88] *NSW Legislative Council, Votes and Proceedings*, (2 August 1853).
[89] Rebekah McWhirter, "Smallpox and Vaccination in Tasmania," *Papers and Proceedings of Tasmanian Historical Research Association* (2009): 143.
[90] Parliament of Victoria, "Sir James Frederick Palmer," accessed 5 September 2021, https://www.parliament.vic.gov.au/about/people-in-parliament/re-member/details/24/760.
[91] *Victorian Parliamentary Debates, Legislative Council*, (21 February 1860), 615; (25 August 1868), 759.
[92] Ibid., (20 February and 15 July 1857), 490, 966 and (8 April 1862), 946.

A Dangerous Migration

This second group of biographies illustrates the history of certain hazards and challenges of nineteenth century medical migration to Australia—human issues that cannot be captured by the mainly quantitative methods in earlier chapters. It also explores one of the 'pull factors' for migration to colonial Australia: a topic that is taken up again for the twentieth and twenty-first century migrants in Chapter 10.

Figure 6.1: Tombstone; grave of Dr George Glendinning and Mrs Annie Buntin, Geelong Western Cemetery, location WST-PRES-01-807-0002. Photograph by author.

While entering data from the Victorian and Queensland archives to the prosopography, it became apparent that some of the doctors died soon after they were registered.[93] This provoked a systematic exploration of the early deaths. From the entries for Victoria and Queensland, details of all who obtained their primary medical qualification overseas during the years 1861–1900 were extracted. Those registered during this period, and then removed within three years due to death, were retrieved and a cause sought.[94] These are some of their stories.

George Glendinning was born in Berwick, Scotland on 23 June 1853 and graduated MB ChM from Edinburgh in 1874, aged twenty-one.[95] He probably practised in Scotland for at least a year, then travelled to Melbourne where he was registered by the Medical Board of Victoria on 4 August 1876.[96] After a short stint as a House Surgeon at Melbourne's Alfred Hospital, he set up practice in 1877 in the

[93] The clerks in these two colonies were usually diligent in recording when and why registrations were cancelled; other colonial registers either did not contain this information or recorded it inconsistently.

[94] Prior to 1861, the clerk(s) who maintained the Victorian register inconsistently recorded removal of practitioners and the reasons. Hence, records earlier than 1861 were ignored. During the period thus studied (1861-1900), 532 graduates from Australian universities were excluded.

[95] Family History Library film no. 106789, ref. ID 2:15XQPKF.

[96] VPRO: Medical Register, Medical Board of Victoria, VPRS16394/P1, vol. 2, 1862-1949, certificate no. 823.

nearby city of Geelong. Within a year, at the age of twenty-four, he was dead. The death certificate stated the cause as phthisis (tuberculosis), its duration 18 months, and haemoptysis (coughing of blood) as a preterminal event.[97] *The Geelong Advertiser* reported:

> Being in delicate health, suffering from phthisis, he came to this colony and settled in the Inverleigh district, near to Geelong, where he soon made himself a favorite, but he afterwards came to Geelong and commenced to practise his profession ... A violent cold, which he caught a few weeks ago, settled upon his chest, and during his illness he burst a blood vessel, which hastened death.[98]

The Advertiser continued:

> The funeral of the late Dr. Glendinning took place yesterday afternoon. The mournful cortége [*sic*] was a long one, the deceased gentleman's remains being followed to their last resting-place in the New General Cemetery by nearly the whole of the medical profession of the district, together with many of the leading townspeople.[99]

The narrative does not quite end there. The previous month, on 10 December at Scots' Church in Melbourne, George had married the eighteen-year-old Mary Buntin.[100] She had arrived in Melbourne only eight days earlier, from Glasgow on the *Loch Tay*.[101]

Mary's widowed mother, Annie Buntin, had accompanied her on the Loch Tay, but died at sea, a day east of the Cape of Good Hope, on 14 November. The ship's surgeon certified the cause as 'stricture of bowel' of duration 'three weeks.'102 There is no record that an autopsy was performed and, at Annie's age of forty-seven, malignancy of the bowel would be unusual, so it is likely the cause of the stricture was tuberculosis of the small intestine. She was buried with her intended son-in-law in Geelong (Figure 6.1).

Having lost both her new husband and her mother, Mary had little reason to stay. She was the sole beneficiary of George's estate of over a thousand pounds,[103] and departed for London on the *Lusitania* in March 1878.[104] In July 1881, she married again,

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[97] George Glendinning, death certificate, 26 January 1878, file no. 1739/1878, BMDV.
[98] "Town Talk," *Geelong Advertiser*, 28 January 1878, 2.
[99] Ibid.
[100] George Glendinning and Mary Grant Buntin, marriage certificate, 10 December 1877, 4664/1877, BDMV.
[101] Mary Buntin, Inwards Unassisted Passengers to Victoria, Loch Tay, Fiche 355, p. 2; "Intercolonial Arrivals and Departures," *Hobart Mercury*, 10 December 1877, 2.
[102] Annie Buntin, death certificate, 14 November 1877, 12834/1877.
[103] VPRO: Probate and Administration Files (hereafter Probate), VPRS28/P2, unit 73, item 17/081.
[104] VPRO: Outward Passengers to Interstate, U.K. and Foreign Ports, VPRS948/P1, March 1878, p.1.

this time to the Reverend Martin Lewis.[105] But just six years later, she died in Bournemouth with her husband at her side, at the age of twenty-eight. The cause was *phthisis pulmonalis*, which her doctor certified had been present for five years.[106] Quite likely she contracted it earlier than that, and her mother and George Glendinning would have been obvious sources. The disease that killed so many in the nineteenth century world had claimed another young victim.

We can surmise from the above, though without advantage of correspondence or other direct evidence, that George Glendinning contracted tuberculosis in Scotland—likely contributed to by his occupation as a doctor—and decided to emigrate to Australia in the hope that the change of climate would promote a cure. This theme of 'therapeutic emigration' will be taken up later.[107] We can assume that George and Mary became engaged in Scotland, arranging for her to follow him to Australia to marry; and it does not need much imagination to guess that they hoped the health of Mary's mother would benefit as well.

George Glendinning's early demise, after leaving Scotland to practise medicine in Australia, is not unique. This section explores the deaths of a group of other medical immigrants who were registered in the colonies of Victoria and Queensland, and died soon after arriving. It argues that, while many of these immigrants may have faced similar health risks had they stayed in their home country, their decision to migrate was an inauspicious one.

Causes of the Early Deaths of Immigrant Doctors

Of the 1970 overseas-trained doctors entered in the Victorian and Queensland registers, 75 (of 1351) in Victoria and 31 (of 619) in Queensland died within the three-year window. All were male and all but seven obtained their qualification in the United Kingdom. Nine were actually born in Australia, but received their medical education in Britain; although not immigrants, they are included with the others because of their shared medical training and lived environment prior to their death. The causes of death were ascertained in most instances from death certificates, and in the remainder from reports of inquests or death notices. Table 6.2 lists them grouped by major categories.

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[105] "Rev Martin Lewis DD, 1856-1938," Ancestry.com.au, https://www.ancestry.com.au/family-tree/person/tree/83027844/person/38469091229/facts?_phsrc=rDz884&_phstart=successSource (accessed 20 June 2020).

[106] Mary Lilias Grant Lewis, death certificate, December 1887, General Register Office (UK), Christchurch, Hants, vol. 02B, p. 408.

[107] Robin F Haines, "Therapeutic Emigration: Some South Australian and Victorian Experiences," *Journal of Australian Studies* 16, no. 33 (1992): 76; Linda Bryder, "'A Health Resort for Consumptives': Tuberculosis and Immigration to New Zealand, 1880-1914," *Medical History* 40, no. 4 (1996): 453.

Table 6.2: Categories of death in 103 IMGs who died ≤3 years from the year of their registration in colonial Victoria and Queensland

Cause of death	N	Mean age (y) ± SD	% married
Accident	6	32.0 ± 6.5	80
Apoplexy	8	39.8 ± 13.9	86
Apoplexy, Serous	4	42.0 ± 9.6	75
Drug overdose (?accidental)	2	32.0 ± 0.0	0
Heart Disease	8	41.0 ± 13.0	88
Liver disease	3	38.3 ± 2.1	67
Miscellaneous infections	9	43.0 ±15.1	44
Nephritis	4	31.8 ± 1.9	25
Sepsis (bacterial infections)	3	29.7 ± 3.2	33
Suicide and possible suicide	12	34.4 ± 8.4	33
Tuberculosis	33	30.9 ± 5.9	44
Tuberculosis (possible)	3	37.0 ± 11.1	67
Typhoid	4	39.5 ± 12.2	75
Uncertain	4	33.8 ± 4.0	0

SD=Standard Deviation; % married includes widowed and excludes 8 whose marital status unknown. One who died by suicide may have also had tuberculosis, judging by autopsy report.

Tuberculosis

Tuberculosis has afflicted humans for at least 5000 years, and perhaps much longer.[108] Barbara Bates writes that it was the most common cause of death throughout Western Europe in the nineteenth century.[109] That was the case also for this subset of early deaths in colonial doctors, accounting for almost a third of the fatalities. Their death certificates stated variously *phthisis*, *phthisis pulmonalis, phthisis pulmonale* and *phthisis pulmonales.*[110] A further three may have died from tuberculosis but been misdiagnosed. One was Anatole Lapierre, who probably qualified MD in Paris *ca.* 1868 and was registered in Victoria in 1891.[111] His death three years later, aged 49, was certified due to 'acute enteritis' (inflammation of the small intestine).[112] No autopsy was performed, and his obituary in the *Kyabram Union* told a different story:

[108] Thomas M Daniel, "The History of Tuberculosis," *Respiratory Medicine* 100, no. 11 (2006): 1863.
[109] Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis, 1876-1938* (Philadelphia: Pennsylvania University Press, 1992), 1.
[110] While most British graduates were required to have studied some Latin, this hotchpotch of diagnoses indicates a loose attention to its grammar—better would be *phthisis pulmonis,* although *pulmonalis* was usually written in nineteenth century textbooks.
[111] His qualification is listed in the Victorian Register as Officier de Santé (dated 1879), but this is probably incorrect since he would have been aged thirty-four, and his obituary indicates he 'had extensive practice in France's gay capital' before serving in the (1870-71) Franco-Prussian war.
[112] Anatole Francois Lapierre, death certificate, 16 January 1894, 2425/1894.

> Anatole Francois Lapierre, M.D., [died] after being confined to his bed for nearly three months ... but medical skill proved powerless to prevent a fatal termination to his illness, acute enteritis and chronic peritonitis being the cause of death. Dr Lapierre was a native of Paris ... During the Franco-German War he accompanied the French troops as surgeon, on their disastrous campaign, and rendered great service to many of his countrymen. Not being over robust of constitution, he some three years ago determined to see whether the climate of Australia would agree with him better than that of his beloved France.[113]

As with Annie Buntin, this narrative, with its long duration of illness, strongly hints at the diagnosis of intestinal tuberculosis.

Two other deaths might have been tubercular, though the evidence is weaker. One was Alexander Barker. He was not an immigrant but born in Wannon, Victoria. And like a number of colonial Australians, he travelled to Scotland to study medicine.[114] Barker qualified in 1891, returned to Melbourne in 1892 and died the following year. His death certificate stated 'bronchitis (18 mo.) and gangrene of lung (4 d.).'[115] There was no autopsy, and the long duration of illness (which preceded his voyage to Melbourne) is again compatible with pulmonary tuberculosis. The other was William Rowe, who qualified in Ireland in 1861, registered in Victoria in 1865, and died the following year. The cause was recorded as 'epileptic apoplexy', of duration ten months, and again no autopsy was performed.[116] Tubercular meningitis might have been responsible, though it would have been unusual for a patient with this to survive so long.

Two of these doctors, who died from tuberculosis soon after their arrival, did so at sea. Percy Cree died in 1885, a year after being registered in Queensland and nine years after he qualified in England with LSA MRCS.[117] He had taken over the practice of his brother-in-law, Morley Eddison Clough, in Gympie (rural Queensland) in July 1884. They had both been registered on the same day in Brisbane.[118] Four months later, Morley died from 'Pulmonary pthisis'; and in May the following year, tuberculosis claimed the life of Percy on the *Dorunda* as he tried to return to England.[119]

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[113] "Death of Dr. Lapierre," *Kyabram Union*, 19 January 1894, 2.

[114] TS Pensabene, *The Rise of the Medical Practitioner in Victoria* (Canberra: Australian National University, 1980), 63-4; Laurence M Geary, "The Scottish-Australian Connection 1850-1900," in *The History of Medical Education in Britain*, eds. Vivian Nutton and Roy Porter (Amsterdam: Rodopi, 1995), 59.

[115] Alexander Scot Barker, death certificate (VIC), 2 July 1883, 8810/1883.

[116] William Babington Rowe, death certificate (VIC), 22 May 1866, 5163/1866.

[117] QSA: Register of Medical Practitioners, ITM1101596-1101603, no. 277.

[118] Ibid., no. 276.

[119] "Notice," *Gympie Times and Mary River Mining Gazette*, 10 July 1884, 2; Morley Eddison Clough, death certificate, 12 November 1884, Queensland Government Register, cert. no. 1312; Percy Kinburn Cree, death certificate, 18 May 1885, General Register Office (UK), West Ham, Essex, no. 426, 1885.

The other who succumbed at sea was Henry Brown, who was registered in Queensland in 1868, then died three years later on the *City of Brisbane* as it sailed from Sydney to Brisbane.[120] Aged 45 when he died, Brown had come to Australia just three years after he qualified and was first registered in NSW in 1851.[121] His movements in the 1850s are something of a mystery. Although not medically registered in Queensland till the late 1860s, he was a profuse writer of letters to newspapers from several addresses in Queensland as early as 1858. Most were on the theme of the Queensland gold fields, hence we can speculate that he had become a prospector.[122] The doctor certifying his death estimated the duration of illness as eight months, though his death in transit suggests the disease was advanced by that time. Perhaps his travel to Sydney was for medical advice.

The mortality rate for tuberculosis in the immigrant doctors is difficult to calculate, or at least the problem is what denominator to use for the purpose. Using the number of doctors *newly* registered in each decade, I calculated that the annual mortality from tuberculosis in this group ranged from 320 to 973 per 100,000. If the denominator is instead the *total* number of international graduates on the register each decade, the annual rates are a little lower (Table 6.3).[123] All but three of the 33 with definite tuberculosis were younger than forty when they died. From several sources, we can calculate the tuberculosis mortality rates in the whole Victorian population in the age group twenty to forty-five where that breakdown is available, or for the whole population if not.[124] These are shown for comparison in Table 6.3. While the number of immigrant doctors is small, and they were selected because of their early death, their mortality was higher than for the general population. A plausible explanation is that their disease was more advanced than the average case already in the colonies; we will explore later whether some migrated in the hope Australia would offer them a better chance of survival.

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[120] QSA: ibid., no. 78; Henry Hort Brown, death certificate (QLD), 18 November 1871, 835/1871.

[121] NSWSA: NRS-15581, no. 338.

[122] Henry Hort Brown, "Fitz Roy Goldfields," *Moreton Bay Courier*, 15 September 1858, 4; *Maitland Mercury and Hunter River General Advertiser*, 7 October 1858, 2.

[123] Data for the denominators in these calculations were extracted from the Prosopography constructed in Chapter 5.

[124] CF Coxwell, "A Study of Phthisis Mortality in Victoria," *Australian Medical Journal* 15, no. 4 (1893): 197; Henry Haylyn Hayter, *Victorian Year Book for 1879-80* (Melbourne: Government Printer, 1880), 159; James Jemison Fenton, *Victorian Year-Book, 1895-8* (Melbourne: Government Printer, 1901), 730; FB Smith, *Illness in Colonial Australia* (Melbourne: Australian Scholarly Publishing, 2011), 118; The New Zealand Official Year-Book 1893, "Death-Rates from Phthisis Per 10,000 Persons Living [Victoria] " https://www3.stats.govt.nz/New_Zealand_Official_Yearbooks/1893/NZOYB_1893.html#id344E848.

Table 6.3: Tuberculosis mortality/100,000 population p.a. in immigrant doctor group versus whole of Victoria*

Period	Immigrant doctors		Victorian population aged 20-45				
	Method 1	Method 2	Coxwell	Hayter	Fenton	Smith	NZ Year book
1860-1869	320	189	168	106†	–	–	–
1870-1879	973	489	209	119†	–	–	–
1880-1889	430	378	255	202	–	–	143†
1890-1900	517	191	220	–	404	189‡	–

*Sources for population rates cited in footnote 91; †all age groups combined, not just 20-45; ‡greater Melbourne only.
Method 1: denominator = those *newly* registered during decade.
Method 2: denominator = total on the register during the decade.

Suicide and drug overdose

Suicides and drug overdoses (accidental or not) were the second highest causes of early death. The doctors' ages ranged from 26 to 54, and two thirds were unmarried. All were subjects of coronial/magisterial enquiries and most underwent an autopsy. Some examples of clearly deliberate cases, with the wording taken from their inquests, are: Andrew Alexander ('Exhaustion due to refusal to take food'), Thomas Andrews ('Cut his throat when of unsound mind from excessive drinking'), John Gibson ('Suicide by prussic acid'), Henry Hobbs ('Haemorrhage from self-inflicted wounds whilst labouring under temporary insanity'), Robert Sinclair ('Poison. Prussic acid (self-administered)') and William Towle ('Overdose of chloral').[125]

Four deaths occurred in circumstances where the evidence at inquests suggested suicide was possible, yet juries opted for accidental death—an issue I take up later. Edward Colden was reportedly 'accidentally drowned … while bathing.'[126] He had been resident surgeon at the Beechworth Lunatic Asylum, after registering in Victoria in 1877. He married Mary Gennell the next year and died in January 1879.[127] Surprisingly, there is no mention of a wife in any of the depositions or the press reports. One witness

[125] Andrew Alexander, death certificate (VIC), 22 January 1871, 2221/1871; Robert Duffy Sinclair, death certificate (VIC), 21 August 1892, 9977/1892; VPRO: Inquest Deposition Files (hereafter Inquest), VPRS24/P0, unit 481, item 1885/458; ibid., unit 344, item 1878/558; ibid., unit 277, item 1872/837; "Death from Chloral," *Brisbane Courier*, 22 November 1898, 5.
[126] Inquest, VPRS24/P0, unit 386, item 1879/119.
[127] VPRO: Medical Register, no. 854; Edward Colden and Mary Agnes Laura Gemmell, marriage certificate, 30 March 1878, 21/1878, BDMV.

stated: 'he was a man of very intemperate habits.' Others gave evidence he was 'in a state of intoxication' at 8.30 am in the bar of the local hotel, then seen later sitting on the edge of a water hole. He asked two passing boys to take off his socks (which they did), then his trousers (which they refused). When next seen he had drowned. While this may indeed have been accidental, in a setting of equivocal marital status, lack of friends and sustained heavy drinking, intentional drowning is conceivable.

In 1864, the jury at the inquest of Robert Pattinson unanimously concluded that he 'came to his death from accidentally taking an overdose of prussic acid as a sedative, administered by himself.' A bottle was found by his body, and his organs at autopsy smelled strongly of prussic acid (bitter almonds).[128] Hydrocyanic acid is a potent poison, though it was used during the nineteenth century in small doses as a sedative.[129] Pattinson, who qualified four years earlier in England,[130] would almost certainly have known the danger of overdose, so to conclude his death was accidental appears risky.

Waldemar Roeckel qualified in London in 1874, registered in Victoria in 1892 and died two years later.[131] The cause was certified: 'by misadventure, having taken an overdose of cocaine by injection which produced asphyxia.' However, the inquest was told he had been in bed all day in a hotel in Ballarat, then sent a waiter to a chemist for some cocaine. The chemist deposed that Roeckel had stayed at the hotel on several weekends before, and that he had previously supplied him with the drug. Dr Herman Lawrence told the inquest that Roekel worked with him as an assistant in Melbourne, and he had counselled him several times to abstain from cocaine use. On this last occasion, the packet from the chemist contained 30 grains (almost 2 gm), about 4–5 times a lethal dose if all taken at once.[132] A constable who attended the scene reported that a number of photographs, some letters and a syringe were laid out on the bed near the body. The autopsy revealed eighteen puncture marks on the right side of the chest and more on the right forearm.[133] This mode of seemingly frenzied administration, and the memorabilia arrayed around the body, do suggest an intentional death.

Henry Armstrong's death in 1861 was labelled 'Laudanum overdose while suffering delirium tremens.' His widow, Emily, gave evidence that he had 'been moving about from one diggings to another … [and] drinking hard. After each fit of drinking he

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[128] "The Death of Dr. Pattinson: The Inquest," *Mount Alexander Mail*, 14 March 1864, 3.
[129] Melvyn P Earles, "The Introduction of Hydrocyanic Acid into Medicine: A Study in the History of Clinical Pharmacology," *Medical History* 11, no. 5 (1967): 311-2.
[130] VPRO: Medical Register, no. 316.
[131] Ibid., 1786.
[132] Charles V Wetli and Ronald K Wright, "Death Caused by Recreational Cocaine Use," *Journal of American Medical Association* 241, no. 23 (1979): 2522.
[133] Inquest, VPRS24/P0, unit 632, item 1894/1194.

used to get attacks of temporary insanity and try to destroy himself.' On the day he died, he had been drinking heavily for three days. He told his wife 'that he should cut his throat', whereupon she removed 'a razor that was near him'. She left him for a time but when she returned, he said to her: "I have done it Emily." An empty bottle marked tincture of opium was found by his bed, and the doctor who performed the autopsy noted that the stomach contained 'fluid which smelt very strongly of opium.'[134] It is difficult to regard this as an accidental death, even though the jury refused to use the word *suicide*. As a commentary on how women who suffer domestic violence often forgive the perpetrator, Emily wrote:

> The deceased was very violent when he was in liquor, not alone with me but with every body [*sic*]. He has often struck me when drunk. I would be afraid to tell him of it when he was sober as it would cause him to fret very much. When he was sober he was a kind good husband. It was his straightened [*sic*] circumstances that first made him take to drink.[135]

Two more doctors (both single) died from drug overdoses, deemed accidental at inquest, but perhaps incorrectly. Charles Drinkwater died in 1889, from 'Failure of the heart's action, probably caused by the inhalation of chloroform.'[136] His inquest heard he suffered from neuralgia, had seemed well when last seen on the night he died, and that a bottle containing chloroform was found in the room with his body. Dr Francis Keyes performed the autopsy and, on what reads as rather flimsy evidence, concluded that 'The heart was one that would fail were any sudden strain put upon it.'[137]

The other to die from a drug overdose was Stanley Roome. The inquest recorded: 'The cause of his death was an over-dose of morphia self-administered but not intentionally.'[138] A colleague gave evidence that Roome took morphine in excessive doses, and others reported that he was suffering severe stomach cramps on the evening he died (likely narcotic-withdrawal symptoms). His overdose may indeed have been accidental.

Other causes of death

As can be seen in Table 6.2, a variety of diseases were responsible for the other 58 early deaths in the two colonies. Six resulted from an accident: three a fall from a horse, two

[134] Ibid., unit 103, item 1861/1033.
[135] Ibid.
[136] Charles Drinkwater, death certificate (VIC), 31 August 1889, 10781/1889.
[137] Inquest, VPRS24/P0, unit 551, item 1889/1167.
[138] Ibid., unit 594, item 1892/320.

accidentally shot.[139] Another death, of George Lawrence in 1866, is instructive because it highlights the then practice of autopsies being performed by attending doctors (often inexperienced) rather than skilled pathologists. Dr Lawrence's death was certified: 'Acute alcoholic poisoning.' However, he was seen to be very drunk, then brought unconscious to the Melbourne Hospital where the doctor who performed the autopsy appears not to have appreciated the significance of the discovery, when he opened the skull, of 'a large quantity of blood effused between the pia mater and the brain.'[140] Those findings strongly suggest Lawrence had fallen and hit his head while drunk, causing a subdural haemorrhage (bleeding between the brain and the skull), which was the actual cause of death.

As would be expected, deaths due to heart disease or apoplexy (stroke) tended to be in older doctors. One of the first to define what physicians meant by apoplexy was William Cullen, who, using the Latin of educated practitioners of physic of his day, defined it as 'Soper profundissimus cum stertore vel sonora respiratione [deepest sleep with snoring or noisy breathing].'[141] Émile Littré and Charles-Philippe Robin gave a more detailed definition in 1855:

> An illness characterised by a sudden spontaneous paralysis—more or less complete, more or less extensive, more or less persistent—of consciousness and movement; paralysis produced in most cases by an effusion of blood into the cerebral membranes, ventricles, or the substance of the brain itself.[142]

Leonard Robinson died in 1900; his death was certified by his medical father using the by then modern term, cerebral haemorrhage.[143] However, in other doctors diagnosed with apoplexy, the term was clearly used more loosely. Only one had an autopsy: John Boxwell died aged thirty-one from 'Pulmonary appoplexy [*sic*] with consequent regurgitation of venous blood into heart.'[144] The autopsy description was brief in the extreme. Although the practitioner provided no evidence, he may have thought Boxwell

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[139] "Death of Dr. O'Reilly," *Kyneton Observer*, 20 July 1867, 2; *The Telegraph (Brisbane)*, 26 September 1888, 2; "William James Gray," *The Argus*, 17 May 1899, 1; "Distressing Fatal Accident," *Sydney Morning Herald*, 22 June 1886, 5.

[140] Inquest, VPRS24/P0, unit 175, item 1866/604. A subdural haemorrhage is usually a consequence of head trauma, resulting in blood accumulating between the brain and the overlying dura mater which compresses the brain, often fatally unless treated.

[141] William Cullen, *Synopsis Nosologiae Methodicae* 3rd ed. (Edinburgh: Publisher not identified, 1769), 47.

[142] Émile Littré and Charles-Philippe Robin, *Dictionnaire de Médecine, de Chirurgie, de Pharmacie, des Sciences Accessoires et de L'art Vétérinaire de P.H. Nysten* 12th ed. (Paris: J B Baillière, 1855), 95 [my translation].

[143] Leonard Robinson, death certificate (QLD), 23 December 1900, 742/1901.

[144] John Henry Boxwell , death certificate (VIC), 29 April 1876, 4344/1876.

died from a pulmonary embolus (clot of blood lodging in the pulmonary artery).[145] In the other six, it was a clinical diagnosis, without inquest or autopsy.[146]

Many of the other deaths were due to infections, which in an era before antibiotics posed a constant threat to people of all ages. Even those who died from nephritis probably had a type that follows streptococcal bacterial infections, which thanks to antibiotics is now usually treated early.[147] The three deaths attributed to liver disease were likely due to alcoholism—a hazard of that period which I discuss later.[148]

The Controversy about the 'Beneficial' Australian Climate

Tuberculosis was greatly feared in the nineteenth century. As Barry Smith wrote: 'there was a lot of it about and Violetta and Mimi notwithstanding, it was not a gentle way to die.'[149] Brian Thompson calculated that, even as late as 1930, three quarters of those with active disease would die.[150]

A prevalent view in the nineteenth century was that Australasia was a safer place for consumptives, and migrating from Britain might facilitate a cure.[151] Bryn Thomas and Bryan Gandevia refer to southern Australia as 'a haven of hope to the phthisical.'[152] Robin Haines writes about 'therapeutic emigration', noting the emergence of 'invalid' or 'hospital' ships in the second half of the century.[153] But this was not without risks: some consumptive emigrants died during the long journey, reminiscent of the fate of George Glendinning's prospective mother-in-law. Linda Bryder, writing about a similar immigration to New Zealand, describes that country in the late nineteenth century as a

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[145] Inquest, VPRS24/P0, unit 342, item 1876/390.

[146] Death certificates (VIC): Sigmund Conradi, 18 May 1882, 5528/1882; James Leahy, 27 May 1870, file no, 5085/1870; George Milner Cole, 5 May 1884, 7575/1884; John Adam Swindells, 14 November 1892, 15107/1892; George Spearman, 12 August 1869, 7325/1869; "Mc Laurin," *The Argus*, 26 July 1884, 1.

[147] William Osler, *The Principles and Practice of Medicine* (New York: D Appleton and Co., 1892), 741; Hugh R Brady, Yvonne M O'Meara, and Barry M Brenner, "The Major Glomerulopathies," in *Harrison's Principles of Internal Medicine*, eds. Eugene Braunwald, et al. (New York: McGraw Hill, 2001), 1582.

[148] Cirrhosis of the liver was diagnosed in two, and the third 'hepatitis for 3 months' may have been alcoholic hepatitis. Charles Chambres, death certificate (VIC), 13 December 1868, 5839/1868; Louis Gordon Leslie, ibid., 17 July 1892, 89/1892; Denis Paul O'Farrell, ibid., 14 October 1891, 108/1891.

[149] Barry Smith, "Gullible's Travails: Tuberculosis and Quackery 1890-1930," *Journal of Contemporary History* 20 (1985): 734.

[150] Brian C Thompson, "Survival Rates in Pulmonary Tuberculosis," *British Medical Journal* 2, no. 4326 (1943): 721.

[151] JM Powell, "Medical Promotion and the Consumptive Immigrant to Australia," *Geographical Review* 63, no. 4 (1973); Robin Walker, "The Struggle against Pulmonary Tuberculosis in Australia, 1788-1950," *Historical Studies* 20, no. 80 (1983): 441.

[152] Bryn Thomas and Brian Gandevia, "Dr. Francis Workman, Emigrant, and the History of Taking the Cure for Consumption in the Australian Colonies," *Medical Journal of Australia* 2, no. 1 (1959): 2.

[153] Haines, "Therapeutic Emigration," 76-90.

'Health Resort for Consumptives.' However, the confined quarters on board ship posed a risk that healthy passengers would actually *contract* it en route.[154] Sergio Sabbatani describes the risk of infection as very high, and quotes an Italian migrant's description of her voyage in steerage class to New York:

> Uomini, donne, e ragazze stavano tutti nello stesso letto, separati solamente da un'assicella per evitare di rotolare uno sopra l'altro [men, women and children were all in the same bed, separated only by a thin wooden strip to prevent them rolling one on top of the other].[155]

Bryder examines the age distribution of migrants who died within one year of arrival: nearly three-quarters of adults were aged between twenty and thirty-four, similar to the medical immigrants in this paper.[156] Most if not all of them would have been infected before they emigrated, based on an average interval of three years between disease onset and death.[157]

The idea that climate might be important is an old one. In 1756, Ebenezer Gilchrist wrote about the sea voyage for consumption as 'a grand remedy of antiquity':

> It has been chiefly in consumptive cases that I have recommended sailing; to the cure of which it seems altogether suited; and as no adequate remedy has yet been discovered, this encourages and justifies a serious trial of it, in this particular distemper, so frequent and fatal in Great Britain.[158]

By the nineteenth century, with the opening up of the antipodean colonies, others began to take up the theme. In 1827, Peter Cunningham wrote:

> The extraordinary healthiness of the climate of New South Wales must be of no trifling important in the eyes of a European … the European phthisis is uniformly cured or at least relieved by a removal hither, if easily resorted to.[159]

Probably the most influential of these Australian proponents of therapeutic migration was Samuel Dougan Bird, an English physician whose own tuberculosis became apparent about 1860, when he was in his late 20s. Following the then

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[154] Bryder, "'A Health Resort," 462.

[155] Sergio Sabbatani, "Le Epidemie sul Mare: Odissee di Migranti del XIX Secolo," *Le Infezioni nella Storia della Medicina* 23, no. 2 (2015): 204. *Ragazze* ought to be translated as girls since Italian normally uses the masculine plural (would have been *ragazzi*) for a collective which includes both males and females. It seems unlikely though that the boys would sleep elsewhere.

[156] Bryder, "A Health Resort," 465.

[157] Edine W Tiemersma et al., "Natural History of Tuberculosis: Duration and Fatality of Untreated Pulmonary Tuberculosis in HIV Negative Patients: A Systematic Review," *PLOS One* 6, no. 4, e17601. doi:10.1371/journal.pone.0017601 (2011): 9-10.

[158] Ebenezer Gilchrist, *The Use of Sea Voyages in Medicine* (London: Millar, Wilson and Durham, 1756), 44.

[159] Peter Cunningham, *Two Years in New South Wales: A Series of Letters Comprising Sketches of the Actual State of Society in That Colony, of Its Peculiar Advantages to Emigrants; of Its Topography, Natural History, &c. &c.*, vol. 1 (London: Henry Colburn, 1827), 183-4.

fashionable advice, he travelled twice to Melbourne, where he eventually settled in 1862 and subsequently recovered.[160]

Bird became a passionate advocate for the benefit of the antipodean climates and the long sea voyage: 'where the patient 'is exposed to the complete and continuous alterative of constantly breathing the pure, stimulant, ozoniferous, and yet soothing air of mid-ocean.'[161] David O'Sullivan wrote: 'With his health restored, Bird's ability as a physician soon placed him among the leaders of his profession.'[162] His recovery from phthisis appears to have left no sequelae, as attested by his longevity. He died at the age of 71 from cancer of the oesophagus, and was buried in Melbourne's Kew Cemetery (Figure 6.2).[163]

Figure 6.2: Tombstone of S Dougan Bird and his young son. Kew Cemetery**,** Melbourne, grave R/C A0240. His wife was buried in the same plot but not noted on this tombstone. Photograph by author.

Others followed suit, but cautioned against sending patients with advanced disease for fear they die on the journey and suffer, as Isaac Brown writes, 'many sorrowful partings, and the separation from spiritual communion with those nearest and dearest, which in this fatal type of the disease is the only consolation left.'[164] Marie Rogers noted that there was also criticism 'about bringing people to the colony to die among strangers almost

[160] David M O'Sullivan, *Bird, Samuel Dougan (1832-1904)*, Australian Dictionary of Biography (National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/bird-samuel-dougan-2996/text4383, published first in hardcopy 1969, accessed online 1 August 2020.

[161] S Dougan Bird, *On Australasian Climates and Their Influence on the Prevention and Arrest of Pulmonary Consumption* (London: Longman [etc.], 1863), 25, 116-7.

[162] O'Sullivan, *Bird, Samuel Dougan*.

[163] Samuel Dougan Bird, death certificate (VIC), 15 May 1904, 4377/1904.

[164] Isaac Baker Jr Brown, *Australia for the Consumptive Invalid: The Voyage, Climates, and Prospects for Residence* (London: Robert Hardwicke, 1865), 27; Richard Payne Cotton, "Consumption and Climate," *British Medical Journal* 1, no. 838 (1877): 67; John C Thorowgood, "Ocean Voyages in Pulmonary Phthisis," ibid. 2, no. 2028 (1899): 1388; J Burney Yeo, "Sea Voyages and Phthisis," *Lancet* 142, no. 3661 (1893): 1089; Hermann Johnston Jones, "Ocean Voyages in Pulmonary Phthisis," *British Medical Journal* 1, no. 2036 (1900): 47.

immediately on landing … [since] the image of Victoria, as a vibrant, expanding colony, was being tarnished.'[165]

On the other hand, two in particular argued against the notion that the Australian climate offered any benefits to consumptives. In 1855, James Kilgour wrote a book in which he argued that far from benefiting tuberculosis, it must instead be 'extremely *favourable* [my emphasis] to its origin and growth.'[166]

Perhaps the most important dissenter to the dogma that the climate was beneficial was William Thomson. Thomson was surgeon-in-charge of many passenger ships sailing between England and foreign ports and had heard 'about the good repute Australian climates were rapidly gaining for their supposed salutary influence, especially over phthisis.' He began practice in Victoria in 1854 and saw many cases of the disease. This led him to a detailed assessment of mortality statistics in the colony. He noted that, in 1876–77, just under a quarter of those who died from phthisis were born in Australia; and of those born overseas, 90 percent had lived in Victoria for five or more years (implying they contracted it there).[167] His strident questioning of the dogma that the climate was beneficial led him into conflict with the Victorian medical establishment, including the *Australian Medical Journal*, of which he had been editor.[168] After his death in 1883, his obituarist refers to his tempestuous and argumentative relationship with the Medical Society of Victoria and the *Journal*, but also pays tribute to Thomson's advocacy for a germ aetiology of tuberculosis, three years before Robert Koch presented his elegant experiments to the Berlin Physiological Society.[169] Koch had not only identified the bacteria in tuberculous organs but cultured them and proved they reproduced the disease in experimental animals—'Bazillen nicht nur Begleiter des tuberkulösen Prozesses, sondern die Ursache desselben sind' [the bacilli are not only companions of the tuberculous process, but the cause of it].[170] Of course, even knowledge that the disease was an infection would not necessarily negate warmer climates helping

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[165] Marie G Rogers, "For the Good of Their Health: A Social History of Consumption, Victoria 1863-1900" (MA, University of Melbourne, 1984), 5.

[166] James Kilgour, *Effect of the Climate of Australia Upon the European Constitution in Health and Disease* (Geelong, Vic: William Vale, 1855), 11-17.

[167] William Thomson, *On Phthisis and the Supposed Influence of Climate: Being an Analysis of Statistics of Consumption in This Part of Australia with Remarks on the Increase of That Disease in Melbourne* (Melbourne: Stillwell & Knight, 1879), vi-vii, 3-50.

[168] Bryan Gandevia, *Thomson, William (1819-1883)*, Australian Dictionary of Biography (National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/thomson-william-4718/text7823, published first in hardcopy 1976, accessed online 2 August 2020; Smith, "Gullible's Travails," 119-24.

[169] "Mr William Thomson FRCS Ed," *Australian Medical Journal* 5, no. 7 (1883): 318.

[170] Robert Koch, "Die Ätiologie der Tuberkulose," *Berliner Klinische Wochenschrift* 19, no. 15 (1882): 221-30, 442.

recovery; Bryder mentions there were still proponents for that early in the twentieth century.[171]

Suicide and Alcohol Abuse in the Medical Immigrants

The second most common cause of death in these doctors was by their own hand. I remarked earlier that some were certified as accidental, though the evidence seems suggestive of suicide. Timothy Coghlan notes in 1898 the 'growing disposition … of coroners' juries to attribute [charitably] to accident what is really the result of an impulse at self-destruction'; Alannah Tomkins, in her aptly titled chapter *Despairing doctors*, notes a similar practice in nineteenth century Britain.[172] It is hard to calculate an accurate mortality rate for the immigrant doctors, but using the more conservative of the methods described above, their suicide rate may have been around 120 per 100,000 p.a. This is somewhat higher than estimated by Coghlan and JJ Fenton for the whole population.[173] Tomkins found that suicide accounted for almost three percent of all deaths in practitioners under the age of forty-four.[174] It was responsible for an even higher proportion (11 percent) of the early deaths described in this paper.

What factors may have driven these, mostly young, professionals to suicide? Financial insecurity may have played some part. Probate records could be retrieved for five, all of whom died intestate.[175] The mean value of their estates was £48; and for two with estates of £20 or less, there would have been little in reserve for contingencies. Tomkins also found impending financial failure to be a quite common precipitant in her British study.[176]

Notably, two-thirds of those who suicided were single, and the wife and children of another were still in England.[177] Émile Durkheim's classic studies in nineteenth century France showed that unmarried males aged thirty to fifty were three times more likely to suicide than married men: 'la vie de famille y agit très différément sur le suicide.'[178] Loneliness might have been common in those who came out by themselves to practise in an unfamiliar country; more than half of those who killed themselves did

[171] Bryder, "'A Health Resort," 457.
[172] Timothy A Coghlan, *A Statistical Account of the Seven Colonies of Australasia, 1897-8* (Sydney: Government Printer, 1898), 117; Alannah Tomkins, *Medical Misadventure in an Age of Professionalisation, 1780-1890* (Manchester: Manchester University Press, 2014), 236.
[173] Coghlan, *A Statistical Account*, 74,748.
[174] Tomkins, *Medical Misadventure*, 232.
[175] Probate: VPRS28/P1, unit 9, item 4/684; VPRS28/P2, unit 9, item 10/162; ibid., unit 51, item 14/807; ibid., unit 346, item 50/034; ibid., unit 393, item 56/020.
[176] Tomkins, *Medical Misadventure*, 250.
[177] Probate: VPRS28/P2, unit 51, item 14/807.
[178] 'Family life affects very differently [the risk of] suicide': Émile Durkheim, *Le Suicide: Étude de Sociologie* (Paris: Félix Alcan, 1897), 183, 203.

it within a year of arrival. David Fitzpatrick writes that 'many nineteenth century emigrants ... found Australia a harsh and hostile environment ... their letters home, when preserved, provide invaluable testimony to the personal costs and pains entailed by migration.'[179] Much more recently, the Midtown Manhattan Project showed that social isolation in an urban environment was one of the risk factors for depression.[180]

Some of these migrants who found their lives in Australia so difficult that they ended them may well have been on a downward trajectory even before they left Britain. This may have been why they left in the first place, in the hope of better times. I mention in Chapter 5 that some may have been running away from charges of negligence by the inspectorate of the Poor Law. Anne Digby and ISL Loudon remarked on the nineteenth century competition with other doctors, as the profession in England became crowded, so that establishing a financially viable practice became challenging.[181] Moving to potentially greenfield sites in the new colonies would likely have been a magnet: indeed, Charles Keetley wrote a treatise that encouraged it.[182] One can speculate that other reasons might have been to escape an unhappy marriage, as described by some of the contemporary migrants in Chapter 10, or avoiding debts.

Alcohol probably contributed to the death of perhaps ten percent of this group of immigrant doctors. Four who committed suicide were reported to drink very heavily, and had been doing so around the time they died. Others died from or with alcoholic liver disease or alcohol-related trauma. Alcohol is often the refuge of the disillusioned and the despairing. Timothy Coghlan reports that, in 1896, there were 47,578 arrests in Victoria for drunkenness.'[183] James Backhouse travelled extensively in Australia in the 1890s, where he notes that 'drunkenness and debauchery' were 'awfully prevalent.'[184] At a time when doctors still prescribed alcohol for various ailments,[185] too many fell victim to their own remedy.

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[179] David Fitzpatrick, Patrick Comber, and Edward Comber, "'An Outside Part of the World': Patrick and Edward Comber, 1862-92," in *Oceans of Consolation: Personal Accounts of Irish Migration to Australia*, ed. David Fitzpatrick (Ithaca, NY: Cornell University Press, 1994), 230.

[180] Leo Srole, "Community Institutions and Psychosocial Climate," in *Mental Health in the Metropolis: The Midtown Manhattan Study*, eds. Leo Srole, et al. (New York: McGraw-Hill, 1962), 119-21.

[181] Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*, (Cambridge: Cambridge University Press, 1994), 15,43; Loudon, "A Doctor's Cash Book: The Economy of General Practice in the 1830s," 255.

[182] Keetley, *The Student's and Junior Practitioner's Guide to the Medical Profession*. 46.

[183] Coghlan, *A Statistical Account*, 112..

[184] James Backhouse, *A Narrative of a Visit to the Australian Colonies* (London: Hamilton, Adams and Co., 1843), 332, 413.

[185] FB Smith, "Curing Alcoholism in Australia, 1880s-1920s," *Journal of Australian Colonial History* 8 (2006): 142-3.

One of the challenges of researching deaths, in any era, is the accuracy of death certificates. From comments made above, it will be clear that the pathological expertise of some doctors who performed autopsies was questionable. Nineteenth century medical education in Britain generally assured anatomical knowledge, but training in pathology and understanding of diseases was still in evolution.[186] For most of these doctors diagnosed by their contemporaries with phthisis, the conclusion was very likely correct. The features of that disease were characteristic and well known. Similarly, there should be little doubt about those definitively certified as suicide— the second main theme to emerge from these histories. However, for others I have often applied retrospective diagnosis—a risky process that Axel Karenberg writes should be 'used [only] in the form of an historical interpretation within a certain historical context.'[187]

This compilation of case histories paints a picture of the burden of illness that afflicted some of Victoria's and Queensland's earliest doctors, though it should be noted that a much greater proportion survived this arbitrary three-year window, often continuing to practise for decades in an era when mean life expectancy was little more than fifty years. But, for those featured here, it was in truth a dangerous migration.

Conclusion

The two groups of immigrant doctors identified through the prosopography and examined in this chapter are strikingly different. The small proportion who ended up in colonial politics had managed to do so as a consequence of acquiring some standing in their community. What part, if any, their medical skills played in that can only be surmised. However, Raymond Duplain's study of the elites in colonial Victoria indicates that the doctors were often highly regarded, and would have had networks that helped them get elected.[188] Once in parliament, I present evidence that their medical background informed at least some of their legislative activities, and we can speculate that a desire to influence the standing and activities of the profession may have motivated some to seek election in the first place. While some of those outcomes may appear self-serving, others were likely to the benefit of the community's health.

The second group of colonial doctors is of course very different. Their stay in Australia was, by definition, brief, and is a reminder of the occupational hazards that were part and parcel of medical practice in that era. The causes of their death reflect

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[186] Charles Newman, *The Evolution of Medical Education in the Nineteenth Century* (London: Oxford University Press, 1957), 107-9.

[187] Axel Karenberg, "Retrospective Diagnosis: Use and Abuse in Medical Historiography," *Prague Medical Report* 110, no. 2 (2009): 140-45.

[188] Raymond C. Duplain, "Elites in the Colony and State of Victoria 1860-1939: A Prosopographical Analysis" (PhD, Deakin University, 1994), 256-60.

many of the health hazards in the nineteenth century world, before our modern understandings of disease and therapeutics. And that there was controversy about whether climate contributes to outcomes in tuberculosis points to some of the deficiencies in the application of scientific methods in the nineteenth century.

These are just two examples of how the names that populate a prosopography can be used to link with other sources for historical research. Future work might examine, for instance, the history of doctors who became farmers, winemakers, created hospitals, descended into infamy or moved back overseas. The database will be made available to others who, as well as the author, may wish to pursue such questions.

Future research could of course draw on other methodologies, such as the use of memoirs and more extensive use of newspaper articles than the limited purpose (searching for causes of death) to which I used them here.

Chapter 7

The Prosopography: IMGs in Australia, 1901–1984

For the next half century after the Australian federation, the pattern of IMG migration that became established late in the nineteenth century continued with only minor fluctuations. The overwhelming majority of the IMGs had qualified in England, Scotland, or Ireland, though they were rapidly outnumbered by graduates from the Australian medical schools (Figures 7.1 and 7.2).

John Seale and JM Last documented the numbers of British doctors migrating to Australia between 1901 and 1962.[1] However, there are some errors in each paper. Last tabulated registrations by state and territory from 1901 to 1962. His figures are a marked underestimate, even though he attempted to report only those who were registered and *resident* in the jurisdiction at each time. Seale's report of the British and Irish graduates registered in 1930-61 was much more accurate. He used information provided by the registrars of the medical boards/councils in five states (Queensland declined to assist): the result was correct for Victoria, and the discrepancy between my prosopography and his tabulation was never greater than 13 in the other four states. There also appears to be a typographical error in Fallon Mody's recent thesis. She reports a total of 569 British and Irish graduates registered in Victoria in the period 1931-60, whereas my calculation is 669 and Seale's was 673.[2]

From 1950 onwards, there was a marked, progressive increase in the IMGs registering in every state and territory. Between 1970 and 1984, the proportion coming from countries outside the British Isles reached or exceeded parity with that from UK and Ireland in every state except Queensland. The inflexion point for these striking changes began around 1960, as Australia's restrictive migration policy began to be relaxed. The changes are illustrated in Table 7.1, which lists the countries in which IMGs had qualified by UN geographic regions.[3] Altogether, 23,035 IMGs were registered in the eight states and territories between 1901 and 1984, 76 percent in just the final 24 years. Those figures are derived by totalling the IMG registrations in the separate records of each jurisdiction, so are an overestimate of all IMGs coming to Australia in the period—some will have registered in more than one state or territory. The precise data are in the separate sections for each jurisdiction in the prosopography database uploaded to https://figshare.com (link in Appendix B).

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[1] JM Last, "Migration of British Doctors to Australia," *British Medical Journal* 2, no. 5359 (1963): 744; John Seale, "Medical Emigration from Britain, 1930–1961," ibid., 1, no. 5280 (1962): 782. Last's total for the period 1901-1962 was only 1766, compared with my calculation of 4386 registered 1901–60.

[2] Fallon Mody, "Doctors Down Under: European Medical Migrants in Victoria (Australia), 1930-60" (PhD, University of Melbourne, 2018), 9, Table 1.

[3] "United Nations Statistical Division: Geographic Regions," accessed 26 August 2018, https://unstats.un.org/unsd/methodology/m49/.

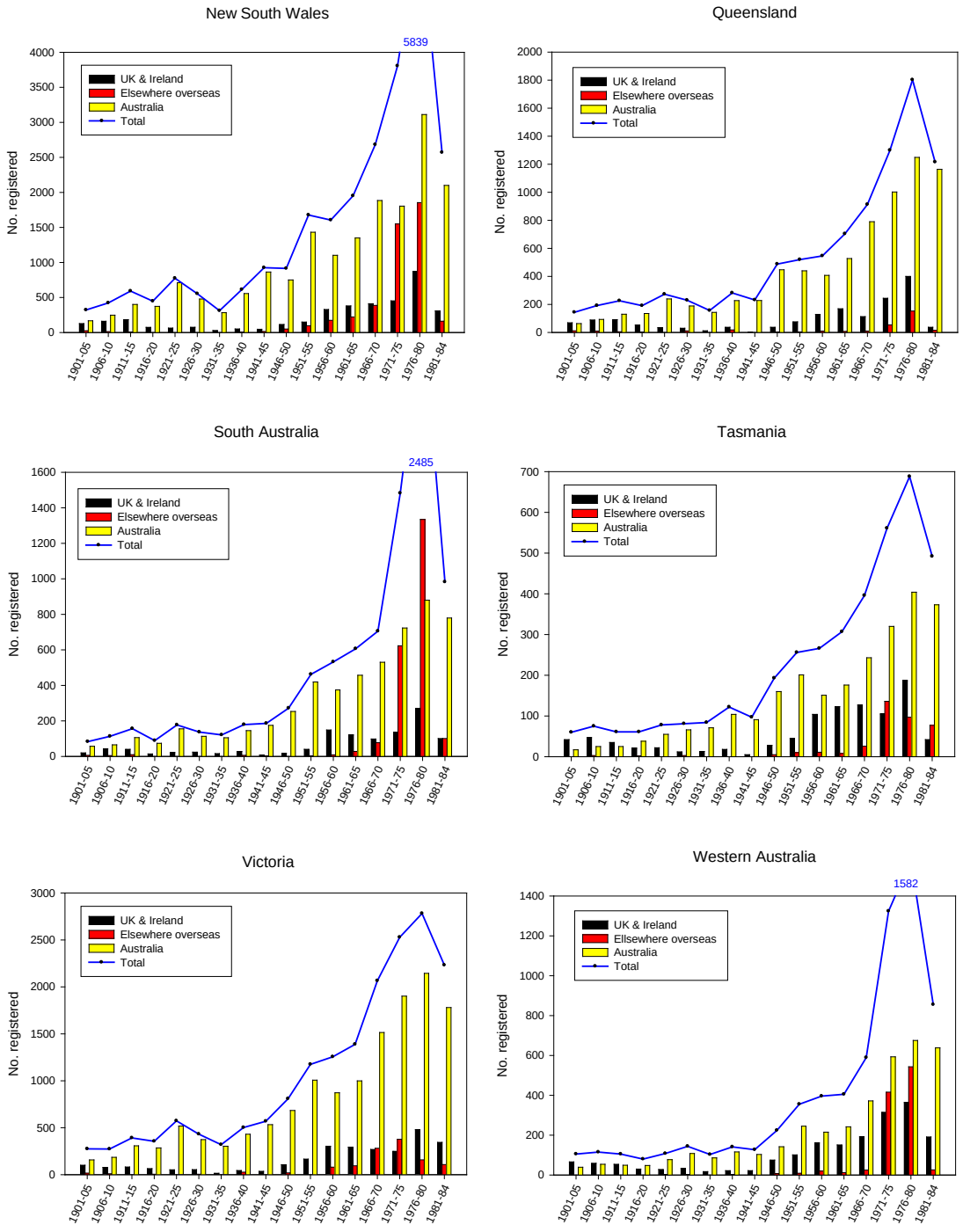

Figure 7.1: IMGs newly registered in each state between 1901 and 1984. The decrease in total numbers in the final period is *partly* artefactual since the interval is 4 years not 5 (but see discussion of other factors in text).
Not included in the NSW graph are 25 IMGs registered between 1947 and 1955 where neither the Register nor Board Minutes list their qualifications and where or when obtained, only that they were registered under Sec. 17B or 17(1)(c) of the 1945 or 1950 Medical Act; a further 10 between 1957 and 1977 were registered without record of the country of qualification (3 under Sec.17(2A) of the Act).

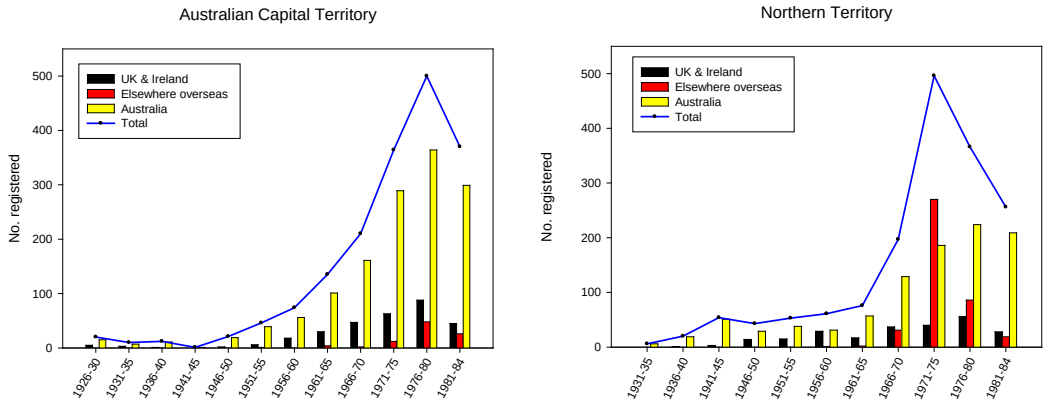

Figure 7.2: IMGs newly registered in the Australian territories, from the commencement of their medical boards (ACT 1930, NT 1935) until 1984.

Table 7.1: IMGs newly registered in an Australian state or territory, by region of country of primary medical qualification

UN Statistical Region	1901-60		1961-84	
	No. registered	No. per annum	No. registered	No. per annum
Northern Europe	4776	79.60	8075	336.46
Eastern Europe	174	2.90	272	11.33
Southern Europe	162	2.70	145	6.04
Western Europe	185	3.08	149	6.21
Central Asia	0	0.00	1	0.04
Eastern Asia	26	0.43	1399	58.29
South-eastern Asia	24	0.40	2443	101.79
Southern Asia	43	0.72	2738	114.08
Western Asia	2	0.03	27	1.13
Northern America	73	1.22	464	19.33
Central America	0	0.00	2	0.08
Latin America & Caribbean	0	0.00	1	0.04
South America	4	0.07	26	1.08
Northern Africa	4	0.07	126	5.25
Sub-Saharan Africa	63	1.05	1606	66.92
Oceania	0	0.00	25	1.04

*https://unstats.un.org/unsd/methodology/m49. UK and Ireland are in UNSTAT's Northern Europe zone. An unknown number of IMGs will have registered in more than one state or territory.

The change in the regions which were the source of most IMGs before and after 1960 is striking. Australia, for its IMGs as well as its population as a whole, had moved to embrace Asia. Although Northern Europe (which includes UK and Ireland) was still

the largest single source, more IMGs had for the first time qualified elsewhere in the world—most notably in Southern and South-eastern Asia. An emerging source region was Sub-Saharan Africa, nearly entirely due to increasing medical migration from South Africa.

How quickly the IMGs migrated after they had qualified varied significantly during the period from Federation till 1984, as can be seen in Figure 7.3. In the years surrounding the two World Wars, the interval between qualifying and migrating (a surrogate for the IMG's ages) increased substantially. Some of the younger ones would have seen active military service as doctors and had to put their civilian careers on hold; and, in any case, the wars curtailed travel for populations as a whole except for refugees.

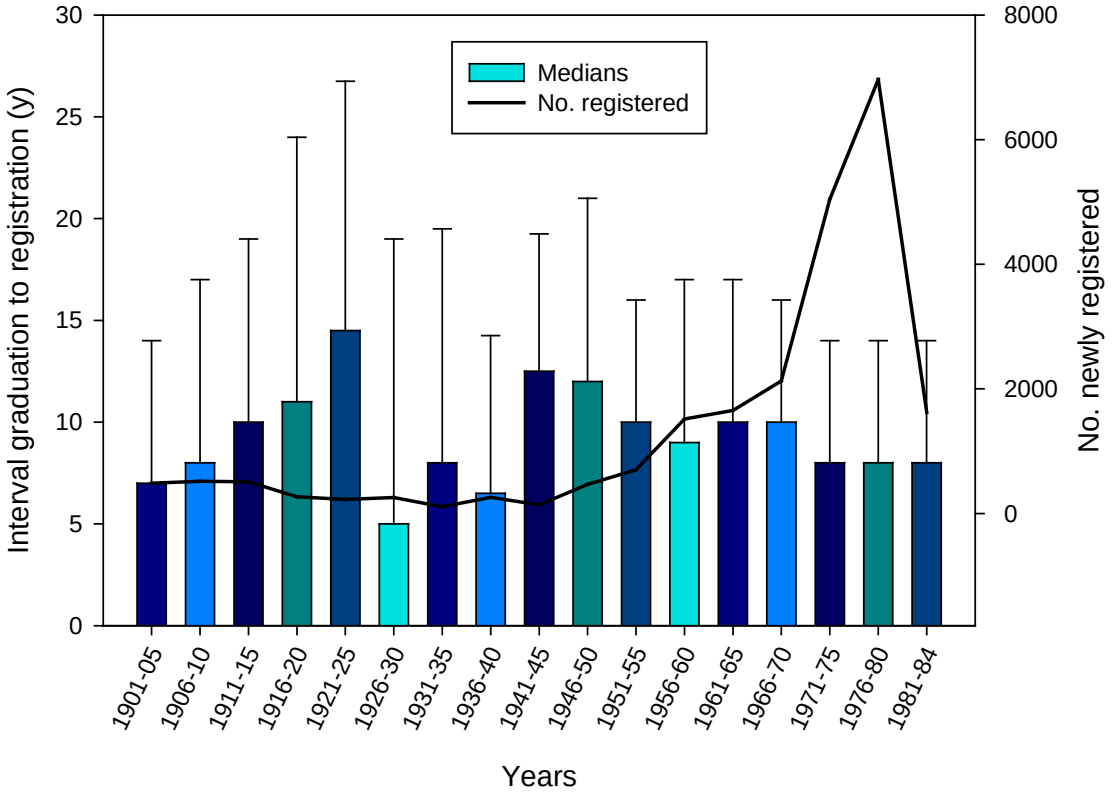

Figure 7.3: Time elapsed between obtaining first medical qualification and registration in an Australian state or territory, 1901-84. Medians and upper quartile. p<0.001 (ANOVA on ranks).

This was the panoramic view: post-colonial medical migration to Australia seen as a whole. Some patterns and themes, such as those noted above, were evident right across the country. Others were more specific to particular jurisdictions or particular periods and will be explored below. Tables 7.2 to 7.7 list the numbers of IMGs registered in the Australian States by decade between 1901 and the prosopography cut-off date of 1984. Tables 7.8 and 7.9 provide the data for the Australian Capital Territory and Northern Territory from when their medical registers commenced in 1930 and 1935 respectively. These tables list only countries which contributed at least one percent of

the IMGs registered in each jurisdiction. The complete tabulated information for *all* countries is in Supplementary Table 4, Appendix A.

Table 7.2: Country of qualification: IMGs registered in NSW, 1901–84*

Country	1901-10	1911-20	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Canada	3	2	0	0	1	0	20	123	10	159	1.9
Ceylon†	0	0	0	0	1	6	28	250	7	292	3.5
Egypt	0	0	0	0	0	0	11	61	8	80	1.0
England	103	95	55	28	89	270	517	821	209	2187	26.6
Hong Kong	0	0	0	1	2	4	52	502	3	564	6.9
Hungary	0	0	0	0	5	40	36	10	0	91	1.1
India	0	0	0	0	1	1	131	656	42	831	10.1
Ireland	38	41	13	8	22	67	65	209	28	491	6.0
Malaya‡	0	0	0	0	0	3	10	256	2	271	3.3
N. Ireland	0	0	3	1	5	17	20	36	9	91	1.1
Pakistan	0	0	0	0	0	0	31	87	4	122	1.5
Poland	1	0	0	0	5	31	27	23	2	89	1.1
Scotland	148	121	67	43	45	116	180	246	58	1024	12.4
Singapore	0	0	0	0	2	1	14	391	3	411	5.0
S. Africa	0	0	0	0	1	36	88	676	41	842	10.2
USA	3	1	1	0	0	1	39	70	6	121	1.5
All others	31	5	0	5	30	123	108	237	28	567	6.9
Totals	327	265	139	86	209	716	1377	4654	460	8233	100

*Excludes countries contributing <1.0% of the total. Data for all countries is in Supplementary Table 4, Appendix A (applies to Tables 7.3-7.9 also). †Sri Lanka after 1972; ‡Malaysia after 1963: applies also to Tables 7.3 to 7.9, where only the old name is listed, irrespective of the country's name when IMG graduated.

Not included: 38 where neither the Register nor Board Minutes list country of qualification, only the section of Act under which they were registered.

Table 7.3: Country of qualification: IMGs registered in Queensland, 1901–84*

Country	1901-10	1911-20	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Canada	3	2	1	0	0	1	0	50	0	57	3.0
Ceylon	0	0	0	0	0	2	0	18	2	22	1.2
England	54	52	23	17	23	134	195	356	22	876	46.2
Hong Kong	0	0	0	1	0	0	0	19	0	20	1.1
Ireland	20	17	10	6	4	13	5	124	5	204	10.7
Italy	10	2	9	18	2	1	0	0	0	42	2.2
N. Ireland	0	0	0	1	3	8	7	22	1	42	2.2
Scotland	84	75	31	25	10	48	72	134	9	488	25.7
S. Africa	0	0	0	0	0	1	6	72	3	82	4.3
All others	6	2	0	0	1	4	4	47	1	65	3.4
Totals	177	150	74	68	43	212	289	842	43	1898	100

*Excludes countries contributing <1.0% of the total. No country of origin recorded in minutes/register for 12 IMGs in 1970s: notated only as 'AMEC certificate'.

Table 7.4: Country of qualification: IMGs registered in South Australia, 1901–84*

Country	1901-10	1911-20	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Canada	1	0	0	1	0	1	3	18	9	33	1.0
Ceylon	0	0	0	0	1	1	2	53	4	61	1.9
England	19	19	26	19	16	118	142	259	80	698	21.5
Hong Kong	0	0	0	0	0	0	6	360	6	372	11.4
India	0	0	0	0	0	3	47	297	17	364	11.2
Ireland	11	7	3	3	3	12	13	54	5	111	3.4
Malaya	0	0	0	0	0	0	0	341	2	343	10.5
Pakistan	0	0	0	0	0	0	4	26	3	33	1.0
Scotland	33	28	17	22	6	44	51	82	14	297	9.1
Singapore	0	0	0	0	2	0	4	432	2	440	13.5
S. Africa	0	0	0	0	0	3	17	339	5	364	11.2
USA	7	6	0	0	0	0	4	15	14	46	1.4
All others	0	0	0	5	2	17	20	38	8	90	2.8
Totals	71	60	46	50	30	199	313	2314	169	3252	100

*Excludes countries contributing <1.0% of the total.

Table 7.5: Country of qualification: IMGs registered in Tasmania, 1901–84*

Country	1901-10	1911-20	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Canada	0	1	1	0	1	1	1	15	5	25	1.9
Ceylon	0	0	0	0	0	0	1	19	2	22	1.7
England	33	19	12	12	20	86	136	173	22	513	39.8
Hong Kong	0	0	0	0	0	1	3	9	2	15	1.2
India	0	0	0	0	0	1	12	103	5	121	9.4
Ireland	10	5	8	2	3	10	15	49	5	107	8.3
N. Ireland	0	0	0	0	1	6	6	7	1	21	1.6
Pakistan	0	0	0	0	0	0	0	19	0	19	1.5
Scotland	46	32	14	17	9	47	87	59	14	325	25.2
S. Africa	0	0	0	0	0	2	8	43	50	103	8.0
All others	0	0	0	0	0	2	6	9	0	17	1.3
Totals	89	57	35	31	34	156	275	505	106	1288	100

*Excludes countries contributing <1.0% of the total.

Table 7.6: Country of qualification: IMGs registered in Victoria, 1901–84*

Country	1901-10	1911-20	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Ceylon	0	0	0	0	0	3	36	65	11	115	3.0
England	59	57	41	25	82	301	396	450	236	1647	42.9
Hong Kong	0	0	0	0	0	1	53	105	4	163	4.2
India	0	0	0	0	0	7	141	193	22	363	9.5
Ireland	14	19	8	6	13	43	35	111	32	281	7.3
Italy	5	2	6	27	0	1	2	3	0	46	1.2
Malaya	0	0	0	0	0	3	21	21	4	49	1.3
N. Ireland	0	0	0	1	4	18	12	27	5	67	1.7
Scotland	107	71	57	27	43	101	114	126	63	709	18.5
Singapore	0	0	0	0	0	1	35	28	2	66	1.7
S. Africa	0	0	0	0	0	12	35	36	13	96	2.5
All others	20	5	2	1	17	51	43	60	38	237	6.2
Totals	205	154	114	87	159	542	923	1225	430	3839	100

*Excludes countries contributing <1.0% of the total.

Table 7.7: Country of qualification: IMGs registered in Western Australia, 1901–84*

Country	1901-10	1911-20	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
England	45	32	29	23	52	155	216	414	123	1089	37.7
Hong Kong	0	0	1	0	0	2	8	221	1	233	8.1
India	0	0	1	0	1	2	3	30	4	41	1.4
Ireland	20	16	12	2	13	23	34	105	18	243	8.4
Malaya	0	0	0	0	0	1	0	145	1	147	5.1
N. Ireland	0	0	0	0	0	12	6	15	3	36	1.2
Scotland	59	35	20	14	35	67	77	145	41	493	17.1
Singapore	0	0	0	0	0	3	1	428	4	436	15.1
S. Africa	1	0	0	0	0	5	14	78	3	101	3.5
All others	0	0	0	0	1	5	10	46	9	71	2.5
Totals	125	83	63	39	102	275	369	1627	207	2890	100

*Excludes countries contributing <1.0% of the total.

Table 7.8: Country of qualification: IMGs registered in Australian Capital Territory, 1930–84*

Country	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Ceylon	0	0	0	0	0	1	6	7	1.8
England	2	1	2	17	48	93	32	195	49.0
Hong Kong	0	0	0	0	2	10	1	13	3.3
India	0	0	0	0	0	2	7	9	2.3
Ireland	2	0	0	0	7	23	4	36	9.0
Malaysia	0	0	0	0	0	8	2	10	2.5
N. Ireland	0	0	0	2	5	3	1	11	2.8
Scotland	1	3	0	5	17	31	8	65	16.3
Singapore	0	0	0	0	0	18	0	18	4.5
South Africa	0	0	0	1	3	20	2	26	6.5
All others	0	0	0	0	1	2	8	11	2.8
Totals	5	4	2	25	83	210	69	398	100†

*Excludes countries contributing <1.0% of the total. †Total of column appears >100, but is artefactual due to rounding cells to one decimal place.

Table 7.9: Country of qualification: IMGs registered in Northern Territory, 1935–84*

Country	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Burma	0	0	0	0	7	1	%	1.2
Canada	0	0	0	1	12	1	14	2.2
Ceylon	0	0	0	1	89	2	92	14.2
Egypt	0	0	0	1	5	1	7	1.1
England	1	9	25	31	56	16	138	21.3
Hong Kong	0	0	0	4	7	0	11	1.7
India	0	0	0	17	150	7	174	26.8
Ireland	0	4	5	4	16	2	31	4.8
Malaysia	0	0	0	2	13	0	15	2.3
N. Ireland	0	0	2	1	2	2	7	1.1
Pakistan	0	0	0	1	7	0	8	1.2
Philippines	0	0	0	0	10	0	10	1.5
Scotland	0	4	11	16	21	8	60	9.2
Singapore	0	0	0	2	9	0	11	1.7
South Africa	0	0	1	4	9	3	17	2.6
All others	0	0	1	3	40	2	46	7.1
Totals:	1	17	45	88	453	45	649	100.0

*Excludes countries contributing <1.0% of the total. Between inauguration of the NT Medical Board (1935) and 1940, all but one who registered in NT were Australian graduates (see Fig. 6.2).

One point about these tables warrants comment. The numbers of IMGs registered in the final period in every state and territory is less than for the preceding period. This of course is partly artefactual—that period is just four instead of ten years. However, for most source countries, the numbers registering in those final four years was disproportionately low: the total number of IMGs registered across the country in 1971-80 was 11,830, compared with only 1,529 in 1981–84: an 87 percent reduction versus the expected 60 percent reduction due to the compressed time scale of the last column.[4] Thus other factors must have been at play. One that began to apply across jurisdictions was the medical boards starting to require non-British IMGs to have passed the AMEC examinations before they would be registered (see Chapter 4). It seems self-evident that this would have deterred some potential medical immigrants. Another factor was changes in the medical Acts that had the effect of restricting eligibility of IMGs for registration; the cause and consequences of one of these concerning non-residents is examined later for Western Australia.

Several themes in post-Federation IMG migration can be discerned from the data compiled in the prosopography and summarised in Tables 7.2–7.9. These will be discussed in approximately chronological order as they emerged during the period.

The World Wars and the Great Depression

WWI had an effect on medical immigration in every state, with the biggest impact on Tasmania and Western Australia, where only about two thirds as many registered in 1911–20 compared with the previous decade. As noted already, the IMGs at this time were nearly all from Great Britain and Ireland; they probably were needed at home, Australia was also at war, and the sea voyage may have been more hazardous. The Great Depression of the 1930s and late 1920s had an even larger impact, particularly on migration to New South Wales, Queensland and Western Australia, where the number of IMGs arriving in the 1930s was less than half that in 1911–20. Curiously, the least affected state was South Australia, despite evidence it was the Australian state most affected economically by the Depression.[5]

The effect of WWII on IMG migration is masked in the tables because the data shown are for the whole decade of the 1940s. However, the year-by-year data in the prosopography show that there were few IMG registrations during the war years then

[4] The difference between observed and expected is highly significant: $p<0.001$

[5] John Wanna, *Defence Not Defiance: The Development of Organised Labour in South Australia* (Adelaide: Adelaide College of the Arts and Education, 1981), 102; Susan Martin, "South Australia and the Great Depression," *Cabbages and Kings* 23 (1995): 10.

a substantial surge, mainly from Britain and Ireland, in the years immediately after cessation of hostilities.

Refugee Doctors circa WWII

Graduates from Britain and Ireland continued to provide the great majority of medical immigrants to Australia in the interwar period and up till about 1960. Between 1935 and 1960, a total of 3184 IMGs were registered in the States and Territories, of whom 2576 (80.9 percent) qualified in the British Isles. However, two overlapping waves of refugee migrants reached Australia during those years, and some of them were doctors. They were part of a world-wide response to the approximately 60 million Europeans forced to move (even temporarily) as a result of the war, its prelude, and its aftermath.[6] The first wave commenced immediately before World War II, comprised mainly of German, Austrian, Polish and other European Jews fleeing the imminent and actual danger of the Nazi pogroms.[7] Jacques Vernant estimates that about 4500 came to Australia and New Zealand in 1939, and Suzanne Rutland calculates a total of about 26,000 Jewish refugees over the longer period 1938–54.[8] The second wave, which occurred in the aftermath of the war, was the arrival of displaced persons (DP) escaping particularly from the Soviet Bloc countries of Eastern Europe. Gabrielle Wolf and Egon Kunz have made important contributions to the historiography of the medical migrants in each of these periods, including documentation of the machinations of the Australian medical profession to exclude them.[9] Other contributors to this literature are John Weaver and Fallon Mody.[10]

1935–1950

Between 1935 and 1950, 151 of the 904 IMGs registered in the Australian jurisdictions (16.7 percent) had graduated in Continental Europe (Table 7.10). Most registered in New

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[6] Malcolm J Proudfoot, *European Refugees, 1939-52: A Study in Forced Population Movement* (London: Faber, 1957), 21.

[7] Jacques Vernant, *The Refugee in the Post-War World* (New Haven: Yale University Press, 1953), 703.

[8] Ibid., 60; Suzanne D Rutland, *The Jews in Australia* (Cambridge: Cambridge University Press, 2005), 51.

[9] Gabrielle Wolf, "Moritz Meyer and the Medical Board: Preventing Refugee Doctors from Practising Medicine in Victoria, Australia, 1937-1958," *Journal of Law and Medicine* 26, no. 1 (2018); Ibid., "Machinations of the British Medical Association: Excluding Refugee Doctors from Queensland's Medical Profession, 1937-1942," *American Journal of Legal History* 59 (2019); Ibid., "The Law and Politics of Registering Doctors: Lessons from New South Wales, 1937-42," *UNSW Law Journal* 43, no. 4 (2020); Egon F. Kunz, *The Intruders : Refugee Doctors in Australia* (Canberra: Australian National University Press, 1975); "Some Basic Determinants of Post-War Refugee Naturalisations in Australia," *Australian and New Zealand Journal of Sociology* 7, no. 2 (1971).

[10] John Weaver, "'A Glut on the Market': Medical Practice Laws and Treatment of Refugee Doctors in Australia and New Zealand, 1933-1942," *Australian and New Zealand Law and History E-Journal* 2 (2009): 1, 4-10, 16-18; Fallon Mody, "'The Intellectual Boys Are the Ones in a Mess': The Unregistered Doctors Association in Victoria, 1951-56," *Health and History* 17, no. 1 (2015): 21-3.

South Wales and Victoria, and many had family names suggesting they were likely to be Jewish.[11] Twenty were registered by Queensland, all but two of whom had qualified in Italy (only four with recognisably Italian names); very few were licensed in South Australia, Tasmania, or Western Australia.

Table 7.10: IMGs registered in Australia 1935–1950 from Continental Europe*

Country of qualification	NSW	QLD	SA	TAS	VIC	WA
	No. registered (% of all IMGs in period)					
Austria	13 (4.5)	0	0	1 (1.6)	8 (3.4)	4 (2.9)
Czechoslovakia	3 (1.0)	1 (1.0)	0	0	0	0
France	5 (1.7)	0	0	0	1 (0.4)	0
Germany	8 (2.8)	0	0	1 (1.6)	6 (2.5)	2 (1.4)
Hungary	5 (1.7)	0	0	0	1 (0.4)	0
Italy	3 (1.0)	18 (17.8)	7 (9.3)	3 (4.8)	26 (11.0)	3 (2.1)
Lithuania	0	0	0	0	1 (0.4)	0
Malta	0	1 (1.0)	0	0	0	0
Netherlands	1 (0.3)	0	0	0	0	0
Poland	5 (1.7)	0	0	0	2 (0.8)	0
Romania	2 (0.7)	0	0	0	0	0
USSR	2 (0.7)	0	0	0	0	0
Not recorded†	14 (4.8)	0	2 (2.7)	0	0	0
Total all IMGs	290	101	75	62	236	140

*i.e., excludes graduates from Britain and Ireland.
†Country of primary medical qualification not recorded in either Medical Register or Board Minutes.

Those who managed to be registered were the fortunate ones. Gabrielle Wolf forensically investigated the forces that were stacked against many of these Jewish IMGs. One notable case was Dr Moritz Meyer, who graduated MD in Leipzig about 1920, fled Germany after 15 years practice in Berlin and Dresden,[12] then studied again in Scotland to be awarded the 'Scottish triple qualification' in 1937.[13] When he came to Melbourne, the Medical Board of Victoria refused to register him, at a time when antisemitic sentiment was prevalent in the community at large,[14] and the BMA and Medical Boards mounted campaigns to exclude European doctors.[15] Wolf describes Meyer's travails, starting with his argument to the Supreme Court of Victoria that the Board's decision was contrary to its governing Act, to the ruling by that Court that he

[11] Prosopography, NSW and Victorian sections 1935-50.
[12] His medical licence was cancelled by the Nazis since he had four Jewish grandparents.
[13] See Chapter 1 for history of the 'Scottish Triple'.
[14] Suzanne D Rutland, "Australian Responses to Jewish Refugee Migration before and after World War II," *Australian Journal of Politics and History* 31, no. 1 (1985): 39.
[15] Wolf, "Machinations of the British Medical Association," 513-4.

was entitled to be registered, the Board's appeal against that ruling to the High Court, and the High Court's eventual decision to disallow the appeal.[16]

A close reading of the minutes of the Board's meeting, when it was forced to finally register Meyer, indicates it bitterness at its High Court defeat. At the end of the meeting, the Board member and influential surgeon, Sir Hugh Devine,[17] moved:

> That it be a recommendation to the Chief Secretary [State Premier] that section 14 of the Medical Act 1928 be amended as follows:
> (a) At the end of subsection (1) there shall be inserted the words "in a country recognised by the Board";[18]

This would have effectively allowed the Board to exclude doctors who had qualified in any country it chose. In the event, the 1938 amendment to the Victorian Act confined itself to requiring: 'Notwithstanding that he is possessed … of any one or more of the qualifications described in the Fourth Schedule to this Act [which still listed the Scottish triple qualification]', the country in which the IMG qualified must give reciprocity for practice by Victorian-registered doctors.[19] This let the Board exclude many from non-British countries until a degree of flexibility began to be introduced in amendments to the Act in the 1950s.[20] As Wolf points out, it is difficult to know how many refugees were affected: once the 1938 Act came into force it would have been pointless for them to apply and their names would not appear in the Board's minutes.[21] That 26 IMGs with Italian qualifications, most with Germanic names, managed to be registered up till 1950 was likely a result of Italy having given reciprocity for the registration of Victorian-licensed doctors.

Victoria was not the only state to vigorously oppose the registration of European Jewish doctors at that time. Wolf documents the actors inside and outside the Queensland Medical Board as it campaigned against the 'registration of aliens', including its lobbying of the government to amend the State's medical Act.[22] In New South Wales, too, the Board, the BMA, and the University of Sydney Senate combined to restrict the registration of non-British European doctors. In 1938, the Medical Act was redrafted so the Medical Board could not 'in any one year, grant the applications of

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[16] Wolf, "Moritz Meyer," 65-7.
[17] John Horan, *Devine, Sir Hugh Berchmans (1878-1959)*, Australian Dictionary of Biography (National Centre of Biography, Australian National University, 1981).
[18] VPRO: Medical Board of Victoria Minutes: VPRS16389, 1 September 1937.
[19] *Medical Act 1938 (3 Geo. VI No. 4617)*(VIC).
[20] *Medical Act 1950 No. 5498* (VIC); *Medical Act 1950 No. 5498* (VIC); *Medical (Registration) Act 1956 No. 5965* (VIC).
[21] Wolf, "Moritz Meyer," 70.
[22] Wolf, "Machinations of the British Medical Association," 515-22, 25.

more than eight persons who are not natural born British subjects.'[23] Furthermore, they needed to complete the last three years of the medical course at The University of Sydney.[24] Speaking to the 1938 Bill, the Minister for Health was explicit about the purpose of requiring foreign graduates to enrol for and pass the final half of the Sydney course:

> That has been done very deliberately because we do not want a great influx of foreign doctors. There are 2,000 young Australian medical students in the universities of the Commonwealth, of whom nearly 900 are students of the University of Sydney. Many of these young men [*sic*] [25] come from humble homes, and their parents have faced great financial stress and responsibility to provide them with an education for a high profession, the standard of which, at the University of Sydney, is probably unequalled in any other part of the world.[26]

Thus, as Wolf argues, the motives at the time were both xenophobia and protectionism, to which we could add hubris, given the Minister's conviction about the standing of the Sydney degree.[27] Wolf provides further evidence for the first two in her analysis of the activities of the Commonwealth Alien Doctors Board, set up during WWII to allow some of the European refugee doctors to practise under controlled conditions, because of the shortage of local doctors during the war.[28]

Despite the forces opposing their opportunity to practise, as Table 7.10 shows, some of these European IMGs managed to be registered between 1935 and 1950. Of the 63 in New South Wales, the largest numbers were trained in Austria and Germany. However, that State's Medical Board failed to record the country where 14 had qualified, noting merely that they had been registered under either s17B of the 1938/45 Act (eight in 1947) or s17(1)(c) (six in 1950).[29] The former group had been registered under the 'Temporary Registration of Aliens' provision of the National Security (Alien Doctors) Regulations,[30] and had managed to subsequently get permanent registration by the Board. The latter (1950) group were among those who had managed to get a place in the University of Sydney course, successfully graduate after completing years 4–6, and fit within the quota of eight permitted each year.[31]

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[23] *Medical Practitioners Act 1938 No. 37* (NSW), s 18 (6).
[24] Wolf, "The Law and Politics," 1528.
[25] The Minister appeared unaware there were women medical students at University of Sydney then.
[26] Herbert Fitzsimons, *NSW Parliamentary Debates, Legislative Assembly* (4 August 1938), 817.
[27] Wolf, "The Law and Politics," 1532-5.
[28] Wolf, "Controlling the 'Invasion," 1.
[29] The Board failed to record country of original degree for these IMGs in either its Medical Register or its Minutes.
[30] See Chapter 3.
[31] Prosopography, NSW section.

1951–1960

While these divisions into the years before and after 1950 are somewhat artificial, they bring into focus the main differences in IMG composition in the two periods: the first, peri-war, composed particularly of Jewish refugees; the second, post-war, who were mainly fleeing the Soviet Union and its satellites. Jacques Vernant calculated that about 180,000 refugees were resettled in Australia between 1947 and 1951, with the main donor countries being Poland (60,000), Baltic States (36,000), Yugoslavia (23,000), Ukraine (20,000), Hungary (13,300), and Czechoslovakia (9,900). For two of these countries (Czechoslovakia and Yugoslavia), Australia was the largest resettlement country; for three others it was second only to the United States.[32] Louise Holborn notes that just over 8000 in this later wave were classified as Jewish refugees.[33]

The General Assembly of the United Nations, at its first meeting after the end of the war in Europe (January 1946), began the process of creating the International Refugee Organization (IRO). One of its early tasks was to define refugees and displaced persons (DP), which read in part:

> The Refugee [is] a person who has left, or is outside of, his country of nationality … [and] as a result of events subsequent to the outbreak of the second world war, is unable or unwilling to avail himself of the protection of the government of his country of his nationality or former nationality.
>
> The Displaced Person(s) [is] a person who … has been deported from, or has been obliged to leave his country of nationality or of former habitual residence …[34]

In July 1947, the IRO acquired full responsibility for 712,675 refugees and displaced persons (DP).[35] And over the full period of its operation—to December 1951—it registered and assisted just over 1.6 million. Most were housed in assembly centres and refugee camps, the largest number in the western zones of Germany.[36] Holborn states that of those needing resettlement, about 10 percent were classified by the IRO as intellectuals or professional persons. Medical graduates were interviewed by 'special qualification boards' which verified their credentials; if satisfied about their professional standing, they issued a Certificate of Professional Status.[37] Their names, qualifications

[32] Vernant, *The Refugee in the Post-War World*, 68-90.
[33] Louise W Holborn, *The International Refugee Organization, a Specialized Agency of the United Nations: Its History and Work 1946-1952* (London: Oxford University Press, 1956), 433.
[34] Proudfoot, *European Refugees,* 409-10.
[35] Ibid., 406.
[36] Ibid., 188-9.
[37] Holborn, *International Refugee Organization,* 426-7.

and other professional details were published in 1949 in *The Displaced Persons Professional Medical Register,* which lists almost 5000 medically qualified DPs.[38]

After some hesitation, Australia agreed to resettle a total of 182,159 refugees between 1947 and 1951. Upper age limits for selection were 45 for single men, 40 for single women, and 50 for married couples with children. Holborn wrote that the Australian involvement in the IRO process 'provided unlimited opportunities for suitable refugees' though adding the caveat that initially housing and employment could not be found quickly enough.[39] Her optimistic assessment may have been true for some resettled groups, but it was not for many of the medical refugees. Those who accepted resettlement had to sign a contract with the Australian Government to work wherever it placed them and in whatever position.[40]

Table 7.11: IMGs registered in Australia 1951–60 from Eastern Europe and Baltic States*

Country of qualification	NSW	QLD	SA	TAS	VIC	WA
	No. registered (% of all IMGs in period)					
Czechoslovakia	22 (3.0)	2 (0.9)	0	2 (1.2)	1 (0.2)	1 (0.6)
Estonia	6 (0.8)	0	0	0	0	0
Hungary	40 (5.5)	1 (0.5)	0	2 (1.2)	11 (2.0)	2 (1.2)
Latvia	9 (1.2)	0	0	2 (1.2)	6 (1.1)	3 (1.8)
Lithuania	3 (0.4)	0	0	0	2 (0.4)	0
Poland	31 (4.2)	0	0	1 (0.6)	2 (0.4)	1 (0.6)
Romania	6 (0.8)	0	0	0	0	0
USSR	4 (0.5)	0	0	0	2 90.4)	0
Total all IMGs	730	219	201	168	550	168

*Country of primary medical qualification. Many will have been displaced persons.
No IMGs from these countries were registered in ACT or NT.

Despite the substantial number of Eastern European and Baltic country refugees accepted as Displaced Persons by Australia in the years shortly after the war, only 162 IMGs from those countries succeeded in being registered by a medical board between 1951 and 1960 (Table 7.11). How many more came to Australia but were not registered is difficult to calculate, though based on Egon Kunz's survey of members of the Unregistered Doctors' Association, it was probably at least 220.[41] At the end of 1951, just under half were working in a paramedical setting: as orderlies, hospital cleaners, nurses,

[38] Health Division Headquarters, *Displaced Persons Professional Medical Register* (Geneva: International Refugee Organization, 1949), 393-421.
[39] Holborn, *International Refugee Organization*, 389,93-6.
[40] Charles Haszler, "The New Australian Doctors in New Guinea," *Papua and New Guinea Medical Journal* 10, no. 2 (1967): 35.
[41] Kunz, *The Intruders*, 23.

or rarely laboratory assistants. The remainder worked in non-medical areas such as factories.[42]

As can be seen in the table, New South Wales registered far the largest proportion of IMGs from the Soviet bloc, and it is likely that most were refugees or DPs. The Victorian Medical Board rejected some without interview or explanation, although it did register 24 in this period.[43] The major source countries were Hungary, Poland, the Baltic States, and Czechoslovakia.

Table 7.12: IMGs registered in Australia 1951–60 and listed in the IRO DP's Professional Medical Register

		No.
Gender	Female	8
	Male	48
State registered	NSW	35
	TAS	3
	VIC	12
	WA	6
Country of qualification	Czechoslovakia	8
	Estonia	4
	Hungary	14
	Latvia	19
	Lithuania	5
	Poland	3
	Romania	3
Specialties	General Practice	14
	Obstetrics & Gynaecology	10
	Surgery	6
	Paediatrics	3
	Psychiatry	3
	Ophthalmology	1
	Others*	9
Job in 1949	D.P. Camp doctor	17
	D.P and other hospitals	28
	Other†	11

IRO = International Refugee Organization; D.P. = Displaced Persons.

*Only hospital posts listed, not specialties; some listed as private practice; some in armed services.

†Includes Dr Albert Gyory, Chief Psychiatrist at War Crimes Hospital; Dr Louis Huzella, Public Health Commissioner for Hungary.

Mean age (± SD) in 1949: 39 ± 7.5 years

Like the opposition the Jewish doctors faced earlier, Kunz describes concerted campaigns (independent of religion) against the European IMGs who arrived in the second wave. He laid blame particularly at the door of the AMA, saying it 'used its unfettered freedom, high status and ample finance to command considerable publicity to its closed shop policies.'[44] Some of these IMGs simply moved on, most to USA. By checking the Australian Immigration Department's list of DP doctors against the *American Medical Directory* of 1959, Kunz identified 22 who were by then working in the US.[45]

Linking the prosopography to the IRO's *Displaced Persons Professional Medical Register*, allowed me to identify as documented DPs about a third of

[42] Ibid., 27, 99-100.
[43] Ibid., 110.
[44] Ibid., 47, 60.
[45] Ibid., 112.

the European IMGs who managed to get registered in Australia during the 1950s.[46] A summary of their details, extracted from the IRO Register, is in Table 7.12. Most had qualified in Latvia or Hungary, more than half were categorised by the IRO panels as specialists, and most had been working as doctors in the Displaced Persons camps or hospitals before their resettlement.

It is instructive to look at the route several of these DP doctors took after the war before eventually being registered in New South Wales.

Dr Charles (Karl) Haszler graduated MD from Budapest in 1931, was classified by an IRO panel as a surgeon, and served as Chief Doctor at the Hungarian Hospital during the war then the Föhrenwald Hospital, Germany, immediately after.[47] He was in the first batch of DPs to arrive in Australia and was given a job as a doctor in Papua New Guinea (then an Australian Territory), where he ended his career 18 years later as First Assistant Director of Public Health. Years later, looking back on the years in the DPs' and Refugees' Camps, he wrote that 'all were just hopelessly waiting for the big opportunity to leave Europe where they had lost all hope, and where they had suffered so much.'[48] He was registered in New South Wales on 14 June 1947, only when the Medical Act was amended to allow registration of those who had served in an Australian Territory for at least five years.[49]

Dr Serafima Perendi graduated from Tartu University Estonia in 1942, became a gynaecologist, then served as a camp doctor and in DP hospitals between 1945 and 1948. She arrived in Australia in March 1949, where she was placed in an immigration camp in Bathurst, NSW, employed first as a night nurse then later as a medical orderly.[50] In July 1950, the New South Wales Medical Board gave her permission to enrol in the final three years of the University of Sydney medical course, from which she graduated and was registered by the Board in June 1954.[51] The month prior, the Estonian language newspaper in Sydney proudly announced her success. She was one of many European refugees who had to go that route in order to finally be registered.

Dr Stefan Csordas graduated in Budapest the year before the war ended, then worked in the 11th Garrison Hospital there before moving to Austria in 1945. He was

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[46] The actual number may have been greater—it was common for these immigrants to change their name after coming to Australia.

[47] Health Division Headquarters, *Displaced Persons Professional Medical Register,* 211.

[48] Haszler, "The New Australian Doctors," 35.

[49] NSWSA: NRS-9871, 14 June 1957; *Medical Practitioners (Amendment) Act 1957 No. 20* (NSW), s17(2B).

[50] "Sydney Eesti Arst: Dr S Perendi Lôpetas Ülikooli [Sydney Estonian Doctor: Dr S Perendi Graduates from University]," *Meie Kodu (Sydney)*, 20 May 1954, 1.

[51] NSWSA: NRS-9871, 5 July 1950, 2 June 1954.

then a medical officer in a DP camp before resettlement to Australia in 1950.[52] As was the case for many other DP IMGs at the time, the Victorian Medical Board refused to register him. However, the Director of the Australian Antarctic Division appointed him medical officer to the 1955 Australian National Antarctic Research expedition to Macquarie Island. While waiting to be registered in Australia, he took two further postings to Antarctica, the last in 1959, where he was said to have done significant environmental research.[53] The 1957 amendment to the Victorian Act had created the Foreign Practitioners Qualification Committee, which began to examine the European refugees that the earlier Act had excluded.[54] He sat its examination twice in 1958, but failed, then was successful in September 1960; the Board registered him the following month.[55] Like many of these refugee IMGs, Dr Csordas subsequently made valuable contributions to Australian medicine, working in the tuberculosis section of the Victorian Department of Health.[56]

The British 'Refugees' from the NHS

Between 1951 and 1980, an average of 290 British and Irish graduates registered in an Australian jurisdiction every year. This was a five-fold increase over the average annual rate of 59 during the previous half century.[57] What factors might have been responsible for such a marked increase? Using her prosopography of British IMGs registered in Victoria 1930–60 as the starting point, Fallon Mody provides insights into the motives for migration of several of them. By interviewing surviving members (or family) of a cohort of graduates from the University of Bristol, she found that many were motivated ideologically to escape the UK National Health Service (NHS). The NHS commenced in 1949, and many found it hierarchical and bureaucratic, as well as limiting to doctors' earning capacity. The ladder for promotion to consultant positions was crowded, and achieving them usually took many years. Others who have contributed to the historiography of the exodus from the NHS were John Seale, who came to similar conclusions to Mody's, and David Wright et al. who reported the depiction of the NHS

[52] Health Division Headquarters, *Displaced Persons Professional Medical Register*, 12; "Csordas, Stefan Eugen (1920-2000)," accessed 26 January 2022, https://www.asap.unimelb.edu.au/bsparcs/biogs/P004784b.htm.

[53] "Csordas, Stefan Eugen".

[54] *Medical (Registration) Act 1957 No. 6084* (VIC).

[55] VPRO: Medical Act, Foreign Practitioners Qualification Committee General Correspondence Files, VPRS 6345/P0000/300, 1960-1998, memorandum from Secretary, 25 august 1967.

[56] "Sharp Rise in TB Cases in Victoria," *Canberra Times*, 5 June 1980, 7; "TB Spreading in Destitute in Sydney and Melbourne," *Canberra Times*, 16 November 1982, 3.

[57] Calculated from numbers from England, Ireland, Northern Ireland, Scotland and Wales in Supplementary Table 4, Appendix A (the number of Welsh university graduates was below the threshold for inclusion in Tables 7.2-7.9).

by a UK IMG as 'worse than being married.'[58] David Alltree compiled a book with contributions from his medical classmates at the University of Liverpool who migrated to Perth as a chain migration in the 1960s. Their reasons for leaving the NHS were similar to those above. One described his outrage when disciplined by his supervisor for telling a patient there would be a five year wait for a hernia operation under the NHS and advising him to travel to London to have the operation done privately.[59] Similar reasons for migrating from Britain to Australia were also enunciated by some who gave me their oral histories in Chapter 10.

Not all who left the NHS to be part of the more free-enterprise style of medicine in Australia were impressed, though. One notable critic was Hugh Dudley, an Edinburgh graduate who was registered by the Medical Board in Victoria in 1963 as he took up the Foundation Chair of Surgery at Monash University.[60] During his *Guest of Honour* oration for the Australian Broadcasting Commission on 10 December 1972, he offered this scathing analysis:

> Apart from its ability to seduce and its negative effect on the concept of medicine as a healing profession, fee-for-service makes us quite unable to move from sickness-care to health-care, quite unable to educate for a profession as distinct from a group of medical shop-keepers.[61]

A few days later he departed to take up the Chair of Surgery at St Mary's Hospital, London —leaving, it was said, a number of irate former Australian colleagues.[62]

The 1970s South-East Asian Surge

The number of IMGs registering in every jurisdiction increased in the 1970s compared with the previous decade. The States in which it was most marked were New South Wales, South Australia, and Western Australia (Tables 7.2, 7.4 and 7.7), where the overall increase was at least threefold. The most striking increase was in registrations by graduates from the universities of Hong Kong, Singapore, and Malaya.

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[58] Seale, "Medical Emigration from Britain," 785; David Wright, Sasha Mullally, and Mary Colleen Cordukes, "'Worse Than Being Married': The Exodus of British Doctors from the National Health Service to Canada, c. 1955-75," *Journal of the History of Medicine and Allied Sciences* 65, no. 4 (2010): 566.

[59] David Alltree, *The Leaving of Liverpool : Medical Migration to Western Australia* (Guildford, WA: Vineyard Publishing, 2008); Val Lishman, "Val Lishman," in *The Leaving of Liverpool,* 160.

[60] Prosopography, Victorian section; "Obituary: Emeritus Prof Hugh Dudley, Surgeon Who Set up World-Class Medical School," *The Scotsman*, 15 July 2011.

[61] Hugh Dudley, "Professor Critical of Australian Doctors," *Canberra Times*, 11 December 1972, 3; Professor Dudley was giving the *Guest of Honour* address on ABC Radio on 10 December 1972.

[62] Personal communication, Professor DJB St John, 27 January 2022.

Figure 7.4 illustrates the contributions from the South-East Asian countries in Western Australia. The numbers began to increase about 1972 then reached a very large peak in 1976, only to return almost to zero the following year. The pattern was similar in the other two states, although in New South Wales there was also an earlier surge in Hong Kong graduates in 1971.

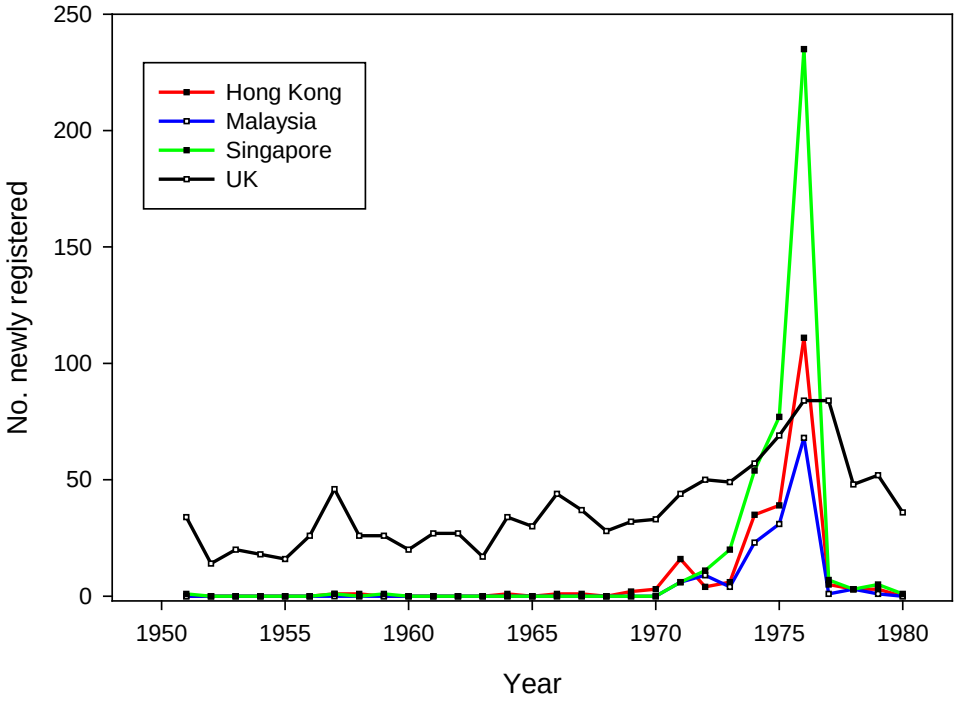

Figure 7.4: WA Medical Board: surge in new South-East Asian registrations in 1970s

Why did this marked influx occur, and why did it end as abruptly as it began? Some clues can be found by looking at events in Western Australia in more detail. Since the 1945 amendment to the Western Australian medical Act, the Board had discretion to register practitioners whose qualifications it judged 'not inferior to the degrees' from the medical schools in Sydney, Melbourne, Brisbane, and Adelaide.[63] And by the 1970s, Australia's restrictions on non-British immigrants were markedly loosening. One important factor that may have motivated some or many of the Malaysian graduates was the discrimination ethnic Chinese suffered in Malaysia, particularly during the 1970s. The ethnic riots (Malay versus Chinese) in Malaysia in 1969 were estimated to have led to about 600 deaths, and Chinese (and ethnic Indian) political disadvantage at the hands of the Malays continued.[64]

[63] Medical Act Amendment Act 1945 No. 22 (WA), s 8(1)(a)(iii).

[64] Martin Ravallion, "Ethnic Inequality and Poverty in Malaysia since May 1969. Part 1: Inequality," *World Development* 134, no. October (2020): 1; "Malaysian Riots: Forces Impose Calm on Capital,"

The clerk(s) who entered the data in the medical register recorded the address of each registrant at the time of registration. Nearly all had Chinese (sometimes Indian) names. Where they lived in 1976 is shown in Table 7.13: it is apparent that most were still living in the country in which they graduated; however, about 30 percent of the University of Malaya graduates had a Singapore address and the same proportion of Singapore graduates were living in Malaysia. Thus, it is possible that many of the Malaysian Chinese had taken the opportunity to establish an escape route to a third country in case the need arose later. The oral history of Dr Yiu-po Soo (pseudonym) in Chapter 10 bears this out. There seem to have been less obvious reasons, though, why the Hong Kong and Singapore residents were motivated to migrate at that time.

Table 7.13: South-East Asian IMGs registered by WA Medical Board in 1976: country of medical degree vs. place of abode when registered

Country of abode*	Country of qualification		
	Malaysia	Hong Kong	Singapore
	No. registered (%)		
Hong Kong	0	**69 (62.2)**	0
Malaysia	**45 (66.2)**	8 (7.2)	72 (30.6)
Singapore	20 (29.4)	8 (7.2)	**143 (60.9)**
Other	2 (2.9)	3 (2.7)	0
Australia	1 (1.5)	23 (20.7)	20 (8.5)
Total	68	111	235

*Address entered in medical register at date of registration.

The large influx of overseas resident doctors in 1976 provoked a rapid reaction in Western Australia. The *Medical Act 1894* was promptly amended by addition of a clause that read:

> Notwithstanding any other provision of this Act, where a person – (a) was not, at the time that his application for registration was made, ordinarily resident in the State; (b) has not taken up residence in the State within six months after the date on which his registration was granted, the Board may order that his name be erased from the register, and in that event the person shall not, except with the special approval of the Board, be entitled to make a further application for registration … until … five years commencing on the day his application for registration was granted.[65]

In speaking to the second reading of the Bill, the Minister for Lands said:

Canberra Times, 19 May 1969, 6; Kenneth Whiting, "P.M. Inherits Old Problems: Political, Racial Unrest in Malaysia," ibid., 21 January 1976.

[65] *Medical Act Amendment Act 1976 No. 70* (WA), s 4(c).

> Of recent months the [Medical] board has been deluged with applications from doctors in countries where political conditions are threatening to become unstable. It is known that these doctors have applied to other States and countries. It is unlikely that many of the applicants will ever take up practice in this State. The result is that the board has been inundated with such a volume of work that its operations are being disrupted, and about one name in three on the register is a doctor who has never practised, and probably will never practise, in Western Australia.[66]

The result was that by the end of the following year, only 68 (16 percent) of the Hong Kong, Malaysian and Singaporean graduates registered in 1976 were still on the Western Australian register. New South Wales added a domiciliary requirement when its Act was amended in 1981; in 1976, South Australia amended its Act to allow the Board to require applicants to appear before it in person.[67] In both those States, the number of newly registered South-East Asian graduates dropped by more than 90 percent in 1977. An important contributor is likely to have been the uniform move in 1977 by all states to require most non-British graduates to pass the AMEC examinations before they could be registered.[68]

The testimony of Dr Yiu-po Soo (Chapter 10) very clearly spelled out the motives of at least the Malaysian doctors at that time. He came to Sydney for a holiday in 1975 with the intention of registering with the New South Wales Medical Board.

> At that time this was a very hot topic among non-Malay graduates ... [they] always thought of migration. ... A lot of doctors then came to register ... as insurance in case they really decided to migrate ... It was a widespread practice and doctors came by plane loads to come to register, and then go home.

His wife was very against migration, "but I just felt I may miss the boat if I don't do it." In the event, all he had to do was turn up at the Medical Board office, show his testamur, and pay the fee.[69]

South Africa

Between 1951 and 1984, 1,669 South African doctors registered throughout Australia, and their numbers increased nineteen-fold between the 1950s and 1970s.

Their distribution as a percentage of all IMGs varied significantly across the country. They made up the largest proportion of IMGs in South Australia and New

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[66] Keith Ridge, *Western Australia Parliamentary Debates, Legislative Assembly* (7 September 1976), 2246.

[67] *Medical Practitioners (amendment) Act 1981 No. 55* (NSW); *Medical Practitioners Act Amendment Act 1976 No. 58* (SA).

[68] SRSA: Minutes, Medical Board of South Australia, GRS/14056, 21 July 1977.

[69] Yiu-po Soo, interviewed by author, Sydney (video), 17 July 2020.

South Wales, more than three times that in the Northern Territory and Victoria. There was not clear evidence that they were migrating to states or territories with large diaspora of South African residents: Table 7.14 shows that Western Australia, the state with the highest proportion of South African-born Australian residents at the 1976 census,[70] had one of the lowest proportions of South African IMGs. The converse relationship was found in South Australia. Peter Arnold's study of the South African medical migration identified several distinct phases. The one that corresponds to the period we are discussing here was the first wave, which consisted mainly of Jewish South Africans who were escaping from anti-Semitic sentiments in the ruling polity, and particularly from what many felt was an unconscionable apartheid regime.[71] Some further evidence about reasons to emigrate from South Africa will be seen among the oral histories presented in Chapter 10.

Table 7.14: IMGs registering between 1951 and 1984 from South Africa and India versus proportion of population born in each country by state and territory (1976 census[72])

State/Territory	South Africa		India	
	% of all IMGs 1951–84	No./100,000 population (1976)	% of all IMGs 1951–84	No./100,000 population (1976)
NSW	11.67	122	11.52	220
QLD	5.92	86	0.87	124
SA	12.15	88	12.15	189
TAS	9.88	88	11.61	100
VIC	3.08	105	11.63	308
WA	4.04	204	4.88	863
ACT	6.58	148	1.18	265
NT	2.67	104	14.09	254

The differences in proportions of IMGs and total migrants between states and territories are all significant, $p<0.001$ (chi square).

India, Pakistan and Sri Lanka

The very substantial contributions that IMGs from South Asia began to make to Australia from about the 1960s has been mentioned already. However, as can be seen

[70] Australian Bureau of Statistics, "Census of Population and Housing, 1976," accessed 11 January 2022, https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2104.01976?OpenDocument; chosen for comparison because it was in the decade with the largest number of South African IMG arrivals.

[71] Peter Arnold, *A Unique Migration: South African Doctors Fleeing to Australia.* (Seattle, WA: CreateSpace, 2011), 32-4; PC Arnold and DE Lewinsohn, "Motives for Migration of South African Doctors to Australia since 1948," *Medical Journal of Australia* 192, no. 5 (2010): 289.

[72] Australian Bureau of Statistics, "Census".

in Tables 7.2 to 7.9, there was a marked disparity between the numbers registered in the different jurisdictions up till the end date of the prosopography. In the period 1951–84, only eight Indian-qualified doctors were registered in Queensland, compared with 830 in New South Wales, more than 300 in Victoria and South Australia, 121 in Tasmania and 41 in Western Australia (Table 7.14). The reason for such large differences is unclear, but may partly be due to different approaches taken by the different Medical Boards. The explanation is unlikely to be the presence of a larger diaspora of Indian-born residents in the states with more Indian IMGs. In the 1981 census, Western Australia had the largest Indian-born population at 793 per 100,000 (and second lowest IMG population), followed by Victoria with 325; Queensland did have the lowest proportion though, at 128 per 100,000.[73]

IMGs who had qualified in Ceylon/Sri Lanka were also distributed asymmetrically. They contributed 14 percent of all IMGs registered in the Northern Territory, compared with less than 1 percent in Western Australia.

While the Indian and Sri Lankan IMGs did not appear to be strongly attracted to settle where there was an overall diaspora of their compatriots, it is more likely that they clustered with a *medical* diaspora who followed each other by chain migration, similar to what occurred with the Liverpool graduates who smoothed the path for their classmates coming later to Western Australia, as mentioned earlier, and as also found in some of the oral histories in Chapter 10.

Australian Capital Territory

The ACT had demographic characteristics that were reflected in the composition of its medical migrants. It can be seen from Table 7.8 that, even as late as the 1970s, most newly arriving IMGs had qualified in Britain or Ireland. As the seat of government, the ACT population contains a high proportion of government employees. In the 1981 census, only 14 percent of its residents were born elsewhere than Australia, New Zealand, UK or Ireland.[74] Thus, in the absence of a large non-British diaspora, it is not surprising that the proportion of IMGs who came from all other countries was lower at that time than in the other states.

Local Factors in Northern Territory

The Northern Territory acquired its own Act and Medical Board in 1935 and, with the exception of Dr Brenda Fife (MB ChB *Birmingham* 1936), only Australian graduates

[73] Ibid., 1981, accessed 11 January 2022, https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2103.01981?OpenDocument.
[74] Ibid., Table 3.

were registered there before 1941 (Figure 7.5). The non-Aboriginal population of the Territory was only about 5000 in 1935, but the military build-up in response to WWII and the 1942 bombing of Darwin led to it doubling by 1947.[75] As the population grew, the need for doctors increased, and some IMGs began to appear in the Territory. Up till 1960, they totalled only 63, all but two of whom had trained in UK or Ireland (Table 7.9). In the 1960s, the Territory's population increased markedly, as did the number of new medical registrations. The Australian graduates led the way, but by the early 1970s were overtaken by a surge in IMGs—from many countries, but particularly India, Sri Lanka, and England.[76] Figure 7.5 illustrates the massive exodus from the Territory in

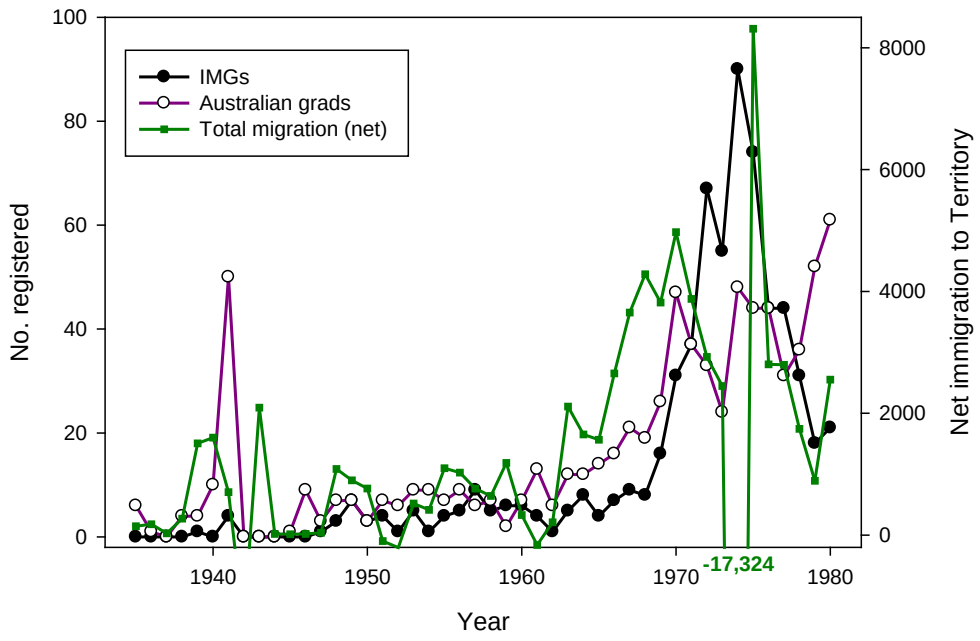


Figure 7.5: Northern Territory: annual IMG registration versus net population change. Population data from Charles Price.[77]

the aftermath of the destruction of Darwin by Cyclone Tracy in December 1974. The population of Darwin declined by almost half between June 1974 and June 1975.[78] As the population returned for the reconstruction of Darwin over the remainder of the decade, registrations of Australian graduates began to predominate again over IMGs.

[75] JC Caldwell, "Population," in *Australians, Historical Statistics*, ed. Wray Vamplew (Broadway, NSW: Fairfax, Syme & Weldon Associates, 1987), 26. Caldwell quotes the NT population for 1933 as 4850, but First Australians were not counted in Australian censuses until 1971.

[76] Supplementary Table 4, Appendix A.

[77] Charles Price, "Immigration and Ethnic Origin," in *Australians, Historical Statistics*, ed. Wray Vamplew (Broadway, NSW: Fairfax, Syme & Weldon Associates, 1987), 6-7.

[78] Population Studies Group, "Demographic Changes in the Northern Territory Following Cyclone Tracy (1974/5)," (2008), https://www.cdu.edu.au/sites/default/files/research-brief-2008-18.pdf.

New South Wales 'Area of Need' IMGs, 1957–1970

While the focus of this chapter is an analysis of material in the prosopography compiled for the thesis—in other words, based on those IMGs who received general registration in one of the jurisdictions, and hence appeared on a medical register—one group, largely missing from the prosopography, is worth discussing. Between 1957 and 1970, some IMGs from non-Commonwealth countries were given a special licence in New South Wales. While eligible to be eventually granted general registration, none of them were, although some do appear in the prosopography as a result of being granted registration by a different state. Information about them is held in a file in the NSW State Archives.[79] In contrast with the Medical Board minutes, which rarely offered details about applicants other than their qualifications and whether or not the Board chose to register them, this file gives some insight into how these non-British/Irish IMGs were handled. It contains copies of application forms and IMGs' credentials, but mainly correspondence—between the Board Secretary and applicants, hospital administrators, other medical referees, and the Minister's office.

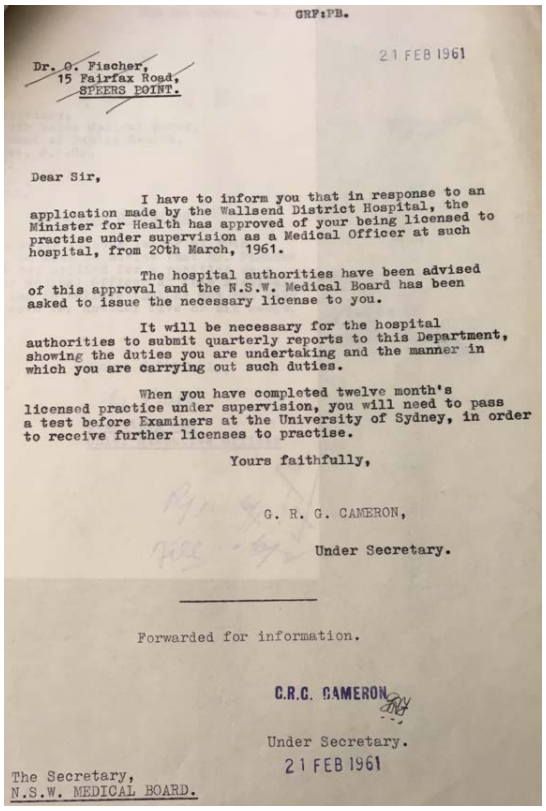
The file was created in response to an amendment in 1957 to section 17c of the *Medical Practitioners Act 1938* and addition of a new section, 21c. It gave the Minister of Health power to issue a 'regional licence' to medical practitioners who had obtained their qualifications in (essentially) non-English-speaking countries, provided they worked under supervision as 'a medical officer in such State hospital, mental hospital, public hospital, private hospital or other institution as the Minister may direct.'[80] If after a year the IMG passed an oral examination administered by three examiners from the University of Sydney, they could be licensed to practise without supervision, but still only within those specified categories of institutions. In effect, such licences were issued when hospitals were unable to attract sufficient medical staff and asked for the Minister's help. If the IMG's performance was satisfactory, the Act allowed them to apply for general registration after five years.

Three case histories will be discussed, illustrating the administrative processes used by the Medical Board secretariat, and difficulties some of these IMGs experienced. Their real names are used for two who are known to have died, and a pseudonym for the third, even though he would be 109 if still alive.

[79] NSWSA: NRS 9875-1.
[80] *Medical Practitioners (Amendment) Act 1957 No. 20* (NSW), s 21c(3)(b).

Dr Ottomar Fischer

Dr Fischer graduated in Prague in 1939, and worked after the war as a Displaced Persons Camp doctor in Austria until April 1949. He was resettled with his wife and two children in New South Wales later that year, where he worked as a medical orderly in the Immigration Centre Hospital in Greta. In April 1953, he applied to the NSW Board for an s21c licence, to work at Ivanhoe in the State's outback. It was refused, without interview by the Board, and with no reasons stated in the Board Minutes.[81] Six years passed before he tried again and this time, now 1961, he was granted the licence to work at the Wallsend Hospital in Newcastle. The letter to him from the Under-Secretary of Health (JD Rimes), which indicates the conditions of his appointment, is reproduced in Figure 7.6. After 12 months he applied, as required, for renewal of his licence at Wallsend Hospital, which was granted. He then sat but failed the oral examination at University of Sydney. The examiners were obviously trying to be helpful, recommending that he be found a job in another hospital where he could get broader experience. Rimes then wrote to him 'enclosing a list of Public Hospitals that have recently employed licensed foreign doctors in the past, to assist you in obtaining another appointment.' However, Ottomar Fischer died the following year, aged 53.[82]



GRF:PB.

21 FEB 1961

Dr. O. Fischer,
15 Fairfax Road,
SPEERS POINT.

Dear Sir,

I have to inform you that in response to an application made by the Wallsend District Hospital, the Minister for Health has approved of your being licensed to practise under supervision as a Medical Officer at such hospital, from 20th March, 1961.

The hospital authorities have been advised of this approval and the N.S.W. Medical Board has been asked to issue the necessary license to you.

It will be necessary for the hospital authorities to submit quarterly reports to this Department, showing the duties you are undertaking and the manner in which you are carrying out such duties.

When you have completed twelve month's licensed practice under supervision, you will need to pass a test before Examiners at the University of Sydney, in order to receive further licenses to practise.

Yours faithfully,

G. R. G. CAMERON,

Under Secretary.

Forwarded for information.

C.R.G. CAMERON

Under Secretary.

21 FEB 1961

The Secretary,
N.S.W. MEDICAL BOARD.

Figure 7.6: Correspondence between Under-Secretary of Health and Dr O Fischer. NSWSA: NRS 9875-1.

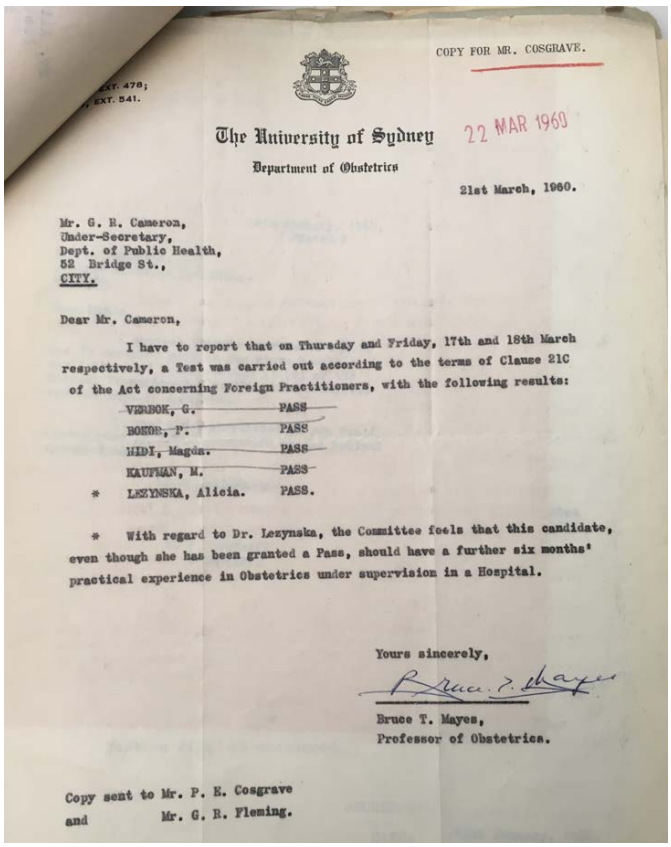
Commentary on case: His is an example of the long period, 12 years, between migrating to Australia and being able to resume his medical practice that many of these doctors experienced. That he failed the examination, after such a long time on the sidelines of the profession, is unsurprising. The Board and university were not always helpful but, on this occasion, both showed evidence of trying to assist.

[81] NSWSA: NRS 9871, 7 July 1954.
[82] NSWSA: NRS 9875-1, Dr Ottomar Fischer papers, 1954-63.

Dr Alicja Lezynska

Figure 7.7: Photograph of Dr Lezynska attached to her application.

Alicja Lezynska (Figure 7.7) graduated in Medicine in 1951 from the Academy of Medicine in Warsaw. She had started her studies at the University of Paris in 1938, but the war interrupted them. She spent the next three postgraduate years training in oto-laryngology and was recognised as a specialist in that discipline in 1954. For the subsequent four years she practised her specialty as head of a hospital unit in Warsaw. In June 1958, she arrived in Sydney with her husband and seven-year-old daughter and applied to the Medical Board for an s21c licence. The application was approved by the Board and the Minister in January 1959, and she was posted to Lithgow Hospital, 150 km west of Sydney.[83]



COPY FOR MR. COSGRAVE.

EXT. 478;
EXT. 541.

The University of Sydney

22 MAR 1960

Department of Obstetrics

21st March, 1960.

Mr. G. R. Cameron,
Under-Secretary,
Dept. of Public Health,
52 Bridge St.,
CITY.

Dear Mr. Cameron,

I have to report that on Thursday and Friday, 17th and 18th March respectively, a Test was carried out according to the terms of Clause 21C of the Act concerning Foreign Practitioners, with the following results:

VERBOK, G. PASS
BOHOR, P. PASS
HIDI, Magda. PASS
KAUFMAN, M. PASS
* LEZYNSKA, Alicia. PASS.

* With regard to Dr. Lezynska, the Committee feels that this candidate, even though she has been granted a Pass, should have a further six months' practical experience in Obstetrics under supervision in a Hospital.

Yours sincerely,

Bruce T. Mayes,
Professor of Obstetrics.

Copy sent to Mr. P. E. Cosgrave
and Mr. G. R. Fleming.

Figure 7.8: Correspondence from University of Sydney re Dr Alycja Lezynska.

The licence was renewed after 12 months, and she sat and passed all subjects in the required examinations at University of Sydney, though with the caveat that she should have a further six months' experience in obstetrics under supervision (Figure 7.8). She was then approved to move into practice, under the supervision of a Dr Leslie, after receiving highly supportive references from the hospital CEO, Dr Leslie and another Lithgow doctor. Her licence was renewed annually until, in her fifth year under s21c, she applied to move to Sydney; her husband had got a job there, having been unable to work during the years they were in Lithgow. Dr Leslie supported her application, writing: 'Her work while my assistant was highly competent in all spheres

[83] NSWSA: NRS 9875-1, Dr Alicja Lezynska papers, 1958-63; NSWSA: NRS 9871, 7 January 1959.

of practice.' The Board approved her move in May 1963, but she left the new position in October of that year, dying from widespread breast cancer a few months later.[84]

Commentary on case: This case illustrates how ineffectually the New South Wales Board and its Anglocentric legislation coped with someone who was a specialist in her own country, and would have been able to contribute in that discipline if she had been allowed. That she passed the examination in obstetrics, though with the caveat she get some more experience in it, was highly creditable since the last time she would have studied this was as a student ten years earlier. She was on the verge of being given an unrestricted licence in New South Wales (after the five years of limited registration) when her illness overtook her.

Dr Konstantin Balkus (pseudonym)

Dr Balkus graduated MD from Kaunas University, Lithuania in 1943, worked in the Lithuanian Red Cross dispensary during the war, and was the chief DP camp doctor in Judenburg until 1949.[85] He was resettled in New South Wales later that year. It is not clear what happened to him in the intervening years, but in 1960 he was living in Sydney and applied to the NSW Board to be registered. The Secretary of the Board advised him that his options were to apply to study the last three years of the University of Sydney course or ask for an s21c licence to work under supervision in an area of need. In July that year, the Minister granted him a licence, and he was offered an HMO position under supervision at Lithgow Hospital, which he commenced the following month.[86] He sat the obligatory test at University of Sydney in 1961 but failed. His licence continued to be renewed but he failed the test again in 1963 and 1967. The Examining committee noted he had 'failed badly' and there had been no improvement in the 6 years since first test. By then he had been relocated to Bankstown Hospital in metropolitan Sydney. The Medical Superintendent at Bankstown Hospital wrote in September 1967, saying Dr Balkus 'was hopeless' and perhaps paranoid. He decided another RMO must always be rostered on with him. 'Although we all feel sorry for him, there appears to be little we can do to ensure his success.' The Board asked Dr Balkus to meet with them in November 1967. Meanwhile, four other doctors at Bankstown wrote to say they believed 'he was in urgent need of psychiatric investigation … is quite

[84] Ibid.; Alicia Malgorzata Lezynski, death certificate, 13 January 1964, file no. 827/1964, Registry of Births, Deaths and Marriages, Sydney. Note anglicisation of her first name; last name used her husband's spelling (Polish last names commonly have gendered endings).

[85] Health Division Headquarters, *Displaced Persons Professional Medical Register*, page no. omitted to maintain anonymity; NSWSA: NRS 9875-1.

[86] Earlier correspondence in the s 21c file indicated that Lithgow Hospital repeatedly had trouble attracting HMOs.

unfit to work in hospitals, and represents a probable threat to those people with whom he is associated'. In November of that year, the Board withdrew his licence.[87]

Commentary on case: Despite Dr Balkus's apparently successful career in Europe, this case underscores the importance of systems to measure and monitor on-the-job performance. The 11-year lag between his last clinical experience in 1949 and the placement at Lithgow meant that his clinical skills and knowledge would be likely to have degraded, and reports from the hospitals that his command of English was still poor would not have helped. Whether he indeed had developed a mental illness is uncertain. The question of 'recency of practice' is one that is revisited in Chapter 10 and the Conclusion chapter.

These case histories give an indication of the processes that the IMGs who sought to practise in New South Wales via this route needed to negotiate. Altogether, the file contains the details of 38 IMGs who qualified in 19 different countries: the largest number from Hungary, Italy, Czechoslovakia, Germany and Poland. A quarter of the group were female; the mean (± SD) time between graduation and first application to the Board was 10.4 ± 8.5 years, although the delays created during their migration and resettlement meant that many had not practised for a few years. The purpose of this section of the Act was to assist New South Wales hospitals that were struggling to attract medical staff, and 22 of these IMGs were placed in outer metropolitan hospitals in Sydney rather than more rural areas—at that time, working in the Western regions of Sydney was not particular attractive for the local doctors.[88]

The most significant feature of this whole group is that none managed to achieve general registration in New South Wales. Dr Lezynska, as mentioned above, went very close. Four were successfully registered in another Australian state, three in Victoria and one in Queensland. However, others failed the test at University of Sydney, a few received bad reports from their placement (e.g., Dr Balkus, above) and fourteen left permanently—seven to try for a more sympathetic reception in USA and seven to return to their home country.

Three wrote scathing letters to the Board when they announced their departure, criticising the annual uncertainty about whether their registration would be renewed and where they would be posted, and the attitude of colleagues or administrators to

[87] NSWSA: NRS 9875-1, correspondence between 1960 and 1967, name omitted for anonymity.

[88] This continued to be true till very recently; a major motivation for the Commonwealth Government to create a new medical school in Western Sydney in 2004 was the difficulty of attracting medical staff to the very busy hospitals in the city's outer reaches (personal communication, Emerita Professor Janice Reid, 30 January 2022).

immigrants. One wrote to say: 'many Australians are not fair dinkum in their attitude towards the immigrants.'[89] Another, returning to the Netherlands, said: 'the Government's attitude to us is quite negative, the attitude of the average doctor is not very different.'[90] On the whole, it can be argued that the program New South Wales embarked on at that time to use IMGs, unregistrable by its normal pathways, to bolster its health system was of dubious fairness.

Conclusion

Throughout most of the period examined in this chapter, the IMGs made a smaller contribution numerically than the local graduates. Three of the Australian medical schools were well underway at the start of the century, and others were created successively. As we saw in chapter 5, the IMGs were initially from the hub of the British Empire—consequences of the arguably xenophobic medical Acts and societal attitudes, and national immigration policies. However, the gradual demolition of 'fortress Australia', in the final years of the period covered by the prosopography, coincided with dramatic changes in the source countries of the IMGs.

Some geopolitical events in the 1970s resulted in particularly marked influxes of IMGs from South-eastern Asia, which were met with legislative or regulatory activity to switch them off. To what extent that reaction was xenophobic or protectionist on the one hand, or motivated by a perhaps laudable intent to not change the composition and size of the medical workforce too rapidly on the other, is debatable. I suggest that both played a part.

There is much information in this prosopography that space does not allow to be completely analysed here—almost 30,000 entries and more than 2 million characters. It is hoped that by making it available as a resource for other researchers, further analyses may be possible in the future. I note, as in Chapter 5, that one limitation of the prosopography is that some of the handwriting in medical registers was difficult to discern, so that some names may be misspelled in the database. This ceased to be a problem in the later years, when the entries were often typed.

This chapter and chapter 5 have drawn heavily on the numerical data that populate the prosopography. But it is worth remembering the tension Jean-Yves Tirat

[89] NSWSA: NRS 9875-1, letter dated 22 November 1963, name withheld since IMG may be still alive.
[90] Ibid., letter dated 23 September 1963, name withheld as above.

identified more than half a century ago, when applying prosopography to the study of social structures:

> The statistical method is not a means in itself of discovering the truth, but only of giving numerical answers to correctly asked questions; the conditions of its validity are the correctness of the working hypotheses and the rigor in the use of the method.[91]

One of the aims of Chapters 6 and 10-12 of this thesis is to apply more qualitative methods to partly ameliorate that tension.

[91] Jean-Yves Tirat, "Problèmes de Méthode en Histoire Sociale," *Revue d'Histoire Moderne et Contemporaine* 10, no. 3 (1963): 217; my translation of: *La méthode statistique n'est pas un moyen en soi de découvrir la vérité, mais seulement de donner des réponses chiffrées à des questions correctement posées; les conditions de sa validité sont la justesse des hypothèses de travail et la rigueur dans l'emploi de la méthode*.

PART 3

The Medical Immigrants: ca. 1984 to 2021

Chapter 8

The IMGs Currently Practising in Australia

For reasons discussed in the previous chapter, including the embargo of Medical Board minutes after different dates in different states, the prosopography is truncated at 1984—coincidentally the date when the Australian Medical Council was formed and took primary responsibility for assessing IMGs for registration. This chapter fills the gap beyond 1984 by exploring the characteristics of IMGs who came to Australia up till 2020 and are still practising, using a database of current medical doctors.[1] The research questions asked were: what was the composition of the immigrant medical workforce practising in Australia in 2020, where did these practitioners come from, when did they arrive, and in what specialties and geographical locations were they working? Much of the material in this chapter has also been published (the paper is reproduced in Appendix C).[2]

The Medical Directory of Australia (MDA) is a searchable database, accessible by subscription, which provides free listing to any medical practitioner who wishes to be included. First published in 1948 in hard copy, it is now published online by the Australasian Medical Publishing Company, a wholly owned subsidiary of the AMA.[3] This database has some limitations, referred to later in the chapter, but its great advantage over the website of the Medical Board of Australia (MBA) is that it is searchable without the 'Catch-22' requirement of having to first know the name of the practitioner.

On 23 April 2020, the entire MDA dataset was downloaded to an MS Excel spreadsheet, using the wild card character '*' in the last-name field. At that time, the database contained the records of 60,082 practitioners. While it would have been possible to examine every entry, looking for those whose primary medical qualification was obtained overseas, it was decided that a more time-effective option was to choose a random sample that ought to be representative of the whole. Thus, using the random number generator function '=RAND()' in Excel, two samples of approximately five percent of the whole were taken, then combined.[4] The reason for taking duplicate samples was to be able to calculate a confidence interval for the observed proportion of IMGs in the combined sample, which contained 5926 practitioners, 9.9 percent of the total in the MDA database.

The entry was cross-checked from the website of the Medical Board to ensure the practitioner still had a current registration and sometimes to correct missing information about the country of their primary medical degree.[5] The checks led to the removal of 36

[1] The starting point for Part 3 is titled 'ca.' 1984, since that was the date the AMC was created, and was the closing date for the prosopography presented in Part 2. However, a few (2 percent) of the IMGs who populate Part 3 arrived slightly earlier.

[2] Neville D Yeomans, "Demographics and Distribution of Australia's Medical Immigrant Workforce," *Journal of Migration and Health* 5, (2022): https://doi.org/10.1016/j.jmh.2022. 100109.

[3] "Medical Directory of Australia: About MDA Online," Australian Medical Publishing Company Pty Ltd, accessed 23 April 2020, https://www.mdaonline.com.au/information/about.

[4] The function for obtaining two 5 percent samples is '=INT(random number from 0-1 in cell*20)' then choose those where the resulting integer is 5 or 15.

[5] "Medical Board of Australia," accessed 23 April 2020, https://www.medicalboard.gov.au/.

from the MDA sample because they were no longer registered. Thus, the final sample for analysis comprised 5890 medical practitioners who held a licence to practise that was current at the time each was checked in 2020.

The information extracted for each IMG in the sample included their name, gender, year and country of graduation, and year they were first registered to practise in Australia. In addition, the specialty in which they were authorised to practise and their postal code of practice were recorded.[6] The practice locations were then matched to one of the five geographical areas in the most recent Australian Bureau of Statistics (ABS) classification: major cities, inner regional, outer regional, remote, and very remote (Figure 8.1).[7] An example of a locality classified as very remote is Kununurra in the far north of Western Australia, 2230 km from the state capital and about 45 km from the Northern Territory border; the region, with an area of 118,000 km^2, had a population of just over 7000 in 2017.[8] It has five doctors, three of them IMGs.[9] By contrast, the compact southern state of Victoria, where the interstate border is never more than 500 km from its major city, has only one locality classified as remote or very remote. For comparison with the IMGs, a random sample of 1701 Australian graduates (matched to the number of IMGs in the primary sample) was extracted from the database, and their current postcodes and specialties recorded.

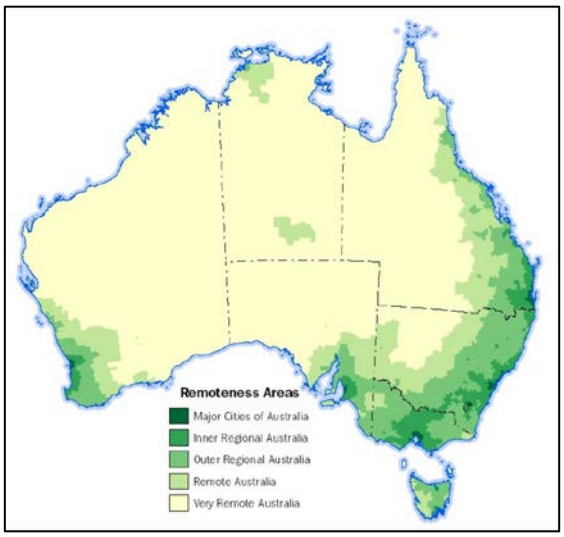


Figure 8.1: ABS remoteness classification 2016[6]

Medians and Interquartile Ranges (IQR) were used since data were often not Gaussian.[10] The statistical significance of differences in frequencies was assessed using the chi square test, and differences in medians with the Mann-Whitney test. The level of significance was taken as $p \leq 0.05$.

[6] General Practice is a designated specialty in Australia, with its own postgraduate training programs. However, AHPRA registers some IMGs as specialists in General Practice without them being Fellows of one of the two Australian colleges of GP.

[7] Australian Bureau of Statistics, "Australian Statistical Geography Standard (ASGS): Volume 5—Remoteness Structure, July 2016," accessed 16 November 2020, https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/ 1270.0.55.005Main+Features1July%202016?OpenDocument.

[8] "Population of Kununurra," accessed 20 September 2021, https://population.com.au/sa2/510011265.

[9] Medical Board of Australia, "Regulating Australia's Medical Practitioners," accessed 20 September 2021, http://www.medicalboard.gov.au/.

[10] Data were often from skewed (non-Gaussian) distributions. In such cases, medians and interquartile ranges should be used instead of means and standard deviations.

Demographics of the Current IMG Workforce

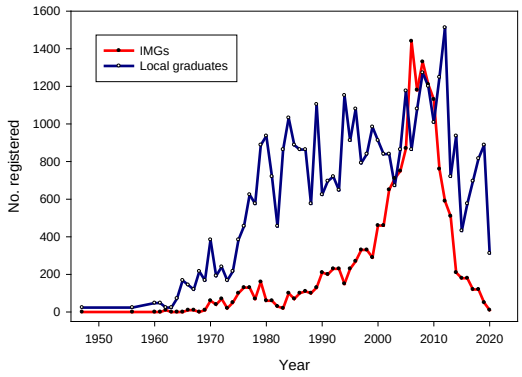


Figure 8.2: Numbers of IMGs and local graduates registered annually since 1945. The numbers are approximate, since they have been extrapolated from the two samples, and the listing method used by the MDA produces artefactually low numbers for the last decade.

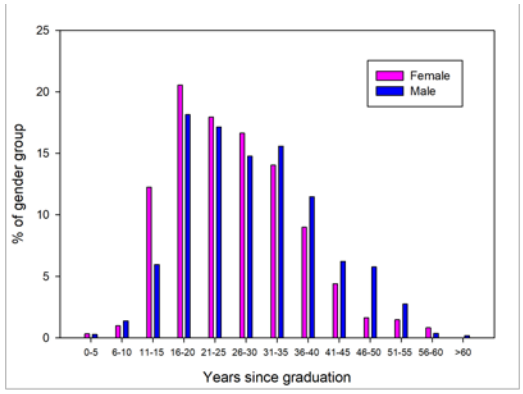


Figure 8.3: Percent of each gender, currently practising in 2020, by years since medical graduation. The low number in the 0-10 years interval is partly artefactual due to those who recently arrived (and are still under supervision) being under-represented in the MDA database. Medians: female 25 (18-33) y; male 28 (20-36 y); p<0.001 (Mann-Whitney test).

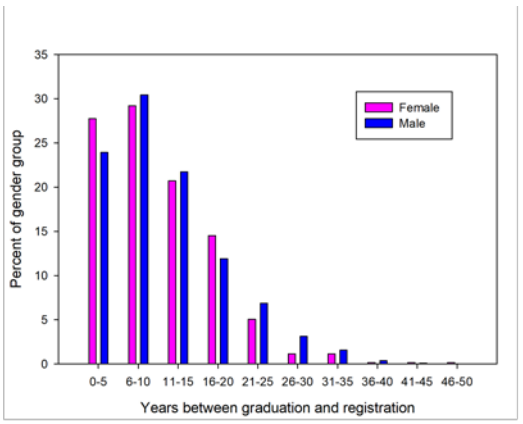


Figure 8.4: Percent of each gender, currently practising in 2020, by interval between medical graduation and first registration as a medical practitioner in Australia. Median (IQR): female 9 (5-14) years; male 10 (6-15) years; p=0.032 (Mann-Whitney test).

In this sample of just under ten percent of the practitioners in the MDA database, 1704 (28.8 percent; 95 percent confidence interval (CI) 27.7-29.9%) obtained their medical degree outside Australia.[11] Of these, 36.0 percent were women, a slightly smaller proportion than the 39.9 percent of females in the random sample of Australian graduates from the MDA (p<0.001).

Figure 8.2 plots the year of registration of the IMGs in comparison to that of the local graduates in the MDA sample, and shows the marked increase in IMG registrations since about 1990.[12] A few IMGs who were still practising in Australia in 2020 graduated more than 40 years ago but, not surprisingly, their number is small. Figure 8.3 shows the time that has elapsed since their graduation for women and men separately. The mode was 16–20 years for both, with

[11] This is close to the figure of 26 percent calculated by Sumption and Fix in 2014: Madeleine Sumption and Michael Fix, "Immigration and the Health-Care Workforce since the Global Economic Crisis: Overview," in *Migration of Health Workers: WHO Code of Practice and the Global Economic Crisis*, eds. Amani Siyam and Mario R. Dal Poz (Geneva: World Health Organization, 2014), 100.

[12] As indicated later in this chapter, the sharp decreases after about 2010 for IMGs and 2015 for locals is an artefact of the way recent registrants get added to the MDA.

medians (IQR) 25 (18–33) and 28 (20–36) years for women and men respectively (p<0.001). Only 50 (2.9% of the sample) practising in 2020 had graduated more than 50 years earlier. Most migrated to Australia early in their careers, arriving and being licensed within ten years of their overseas qualification (Figure 8.4). For women, the median (IQR) interval between medical graduation and registration in Australia was 9 (5–14) years, minimally shorter than 10 (6–15) years for men (p=0.032). This accords with data on skilled migration more broadly, where in 2018 the median age of *all* skilled migrants arriving in Australia was 31.[13]

Table 8.1: Countries of training of IMGs practising in Australia in 2020[a]

Country	N	%
India	363	21.30
UK	326	19.13
South Africa	140	8.22
Sri Lanka	94	5.52
Bangladesh	67	3.93
Egypt	59	3.46
Pakistan	56	3.29
Ireland	50	2.93
Iran	46	2.70
Philippines	44	2.58
Iraq	41	2.41
China	39	2.29
Myanmar	36	2.11
Russia	28	1.64
Germany	27	1.58
Nigeria	20	1.17
Romania	16	0.94
Malaysia	15	0.88
Zimbabwe	14	0.82
Hong Kong	13	0.76
Poland	13	0.76
Serbia	12	0.70
Ukraine	12	0.70
Netherlands	11	0.65
Canada	9	0.53
Singapore	9	0.53

[a]From random sample of 10% of all IMGs listed in Medical Directory of Australia at April 2020. Table excludes countries contributing < 0.5% of the total sample of 1704 practitioners.

Since medical practitioners most commonly graduate around the age of 23–25, the modal age of the IMGs in Figure 8.4 would have been approx.-imately 31–33. However, there is a quite long tail for the next 10–15 years which would be partly due to migrating at older ages and partly to delays in getting through the Australian licensing processes (see Chapters 8 and 10).

The IMGs in the random sample obtained their medical degree in a total of 82 countries. Those that contributed at least 0.5 percent of the total are listed in Table 8.1, and the decades in which they arrived in Appendix A, Supplementary Table 5. The major donor countries for those currently practising in Australia are India, the United Kingdom, and South Africa. When classified into United Nations (UN) geographic regions,[14] the main

[13] Australian Bureau of Statistics, "Australian Demographic Statistics, Jun 2018," https://www.abs.gov.au/ausstats/abs@.nsf/featurearticlesbyCatalogue/7A40A407211F35F4CA257A2200120EAA., The data are for permanent skilled visas; median age for temporary skilled work visas was 29 years.

[14] United Nations Statistics Division, "Countries or Areas / Geographical Divisions," accessed 18 April 2020, https://unstats.un.org/unsd/methodology/m49/.

contributors are UK and Ireland, Southern Asia, Sub-Saharan Africa, South-eastern Asia and Eastern Europe. UK and Ireland are actually part of the UN Northern Europe division, but separated out here because of the preferential treatment now given to their graduates by the AMC, and previously by State and Territory medical boards.[15] Figure 8.5 illustrates how their relative contributions have changed over time.[16] For those still practising who were registered in Australia prior to 2000, the largest contribution came from UK and Ireland, as was seen in the prosopography in Chapter 7. But among IMGs who were first registered in the 2000s, Southern Asia is now the dominant source. This is also the case in New Zealand, a country with many similarities to Australia.[17]

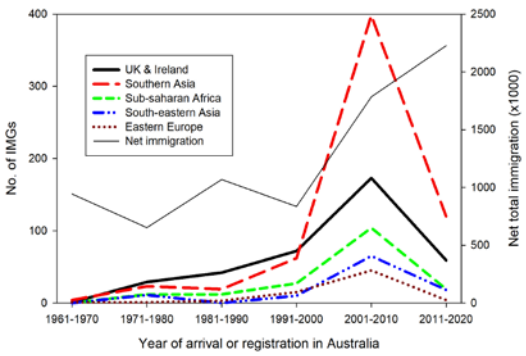


Figure 8.5: UN geographic regions of origin of the IMGs practising in 2020 versus year of registration. UK and Ireland are in the Northern Europe region, but plotted here by themselves because of the favoured registration status they have enjoyed from the Australian Medical Council and historical medical boards. The decrease in the final decade is an aberration, due to the delayed listing process for IMGs in the MDA.

This random sample of IMGs practising in Australia in 2020 reflects the waves of medical migration to the country over the last 60 years. The shift in countries of origin, from mainly UK and Ireland in those who arrived before 1990, to mainly Southern Asia in the last twenty years, has been striking. But these changes in the countries of origin of IMGs reflect major changes in the composition of Australia's migrants generally over that period. Immigration policies that were widely criticised as racist have become more inclusive. The proportion of Australia's population born overseas has increased from 10 percent at the end of WWII to 30 percent in 2019.[18] And in 2018–19, the countries that made the largest contribution to the 160,323 new permanent migrants were India (21%), China (15%) and UK (9%).[19] It is no surprise that Indian doctors are now the major contributors of IMGs to Australia. India has a large population, a robust medical education system, and many links to its diaspora in Australia that facilitate chain migration.[20] The

[15] For a discussion, see Chapter 3.
[16] The line in Figure 8.5 for total immigration is from Australian Bureau of Statistics, "Australian Demographic Statistics, Jun 2018".
[17] Rishi Kumar, "Indian Medical Graduates in New Zealand: Does Anyone Win?" *Postgraduate Medicine* 97, no. 1147 (2021): 276.
[18] Australian Bureau of Statistics, "Migration, Australia."
[19] Ibid. New Zealand is excluded here because it has a freedom of movement agreement with Australia; data for 2019-20 were impacted by the Australian border closure due to the COVID-19 pandemic.
[20] Man Mohini Kaul, "The Indian Diaspora in Australia and New Zealand: Challenges and the Way Forward," *Diaspora Studies* 2, no. 2 (2009): 187-8.

presence of a substantial diaspora was one of three factors Yasser Moullan found to be a strong determinant of medical migration to OECD countries.[21] India is also the biggest exporter of medical practitioners to USA and Britain, again countries with a large Indian diaspora.[22]

It is perhaps surprising that only 2 percent of Australian IMGs were trained in China since, as mentioned, it is now the second largest source of immigrants overall. However, the number of Chinese medical migrants is beginning to increase: excluding Hong Kong, more than a thousand Chinese-trained doctors sat the AMC examinations between 2000 and 2019.[23] By contrast South Africa, which ranks third overall as country of origin for those IMGs currently practising, and was an important contributor in the 1960s to 1980s (Chapter 7), provided only 2 percent of migrants in all categories in 2019. Medical migration from that country was prominent during the Apartheid period and right up till about 2010, but seems to be now slowing.[24]

Geographical Distribution of IMGs and Local Graduates

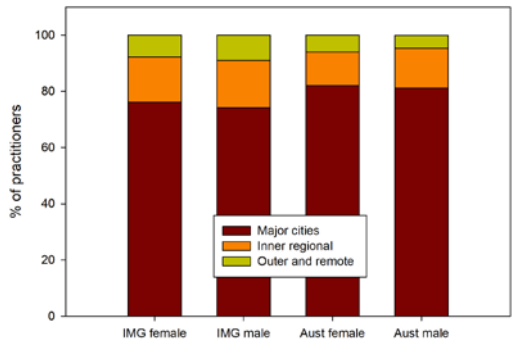


Figure 8.6: Geographic place of practice of IMGs and local graduates in Australia in 2020, by Australian Bureau of Statistics (ABS) geographical regions. 'Outer' is sum of 'outer regional' plus 'remote' plus 'very remote' areas. IMGs vs Australian graduates, p<0.001 (chi square).

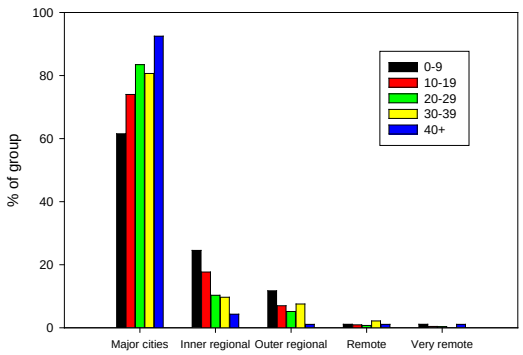


Figure 8.7: Geographic place of practice of IMGs in Australia in 2020, by ABS geographical regions and years since first registered in Australia.

[21] Yasser Moullan, "What Fundamentals Drive the Immigration of Medical Doctors?," in *High-Skilled Migration: Drivers and Policies*, ed. Mathias Czaika, 301-19, (Oxford: Oxford University Press, 2018), 211.
[22] Manas Kaushik et al., "High-End Physician Migration from India," *Bulletin of the World Health Organization* 86, no. 1 (2008): 40-5.
[23] Neville D Yeomans et al., "Demographics and Performance of Candidates in the Examinations of the Australian Medical Council, 1978-2019," *Medical Journal of Australia* 214 (2021): 55.
[24] Peter Arnold, *A Unique Migration: South African Doctors Fleeing to Australia.* (Seattle, WA: CreateSpace, 2011), 61.

Compared with the random sub-sample of 1701 Australian graduates, the IMGs are more likely to be practising in outer regional and remote areas (8.7% of IMGs vs 5.2% of local graduates), though far the largest number are in major cities (Figure 8.6). A marginally higher proportion of females than males are in the cities, but the gender differences were not statistically significant. IMGs practising outside the major cities are more likely to be recent graduates, unlike the medical workforce as a whole, which in 2020 showed no such age gradient.[25] Figure 8.7 shows the distribution of IMGs in the five geographical regions versus time since they registered in Australia: 38.5 percent of those registered since 2010 are practising outside major cities compared with only 15.3 percent of those registered prior to 2000 ($p<0.001$).

The finding that IMGs were more likely to be practising in a rural or remote area of the country than the local graduates is no surprise. Indeed, it is government policy. Visas and registration are more likely to be obtained if the immigrant goes to an area of need.[26] Another factor since 1997 has been a requirement for most IMGs to work in an area of workforce shortage for ten years before they can bill patients under the universal medical insurance (Medicare) scheme.[27]

These findings from the MDA sample for IMGs registered less than ten years in Australia are similar to those of O'Sullivan et al., who surveyed the practising medical workforce in the period 2008–2013. Their longitudinal cohort study—*Medicine in Australia: Balancing Employment and Life (MABEL)* —mailed questionnaires to every doctor on the MDA database in 2008, offering the option of reply by mail or to a secure website (though a limitation is a response rate just under 20 percent). Sixteen percent of their respondents were IMGs, and they found those who were practising in small rural and remote areas in that period were about twice as likely to be IMGs as local graduates.[28] The same authors found that mandating IMGs to practise in rural areas leads to significant dissatisfaction. This was in both life-style (non-professional) and professional areas—the former due to reduced access to family and friends, choice of schools, and employment

[25] Australian Government Department of Health, "Summary Statistics, Remoteness Area," accessed 17 May 2022, https://hwd.health.gov.au/resources/data/summary-remote.html.

[26] Robyn Iredale, "Luring Overseas Trained Doctors to Australia: Issues of Training, Regulating and Trading," *International Migration* 47, no. 4 (2009): 51; Medical Board of Australia, "Area of Need," accessed 4 January 2021, https://www.medicalboard.gov.au/registration/types/limited-registration/area-of-need.aspx.

[27] See Chapter 3; Department of Health [Cth], "Medicare Provider Number Restrictions," accessed 6 January 2021, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-pubs-mtrp-13-toc~work-pubs-mtrp-13-5~work-pubs-mtrp-13-5-med.

[28] Belinda O'Sullivan et al., "Reviewing Reliance on Overseas-Trained Doctors in Rural Australia and Planning for Self-Sufficiency: Applying 10 Years' Mabel Evidence," *Human Resources for Health* 17, no. 1 (2019): 5.

opportunities for spouses; the latter due to unhappiness about reduced professional autonomy.[29]

That those in the rural areas are younger is also not surprising. Some older IMGs would have started there then moved to a city, often motivated by better opportunities for their children's education or work for a spouse, after having 'served their time' in a more remote area.

Areas of Specialisation

A much larger proportion of IMGs is in general practice compared with the local graduates: 56 percent versus 35 percent (Table 8.2). In nine of the other specialty areas shown in the table, immigrants are significantly under-represented, often by a factor of more than two. Among the larger specialties, one where the difference is less marked is Internal Medicine, where 14.2 percent of the Australian graduates in the sample are in that specialty compared with 11.5 percent of IMGs. One reason the difference between IMGs and local graduates is less marked in Internal Medicine is because the IMG specialists were more likely to be geriatricians than the local graduates—a subspecialty not strongly preferred by the locals. IMGs numbers in Psychiatry were also higher than in the Australian grad- uate sample; that specialty, too, is not in great demand by Australian graduates. Michael Goldacre and colleagues found those 'undesirable' specialties were also more likely to be filled by IMGs in the UK NHS.[30]

Not surprisingly, the Medical Board designated many more of the local graduates as 'Doctor-in-Training' (hospital residencies or specialty training programs); and as mentioned below, IMGs would rarely be listed in the MDA while they were still in the supervised positions required by AHPRA, since they would not have full registration.

An important reason so many more IMGs are working as general practitioners is the difficulty those who were specialists at home often have in negotiating acceptance by the Australasian specialist colleges. Some, who migrate soon after graduation, pass the AMC exams then manage to get into a college training program at the ground floor. Others, though, find themselves blocked by the corresponding college and give up the struggle. Examples of both outcomes are found in the oral histories reported in Chapter 10, and the responses of senior Fellows who manage this for their colleges are presented and discussed in Chapter 11. There has been some increase, though, in the proportion of practising IMGs working in specialties (other than general practice) during the last thirty years. Currently

[29] Matthew R McGrail et al., "International Medical Graduates Mandated to Practise in Rural Australia Are Highly Unsatisfied: Results from a National Survey of Doctors," *Health Policy* 108 (2012): 136-7.

[30] Michael J Goldacre, Jean M Davidson, and Trevor W Lambert. "Country of Training and Ethnic Origins of UK Doctors: Database and Survey Results," *British Medical Journal* 329, no. 7466 (2004), 3.

they make up 41 percent of the workforce (from Table 8.2), whereas at the time of the Doherty Report in 1988, only 29.5 percent were 'non specialists.'[31] Nevertheless, as can be seen in Table 8.3, some source countries have much lower proportions of non-GP specialists in the Australian workforce than others, and this may reflect country-to-country variations in successfully having their experience and training recognised by the Australasian colleges. This theme is returned to in Chapters 10 and 11.

[31] Ralph L Doherty, *Australian Medical Education and Workforce into the 21st Century: Committee of Inquiry into Medical Education and Medical Workforce* (Canberra: AGPS, 1988), 385.

Table 8.2: Numbers of IMGs and Australian Graduates practising in each medical specialisation or category in Australia in 2020

	Number (%) in discipline		
Discipline	**IMGs**	**Aust. Grads.**	**P value***
Alcohol/Drug Dependency	0	1 (0.1)	NA
Anaesthesia	65 (3.8)	123 (7.2)	<0.001
Dermatology	6 (0.4)	25 (1.5)	0.001
Diagnostic Radiology	30 (1.8)	50 (2.9)	0.031
Doctor In Training	8 (0.5)	122 (7.2)	<0.001
Emergency Medicine	64 (3.8)	48 (2.8)	0.152
General Practice	953 (55.9)	587 (34.5)	<0.001
Genetics	1 (0.1)	1 (0.1)	NA
Intensive Care	30 (1.8)	24 (1.4)	0.497
Internal Medicine	196 (11.5)	241 (14.2)	0.023
Medical Administration	4 (0.2)	7 (0.4)	0.544
Medical Education/Research	4 (0.2)	12 (0.7)	0.079
Medical Officer	44 (2.6)	77 (4.5)	0.003
Medico Legal Consulting	1 (0.1)	1 (0.1)	NA
Microbiology	2 (0.1)	3 (0.2)	NA
Obstetrics & Gynaecology	36 (2.1)	34 (2.0)	0.910
Occupational Medicine	3 (0.2)	4 (0.2)	NA
Ophthalmology	15 (0.9)	29 (1.7)	0.048
Paediatric Medicine	42 (2.5)	40 (2.4)	0.917
Palliative Medicine	3 (0.2)	3 (0.2)	NA
Pathology	10 (0.6)	28 (1.6)	0.005
Physical Medicine	1 (0.1)	0	NA
Psychiatry	83 (4.9)	65 (3.8)	0.156
Public Health	1 (0.1)	5 (0.3)	NA
Radiation Oncology	6 (0.4)	8 (0.5)	0.786
Rehabilitation	16 (0.9)	7 (0.4)	0.095
Sexual Health	3 (0.2)	0	NA
Sports Medicine	4 (0.2)	3 (0.2)	NA
Surgery	73 (4.3)	153 (9.0)	<0.001
Totals	1704	1701	

*chi square test; significant differences shaded.

Table 8.3: Proportion of non-GP specialists from top 10 donor countries

Country	General Practice	All other specialties	% non GP specialists
UK	144	171	54.3
India	162	190	54.0
South Africa	67	68	50.4
Iran	25	20	44.4
Ireland	28	21	42.9
Sri Lanka	64	26	28.9
Pakistan	38	14	26.9
Bangladesh	51	11	17.7
Egypt	48	10	17.2
Philippines	38	4	9.5

Excludes doctors in training and non-specialist medical officers. P<0.001 for differences between rates in countries (chi square).

Limitations of the Data

The number of IMGs in the medical directory sample who were registered after 2011 is quite small. This is very likely to be artefactual, as many IMGs continued to sit and pass the AMC examinations during that final decade, although their number has fallen by about a half since 2010.[32] The other reason for the lower numbers of IMGs in the MDA database in 2011–20 is probably that many are still in supervised positions: with the relevant specialty colleges; in mandated hospital medical officer positions after passing the AMC examinations; or, as mentioned previously, in supervised general practice positions where they are not yet permitted to bill patients for private services in their own right. Thus, what is examined in this chapter is the distribution and characteristics of the *established* medical workforce—not the total workforce, which includes doctors still in supervised positions. A further limitation is that some doctors who work solely in hospitals, without private practice, do not get listed in the MDA. The data in the next chapter will help fill this gap by examining the numbers and demography of IMGs who presented for the AMC examinations during that final decade.

[32] Yeomans et al., "Demographics and Performance of Candidates," 55.

Conclusion

This chapter provides up-to-date information about the demography of the immigrant doctors who are currently practising in Australia. It shows that most IMGs arrived and were registered in Australia within 10 years of graduating in the parent country, and are underrepresented in medical specialties other than general practice. As will be seen in Chapter 10, this is likely to be due to the difficulty many who were specialists in their home country have in persuading the Australian colleges to recognise their credentials. The IMGs' countries of origin have changed greatly over the last 60 years, and this continues a trend that was becoming apparent in the final years of the prosopography in the previous chapter. They are more likely than local graduates to provide medical services in rural and remote areas, though the cities continue to be a magnet for the majority. As noted above, Australia is not alone in using IMGs to plug these healthcare gaps: Canada, New Zealand and USA are among others that have relied on them for years. [33]

The next chapter, rather than looking at a point-in-time history of those who were practising in 2019 as we do here, examines the historical changes in the demographics of the IMGs during the years since 1978 as reflected in the data from the AMC and AMEC examinations.

[33] N Dove, "Can International Medical Graduates Help Solve Canada's Shortage of Rural Physicians?," *Canadian Journal of Rural Medicine* 14, no. 3 (2009): 120-1; Arlene Garces-Ozanne, Ameline Yow, and Rick Audas, "Rural Practice and Retention in New Zealand: An Examination of New Zealand-Trained and Foreign-Trained Doctors, " *New Zealand Medical Journal* 124, no. 1330 (2011): 17; Jordan J Cohen, "The Role and Contributions of IMGs: A U.S. Perspective," *Academic Medicine* 81, no. 12 Supplement (2006): S17.

Chapter 9

Recent history of examinations used for licensing IMGs

In Chapter 4, the history of processes Australia has used to assess suitability of its medical immigrants to be licensed to practice was reviewed. This chapter examines in more detail the tools used for this purpose in the last forty years, what can be discerned from these data about the changes in medical immigrant flows during the period, and what factors have influenced candidates' success. The main focus is the examinations mounted by the Australian Medical Council for IMGs who have come by what is now termed the 'Standard Pathway'. Data about the other current pathways (Specialist, and Competent Authority) are examined more briefly at the end.

The AMC Examinations

As mentioned in Chapter 3, IMGs whose primary qualification was from a country outside the British Empire or Commonwealth, for a long time given a special status by the medical acts, began to be required by state medical boards to pass a national examination from 1978. The examination was conducted by the Australian Medical Examining Council until it handed it over to the Australian Medical Council (AMC) in 1986.[1] Information about the format of those examinations and their evolution was also provided in Chapter 4. The last detailed accounting of the demographics of IMGs attempting the examinations and their performance was published by the AMC itself in 2009 and by Lesleyanne Hawthorne in 2007 and 2012.[2] Now, a decade later, there have been striking changes in both these parameters, which this chapter documents and discusses.

In March 2019, the AMC provided me with a complete de-identified set of spreadsheets from its database of applicants from 1978 to October 2018. The information included each candidate's country of medical training, gender, birth year, year of overseas qualification, year of first attempting each of the two parts of the AMC examination, number of attempts, and year of eventual success.[3] The de-identification of the data required customised programming, and I am grateful to Mr Kevin Ng and Ms Prathyusha Sama at the AMC for performing this.

From the data thus supplied, annual numbers of candidates, mean numbers of attempts, the success rate per attempt and proportion eventually achieving success each

[1] The AMC was constituted in 1984, but did not take over running the AMEC exams until 1986 (Ian Frank, personal communication 2018).

[2] Laurence Geffen, *Assuring Medical Standards: The Australian Medical Council 1985-2010* (Kingston, ACT: Australian Medical Council, 2010), 159-66; Lesleyanne Hawthorne, Graeme Hawthorne, and Brendan Crotty, *The Registration and Training Status of Overseas Trained Doctors in Australia* (Parkville, Vic.: The University of Melbourne, 2007), 32-52; Lesleyanne Hawthorne, "International Medical Migration: What Is the Future for Australia?," *Medical Journal of Australia Open* 1, no. Suppl. 3 (2012): 19-20.

[3] The information in the first few years was sometimes incomplete (e.g., gender was omitted until 1985).

year were calculated. To examine the contributions of individual countries, results were aggregated into decades. Countries of training were also consolidated into regions, using the categories 'developed' or 'developing', according to the United Nations (UN) geographical regions report, last updated 1999.[4] For the former Soviet Union and Czechoslovakia, the country of qualification appears to have been listed sometimes by the candidate's self-report (e.g., training in Ukraine when that republic did not exist). Where applicable, these were altered to specify the actual country at the date of qualification (e.g., USSR if before 1992 or Czechoslovakia before 1993).

Medians and interquartile range (IQR) are presented, since few distributions were Gaussian. The statistical significance of differences in proportions was assessed with the chi square test.[5]

Demographics of Candidates

Over the 42-year period, a total of 35,699 IMGs from 153 countries sat the Multiple Choice Questions (MCQ) examination, 46.5 percent of whom were female. The median age of all candidates at their first attempt was 32 (IQR 28–37), with range 20 to 73 years.

Tables 9.1 and 9.2 show numbers of candidates from the top thirty countries of primary medical qualification for each examination. The data for all countries contributing ≥10 IMGs are provided in the supplementary tables to the published paper in Appendix C2.[6] The largest contributor in each of the four periods was Southern Asia, which provided just under half the total—predominantly graduates from India, Pakistan, and Sri Lanka. However, it needs to be remembered that IMGs from particularly Great Britain were exempted from sitting the AMC examinations for substantial segments of these 42 years (Chapter 3). Next in order were those from South-eastern Asia and Northern Africa. For the regions contributing at least 500 IMGs overall, the number increased eight-fold from Southern Asia and South America between the second and fourth decades, and six-fold from South-eastern Asia and Sub-Saharan

[4] United Nations Statistics Division, "Countries or Areas / Geographical Divisions". accessed 18 April 2020, https://unstats.un.org/unsd/methodology/m49/.

[5] See p. 84 for statistical analyses used in thesis.

[6] Data for countries with very small numbers (<10 IMGs) are omitted from those supplementary tables, since they show pass rates and years, hence performance of some individuals might be ascertainable.

Africa. Conversely, during the last thirty years, numbers from Northern and Southern Europe decreased, and from Western and Eastern Europe increased only slightly.

Table 9.1: MCQ examination—numbers of candidates and results, top 30 countries*

Country of Training	1978-1989		1990-1999		2000-2009		2010-2019		Total	
	No.	% pass	No.	% pass	No.	% pass	No.	% pass	No.	% pass
India	351	34.7	496	44.6	2619	52.5	2483	56.3	5949	51.7
Pakistan	32	23.3	113	28.4	1007	51.3	1838	59.4	2990	53.5
Sri Lanka	159	45.4	246	58.4	1005	75.4	1394	76.9	2804	72.0
Egypt	179	30.8	356	34.4	375	51.4	1171	67.0	2081	51.0
Bangladesh	16	26.7	99	37.0	777	56.9	1107	60.5	1999	56.8
Iran	32	32.3	34	45.0	664	62.3	1197	68.0	1927	64.6
Philippines	83	18.5	182	27.4	646	33.6	714	40.6	1625	34.0
China	4	0.0	219	39.7	641	50.9	745	41.5	1609	44.8
Myanmar	21	32.6	66	32.9	485	66.7	772	71.0	1344	65.1
Iraq	8	25.0	160	53.3	420	71.3	602	70.2	1190	67.4
South Africa	164	58.6	148	70.8	400	80.1	302	72.7	1014	72.6
Russia	0	0.0	9	25.0	286	38.0	458	42.4	753	40.3
Nigeria	2	33.3	9	58.3	242	42.2	487	45.4	740	44.3
United Kingdom	12	36.8	316	86.6	362	83.0	20	78.3	710	83.3
Malaysia	32	59.1	12	69.2	108	50.3	385	66.9	537	62.6
Germany	66	32.8	74	59.6	212	69.1	127	78.7	479	63.3
Sudan	2	50.0	24	45.8	77	40.3	254	59.1	357	52.5
Ukraine	0	0.0	8	35.0	133	33.8	200	43.0	341	38.4
Nepal	0	0.0	2	50.0	131	52.3	206	51.2	339	51.6
USSR	34	12.0	128	25.2	124	38.1	26	38.0	312	28.7
Fiji	14	27.5	45	54.8	105	42.5	118	44.4	282	43.8
Hong Kong	68	57.6	168	82.9	17	78.9	18	85.0	271	75.5
Poland	77	29.9	98	35.3	41	55.6	49	60.0	265	38.8
Romania	14	10.0	76	30.9	94	44.5	62	33.3	246	34.4
Viet Nam	63	30.6	64	23.1	64	46.1	55	50.0	246	34.2
Brazil	5	28.6	9	33.3	43	50.7	173	60.1	230	55.1
Colombia	1	100.0	5	20.0	81	50.0	138	52.9	225	51.0
Ireland	0	0.0	38	63.0	118	65.6	63	62.2	219	64.2
Indonesia	13	36.4	15	22.2	69	33.3	121	35.0	218	33.4
Jordan	0	0.0	5	80.0	70	65.5	123	67.4	198	67.0

*Ordered by total number of candidates. Data are listed by the year each candidate first attempted the examination; pass rates are per attempt (many candidates made several); most who trained in Canada, Ireland, UK and USA ('Competent Authority' countries) were exempted from taking the AMC examinations from 2007.
Significance of differences in pass rates per country of training, $P<0.001$.

Many countries contributed few or no IMGs before 1990. Among those providing at least 100 over the whole period, the largest percentage increases between 1990–99

and 2000–09 were from Iran, Nigeria, Colombia, Zimbabwe, and Nepal (each >10-fold, p<0.001), though from a low pre-1990 base. Between 2000–09 and 2010–19, the largest increases were from Brazil, Malaysia, and Sudan (each >3-fold, p<0.001). Numbers of immigrants from two countries showed striking fluctuations. Hong Kong applicants peaked at 168 between 1990 and 1999, then fell by 90 percent in the next decade (p<0.001). IMGs from the former Yugoslavia increased sevenfold between 1978–89 and 1990–99, then declined markedly: 49 percent of the 321 who came from those republics sat the

Table 9.2: Clinical examination—candidate numbers and results, top 30 countries*

Country of Training	1978–1989		1990–1999		2000–2009		2010–2019		Total	
	No.	% pass	No.	% pass	No.	% pass	No.	% pass	No.	% pass
India	190	40.8	392	46.7	1059	61.3	2074	40.6	3715	46.4
Sri Lanka	101	40.2	194	47.9	399	66.5	960	49.4	1654	52.1
Pakistan	13	55.6	59	45.8	342	56.7	1168	42.7	1582	45.9
Bangladesh	7	46.2	53	41.7	483	47.2	831	31.6	1374	37.4
Iran	8	40.0	27	56.5	263	69.7	688	41.1	986	47.9
China	0	0.0	109	46.9	398	64.4	475	41.0	982	50.4
Egypt	78	32.9	296	39.6	195	54.3	375	38.3	944	40.8
Myanmar	5	36.4	45	32.7	175	51.5	661	48.6	886	47.9
Philippines	11	13.0	104	34.8	198	38.0	507	29.5	820	31.8
Iraq	2	50.0	85	51.0	303	62.0	358	40.8	748	49.9
South Africa	115	69.5	102	67.4	192	90.8	269	67.5	678	73.7
United Kingdom	5	80.0	218	79.0	256	89.0	10	28.6	489	82.6
Russia	0	0.0	9	42.1	116	67.9	278	33.2	403	41.4
Germany	26	54.8	60	52.4	109	69.7	108	62.0	303	61.5
Nigeria	0	0.0	6	50.0	68	54.1	226	30.1	300	35.1
Malaysia	22	45.2	10	53.3	15	78.9	216	49.7	263	50.9
Nepal	0	0.0	1	50.0	39	79.2	159	42.0	199	47.6
Ukraine	0	0.0	6	100.0	50	61.3	126	30.6	182	38.7
Fiji	5	50.0	37	52.4	50	65.3	87	47.2	179	53.3
Poland	38	42.2	81	46.0	27	53.7	29	22.6	175	42.3
Hong Kong	36	57.7	123	60.9	4	75.0	7	66.7	170	60.6
USSR	8	66.7	49	40.6	80	45.0	28	24.6	165	40.6
Viet Nam	34	30.4	40	28.6	51	48.2	40	28.4	165	33.3
Romania	1	33.3	49	34.8	60	61.4	35	20.5	145	39.5
Colombia	1	33.3	1	100.0	34	78.6	100	51.7	136	57.7
Zimbabwe	4	75.0	6	66.7	49	82.1	67	45.8	126	59.1
Ireland	0	0.0	26	75.0	65	78.7	33	62.5	124	73.5
Sudan	0	0.0	15	60.9	33	50.0	68	28.0	116	38.6
Indonesia	7	50.0	6	28.6	23	43.2	76	36.0	112	37.9
Brazil	3	28.6	8	54.5	11	76.9	86	47.2	108	49.4

*Ordered by total number of candidates. Data as described in footnote to table 9.1.
Significance of differences in pass rates per country of training, P<0.001.

examination in 1990–99 and 32 percent in 2000–09, compared with 7 percent and 12 percent in the first and fourth decades (p<0.001). Geopolitical events that probably contributed to these major fluctuations are discussed a little later.

Using the 1999 UN classification of developed and developing countries, the 42 developed countries contributed only 4645 (13.0%) of the total 36,599 IMGs who attempted the MCQ examination over the four decades.[7] The Clinical Examination (Clinical) was attempted by 20,494 candidates, at an average time half a year later than the MCQ. Their demography resembled that of the candidates for the MCQ examination.

Candidate Performance

Figures 9.1 and 9.2 show the numbers sitting the MCQ and Clinical annually, the total number of attempts and the proportion who passed each time. From a low base till about 2000, there was a marked increase in those attempting each examination—reaching a peak in 2009 for the MCQ, and four years later for the Clinical. Although the candidate numbers declined slightly after these peaks, they remained almost fourfold higher than in 2000.

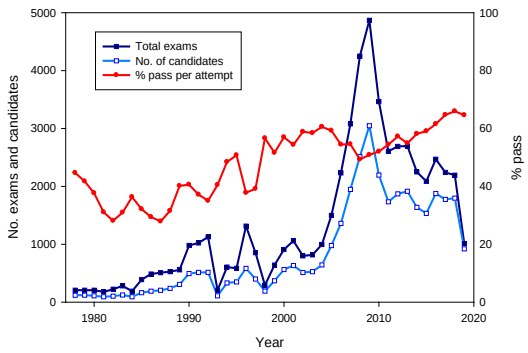


Figure 9.1: Numbers of candidates and success rate per attempt in the written (MCQ) examinations since 1978. Also shown is total number of attempts by candidates each year. Data for 2019 truncated at October. P<0.001 for differences in candidate numbers and proportion passing over the whole period.

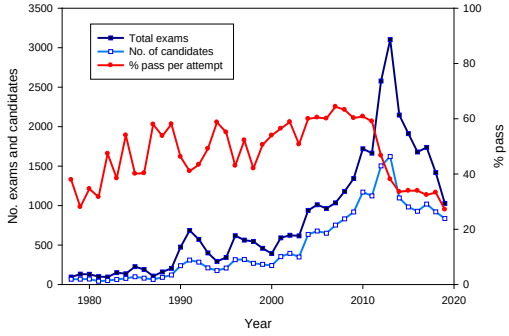


Figure 9.2: Numbers of candidates, success rate per attempt and total attempts in the Clinical examinations. Data for 2019 truncated at October. P<0.001 for differences in candidate numbers and proportion passing.

The pass-rate at each attempt in the MCQ examination fluctuated, with most year-to-year variations not reaching statistical significance (exceptions were the marked

[7] But with caveat that British graduates often did not need to sit the exams.

decrease 1995–6 and increase 1997–8, both $p<0.001$). However, the overall trend was for higher pass-rates per examination, from a low of 28% in 1987 to a high of 66% in 2018 ($p<0.001$). Most candidates took less than two tries to pass the MCQ, and the overall mean was 1.56 for the entire period. Some candidates showed great persistence: 86 attempted the examination ten or more times; the most attempts were 24 by a candidate from the USSR, who sat it first in 1985 and passed in 2008 at the age of 65.

As with the MCQ examination, the pass-rate in the Clinical increased between the 1980s and the 2000s, reaching a peak of 64% in 2007. Between 2011 and 2012 it fell by more than 10% ($p<0.001$), followed by a further decline; and for the last five years (excepting 2019 when data incomplete) it has been just above 30%. Nevertheless, most candidates who persevered managed to pass after not more than two attempts. As with the MCQ, there were a few who found it much more difficult. Thirty (0.15%) took ten or more attempts and, of those, only eight eventually passed. Five or more attempts were made by 621 candidates (3.0%), 144 of whom have not succeeded (though several of the most recent ones may still be trying).

Examination success rates by country (from the 30 countries contributing most candidates) are shown in Tables 9.1 and 9.2. Rates varied substantially between these countries. The highest pass-rate per attempt in the MCQ was by IMGs from UK, Hong Kong, South Africa and Sri Lanka. In the Clinical, they were from UK, South Africa and Ireland—countries with similar medical education and examination systems to Australia.

Table 9.3 shows the pass-rates and numbers of attempts separately for women and men. In the MCQ, during the last three decades, women had a significantly higher pass-rate per attempt and overall, though the magnitude of the difference (about 3%) was small. In the Clinical since 1990, women had both a higher pass-rate and fewer attempts. In the final decade, the difference in pass-rates was substantial (+12%).

Table 9.3: Influence of gender on examination success*

Period	Gender	N	Total attempts	Total passes	Mean (±SD) attempts	% pass total	% pass/ attempt
MCQ examination							
1978-1989	Female	568	1299	412	2.29±1.84	72.5	31.7
	Male	1142	2431	817	2.13±1.68	71.5	33.6
1990-1999	Female	1691	3279	1434	1.95±1.57	84.8	43.7
	Male	2164	4275	1729	1.98±1.71	79.9	40.4
2000-2009	Female	5438	8666	4813	1.59±1.14	88.5	55.5
	Male	7287	11846	6192	1.63±1.32	85.0	52.3
2010-2019	Female	8891	12238	7378	1.38±0.86	83.0	60.3
	Male	8365	12041	6845	1.35±0.85	81.8	56.8
Clinical examination							
1978-1989	Female	257	503	233	1.96±1.58	90.7	46.3
	Male	543	1085	471	2.00±1.47	86.7	43.4
1990-1999	Female†	1156	2037	1084	1.76±1.07	93.8	53.2
	Male	1432	2917	1243	2.04±1.35	86.8	42.6
2000-2009	Female†	2636	3662	2428	1.39±0.82	92.1	66.3
	Male	3170	5036	2772	1.59±1.08	87.4	55.0
2010-2019	Female†	6150	9802	4535	1.59±1.03	73.7	46.3
	Male	5053	9184	3132	1.82±1.30	62.0	34.1

* AMC's precursor (AMEC) did not list candidates' gender in a few instances during the first decade. †$p<0.001$ cf. males (t-tests and chi square). SD = standard deviation.

Figures 9.3 and 9.4 show the pass-rates in each examination graphed against candidates' age, and interval (recency) since their medical graduation. In each, there is a highly significant negative correlation. The decline in success with increasing age and decreasing recency was more marked in the Clinical. While the number who were 55 years or older was small (245; 1.2% of total), their pass-rate was one-third that of candidates aged 20-29, and only 45% of the older group eventually passed.

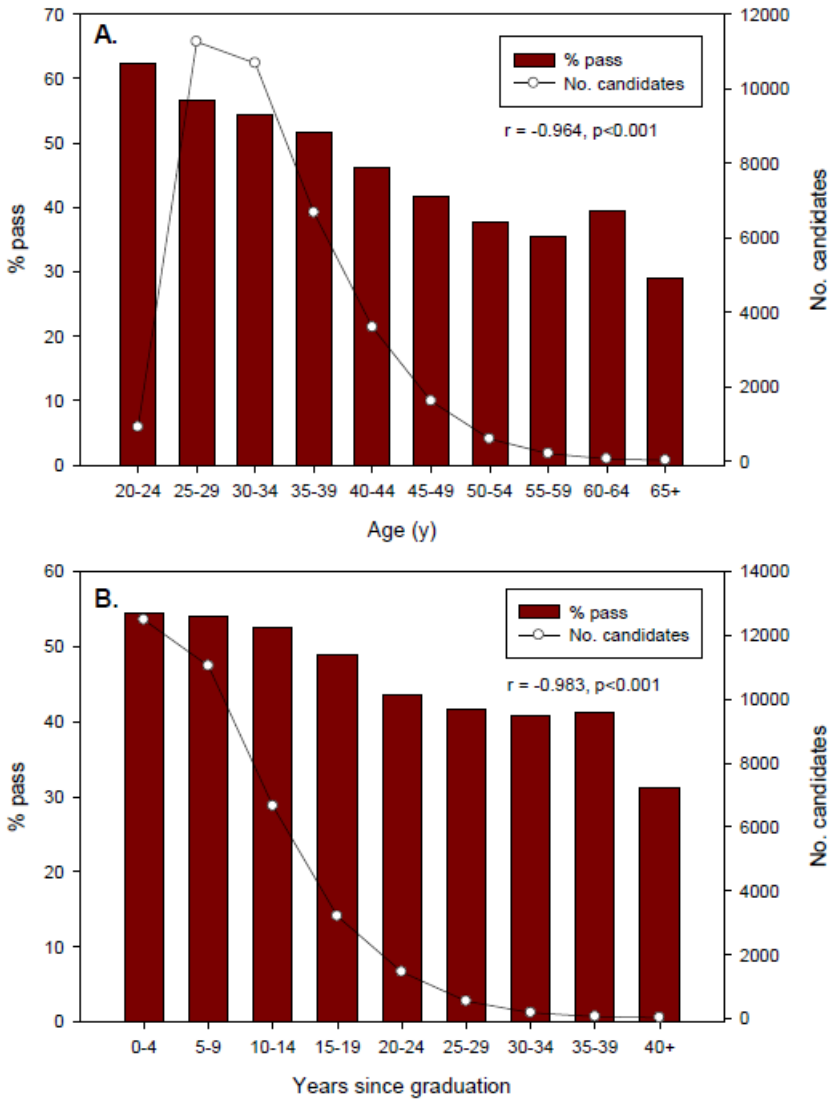


Figure 9.3: AMC MCQ examination, 1978-2019: pass rates vs. age (A) and recency since graduation (B) in the year when candidates first attempted the examination (all countries combined). r-values are Spearman rank correlations.

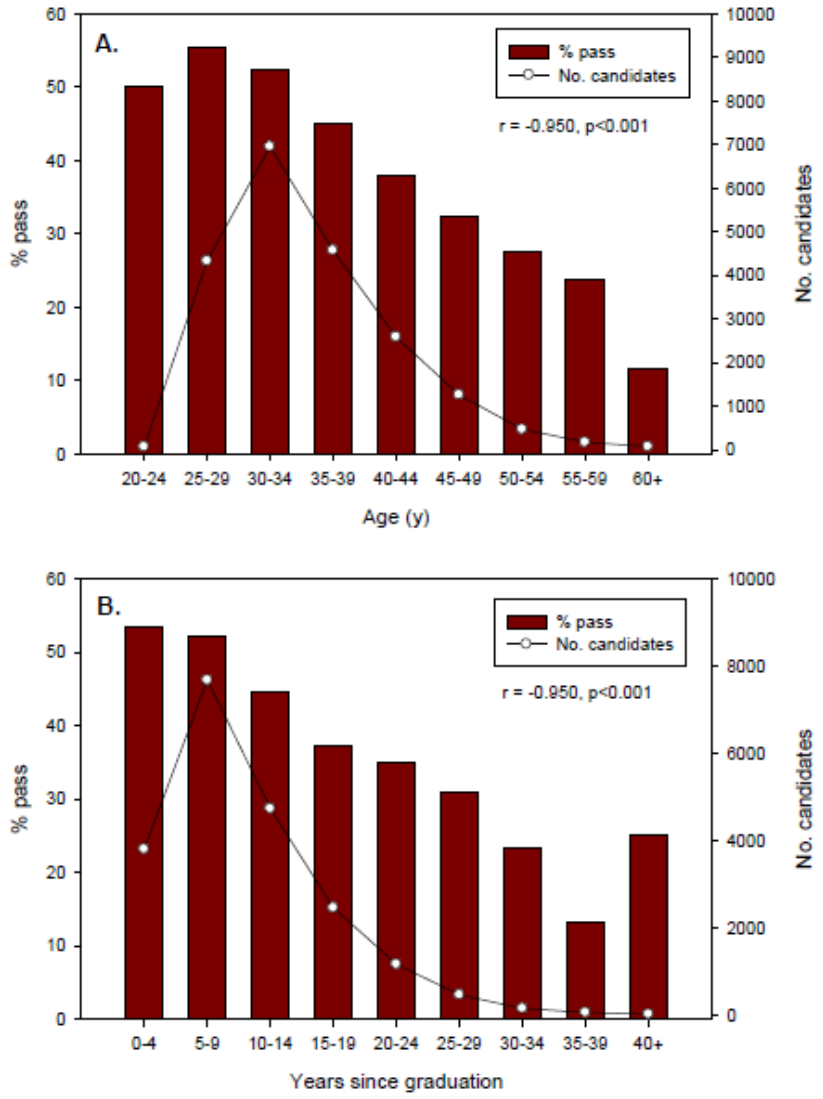


Figure 9.4: AMC Clinical Examinations, 1978-2019: pass rates vs. age (A) and recency since graduation (B) in the year the examination was first attempted.

Commentary

Before 2000, the number attempting AMC examinations annually was usually less than 300 and never exceeded 600. However, between 2000 and 2018, candidate numbers increased more than 3-fold during a period when the number of all Australians born overseas increased only from 4.5 to 7.3 million.[8] Some factors likely to have contributed to the increase in candidates were removal in 1998 of the requirement to be an Australian citizen, and offering the computer-delivered MCQ examination from 2005 in several centres outside Australia. A further increase in candidates for the MCQ examination resulted from the 2006 decision by the Council of Australian Governments

[8] Australian Bureau of Statistics, "Migration, Australia". accessed 5 January 2021, https://www.abs.gov.au/statistics/people/population/migration-australia/latest-release.

that all IMGs with limited or temporary registration be required to pass that examination.[9] The peak in attempts at the Clinical in 2013 followed the establishment of the National Registration and Accreditation Scheme in July 2010 and the requirement that limited registrants (non-specialists) demonstrate progress towards full registration (including passing the AMC clinical examination where applicable).[10] However, this marked increase in numbers of doctors migrating to Australia, reflected in the numbers sitting AMC exams, is part of a world-wide phenomenon that has been accelerating since the start of the twenty-first century. Data from the Organisation for Economic Cooperation and Development (OECD) show that the number of foreign-trained doctors working in OECD countries increased by 50 percent in just the ten years since 2006.[11]

It is important to note that these data are specific to those sitting the AMC examinations. They give only a partial picture of medical immigration over this period. Firstly, they do not include IMGs who were registered as specialists by the various states, and subsequently by AHPRA on advice from specialist colleges. Secondly, until 1992 the Medical Acts in all Australian states allowed graduates from UK (and usually Ireland) exemption from the need for further examination. For the next 15 years, generalists from those countries usually had to take the AMC examinations, but from 2007 they were again exempted (along with IMGs from Canada and USA) when the AMC introduced the Competent Authority pathway.[12] Some information from these other pathways will be examined later in this chapter.

What can be discerned from these data about IMGs' motives for migrating to Australia since 1978? Some IMG influxes correlate with historical events that promoted exodus from their parent countries. The sharp increase and subsequent fall in IMGs applying from Hong Kong in the 1990s suggests an "insurance policy" motive as a result of political and social uncertainty before the handover to China in 1997, and post-1997 reassurance for many Hong Kongians that their situation was now more secure. Civil war may have been an important factor in IMG emigration from the former

[9] Australian Government Department of Health, "Requirements for Practising Medicine in Australia," accessed 1 September 2021, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-pubs-mtrp-15-toc~work-pubs-mtrp-15-chap5~work-pubs-mtrp-15-chap5-rep.

[10] See Chapter 4.

[11] Karolina Socha-Dietrich, Gaétan Lafortune, and Erik Vickstrom. "Recent Trends in International Mobility of Doctors and Nurses," in *Recent Trends in International Migration of Doctors, Nurses and Medical Students*, eds. Karolina Socha-Dietrich and Gaétan Lafortune (Paris: OECD Publishing, 2019), 11.

[12] Medical Board of Australia, "Competent Authority Pathway, 2019," accessed 12 January 2020, https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Competent-Authority-Pathway.aspx

Yugoslavia, which reached a peak between 1990 and the early 2000s. Civil war and other forms of political unrest or discrimination may also have motivated emigration from several other countries (e.g., Sri Lanka, Egypt, Iran, Iraq, and Myanmar) that have contributed large numbers of candidates.

Economic factors have often been mentioned as drivers of migration from poorer countries (the "global south") to richer ones,[13] and it is notable that most who took the AMC examinations during the last 40 years came from countries classified by the UN as developing. Two developed countries (UK and Ireland) have been important contributors over the whole period but, as mentioned, their graduates usually did not need to sit these examinations.

Another important pull factor for many IMGs is likely to have been the presence in Australia of a substantial diaspora, as mentioned in Chapter 7. For instance, India, which contributed most candidates for the AMC examinations in each of the four decades, ranked behind only England and China as a source of all migrants living in Australia in 2018.

The overall success rate in the MCQ examination increased significantly from the 1980s. The AMC made several changes over that time to increase reliability and fairness. One was altering question types to formats less dependent on English-language skill; another was publication of annotated question banks to assist candidates in their preparation.[14] From 2000, the pass-mark has been set by criterion-referenced methodology. A further refinement from 2011 was administering the MCQ examination in computer-adaptive format, where the difficulty of items is adjusted in real time according to a candidate's performance; this is considered to increase fairness and precision.[15]

A factor likely to have contributed to the recent lower pass-rate in the Clinical (Figure 8.2) is the removal of nearly all candidates from the Competent Authority countries. Up till 2009, UK graduates had the highest pass-rate in this examination (Table 9.2), and their removal from the pool would inevitably lower the overall rate. However, the decline since 2010 cannot be accounted for by this since Competent Authority candidates comprised less than 10% of the 2000–2009 total. Thus, other

[13] Stephen Castles, "Understanding Global Migration: A Social Transformation Perspective," *Journal of Ethnic and Migration Studies* 36, no. 10 (2010): 1567-9.

[14] Geffen, *Assuring Medical Standards*, 128-34; Australian Medical Council Limited, "IMG Guides," accessed 3 July 2020, https://www.amc.org.au/publications/img-guides/; K Breen, I Frank, and T Walters, "Australian Medical Council: A View from the Inside," *Internal Medicine Journal* 31, no. 4 (2001): 245-7.

[15] Paul McCoubrie, "Improving the Fairness of Multiple-Choice Questions: A Literature Review," *Medical Teacher* 26, no. 8 (2004): 711.

factors affecting the most recent cohorts of candidates, for example the changing mix of parent countries, are likely to have contributed. IMGs must often overcome hurdles not faced by those from Competent Authority countries. These include adapting to an unfamiliar health system, developing fluency in English, preparing for the examinations while under time pressure from short-stay visas, and needing to support themselves with sometimes long hours of work outside the health system.[16] However, it is also possible that changes in the format or content of the OSCE examination, or even the attitudes of some examiners to non-European IMGs, have contributed.

The differences between the results for women and men in the MCQ should not be overplayed, since the magnitude was small. Others have found little gender effect in postgraduate written examinations in the UK and USA.[17] However, the outperformance by women in the Clinical, particularly in the past decade, is more striking. Those findings have been seen elsewhere. Women perform better than men in Step 2 of the United States Medical Licensing Exam.[18] Female overseas-trained doctors were twice as likely as males to pass the UK Royal Colleges of Physicians' Practical Assessment of Clinical Examination Skills (PACES) at their first attempt.[19] The PACES examination has many similarities to the AMC OSCE examination, with communication skills important for both. Female superiority in patient-doctor communication has been documented previously, and may partly explain the present findings.[20]

That performance in the MCQ deteriorated with both age and recency of graduation is not entirely surprising: the examination tests knowledge in all domains of medicine, including some of the basic sciences. The longer since these were studied, the more difficult it might be to pass questions based on them, especially for IMGs who had practised as a specialist in their original country.

More unexpected was the much lower performance in the Clinical by older candidates. Clinical experience might have been expected to give them an advantage, but this does not appear to have been generally so. I have been unable to find exactly comparable data from medical licensing examinations in other countries. Lara Menzies et al. observed that international graduates aged >37 years actually performed *better* in

[16] Evidence is in the oral histories in Chapter 10.

[17] Neil G Dewhurst et al., "Performance in the MRCP (UK) Examination 2003–4: Analysis of Pass Rates of UK Graduates in Relation to Self-Declared Ethnicity and Gender," *BMC Medicine* 5, no. 8 (2007): 2.

[18] Jonathan D Rubright, Michael Jodoin, and Michael A Barone, "Examining Demographics, Prior Academic Performance, and United States Medical Licensing Examination Scores," *Academic Medicine* 94, no. 3 (2019): 368.

[19] Emily Unwin et al., "Passing MRCP (UK) Paces: A Cross-Sectional Study Examining the Performance of Doctors by Sex and Country," *BMC Medical Education* 18, no. 70 (2018): 5-6.

[20] Harbinder Sandhu et al., "The Impact of Gender Dyads on Doctor–Patient Communication: A Systematic Review," *Patient Education and Counselling* 76 (2009): 350-3.

a postgraduate paediatric examination. On the other hand, Rebecca Lipner and colleagues noted a negative correlation between age when first certified by the American Boards of Internal Medicine and Surgery and subsequent success in Maintenance of Certification examinations.[21]

Workplace-based Assessment Pathway (WBA)

The history and structure of this pathway towards medical registration of IMGs, which sits within the Standard Pathway, was outlined in Chapter 4. The program at the time

Table 9.4: AMC Workplace-based assessment candidates—major countries*

	Year of overseas qualification					
Country	1971-80	1981-90	1991-00	2001-10	2011-20	Total
Bangladesh	2	3	9	23	1	38
Egypt	0	0	5	22	1	28
India	7	16	69	118	16	226
Iran	0	1	2	20	2	25
Iraq	0	1	8	27	4	40
Malaysia	0	0	1	9	5	15
Myanmar	0	1	2	10	1	14
Nepal	0	0	0	9	1	10
Nigeria	0	0	3	28	2	33
Pakistan	1	5	11	82	7	106
Philippines	0	7	23	16	1	47
Russia	0	1	7	13	1	22
South Africa	0	1	2	14	6	23
Sri Lanka	0	1	5	30	3	39

*Excludes countries with <10 IMGs

of writing was small, but some deidentified data to October 2018 were provided by the AMC. Between 2010 and 2018, 801 IMGs had entered this pathway from 62 countries. At October 2018, all but nine had passed (success rate 98.9 percent). Whether this very high passing rate can be seen as problematic is discussed again in Chapter 11, but it needs to be remembered that hospitals are highly selective about who they take into this pathway, based on both the applicant's performance in the AMC MCQ examination and an interview.[22]

[21] Lara Menzies et al., "An Evaluation of Demographic Factors Affecting Performance in a Paediatric Membership Multiple-Choice Examination," *Postgraduate Medicine* 91 (2015): 74; Rebecca Lipner et al., "Factors That Influence General Internists' and Surgeons' Performance on Maintenance of Certification Exams," *Academic Medicine* 86 (2011): 56.

[22] Interview with Barbara Johnson (pseudonym), Chapter 11.

Table 9.4 shows the numbers and years of overseas qualification from each of the major countries whose IMGs were taking part in this stream. As with the much larger number who did not have the benefit of the WBA program, the major donor region was South Asia. Because this program started only recently, most had obtained their medical qualification in the decade 2001–2010.

Only 30.7 percent of this group was female, significantly less than the 48.8 percent who took the AMC clinical exam over the total period from 1978 ($p<0.001$). Since most in the WBA pathway had graduated from 2000 onwards, that subset of all who took the AMC clinical examination is a better basis for comparison. Here the difference is even more marked: 31.7 percent women in the WBA pathway compared with 54.1 percent among all who undertook the Clinical ($p<0.001$). Why there is such an under-representation of women in the WBA pathway is unclear. Since candidates in the mainstream of the Standard Pathway and those admitted to the WBA scheme all had to pass the MCQ examination, and since females performed slightly better in the MCQ (see Table 9.3), other factors must be responsible. One may be the relative difficulty for some married female IMGs to relocate to a region that took part in the WBA. Some oral histories in Chapter 10 suggest that this may play a part. The possibility that the interview to gain entry to WBA is biased against women would have to be entertained, although equal opportunity legislation, such as the one in Victoria, require hospitals to not discriminate on the basis of gender.[23]

[23] Equal Opportunity Act 2010 (Vic.).

Specialist Pathway

As described in Chapter 4, in the last 30 years, overseas-trained specialists have been able to be triaged by the AMC to be evaluated by the corresponding Australian or Australasian specialist college. The total number who applied by this route increased almost eightfold, from 188 to 1437 between 1993 and 2013.[24] Much more information was available from the annual reports of the Medical Board of Australia since 2016.[25] The number of IMGs processed by the colleges in 2015 and 2020, and the proportion that each judged to be 'substantially comparable' to the training and experience of one of their own Fellows has been extracted into Table 9.5. Some colleges were much more

Table 9.5: Specialty pathway for IMGs—college decisions, 2015-20

	2015					2020				
	Comparable to Australian Fellows?					Comparable to Australian Fellows?				
College	N	Not	Part.	Subst.	% Subst.	N	Not	Part.	Subst.	% Subst.
ACD	9	2	5	0	0.0	26	5	4	7	43.8
ACEM	14	1	12	0	0.0	27	1	18	5	20.8
ACRRM	0	2	0	4	66.7	17	6	1	10	58.8
ANZCA	59	4	27	27	46.6	58	18	30	20	29.4
CICM	14	0	8	0	0.0	45	8	13	2	8.7
RACGP	257	0	26	175	87.1	52	2	2	59	93.7
RACP	147	15	28	114	72.6	147	18	48	86	56.6
RACS	83	33	27	15	20.0	84	19	25	8	15.4
RANZCO	9	4	12	4	20.0	10	7	8	0	0.0
RANZCOG	38	7	14	22	51.2	45	16	14	15	33.3
RANZCP	39	3	29	18	36.0	65	1	36	34	47.9
RANZCR	24	4	46	1	2.0	55	1	33	1	2.9
RCPA	12	3	5	1	11.1	17	1	11	0	0.0

Abbreviations for colleges are in the thesis glossary on p. xi. Excludes colleges with <5 applicants. Part. = partially comparable, Subst. = substantially comparable. Those judged substantially comparable are usually registered as specialist but normally with conditions that must be met, such as a period of mentored or supervised practice.

Data from MBA reports for 2015 and 2020.

restrictive than others. The three most 'generous' colleges— each approving training as

[24] Data supplied by AMC (2019).

[25] Medical Board of Australia, "Standards, Reports and Resources," accessed 27 September 2021, https://www.medicalboard.gov.au/registration/international-medical-graduates/specialist-pathway/guides-and-reports.aspx.

substantially comparable for more than 60 percent of applicants—were the Royal Australian College of General Practitioners, the Royal Australasian College of Physicians, and the Australian College of Rural and Remote Medicine. The most restrictive, accepting the standing of less than 20 percent of applicants, were the College of Intensive Care Medicine, the Royal Australian and New Zealand College of Ophthalmologists, the Royal Australian and New Zealand College of Radiologists, and the Royal College of Pathologists of Australasia.

Table 9.6 shows the data by IMGs' countries of training, with the decisions of all colleges combined. There is marked variation in the way different source countries have been judged. For the two countries with most applicants in 2015 and 2020, almost 80 percent of those regarded as specialists in the UK were assessed as substantially comparable by the Australasian colleges; for those from India, less than 20 percent were similarly judged. Numbers were small for some in this table, so comparisons of their rates are not very meaningful.

Table 9.6: Specialist pathway for IMGs – college decisions by country of IMG training, 2015 and 2020

Country of training	2015				2020			
	Comparable to Australian Fellows?				Comparable to Australian Fellows?			
	Not	Partially	Subst.	% Subst.	Not	Partially	Subst.	% Subst.
UK	11	70	267	76.7	6	26	115	78.2
India	32	47	14	15.1	33	68	13	11.4
South Africa	0	18	6	25.0	6	21	20	42.6
Ireland	2	6	23	74.2	0	5	14	73.7
Sri Lanka	0	11	6	35.3	1	14	11	42.3
USA	2	13	16	51.6	5	4	2	18.2
Iran	4	6	5	33.3	8	9	6	26.1
Egypt	8	6	0	0.0	2	9	5	31.3
Pakistan	5	7	1	7.7	7	4	3	21.4
Canada	2	5	7	50.0	0	4	7	63.6
Brazil	2	6	0	0.0	5	6	4	26.7
Hong Kong	0	0	0	NA	1	7	12	60.0
Netherlands	0	6	2	25.0	1	4	2	28.6
Malaysia	0	4	1	20.0	0	7	2	22.2
Syria	3	3	0	0.0	1	2	3	50.0
Singapore	0	1	4	80.0	1	1	3	60.0

*See footnote to table 9.5 re terminology. Excludes countries with <10 IMGs total in the two years

Conclusion

Since 1978, the AMC has played a central role in judging the training and skills of IMGs, originally to assist the Medical Boards of each state and territory make their decisions about whom to register. Since 2009, it has played that role for the unified national board under AHPRA for many applicants, while delegating decisions about the suitability for registration of overseas-trained specialists to the Australasian colleges, and those who managed to get a place in the Workforce-based Assessment stream to the hospitals that took them. The data analysed here show substantial historical changes over the four decades in the demography of candidates (with many more coming from Southern Asia recently), and how the country of their prior medical training has influenced their success in clearing those hurdles. These demographic trends continue a pattern that was becoming established in the last few years covered by the prosopography in Chapter 7. Some of the changes in donor countries are striking. A number of factors that have influenced IMGs' likelihood of success in AMC examinations, and in the judgments the specialty colleges make about overseas-trained specialists, have also been uncovered. These include the age, gender, and country of origin of candidates who have taken the Standard Pathway, and the specialty and country of origin of those who attempted the Specialist Pathway. The proportion who succeed in being registered in those specialties which are fiercely competed for by local graduates is substantially lower if the IMG specialised in a country other than the UK or Ireland. This may indicate bias by those making the assessments, or may just be consequent on greater differences between local and overseas specialty training programs. The findings will be of interest to overseas-trained medical graduates who may be considering migrating to Australia in future.

The information in this chapter is primarily numerical and statistical. The remaining chapters of the thesis take up the challenge of putting a human face to some of the most recent immigrants, during these almost two centuries of Australian history.

Chapter 10

Oral Histories of Contemporary Immigrants

The processes used by the colonies, states, and most recently the Commonwealth, for licensing medical practitioners whose qualifying degree was obtained outside Australia and New Zealand were described in Chapters 3 and 4. That was necessary background for some of the material presented in this chapter, which documents the oral histories of 87 living graduates who arrived in Australia since 1969. It examines their reasons for leaving their home country and choosing to come to Australia, and their experiences as they negotiated the licensing requirements at various times in this period of history. It reflects on some of the factors that led to success or failure in gaining medical registration, and on the roles in Australian health care played by those who were fully licensed at the time of interview.

Methodology

The Interviews

Participants were interviewed by the author between March 2018 and November 2021. They were recruited by several methods. Forty-two were recruited by what Michael Patton describes as criterion sampling.[1] These were IMGs who were either attempting to pass examinations required by AHPRA, or had recently completed them. They were referred by Alan Roberts, the principal of ARIMGSAS, who runs training courses for IMGs preparing for the AMC examinations.[2] Fourteen were recruited by the snowball method—word of mouth from others aware of the purpose of the project, or two who were discussants in a webinar on IMGs held by the AMA.[3] A further 30 were recruited by writing to a random sample of 108 IMGs drawn from the Medical Directory of Australia. And one individual was contacted after he featured in a press article in 2004.[4]

Potential participants were provided with the Plain Language Statement for the interview; all who took part gave written, or audio-recorded informed consent. The Plain Language Statement mentioned that the interviewer was medically qualified: the reason for this was to facilitate the interview process by making participants aware they would be talking to a colleague, who understood the terminology of the profession, and who had shared at least some of their educational and professional experiences. This can be a two-edged tool, as James Spradley points out—the ethnographer who is too familiar with the field may take too much for granted because it is 'part of his own cultural knowledge.'[5] On the other hand, William Shaffir and Robert Stebbins argue, as have I,

[1] Michael Q Patton, *Qualitative Research and Evaluation Methods* (Thousand Oaks, Calif.: Sage Publications, 2002), 238.
[2] ARIMGSAS=Alan Roberts International Medical Graduates Support and Advisory Services.
[3] James S Coleman, "The Study of Social Organizations with Survey Methods," *Human Organization* 17, no. 4 (1958): 29.
[4] Bridie Smith, "Physician's Working Life Spent Cleaning and Selling Petrol," *The Age*, 22 July 2004, 4.
[5] James P Spradley, *The Ethnographic Interview* (Long Grove, IL: Waveland Press, 1979), 50.

that 'the chances of getting access to participants are increased when the researcher's interests appear to coincide with those of the subjects.'[6] The research was approved by the university's Human Research Ethics Committee, with the proviso that participants were informed that if they experienced distress as a result of recalling painful experiences they could receive the support of a psychiatrist who was not involved in the research. They were also informed that they could withdraw their information if it had not yet been submitted in the thesis or for publication.[7]

Thirty-eight of the 'criterion' sample were interviewed face-to-face in Melbourne, and the remainder by telephone or video elsewhere. Most in the randomly-sampled and snowball groups were interviewed by video (Zoom, Skype or Snapchat), particularly once travel became difficult during the pandemic caused by the SARS-Cov-2 virus; they included participants in every state and territory. Details of all participants are given in Supplementary Table 6 (Appendix A).

The interviews were recorded with a digital audio recorder, then transferred securely to a password-protected computer for later transcription.[8] Those who were interviewed prior to 2021, and who had not at that time achieved full unrestricted medical registration, were followed up at the end of 2021 by checking whether they had a listing on the Medical Board of Australia (MBA) website.

In what follows, most individuals are identified by a pseudonym, matched for their gender and country of birth, as promised them in the Plain Language Statement and reiterated during interviews. Some participants were concerned about confidentiality, despite being given a pseudonym. For this reason, names of hospitals or precise locations in which they worked have often been omitted, as have been details of an unusual area of specialisation if that might have risked identifying them. One participant is identified only as Dr X at their request. This IMG is very concerned about repercussions from AHPRA, or the college that refused to recognise their specialty, if their identity were guessed. They asked that neither their gender, specialty nor country of training be divulged. On the other hand, eight participants requested that their own name rather than a pseudonym be used in this thesis.[9]

In March 2022, all participants were sent a draft of this chapter, requesting their approval for what is written, or any suggested changes. Several offered minor corrections of fact and six asked for some editing to further obscure their identity. One

[6] William Shaffir and Robert Alan Stebbins, *Experiencing Fieldwork: An inside View of Qualitative Research* (Newbury Park: Sage Publications, 1990), 26.
[7] Humanities, Law & Social Sciences subcommittee, approval ID 1750338.2, 5 March 2018.
[8] One participant (no. 64) requested that I just take notes of the interview and not record it.
[9] Drs Almeida, Chaturvedi, Eskander, Hakobyan, Mrowka, Rao, Strutt, and Varadarajan.

response, which showed the benefit of this consultation, was the suggestion that I change the pseudonym I originally chose to a last name whose political ramifications were far more in tune with what the participant was quoted as saying about religious prejudice he experienced.[10] It was in this consultation phase, after reading what was drafted, that six of the eight who preferred their own name be used made that election (two had made the decision initially).

Thematic Analysis

Interviews were transcribed, then subjected to thematic analysis using a data-driven inductive approach similar to that described by Richard Boyatzis.[11] Some of the theme nodes or codes were derived *a priori*, based on the major headings used for the semi-structured interview (e.g., country of origin, push and pull factors). Others emerged from the data, assisted by creating a word cloud and assigning sections of transcript text to nodes, using the software package NVivo (release 1.5.1, QSR International).[12] The software is a highly flexible platform to identify and quantify themes and their relationships in text material.[13]

[10] Antony Jose, interviewed by author, regional town (state obscured) (video), 9 August 2020.
[11] Richard E Boyatzis, *Transforming Qualitative Information: Thematic Analysis and Code Development* (Thousand Oaks, Calif.: Sage Publications, 1998), 41.
[12] QSR International, "Empowering Discovery. Advancing Knowledge," https://www.qsrinternational.com/.
[13] Tom Richards, "An Intellectual History of NUD*IST and NVivo," *International Journal of Social Research Methodology* 5, no. 3 (2002): 201.

Demographic Characteristics and Registration Status

Table 10.1 provides several characteristics of the participants. They ranged in age from 26 to 80, with three quarters under the age of 55. Four were Australian citizens (two born in Australia, two came as a child) who are IMGs only because they chose to travel to qualify in medicine overseas. Almost half of those interviewed had graduated in medicine this century but the oldest did so in 1960. And while one had practised overseas for thirty-seven years before she came to Australia, the median interval between graduation and arrival was only 7.5 years. Thus, most had made the decision to emigrate promptly after they qualified. At the end of 2021, for those who had managed to be registered by the MBA or a State Board (including limited and provisional registration),[14] the process had taken a median of two years after they arrived in Australia; for one person it took 15 years.

Table 10.1: Oral histories: Participants' ages, and years of qualification, arrival, and registration

	Age when interviewed	Year qualified	Year arrived in Australia	Year registered in Australia*	Time (y) qualification till arrival	Time (y) arrival till registration*
Median†	44	1999	2012	2013	7.5	2
IQR	33.5-55	1987-2012	2003-2016	2002-2019	3-12	0-3
Range	26-80	1960-2017	1969-2021	1969-2021	0-37	0-15
No.	87	87	87	74	87	74

*Lists data for those who were registered (full, provisional, or limited) by the end of 2021. †The data are not normally distributed (Shapiro-Wilk probability <0.001 for all), so mean and SD not appropriate (IQR and SD defined in thesis glossary).

Table 10.2: Age, year of qualification and time to arrival by recruitment group

Recruitment method*	N	Age at interview	Year qualified	Interval degree to arrival (y)†	Interval arrival to interview (y)
Criterion sampling	42	34 (29-44)	2010 (1999-2014)	6 (2-10)	3 (1-6)
Random + snowball	44	52 (43-61)	1992 (1981-1999)	8 (3-14)‡	15 (11-30)
p (Mann-Whitney test)		<0.001	<0.001	0.18	<0.001

Data are medians and IQR. *1 individual identified from press article excluded.

†Time elapsed after overseas medical qualification till arrival in Australia.

‡Excludes 5 (all English or Irish) who came for a short appointment then later returned to Australia permanently.

[14] As explained in Chapter 4, IMGs who took the standard pathway for registration could work with limited registration (while preparing for the second AMC exam) if they had passed the AMC MCQ exam and managed to find a supervised job. Everyone who passed the second AMC exam had to find an approved supervised job for 12 months under Provisional Registration.

Table 10.2 compares characteristics of the criterion sample group with the random-sampled and snowball groups. Not surprisingly, there were differences, since IMGs in the latter groups were already registered.[15] The criterion sample IMGs were younger by almost 20 years than those in the other groups. The interval between graduation and arrival in Australia was similar in both groups, though. Of the 42 in the criterion sample, 36 at the time of their interview were trying to be registered. In December 2021, 26 of these had achieved full, provisional, or limited registration, but 10 were still trying up to three years later. One (in snowball group) had given up entirely, 20 years earlier.[16] The randomly-sampled and snowball groups, having been in Australia for a median 12 years longer than the criterion sample, were further into their new career; 38 of the 44 were listed as specialists in some discipline. Some of these IMGs had come to Australia while they were young, obtained general registration by a State Medical Board or AHPRA, then were accepted into an Australian specialist college's training program. Table 10.3 shows the numbers with Fellowships of the various colleges.

Table 10.3: Specialties in which random and snowball-sample IMGs were registered in 2021

Specialist type	Specialty college	No, of IMGs
Anaesthesia	RANZCA	2
Dermatology	ACD	1
Emergency Medicine	ACEM	1
General Practice*	RACGP	9
Internal Medicine ('Physician')	RACP	17
Medical administration	RACMA	1
Obstetrics & Gynaecology	RANZCOG	1
Palliative Care	AChPM (RACP)	1
Psychiatry	RANZCP	2
Radiology	RANZCR	1
Rehabilitation Medicine	AFRM (RACP)	1
Surgery	RACS	2
None†		6

*One had both FRACGP and FRACMA

†General registration 3, in specialty training 1, 'in limbo' 2.

Table 10.4 gives details of the participants by place of prior medical degree. They came from 31 countries, with the largest numbers from India, England, and South

[15] One who was registered when sampled from the MDA had his registration suspended due exam failure when interviewed.

[16] Dr Magdy Eskander came from Egypt in 1988 but failed the AMC exams and retrained as a practitioner of Traditional Chinese Medicine.

Table 10.4: Countries of first medical qualification vs. registration status when interviewed

Country where qualified	No. and sex (F/M)	Year(s) qualified	Year(s) arrived*	Achieved registr-ation†	Specialist overseas	Registered in same specialty‡
Albania	1 (1/0)	1998	2008	0	1	0
Argentina	1 (1/0)	1996	2011	0	1	0
Armenia	1 (0/1)	2004	2015	0	1	0
Bangladesh	3 (1/2)	1983-2014	1985-2017	3	0	0
China	3 (1/2)	2006-2017	2015-2019	2	1	1
Columbia	1 (0/1)	2014	2016	1	0	0
Ecuador	1 (1/0)	2015	2016	1	0	0
Egypt	4 (1/3)	1976-2007	1988-2014	2	2	0
England	8 (4/4)	1978-2015	1987-2018	8	4	4
Germany	2 (1/1)	1977-1998	1985-2000	2	1	0
India	16 (8/8)	1960-2017	1969-2018	13	8	5
Indonesia	1 (1/0)	2007	2013	1	0	0
Iraq	2 (2/0)	1987-2012	1993-2016	2	0	0
Iran	4 (1/3)	2002-2016	2012-2017	3	0	0
Ireland	3 (2/1)	1998-2017	2004-2017	3	1	1
Kenya	1 (1/0)	2010	2017	1	0	0
Malaysia	3 (0/3)	1972-2012	1977-2015	3	1	1
Nepal	2 (1/1)	2009-2016	2016-2017	2	0	0
Nigeria	1 (1/0)	2017	2019	0	0	0
Pakistan	3 (3/0)	2002-2016	2012-2017	2	0	0
Philippines	2 (2/0)	1986-2014	2007-2019	2	1	1
Poland	3 (3/0)	1986-2003	1988-2010	3	1	1
Russia	4 (2/2)	1997-2012	2007-2017	3	1	0
Samoa	1 (0/1)	2012	2017	1	0	0
South Africa	8 (1/7)	1968-1981	1978-2007	8	6	6
Sri Lanka	1 (0/1)	1986	2009	1	1	1
Venezuela	1 (1/0)	2013	2014	1	0	0
Wales	1 (0/1)	1998	2010	1	0	0
West Europe**	2 (1/1)	1992-3	2012-13	2	2	0
Yugoslavia	2 (1/1)	1988-1995	2004-2016	2	1	0

*Four Australian citizens went overseas to study medicine (however, by definition, they are IMGs). †Includes Limited and Provisional Registration. Proportions achieving registration from each country are not comparable, since the three samples combined in the table. ‡Many trained and qualified in a specialty (or different one) *after* they arrived in Australia. **Countries obscured at IMGs' requests.

Africa. Surprisingly (see Chapters 7 and 8), there were no Scottish graduates in any of the three samples. Forty-four were female and 43 male. The table also lists how many were registered at the time of their interview, and regarded as specialists in their home country. Thirty-three had practised as specialists in their parent country, but by the end of 2021 only 20 of these were registered by AHPRA to practise in the same specialty in Australia. Reasons for this will be examined later. As mentioned above, some of the

younger ones embarked on a specialist training program in Australia once they had general registration, most often to become specialist general practitioners.

Themes Identified from the Transcripts

Some of the themes examined below were identified *a priori*. Others emerged from the coding of the transcripts with the help of the NVivo software. Figure 10.1 shows the cluster analysis obtained using this text analysis tool, while. Figures 10.2 and 10.3 show examples of the coding outputs from transcripts.

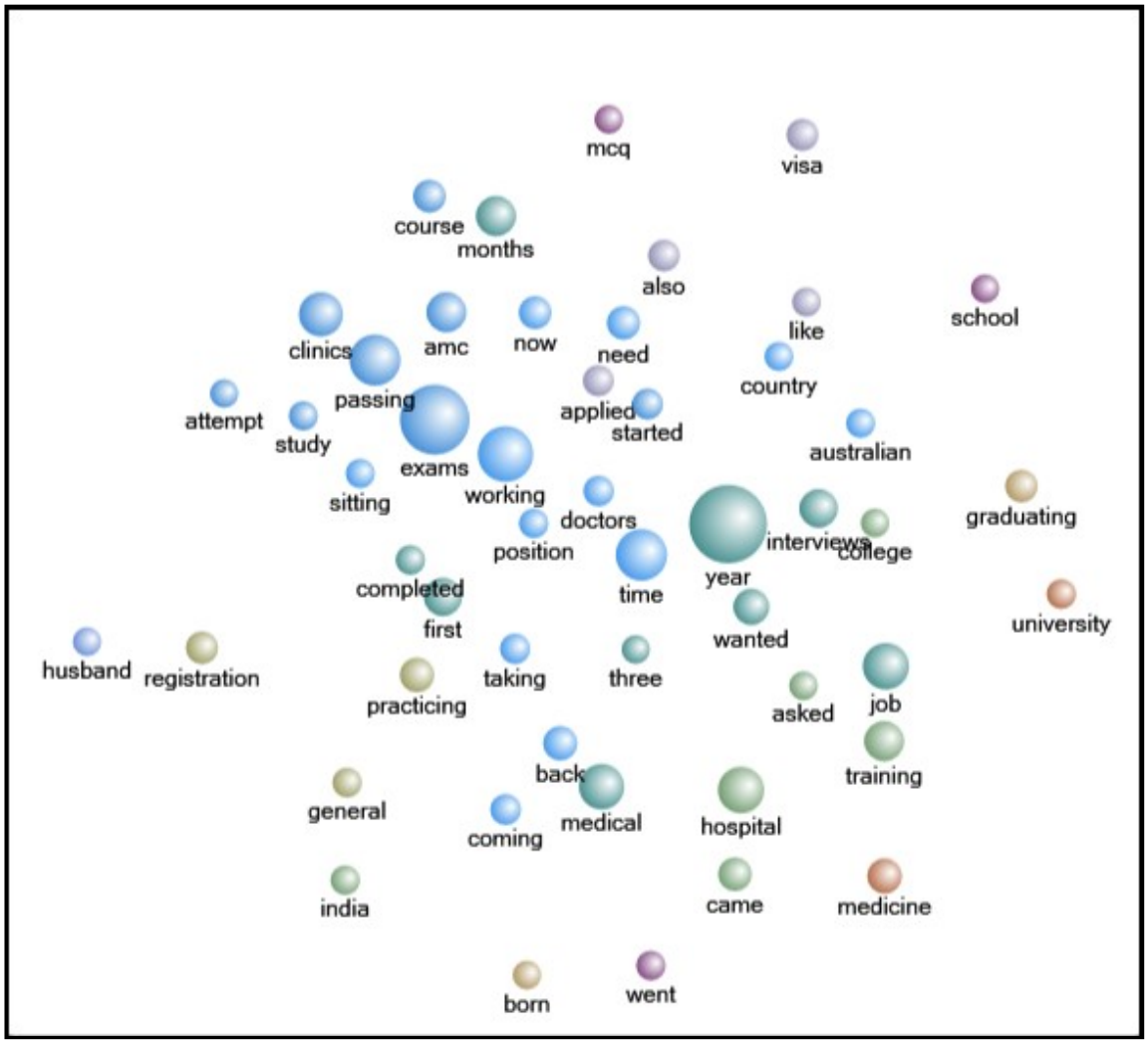


Figure 10.1: Cluster analysis of 50 most common words in the oral history transcripts.

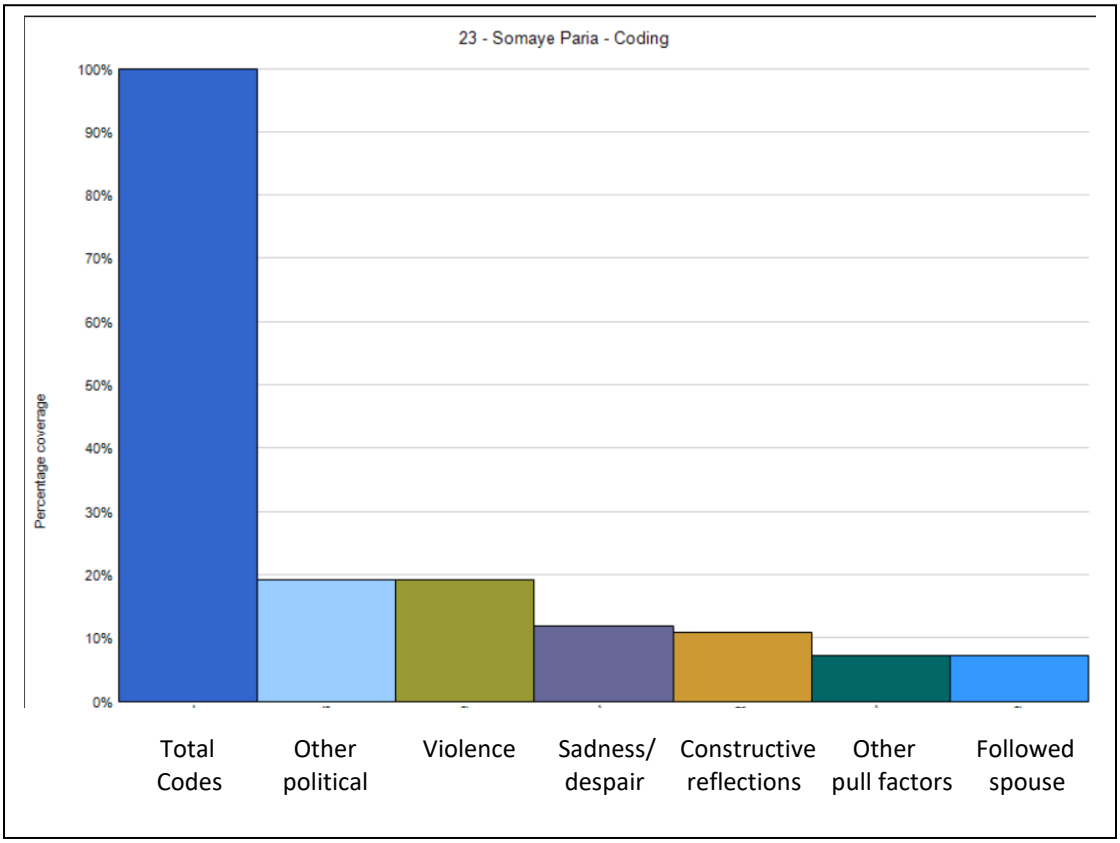


Figure 10.2: Example of NVivo coding proportions from interview transcript of an individual IMG

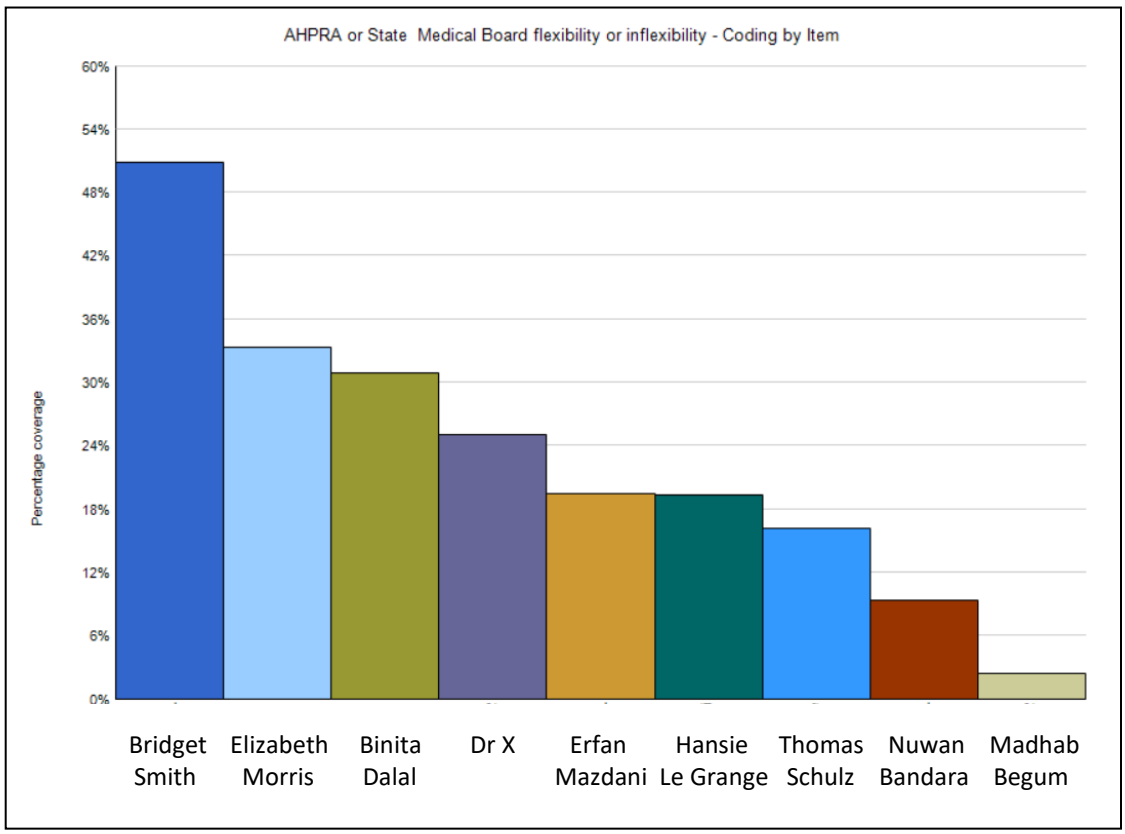


Figure 10.3: Example of proportions of text contributing to a specific node in transcripts (in this case, AHPRA or State Medical Board issues experienced by participants)

It is not surprising, given the focus of particularly the criterion sampling group on passing the AMC or college assessments, that among the most prevalent words in the transcripts were *exam*, *year*, *time*, *medical*, *clinical*, *job*, *hospital*, *AMC*, *passed* and *training*. The diagrammatic analysis in the figure shows one large cluster in blue centered around the need of the criterion sample to study for and pass the AMC exams; another cluster in pale green reflects the challenge recent arrivals faced to get hospital and other training jobs before they could be fully registered. Those issues are amplified later in some of the oral histories.

The coding of the transcripts, facilitated by NVivo, identified eight themes that warrant analysis. These are: (i) reasons IMGs left their countries, (ii) reasons they chose Australia, (iii) experiences with the AMC examinations, (iv) experiences at the hands of specialist colleges, (v) difficulties attributable to AHPRA policies and administration, (vi) issues with visas, (vii) other difficulties, and (viii) reflections on what could be improved for IMG immigration and registration. How multiples of these played out will be seen when illustrative oral histories are presented later in the chapter.

Reasons for leaving parent country

Unsurprisingly, the participants reported a variety of reasons for choosing to leave their birth country. The literature on immigration studies usually refers to these as 'push factors', in contrast to the 'pull factors' that draw emigrants to a particular location.[17] In the instances reported here, more than one motive for migrating was often mentioned, but the two most common fell into the broad categories of political (including violence or risk of violence) and economic/lifestyle.

Political reasons were described in about a third of these oral histories, ranging from escaping violence at a national or local level, to concern about the direction of the country's political trajectory, to avoiding religious discrimination. Maria López and Daniela Almeida both left Venezuela in 2014 because of the escalating street violence and economic collapse.[18] Maria's family had fled Cuba for Venezuela when she was a small child, to escape the brutal Battista regime; more than fifty years later, she left Venezuela, saying: "It's not safe … you can't walk … you drive in your car with the windows up. Inflation is the highest in the world."

[17] Guido Dorigo and Waldo Tobler, "Push-Pull Migration Laws," *Annals of the Association of American Geographers* 73, no. 1 (1983); Everett S Lee, "A Theory of Migration," *Demography* 3, no. 1 (1966).

[18] Maria López, interviewed by author, Melbourne, 14 March 2018; Daniela Almeida, interviewed by author, Melbourne, 28 March 2018.

Most of the South African interviewees cited concern about violence and/or antipathy to the apartheid regime as important factors in their decision to leave.[19] For example, when Hansie Le Grange and his family returned home after working for several years in Angola, fear for their young daughters became a powerful motive to permanently leave South Africa in 2006. The AIDS epidemic was at its height and one of the risks was sexual assaults on female children, even infants, because of the myth that this would cure the male assailant of their HIV infection.[20] Violence and increasingly chaotic public administration were factors in William Pietersen's decision to leave South Africa to accept an anaesthetist job in Victoria in 2007 when he was approached by a large rural hospital.[21]

It was not always concern for themselves that was the motive to migrate: in 2004, Nina Kovačević left Serbia because she was afraid her teenage sons would be called up for military service.[22] Warfare in Iraq and political uncertainty in Iran were motives for three others to leave.[23] And the race riots in Kuala Lumpur, directed at Chinese and Indian ethnic Malaysians (Chapter 7), were why Yiu-po Soo established an escape route by registering in New South Wales in 1975.[24]

Sometimes violence emanated from more focused sources. Valentina Alonso suffered domestic violence for two years in Argentina, then had to wait several years after her divorce before a court allowed her to emigrate with her two children.[25] Two Indian men cited the risk of physical violence from relatives if their patients had an adverse outcome. One was Deepak Mukherjee, who was hidden by his nurses in a hospital pantry while a large group of relatives searched for him. He had tried without success to resuscitate their electrocuted relative, who was clinically dead when Deepak first attended him.[26] This problem is clearly continuing in India—in June 2019, about

[19] Roger Smit, interviewed by author, Regional South Australia (video), 17 August 2021; Lawrence Frederiks, interviewed by author, Sydney (video), 9 October 2020; Peter Visser, interviewed by author, Melbourne (video), 27 April 2021; Livia Morecroft, interviewed by author, Melbourne, 19 July 2019.

[20] Hansie Le Grange, interviewed by author, Regional Western Australia (video), 23 June 2020; Rachel Jewkes and Naeema Abrahams, "The Epidemiology of Rape and Sexual Coercion in South Africa: An Overview," *Social Science & Medicine* 55, no. 7 (2002).

[21] William Pietersen, interviewed by author, Traralgon (video), 17 July 2018.

[22] Nina Kovačević, interviewed by author, Melbourne (video), 3 July 2018.

[23] Erfan Mazdani, interviewed by author, Melbourne, 28 March 2018; Latoya Khouri, interviewed by author, Melbourne, 11 April 2018; Radeyah Hadi, interviewed by author, Sydney (telephone), 23 June 2020.

[24] Yiu-po Soo, interviewed by author, Sydney (video), 17 July 2020.

[25] Valentina Alonso, interviewed by author, Melbourne, 11 June 2019. Argentinian law required her ex-husband to agree, and for years he did not.

[26] Deepak Mukherjee, interviewed by author, Albury (telephone), 25 April 2018; Chaaran Malhotra, interviewed by author, Melbourne, 18 June 2019.

800,000 doctors went on strike after a brutal assault on a junior doctor in Kolkata, and the 2020 COVID-19 pandemic appears to have intensified attacks.[27]

The Egyptian revolution of 2011 impacted Walid Mostafa by closing his university while he was half-way through his postgraduate degree.[28] Bahiri Khademi was a ten-year old boy when his father sent him and his older brother from Tehran to boarding school in Los Angeles, home to the largest concentration of the Iranian diaspora in the United States at the time.[29] His father was a principal advisor to the Prime Minister, Amir-Abbas Hoveyda. Using recovered US State Department documents, Zachary Karabell later concluded that Bahiri's father had given the CIA information pointing to the likely overthrow of the Shah in the 1979 revolution.[30] Thus, armed with this foreknowledge, he would have had a powerful motive to move his sons to safety.

While not motivated directly by escaping violence, some wanted to leave for other political reasons. Anniker Schmid left Germany in 1985, having worked in the peace movement at the time of the Cold War, and wanting to get away from the adversarial relations with the Soviets.[31] Erfan Mazdani and Asad Tehrani left Iran in 2017 for similar political reasons, and Anna Antonova was disillusioned with the direction of Russian politics when she left in 2007.[32] Ram Verosha left South Africa in 1978, since as a newly graduated doctor he had treated survivors shot in the back during the 1976 Soweto riots, became politically active in opposition to the Vorster regime, and had to flee for his safety.[33]

Four others cited religious discrimination as an important factor in their decision to emigrate. Magdy Eskander, an Egyptian Coptic Christian, was blocked from practising as a paediatrician in the 1980s because of his religion.[34] Shreya Dayal, born in India but who had practised in the Middle East for twenty years, moved to Australia in 2012 with her husband because of what they felt was increasing discrimination

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[27] Amrit Dhillon, "Doctors in India Strike over Violent Attacks by Patients' Families " *The Guardian*, 17 June 2019; Astha Bhattacharya, "The Alarming Rise in Violence against Doctors in India and Its Immediate Solution," *Jurist*, 26 July 2021.

[28] Walid Mostafa, interviewed by author, Mildura (video), 24 March 2018.

[29] Bahiri Khademi, interviewed by author, Melbourne, 28 March 2018; Mehdi Bozorgmehr and Georges Sabagh, "High Status Immigrants: A Statistical Profile of Iranians in the United States," *Iranian Studies* 21, no. 3-4 (1988): 18.

[30] Zachary Karabell, "'Inside the US Espionage Den': The US Embassy and the Fall of the Shah," *Intelligence and National Security* 8, no. 1 (1993): 53. Karabell mentions several who met with US embassy staff. I have deliberately not given more detail, to protect Khademi's identity, since those who were close to the Shah's inner circle may still be at some risk.

[31] Annika Schmid, interviewed by author, Melbourne, 14 March 2018.

[32] Mazdani, interview; Asad Tehrani, interviewed by author, Melbourne, 11 April 2018; Anna Antonova, interviewed by author, Melbourne, 11 April 2018.

[33] Ram Verosha, interviewed by author, Regional Victoria (video), 14 October 2020.

[34] Magdy Eskander, interviewed by author, Melbourne, 8 August 2018.

against Christians.[35] Another was Antony Jose, who left India very recently, giving as one reason:

> India is not a good place to be right now, with the political situation and the rise of the right-wing majority. Catholics and Christians are not regarded as being quite Indians, because they are looked on with suspicion as having allegiance to the West.[36]

Somaye Paria left Iran because she found the restrictions imposed by the state and the religious police unbearable. She hated the requirement to wear the hijab, and was threatened with expulsion from medical school on one occasion when she had coffee with a male student—they had been working together on an assignment, which was permissible, but her mistake was to accept his suggestion they go together to the university's cafeteria after they finished.[37] Somaye's reaction was reminiscent of that of another female emigrant to Melbourne from post-revolutionary Iran: Mammad Aidani quotes her as saying that the revolution changed the "social and psychological style and feelings of the society … we became veiled in black, angry, unhappy and disrespected."[38]

Economic and/or lifestyle motives were mentioned by many as reasons they sought to move to another country.[39] Thus, these were both 'push' and 'pull' factors, since these IMGs had judged Australia to offer better opportunities for living in the broad sense. Anjali Nair was explicit about the difficulty, even with two incomes, of paying for expensive schooling for their children plus their mortgage in India.[40] Boris Ivanov said that, although salary ranked only about number three in his reasons for coming to Australia, he was earning at least four times as much here as a trainee anaesthetist than he did as a specialist anaesthetist in Russia.[41] Mary O'Shea originally came to Perth from Ireland so her husband could get further training in a specialty that was still developing at home. She was already a UK-qualified specialist GP. After her

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[35] Shreya Dayal, interviewed by author, Melbourne, 11 April 2018.

[36] Jose, interview.

[37] Somaye Paria, interviewed by author, Melbourne, 16 May 2018.

[38] Mammad Aidani, "Iranian Poetic Testimonies of Revolution, Trauma and Displacement," *Australian Feminist Studies* 26, no. 69 (2011): 338.

[39] Shamim Mahmud, interviewed by author, Melbourne, 14 March 2018; Rahul Mangal, interviewed by author, Melbourne, 14 March 2018; Priya Datta, interviewed by author, Melbourne, 14 March 2018; Shailja Chaturvedi, interviewed by author, Sydney (telephone), 10 April 2018; Antonova, interview; Emina Shehu, interviewed by author, Melbourne, 2 May 2018; Faiza Qazi, interviewed by author, Melbourne, 2 May 2018; Nabilah Reddy, interviewed by author, Melbourne, 16 May 2018; Anjali Nair, interviewed by author, Melbourne, 30 May 2018; Rakesh Madan, interviewed by author, Melbourne, 27 May 2018; Vlado Nikolić, interviewed by author, Melbourne, 25 June 2019; Sean Murphy, interviewed by author, Sydney (video), 20 August 2019; Mary O'Shea, interviewed by author, Perth (video), 28 August 2019; Kalasia Naufahu, interviewed by author, Melbourne, 11 June 2019; Roger Jones, interviewed by author, Melbourne (telephone), 8 October 2020; Blessica Ramos, interviewed by author, Rockhampton (video), 10 August 2021.

[40] Nair, interview.

[41] Boris Ivanov, interviewed by author, Melbourne, 29 June 2019.

husband completed his specialisation, they returned to Ireland with their three children in 2012. But the ongoing recession that followed the 2008–09 Global Financial Crisis meant that even with two medical incomes they could barely make ends meet, living in a Dublin suburb.[42]

The Australian lifestyle sometimes grew on people who had come here for another reason. Xiu-ying Wang came to Melbourne from China in 2015 with his IMG wife and one young child, specifically to learn skills for clinical research. At first, their plan was to return to China, but after two years they decided they would like to stay.[43] Sean Murphy's oral history is described in more detail later, but fits this category of IMGs who had not originally intended to settle in Australia (it was a "working holiday" with fellow Irish graduates). He came back later because he had so enjoyed the lifestyle.[44]

Reasons other than political or economic motivated some of these IMGs. Several participants described job dissatisfaction as factors in their decision to emigrate. Jose Hurtado left Colombia because, "Once I started working, I just realised I learnt many things, but I couldn't apply them because of the system". He gave the example of Computerised Tomography (CT) scans, essential to determine the appropriate immediate treatment for a stroke: "Sometimes you arrange the test, and that test can't be ready for four months for something we need to do immediately." There were quotas for both tests and medications and, if he exceeded them, the cost would be deducted from his salary.[45] Daniela Almeida hated having to ask her patients to pay for basic resources for quality medical care that were not provided in Venezuela; Sherif Sarraf bemoaned the fact that the lack of socialised medicine in Egypt meant many of his patients could not afford necessary investigations.[46] Three UK graduates were motivated to emigrate because of the limited opportunities for promotion within the UK National Health System (NHS), while Hans Weber cited a rigid hierarchy as a reason to leave German medicine.[47]

Rebecca Strutt migrated because of the long working hours in the British National Health Scheme (NHS), having been told by others that conditions in Australia were

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[42] O'Shea, interview; Rob Kitchin, Cian O'Callaghan, and Justin Gleeson, "The New Ruins of Ireland? Unfinished Estates in the Post-Celtic Tiger Era," *International Journal of Urban and Regional Research* 38, no. 3 (2014).

[43] Xiu-ying Wang, interviewed by author, Melbourne, 31 July 2019.

[44] Murphy, interview.

[45] Jose Hurtado, interviewed by author, Melbourne, 2 May 2018.

[46] Almeida, interview; Sherif Sarraf, interviewed by author, Melbourne, 11 June 2019.

[47] James Phillips, interviewed by author, Sydney (video), 25 May 2018; Penelope Roberts, interviewed by author, Melbourne, 4 July 2018; David Lloyd, interviewed by author, Regional Western Australia (video), 19 August 2021; Hans Weber, interviewed by author, Brisbane (video), 30 July 2020.

more humane.[48] Others from UK and South Africa emigrated because they were either 'head-hunted' to senior jobs in Australia, or decided that the opportunities for promotion in the NHS were blocked by the numbers ahead of them in the pipeline, or both.[49]

An unusual motive to leave her home country was described by Rosa Mendoza. Rosa graduated in medicine in Davao in the Philippines, and did her internship in a large teaching hospital. However, she was diagnosed with tuberculosis, the treatment of which was difficult because she was allergic to one of the most important antibiotics in the 'cocktail' of drugs needed to cure it. The disease is an occupational hazard for clinical staff in endemic areas, and it was concern about reinfection that played a major part in her decision to try to move to a country where tuberculosis was rare.[50]

Several decided to travel overseas specifically to gain a particular skill or qualification, and ended up staying in Australia after achieving it. One was Nuwan Bandara, who was a specialist paediatrician in Malaysia but wanted to further specialise in neonatology, so accepted a job in the university hospital in Townsville. The RACP accepted his overseas credentials and required only that he be mentored for a year by another neonatologist before awarding him FRACP.[51] On the other hand, the RACP required Chandresh Balakrishnan to pass its exams after he came to Adelaide in 2003, although he had been trained in Internal/General Medicine in India.[52] Vivaan Kumar had become a specialist in Intensive Care Medicine in Delhi, but wanted a formal qualification in this specialty. He stated that the only options to obtain this in 2005 seemed to be in USA or Australia. He chose the latter, arriving in 2006.[53]

Marriage or relationship breakup was another event that encouraged some to leave the wreckage behind them and seek a new country. Bridget Smith was sleeping on a friend's couch in London after breaking up with her partner when she saw an advertisement in the British Medical Journal with a large crocodile at the top, saying: 'Do you like tropical medicine? We have the job for you in the Northern Territory in a trauma centre.' She thought: "I've just turned down a job, I've got no children, no commitments, why wouldn't I apply?"[54] Others who cited this as a reason were Roger Jones and Boris Ivanov.[55]

[48] Rebecca Strutt, interviewed by author, Sydney (telephone), 3 July 2018.
[49] Phillips, interview; Roberts, interview; Morecroft, interview.
[50] Rosa Mendoza, interviewed by author, Melbourne, 11 June 2019.
[51] Nuwan Bandara, interviewed by author, Townsville (video), 19 June 2020.
[52] Chandresh Balakrishnan, interviewed by author, Darwin (video), 5 August 2020.
[53] Vivaan Kumar, interviewed by author, Townsville (video), 8 August 2021.
[54] Bridget Smith, interviewed by author, Alice Springs (video), 4 August 2020.
[55] Jones, interview; Ivanov, interview.

Four of the IMGs reported here had no identifiable 'push factor' – they really did not want to leave the country in which they were practising and had good jobs they were enjoying, but were either persuaded by their husband or initiated the move for his sake.[56] Shivangi Das was happy working in Nairobi, and intended to specialise in paediatrics. But her engineer husband convinced her to come with him to Australia in 2014. The battle to negotiate the AMC process had taken its toll on her: even though she passed the last exam in 2017. When interviewed, she was struggling to find a medical position because she had not worked for almost four years and was falling foul of AHPRA's recency of practice provision. More will be said about that later.[57] Prisha Sharma was born in India, but moved to England with her medical parents, and subsequently graduated in medicine from the University of London. She married an Australian journalist who was living in the UK, and gave the following reason for deciding to leave:

> My husband hated it [...] he hated the weather. We lived in Manchester ... it rains virtually every day in Manchester, and one day our very lovely Jamaican neighbour was waiting at the gate for when I came home from work, and he said to me 'I'm very worried about John [pseudonym].' I said 'Why, what's going on?' and he said 'Well! Well, he's just been sitting in the car.' And of course, he thought he was sitting in the car with some awful thing in mind, but what John was doing was taking his coffee and newspaper and sitting in the car to take advantage of what little sunlight there was. So, I thought, 'Maybe enough's enough'.[58]

Reasons for choosing Australia

In a paper to the Royal Mathematical Society in London in 1885, Ernst Ravenstein listed seven 'laws of migration', based on his exhaustive study of census data throughout Europe. His fifth law states: 'Migrants proceeding long distances generally go by preference to one of the great centres of commerce or industry.'[59] Ravenstein based his conclusion on census data in nineteenth century Britain, and he would have been surprised to consider Australian cities in that light. Nonetheless, most of those who participated in the present research came first to an Australian state capital, where economic and lifestyle 'pull factors' are likely to have been important in their decisions.

Marriage to an Australian. A factor that drew many participants to Australia was marrying (or being the partner of) an Australian citizen or permanent resident, who either lived in Australia or wanted to return. Seventeen (20 percent) of those interviewed

[56] Shivangi Das, interviewed by author, Melbourne, 27 May 2018; Karolina Wiśniewski, interviewed by author, Hobart (video), 24 May 2018; Sanura Shaheen, interviewed by author, Melbourne, 19 November 2021; Prisha Sharma, interviewed by author, Melbourne (video), 18 September 2020.
[57] Das, interview.
[58] Sharma, interview.
[59] EG Ravenstein, "The Laws of Migration," *Journal of the Royal Statistical Society* 48, no. 2 (1885): 199.

fell into this category, and all but three were women.[60] This gendered effect, with women more likely to follow men than the converse, has been long known in the migration literature.[61]

An example was Aisha Shirazi, who qualified in medicine in Karachi and completed her internship in 2016. She explained that there were strong social pressures for a Pakistani Muslim woman to be married before the age of thirty. She would come home from work, get dressed up, and have to meet prospective husbands and their parents at her parents' home. Some might have been suitable, but she had several rejections because the men did not want to have a wife who worked. Her parents then spoke to the parents of another Pakistani man who had been living in Australia for 13 years and was an Australian citizen. He came out to meet her and they decided to marry; since it was expected that she would go to her husband's country, she arrived in Melbourne in 2017, has passed all stages of the AMC examinations, and was awaiting a hospital HMO job when interviewed in 2019. Her husband was an accountant but retrained as a nurse after he came to Australia on the grounds there is always work for nurses. She commented, "He always tells me how much he enjoys his job each day, so it was a good decision in many ways."[62]

Another was Karolina Wiśniewski, who married an Australian in Poland, where they lived for a decade until he persuaded her to come back to Hobart with him. She was happy with her career as a paediatrician in Poland, and had many opportunities for advancement, but agreed to migrate for his sake. Although Australia eventually recognised her as a paediatrician, and the RACP awarded her Fellowship, she could not work for almost a year while her application for initial medical registration was being slowly processed.[63]

It is of course difficult to know whether some of the marriages were 'marriages of convenience' to smooth the path for migration to Australia. In one instance, it probably was. Nina Kovačević, mentioned previously for her 'push factor' of wanting her sons to escape military service in war-torn Yugoslavia, was candid that the

[60] Schmid, interview; Sanjana Chopra, interviewed by author, Sydney (video), 2 April 2018; Antonova, interview; Mukherjee, interview; Artur Hakobyan, interviewed by author, Melbourne, 16 May 2018; Wiśniewski, interview; Das, interview; Kovačević, interview; Roberts, interview; Aisha Shirazi, interviewed by author, Melbourne, 18 June 2018; Ayomide Okonkwo, interviewed by author, Melbourne, 25 June 2019; Suresh Varadarajan, interviewed by author, Melbourne, 24 July 2019; Niharika Thapa, interviewed by author, Melbourne, 13 June 2018; Qazi, interview; Sharma, interview; Dr X, interviewed by author, location redacted at IMG's request (video), 6 October 2020; Shirisha Tamang, interviewed by author, Melbourne, 16 May 2018.

[61] Jacob Mincer, "Family Migration Decisions," *Journal of Political Economy* 86, no. 5 (1978): 770-2.

[62] Shirazi, interview.

[63] Wiśniewski, interview.

Australian/Yugoslav man who persuaded her to marry him did so initially by telling her it would help her get out of that country. She described him fondly, saying that he wanted to have an instant family. He died from a heart attack eighteen months after they arrived in Melbourne.

While those IMGs came because the spouse was Australian, others came because their spouse already had a job, or at least a job arranged, in Australia—usually in an area other than medicine where it was simpler for them to work without the complex process the medical immigrant generally had to traverse.[64] One example was Jaamini Tuli. Born in Kashmir, India in 1983, she went to Russia to study medicine, then returned to India where she had to pass the licensing examinations of the Indian Medical Council before she could practise. Her husband was working in Singapore in a senior position in the banking sector, but she could not work there because Singapore only gives medical licences to graduates from a limited number of medical schools elsewhere in the world. Since he did not want to return to India—because jobs in his area of IT were scarce—they compromised. He applied for Australian permanent residency, on the strength of his IT qualifications, and she moved there subsequently after returning to Kashmir to earn some money and take advantage of child-minding by her parents.

Relatives in Australia. Many others, having contemplated leaving their home country, were motivated to make Australia their final choice because of relatives or close friends already living there.[65] This process of chain migration was referred to in Part 2 of the thesis. In most cases, they were looking for an English-speaking, developed country with high standards of medical care. Thus, Canada, the UK and USA were often considered as alternatives. The Canadian climate was a disincentive for some living in temperate or tropical areas, and Muslim IMGs were wary of the US during the 2010s because of perceived or actual hostility in response to the rise of Islamic terrorism. Several described Australia as a safe place and a good place to bring up children; the existence of Australian relatives, who had migrated before them, often crystallised the IMG's decision.

[64] Shehu, interview; Qazi, interview; Thapa, interview; Mohammad Dekhordi, interviewed by author, Melbourne, 13 June 2018; Jaamini Tuli, interviewed by author, Melbourne, 25 June 2019.

[65] López, interview; Mangal, interview; Mazdani, interview; Dayal, interview; Shehu, interview; Reddy, interview; Thapa, interview; Madan, interview; Eskander, interview; Sarraf, interview; Murphy, interview; Le Grange, interview; Jose, interview; Madhab Begum, interviewed by author, Sydney (video), 15 August 2021; Anadia Malik, interviewed by author, Regional NSW (video), 15 August 2021; Iwona Mrowka, interviewed by author, Sydney (video), 9 August 2020.

Specifically targeted for a job (i.e., 'Head-hunted'). A few of those interviewed had been attracted to come to Australia by the offer of specific jobs. James Phillips was a young clinical academic in Oxford when he was offered a senior post in nephrology to start up a new program at a major hospital in Sydney in 1987.[66] William Pietersen, a South African, was approached by a rural Victorian hospital which was trying with difficulty to fill a specialist position.[67] Livia Morecroft came via a two-stage route to a senior position in a state capital. She was a graduate from the University of Cape Town, and was already a leader in clinical genetics in South Africa when she was persuaded to move to New Zealand to set up the specialty in 1994. It was a decade later that she succumbed to the offer to take a senior position in clinical genetics in Australia. She says that she did so reluctantly, not really wanting to leave what she had created in New Zealand, but it was because her clinician husband wanted to practise in Australia.[68] The last of this group, David Evans, was the gold medalist in his graduating class at the University of Cape Town, had completed his nephrology training and a DPhil at Oxford in 1976, then found himself heavily courted by two University of Melbourne professors after he gave a paper at a conference in Melbourne. He resisted at first, partly because of his academic wife's reluctance to leave Oxford, but succumbed to take up the position early in 1977.[69]

Responded to a job advertisement. A number of these IMGs had made a tentative decision to emigrate without necessarily knowing where, but chose Australia when they successfully responded to an advertised position. Some have been mentioned already under other headings. An example is Rebecca Strutt. She graduated in medicine, sociology and philosophy from the University of London in 1967, but found the very long hours as a House Officer at her hospital taxing. An Australian doctor working with her said: "It doesn't have to be this hard", and drew crosses on a map of Sydney to indicate hospitals. That day she wrote to the hospitals. She had few ties in UK, since her father had died. After several weeks she received an offer for an HMO position in one of the smaller Sydney hospitals. Two weeks later she was on an aircraft. "It felt like a fresh start. [...] At St Mary's [her London hospital] it was a matter of who you knew rather than what you knew." She felt that there was a more egalitarian attitude in Australia towards ability.[70] Another example is Ishaan Varma. He graduated in India in 1992, then worked in general practice and as a specialist anaesthetist. Why did he consider migrating? "I was not thinking about that at the time, because I was doing quite well

[66] Phillips, interview.
[67] Pietersen, interview.
[68] Morecroft, interview.
[69] David Evans, interviewed by author, Melbourne (video), 22 September 2021. His 'reluctant' wife subsequently had a stellar academic career in Australia.
[70] Strutt, interview.

in anaesthesia. I had a good job with the federal government." And his wife was also well settled in a government job. However, he saw an advertisement from Queensland Health, advertising for doctors, and was surprised to get a response. Their second child was just a baby and his wife was taking maternity leave so they were flexible and able to move for a year or longer. After an interview he was offered the job and they thought there was no harm in trying a new option in life.[71]

Australians who studied overseas. Five of the IMGs interviewed were already Australian citizens or permanent residents, so the choice of country to settle was simple. Elizabeth Morris was born in Australia but narrowly missed entry to a medical course in the city where she lived, so showed her determination to do medicine by going as an international fee-paying student to Dublin. She graduated with honours in 2017. By then she had partnered with another Australian in the same graduating class, and they returned to rejoin their families.[72] Vani Gokhale was born in India, but her family migrated to Launceston when she was twelve. She chose to study medicine at the Ghandi Medical College in Bhopal, India, graduating in 2015 and staying for a year to complete her internship. She had not got a place in medicine at the University of Tasmania, and was about to tackle a biomedical science degree as a steppingstone to medicine when the offer of a place in India came through. She said that she had always wanted to see a little of her country of birth, but regarded Australia as home and returned in 2017.[73]

Valentina Alonso's reason for migrating (domestic violence in Argentina) was mentioned previously. She had been brought to Australia from Argentina by her Italian-Argentinian parents when she was only two. But near the end of her secondary schooling, her parents decided to move the family back to Argentina: "They didn't want us to lose our culture." She had to learn Spanish for the first time, completed the last two years of secondary education, then studied medicine at the National University of Rosario in Santa Fe province. When disaster struck her marriage, the choice of returning to Australia was easy (once she could negotiate the blocking tactics of her ex-husband). Not so easy had been supporting herself and her young daughters and negotiating the AMC exam process once she returned. When interviewed she had passed the MCQ exam but needed to take the clinical exam once more.[74]

Another of this group, with strong existing linkages to Australia who studied overseas, was Tau Dhakal.[75] Tau came to Australia with his family in 2007, where he

[71] Ishaan Varma, interviewed by author, Regional NSW (video), 19 August 2021.
[72] Elizabeth Morris, interviewed by author, Wagga Wagga (telephone), 3 August 2018.
[73] Vani Gokhale, interviewed by author, Melbourne, 28 March 2018.
[74] Alonso, interview.
[75] Tao Dhakal, interviewed by author, Melbourne, 18 June 2019.

completed the final two years of secondary school. He was an Australian permanent resident (but not a citizen), so was eligible to apply for a Commonwealth supported medical place but would have had to pay the fees upfront rather than deferring them via the HECS scheme.[76] Mainly for this reason, he chose to return to Nepal, where he completed his medical degree in Kathmandu in 2016.

Jeremy Vassy was not only an Australian citizen, his first degree was from Australia (BSc, *Syd.*). However, his Australian girlfriend (later his wife) was studying at Cambridge in UK, so he applied for medicine at Oxford and was accepted. After graduation, he embarked on an academic preparation program at Cambridge, passed his MRCP (UK), but decided to come home to Australia because his girlfriend had already returned.[77]

Previously worked in Australia. Five participants were motivated to choose Australia as their eventual destination because they had worked there before, and enjoyed the experience and lifestyle. Hans Weber did two thirds of the final year of his German medical degree in Perth and Hobart. "That's how I got to know Australia. [...] It was these eight months as an exchange student that gave me an insight into the Australian medical system."[78]

Surjan Kohli spent a year working in Melbourne with a leader in an area of orthopaedic surgery, and after he returned to Britain would fly back to Australia to run courses to teach Australian surgeons a particular method of joint replacement. Thus, it seemed natural to come back in 2010 when he was encouraged to move his practice to Melbourne.[79]

Roger Jones and David Lloyd were British graduates who had worked for a year in Sydney and Townsville respectively, then returned permanently eight and ten years later, both having become somewhat disillusioned with the NHS in the UK.[80]

Ram Verosha graduated from the University of the Witwatersrand, Johannesburg, in 1975 during South Africa's apartheid years, and his political activism was referred to earlier in the chapter. The reason for his first trip to Australia was that he and his new wife managed to get HMO jobs in New South Wales in 1978. His wife was also South African, but had taken her medical degree in Dublin, so it was easy for her to get a visa

[76] The Higher Education Contribution Scheme (HECS), introduced in Australia in 1989, enables citizens to access a loan scheme for their university fees, which only need to be paid back when they graduate and earn above a certain threshold level.
[77] Jeremy Vassy, interviewed by author, Sydney (video), 25 June 2020.
[78] Weber, interview.
[79] Surjan Kohli, interviewed by author, Melbourne (video), 25 September 2020.
[80] Jones, interview; Lloyd, interview.

and medical registration in Australia. In fact, they had eloped—it was a mixed marriage and her parents disapproved strongly. Ram spoke a little about his ethnic background: his mother's parents were Dutch and Javanese; his father was Indian and had been a colleague of Mahatma Gandhi. At the end of the year in Australia they decided to return, to try to reconcile with his wife's parents, and both worked again as doctors in South Africa for several years. It was their familiarity with Australia that drew them back there again in 1984. The systemic racism in 1980s South Africa had worn him down. Although he experienced some racism in Australia, he was glad he had settled there, saying:

> Australia is still one of the most successful, multicultural, diverse, stable and robust democracies in the world. In South Africa, I was treated as less than human in public spaces. [...] It gets to your psyche, you know at a subconscious level, and you don't realise how negatively it's impacted you until you get to a society where there is a bit more tolerance ... more accepting of common humanity.[81]

Other reasons for choosing Australia. Two others made the choice of Australia as their destination for reasons slightly different from the themes discussed above. Latoya Khouri probably could have applied to come to Australia from war-torn Iraq as a refugee, but came instead on a student visa because Australian Catholic University had an exchange program with her Catholic University in Erbil.[82] And social media played a part in Jose Hurtado's decision about where to go: he discovered an active Facebook group of Colombian doctors in Australia that provided him information and encouragement.

It can be seen that a variety of factors have operated to make Australia the chosen destination for those whose histories were recorded here. As found in other studies of migration history, the theme of chain migration—people moving where friends, family or compatriots have moved before—has been one prominent feature.[83] A frequent factor was IMGs' perceptions of the safety and amenity of Australia; others took the opportunity, sometimes unpremeditated, to take a job that would enhance their professional skills and standing.

Experiences with the AMC examinations

It is not unexpected that IMGs who had difficulty with these examinations, which those who came to Australia after 1978 seeking general registration and were not exempted

[81] Verosha, interview.
[82] Khouri, interview.
[83] Simone A Wegge, "Chain Migration and Information Networks: Evidence from Nineteenth-Century Hesse-Cassel," *Journal of Economic History* 58, no. 4 (1998): 958.

had to pass,[84] often had negative views about them. Those who managed to pass either exam at the first attempt usually said that they felt the standard required and the processes were appropriate, but most had done some studying before attempting them. Hans Weber was one of those, commenting that he was fortunate to sit the exams less than two years after his final medical school exams in Germany, when all the disciplines tested were still fresh in his mind. His was the second highest score among those who sat in 2001, so he was given an expedited place in the Clinical Exam, which he also passed at first attempt.[85]

Not so fortunate was Radeyah Hadi. She was ranked 215 out of 322 who sat the MCQ exam in 1994, but was told she would have to sit it again since there was a quota of only 200 for the clinical exam at that time.[86] However, the quota was removed the following year and she did not have to resit the MCQ.

Hans Weber mentioned other IMGs he had studied with as they prepared for the AMC exams, who were older and often were specialists in their home country. "They struggled with gynaecology and dermatology and psychiatry … [that they had not studied or needed to use for years]"[87] Anjali Nair said that in her view it would be better for the AMC exams to be tailored more to the experience of each IMG: for someone who had been practising for many years, the MCQ paper might be less relevant, and it might be better to just require them to sit the clinical exam.[88]

The different requirements in some states for passing the AMC or equivalent exams were exemplified by the histories of two South African graduates. Peter Visser was registered immediately by New South Wales when he transited Sydney in 1979, en route to a job he had been offered as a radiologist in Melbourne. However, the Victorian Medical Board required him to pass its Foreign Practitioners Qualification Committee exam (the forerunner of the AMEC and AMC exams), which meant his new job had to be on hold till he passed it the exam the next year.[89] Ram Verosha had family in Melbourne, so he and his Irish-trained wife would have liked to settle there immediately. However, he too had to do the Victorian exam so, while preparing for that, they lived on the New South Wales side of the border where he was able to be immediately registered and practise.[90]

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[84] See Chapter 4.
[85] Weber, interview.
[86] See Chapter 4.
[87] Weber, interview.
[88] Nair, interview.
[89] Visser, interview.
[90] Verosha, interview. His wife was immediately registered under the Victorian Act because of her Irish degree.

The AMC clinical exam caused dissatisfaction among those who were not able to pass it immediately, mainly because they felt unclear about what examiners were looking for, and did not receive useful feedback about their performance. Five who sat the exam in its present configuration as an Objective Structured Clinical Examination (chapter 4) complained that the feedback on stations where they had been unsuccessful referred only to 'keysteps', in what was obviously the marking schedule for points on which the examiner needed to be satisfied. The problem is the candidates were not told in the feedback what the 'keystep' was.[91] For example, Asad Ehrani was given this feedback on a station he failed: "I got a station [scored] 4, 3, 4, 4, all keypoints covered, but the overall score was 3 [a fail]." (The maximum possible for a 'keypoint' was 7). The others had similar comments. Of course, what Asad could not know is that the marking schedule the examiner used might have required them to allot a final global competency score for the station, which might have overridden what otherwise seemed a narrowly passing score. Nonetheless, their complaint about opaqueness of the feedback does seem justified. There is now an opportunity for candidates to appeal a narrow failure. One who went this route and was delighted with the outcome was Jose Hurtado, who failed the 'retest' clinical exam narrowly by one station.[92] In this appeal process, the AMC now arranges for candidates to sit with an examiner and view the video recording which is now made for every station in the clinical exam. It took eight months for that to be arranged, but he was delighted to have the original failing result overturned in January 2020.[93]

There is of course a risk that some who fail the exams are unable to objectively assess their limitations. Alicja Robertson, who graduated in Poland, passed her AMC exams in 1995, and had been in practice in Victoria and Western Australia since then, said:

> I worked for quite a lot of years with overseas doctors [...] I must admit that quite a big percent ... I didn't find terribly suited to work in Australia ... I suppose a different culture [...] and the level of knowledge was not particularly good. [...] Some of them they were complaining that they didn't pass the exam but when you work with them you feel like I'm not surprised you didn't pass the exam.[94]

Experiences with specialist colleges

The interviewees who were specialists in their home country, and wanted to practise in the same specialty in Australia, had widely varied experiences in having their

[91] Mostafa, interview; Tehrani, interview; Reddy, interview; Thapa, interview; Dhakal, interview.

[92] At that time (2019), candidates who narrowly failed the 16 station OSCE were offered a supplementary ('retest') exam consisting of an eight station OSCE after a short interval.

[93] Hurtado, interview. The appeal result was communicated to the author on 14 January 2020.

[94] Alicja Robertson, interviewed by author, Melbourne (video), 17 October 2020. She then joined the FRACGP training program to become a Fellow in 2003.

credentials assessed in Australia. It was not always easy, for the author or the IMG, to ascertain why some were required to pass the specialist college's exams and undertake at times considerable further training, while others were almost waved through and awarded Fellowship. The stories of several who had substantial difficulty are recounted in detail among the edited oral histories later in the chapter.[95] It is likely that the decisions colleges have to make about comparability of specialist training in the overseas country and Australia are sometimes difficult. The perspectives of college representatives who had experience with this are discussed in Chapter 11, and provide some balance to this overall discussion. However, the examples in the interviews reported here suggest that those who held a specialist qualification from the UK, and perhaps South Africa, were more likely to have it accepted as comparable or substantially comparable by Australian colleges than those who were specialists elsewhere.

For James Phillips and Mary O'Shea, registration as a specialist was very straight forward. James had been recruited to a specialist physician job in a major Sydney hospital. All he had to do was show his UK specialist credentials (FRCP) to a senior Fellow of the RACP in his Sydney rooms to be immediately awarded the FRACP in 1987.[96] Mary graduated in Ireland in 1998, obtained her Fellowship of the UK college of general practitioners in 2005, and was promptly awarded the FRACGP on the basis of her British qualification when she arrived in Australia in 2008.[97] Roger Jones was another who had his FRCGP immediately recognised by the Australian RACGP and was awarded its Fellowship.[98] William Pieterson was an experienced South African anaesthetist who, when recruited in 2007 to an area of need in a regional Victorian hospital, needed only to have a brief on-site visit by an ANZCA team to certify his competency.[99]

Others who arrived in the last 20 years, and were assessed by a college as having training and experience similar to Australian-trained specialists, often needed only to be mentored and assessed for (usually) a year by an Australian Fellow. One was Nuwan Bandara, who trained in paediatrics in Malaysia, had passed his MRCP (UK) exam, then took a job in Townsville (classified as an area of need). He was registered by the Queensland Medical Board in 2004; the RACP interviewed him, exempted him from its exams, but required him to be peer-reviewed by a mentor for 12 months. Another was

[95] Jana Rao, interviewed by author, Melbourne, 30 August 2019; Ivanov, interview; Thomas Schulz, interviewed by author, Regional Victoria (video), 28 August 2020; X, interview.
[96] Phillips, interview.
[97] O'Shea, interview.
[98] Jones, interview.
[99] Pietersen, interview.

Antony Jose, who qualified in neurology in India, had practised as a specialist for ten years (including one year in UK), and was promptly registered as a specialist by AHPRA when he took a job in a regional town. Before awarding him Fellowship, however, the RACP required him to be mentored for a year by a neurologist 200 km away in the state capital. Similarly, Ashal Weerasinghe was judged by the RACP to just need one year of mentoring, when he came to set up cardiac services in rural New South Wales—he had been well trained in the specialty in Sri Lanka and England.[100] All of these IMGs said that the supervised year, far from being onerous, helped them greatly to settle into their specialty in Australia with the help of their mentors.[101] These doctors who were accepted with little difficulty all had some UK experience, which as seen in many places in this thesis, tended to advantage IMGs when licensing decisions were made in Australia.

Karolina Wiśniewski graduated in Poland in 2003, then trained for almost six years as a paediatrician. When she came to Hobart with her Australian husband, the RACP decided that she must sit the RACP clinical exam and also have a year of additional training, specifically in neonatal as well as rural paediatrics. Karolina has since been an examiner in the RACP exam herself, and defended the college's decision to make her do those rotations and the exam, saying:

> I agree that an overseas doctor should do this exam because [...] the medical system is different in each country. [...] In paediatrics, you need to know the support structure, what services are available, where to refer patients, how it works, how child protection and safety works [...] I think it made me a better doctor and it helped me to understand the system in Australia.

Sanura Shaheen ended up having to change specialties after she arrived in Australia in 2010, a fully qualified rheumatologist with a PhD and university appointment in Cairo. She had come with her husband who wanted to learn robotic surgery in Melbourne. The RACP judged her specialty training in Egypt as only minimally comparable to that for the FRACP and told her she would have to complete five of the six years of the college program, and pass its exams. Partly because her husband was having to study for the FRACS exams, and partly because she needed time to care for their children, she opted instead to pass the AMC exams, after which she completed the training program and exams of the RACP's Faculty of Rehabilitation Medicine. When interviewed, she was Director of Rehabilitation Medicine at a major Melbourne health service—a job that makes use of some of her skills in rheumatology, although she regrets a little having to let her original specialty go.[102]

[100] Ashal Weerasinghe, interviewed by author, Regional NSW (video), 12 August 2021.
[101] Bandara, interview; Jose, interview.
[102] Shaheen, interview.

Surjan Kohli was trained in England, obtained his FRCS (UK) in orthopaedic surgery and was beginning to be regarded as an expert in a particular orthopaedic technique—one he had come to Australia several times to teach Australian surgeons. When he took a job in Melbourne, the RACS told him he would have to do its exams. "So, we launched an appeal ... [but] the board were biased" and the appeal was dismissed. He appealed again, and a meeting was then held at the RACS where "They said why on earth are we even in this situation." He was given an apology at the meeting. "Some of the professors there said you've done more work [books etc.] than we have. [...] Then they gave it [FRACS] to me, but it was quite traumatic and stressful."[103]

Still others, usually who had come to Australia not long after graduation, were registered as generalists after passing the AMC exams, and then joined a college training program to qualify as a specialist along with the local graduates.[104]

Difficulties attributable to AHPRA's policies and administration

Those interviewees who came to Australia before 2010, and were processed by one of the state or territory medical boards, generally found the registration process straightforward. If they had difficulties, it was usually with either passing the AMC exams or persuading one of the specialist colleges to approve their credentials. However, several who came after AHPRA became the final gatekeeper to registration have had difficulties that need to be discussed here.

The first has arisen because of AHPRA's policy of giving either Limited Registration or Provisional Registration (see Chapter 4 for the difference) *only* once the IMG receives a job offer for the required year of supervised practice. Madhab Begum described this as a 'catch-22' requirement—if hospitals or teaching general practices know the IMG has not yet been registered, they are less likely to choose that applicant over one who already has general registration.[105] This reluctance by hospitals is well founded, since even after a job was obtained, there was evidence among these interviews of delays while AHPRA got around to complete the paperwork. For instance, in 2017, Elizabeth Morris was offered a supervised position in a major city hospital shortly after she passed her AMC MCQ exam—the hospital had a casual vacancy part way through the year. It was not till almost three months after the hospital had advised AHPRA of the job offer that the regulator completed its essentially rubber-stamping process. Dr Morris said this was despite the hospital, keen to fill its vacancy, phoning AHPRA almost

[103] Kohli, interview.

[104] Daneen Muthalaly, interviewed by author, Canberra (video), 3 August 2020; Begum, interview; Murphy, interview; Robertson, interview.

[105] Begum, interview.

weekly. The hospital's workforce officer told her that they often had this difficulty.[106] Other examples are given among the extracted oral histories later in this chapter. In 2018–19, 40 percent of complaints to the National Health Practitioner Ombudsman were in relation to the registration process—specifically delays, unfair processes or policies, or registration fees.[107]

Mandatory reporting of health issues experienced by a practitioner is administered by AHPRA, under the national law. One example of a troubling consequence of this is illustrated in the oral history of Bridget Smith later in this chapter.

AHPRA has, among its requirements for registering health practitioners, one related to recency of practice.[108] *Prima facie*, it seems self-evident that if a clinician has not practised their art for a while their skills may have declined (although there is a surprising lack of epistemological evidence either way). AHPRA's recency of practice requirement has posed difficulties for some of the IMGs interviewed here, most of whom were women. The current requirement is that a practitioner work for a minimum of 152 hours per year (or pro rata over three years) within their scope of practice. Pregnancy and child rearing sometimes make it hard for even Australian-trained doctors to meet the provision, though they at least have the chance to do so by working a day a week (because, unlike the IMGs, they are already registered).

Restrictions related to recency of practice impacted on several interviewed here who were still trying to be registered. For example, Shivangi Das migrated from India with her Australian husband in 2017. It took a while for her to prepare for and pass the AMC examinations, but she then needed to spend time looking after her new baby. By the time she was ready to look for the obligatory supervised job, her 'recency of practice' had nearly expired:

> I am searching for jobs. Last year I was pregnant and couldn't do that. This year when I search for jobs, the 'gap' is becoming a trouble. ... [Australia should] have some kind of bridging courses like the way nurses have ... where you are guaranteed that after this step [the exams] you will be able to get into the medical workforce and work rather than just leave you hanging after doing the exams.

Others caught out in this way, often because of pregnancy or other family circumstances, have had to return to their parent country to reinstitute their 'recency of practice'. An example is Jaamini Tuli, who passed the AMC MCQ exam in 2017, but had a gap in practice of six years because of family illness and moving between

[106] Morris, interview.

[107] National Health Practitioner Ombudsman, "Registration Complaints," accessed 14 March 2022, https://www.nhpo.gov.au/registration-complaints.

[108] AHPRA Medical Board, "Registration Standards," accessed 13 September 2021, https://www.medicalboard.gov.au/registration-standards.aspx.

countries. Consequently, she went back to India with her daughter and worked for six months in a government hospital so she could meet AHPRA's recency requirement when she returned.[109]

The last issue concerning AHPRA's administrative performance can be characterised as bureaucratic bullying. There were two instances of an AHPRA officer telling an IMG, who had passed the AMC examination, then received an offer for a necessary supervised job, that the issuance of a Limited or Provisional licence was guaranteed to occur within 90 days—but that the official would not be able to manage it, and required the IMG to agree to an extension of time. While criticism could be made, in any case, that this simple final step would need to take so long,[110] much more concerning was a threat made by the official to get the IMG to agree to an extension. Thomas Schulz was told that, if he did not agree, he would lose the considerable application fee and have to start again from the beginning. The same threat and consequence was conveyed, just before the 90 day deadline, to Elizabeth Morris's IMG husband who had been offered a job in a large regional hospital.[111]

Issues with visas

Obtaining an appropriate visa was not always easy, and led to some innovative solutions. Several of those interviewed came initially on a student visa, to get them into the country and to give them time to prepare for the AMC examinations. Boris Ivanov's story is recounted later among the extracted oral histories—he had been a nurse before he qualified as a doctor in Russia, so enrolled in two nursing degrees to stay in Australia.[112]

Kumi Appiah came from Ghana, with a Chinese medical degree, but while studying for the AMC exams was enrolled in two different Masters degrees: a Master of Public Health at Curtin University, then a Master of Nursing Practice at University of New England, which he completed in 2019. His view was that the latter would at least let him practise in an area of health care in Australia if he were unsuccessful in the AMC exams.[113]

Others who used student visas—both to allow them to live here while studying for the AMC exams and to offer an alternative job opportunity if needed—were Rakesh

[109] Tuli, interview.

[110] IMGs in this situation had passed all of the AMC's and AHPRA's requirements—all that remained was for AHPRA to note the evidence a supervised job had been offered to the IMG, and provide the certification.

[111] Schulz, interview; Morris, interview.

[112] Ivanov, interview.

[113] Kumi Appiah, interviewed by author, Regional Victoria (video), 11 August 2021.

Madan (who completed a Master of Public Health and Master of Health Services Management), Franchesca Rodriguez (Diploma in Community Service), and Daniela Almeida (certificate courses in disability and aged care). Daniela said that, whether it would be of future use to her, her diploma improved her English, and the course needed to be reasonably long (to give her time to pass the AMC exams) and not too expensive.[114]

Other difficulties

When asked if they felt they had experienced racial discrimination, most of those interviewed downplayed or denied this. But some confessed that it happened occasionally. Jana Rao's comment, in his oral history later in the chapter, was illuminating, gracious, and insightful. Yiu-po Soo said that patients had sometimes said they would rather see another doctor, but that it was his wife who had probably experienced this problem more often in the community in which they lived.

Financial difficulty was another that often impacted on those IMGs who were still trying to become registered, since they could not earn a living as a doctor. Franchesca Rodriguez had been living on her savings, mainly a legacy from her father in Ecuador. She had been able to earn some money by baby-sitting, dishwashing, and cleaning. She would go to bed at 9 pm, start her cleaning job at 4 am, finish at 9 am, then go to class for the rest of the day at the ARIMGSAS exam preparation course. "It almost killed me."[115] Several also commented on the high cost of the AMC exams, the English exam, and the commercial preparatory courses for the AMC exams. Anadia Malik said that when she and her husband arrived in Perth in 2012 (they left Pakistan hoping for a better future for their children), finances were difficult, rental costs high, and she could not initially afford the fees for the AMC exams.[116]

A different problem was encountered by Nabilah Reddy. She and her medical husband both passed the AMC MCQ exam in 2012 while they were still living in Malaysia. They were then eligible to be employed while they prepared for the clinical exam. A former compatriot offered both of them a job in his general practice in an outer metropolitan area classified as an area of need. He was required to give them supervision, but they rarely saw him since he put them on the evening and public holiday shifts. They were probably exploited financially as well, since they were paid only 40 percent of their billings. Eventually they managed to be relocated to a different practice, where they received much better supervision and support.[117]

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[114] Madan, interview; Franchesca Rodriguez, interviewed by author, Melbourne, 27 May 2018; Almeida, interview.
[115] Rodriguez, interview.
[116] Malik, interview.
[117] Reddy, interview.

Reflections on possible improvements to IMG immigration and licensing

A number of those interviewed responded to my question about how the processes for judging the competence of IMGs wishing to be registered in Australia might be improved. There was a range of useful suggestions, which will be discussed in the final chapter. However, one recommendation about judging procedural competence warrants also mentioning here, in light of the difficulties some proceduralists recounted in the next section through their oral histories.

Ms Binita Dalal, whose own history is given in detail later, and who is now Director of her specialty in a major city hospital, said:

> For a field that is surgical, it seems to me that to assess people with an interview seems inherently flawed. You cannot assess a surgical capability based on somebody telling you: 'Yes, I can do this surgery.' That makes no sense at all. Secondly, the Australian colleges base their decision on number of years of training. What we don't take into consideration is the *depth* of training. I learned a whole lot more in my three years of training in India … than I got out of seven years in the UK. But the UK training is recognised [in Australia], Indian training is not. […] Colleges will let IMGs work in an area of need, but you are sending someone who you think is 'not comparable' [to an Australian specialist] to an area where they won't have enough support … and let them loose, for want of a better word, in that area, but you don't want them to operate or practise in an area like a city where they *would* have support.[118]

She also doubted how well the assessment processes (she was talking about for specialists) judged communication skills. I asked how she thought IMGs' skills could be better assessed:

> Two things: (1) use simulation to assess surgical skills.[119] (2) Put everybody into a supervised position for say 3–6 months. That could be done for everyone. Have one rule and apply it to everybody. It's like having a leash—an invisible leash—that keeps you in check.

She also suggested IMGs should be given a panel of mentors/supervisors, rather than a single one, so the supervisors could monitor each other's performance, helping to reduce the possibility of overt biases and/or personality conflicts with their mentored IMG.

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[118] Binita Dalal, interviewed by author, Melbourne (video), 23 April 2021.

[119] High fidelity simulators are available for most surgical and endoscopic procedures, and are used extensively in many countries for training. This parallels the use of simulators for both the initial training of pilots then periodically assessing their ongoing competence to fly and manage emergencies.

Illustrative Oral Histories

This section presents edited transcripts of ten of the oral histories, to illustrate in more detail the range of experiences and challenges that IMGs have faced—at times with equanimity and other times not.[120] In the sections above, factors impacting migration have been examined one by one. But that does not interrogate the complex interaction of multiple forces on life histories and experiences as they impact individual migrants. That is the purpose here.

The convention I have adopted (following the Chicago manual of style) in writing *direct speech* as distinct from other quotations, in this and the next chapter, is to use the ellipsis to indicate a *pause* by the speaker. An ellipsis in square brackets [...] indicates that a portion of the stream of dialogue (by participant or interviewer) has been omitted.[121] Elsewhere in the thesis, the usual convention is followed: an ellipsis (without square brackets) means missing text in a quotation.

Mr Jana Rao [122]

Jana Rao was born in Madras, India in 1939 and graduated from Madras Medical College in 1960. After three years of junior jobs, he was accepted into surgical training in Madras, graduating with a Master of Surgery in April 1966. It was very similar to the training for Fellowship of the Royal College of Surgeons of England: assessed at the end with a written paper, an oral examination, and finally a clinical examination. The Indian government, at the time, required two additional years of surgical practice under supervision in a teaching Hospital; thus, by the end, his specialty training had lasted for five years.

He said that one problem for him as a salaried government surgeon was needing to lobby for places to work. “Everyone likes to be in a city hospital. So, you don't know when you'll get butted out and posted out into the rural setting.” He was lucky to have as a mentor the Professor of Surgery, and under his protection he was able to continue to practise as a surgeon in the Government Hospital in Madras. The professor had taken a close personal interest in his training and attended most of his early surgical cases to help him, and later delegated most of his own cases to him. His team often got through 25 to 30 operations in a day.

However, when the professor retired, things got much more difficult. No longer having his political protection, others tried to push him out so they could have his

[120] These were chosen among the 87 oral histories to exemplify particular issues and difficulties, as well as instances where the migration process was straight forward.
[121] *The Chicago Manual of Style*, 17th ed. (Chicago: University of Chicago Press, 2017), 13:58.
[122] Rao, interview. It is still conventional in Victoria to use the title *Mr* for specialist surgeons.

position in the city. Twice he was transferred to the periphery and each time, to get back, he had to "take the blessings of a politician." "You've got to be subservient to them, the politicians, which I hated." He hinted there was corruption in the appointments process. So eventually, he resigned.

He started to consider his options. One was to start his own private hospital. "I came from an upper middle-class family and finance was not a problem." He had already passed the US licensing exam (ECFMG) and could have tried that country. But a classmate, who was working at a Melbourne hospital, said: "Why don't you consider Australia?"

"At that time [1968], I saw an advertisement in an Indian newspaper: 'doctors wanted for Australia'." It simply encouraged Indian doctors to come to Australia but did not provide any information about specific jobs. He applied and there was an almost immediate response. An Australian immigration officer came to Chennai to interview him, and he was asked to return with his wife and young son the next day. They were promptly issued with permanent resident visas, which allowed him to work or travel in any way that he wanted. They would need to have medical examinations, but the officer said that could be done in Melbourne.

So, they came to Melbourne in March 1969, with no job lined up. India had tight currency restrictions and they were able to take only $7.50 each out of the country. He had sent a telegram to his Melbourne surgical friend before they started their journey, but it had not reached him. They arrived at the airport in the morning and tried all day to contact the friend. Their two-year old son was crying with hunger, so they shared one sandwich and a milkshake between them, and by then had just $3 to their name. When they finally managed to contact the friend, he told them to take a taxi to his home, which he paid for when they arrived. "So that is where we started our life."

The search for a job in surgery was fruitless. He left his resumé with the staff of the department of surgery at Royal Melbourne Hospital. They never contacted him. There were similar experiences as he looked for a surgical registrar job at other hospitals—a position he wanted so he could prepare for the Australian surgical final fellowship exam. The Director at one hospital did meet with him, but told him he was "overqualified" since he was a fully qualified surgeon in India. At other Melbourne hospitals, no-one saw him. He could only leave his resumé and hope for a reply.

He had already been registered by the Medical Board of Victoria, which recorded both his MBBS Madras and his Master of Surgery.[123] I asked whether he was aware when

[123] Certificate no. 11974, 5 June 1969, VPRO: Medical Register, Medical Board of Victoria, VPRS 16394/P1, vol. 3, 1949-1972.

he left India of the difficulties he would experience to be recognised as a surgeon? He said he was not. The English college stated at that time that it recognised a Masters degree from Madras, Bombay and the Armed Forces medical service as the three Indian degrees that were equivalent to the FRCS. He had expected Australia would similarly recognise his qualification.

> I went to the College of Surgeons, waited a few hours, showed a gentleman my registration papers and the cutting from the [English] Royal College of Surgeons, and I said I'm prepared to take the [final] Fellowship exam, and what do I do?" He said, "Go and work in one of the hospitals first, and then you apply.

For two months he was without a job, and was contemplating going back to India. However, his friend put him in contact with a medical agent who knew many of the general practitioners who might be interested to have a surgeon join their group. Three groups interviewed him, and all offered him a job. At that time many Melbourne general practitioners did some surgery.

He took up a position with five GPs at a clinic in a Melbourne suburb. He was supposed to do mainly surgical work. However, if there was none, he was required to see patients as a general practitioner. He had been a specialist for some time and was apprehensive about his general practice skills, but his partners offered to help with advice when it was needed. They then began to "drive me like a slave." He would do his operations early in the morning, then be back consulting general practice patients till usually 9:00 pm, as well as having to do house calls.

One day he had to go to the parent-teacher meeting for their son and was told: "Your son talks only about the mother never about the father." He was rarely home in time to see the child. So, he tried to negotiate with his colleagues to be able to work shorter hours. At that time, 70 percent of the total practice earnings was coming from surgery. He said, "I'm bringing in so much of the income, give me more time off; I'm not asking for more share of the money." They would not agree.

Thus, he left the practice in 1971 and set up solely in surgical practice in a mainly working-class suburb. He needed a private hospital with operating rooms and beds for his patients and approached the Sacred Heart Hospital (later named John Fawkner Hospital). The sister in charge, after inspecting his registration and qualifications, gave him operating rights—on the condition that people who came to the hospital without any health insurance would be treated free of cost. He agreed. "It was a real symbiosis ... we got along really well." Slowly he built up the surgical practice.

Several times he approached the college about taking the FRACS clinical exams and they said no. They wanted him to do all the three parts of their examinations,

including the written paper on primarily the basic sciences, which he had passed about nine years before in India. The college exempted those with the British Fellowship from sitting that part of the exam and his argument was that, since his qualification was equivalent to the British one, they should give him the same exemption. He would be very happy to sit the two clinical parts of the examinations. "You [should] give me the same privileges because I've got the same qualifications." They refused.

At that time, the looming introduction of Australia's universal health insurance scheme (Medibank) meant that, if he were to be able to bill for surgical items and the patient get reimbursement, he would have to be registered as a specialist surgeon.[124] Fortunately for him, at that time a Federal MP (Lenard Reid) came to his house with a family friend who was visiting from India. Rao mentioned that he was a trained surgeon and, unless he got recognition, he was going to have problems. Reid said to give him his CV and all his other papers. "Then I got a letter from the department [Commonwealth Health Dept.] saying that you have been registered as a specialist in the practice of surgery [...] So, I was registered as a specialist surgeon even though I didn't have the local qualification and I was able to continue to practise."

He recounted an episode that is highly relevant to the assessment of the clinical skills of an IMG surgeon, or for that matter any surgeon. He was performing a particularly difficult operation—removal of the right lobe of the liver—at the John Fawkner Hospital.[125] In the other operating room, the head of surgery at St Vincent's Hospital[126] (Mr John Connell) was also scheduled to operate.

> He saw the board [outside the operating rooms, which listed the cases] ... and he knocked at the door, and he said 'Mr Rao can I come in and watch you operate?' I said I have no objection, please come. He came in, he left his [own operating] list for 3 hours ... and he watched me do all the dissection. At the end he said 'OK, let me go and do my list, and meet me at the end of the procedure.'

John Connell asked him to meet for lunch, and over the meal said: "Do you know, we don't even do this big operation in public hospitals. You are doing it in a small private hospital. You know the risk you are undertaking [because of the lack of back up from an intensive care unit and other colleagues]". "I said, I know the risk. I have done all these procedures in India. People stab each other and I've done quite a few of these liver resections in India, so I feel confident to do it here."

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[124] Medibank was introduced on 1 July 1975, under the Whitlam government (see Chapter 2).

[125] The anatomy of the liver, with its multiple blood supplies and network of bile channels, makes major liver resection a dangerous procedure for any but very well-trained surgeons.

[126] A major university teaching hospital in Melbourne.

Connell wanted him to have an attachment to a big hospital and gave him the job as honorary clinical assistant to the outpatients at St Vincent's, where he worked for three sessions per week from about 1973 to 1993 *pro bono*. "I enjoyed the work ... the advantage was someone to talk to."

Regarding the Royal Australasian College of Surgeons, John Connell had written to it several times to recommend that Jana Rao be given Fellowship, saying he was a competent surgeon. "You should invite him." It took the College twenty years before he was invited to meet with three senior Fellows, one of whom was the President. They said: "You are the only consultant surgeon in Australia who is operating without being a Fellow of the College [...] We want you to join the club."

How did his wife cope with migrating to Melbourne? She came from an influential family; she always had servants and chauffeurs and she had never cooked. "She gave up a lot [...] my neighbours, our Australian friends, were outstanding." One of the neighbours would visit his wife at least twice a day, would help her with shopping, cooking and looking after their son.

Did he feel that he experienced racism in Australia? This was a time when there were not many Indian immigrant doctors in Melbourne. He thought about the question, then recalled an incident when he was in the group practice. "When I first started, a patient came into the room, looked at me, and told the sister [nurse]: 'I'll not come here to see a coloured doctor'." I suggested to him that this was racism, but he replied:

> I don't think it's racism, I think it's ignorance ... fear of the unknown [...] But the word went around that I was very kind, compassionate, and that began to change. Within a matter of three months, they would prefer to see me than my colleagues [...] I gave them [the patients] time. The nursing staff at the John Fawkner, if they had something wrong surgically, they came to me.

He stopped operating in Australia in 2007 and went to India where he operated on charity patients as Director of Surgery at a hospital in Chennai for 2 years. While he did not mention this during the interview, Jana Rao was also the Honorary Consul for India in Melbourne for twenty-four years, and among many other honours, was awarded the Medal of the Order of Australia in 1998. In his retirement, he wrote his autobiography.[127]

His is an unusual story in the historiography of Australia's recognition of overseas trained specialists who came from somewhere other than the United Kingdom about fifty years ago. The present detailed processes for registering overseas-trained specialists

[127] Jana Rao, *A Surgeon & Consul General: A Migrant Experience* (Chennai, India: Notion Press, 2017).

were at least twenty years from being implemented.[128] That he managed to negotiate the challenges he faced in the 1970s is a triumph of both skill and determination.

Dr Daniela Almeida[129]

Daniela Almeida was born in Venezuela in 1991, and graduated from medical school in Valencia in 2013. After graduation, she worked for a year in a rural primary care facility before deciding to emigrate. The economic and political situation was fraught in Venezuela in 2014. There was deep political instability, hyperinflation, and indices of social violence that were among the highest in the world.[130] She did not have enough resources to practise quality medical care and would have to ask her patients to pay for antibiotics and even surgical gloves. Added to that, she had always wanted to study abroad and particularly to learn English, which she saw as the world's *lingua franca*.

Venezuela's currency restrictions meant that she could not take her savings with her, and a US visa would not have let her work. So, she settled on Australia, on a student visa, with her first task to learn English. Needing to continue studying to retain a visa, she next took a certificate course in disability at Southern Cross University's Melbourne campus, and at the time of interview was enrolled in a diploma in Community Care. These were at least related to her hoped-for future career.

The first year was the most difficult. "I needed to make money, settle down and find a nice place to live." At first, she was working in hospitality, waitressing. Then she was fortunate to get a job in an aged care facility, as a personal care assistant. That let her get closer to the health system and also helped her with her English. It gave her some familiarity with Australian approaches to medications, care plans and some diseases.

But she was here to practise medicine. She attempted the AMC's MCQ exam twice and failed narrowly each time. The cost of the exams was a further stress. She sat it again and passed in 2017, then passed the Occupational English Test (OET) in January 2018. When I interviewed her in March of that year, she was preparing for the AMC clinical exam and was taking the preparatory course at ARIMGSAS. She was working night shift at her aged care facility, then going to study at ARIMGSAS in the afternoon. Financially, she was managing, though it was not easy.

> I am really strong … and I miss so much my family … and I've had some really horrible experiences, but I feel like the only thing that keeps me strong is … I see the good things … the blessings I have with my life, because actually being in

[128] See interviews with Drs Andrew Roberts and Graeme Campbell in Chapter 11.
[129] Almeida, interview.
[130] Margarita López Maya, "Venezuela: The Political Crisis of Post-Chavismo," *Social Justice* 40, no. 4 (2014): 68,71,74.

> Australia is a blessing, coming from Venezuela, from that country that is short of food, of medicines, I can't complain [...] Sometimes, for example, when I go to my school I feel 'Oh, I waste my time. Why do I do this course? It's not what I want to do ... this is just to keep my visa.' Then I say to myself, 'This is what keeps me here.'

I asked if she regretted migrating. "Not at all. I love Australia." If she could change her student visa for a 457 subclass,[131] she would be very happy to practise in a rural or remote area of need. "I'm not married, don't have kids. I could go anywhere."

Dr Almeida's story illustrates some of the difficulties an IMG experiences while balancing the requirements to keep a visa, earn enough for basic sustenance and pay substantial AMC exam fees, while at the same time preparing for exams that must be more difficult if the candidate is not yet fluent in English. A lack of family and other social supports compounds the difficulties. However, the alternative of returning to a country that is under even greater economic and political strain than when she left is probably unappealing. She needs resilience, and the interview and her follow-up email suggest she has a good deal of it.

Dr Sean Murphy [132]

Sean Murphy was born in Ireland in 1978, graduated in Medicine from the National University in Dublin in 2003, and completed the mandatory intern year in the middle of 2004.

Originally, he did not intend to emigrate permanently, but wanted to have some experience elsewhere. The intern year had been particularly heavy: he was working between 80 and 100 hours a week. He was going to sign up to a GP scheme in the west of Ireland, but several of his classmates came to Australia for a kind of working holiday. He had previously visited Western Australia and had a sister living in Sydney. "For a lot of people in Europe, Australia is your quintessential holiday destination: good weather, nice people, and it was reasonably easy to get jobs here without having to jump through too many hoops."

He sent emails to a few hospitals in Australia. Meanwhile, a friend had got a junior medical officer appointment at the Royal Brisbane Hospital. He emailed that hospital and they were the first to offer him a job—for 6 months in the emergency department. Shortly after, another four Irish graduates from a different medical school arrived, so there were six Irish graduates in that emergency department concurrently.

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[131] When she spoke of that visa, she had not realised it had already been replaced by a Temporary Skill Shortage Visa (subclass 482), although their functions were similar. The 457-visa allowed a skilled worker to stay up to 4 years if they had a sponsored job.

[132] Murphy, interview.

He came on a 451-subclass visa[133] in 2004. It wasn't difficult to get because he had already got a job. "Essentially, Queensland Health sponsored me .... there was a very helpful HR team at the Royal Brisbane Hospital, and they sorted everything out for me in terms of the paperwork ... so it was pretty seamless." Getting registered by the Queensland Medical Board was also very straightforward. He recalled that the AMC had certified him and his colleagues immediately, and that he and one of his friends had gone to the Board where they were simply asked to sign a form stating they would behave ethically.

> I fell in love with basically everything. I loved Brisbane, I loved Australia, loved emergency medicine ... it was sort of the first time I felt I had a little bit of independence and could do some of my own decision-making and didn't just feel like the lowest rung on the ladder, so to speak.

When the time in Brisbane was up, he travelled for a while before returning to do some locum jobs in Ireland. But he was keen to come back to Australia, this time to train formally in Emergency Medicine and with the intention of staying for at least the duration of the training program for Fellowship of the Australian College of Emergency Medicine (FACEM). He passed his Fellowship in 2012 and now holds a senior position in Emergency Medicine in a Brisbane hospital. His partner is English and recently talked about wanting them to go back to the UK. He very much hopes they do not.

Australia has benefited greatly from its Irish IMGs since colonial times, and continues to do so. Dr Murphy is an exemplar of how easily they usually fit into the Australian healthcare scene, helped by a [mostly] common language and similar medical education systems.

Dr Boris Ivanov [134]

Boris Ivanov was born in 1974 in Vladivostok, USSR. He studied medicine at the Vladivostok State Medical University, graduating in 1997. Then he trained as an anaesthetist in teaching hospitals in the Vladivostok area. The first year was an introductory one, during which he rotated through the many different departments serviced by the anaesthetists: including paediatrics, obstetrics, neurosurgery as well as general surgery. After five years, in 2003, he was a fully qualified anaesthetist. He next worked as a staff anaesthetist for two years in Vladivostok Hospital No. 2, which was the biggest in the area and similar in size to Royal Melbourne Hospital. An opportunity then arose to work in a new service on Sakhalin Island, where clinical services were being rapidly developed because of the exploration for offshore oil. He was involved in

[133] A temporary working visa.
[134] Ivanov, interview.

the medical evacuations for people injured on ships and the oil rigs, then looking after them in the Intensive Care Unit when they reached the hospital.[135]

He came to Australia in February 2012 by a circuitous route. He classified his reasons for leaving Russia into personal, climatic, financial, and political. He had been recently divorced and, having no children, wanted a new beginning. Winter in Vladivostok was bitter, with temperatures often minus 30 degrees, and summer was short. Medical practice was not well rewarded financially, and he knew more could be earned overseas. His political concern was the direction Russia was going under Vladimir Putin as president, then prime minister (having installed "a puppet" as president), then becoming president again. "And at that time, because I liked history [...] and Russian history, I knew it was not going to end well."

Why did he choose Australia? This was a little complicated. He spoke first about pursuing a childish dream:

> When I was a kid, it was Soviet Union time, our country was closed ... no exposure to outside world, apart from the few [...] channels controlled by Soviet government, and [...] a small window to outside world was foreign movies. But this channel was also very heavily controlled, with foreign movies only from other socialistic countries [...] but, I don't know why, movies from three capitalistic countries were allowed to be shown in Russia—Italy, France and Australia.

He vividly remembers seeing the movie *Crocodile Dundee* and said: "I loved this movie. It was shown every day for four weeks ... every day I watched it [...] so I watched it about 30 times or so." He told his parents: "One day I'm going to go to Australia."

When he began to seriously consider emigrating, he looked at a few different countries. One was the UK, but the timing was not good because of negative British opinion about Russia in the wake of the polonium poisoning of a former Russian agent.[136] He worked for a time in South Africa, where colleagues suggested he consider Australia. Its climate was comparable, but the crime situation and salaries were much better.

He did some research about what would be needed to practise in Australia, then wrote to the AMC.[137] They replied in 2010, saying that the country had a shortage of doctors, and if he were happy to work in a rural or remote area for a time, his registration would be facilitated.

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[135] In Australian ICUs, the senior medical staff are mostly specialist anaesthetists.

[136] Tony Halpin, David Brown, and Daniel McGrory, "Ex-KGB Spy 'Was Poisoned in Hotel'," *The Times (UK)*, 8 December 2006.

[137] This was the year registration responsibility was transitioning to AHPRA, so it is possible his communication was actually with the Medical Board of Australia.

This seemed ideal, so he went back to Russia to settle some affairs and sell his things. But before making a final commitment he decided to come and talk to the AMC, look at the contract, and perhaps look at where he would work. He got a three-month tourist visa later that year, and flew to Brisbane. But when he arrived, and phoned the AMC, he was told that the scheme they mentioned was now available only to doctors from Commonwealth countries.

> I felt like I was ripped off [...] I had already made up my mind I wanted to come to Australia, and I will do it anyway. No matter how difficult it is.[138]

He wrote to the Australian and New Zealand College of Anaesthetists (ANZCA) but they did not reply. His tourist visa was close to expiring so he contacted the AMC again. They pointed out that they were not able to influence ANZCA and that his other options were to go through the Standard Pathway and sit the AMC exams, or to see if one of the Australian medical schools might take him into its final year and complete like a local graduate. He tried calling ANZCA again, and the person who took the call told him to leave his details and they would get back to him. But they did not.

He read about the AMC exams and realised that: "It's not as though I could sit it tomorrow. I need to have time to get ready." So, he decided he needed to have a legal status in Australia to pursue his options. One that was suggested to him was that he could marry an Australian. "I've just been divorced and that was not a good option", he said. Alternatively, he could get a student visa and take some course.

He looked for a course that would be reasonably long, to give him time to go through the various other hurdles—one that would be likely to lead to a job—and picked nursing. He used to be a nurse before he did medicine in Russia. He contacted a few universities and the first to reply was one in Victoria, suggesting he apply for their three-year Bachelor of Nursing Science. His visa had expired so we went back to Russia to collect the documents required. "And they accepted me ... for the next intake."

It was at the start of 2012 that he returned to start his nursing course, now on a three-year student visa. "I arrive, I start again harassing the college [...] and the AMC as well." He decided to try three different pathways simultaneously and see which one got him there first.

In his first year of nursing, he concentrated just on that, determined not to fail. The next year, though, he began to also study for the AMC exam, passing it at the first attempt at the beginning of 2014. Knowing that he was now eligible for limited medical registration, he started to look for a medical job. But the problem was that he was on a

[138] 'Ripped off' is Australian slang for cheated. The Gold Coast is an area on the south coast of Queensland.

student visa, which limited working to not more than 20 hours per week. He was advised to finish his studies as a nurse and then apply for a doctor's job.

Not wanting to take three years to finish his nursing degree, he searched for a shorter option and found that the University of Sunshine Coast (Queensland) offered a two-year degree. He also discovered that building had started on the Sunshine Coast University Hospital, and realised that would create opportunities to staff it. Furthermore, it would have a brand-new anaesthetics department.

He completed his degree at Sunshine Coast University in June of 2015, with a very high grade. The final part of his training was at nearby Nambour Hospital because the Sunshine Coast Hospital had not yet been completed. During this time, he got to know several of the doctors, and also staff in human resources. "They all knew my story ... and were very supportive." Because of his grades, they said he could choose any of their hospitals for his first postgraduate job as a registered nurse, but also mentioned he could apply for a junior hospital doctor job, which he did. He succeeded, and was appointed as a junior house officer (2nd year medical officer), with obligatory rotations in medicine, surgery and the emergency department. However, the fourth rotation was elective, and he applied for and was given that in anaesthetics. His consultants quickly realised he was a competent anaesthetist and let him function like a registrar (specialist trainee in anaesthesia), doing most of his work unsupervised. The anaesthetics department then contacted him to say one of their registrars had become pregnant and left and they wanted to offer him an anaesthetics position, but with the disadvantage that it was not a post accredited by ANZCA for Fellowship training. He was doing a preparation course for the AMC clinical exam when the message reached him, and "I started screaming and said, 'They offered me a position.'"

His hospital department asked what was the situation with ANZCA, and he said: "It's been a long story." At that stage, the department stepped in and wrote to the college in support of Boris. This time, finally, the college decided to consider him officially. The next step was a face-to-face interview at the college in Melbourne, at a cost of $5500.

At the beginning of 2017 he came for the interview by a panel of anaesthetists. They asked him about his experience, what machines he had used, and about his training. At the end of the interview, they told him that there were three possible outcomes they could reach, regarding his training and experience as an anaesthetist in Russia. It could be judged, *non-comparable*, *partially comparable* or *substantially comparable* to that of an Australian anaesthetist. They told him they had decided his training was *non comparable*. He asked why?

> They said, 'a number of reasons: first of all, your exams did not match the Australian Exam [...] you did not have a short answer part during your exam. And also, you did not work in Russia as a full-time anaesthetist until your relocation to Australia [they would have been referring to his most recent work in Russia as an Intensive Care doctor on Sakhalin Island].' They said, 'This is a mandatory requirement. It must be as full-time anaesthetist, even half-time is not enough'.

He was advised to enter an anaesthetics training program in Australia, but they gave him one year's credit for the time he had already worked as a non-accredited registrar in Queensland. Thus, he now needed to apply for the ANZCA training program, and the college pointed out that he could not do that until he was an Australian permanent resident or a citizen.

Keen to help, his hospital told him he could start as an 'independent' trainee. Not many colleges allow this, but ANZCA does. He became a permanent resident in 2018 and now has a position organised by the college. When interviewed, he was on a twelve-month rotational program in Victoria. He was in year three of ANZCA training and classified as an advanced trainee. He was required to pass the primary exam, which he did successfully the previous month. There will be a final exam at the end of the five-years. He had two years to go to complete his Fellowship, and was applying for a rotation in Queensland the next year.

Boris Ivanov's journey to being able to practise his profession of anaesthetics in Australia has been a long one. If the final two years go according to plan, he will be forty-seven years old, have graduated in nursing twice in two countries, and spent about ten years in formal anaesthetics training in Russia and Australia. Based on the account summarised here from his interview, it is hard to see how a panel of Australasian anaesthetists could judge his Russian training to be *not at all* comparable to that of their own trainees. However, they may have been influenced by the issue on which the Medical Board of Australia now puts much weight—recency of practice. Even that judgment by the ANZCA panel might seem challengeable because, when they interviewed him, he had worked in Queensland in an anaesthetics department for two years. The strong support he enjoyed from his colleagues and mentors in Queensland has probably played a significant part in getting him so close to his final goal. He has a keen sense of humour and a very engaging personality, and I suspect these attributes helped rally people to his cause.

Dr Ayomide Okonkwo [139]

Dr Okonkwo was born in Lagos, Nigeria in 1988, but moved with her family to Russia where she had some of her secondary education. They returned to Lagos for the final

[139] Okonkwo, interview.

years of high school, then she had started on a mathematics and statistics degree (she loved mathematics). However, at the urging of her medical father, she gained entry to the top medical school in Nigeria at the University of Lagos, completing the degree in 2017 and the intern year in November 2018.

She would have been able to get a good job in Nigeria. Her father was an influential doctor and owned his own hospital. However, she has several relatives in the USA, and was considering going there to sit the US Medical Licensing exam (USMLE). But the event that changed those embryonic plans was meeting an Australian/Nigerian engineer at a wedding of their mutual friends, falling in love and becoming engaged to him. They married while she was completing her intern year, and she intended to join him in Melbourne soon afterwards

Her husband had been working as a civil engineer in Sydney for several years after completing a Master of Engineering there, and had been a permanent Australian resident for about three years. But with their impending marriage, his firm agreed to relocate him to Melbourne. Ayomide and he thought it would be a better place for them to bring up children, house prices were a little more affordable than in Sydney, and there was a construction boom that would benefit his work.

She applied twice for a 3-month visitor's visa, intending to come with him to Australia as soon as they were married. The first visa application was rejected; she felt that was warranted because she had applied in haste and it was short on detail. She applied again, but had not provided her marriage certificate. This time it was rejected on the grounds that as a single Nigerian woman, they were unconvinced she had 'enough incentive to return'.

Next, she applied for a partner's visa, and this time decided to use an immigration agent. It was very expensive: $4000 for the agent's fee and $7160 for the visa. At the time of interview, 10 months from when she applied, she had not yet been given a date when the visa would be likely to be approved. She was able to see on the immigration web site that the likely processing times fluctuated from month to month.

So, while waiting for a partner's visa, and needing to make progress towards being able to practise medicine in Australia, she managed to come on a visitor's visa in order to prepare for the AMC written exam. When she was interviewed, in June 2019, she had just finished a course at ARIMGSAS and was booked to sit the AMC MCQ exam in September—unfortunately the earliest date the AMC had available. That was just after her 3-month visa would expire, so she was going to need to return to Nigeria and apply to come back on another visitor's visa. She hoped the next one might be approved for six months, to let her stay to prepare for the AMC clinical exam (assuming she passed

the MCQ). Showing some frustration, she exclaimed: "Immigration, see what you are doing to me!"

Postscript: When contacted in September 2021, she reported that she had been "working as a supervisor and now manager in a care-giving facility while I was preparing for and writing my AMC exams." She passed the AMC MCQ exam in February that year, and was eligible for limited registration by AHPRA provided she could get an offer of an HMO job from a hospital. She had made multiple applications but not been successful. "I am currently living in Melbourne but [...] I am open to moving anywhere as well."

Her oral history illustrates a problem that many IMGs had to deal with: delays and uncertainties associated with Australian visa applications and conditions. A characteristic of the nation state is that it controls who comes and stays within its borders. Administering these processes expeditiously and fairly is not necessarily easy, but Dr Okonkwo's case is an example where more flexibility would seem to have been warranted. Her difficulty getting an offer of an HMO position is another theme that has been mentioned before and will be the subject of further discussion in the Conclusion chapter to the thesis.

Dr Thomas Schulz [140]

Dr Schulz's story is deidentified more than most of these oral histories, because of concerns he has about ongoing bureaucratic difficulties with the registration process. Born in a Western European country with a high standard of healthcare, he graduated in medicine from one of its premier medical schools in the 1990s, then worked for a decade as a GP, qualifying as a Fellow of the equivalent of the RACGP. One problem was a shortage of funding, resulting in insufficient nursing staff, so he began to be dissatisfied with the care his team could give. He had considered specialising in surgery when he was in medical school and his wife encouraged him to see if he could change direction. He was now in his early 40s. With little expectation of success, he applied for and was offered a place in the training program in the premier hospital in the country. By then they had three children, and this was a considerable change to their lives. As soon as he qualified, he was appointed consultant surgeon in a major hospital and practised for three and a half years.

Why did he leave? They had visited Australia on holidays, and his wife had gathered a lot of information about possible work. "We had always been playing with the idea of moving abroad, preferably to an English-speaking country." His wife had

[140] Schulz, interview.

spent four years in England, so I asked did they consider the UK? He said, "I wasn't too keen on working in the NHS." He knew some who did, and they were always complaining. Weather was another impediment. "But [in light of his subsequent difficulties in Australia] maybe we should have done that … until Brexit."

They contacted a recruitment agency, and in about 2013, he was at a conference in Australia when he got a call from a recruitment agent to sound him out about working at a hospital in a rural city—we will call it Jonestown[141]—more than 500 km from the state capital. They needed a surgeon quickly. There had been one at the hospital for about 30 years; but he had announced his retirement, and attempts to find someone within Australia had been unsuccessful.

He was flown to an interview, offered the job, and they decided to accept. One problem was that they did not get permanent resident status immediately, which meant they had to pay about $100,000 annually for more than two years for their three daughters' education.

AHPRA gave him limited specialist registration since the hospital was in an 'area of need'. The RACS evaluated his training and experience and deemed it 'partially comparable'[142] to that of a local surgeon, hence he was required to pass the FRACS examinations within four years. He commented: "I wasn't fully aware of how challenging the Fellowship exam would be." He had to start under the supervision of another Fellow in his subdiscipline, who was 400 km away in a larger city. The previous surgeon had worked mainly from his private rooms, and Dr Schulz had to set up and buy equipment for a service for the hospital. "So, I had to start from scratch." The demand was huge—there was enough work in the surrounding areas for three in the specialty, and he was the only one.

As a result, he spent most of the first two years dealing with the patient workload, and gave little thought to the RACS exam. He was supposed to be getting help with that, but his supervisors would visit briefly about each three months, ask a few questions, and just sign off on what he was doing. His reports "were really, really good." However, he got no formal training for the exam. It was suggested that he could join a study group of all the Sydney registrars (senior trainees) working and preparing for the exam. That was challenging: for example, they would agree to meet at 4:30 on a Monday afternoon which meant that he had to cancel patients for a couple of days.

[141] Pseudonym to avoid embarrassment for Dr Schulz if his travails were recognised by former townspeople.

[142] See chapter 4 for processes and judgments used by specialist colleges at that time.

Then, to make it worse, the study group would not meet after all, and they would not have told him it was cancelled.

At one stage he thought he would just study intensively and sit the FRACS exam. When he did, it was very different from what he expected, and he failed. Afterwards he had a phone call from a surgeon who was responsible for the training program for Australia. He said: "Well, you didn't do too well, what happened?" Dr Schulz said: "I was completely unprepared for how the exam works. I've had no preparation, I had no options to prepare, I have no resources about the exam. I can study all the books, I can learn the theory, but I can't learn about the exam." He said: "You do need to *train* for the exam. So how about you come to Sydney once a month for a couple of days and we'll help." Thomas attempted that for more than a year. A challenge was that his contract with the hospital required him to stay in Jonestown for 10 days after each operation (in case of delayed haemorrhage), and he was the only one there. Often, he would arrive in Sydney, having emailed first, and the surgeon would not be there. At the most he got about 3 or 4 sessions of an hour each over more than a year. He was never given the chance to be an observer at the exam and watch its format.

Next, he contacted the chair of surgery at another hospital, would drive there every Sunday, attend the exam-preparation tutorials on Monday evening, then drive back to his hospital through the night or very early morning. He did that for about eight months. He saw that as the last resort. His exam scores improved dramatically, but not enough to pass. The College was not at all helpful, and would not let him sit again. He had not managed to pass within the given time, and that was it. He tried to appeal but was told there were no grounds for appeal and no more options.

In 2019, still in Jonestown, AHPRA told him that without the backing of the College "We can't allow you to work." He stayed for a few months to try to arrange ongoing care for all his patients. Early that year, he took the AMC MCQ exam and passed it at the first attempt. AHPRA told him that, having passed his MCQ, he should be able to work in a general position under supervision while he prepared for the AMC Clinical. The Jonestown Director of Medical Services said they would help, but did not have a position.

"So, we decided to leave, and moved to Secondtown [pseudonym]." This was a picturesque rural town in a valley in the Australian Alps, about 300 km from the state capital. They came just before the COVID-19 pandemic hit, "So it's a bit lonely, but it's beautiful." He got in touch with a health centre in the area and they were very happy to help him train towards Fellowship of the RACGP—that, after all, was his original

specialty in his home country. Later that year, he studied for the AMC Clinical Exam and passed it in March 2020.

As soon as he got his result, he filed his application for general registration to AHPRA. He already had a job offer from the clinic close to Secondtown. He was aware that AHPRA undertook to process applications within a 90-day window, and the initial deadline was 7 July.

> A couple of days before that, I got an email from the regulatory officer [which he paraphrased as] saying … 'We can't comply with the deadline because I've been on personal leave so not much has happened … and we ask you to agree to extend that to the 31st of August … and if you don't agree, well, you won't get any money back and your application is void.'

It was just three days before that revised deadline that he recorded his oral history with me. He was surprisingly philosophical, but went on to say:

> These things do profoundly affect your health and well being … I still love my job … these are the things I love to do … and I'm happy that I'm still able to retain that … They really need a doctor here. I am here, and I can't do a thing.

Postscript: I contacted him again in January 2021 to see how he was progressing. This was his reply:

> My situation is slowly turning for the better, I hope. As you are aware I have been granted conditional general registration. To get unconditional registration the Board requires me to complete ED [Emergency Department] and Medicine [Internal Medicine] rotations. This may sound simple but turns out not to be straightforward as hospitals' positions for trainees/junior doctors are allocated well in advance. There simply is no budget to create "extra" positions even where there is a shortage of staff. Hopefully, when AHPRA approves the position, I will be able to do the rotations, without renumeration, at a regional hospital in the area. The colleagues at the hospital are very friendly, and helpful, and at the same time the hospital admits a "free doctor" for 5 months is a true gift to them.
>
> It is important to register how ridiculously complicated it is for IMG's to find their way into the Australian system, how the system seems to maintain and even reinforce a closed shop model with definite discriminatory aspects. It's not (just) about safeguarding the Australian public against bad apples in the medical field. There is a huge underlying conservative force trying to defend the rights and position of Australian trained doctors against a perceived threat of scary aliens out there to steal their wealth and power. Even successful court cases proving the system is unfair seem not to have any power to change this.[143]

When we last communicated, in September 2021, he had completed the required rotation under supervision in Emergency Medicine and Internal Medicine and was on the verge of finally having unconditional medical registration in Australia. But he added:

[143] Email to author from Thomas Schulz, 12 February 2021.

> It might be of interest for you [...] that several organisations in the area have approached me in the last year to see whether I would be available to help with their COVID vaccination programs. Obviously, I would be happy to do this, and I would think with 30 years medical practice one might assume it should not be too hard to get me up to speed, do the required training modules and be quite safe giving out vaccinations. However, AHPRA refused to approve me for giving out vaccinations, even under supervision, as it was deemed my registration did not allow for this ...[144]

This oral history, along with some others in this section, illustrates a problem with the way some specialist colleges have judged the capabilities of overseas-trained specialists. Particularly for those older specialists who have had substantial experience in their home country, requiring them to take examinations which have questionable relevance to the practical performance of the specialty may be counterproductive. The issue is discussed further in the next chapter. This is also not the first instance of what can be called bureaucratic bullying by AHPRA, when an IMG was told they would have to start again and lose their money if they did not agree to an extension of processing time beyond what they had been promised.

Dr X [145]

The very fact that Dr X was so frightened about possible repercussions from AHPRA or the specialty college, if either body learned what is written here, raises concerns about the culture of both organisations. This was touched on earlier in the chapter, and more will be said about it later. I have undertaken, therefore, to try to obscure their identity as much as possible and at their request have omitted the country of the overseas medical degree, their gender, and the specialty in which they were trained and wished to work in Australia.[146] This IMG is still battling with the AHPRA bureaucracy to have their medical licence continued, and also fears retribution from members of the college that denied their credentials.

Dr X was born overseas in 1963, graduated in medicine in 1992, then trained in the specialty of propriology [pseudonym], completing that in 2002.[147] The IMG then practised for almost ten years in their home city as a propriologist in a major university teaching hospital, which has a stellar international reputation. Some evidence for the standing of the deidentified hospital in which they trained and practised is its research

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[144] Ibid., 20 September 2021. The government training modules are online and take about 5 hours. The author completed it quickly and easily before he provided vaccination consults during the pandemic.

[145] X, interview.

[146] Dr X approved what is written in this section, after jointly editing with me the first draft from the interview transcript.

[147] Pseudonym for the specialty taken from the Latin, *proprium* = *specialty*. *They/them/their* used as the gender-neutral 3rd person singular pronoun, but *he/she* or *his/her* used instead if needed to unambiguously identify the subject or object of a clause or if it seemed less clumsy.

output compared to other leading European and Australian hospitals: between 2018 and 2020 its output was 1.7 times that of London's Hammersmith Hospital, and 1.3 times Sydney's Royal Prince Alfred Hospital.[148]

In 2012 they moved to live in Australia, urged by their Australian partner. Verification by AMC of their qualifications and training took months, but AHPRA eventually gave provisional registration in 2013. The IMG had applied to be registered via the 'specialist pathway', which required them to be assessed by the Royal Australasian College of Propriology. Dr X's training and experience was judged to be only 'partially comparable', despite having been a consultant in a major hospital in a country with a similar standard of health care, and being highly fluent in English as their second language. Nevertheless, they were permitted to take a position in an 'area of need'—a medium sized Australian city that had a shortage in propriology. The condition was that the IMG would be supervised for two years by a Fellow of the college, but must then pass the full set of college examinations.

Dr X studied hard for the examinations. There was a lot required, especially in the basic sciences such as physiology and biochemistry, which was questionably relevant to their specialised area, and Dr X found it hard: "They focus a lot on theoretical small details." Dr X logged on to several online tutorials for other trainees in propriology and would hear comments such as: "In an exam setting, this is the answer you should give, but in real life we would do this." With all their experience, Dr X felt that the suggested courses of action often were not appropriate anymore. "You have to learn and practise how to perform in an exam setting rather than being a good doctor … on the floor." Dr X sat the college exam in 2017 and failed, noting that in one scenario, the examiners repeatedly pressed them to say they would order a particular X-Ray, which was no longer considered useful in that condition. The assessment of their performance in the exam was "quite humiliating." Dr X had regularly dealt with such cases, including in Australia, and the exam feedback noted they were "not safe to manage [that emergency]." He/she just felt, "they don't want to even try and pass me."

The college exam failure did not match the nominated college supervisor's or Dr X's hospital colleagues' assessment of Dr X's skills: they had never been unhappy with his/her work or practical skills. Also suggestive of possible bias against IMGs, Dr X was told by colleagues that no overseas-trained specialist had been passed in the subspecialty's examinations in the previous four to five years.

[148] Nature Index, "Institution Research Output Table," accessed 8 March 2022, https://www.natureindex.com/institution-outputs/generate/all/global/healthcare.

Dr X's option to ever be registered in their specialty in Australia had now virtually ended. As a consequence, AHPRA has required them to pass the AMC examinations in order to be registered instead as a generalist. When interviewed, Dr X had passed the AMC written exam, which allowed them to be employed in a hospital, and was working in another regional city. His/her colleagues allow Dr X to work as an HMO in his/her specialty under their general supervision, and have been very supportive. One would imagine they are delighted to make use of Dr X's skills, at a much lower salary than if they were on the senior consultant staff. During the 2020 COVID-19 pandemic, AHPRA had been fast-tracking IMGs to be able to work, so all eight of Dr X's colleagues wrote to the state and federal Ministers of Health and the President of AHPRA's Medical Board, pleading for Dr X to be fully registered. They received no reply from AHPRA.

Two examples of AHPRA's performance are worth mentioning, based on Dr X's comments.

> Communication from AHPRA is appalling. They can take nine months to reply to you, then they say: 'You need a new workplace assessment because the old one submitted is too old now', and you have to submit it within three days. Well, you get nine months to not do what you [AHPRA] are supposed to do, then you give me three days, because something expired that I actually submitted on time!

The other example concerned a communication from an AHPRA staff member to Dr X that clearly should have been directed to the supervisor, not the IMG. Dr X's position in the second regional city required their supervisor to write regular reports for AHPRA. In 2019, an AHPRA officer contacted Dr X to demand that their supervisor change his report. The supervisor had written that: "[Gender pronoun] is an absolutely wonderful specialist and we are so happy to have [gender pronoun] on our team." The AHPRA officer told him/her: "We can't accept that. He's not allowed to call you a specialist."

Dr X wanted to go on the record about how important they regarded the proper assessment of an IMG's competence, but questioned the way this has been done in their case:

> I want to be *very* clear that I totally embrace that when you come to a new country, as a medical practitioner, you have to be thoroughly assessed and be sure that you can practise in a safe way … [but] there's not been a single complaint [from my supervisors and colleagues] and only very good reviews … and that's not [been] enough.

Dr X was told once that "it didn't really matter if they didn't pass the [college] exam, because you won't have to work anyway" (their partner's income was sufficient for them both to live off). His/her response was:

> I'm a propriologist [pseudonym]. It's part of my identity. It's who I am. And I can come to this country and contribute.

The irony of Dr X's situation is that they return to their hospital in their home country about twice a year, where their position is kept open. Their colleagues welcome him/her back, and he/she works for about a month to maintain skills. "They just can't believe that I stay [in Australia]." This is one of the oral histories that has raised concerns about the behavior of some of AHPRA's staff—on the evidence given by Dr X, lacking the sensitivity and efficiency expected of the national regulator. Dr X's comments about the examination held by the specialty college raise further questions, to be revisited in the Conclusion chapter of the thesis.

Dr Bridget Smith [149]

Dr Smith was born in 1988 and graduated from Bristol University in 2015. After completing two years in House Officer jobs, she applied for and, in November 2017, was offered a job at the Royal Darwin Hospital. The process of getting AHPRA registration was time-consuming but not difficult. Royal Darwin Hospital was "amazing", helping her step by step through it, so she could start work in February 2018. She spent the first year doing emergency medicine in Darwin, and loved the interaction with Aboriginal patients. The initial appointment was as an HMO, but after six months they said she was doing the job like a registrar and promoted her for the rest of the year.[150]

In 2019, she worked for a year at Alice Springs Hospital, because she wanted more opportunity to work in Aboriginal medicine. When interviewed in August 2020, she had been getting further experience in obstetrics and had applied to join the training program of the Australian College of Rural and Remote Medicine—one of the two colleges whose Fellows are registerable as GP specialists. She had almost completed an Advanced Diploma in Obstetrics through the RANZCOG. To join that College's Fellowship program was not an option because it is only available to Australian citizens or permanent residents, and she was still on a four-year working holiday visa.

Did she think she would stay? "Every year I think I'll go back." But having made the decision to embark on specialist training she will see it through, and had applied for permanent residency.

It was only at the end of the interview, when asked if she had any other comments, that she described a traumatic episode soon after she arrived in Darwin in 2018 that might have ended her career. It resulted from AHPRA's then requirement for mandatory reporting of medical practitioners whose health was impaired. Bridget confided that since the time of her menarche, she has suffered from genetic,

[149] Smith, interview.
[150] See Chapter 2 for roles of HMOs and registrars in hospitals.

hormonally-based depression. This, in her own very minimally edited words, is how it unfolded:

> The regulation around mental health in doctors here is very different to in the UK. I have depression and I've had depression since I was thirteen ... So, it predates my medical school, ... and it's never impacted on my studies ... and never impacted on my F1 or F2 [postgraduate years 1 and 2].
>
> So, when I moved to Darwin, recognising I'd moved to a new country, I made the appointment independently to see a new therapist ... because I've always seen a Counsellor on and off ... if I'm going through a new period of change ... a new country ... and having recently ended a long-term relationship. [Thus] I built up a new therapeutic relationship with someone in Darwin. And I guess what I wasn't aware of was this structure Australia has is very different from England ... that, if they think you have a problem, they can report you to AHPRA and that's what happened to me. [...] I disclosed to my therapist that I had had a few unusual thoughts about suicide [...] I was feeling a bit lost in the country when I first moved here. And I had briefly thought about it ... but these are the things I had done to not take my own life: I had gone for a walk on the beach, I'd made sure I did yoga three times a week, I cut out junk food for a couple of weeks ... thought nothing more of it. And three days later, I had a phone call from her to say: 'I've reported you to AHPRA. There's nothing you can do about it. I have the right to do that.' [...]
>
> They went through the investigation of whether I was fit to work or not. [...] I wished I hadn't said it, but [...] not saying it I'm not being true to myself ... always wanted to be very open. I'm very aware that I have a mental health problem ... and I've always sought help but now I don't want to speak to anyone ever again ... because this is *awful*! Anyway, so I went through the whole process which quite honestly was harrowing [...] And suddenly your registration could be taken away. This will be with you forever [...] The only reason I got through that was the support of the emergency department in Darwin, who were amazing.
>
> So, I had to have a psychiatric assessment [...] with a psychiatrist that the board had appointed. And, they said I was absolutely fine—that I had elements of depression, but I was stable. I'd managed medical school, I'd managed two years [of practice], never had a complaint against me. Clearly, I just had these ruminating thoughts and I managed it appropriately.
>
> I then had to prepare a statement myself, explaining my illness, what treatment I had [...] and they gave me the option to either submit a paper copy or to go into the offices in Darwin at an appointed time and present it in a meeting. And with advice from colleagues that the best thing to do was to present it myself, because you've got the opportunity for people to see you ... see that you're not totally crazy [laughs]. So [...] in front of, I think, eight or nine official people plus a layperson, plus an out of Territory representative who was on a phone, I read a seven page statement that I had prepared, explaining that, yes I had depression, that I'd been on medication since I was 13, that my mother, my grandmother, my auntie and my two female cousins had depression, they believe it's linked to hormonal imbalance since I started my periods—both my mother and my grandmother went to hospital when they started the menopause ... that I'm well medicated ... all of these things. I then had to go away. They allowed me to work during this period, but [...] they deliberated over two weeks if they were going to take my licence away or not – and, and it was *horrible, absolutely horrible.*

AHPRA's Northern Territory Medical Board's judgment, when it came, was that she would have no notation on her registration and could continue to practise. She felt very grateful to Darwin Hospital who had given her a tremendous report, writing: "She is one of the best doctors we have had, we promoted her within a few months, we had absolutely no idea she had any mental health problem." Overall, she had gone through nine weeks of not knowing whether she would lose her licence. She had previously let her UK licence lapse, and had the further concern that if she went back, having been deregistered in Australia, she might not get a licence back in the UK.

Bridget remarked on another negative consequence of the rigid use of AHPRA's then mandatory reporting rules—a consequence that damages the future therapeutic relationship between a doctor with depression and the professional who helps them manage it. She said: "The problem is that it drives you underground." She now has a new therapist, who says to her: "You are so guarded, [real name]." Bridget continued: "That's not helpful for a patient ... for a doctor ... that you feel you can't express yourself."

As a final comment, the way Dr Smith comported herself during the video interview conveyed the impression of a very vibrant and impressive young woman, with not the slightest hint of a depressive illness at that time.

Bridget was the only one of the 87 IMGs interviewed who ran into this problem so more will not be said about it here—except to note that, in 2020, AHPRA raised the threshold for mandatory reporting of a health professional so that the new test is whether the professional's illness constitutes a 'substantial risk of harm to the public.' In announcing the change, which required an amendment to the Health Practitioner Regulation National Law, AHPRA's CEO wrote: 'We ... want to ensure that practitioners with health issues feel safe to seek treatment without fear of an unnecessary mandatory notification being made about them.'[151] Professor Con Michael, President of the Western Australian Medical Board (pre and post AHPRA), said that was precisely why his state never agreed to let their Health Practitioner Act mirror that portion of the other states' 2009 Act.[152]

Dr Xiu-ying Wang [153]

Dr Wang was born in 1982 in southern China. He went to medical school at the prestigious Sun Yat-Sen Academy in Guandong Province, streamed as an elite student to undertake his studies in English in a combined MBBS/MD course, which he

[151] AHPRA and National Boards, "Changes to Mandatory Notifications Requirements in Effect 1 March," accessed 9 March 2022, https://www.ahpra.gov.au/News/2020-03-02-Media-release-Mandatory-notifications.aspx.

[152] Con Michael, personal communication, 16 December 2020, and interview in Chapter 11.

[153] Wang, interview.

completed in 2008. He had already been working during the two-year MD component, so by the time he came to Australia in 2015 he had been practising for nine years, having trained in internal medicine, then endocrinology. After internship there were three years, similar to 'basic physician training' for the FRACP in Australia, with written and clinical exams at the end of that period.[154] He then completed three years of advanced training in endocrinology, passed another written and clinical exam, obtaining the Chinese Fellowship in 2012. Thus, the structure and duration of his training as an endocrinologist closely mimicked what Australian endocrinologists currently undergo. One difference is that he had to pass exit exams at the end of the six years, which is not required for award of the FRACP. This information provides context to the decisions made later by the RACP after he came to Australia.

He then began to think about going overseas. Deciding he might later want to practise in Australia, he prepared for the AMC MCQ exam. But first he had to pass the Occupational English Test, despite his MBBS/MD all being taught in English. He studied for the MCQ for about 10 months, while working full time, and passed it at the first attempt at the AMC exam centre in Guangzhou.

In 2015 he came to Australia to do some Clinical Research. His wife was in the paediatric training program in China but had decided to quit to look after their first child. They came together to the job he had been given at a Melbourne hospital, on a temporary skilled (457) visa the hospital had arranged. His wife did some volunteering during that year, but after 12 months, she was offered a research job in the same unit; she took over the 457 visa and he became the 'dependent'. By now he had decided he would like to go through the process of getting medical registration in Australia, and as a dependent on her visa he was free to work in any area.

Having previously passed the MCQ examination, he was eligible for provisional registration by the Australian Medical Board. That allowed him to get an HMO job in 2017 at another Melbourne hospital. He sat the AMC clinical exam in 2018, missed narrowly at the first attempt, but successfully passed the supplementary ('retest') exam shortly afterwards. If he had wanted at that time to practise as a GP he would have been required to enter the GP training program and do the full three years. But he was fully trained as an Internist and Endocrinologist in China and wanted to practise endocrinology here.

[154] 'Basic physician training' is the first three years of the six-year FRACP program, during which candidates rotate through most of the internal medicine specialties. In FRACP 'advanced training', the last three years usually focus on a particular subspecialty (e.g., endocrinology in Dr Wang's case).

In 2018, he approached the College of Physicians to recognise his specialty credentials. I asked whether this was straightforward or difficult:

> I would say it was not simple. They were very careful in assessing my case. They tried different ways ... they assessed me comprehensively to make sure I'm qualified to work as a registrar, to begin with, in Australia. I think they are defending the Australian population health. I respect that. So, I've presented to the college all my qualification training things in detail.

The detail the college required about his training was considerable. It included a logbook, which fortunately had been filed in his hospital in China. It was quite detailed: for example, for his haematology rotation he had had to write down how many leukaemia patients he had seen. During the eventual interview, this level of detail was asked about again. The interview panel included an endocrinologist from Queensland, by video conference, who asked questions about his expertise in endocrinology. Xiu-ying commented: "If I didn't practise endocrinology properly, I wouldn't have been able to answer those questions." The others on the panel were one person from the college IMG committee, who was there in person, and a third person who was just an observer.

The college judged his training as a specialist physician and endocrinologist to be 'partially comparable' and advised that he should do one year of supervised practice/training as an endocrinologist, but did not require him to sit the college exams.[155] Thus, his job at the Melbourne teaching hospital when interviewed was as an RACP accredited Endocrinology Registrar. The following year, he would be awarded the FRACP.

I asked how he had coped emotionally and financially. He said it was not easy to begin with. Because they had planned to come to Australia just for a short period, they had enough saved up for that; but when they decided to stay, and he was no longer working they did begin to feel the pressure. One of the main problems was uncertainty, but when he got a job everything changed.

He chose the metropolitan hospital where he is working because it is in an area of the city with many Chinese immigrants, some (particularly older ones) with limited skills in English. "I just feel very comfortable to work here with my colleagues. [...] Once I start to talk with them [patients] in Mandarin or Cantonese, I can tell they feel relieved [...] they relax and start to talk a lot."

This oral history demonstrates what appears to be appropriate and equitable decision-making by the RACP. The college recognised that Dr Wang was in many ways

[155] Though he said 'partially comparable', the requirements the College prescribed suggest they had decided he was 'substantially comparable' (see Chapter 11).

an 'elite' graduate, whose training was very comparable to that of an Australian endocrinologist. The composition of the panel who interviewed him—comprised of someone with overall responsibility for the College's processing of IMGs, an expert in the same subspeciality, plus a lay person to observe fairness of the interview—seems commendable. The decision to not require him to sit further exams, but just spend one year under supervision in his specialty in a major hospital, also seems appropriate. More will be written about the history of specialist assessment by this college in Chapter 11. His story is also an exemplar of the benefit IMGs with particular language skills bring to the care of immigrant subpopulations in Australia.

Dr Benita Dalal [156]

Ms Dalal[157] was born in India in 1974 and graduated from the University of Pune in 1997. She trained in India in obstetrics and gynaecology (O & G), graduating with the gold medal from her university. After that she worked as a senior registrar/lecturer, then had a baby, by which time her husband had moved to the UK. She followed him, and got a job in what was called a senior house officer role—the transition point in the UK NHS between an HMO and a specialist registrar. She felt it was reasonable that she should take a more junior job than she had been doing in India. "I was new to the system, so it made sense to start at that level so I could be guided through how things worked in the UK." After just six months she moved to a senior registrar role.

> I quickly realised in those first six months that in the UK I would be stuck in a non-consultant staff specialist type of role if I didn't apply to get on the [UK] training program [in O & G], and that I would have to do my training all over again.

The British college gave her credit for the 18 months she had already worked in UK, but she had to complete the rest of the full 7-year FRCOG training program, despite being qualified already as an obstetrician in India.

As soon as that was completed, her haematologist husband persuaded her to move to Australia. He wanted to do research and had found a job in Melbourne. And so she followed him, noting that in the Indian setting, "It's usually the female partner that follows the male spouse." They arrived in 2010 and she had a second baby, so did not apply for registration till the next year. AHPRA immediately registered her as a specialist in O & G. However, the RANZCOG, despite her FRCOG and previous experience, decided after an interview that she was only 'partially comparable', would have to sit the college exams, and do two years as a senior trainee. She thought: "I am

[156] Dalal, interview.

[157] As a surgeon, she is usually addressed (in most states) as Ms.

not doing this a third time", challenged the college's decision (it has an appeal process), and won.

Subsequently, her career in Australia has been straight forward. She is head of Obstetrics and Gynaecology at a major metropolitan maternity hospital and also has a leadership role in her college. Dr Dalal had many very constructive comments about how Australia could better judge the quality of, especially procedural, specialists. They were mentioned already under an earlier section of this chapter and will be revisited in the thesis Conclusion.

The Findings in Relation to Other Scholarship

Several other authors have analysed data from interviews with Australian IMGs during the last two decades (Table 10.5). All but one of these reports concerned rural IMGs employed in a particular state, who already had full or provisional registration. It is instructive to compare their findings with those from the 16 IMGs in the present study who were working in a rural setting when interviewed, but also with the reflections of the whole group of IMGs interviewed for this chapter.

Table 10.5: Other studies reporting interviews with Australian IMGs

Author(s)	Year published	No. of participants	Setting
Durey[158]	2005	14	Rural Western Australia
Han & Humphreys[159]	2005	57	Rural Victoria
Hawthorne et al[160]	2004	37	Rural Victoria
Laurence[161]	2007	10	Rural South Australia
McGrath[162]	2009	9	Outer metropolitan Brisbane*
Terry[163]	2014	22	Rural and remote Tasmania

*The participants were undertaking an observer program in preparation for the AMC exams.

[158] Angela Durey, "The Changing Face of Rural General Practice: An Ethnographic Study of General Practitioners and Their Spouses" (PhD, Edith Cowan University, 2005).

[159] Gil Soo Han and John S Humphreys, "Overseas-Trained Doctors in Australia: Community Integration and Their Intention to Stay in a Rural Community," *Australian Journal of Rural Health* 13, no. 4 (2005).

[160] Lesleyanne Hawthorne, Bob Birrell, and Doris Young, *The Retention of Overseas Trained Doctors in General Practice in Regional Victoria* (Melbourne: Rural Workforce Agency, Victoria, 2004).

[161] Caroline Laurence, "Overseas Trained Doctors in Rural and Remote Australia: Do They Practise Differently from Australian-Trained Doctors?" (PhD, University of Adelaide, 2007).

[162] Pam McGrath, "Integration into the Australian Health Care System: Insights from International Medical Graduates," *Australian Family Physician* 38, no. 10 (2009).

[163] Daniel Robert Terry, "Health and Wellbeing of International Medical Graduates: Acculturation into the Tasmanian Rural and Remote Context" (PhD, University of Tasmania, 2014), https://eprints.utas.edu.au/21728/.

Reasons for migrating and choosing Australia

Not surprisingly, several of the factors that influenced the IMGs in the present study to move to Australia were also identified by other researchers. One fifth of the rural IMGs interviewed by Hawthorne et al. in 2004, and responding to a survey by Kidd and Braun a decade earlier, cited concerns about their safety as a push factor.[164] Some of the South Africans in Angela Durey's study also mentioned their concern about catching HIV/AIDS.[165] Klein et al reported that more than half their IMG interviewees (most from Africa) in rural Canada migrated to escape violence.[166] In the broader migration literature, Pratikshya Bohra and Douglas Massey found, in their research on civil conflict in Nepal, that violence seemed to need to reach a threshold value before the decision to migrate was triggered.[167] Andrew Morrison observed a similar non-linear effect in those who migrated internally in Guatemala.[168]

Just as hope for a better life for their children motivated some of those reported here, 40 percent of the Victorian rural IMGs interviewed by Hawthorne et al. cited that as important, and one of Durey's IMGs told her that he had come from a place where there was no future for his children.[169]

Not mentioned in those earlier studies of Australian rural IMGs, but a motivation reported by several in the present study, was a desire to practise in a health system that was better resourced for patient care. Yasser Moullan noted, from a survey of medical immigrants to 17 OECD countries, that the 'number of foreign-trained doctors is much greater in countries where the welfare system is well-resourced for healthcare.'[170] While one might expect that would be a stronger motivation for those working in the most disadvantaged health systems, Onyebuchi et al.'s large study in 2008 found that countries with moderate physician income and level of health services were actually more likely to lose doctors than poorer ones.[171] The ethical implication of rich countries taking health workers from poorer ones led Scott et al. to lay out a variety of actions

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[164] Hawthorne et al., *The Retention*, 28; Michael R Kidd and Felicity Braun, *Problems Encountered by Overseas-Trained Doctors Migrating to Australia* (Canberra: AGPS, 1992), 19.

[165] Durey, "The Changing Face," 170.

[166] Douglas Klein et al., "Push, Pull, and Plant: The Personal Side of Physician Immigration to Alberta, Canada," *Family Medicine* 43, no. 3 (2009): 199.

[167] Pratikshya Bohra-Mishra and Douglas S Massey, "Individual Decisions to Migrate During Civil Conflict," *Demography* 48, no. 2 (2011): 401.

[168] Andrew R Morrison, "Violence or Economics: What Drives Internal Migration in Guatemala?," *Economic Development and Cultural Change* 41, no. 4 (1993): 826.

[169] Hawthorne et al., *The Retention*, 28; Durey, "The Changing Face," 171.

[170] Yasser Moullan, "What Fundamentals Drive the Immigration of Medical Doctors?," in *High-Skilled Migration: Drivers and Policies*, ed. Mathias Czaika (Oxford: Oxford University Press, 2018), 311.

[171] A Arah Onyebuchi, Uzor C Ogbu, and Chukwudi E Okeke, "Too Poor to Leave, Too Rich to Stay: Developmental and Global Health Correlates of Physician Migration to the United States, Canada, Australia and the United Kingdom," *Public Health* 98 (2008): 150.

that Australia should take to minimise recruitment from the global South.[172] Indeed, the WHO in 2010 proposed that countries adopt a code of conduct specifically to achieve this.[173] However, when Tam et al. surveyed four high income countries subsequently, they found negligible compliance with the voluntary code.[174] A contrary perspective was provided by Alex Sager, who argues that the benefits of the code can be challenged—on grounds of individuals' rights, but also of possible unintended consequences: 'If health care workers are forced to remain under authoritarian regimes with poor infrastructure, they may end up unemployed or working in other sectors and contributing to "brain waste."'[175] It is of interest that none of my subjects raised this ethical dilemma, but of course they had already made the decision to leave their parent country.

Another frequent motivator to come to Australia for the IMGs I interviewed was the existence in Australia of family, friends or other connections, including marriage to an Australian. Twenty-three percent of Hawthorne et al.'s rural subjects also cited this as important in their migration choice, as did a similar proportion of Terry's participants in rural Tasmania.[176] The importance of kinship networks in migration patterns has been known for a long time: two examples (of many) are the studies of the MacDonalds on late nineteenth century migration to USA from Italy, and Simone Wegge's study of German immigrants.[177] The recent work of Miriam Manchin and Sultan Orazbayev provides some quantitation of the importance of migratory networks. They used data from an international Gallup poll of half a million participants from more than 150 countries. In that large dataset, 1.5 percent of contributors were considering migrating to a second country, and regression analysis showed that 37 percent of the variance was accounted for by social networks as the driver. Broad networks (i.e., diaspora) and close networks (i.e., friends or relatives) were equally influential, and both were much more important than other drivers such as wealth or standard of living. Their subjects were from general not medical populations, and there

[172] Mark Scott et al., "'Brain Drain' or Ethical Recruitment? Solving Health Workforce Shortages with Professionals from Developing Countries," *Medical Journal of Australia* 180, no. 4 (2004): 175.

[173] World Health Organization, *WHO Global Code of Practice on the International Recruitment of Health Personnel* (Geneva: World Health Organization, 2010), 1.

[174] Vivian Tam, Jennifer S Edge, and Stephen J Hoffman, "Empirically Evaluating the WHO Global Code of Practice on the International Recruitment of Health Personnel's Impact on Four High-Income Countries Four Years after Adoption," *Globalization and Health* 12 (2016): 62.

[175] Alex Sager, "Reframing the Brain Drain," *Critical Review of International Social and Political Philosophy* 17, no. 5 (2014): 562.

[176] Hawthorne et al., *The Retention*, 28; Terry, "Health and Wellbeing," 191.

[177] John S MacDonald and Leatrice D MacDonald, "Chain Migration, Ethnic Neighborhood Formation and Social Networks," *The Milbank Memorial Fund Quarterly* 42, no. 1 (1964): 90; Wegge, "Chain Migration," 958-60.

are always potential biases influencing the decision to participate in a poll, but there are echoes in the findings in this chapter.

Experiences once in Australia

Unlike most of my criterion sample IMGs, the rural IMGs interviewed in the studies listed in Table 10.5 all had jobs. They reported quite a high level of satisfaction; one of Durey's participants spoke of their happiness at being accepted by the townspeople who said: 'Don't leave us.'[178] In their study of Polish immigrants, Maciej Duszczyk and Kamil Majuszczyk postulate that 'employment-related security is a vital factor affecting ... individual decision to migrate ...'[179] However, that was not the case for several of my participants, who were still struggling with visas and exams, and uncertainty about whether they would ever be able to practise in Australia. They had taken a risk by migrating. However, for those who had succeeded in clearing the hurdle of registration, security of employment was almost guaranteed. An unemployed doctor is a great rarity in Australia.

The rural IMGs who participated in the other studies in Table 10.5 reported some similar difficulties to those that emerged in the current study. A few of my participants mentioned experiencing racism. Jana Rao's description of some patients initially not wanting to be seen by him, and his insightful analysis of the reasons in his oral history above, is one example.[180] Similarly, some of Han and Humphreys' IMGs reported that patients were at times reluctant to see them because they were foreign; and Hawthorne et al. described the distress of some of their rural GPs who had to send their children to schools elsewhere because they suffered racially-motivated bullying.[181] Similar difficulties in being accepted by medical colleagues were reported to Corinna Klingler and Georg Markmann in their study of German IMGs.[182] Winnifred Louis et al. carried out an innovative study in Queensland in which students were deceived into believing they were giving advice about who should staff a proposed after-hours clinic. They were given closely matched curricula vitae with mythical Australian or Pakistani names and credentials. The result was that the Pakistani persona was judged less than 50 percent as suitable for employment as the Australian one by the panel.[183]

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[178] Durey, "The Changing Face," 172.

[179] Maciej Duszczyk and Kamil Majuszczyk, "Labour Market Security and Migration-Related Decisions: Theoretical Background," in *Why Do People Migrate? Labour Market Security and Migration Decisions*, ed. Maciej Duszczyk (Bingley, UK: Emerald Publishing, 2019), 26.

[180] Rao, interview.

[181] Han and Humphreys, "Overseas-Trained Doctors," 240; Hawthorne et al., *The Retention*, 38.

[182] Corinna Klingler and Georg Markmann, "Difficulties Experienced by Migrant Physicians Working in German Hospitals: A Qualitative Interview Study," *Human Resources for Health* 14 (2016): 63.

[183] Winnifred R Louis, Richard N Lalonde, and Victoria M Essex, "Bias against Foreign-Born or Foreign-Trained Doctors: Experimental Evidence," *Medical Education* 44, no. 12 (2010): 1243-5.

The focus of most of the qualitative studies listed in Table 10.5 was on how the rural GPs were functioning in their rural settings, and on factors that appeared to maximise their chances of staying. However, several did report difficulties and stresses linked to the AMC examinations that were similar to some of the stories told in the oral histories earlier in this chapter. The difficulties included trouble accessing training courses and finding time to study, and the expense of courses and the exams. One of Han and Humphries' subjects talked about being left to 'sink or swim.' While those doing the observership in Brisbane called for more observership positions and bridging courses.[184]

One of the disturbing aspects of several of the oral histories in the present study was participants expressing a fear that, if they were identifiable by someone from AHPRA or a college, they might be penalised. Hence it was interesting to note Daniel Terry's comment that a number of the rural IMGs he approached were reluctant to complete his questionnaire because they 'were concerned [it] may somehow impact their ability to gain full medical registration.'[185]

Anna Harris and Marilys Guillemin have recently published a poignant ethnographic study of immigrant doctors in outer metropolitan Melbourne, 'who linger on the margins of hospitals, without employment.' These are IMGs lucky enough, in one way, to be able to observe medical and hospital practice and be close to spaces which reflect their self-identity while they study for the AMC exams. Harris and Guillermin wrote: 'The medical underground inhabited these places [library, cafeteria, tutorial rooms] in order to study and spend time with other IMGs.'[186] Some of those who gave their histories for this thesis used similar strategies and experienced similar emotions.

Generalisability of conclusions from the oral histories

Finally, a comment should be made about the generalisability of the information derived from the oral histories in this chapter. The criterion sample was chosen from IMGs currently preparing for the AMC exams, or sometimes trying to be accredited by the RACGP, and the response rate was very high. Their number is such that they are probably moderately representative of IMGs traversing the 'standard pathway' who (at the time of interview) had not achieved registration by the Medical Board of Australia. The random sample selected from the Medical Directory of Australia spans a substantially longer period of history, back to 1969. However, the response rate to the

[184] Han and Humphreys, "Overseas-Trained Doctors," 238; McGrath, "Integration," 845-7.
[185] Terry, "Health and Wellbeing," 22.
[186] Anna Harris and Marilys Guillemin, "Notes on the Medical Underground: Migrant Doctors at the Margins," *Health Sociology Review* 24, no. 2 (2015): 163-70.

108 mailed invitations was only 28 percent. While this was higher than the 18 percent in Terry's Tasmanian study, and not very different from 34 percent achieved by Hawthorne et al., it does mean that selection biases are likely, and the sample is quite small. It is notable that just over half those in the random sample who did agree to an interview were consultant physicians (FRACPs). Since this is also the interviewer's specialty, those IMGs may have felt more motivated to devote their time for the research. Nevertheless, the quite wide range of prior and recent experiences of the entire group of IMGs, and the diversity of source countries, has allowed a picture to emerge that reflects the breadth and depth of IMGs' experiences when they choose Australia as their future home. Some of those individual experiences have been traumatic, and raise questions about past and present practices used by the colleges and medical boards to judge the suitability of IMGs for licensing.

Conclusion

As Jessica Hagen-Zanker wrote recently, 'Very broadly, the migration decision entails weighing the costs versus the benefits of migration.'[187] The oral histories described in this chapter indicate that those costs and benefits are financial, social and psychological, and also include the social and financial cost of lost opportunities at home if they had stayed.

I will reserve until the chapter 12 and the Conclusion chapter most of my discussion of the lessons that can be learned from the histories of these contemporary IMGs that might lead to improved processes in Australia. The IMGs' accounts present one side of a story—and a limitation is that it is inevitably subjective. Some of those interviewed were recalling quite distant history, where memory is less reliable and more subject to the recall of dramatic or traumatic events, or events whose memories have been more often rehearsed and reinforced.[188] Others who were recalling recent experiences, where their memory would be expected to have been more reliable, may have been at risk of varying their account according to what Lucy Kenny and Richard Bryant termed their 'level of avoidance' when recalling troubling events.[189]

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[187] Jessica Hagen-Zanker, "Why Do People Migrate? A Review of the Theoretical Literature," (Graduate School of Governance Working Paper No. WP002: Maastricht University, 2008), 20.

[188] Sven-Åke Christianson and Martin Safer, "Emotional Events and Emotions in Autobiographical Memories," in *Remembering Our Past: Studies in Autobiographical Memory*, ed. David C. Rubin (New York: Cambridge University Press, 1996), 224-6; Alistair Thomson, "Memory and Remembering in Oral History," in *The Oxford Handbook of Oral History*, ed. Donald A. Ritchie (Oxford: Oxford University Press, 2011), 91-2; Sigmund Freud, *Das Ich und Das Es: Gesammelte Werke*, (Psychoanalytic Electronic Publishing, 1923), 28.

[189] Lucy M Kenny and Richard A Bryant, "Keeping Memories at an Arm's Length: Vantage Point of Trauma Memories," *Behaviour Research and Therapy* 45, no. 8 (2007): 1918.

One limitation of the findings, particularly in those who arrived recently, is that their history is 'frozen' at the time of the interview. It would be interesting, for future research, to interview some of these participants again at a later time to see how their situation and difficulties subsequently resolved.

These oral histories need to be weighed against the information presented in the next chapter—from interviews with a variety of people who were tasked, or chose the task, of evaluating the skills and competencies of IMGs for the general or specialist registration pathways, or for offering them employment. These, too, will have their potential biases, the most obvious of which will be a conscious or unconscious tendency to defend the processes they had to administer.

What can be concluded at this point is that immigration with the intention of practising medicine in Australia is often not a quick or straightforward journey. Some have found it particularly traumatic, not all have been well-informed of the difficulties that may have lain ahead when they chose to come, and the adjudication of their competence has not always seemed efficient or uniformly fair. But one feature has come through repeatedly—once someone has practised medicine, they are usually reluctant to give it up, whatever the emotional or financial cost. Those who make it over the hurdles placed before them have demonstrated a commitment to practise their profession in their new country. For that commitment, Australia's health system owes them a debt.

Chapter 11

Interviews with Regulators and Others Concerned with IMG Licensure

One of the central objectives of this thesis is to learn from Australia's historical approaches to licensing and supporting IMGs, to understand how these processes might be improved in the future. The oral histories in the previous chapter gave insights into some of the problems contemporary IMGs have experienced, mostly over the last 30 years. The purpose of this chapter is to look at the other side of the equation: the efforts and perspectives of those who take on the task of assessing IMGs for licensing and employing them. In part, the material here is a counterpoise against which to weigh some of the complaints aired in the previous chapter. It also provides an opportunity to see what has changed over the period remembered by these participants.

Methodology and Participants

Interviews were conducted between 2019 and 2022 with 16 individuals who either had responsibility for some part of the process for registering IMGs for practice, or employed or otherwise interfaced with them. They were provided with a plain language description of this part of the project and gave informed consent to participate. Some chose to be given pseudonyms; the organisation to which they belonged has usually been described in sufficient detail to show its role, but sometimes partially obscured to help deidentify the participant. Similarly, the location of the participant was sometimes partially obscured—for example, 'rural NSW' rather than the actual town. The interviews were held face-to-face unless indicated otherwise, and were audio-recorded.

Table 11.1 lists the participants' organisations, and the roles in which they interacted with IMGs.

Table 11.1: Interview participants and their roles

Interview no.	Date of interview	Name or Pseudonym	Organisation	Principal Role*
1	19.06.2019	Joan Ozanne-Smith†	AFPHM	Council member
2	08.07.2019	Barbara Watson	'Major specialty college'	IMG assessment
3	30.07.2019	Andrew Roberts†	RACS	IMG assessment
4	09.08.2019	Rebecca Shanahan‡	RACP	IMG assessment
5	09.08.2019	Graeme Campbell †	RACS	IMG assessment
6	20.08.2019	Joanna Flynn†	MBA/Vic. Medical Board	Chair/President
7	04.09.2019	Joanne Katsoris†	AHPRA	Senior management
8	10.10.2019	Andrew Singer** †	ACEM/Cth. Dept. of Health	IMG assessment
9	25.10.2019	Richard Larkins†	RACP	IMG assessment
10	20.02.2020	Barbara Johnson	Statewide WBA program	IMG assessment
11	23.03.2020	Roger Westmore**	State Medical Board	Senior roles
12	16.03.2021	Con Michael** †	State Medical Board	President
13	20.05.2021	Penny Broadbent	RACGP	IMG assessment
14	18.06.2021	Ashleigh Dunlop‡	Rural Health Service	Senior management

15	19.08.2021	Kumar Gupta‡	Rural Health Network	Senior management
16	01.02.2022	Simon McDonald‡	Rural Health Services	Senior management

*Principal role with respect to the purpose of the interview; many had other senior roles. All abbreviations for their organisations are in the thesis Glossary. Some organisations deidentified at participants' request.

†Participant's real name; ‡Interview by video; **Telephone interview.

Edited Extracts of the Interviews

College representatives responsible for assessment of specialist IMGs

Royal Australasian College of Physicians

Three of those interviewed had or were still playing senior roles in assessing overseas-trained doctors who were specialists in internal medicine or paediatrics or one of their branches (e.g., neurology, cardiology, etc.).[1]

Professor Richard Larkins:[2] Professor Larkins was Chair of the RACP Board of Censors[3] in the 1980s. The Board had overall responsibility for the RACP training program and its examinations, but also for assessing IMG specialists for Fellowship. He recalls that the process was not particularly structured at the time, and judging the comparability of the training and experience of IMG physicians to that of Australian Fellows was often difficult. The guiding principle was to maintain standards, and it was easier to judge comparability of qualifications if they were obtained in a country whose examinations and training programs were familiar to the Board.

Those who were judged distinguished—for example, who had a qualification such as the English or Scottish FRCP and had been offered appointment to a senior hospital position in the specialty—would usually be exempted the RACP examinations.[4] When there was less certainty, applicants would be interviewed to try to ascertain their comparability to an Australian specialist physician. The outcome in those instances would often be to ask them to sit and pass the FRACP clinical examination, or even the written examination as well.

> There was definitely a bias, which we were uncomfortable about, towards countries where we understood the system, where we had frequent exchange of individuals and experience. This was partly because many of us had worked in those countries [...] It certainly was not something that arose out of any form of prejudice. It was to

[1] In Australia, 'physician' or 'consultant physician' is a specialist in Internal Medicine or its branches; this contrasts with US usage where 'physician' is any medical doctor.
[2] Richard Larkins, interviewed by author, Melbourne, 25 October 2019.
[3] Many colleges describe their examiners as 'censors.'
[4] There are several examples of this in the oral histories in Chapter 10.

try to give the most confidence that the quality of practice would meet Australian standards and expectations.

Professor Joan Ozanne-Smith: [5] Professor Ozanne-Smith reflected on her time, in the 1990s, on the Board of Censors and governing Council of the RACP's Faculty of Public Health Medicine. She had worked with many "very good public health physicians coming from other countries", some of whom were studying for a PhD in her university. In her view, the main area for improvement in the Faculty's handling of IMGs would be to have the flexibility to admit to Fellowship or Fellowship training some whose work was confined to academic or government public health. It was to the detriment of the discipline as a whole to require those who did not want to practise as clinicians (i.e., managing individual patients) to pass the AMC clinical exams as a prerequisite, sometimes well over a decade since they had practised clinical medicine.

Professor Rebecca Shanahan: [6] When interviewed, she was chair of one of the RACP's Overseas-trained Physicians (OTP) Committees and noted that, to apply for the pathway, the IMG needed to be a specialist in their own country—to be able to show that they both worked and had recognition as a specialist. The college staff now aim to give early advice to dissuade an IMG from applying if they cannot provide evidence they were recognised as a specialist overseas.

The application form requires details about their primary degree, experience before starting specialisation, then their subsequent institutions and specialty rotations. It asks about the examinations passed, what research they might be doing, and what continuing professional development activities they were undertaking. Those who appear at least partially comparable to an Australian or New Zealand physician will be asked to provide at least five referee reports, and are usually invited to an interview.

The interview is semi-structured. It covers material in the application form, but is aimed to give much more information about the training institution: what supervision was like, what was the nature of formative and summative assessments, what was the patient mix in the hospital, was it a tertiary or just a secondary institution. She gave the example of general paediatrics, saying that autism and behavioural problems are important aspects of Australian practice but not taught in some countries. The questions aim to identify training deficiencies that may need to be remediated prior to awarding Fellowship. "If we find them partially comparable, we know what support and top-up training they require to get to the standard of an Australian-trained paediatrician."[7]

[5] Joan Ozanne-Smith, interviewed by author, Melbourne, 19 June 2019.
[6] Rebecca Shanahan, interviewed by author, Sydney (video), 9 August 2019.
[7] Ibid.

Once the interviewers agree on the report, it is sent to the applicant for review. The OTP Committee then meets to discuss the interview report, the applicant's response, and referee reports. Referees usually need to have known the applicant within the last five years, and several need to be contemporaries within the specialty. The OTP member who was involved in the interview usually does not take part in the discussion, again in the interests of natural justice.

One issue she stressed was the need to allow only those physicians judged to be 'substantially comparable' to undertake 'top-up training' in an 'area of need'. This is because in those areas there are usually far fewer supports for the doctor, and thus greater risk for patient safety.

I asked her what aspects of the process had changed and what more needed to be done. She replied that considerable efforts had been made to improve procedural fairness and consistency of decisions. But there was always room to improve. "I think we are continuing to change things [...] I think we are somewhat more flexible than other specialties [... However,] we sometimes are concerned that we have IMGs supervising IMGs."

Major Specialty College *(deidentified at participant's request)*

Ms Barbara Watson:[8] Ms Watson had been a member of the professional staff at the college since 2014 and was involved in managing the application process for overseas-trained IMGs in the specialty. From about the time she started, the specialist stream applicants were handled directly by the college, with the only role for the AMC being the initial validation and translation of qualifications via the ECFMG.[9] Each specialist IMG applicant is now assigned a case officer, who guides the process and prepares the material for consideration by one of two parallel committees, which between them cover the range of the subspecialties in the college. IMGs are asked to provide logbooks of their previous experience; if these are not available, more detailed questioning is needed at interview. Currently about half are eventually judged to be 'substantially comparable' to an Australian or New Zealand Fellow. A problem with assessing many (non-British) European specialists is that they start training in a subspecialty immediately after their intern year, unlike the much broader training across subspecialties in the first half of the six years in the Australasian program. IMGs from such countries are more likely to be asked to take the college examinations and do some additional training.

[8] Barbara Watson, interviewed by author, Sydney, 8 July 2019.
[9] See chapter 4.

In the initial assessment of specialist IMGs, the committee chair will often consult a member of the relevant Advanced Training Committee.[10] If the candidate is deemed sufficiently comparable to be interviewed, the interview committee will also include a representative of the relevant subspecialty. The Medical Board of Australia, in recent years, has set guidelines for how much additional training will usually be prescribed for specialist IMGs who are deemed partially comparable by a college, to try to achieve more consistency. Ms Watson takes part in meetings with AHPRA and the other colleges several times a year, to share experiences and help comparability of decisions. One thing she believes has improved considerably during her time is the handling of interviews, and the efforts aimed at procedural fairness. Interviews can be in person, by video or telephone, and the applicant can be overseas. There are at least two interviewers: one is a member of the IMG committee; the other is a member of, or recommended by, the relevant Advanced Training Committee.

Royal Australasian College of Surgeons

Mr Andrew Roberts:[11] In the mid-2000s, he helped his college refine its interview processes for assessing overseas-trained surgeons, initially in a relieving role in the department of IMG assessment. A powerful stimulus for its creation had been the Patel case in Queensland (see Chapter 4). He was then appointed to take a new role for the RACS, as Clinical Director of the department. AHPRA and the Medical Board of Australia had not then commenced operation, and the college was still working solely with the AMC.

The process included a paper-based or online assessment, supplemented by referee reports, often international as well as local. If the applicant was applying for one of the surgical subspecialties, a representative of the specialty board also went through the documentation, and they and Mr Roberts would make their assessments independently. If the initial assessors disagreed, they would discuss further to reach a consensus.

Applicants judged partially or substantially comparable would remain under consideration, and be offered an interview by a panel comprising representatives of the college, the specialty board, a jurisdictional representative (e.g., from Department of Health), and the Director of IMG Assessment. In general, there were two components to the interviews. The first would drill down into the applicant's entire experience. Then all candidates, irrespective of their sub-specialty, would be asked a variety of questions

[10] The final three years of the six-year training program (Advanced Training) is spent by most candidates in a subspecialty; each subspecialty has its own Advanced Training Committee.

[11] Andrew Roberts, interviewed by author, Melbourne, 30 July 2019.

directed at their non-technical experience—for example, their response to scenarios about teamwork, ethics, or their understanding of what constituted informed consent. "I was trying to introduce an element of objectivity. It was not ideal, but certainly progress from what had been done hitherto … which was incredibly subjective." He noted the difficulty though with this sort of verbal assessment, and gave the example of an IMG surgeon in one of the subspecialties who was judged as substantially comparable after the paper assessment then interview. But when he was allowed to move to a peer-reviewed position, "It became clear that he had hardly held an instrument in his life. So, people slip through the net."

At the time he finished his tenure, what did he think needed further improvement? "There were many things that could have been improved, from the college's point of view and the [IMG] surgeon's." One was a need for each of the specialty boards to agree to use a more uniform approach, "rather than saying this is how we'll do it." He felt that the several bodies involved outside the RACS—AMC, AHPRA and the different colleges—could have been more streamlined in their definitions and more collaborative in their approach. He also noted that it seemed to be a very expensive process.

Mr Graeme Campbell [12] When interviewed in 2019, Mr Campbell had been in the position of Clinical Director IMG Assessment and Support for three years, and the College was acting to provide advice to the Medical Board of Australia. His position title was changed to add *and support* when he took it on. But he noted that the roles of assessment and support are slightly contradictory, because "you can't entirely be […] supporting someone at the same time as [making] assessments that can lead to outcomes they're not happy with … but it is my job to be the human face of the college in those circumstances […] and to try and sort out problems and manage them before they happen."

The process still starts with paper documentation. "A lot of the IMGs report that the requirements for information are onerous and [the evidence] hard to find. But what we ask for is *details* of their training." A thing that has changed in the last twelve months, as a direct response to the college being regularly accredited by the AMC, is to not just look narrowly at the training, which the college used to do, but to look at experience after training. "This is where it can get pretty difficult […] because if you've got somebody who has never been trained properly, and then has kept doing it [the same things] for the last 20 years, that's probably not the person we would regard as comparable." However, people who have had training which might not quite be

[12] Graeme Campbell, interviewed by author, Melbourne, 9 August 2019.

comparable to that of an Australian trainee, but have supplemented it with additional experience, can still be considered. "We used to define training very narrowly as 'formal training', but now we're quite happy to broaden that out and look at further experience [so long as it has been supervised]." That change occurred just the year before this interview, as a result of a review by the college.

There used to be a major emphasis on trying to compare exams. That was still in place when he took on the role in 2016, but he and his colleagues now look at the whole training package, not in detail at the comparability of the exams themselves. He reflected on the terminology and said: "The word *comparable* doesn't mean *equivalent*." One complication he noted is that "while we're one college, we're nine specialties." He had done some benchmarking and found there were marked differences in the proportions judged non comparable across the nine surgical specialties. Consequently, there is now one overarching committee.

> It was surprisingly easy to get agreement once we were all in one room. [...] We now have a fairly standardised idea of how we look at people – it shouldn't matter whether they're a plastic surgeon or a general surgeon, the principle should be the same.

The committee does put emphasis on recency of practice, and expects that a surgeon should be acting as the primary surgeon (as distinct from an assistant at an operation) for much of the time. Mostly, they can make the decision of 'not comparable' at the paper-based stage. However, the distinction between that and 'partially comparable' can actually be very complex. The committee tends to now focus on details of the consultant-level practice. The committee settled on five years as a threshold, and then looks at the depth and scope of practice. "You would want them to have the skill set that would make them a useful surgeon on call in a medium-sized hospital."

I asked hypothetically about a UK surgeon who had passed the English FRCS and then practised as a junior surgeon for just a year. He replied: "they would very likely be 'partially comparable', asked to sit our exam, and do a period under supervision."

> We also try to assess non-technical ability at the interview ... at least half the interview is related to asking questions of a non-technical nature, giving them scenarios ... often ethical dilemmas, not specialty specific. We get a really interesting mix of responses to those ... some incredibly good responses [and] we get some incredibly un-insightful responses [...] We would like to use that information more in a decision-making way, but are trying to overlay a rating scale to measure it so we can try to reduce a verbal answer to a number [...] We'd like to map it against our own trainees and see how they go at the same interview.

The current breakdown of decisions is about one third in each of the three categories. The partially comparable group will usually have 24 months of supervision recommended, and after nine months they are eligible to sit the FRACS exam, which

they must pass to progress further. The substantially comparable group will nearly always be required to practise under supervision for 12 months. During that time there will be multiple assessments: a direct observation of procedural skills (DOPS), a mini-Clinical Evaluation Exercise (mini-CEX)[13], a 360-degree feedback (by at least eight contributors, including nurses), a logbook, and three-monthly supervisors' reports. He did reflect on some difficulties inherent in the reporting process. Firstly, the supervisors are a volunteer workforce, and it is not their primary job. There is also potential for some biases to arise: for example, if the IMG surgeon and supervisor are competitors in a narrow field, the supervisor needs to try to put that future competition aside; alternatively, an overworked surgeon, who is relying on the IMG to help with their workload, risks being overly generous in assessments.

In summing up, he emphasised the importance of not accepting a lower standard for IMGs who were to work in an area of need—similar comments were made by others in this and the previous chapter. He ended by saying: "The need for IMGs in Australia is undoubted." However, in his view, workforce-planning by governments now and in the past has been haphazard.

Australian College for Emergency Medicine

Associate Professor Andrew Singer:[14] Andrew Singer reflected on how his college handled applications by overseas-trained emergency physicians during the five years he was censor-in-chief of ACEM, from the late 1990s. Being a relatively new specialty, he felt that one advantage they had was the very small number of emergency medicine training programs around the world, so he and his colleagues were mainly assessing IMGs from the UK, USA and Canada. Canada was a little more complicated because it had two training programs that were very different, but few of them came and applied.

As has been noted above by those interviewed from other colleges, a common difficulty was how to judge comparability of the overseas-trained specialists to the home-grown ones. For example, the UK training program looked reasonably like the Australian one, but the US one was very different—it was a much shorter program, just three years immediately after an intern year. He commented that, as a young college trying to establish itself, "there was probably a bit of resistance [at first to] letting some people in. but this relaxed a bit."

In the early 2000s there were some moves to look at the possibility of joint recognition with the UK specialists but, because of the differences in the registration process in the two countries, that proved to be impossible. He had worked in the US for

[13] See Chapter 4.
[14] Andrew Singer, interviewed by author, Canberra (audio), 10 October 2019.

a while, and consequently had a better understanding of its system. Because the US training period was substantially shorter than the Australian one, his college began to rely more on the length of experience the US emergency physician had after they completed their training to decide how comparable they were to an Australian FACEM.

Through the 2000s, the college began to put more emphasis on workplace-based assessment, and less often required candidates (who on paper looked fairly comparable) to take the FACEM exams.

Andrew Singer later took a senior position in the Commonwealth Department of Health, and had been involved with the Medical Board's recent efforts to improve the process of IMG specialist recognition. So, I took the opportunity to ask his current views on the processes more generally. He noted the move to encourage colleges to take a more holistic view of the capabilities of overseas-trained specialists, with more emphasis than previously on an IMG's subsequent practice and experience *after* they finished their specialty training. Without wishing to name particular colleges, he did note some reservations about their limited flexibility.

On a different matter, he also expressed concern about "exploitative practices" directed at IMGs by some corporate GP practices. An example of that was seen in the oral history of Dr Nabilah Reddy and her medical husband in the previous chapter.[15]

Royal Australian College of General Practitioners

Dr Penny Broadbent: [16] Dr Broadbent's position was National Clinical Lead for Assessment Operations and Committee Liaison. She had previously been a censor with the college. When the workload for assessing IMGs was increasing, she was asked in 2008 to take over the handling of Fellowship *ad eundem gradum* (FAEG) candidates. At that time, these were mostly IMGs from New Zealand and UK with a specialist qualification; if considered equivalent, they were awarded FAEG.

About 2010, a more nuanced program was developed. There were three tiers of qualification but even this lacked the subtlety to differentiate between holders of the same qualification'. Category 1 was the FAEG doctors; the category 2 group were asked to sit the FRACGP exams; the category 3 needed to demonstrate they had at least four years in general practice and pass one of the RACGP's written exams before being allowed to enter the program; once they arrived in Australia, they needed to start preparing to sit the other two exams. Most in category 2 then were from Western Europe or South Africa. There were very few category 3, who often had the MRCGP

[15] Nabilah Reddy, interviewed by author, Melbourne, 16 May 2018.
[16] Penny Broadbent, interviewed by author, Melbourne, 20 May 2021.

International—a qualification from the UK RCGP, tailored to the local practice, and not recognised for practice within the UK.

She commented that assessing the equivalency of general practice experience can be very difficult, especially from countries other than those usually put in category 1. For instance, it is common for a doctor to have a hospital job during the day, then run a small general practice in the evenings. Or their hospital work may have many outpatients, which "appears to act as primary care", unlike outpatient clinics in Australia which are all specialty based.

The *ad eundem gradum* approach they took earlier, in which Fellowship would be granted "sight unseen" to GPs from several countries is no longer used. Instead, multiple factors are weighed: the curriculum, type and amount of practical GP experience, and the nature of assessments taken. If judged substantially comparable, they will now usually be asked to work for six months under supervision in a comprehensive general practice setting, have satisfactorily completed workplace-based assessment (WBA), but not need to pass the RACGP exams. Those judged partially comparable will have similar supervision and WBA requirements, but additionally have to pass the exams. She concluded by reflecting that:

> Overall things have improved. One aspect has been to try to improve communications between the multitude of stakeholders [...] Another thing that has improved is which assessments are the responsibility of which bodies.

AMC Workplace Based Assessment Program

Ms. Barbara Johnson:[17] Ms Johnson was managing the Workplace Based Assessment Program (see chapter 4), a stream within the AMC standard pathway, for a whole state. She had previously been responsible for HMO recruitment at one of her hospitals, and it was a natural progression to take on the new AMC program in 2010. It was advantageous for the hospital, because it attracted quality applicants, and for the IMGs, who considered it a much better way to transition to Australian practice while completing the requirements for registration.

The program started as a pilot, but later extended statewide after rigorous evaluation by the AMC. Candidate IMGs needed to have passed the AMC MCQ exam, have obtained employment in a state hospital, provide referee reports from that position, then be selected after a rigorous interview by a three-person panel. In the early years of the program, they might interview 30–40 applicants for just four positions, so it was a very select group.

[17] Barbara Johnson, interviewed by author, Launceston, 20 February 2020.

When they start, she works up an individualised program (usually 12 months) for each.[18] They have regular assessments on every rotation: a total of 12 mini-CEXs and eight case-based discussions. Each mini-CEX is followed by 15 minutes of feedback from the assessor, which candidates find most valuable. The assessors all go through a training program; they are offered payment but only about 10 percent accept it, seeing it as part of their role for the hospital.

The pass rate has been very high, and the two who failed to date did so because of their poor attitude as assessed in the 360-degree assessment. The AMC reaccredits the program each three years, following a site visit, and she remarked that "they are very strict on what we can and can't do."

In summary, this still quite small program—because only a few centres nationally have committed the time and resources to it—but is highly regarded by IMGs who manage to get a place, and by the hospitals who benefit from having them.

Australian Health Practitioner Regulation Agency (AHPRA)

Dr Joanna Flynn: [19] Dr Flynn was the inaugural chair of AHPRA's new Medical Board of Australia when it was founded, but had retired when she was interviewed. Previously, she had been President of the Medical Board of Victoria.

What broadly did she think were the strengths of the process? They included very clear identity checking, clear verification via the AMC process of the qualifications, checking of criminal history, robust standards for English language proficiency. IMGs also must declare whether they were subject to any disciplinary processes elsewhere. Then the individual is assessed through the various pathways: specialist, general registration, or for area of need. The Board then mandates the one year of supervised practice.

I asked is it sometimes too robust and too slow? Taking timeliness first, she said:

> There are some parts of the process that take time, and I recognise that for those who are wanting to get working that can be difficult … and sometimes for those that want to employ them […] but I don't think we should apologise for setting a standard and requiring people to demonstrate that they meet it. […] The onus is on us—all the agencies involved—to make that as quick, efficient, appropriately rigorous, but, you know, achievable, within a reasonable time frame as we can.
>
> On the face of it, it's simple to say: 'let's just design an exam every doctor who comes into Australia has to pass before they can start working.' But you and I know that … if you set an exam that was trying to test everybody, you get back to the AMC exam, which is not an appropriate way to test you or me, or anyone who's had a more specialised area of practice. And if I could pass that exam, it doesn't mean I

[18] For specialty registrars it can be shorter.

[19] Joanna Flynn, interviewed by author, Melbourne, 20 August 2019.

> could step into being a GP or a physician or a surgeon. [...] So then you have to get to an individualised assessment process, which is always going to take time. And if part of that process involves taking into account the context in which the person is going to work, what supervision will be there, what's the role they're actually trying to do— which is effectively an area of need type of assessment—then that again requires a lot of judgment, and interaction between the panel and the person.

She pointed out that timeliness is sometimes in the IMG's hands—for example if they are not in the country, or are waiting to retrieve documentation.

Are funding or staff numbers issues? She felt they probably were not. Sometimes, once the documents are obtained from colleges, AMC, or hospitals where an IMG is to be placed, the process can be simple. However, "there are others that require judgment by a board committee, and that can take time."

I asked what changes she had seen over the period of her involvement. Improvements she highlighted were in timeliness and transparency. There is annual publication of data and of the Board's expectations. The colleges have been encouraged to less often require applicants to do their examinations, and there is now a clear expectation that examinations are not appropriate for all. Another improvement has been in the requirements for supervision of IMGs that the Board has put in place.

Dr Joanne Katsoris:[20] Dr Katsoris currently has a senior role supporting the Medical Board of Australia, now at the policy level. Prior to that, she had been involved in registration processes for more than a decade as a staff member of the Medical Practitioners Board of Victoria.

What changes had she seen in how IMGs are dealt with over the time she has been involved? When she started in 1996, they were using a 1994 Act, an essential feature of which was that all IMGs were treated the same, regardless of which country they came from. However, with the 2006 COAG initiatives,[21] there began to be differentiation depending on where the degree was from. That was when the competent authority pathway was introduced, which greatly simplified the process for IMGs from those countries.

Around the time AHPRA was formed, and the 'Lost in the Labyrinth report,'[22] there was a lot of concern about the amount of red tape for IMG processing. "So, we did a significant amount of work to try to solve that." I spoke about the difficulties some IMGs from countries outside the competent authority ones experience. She recognised

[20] Joanne Katsoris, interviewed by author, Melbourne, 4 September 2019.
[21] See Chapter 4.
[22] Ibid.

there were some problems IMGs experience as they negotiate AHPRA's processes, but replied:

> There is an element of buyer beware. You and I can't go internationally and work anywhere. [...] I understand that people think the bar is set pretty high [but] we do have to worry about our patients. That's our job, to make sure the public is adequately protected. So, we've put a lot of mechanisms in place, and some are to support IMGs better. We don't want them to be out there working unsupervised because that's not fair on them, and not giving them the opportunity to have training.

She noted that one of many things done is to tighten supervision. For instance, supervisors need some training and must pass an online test. "All our registration standards are actually regulatory instruments as approved by the nine health ministers."[23] The board has to see the training plans and supervision plans for each applicant, and the supervisors must confirm they understand their responsibilities. Another achievement has been working with colleges "to try to come to a mutual understanding of the importance of transparency, fairness, accountability, with some flexibility." She summarised AHPRA's remit by saying:

> Whoever comes to us with the appropriate checks and balances will be registered. We administer a piece of law, and the law says if you meet these criteria, including these registration standards, you will be registered.

Representatives of State Medical Boards

Dr. Roger Westmore: [24] Dr Westmore was a former member of a state medical board in the 1980s and 90s, and reflected on his time in that role. He began by saying that there was no doubt that IMGs have contributed to Australian health care in a major way.

> We've got it wrong from time to time by cutting our own numbers [of medical students] too much [...] We've not handled their transition into practice well at all—we've let them sink or swim [...] and we've still ended up with people who can pass the exam but were culturally un-adapted to [Australian] practice, and their lives must have been so difficult.

One problem some would have faced, when they came from countries where the doctor is dominant, would be having to cope with patients who considered the doctor should be their equal.

Prof Con Michael: [25] Prof Michael was President of the Medical Board of Western Australia, and I consulted him specifically for his commentary on the history of the Western Australian version of the *National Law Act.*[26] The context was the oral history

[23] In each state and territory, plus the Commonwealth Minister for Health.
[24] Roger Westmore, interviewed by author, Melbourne (audio), 23 March 2020.
[25] Con Michael, interviewed by author, Perth (audio), 16 March 2021.
[26] *Health Practitioner Regulation National Law (WA) Act 2010 No. 35.*

of Dr. Bridget Smith in Chapter 10, a British IMG who feared she would lose her Australian registration when she consulted a psychologist in Darwin, and was promptly referred to the Northern Territory Board under AHPRA's mandatory notification requirements.

Prof Michael had been involved when the Western Australian Act was drafted, and said that the profession in his state was determined to not have that section included, though it had been agreed by the other states and territories. He recalled that was why Western Australia joined three months after the others, without the requirement for a doctor to be *mandated* to report an illness of a colleague they were treating. Instead, the Western Australian Act allowed a doctor to *choose* to report a doctor under their care if they were likely to be a risk to their patients. A practitioner could be reported by anyone else who became aware of possible impairment, such as a colleague, a patient or an employer. It was only the *treating* relationship that was exempt.

As mentioned in Chapter 10, the national law was amended in 2020 to raise the bar in the other states, but Prof Michael noted that the Western Australian Act's provision remains as originally promulgated.

Employers and Supervisors of IMGs

Ms Ashleigh Dunlop: [27] Ms Dunlop had just retired from her position as Executive Director of Clinical Services in a regional health service. It is in north-west Victoria, about 400 km from the state capital, and caters for people over an area greater than 20,000 square kilometres.

I asked how dependent her hospitals were on IMGs. The answer was very. She recalled an occasion four years earlier when they had only one GP to cover the entire service. Over about the last decade, nearly all the doctors had been IMGs.

> We just had to fill the gap. I don't think we thought of them as being second class, it was just that we needed doctors and we had to look at different ways to do it. The old way of doctors who had a practice and recruited partners and worked 24/7 wasn't a model that was going ahead any more up here.

For part of the previous decade, the doctors had been provided by a very large corporate practice, which had expanded across regional Australia. She felt it had become a money-making business more than a service. Fortunately, it had left, and the care provided was much better from GPs in a local group practice. All were IMGs, from a variety of countries, but particularly from Southern Asia.

[27] Ashleigh Dunlop, interviewed by author, Rural Victoria (video), 18 June 2021.

> You've got to understand, when the doctors come here to small communities [...] they're the only international person that's ever lived in the community—except maybe the Greek greengrocer. [...] So getting the doctors here wasn't too much of a problem, but once they got here [the issue] was how to support them. The doctor might be a female, and the husband perhaps an engineer—and he can't get any work in the area. Education for their children is another important issue. They would say that schools for the junior years were fine, but the doctor would want to send them away to private schools in the senior years. [...] There were a lot of social difficulties [...] in them setting up, which in the end when you only work a certain amount of hours in the day, the rest of your life has to have some cohesion and happiness to it as well, or you don't stay.

Thus, turnover is a problem in a rural area such as hers—something that was also apparent in the studies by Hawthorne et al. and by Terry, described in the previous chapter.[28] Ms Dunlop spoke about some of the supports that are now put in place to help the IMGs to settle in. One that has been self-reinforcing is that as more have come from similar countries, they have been able to establish their own social supports.

> Now it is like a network [...] and there are quite a few nurses from the same areas. They all support each other, even with childcare. Someone's mother or mother-in law might have come out to help mind the children while the nurses work ... and help the doctors mind their children. [...] I can't even imagine how hard it would have been – even just to go to the grocery shop and not have anything that's recognizable.

She said that the largest town in the area now has a whole section devoted to the culinary needs of the immigrants. The doctors are also given rent-free accommodation, and a car if they wish. She mentioned an issue that would be rare among Australian trained doctors: that of Pakistani women doctors, placed in a rural area where a car is essential even to get food, but who had not learned to drive because at home they always had a driver.

Her insightful interview, more even than those with the IMGs described in Chapter 10, brought into crisp focus the cultural challenges that many of Australia's IMGs must have to overcome in their new country, especially when to be registered we require them to be work in a rural setting away from the diasporic supports they might have in a city.

Dr. Kumar Gupta: [29] Dr Gupta was actually part of the random sample of IMGs studied in Chapter 10, but at the end of that interview he volunteered his comments as a medical administrator in a large rural centre—a role in which he frequently employs IMGs. I

[28] Lesleyanne Hawthorne, Bob Birrell, and Doris Young, *The Retention of Overseas Trained Doctors in General Practice in Regional Victoria* (Melbourne: Rural Workforce Agency, Victoria, 2004), 19; Daniel Robert Terry, "Health and Wellbeing of International Medical Graduates: Acculturation into the Tasmanian Rural and Remote Context" (PhD, University of Tasmania, 2014), 234-7, https://eprints.utas.edu.au/21728/.

[29] Kumar Gupta, interviewed by author, Rural NSW (video), 19 August 2021.

particularly asked him about his experience with AHPRA, when he wanted to employ an IMG who was eligible for limited or provisional registration. I mentioned some of the stories in the oral histories in the previous chapter, where there had been long delays in approval of the placements. Did he find that common? He replied:

> I don't think that happens on a regular basis or very often … there might be reasons we don't know here as to why that happened. […] Being in medical admin, one of my jobs is to attract, recruit and retain doctors, and I do it all the time … and don't see that the processes are in any way unfair … anything can be improved, but I think the processes we have are quite reasonable and quite alright.

Dr Gupta ended by explaining why he had agreed to be interviewed, when I randomly approached him to tell his own story as an immigrant doctor. His remarks add useful balance to other accounts of medical immigration that have sometimes been traumatic:

> I wanted to talk with you because generally the perception is that when people come from outside, they are running away from something or the system is not fair to them and things are unnecessarily difficult and they suffer a lot and so on … look, it is not like that for everyone, and it might not be the system, it might be the individual, or it might be something else that has happened.

Dr. Simon McDonald: [30] Dr McDonald has been a Director of Medical Services, responsible for a number of small rural hospitals, since the late 1990s. Most of them rely on local GPs who belong to a solo or group practice, to provide medical services to patients in Urgent Care, hospital inpatients and residents in aged care facilities. The GPs need to be credentialled to be allowed to manage patients in his hospitals.[31] His aim is to appoint people he assesses as being competent and safe, and likely to be well regarded in the community.

> I've heard a lot sometimes from medical practitioners in larger hospitals who have had concerns about various aspects of the overseas-trained doctors I've employed—sometimes fair, sometimes ridiculously unfair, and frankly racially prejudiced. But I'm very pleased to say that over the twenty odd years I've been doing this, the situation has improved a great deal.

He felt that the process (AMC exams included) means they are now better vetted. It might be partly because various countries have improved their medical education and training processes. He also noted that the rural communities have become much more open— much more tolerant and encouraging of the doctors who come to them.

What are some of the challenges, especially for IMGs who arrived recently? He referred to the cultural shock of, for instance, coming from the suburbs of a busy Pakistani city to the rolling wheat fields of rural Victoria. "One of the greatest challenges that every one of them faces is not just their lack of knowledge of the

[30] Simon McDonald, interviewed by author, Rural Victoria (video), 1 February 2022.
[31] They function as independent contractors, not as his employees.

Australian healthcare system, but also their lack of a network within that system." He mentioned his own knowledge of a range of doctors with special skills that he could call up if he needed advice on an issue or a concern. "Having such a network is very powerful, and they come without it."

How important have IMGs been to his rural health services? He thought for a moment, and said:

> Without IMGs we would probably have shut down the health service and shut down the town, they've been that vital to [name of town] and surrounding districts.

Conclusion

The information and insights provided by this group of people, who have played various senior roles in assessing or supporting IMGs, demonstrates historical shifts in those processes over the almost 40-year period they describe. Since AHPRA and the national medical board were created, a concerted effort appears to have been made to better coordinate the way the specialist colleges assess overseas-trained specialists, and other changes aimed at increasing transparency and fairness have been introduced. These were improvements repeatedly called for in the Commonwealth Government's 'Lost in the Labyrinth' report.[32]

The information provided by senior people in the colleges indicates the extensive detail often sought as they make their assessments, yet also underscores the complexity inherent in some of their decision-making. It would be fair to say that there has been substantial recent progress, but none feel their processes have yet reached perfection. Some of the oral histories in the previous chapter indicate what appears to be poor administrative practice by employees of AHPRA, or procedures they were following that should be improved. Similarly, despite the efforts of those leading the assessment processes for colleges, testimony in Chapter 10 indicates injustices probably still occur. Some suggestions for improvement are made in the final chapter.

The interviews with the last group of contributors give us insight into the difficulties that IMGs must face when transplanted into unfamiliar social and professional environments, including being confronted sometimes with xenophobia. But those interviews also show, reminiscent of the statement by the Secretary of Health in

[32] House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the Inquiry into Registration Processes and Support for Overseas Trained Doctors* (Canberra: Commonwealth of Australia, 2012).

the first page of this thesis, that IMGs have had and continue to play a critical role in Australian healthcare.

Chapter 12

Evaluation of Australia's Responses to the *Lost in The Labyrinth Report*;

Recommendations for Improvements in the Assessment and Support of IMGs

The previous two chapters provide information about the lived experiences of IMGs who have come to Australia at various times during the past half century, and others who interact with them. Chapter 10 has shown that some of those experiences, particularly those relating to registration for practice, have been traumatic. Chapter 11 provides a kind of counterpoint, by examining the experiences and views of individuals who were responsible for evaluating and/or supporting IMGs. The purpose of this final chapter is to explore how well, in the author's view, Australia has dealt with the many recommendations in a major Commonwealth report handed down a decade ago. Then, based particularly on an analysis of issues brought up via the oral histories in Chapter 10, I make recommendations for further improvements in how the main actors in IMG assessment and processing perform their tasks.

Evaluation of Australia's responses to the 'Lost in the Labyrinth' report[1]

This important report by the Commonwealth Government in 2012 was referred to in Chapter 4—initiated because of concerns from various quarters (particularly from IMGs) about the assessment and support for IMGs to practise. It made 45 recommendations,[2] many of which have been responded to by the nominated agencies. For example, the AMC has improved access to its Clinical Examination, and provides detailed information for intending IMGs. Evidence was heard in some oral histories that college processes are more transparent and streamlined than previously, though other accounts raised some serious concerns. However, the interviews with senior members of college and MBA representatives (presented in Chapter 11) indicate that recently there has been much better coordination of their activities, and considerable progress in refining the assessment methods of at least those four colleges. All the colleges now have appeal mechanisms, which are well publicised; and the outcomes of appeals described in two of the oral histories suggest they can quite quickly correct what appear to have been poor decisions by the college Fellows who made the initial judgments.[3] Table 12.1 lists examples, though, of recommendations in the report that remain unmet.

[1] House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the Inquiry into Registration Processes and Support for Overseas Trained Doctors* (Canberra: Commonwealth of Australia, 2012).

[2] These are summarised in my Supplementary Table 2, Appendix A.

[3] See interviews of Surjan Kohli and Binita Dalal in Chapter 10.

Table 12.1: Selected non-implemented recommendations: 'Lost in Labyrinth' report*

No.	Recommendation (summary)	Notes
11	AHMAC, Department of Health and Ombudsman develop overarching independent appeals process, sitting above the processes of AHPRA, AMC and the Colleges	This has not been done. The Ombudsman cannot investigate complaints against Colleges,† and the other bodies did not act on this.
12	Health Workforce Australia (HWA), with state and territory health departments, investigate options to ensure equitable and fair access to clinical supervision places for international medical graduates. Consideration should include establishing designated supervised placements for international medical graduates in teaching hospitals or similar settings.	HWA no longer exists, but its activities have been absorbed within the Commonwealth Health Department. No coordinated action on these recommendations has occurred.
13	Australian Medical Council, the Medical Board of Australia and specialist medical colleges collaborate to develop a process which will allow semi or recently retired medical practitioners and specialist practitioners to maintain a category of registration which will enable them to work in the role of a clinical supervisor.	The Medical Board has not created such a category of registration—only a non-practising registration category, which does not allow work as a clinical supervisor.
18	All Pre-Employment Structured Clinical Interview (PESCI) assessments be video-recorded and a copy of the video-recording be provided to the applicant for the purpose of providing appropriate feedback on the assessment and as a record should an international medical graduate wish to appeal the outcome of a PESCI.	This does not appear to have been implemented. The instructions on the MBA website to providers of PESCIs do not mention a requirement to record them.
23	The Medical Board of Australia extend the period of validity for English language proficiency test results as prescribed by the English Language Skills Registration Standard to a minimum period of four years.	The period of currency of a test result remains at two years, though there are circumstances in which it can be extended.
26	The Australian Government Department of Health and Ageing consult with state and territory government departments of health to agree on nationally consistent and transparent approach to determining Area of Need (AoN) status based on agreed criteria	Area of need decisions are still made by the jurisdiction in each state and territory, and there is not evidence of attempts at national consistency.
28	The Medical Board of Australia/Australian Health Practitioner Registration Agency, Australian Medical Council and specialist medical colleges, publish data against established benchmarks on their websites and in their annual reports, on the average length of time taken for international medical graduates to progress through key milestones of the accreditation and registration processes.	The agencies have declined to do this on the grounds that every decision is individual, and circumstances can vary widely.
29	AHPRA's annual report must include many KPIs, including details of results of all AMC examinations, English Language Skills performance, etc.	This level of detail is not included in the AHPRA reports.
40–43	Several recommendations calling for HWA to assist IMGs with streamlined education and training supports, orientation for all IMGs and their families, financial support for IMGs, and providing an individualised case management service for IMGs	HWA no longer exists. Other agencies have met some of these suggested needs, but many have not been.

*Citation in footnote 12. †The Commonwealth Ombudsman can only investigate complaints against Australian Government agencies, and the Colleges are not.

Some of the unmet recommendations were directed at bodies that no longer exist. Perhaps the most neglected suggestions were in recommendations 40–43, which called

for streamlined educational, training and financial supports for IMGs, and orientation to be provided for them and their families. When this currently happens, it seems to be at the local level, and some examples were given in the interview with Ms Ashleigh Dunlop in Chapter 11.

Recommendations for improvement in assessment and support of IMGs

Alix Green wrote recently: 'The explanatory and rhetorical power of historical narrative has made the past a prized possession'. Others, too, have noted the capacity of historical research to underpin the making of good policy.[4] How might this thesis contribute?

If we are to learn from this long history of medical immigration, one conclusion might be that a lot has been done already. The uniform medical Act now mirrored in every jurisdiction no longer discriminates on the basis of race or country of training, although the procedures of the Medical Board of Australia (MBA) do still advantage registration for graduates in five countries via its Competent Authority Pathway. That discrimination has some justification, based on data in Chapter 9 on the very high success rate of those graduates when they were required to take the AMC examinations. Nevertheless, their exemption was a source of resentment for some IMGs from other countries who were interviewed for Chapter 10.

There are aspects of particularly Australia's licensing processes for IMGs that can be improved. They are listed below as recommendations with a brief justification/explanation:

1. Specialist colleges should strive to further improve their assessment of the competence of overseas-trained specialists.
    - Colleges are now attempting to make a more holistic assessment of specialist IMGs, to include the length and depth of specialist practice after their training. However, several of the oral histories indicate that subcommittees in colleges ignored that, and made senior IMGs from countries with strong health systems sit college exams—exams that I and others argue are poorly suited for assessing doctors who have been working successfully for many years as specialists.
    - There appears to be a need still for the different subspecialist disciplines, particular in the RACS, to 'sing from the same song sheet', despite the best

[4] Alix R Green, *History, Policy and Public Purpose: Historians and Historical Thinking in Government* (London: Palgrave-Macmillan, 2016), 3; Edward D Berkowitz, "The Historian and Policy Analyst: The Challenge of HEW," *The Public Historian* 1, no. 3 (1979): 23-5; James McCurley III, "The Historian's Role in the Making of Public Policy," *Social Science History* 3, no. 2 (1979); 205-7.

efforts of senior college Fellows with overarching roles in IMG assessment (see above and Chapter 11).

- The assessment of procedural competence in disciplines such as surgery, obstetrics and gynaecology, gastroenterology and cardiology may benefit from the use of high-fidelity simulators. This was suggested by Ms Binita Dalal (Chapter 10); these are frequently used for training and assessing Australian doctors for highly technical procedures.

2. The Australian Government, in collaboration with state Health Departments, should provide some funding and support for IMGs, who have passed at least the first of the AMC examinations, to get supervised experience in a public hospital or general practice.
   - The present situation has been described as 'sink or swim'. Since the health system still relies on IMGs, it would be a worthwhile investment. The estimated cost of a similar scheme in 2014 was $16,000 per person for a year's placement.[5] IMGs could be offered a loan, repayable once they were registered and earning.
3. The AMC and State Health Departments should work together to expand the opportunities for IMGs in the standard pathway to be assessed via the Workplace-based Assessment stream.[6]
   - This 6 to 12-month placement allows a much more robust assessment of an IMG's clinical competence than a single OSCE examination.
4. AHPRA should consider streamlining its process for providing Limited or Provisional Registration to IMGs who have passed one or both of the AMC exams.
   - IMGs are eligible for these registration categories as soon as they pass the exams, but the oral histories provided examples of long delays while MBA/AHPRA did its processing, to the detriment of at least three hospitals (and the IMGs) who were trying to fill an HMO position.
5. If AHPRA/MBA does not move to a more streamlined process for providing Limited or Provisional Registration as suggested above, it should investigate why delays such as those described in Chapter 10 occur, and institute whatever is needed for their remediation.
6. AHPRA/MBA should respond to the accusations in the oral histories of bullying by some members of MBA staff by instituting better training or disciplinary processes.

[5] Balakrishnan R Nair et al., "Workplace-Based Assessment for International Medical Graduates: At What Cost?," *Medical Journal of Australia* 200, no. 1 (2014): 41.

[6] See Chapter 4.

- Several instances of bullying by AHPRA staff (it could be characterised even as blackmail) to get IMGs to agree to an extension of a processing time beyond what it guarantees are reported by highly credible witnesses in Chapter 10.

7. AHPRA should consider amending its recency of practice provision, which has posed problems especially for female IMGs with children, perhaps by allowing credit for supervised unpaid observerships in Australian hospitals. This would be similar to the situation of Australian graduates, who all train as observers but are allowed to practise under supervision with Provisional registration *immediately* they graduate.
8. AHPRA/MBA should offer more flexibility in the exemptions to its requirement that an English language test should be passed every two years.
    - Ability to communicate well in English is clearly important for clinical practice in Australia. However, 'Lost in the Labyrinth' recommended a test certificate be valid for four not two years. That has not been implemented, though MBA offers some exemptions to the two-year limit.[7] The experiences of several whose oral history was recorded (and who were fluent when interviewed) suggests further exemptions would be warranted. One additional exemption could be for those who passed the first test at a high level. Each test is expensive.

Conclusion and Limitations

My analysis of events that have followed the publication of the *Lost in the Labyrinth* report is that it provoked a number of worthwhile changes to Australia's support and assessment of IMGs. But not all were enacted, and I refer to some more that I think should be done.

The oral histories presented in Chapter 10, and interviews with representatives of those who assess and support IMGs (Chapter 11), were influential in formulating the recommendations I make in the second half of this chapter. As I have said previously, the assessment of IMGs in order to grant them general or specialist registration needs to recognise that safety of Australian patients is paramount, but needs also to be balanced with fairness without compromising the former.

In making these recommendations, I need to acknowledge that some are based on information obtained from individuals whose experiences may have been atypical, and not always shared by others. Nevertheless, they may serve as a starting point for further dialogue between all who play a part in the IMG journey.

[7] AHPRA and National Boards, "English Language Skills," accessed 4 May 2022, https://www.ahpra.gov.au/registration/registration-standards/english-language-skills.aspx.

CONCLUSION

This thesis presents a historiography of Australia's medical immigrants that embraces the entire period since the country began to license its medical doctors. As such, it provides the opportunity to take an overall view of this history—or as Fernand Braudel might have said, the *longue durée.*[1] This has not been previously possible. Existing scholarship has examined various aspects of this subject, but only addressed it in temporal or topic-specific segments.

The prosopography has answered several questions about Australia's IMGs during the period studied. One addressed in Chapters 5 and 6 is what proportion of all new medical registrants at each time and in each jurisdiction was IMGs? It is no surprise, because the Australian medical schools were only just getting underway, that the great majority of newly registered doctors during the nineteenth century were from overseas. However, even during the first half of the twentieth century, they were still making a significant contribution: 3083 (19 percent) of 16,434 registrations between 1901 and 1950 were IMGs. Then, from about 1960 onwards, their proportion steadily increased to be about 30 percent today.

Other important questions answered by the prosopography were where and when did they train, when did they achieve registration in Australia, and where? Taking the latter question first, the IMGs flowed into the colonies, then later the states and territories, roughly in proportion to immigrant inflows in general. Notable perturbations in locations and numbers during the colonial period were very likely due to the gold rushes (particularly in Victoria) followed by the boom and bust of the last two decades of that century. Then, two world wars and the great depression of the 1920s acted as understandable brakes on medical immigration. The other striking change, shown by the last years of the prosopography and the data in Chapters 7 and 8, has been the marked increase in numbers of IMGs over about the last fifty years.

What has the thesis contributed about their countries of origin? The first almost two centuries has likely told us more about Australian attitudes to the countries where the medical immigrants trained than almost anything else. While the thesis has not examined how much demand there was by doctors wishing to come to Australia from countries other than Britain,[2] it is clear that not many succeeded before about 1960. The

[1] Fernand Braudel, "La Longue Durée," *Annales: Histoire et Sciences Sociales* 13, no. 4 (1958): 729. Braudel described this as a period of a century or more.

[2] I somewhat loosely use 'Britain' to describe Great Britain and Ireland, then the UK and Ireland after the separation in 1922.

country that Prime Minister Sir Robert Menzies described as 'British to the Bootstraps'[3] overwhelmingly received its IMGs from the British Isles until the eventual unravelling of the 'White Australia' policy. This is not surprising. The bulk of all immigrants (not just medical) for a long time was from there. In 1910, GH Knibbs wrote: 'the population of Australia is fundamentally British.' And the statistics backed him up: at Federation, 96 percent of all Australians were either born in Australasia or the UK.[4]

But it was not just kinship with Britain that was responsible for such a small number of medical immigrants from elsewhere. The Medical Acts and their Boards, as described in Chapter 3, played major roles in restricting others from being licensed. The case of Dr Fattorini in Chapter 4 was one of the first documented. The scholarship of Gabrielle Wolf and Egon Kunz describing the resistance of the Australian medical profession and the Boards to registering Jewish and other refugee doctors circa WWII was referred to in Chapter 7. And the highly restrictive Medical Act and Board in New South Wales in the 1950s and 60s, which allowed some European IMGs to practise in areas of need but resulted in none ever achieving general registration in that state, was explored in Chapter 7. Both Wolf and Kunz provide strong evidence that the motives for excluding the 'aliens' were xenophobic and protectionist.

Most of the members of the Medical Boards, until the last sixty years, were also members of the BMA.[5] The founders of the first BMA branches in 1880 in the colonies, not surprisingly, were all British graduates, since the Australian medical schools had hardly yet made an impression on the medical workforce.[6] The BMA's attitude to medical immigrants was characterised by Terence Johnson and Marjorie Caygill as motivated to:

> safeguard the interests of migrant United Kingdom graduates in the face of competitors from the continent of Europe … [and ensure] that the monopoly of medical practice in the colonies was maintained through a 'favoured son' policy in medical registration legislation.[7]

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[3] Menzies Research Centre, "Ties That Bind," accessed 4 January 2022, https://www.menziesrc.org/news-feed/ties-that-bind.

[4] GH Knibbs, *Official Year Book of the Commonwealth of Australia, Containing Authoritative Statistics for the Period 1901-1909* (Melbourne: McCarron, Bird and Co., 1910), 114.

[5] Gabrielle Wolf, "The Law and Politics of Registering Doctors: Lessons from New South Wales, 1937-42," *UNSW Law Journal* 43, no. 4 (2020): 1526.

[6] Prosopography; AMA Victoria, "History of AMA Victoria," accessed 30 April 2022, https://amavic.com.au/about-us/history; AMA South Australia, "Past Presidents of the BMA/AMA in South Australia," accessed 30 April 2022, https://sa.ama.com.au/past-presidents-bmaama-south-australia; Martha Rutledge, *Renwick, Sir Arthur (1837-1908)* (Canberra: Australian National University, 1976).

[7] Terence J Johnson and Marjorie Caygill, "The British Medical Association and Its Overseas Branches: A Short History," *The Journal of Imperial and Commonwealth History* 1, no. 3 (1973): 313-4.

The many changes to the medical Acts in each jurisdiction, with their exclusionary import for non-British IMGs, were described in Chapter 3. A complete analysis of the implications of these Acts for medical registration has not been previously published, and the summary in the thesis Appendix may be useful to other scholars of the topic. But although the *outcomes* were more or less uniformly constraining to the non-British, their passage through the parliaments was not always without vigorous opposition. For example, Robert Sholl argued during the debates on the 1894 Medical Bill in Western Australia that the limitation of registration to those with UK qualifications was too restrictive, saying: 'There were very expert medical men of other nationalities who, under this schedule, would be excluded from practising … some of the greatest experts in medicine were Germans'.[8] And during the very lengthy debate in the New South Wales parliament during the second reading of the Bill that led to its 1938 Act, many objections were raised by members. One of the more vocal was James McGirr, who protested:

> A foreigner may have the highest degrees attainable, but such qualifications will be disregarded when he comes to this State. Unless he is prepared to attend the Sydney University [for the last three years of its course], he will be debarred from practising his profession here.[9]

Another member (admittedly without providing evidence) accused the Minister who sponsored the Bill of being under the influence of the BMA.[10]

The very major shifts in the source countries of the medical immigrants after about 1960, as shown in Chapters 5 and 7–8, can be attributed to marked changes in public and government attitudes to immigration generally, and the accompanying liberalisation of the medical Acts.

Over the longer period, the push and pull factors for individual immigrants seem to have altered. The early colonial IMGs usually came as the first in their families to migrate. This is quite different from the recent situation described in Chapter 10, where family reunions and chain migrations of diasporas were frequent features. The most common reason for many of the nineteenth century IMGs to leave was probably economic, although some may have been motivated by a desire for adventure. As mentioned in Chapter 5, it was often difficult for a young doctor to make a living in the early years after graduation in England. Economic factors, or at least a desire more

[8] Robert Sholl, *Western Australia Parliamentary Debates, Legislative Assembly* (15 November 1894), 1434.
[9] James McGirr, *New South Wales Parliamentary Debates, Legislative Assembly* (14 July 1938), 403.
[10] Robert Heffron, *New South Wales Parliamentary Debates, Legislative Assembly* (14 July 1938), 409.

broadly for a 'better life' for the doctor and their family, is still a very frequent contemporary motivator as evidenced in the oral histories.

Escaping warfare and conflict probably played little part in British medical emigration in the nineteenth century, since the British Isles were not under direct attack during the period. This contrasts with the number of recent immigrants who, in their oral histories, listed warfare or political oppression in their home countries as an important reason for escaping. It is possible that internal political reasons (suppression by the English) might have been drivers for some of the nineteenth century Irish graduates to choose Australia as a home; and some of the English might have been Chartists escaping persecution. But the thesis provides no direct evidence for those suppositions.

Chapter 6 has provided the opportunity to show one strength of a prosopography: the ability to link with other databases when researching the characteristics and activities of the group biography. The first of these linkages allowed every medically trained member of the colonial parliaments to be quite rapidly identified, and then some of their legislative activities traced. The second linkage allowed the causes of early mortality in the medical immigrants to two colonies to be explored by linking names from the prosopography to death certificates and coronial findings. One result of the latter (in light of prior scholarship) was expected—the high proportion who died from tuberculosis, probably migrating in the hope of cure. The other was not expected—the number who died by their own hand soon after they arrived. Life as a new medical migrant in the colonies was often not easy.

The oral histories have provided the largest collection of first-hand accounts of contemporary medical migrants to Australia. Some of the push and pull factors for migration that they uncovered were mentioned above, and there were many similarities to the findings of previous scholarship of international migration in general. But each oral history was, of course, unique. Perhaps no single reason for choosing Australia as a destination was as singular as that described by Boris Ivanov: as a boy in Soviet Russia he had fallen in love with an Australian movie called *Crocodile Dundee* which, despite censorship of most foreign films, was allowed to screen in his local cinema.

For some, the journey was easy and their subsequent life and practice in the new country rewarding. For others, the processes of obtaining visas, medical licensure, and somewhere to work were reminiscent of Egon Kunz's characterisation of his post-war medical refugees:

> Lost between [agencies] … puzzled by differing conditions laid down by the various [other agencies] … confused betwixt past promises and more recent realities, many foundered on the Scylla of easy hope or the Charybdis of despair.[11]

One group who had very variable experiences were those who had specialised in their home country but then had to persuade an Australian specialist college to judge them comparable to its members. Chapter 10 shows that there has been a quite substantial change in the way the colleges have done this over the past 60 years. An example of the early years was the oral history of the Indian-trained surgeon, Jana Rao— ignored by the RACS for many years, then watched spellbound for three hours by a senior Melbourne surgeon who stumbled on Rao performing an extremely difficult operation in a minor Melbourne hospital. Others, mostly UK-trained specialists, were essentially 'waved through' to Fellowship when they arrived 20–30 years ago. The process is much more rigorous now, and the interviews with senior members of colleges and the Medical Board in Chapter 11 shows the efforts that have been made recently to improve precision and fairness in their judgments. But sufficient examples emerged in the oral histories to show what appear still to be injustices.

The other group, who mainly constituted the 'criterion-sampled' IMGs in Chapter 10, were those negotiating visas, the AMC examinations, and the need to get a supervised hospital or GP teaching-practice position before they could be registered. Some of their difficulties could perhaps have been anticipated, under the 'buyer beware' caveat Dr Katsoukis very reasonably raised in Chapter 11. But other difficulties, notably the problem many have getting supervised positions, and the stress some endure while trying to comply with AHPRA's recency of practice requirements, warrant attention. A further difficulty arose for several, who had passed required examinations, but they and the employer had to deal with excessive delays in the completion of paperwork by the MBA. In some instances, the behaviour of individual MBA staff members (as reported in several oral histories) appears to have been unconscionable. Sometimes this may have been a result of staff shortages; at other times a junior person may have been blindly following a protocol without exhibiting interpersonal skills. All large bureaucracies are at risk of having their reputation damaged by staff at the coalface, and AHPRA appears to need to examine how the performance of some can be improved.

Limitations of the thesis

I have aimed, in the von Rankean tradition, to write this history *wie es eigentlich gewesen (ist)*[12], but with some inevitable limitations. The most objective section is

[11] Egon F Kunz, *The Intruders : Refugee Doctors in Australia* (Canberra: Australian National University Press, 1975), 28.

[12] Leopold von Ranke, *Geschichten der Romanischen und Germanischen Völker von 1494 bis 1535*, vol. 1 (Leipzig and Berlin: G.Reimer, 1824), vi. Usually translated as 'how it actually happened', but I think a

provided by the prosopography. If there are errors in that, some will have arisen from the occasional omission of information by the clerks compiling medical registers, others because I failed to correctly interpret a clerk's handwriting, and others from my interpretation of the most likely reasons for the temporal fluctuations in the data. An obvious limitation, though, is that the material in the interviews relies on the memory, perceptions and viewpoints of the participants—coloured by their experiences, which were sometimes traumatic, perhaps occasionally self-inflicted, but unmistakeably subjective.

Concluding remarks

This thesis has ranged over a long period of Australian immigration and medical history. Some of its findings reflect changes in attitudes in Australians overall during almost two centuries. But the thesis ends in the present, where the distribution of doctors outside major metropolitan centres still relies heavily on IMGs. This is an indication that our medical schools are still not producing sufficient graduates for the country's needs, and/or that our policies about where local graduates practise may need further refinement. Places in medical schools are tightly regulated by the Australian Government, and it is probably time to suggest a further expansion in these. However, even if Australia moves closer to self-sufficiency in the future, the part the medical immigrants have played since colonisation has been more than just providing enough doctors for our health needs—it has enriched this country with the immigrants' multiple voices and skills from a globalised world.

more faithful translation of what von Ranke intended by *gewesen* is 'how it actually had been': 'happened' implies motion and causation, the latter is a statement of fact.

BIBLIOGRAPHY

Primary Sources

Oral Histories [1]

Alonso, Valentina. Interviewed by author. Melbourne, 11 June 2019.

Antonova, Anna. Interviewed by author. Melbourne, 11 April 2018.

Appiah, Kumi. Interviewed by author. Regional Victoria (video), 11 August 2021.

Balakrishnan, Chandresh. Interviewed by author. Darwin (video), 5 August 2020.

Bandara, Nuwan. Interviewed by author. Townsville (video), 9 June 2020.

Begum, Madhab. Interviewed by author. Sydney (video), 15 August 2021.

Cadenas, Pierina. Interviewed by author. Melbourne, 28 March 2018.

Chaturvedi, Shailja.* Interviewed by author. Sydney (telephone), 10 April 2018

Chopra, Sanjana. Interviewed by author. Sydney (video), 2 April 2018.

Dalal, Binita. Interviewed by author. Melbourne (video), 23 August 2021.

Das, Shivangi. Interviewed by author. Melbourne, 27 June 2018.

Datta, Priya. Interviewed by author. Melbourne, 14 March 2018.

Dayal, Shreya. Interviewed by author. Melbourne, 11 April 2018.

Dekhordi, Mohammad. Interviewed by author. Melbourne, 13 June 2018.

Dhakal, Tau. Interviewed by author. Melbourne, 18 June 2019.

Dr X. Interviewed by author. Location redacted at IMG's request (video), 6 October 2020.

Eskander, Magdy.* Interviewed by author. Melbourne, 8 August 2018.

Evans, David. Interviewed by author. Melbourne (video), 22 September 2021.

Frederiks, Lawrence. Interviewed by author. Sydney (video), 9 October 2020.

Gokhale, Vani. Interviewed by author. Melbourne, 28 March 2018.

Hadi, Radeyah. Interviewed by author. Sydney (telephone), 23 June 2020.

Hakobyan, Artur.* Interviewed by author. Melbourne, 16 May 2018.

Hurtado, Jose. Interviewed by author. Melbourne, 2 May 2018.

Ivanov, Boris. Interviewed by author. Melbourne, 29 June 2019.

Jones, Roger. Interviewed by author. Melbourne (telephone), 8 October 2020.

Jose, Antony. Interviewed by author. Regional town (state obscured) (video), 12 August 2020.

Khademi, Bahiri. Interviewed by author. Melbourne, 28 March 2018.

[1] Names are pseudonyms (except when indicated with asterisks): the asterisked participants asked that their real name be used. Dr X (6 October 2020) was so concerned about possible repercussions to their ongoing attempts to navigate the AHPRA processes that they asked their gender to be obscured and that no pseudonym (which might identify their country of origin) be used. Some locations are also obscured (e.g., 'Regional Victoria' without mentioning town) to protect IMGs concerned about their privacy. When medium of interview not mentioned, they were face-to-face. Actual names of participants are held in a locked confidential file; if future researchers wish to be able to contact any of them, the author is prepared to discuss with the participant whether they would agree.

Khouri, Latoya. Interviewed by author. Melbourne, 11 April 2018.
Kohli, Surjan. Interviewed by author. Melbourne (video), 25 September 2020.
Kovačević, Nina. Interviewed by author. Melbourne (telephone), 3 July 2018.
Kumar, Vivaan. Interviewed by author. Townsville, QLD (video), 8 August 2021.
Le Grange, Hansie. Interviewed by author. Regional Western Australia (video), 23 June 2020.
Lloyd, David. Interviewed by author. Regional Western Australia (video), 19 August 2021.
López, Maria. Interviewed by author. Melbourne, 14 March 2018.
Madan, Rakesh. Interviewed by author. Melbourne, 27 June 2018.
Mahmud, Shamim. Interviewed by author. Melbourne, 14 March 2018.
Malhotra, Chaaran. Interviewed by author. Melbourne, 18 June 2019.
Malik, Anadia. Interviewed by author. Regional NSW (video), 15 August 2021.
Mangal, Rahul. Interviewed by author. Melbourne, 14 March 2018.
Mazdani, Erfan. Interviewed by author. Melbourne, 28 March 2018.
Mendoza, Rosa. Interviewed by author. Melbourne, 11 June 2019.
Morecroft, Livia. Interviewed by author. Melbourne, 19 July 2019.
Morris, Elizabeth. Interviewed by author. Sydney (telephone), 3 August 2018.
Mostafa, Walid. Interviewed by author. Regional Victoria (telephone), 24 March 2018.
Mrowka, Iwona.* Interviewed by author. Sydney (video), 9 August 2020.
Mukherjee, Deepak. Interviewed by author. Regional NSW (telephone), 25 April 2018.
Murphy, Sean. Interviewed by author. Brisbane (video), 20 August 2019.
Muthalaly, Daneen. Interviewed by author. Canberra (video), 3 August 2020.
Nair, Anjali. Interviewed by author. Melbourne, 30 May 2018.
Naufahu, Kalasia. Interviewed by author. Melbourne, 11 June 2019.
Nikolić, Vlado. Interviewed by author. Melbourne, 25 June 2019.
Okonkwo, Ayomide. Interviewed by author. Melbourne, 25 June 2019.
O'Shea, Mary. Interviewed by author. Perth (telephone), 28 August 2019.
Paria, Somaye. Interviewed by author. Melbourne, 16 May 2018.
Phillips, James. Interviewed by author. Sydney (telephone), 25 June 2018.
Pietersen, William. Interviewed by author. Regional Victoria (video), 17 July 2018.
Qazi, Faiza. Interviewed by author. Melbourne, 2 May 2018.
Ramos, Blessica. Interviewed by author. Rockhampton, QLD (video), 10 August 2021.
Rao, Jana.* Interviewed by author. Melbourne, 30 August 2019.
Reddy, Nabilah. Interviewed by author. Melbourne, 16 May 2018.
Roberts, Penelope. Interviewed by author. Melbourne, 4 July 2018.
Robertson, Alicja. Interviewed by author. Melbourne (video), 17 October 2020.
Rodriguez, Franchesca. Interviewed by author. Melbourne, 27 June 2018.
Sarraf, Sherif. Interviewed by author. Melbourne, 11 June 2019.

Schmid, Anika. Interviewed by author. Melbourne, 14 March 2018.
Schulz, Thomas. Interviewed by author. Regional Victoria (video), 28 August 2020.
Shaheen, Sanura. Interviewed by author. Melbourne, 19 November 2021.
Sharma, Prisha. Interviewed by author. Melbourne (video), 18 September 2020.
Shehu, Emina. Interviewed by author. Melbourne, 2 May 2018.
Shirazi, Aisha. Interviewed by author. Melbourne, 18 June 2019.
Smit, Roger. Interviewed by author. Regional SA (video), 17 August 2021.
Smith, Bridget. Interviewed by author. Alice Springs (video), 4 August 2020.
Soo, Yiu-po. Interviewed by author. Sydney (video), 17 July 2020.
Strutt, Rebecca.* Interviewed by author. Sydney (telephone), 3 July 2018.
Tamang, Shirisha. Interviewed by author. Melbourne, 16 May 2018.
Tehrani, Asad. Interviewed by author. Melbourne, 11 April 2018.
Thapa, Niharika. Interviewed by author. Melbourne, 13 June 2018.
Tuli, Jaamini. Interviewed by author. Melbourne, 25 June 2019.
Varadarajan, Suresh. Interviewed by author. Melbourne, 24 July 2019.
Varma, Ishaan. Interviewed by author. Regional NSW (video), 19 August 2021.
Vassy, Jeremy. Interviewed by author. Sydney (video), 25 June 2020.
Verosha, Ram. Interviewed by author. Regional Victoria (video), 14 October 2020.
Visser, Peter. Interviewed by author. Melbourne (video), 27 April 2021.
Wang, Kiu-ying. Interviewed by author. Melbourne, 31 July 2019.
Weber, Hans. Interviewed by author. Brisbane (video), 30 July 2020.
Weerasinghe, Ashal. Interviewed by author. Regional NSW (video), 12 August 2021.
Wiśniewski, Karolina. Interviewed by author. Hobart (telephone), 24 May 2018.

Other Interviews [2]

Broadbent, Penny. Interviewed by author. Melbourne, 20 May 2021.
Campbell, Graeme.* Interviewed by author. Melbourne, 9 August 2019.
Dunlop, Ashleigh. Interviewed by author. Rural Victoria (video), 18 June 2021.
Flynn, Joanna.* Interviewed by author. Melbourne, 20 August 2019.
Gupta, Kumar. Interviewed by author. Regional NSW (video), 19 August 2021.
Johnson, Barbara. Interviewed by author. Launceston, Tas., 20 February 2020.
Katsoris, Joanne.* Interviewed by author. Melbourne, 4 September 2019.
Larkins, Richard.* Interviewed by author. Melbourne, 25 October 2019.
McDonald, Simon. Interviewed by author. Rural Victoria (video), 1 February 2022.
Michael, Con.* Interviewed by author. Perth (audio), 16 March 2021.
Ozanne-Smith, Joan.* Interviewed by author. Melbourne, 19 June 2019.

[2] Asterisked names are real names, the rest are pseudonyms.

Roberts, Andrew.* Interviewed by author. Melbourne, 30 July 2019.

Shanahan, Rebecca. Interviewed by author. Sydney (video), 9 August 2019.

Singer, Andrew.* Interviewed by author. Canberra (telephone), 10 October 2019.

Watson, Barbara. Interviewed by author. Sydney, 8 July 2019.

Westmore, Roger. Interviewed by author. Melbourne (audio), 23 March 2020.

Archival Records

ACT Board of the Medical Board of Australia: Medical Register 1930-1984.

NAA: National Archives of Australia (records are cited by year and control symbol).

New South Wales State Archives (NSWSA): Medical Board Registration Files of Medical Practitioners Registered under Section 21c of the Medical Practitioners Act, 1938 (as amended), NRS-9875/1.

NSWSA: Minutes of Proceedings of the New South Wales Medical Board, 1854-1984, NRS-9871.

NSWSA: Register of Medical Practitioners for New South Wales, 1838-1980, NRS-15581.

Northern Territory Board of the Medical Board of Australia: Medical Register, 1935-1984.

Queensland Government, Births, Deaths, Marriages and Divorces, https://www.qld.gov.au/law/births-deaths-marriages-and-divorces.

Queensland State Archives (QSA): Minute Books, Medical Board of Queensland, 1860-1973, IDS9217.

QSA: Register of Medical Practitioners in Queensland, 1860-1973, ITM1101596-1101603.

State Records of South Australia (SRSA): Index to Foreign Doctors, 1979-1982.

SRSA: Minutes, Medical Board of South Australia, 1961-1984, GRS/14056.

SRSA: Register of Medical Practitioners and Minutes of the Medical Board to 1961, GRS/11897.

SRSA: Register of Medical Practitioners, 1934-1984, GRS/13285.

Tasmanian Archives (TA): Minutes of Meetings of the Court of Medical Examiners, 1841-1901, CB12/1.

TA: Minutes of Meetings of the Medical Council of Tasmania, 1908-1987, AE408/1/1-8.

TA: Register of Legally Qualified Medical Practitioners in Tasmania (1930-1967), AE410-1/1.

TA: Register of Legally Qualified Medical Practitioners in Tasmania – Annual Printed Lists 1908-2003, AE409.

UK General Register Office: Births, Deaths and Marriages.

Victorian Public Records Office (VPRO): Medical Board of Victoria, Medical Register, 1844-1998: VPRS16394.

VPRO: Medical Act, Foreign Practitioners Qualification Committee General Correspondence Files, VPRS 6345/P0000/300, 1960-1998.

VPRO: Medical Board of Victoria Minutes, 1853-1965: VPRS16389.

VPRO: Medical Board of Victoria – Foreign Register, 1957-1981: VPRS16392.

Western Australian Board of the Medical Board of Australia: Medical Register, 1895-1984.

Dataset

"Database of Applicants, 1978-2019 (deidentified)." Australian Medical Council Limited, provided to author 13 November 2019. (This database was of all applicants sitting the AMC examinations for those inclusive dates, plus others processed as specialists or via the Workplace-Based Assessment pathway).

Government Acts and Regulations[3]

Australia (Commonwealth):

Health Insurance Act 1973 No. 42 (of 1974) (Cth.)

Immigration Restriction Act 1901 No. 17 (Cth.)

Medical Practitioners National Security (Alien Doctors) Regulations." NAA: Control symbol 652/17/1, 1942.

National Security Act 1939 (Cth.).

Australian Capital Territory:

Health Practitioner Regulation National Law (ACT) Act 2010 No. 10 (ACT).

Medical Practitioners (Maternal Health) Amendment Act 2002 No. 26 (ACT).

Medical Practitioners Registration (Amendment) Act 1993 No. 21 (ACT).

Medical Practitioners Registration (Amendment) Act 1997 No. 109 (ACT).

Medical Practitioners Registration (Amendment) Ordinance (No. 2) 1982 No. 41 (ACT).

Medical Practitioners Registration (Amendment) Ordinance 1976 No. 40 (ACT).

Medical Practitioners Registration (Amendment) Ordinance 1978 No. 43 (ACT).

Medical Practitioners Registration (Amendment) Ordinance 1979 No. 38 (ACT).

Medical Practitioners Registration (Amendment) Ordinance 1980 No. 47 (ACT).

Medical Practitioners Registration (Amendment) Ordinance 1981 No. 48 (ACT).

Medical Practitioners Registration (Amendment) Ordinance 1982 No. 30 (ACT).

Medical Practitioners Registration (Amendment) Ordinance 1984 No. 13 (ACT).

Medical Practitioners Registration (Amendment) Ordinance 1985 No. 13 (ACT).

Medical Practitioners Registration (Amendment) Ordinance 1987 No. 57 (ACT).

Medical Practitioners Registration Ordinance 1930 No. 13 (ACT).

Medical Practitioners Registration Ordinance 1931 No. 7 (ACT).

Medical Practitioners Registration Ordinance 1933 No. 23 (ACT).

Medical Practitioners Registration Ordinance 1939 No. 2 (ACT).

Medical Practitioners Registration Ordinance 1950 No. 4 (ACT).

Medical Practitioners Registration Ordinance 1954 No. 9 (ACT).

Medical Practitioners Registration Ordinance 1956 No. 5 (ACT).

Medical Practitioners Registration Ordinance 1958 No. 13 (ACT).

[3] Statutes consulted are listed alphabetically by jurisdiction in the bibliography. The medical Acts are listed in order of year in Appendix A, Supplementary table 1.

Medical Practitioners Registration Ordinance 1962 No. 2 (ACT).

Medical Practitioners Registration Ordinance 1963 No. 3 (ACT).

Medical Practitioners Registration Ordinance (No. 2) 1963 [No. 1 of 1964] (ACT).

Medical Practitioners Registration Ordinance 1967 No. 14 (ACT).

Medical Practitioners Registration Ordinance (No. 2) 1967 No. 15 (ACT).

Medical Practitioners Registration Ordinance 1969 No. 21 (ACT).

Medical Practitioners Registration Ordinance 1970 No. 34 (ACT).

Medical Practitioners Registration Ordinance 1973 No. 44 (ACT).

Imperial:

An Act for Better Regulating the Practice of Apothecaries Throughout England and Wales 1815 (55 Geo. 3 c. 194) (Imperial).

An Act for the Appointing of Physicians and Surgeons 1511 (3 Hen. VIII c. 11) (Imperial).

An Act to Provide for the Attendance and Remuneration of Medical Witnesses at Coroners' Inquests 1836 (6 & 7 Wm. IV, c. 89) (Imperial).

An Act to Regulate the Qualifications of Practitioners in Medicine and Surgery 1858 (21&21 Vict. c. 90) (Imperial).

The New South Wales Constitution Act 1855 (18 & 191 Vic. c. 54) (Imperial).

Ireland:

Republic of Ireland Act 1948 No. 22 (Éire).

New South Wales:

An Act to Define the Qualifications of Medical Witnesses at Coroner's Inquests and Inquiries Held by Justices of the Peace in the Colony of New South Wales 1838 (2 Vic. No.22) (NSW).

An Act to Provide for the Attendance of Medical Witnesses at Coroner's Inquests and Inquiries Held by Justices of the Peace 1838(1 Vict. No.3) (NSW).

An Act to Provide for the Registration of Legally Qualified Medical Practitioners 1855 (19 Vic. No. 17) (NSW).

Health Practitioner Regulation National Law Act 2009 No. 86 (NSW).

Medical Practice Act 1992 No. 94 (NSW).

Medical Practice Amendment Act 2000 No. 64 (NSW).

Medical Practitioners (Amendment) Act 1939 No. 5 (NSW).

Medical Practitioners (Amendment) Act 1945 No. 11 (NSW).

Medical Practitioners (Amendment) Act 1950 No. 29 (NSW).

Medical Practitioners (Amendment) Act 1953 No. 22 (NSW).

Medical Practitioners (Amendment) Act 1955 No. 23 (NSW).

Medical Practitioners (Amendment) Act 1956 No. 14 (NSW).

Medical Practitioners (Amendment) Act 1957 No. 20 (NSW).

Medical Practitioners (Amendment) Act 1958 No. 12 (NSW).

Medical Practitioners (Amendment) Act 1963 No. 22 (NSW).

Medical Practitioners (Amendment) Act 1964 No. 13 (NSW).

Medical Practitioners (Amendment) Act 1972 No. 52 (NSW).

Medical Practitioners (Amendment) Act 1981 No. 55 (NSW).

Medical Practitioners (Amendment) Act 1982 No. 51 (NSW).

Medical Practitioners (Amendment) Act 1983 No. 41 (NSW).

Medical Practitioners (Amendment) Act 1987 No. 127 (NSW).

Medical Practitioners (Further Amendment) Act 1983 No. 177 (NSW).

Medical Practitioners Act 1855 (19 Vict. No. 18) (NSW).

Medical Practitioners Act 1898 No. 26 (NSW).

Medical Practitioners Act 1915 No. 33 (NSW).

Medical Practitioners Act 1938 No. 37 (NSW).

Medical Practitioners Act Amendment Act 1900 No. 33 (NSW).

Medical Practitioners Acts Further Amendment Act 1900 No. 70 (NSW).

Medical Witnesses at Inquests Act 1838 (1 Vict. No. 3) (NSW).

Medical Witnesses at Inquests Act 1838 (2 Vict. No. 22) (NSW).

Medical Witnesses at Inquests Act Amendment Act 1844 (8 Vict. No. 8) (NSW).

Medical Witnesses at Inquests Act Amendment Act 1845 (9 Vict. No. 12) (NSW).

Northern Territory:

Health Practitioner Regulation (National Uniform Legislation) Act 2010 (NT).

Medical Act 1995 No. 5 (NT).

Medical Practitioners Registration Act 1980 No. 45 (NT).

Medical Practitioners Registration Amendment Act 1983 No. 26 (NT).

Medical Practitioners Registration Amendment Act 1984 No. 29 (NT).

Medical Practitioners Registration Amendment Act 1985 No. 3 (NT).

Medical Practitioners Registration Ordinance 1935 No. 1 (NT).

Medical Practitioners Registration Ordinance 1945 No. 5 (NT).

Medical Practitioners Registration Ordinance 1957 No. 4 (NT).

Medical Practitioners Registration Ordinance 1961 (No. 3 of 1962) (NT).

Medical Practitioners Registration Ordinance 1962 (No. 5 of 1963) (NT).

Medical Practitioners Registration Ordinance 1971 No. 31 (NT).

Medical Practitioners Registration Ordinance 1972 No. 73 (NT).

Medical Practitioners Registration Ordinance 1976 No. 67 (NT).

Queensland:

Health Practitioner Regulation National Law Act 2009 No. 45 (Qld.)

Medical Act 1861 (25 Vic. No. 5) (Qld.)

Medical Act 1861 (25 Vic. No. 5) (Qld.)

Medical Act Amendment Act 1969 No. 3 (Qld.)

Medical Act Amendment Act 1973 No. 30 (Qld.)

Medical Act Amendment Act 1976 No. 4 (Qld.)

Medical Act Amendment Act 1978 No. 85 (Qld.)

Medical Act Amendment Act 1979 No. 34 (Qld.)

Medical Act Amendment Act 1980 No. 7 (Qld.)

Medical Act Amendment Act 1981 No. 37 (Qld.)

Medical Act Amendment Act 1984 No. 20 (Qld.)

Medical Act Amendment Act 1987 No. 24 (Qld.)

Medical Act and Other Acts (Administration) Act Amendment Act 1973 No. 3 (Qld.)

Medical Act and other Acts Amendment Act 1981 No. 76 (Qld.)

Medical Practitioners Registration Act 2001 No. 7 (Qld.)

Medical Practitioners Registration Amendment Act 2005 No. 30 (Qld.)

The Medical Act Amendment Act 1932 (23 Geo. V No. 33) (Qld.)

The Medical Act Amendment Act of 1940 (4 Geo. VI No. 21) (Qld.)

The Medical Act of 1925 (16 Geo. V No. 24) (Qld.)

The Medical Act of 1939 (3 Geo. VI No. 10) (Qld.)

The Medical Acts Amendment Act 1935 (26 Geo. V No. 5) (Qld.)

The Medical Acts Amendment Act of 1946 (10 Geo. VI No. 27) (Qld.)

The Medical Acts Amendment Act of 1955 (4 Eliz. II No. 27) (Qld.)

The Medical Acts Amendment Act of 1963 No. 9 (Qld.)

The Medical Acts Amendment Act of 1966 No. 23 (Qld.)

The Medical Acts Amendment Act of 1968 No. 53 (Qld.)*The Medical and Other Acts Amendment Act 1933 (24 Geo. No. 31)* (Qld.)

South Australia:

An Ordinance to Define the Qualifications of Medical Practitioners in this Province for certain purposes 1844 (8 & 9 Vict. No. 17) (SA).

An Ordinance to Define the Qualifications of Medical Practitioners in this Province for certain purposes (Amendment) 1846 (10 Vict. No. 1) (SA).

Health Practitioner Regulation National Law (South Australia) Act 2010 No. 5 (SA).

Medical Act 1880 (43 & 44 Vict. No. 193) (SA).

Medical Act Amendment Act 1889 (52 & 53 Vict. No. 471) (SA).

Medical Practice Act 2004 No. 53 (SA).

Medical Practitioners Act 1919 (10 Geo. V No. 1372) (SA).

Medical Practitioners Act 1983 No. 25 (SA).

Medical Practitioners Act Amendment Act 1921 (12 Geo. V No. 1495) (SA).

Medical Practitioners Act Amendment Act 1946 (10 Geo. VI No. 41) (SA).

Medical Practitioners Act Amendment Act 1950 (14 Geo. VI No. 42) (SA).

Medical Practitioners Act Amendment Act 1954 No. 5 (SA).

Medical Practitioners Act Amendment Act 1955 No. 41 (SA).

Medical Practitioners Act Amendment Act 1966 No. 60 (SA).

Medical Practitioners Act Amendment Act 1970 No. 62 (SA).

Medical Practitioners Act Amendment Act 1971 No. 68 (SA).

Medical Practitioners Act Amendment Act 1976 No. 58 (SA).

Medical Practitioners Act Amendment Act 1986 No. 110 (SA).

Medical Practitioners Act Amendment Act 1988 No. 43 (SA).

The Hospitals Act 1867 No. 7 (SA).

Tasmania (Van Diemen's Land):

An Act to amend an Act intituled An Act to regulate the Practice of Medicine in this colony 1840 (4 Vict. No. 24) (VDL).

An Act to amend and consolidate the laws now in force in this island regulating the practice of medicine therein 1842 (6 Vict. No. 2) (VDL).

An Act to provide for the attendance of medical witnesses at inquests 1836 (1 Vict. No. 14) (VDL).

An Act to regulate the Practice of Medicine in this colony 1837 (1 Vict. No. 17) (VDL).

Health Practitioner Regulation National Law Act 2010 No. 2 (Tas.).

Medical Act 1937 (1 Geo. VI No. 53) (Tas.).

Medical Act 1951 No. 26 (Tas.).

Medical Act 1954 No. 6 (Tas.).

Medical Act 1955 No. 10 (Tas.).

Medical Act 1957 No. 87 (Tas.).

Medical Act 1959 No. 80 (Tas.).

Medical Act 1961 No. 12 (Tas.).

Medical Act 1962 No. 22 (Tas.).

Medical Act 1963 No. 91 (Tas.).

Medical Act 1966 No. 36 (Tas.).

Medical Act 1968 No. 52 (Tas.).

Medical Act 1972 No. 30 (Tas.).

Medical Act 1973 No. 61 (Tas.).

Medical Act 1974 No. 16 (Tas.).

Medical Act 1977 No. 98 (Tas.).

Medical Act 1978 No. 36 (Tas.).

Medical Amendment Act 1982 No. 40 (Tas.).

Medical Amendment Act 1983 No. 37 (Tas.).

Medical Amendment Act 1986 No. 8 (Tas.).

Medical Amendment Act 1988 No. 33 (Tas.).

Medical Practitioners Amendment Act 1867 (31 Vict. No. 4) (Tas.).

Medical Practitioners Registration Act 1996 No. 2 (Tas.).

Medical Practitioners Registration Amendment Act 2004 No. 17 (Tas.).

Medical Practitioners Registration Amendment Act 2007 No. 50 (Tas.).

The Medical Act 1908 (8 Edw. VII No. 32) (Tas.).

The Medical Act 1918 (9 Geo. V No. 71) (Tas.).

The Medical Act 1919 (10 Geo. V No. 48) (Tas.).

The Medical Act 1920 (11 Geo. V No. 9) (Tas.).

Victoria:

Health Practitioner Regulation National Law (Victoria) Act 2009 No. 79 .

Medical (Amendment) Act 1960 No. 6643 (Vic.).

Medical (Amendment) Act 1961 No. 6837 (Vic.).

Medical (Amendment) Act 1964 No. 7212 (Vic.).

Medical (Foreign Practitioners Qualification Committee) Act 1966 No. 7408 (Vic.).

Medical (Foreign Practitioners) Act 1965 No. 7277 (Vic.).

Medical (Foreign Practitioners) Act 1967 No. 7565 (Vic.).

Medical (Registration) Act 1953 No. 5765 (Vic.).

Medical (Registration) Act 1956 No. 5965 (Vic.).

Medical (Registration) Act 1957 No. 6084 (Vic.).

Medical (Temporary Registration) Act 1951 No. 5546 (Vic.).

Medical Act 1890 (54 Vict. No. 1118) (Vic.).

Medical Act 1906 (7 Edw. No. 2069) (Vic.).

Medical Act 1915 (6 Geo. V No. 2695) (Vic.).

Medical Act 1915 No. 2 (6 Geo. V No. 2753) (Vic.).

Medical Act 1916 (7 Geo. V No. 2825) (Vic.).

Medical Act 1928 (19 Geo. V No. 3730) (Vic.).

Medical Act 1933 (24 Geo. V No. 4131) (Vic.).

Medical Act 1935 (26 Geo. V No. 4289) (Vic.).

Medical Act 1937 (1 Geo. VI No. 4504) (Vic.).

Medical Act 1938 (3 Geo. VI No. 4617) (Vic.).

Medical Act 1950 No. 5498 (Vic.).

Medical Act 1958 No. 6309 (Vic.).

Medical Act 1959 No. 6528 (Vic.).

Medical Practice Act 1994 No. 23 (Vic.).

Medical Practice and Nurses Acts (Amendment) Act 1995 No. 49 (Vic.).

Medical Practitioners (Amendment) Act 1981 No. 9670 (Vic.).

Medical Practitioners (Amendment) Act 1983 No. 9918 (Vic.).

Medical Practitioners (Amendment) Act 1991 No. 52 (Vic.).

Medical Practitioners (Amendment) Act No. 8424 (Vic.).

Medical Practitioners (Conditional Registration) Act 1983 No. 9948 (Vic.).

Medical Practitioners (Further Amendment) Act 1984 No.10132 (Vic.).

Medical Practitioners (Miscellaneous Amendments) Act 1984 No. 10072 (Vic.).

Medical Practitioners Act 1862 (25 Vict. No. 158) (Vic.).

Medical Practitioners Act 1889 (53 Vict. No. 1041) (Vic.).

Medical Practitioners Act 1970 No. 8061 (Vic.).

Medical Practitioners Registration Act 1946 No. 5151 (Vic.).

Medical Practitioners Statute 1865 (28 Vict. No. 262) (Vic.).

Western Australia:

Health Practitioner Regulation National Law (WA) Act 2010 No. 35.

Medical Act 1894 (58 Vict. No. 36) (WA).

Medical Act Amendment Act 1895 (59 Vict. No. 17) (WA)

Medical Act Amendment Act 1940 (4 & 5 Geo. VI No. 51) (WA).

Medical Act Amendment Act 1945 (9 & 10 Geo. VI No. 22) (WA).

Medical Act Amendment Act 1946 (10 Geo. VI No. 8) (WA).

Medical Act Amendment Act 1950 (14 Geo. VI No. 21) (WA).

Medical Act Amendment Act 1952 (1 Eliz. II No. 65) (WA).

Medical Act Amendment Act 1955 (4 Eliz. II No. 10) (WA).

Medical Act Amendment Act 1956 (5 Eliz. II No. 35) (WA).

Medical Act Amendment Act 1961 (10 Eliz. II No. 42) (WA).

Medical Act Amendment Act 1966 No. 43 (WA).

Medical Act Amendment Act 1968 No. 19 (WA).

Medical Act Amendment Act 1975 No. 19 (WA).

Medical Act Amendment Act 1976 No. 70 (WA).

Medical Act Amendment Act 1979 No. 56 (WA).

Medical Amendment Act 1981 No. 28 (WA).

Medical Amendment Act 1985 No. 70 (WA).

Medical Amendment Act 1988 No. 45 (WA).

Medical Amendment Act 1991 No. 29 (WA).

Medical Amendment Act 1994 No. 67 (WA).

Medical Amendment Act 1996 No. 38 (WA).

Medical Amendment Act 2000 No. 48 (WA).

Medical Amendment Act 2006 No. 49 (WA).

Medical Ordinance 1869 (33 Vict. No. 8) (WA).

Medical Practitioners Act 2008 No. 22 (WA).

Government Databases

Parliament of New South Wales, Former Members, https://www.parliament.nsw.gov.au/members/formermembers/Pages/former-members.aspx

Queensland Parliament, Former Members Register, https://www.parliament.qld.gov.au/Members/Former-Members/Former-Members-Register

Parliament of South Australia. All Former Members, https://www.parliament.sa.gov.au/en/Members/All-Former-Members

Parliament of Western Australia. Biographical Register of Members of the Parliament of Western Australia. https://www.parliament.wa.gov.au/parliament/library/MPHistoricalData.nsf/screenMemberBios

Government Gazettes

Hobart Town Gazette (later Hobart Gazette, then Tasmanian Government Gazette), 1840-1984, https://stors.tas.gov.au/TGG$tv.

NSW Government Gazette, 1850-1942, https://trove.nla.gov.au/search/category/newspapers?keyword=new%20south%20wales%20government%20gazette

Queensland Government Gazette, 1861-1900, https://www.textqueensland.com.au/gazette

South Australian Government Gazette, 1846-1984, https://governmentgazette.sa.gov.au/

Victoria Government Gazette, Online Archive 1836-1997, http://gazette.slv.vic.gov.au/

Western Australian Government Gazette, 1870-1984, https://www.legislation.wa.gov.au/legislation/statutes.nsf/gazettes.html

Government Reports and Documents

House of Representatives Standing Committee on Health and Ageing. *Lost in the Labyrinth: Report on the Inquiry into Registration Processes and Support for Overseas Trained Doctors*. Canberra: Commonwealth of Australia, 2012.

Legal Cases

Australian Medical Council v. Sir Ronald Wilson, Elizabeth Hastings and Jenny Morgan (Constituting the Human Rights and Equal Opportunities Commission) and Dr B Siddiqui and Commonwealth Minister for Health, (1996) 68 FCR 46.

Dr Siddiqui v. Australian Medical Council and Commonwealth Minister for Health, (1995) EOC 92-730.

Medical Board of Australia v Patel, (2015) QCAT 133.

Patel v the Queen, (2012) HCA 29.

Newspaper Articles, Press Releases and Other Media (primary)

AHPRA and National Boards. "Changes to Mandatory Notifications Requirements in Effect 1 March." accessed 9 March 2022, https://www.ahpra.gov.au/News/2020-03-02-Media-release-Mandatory-notifications.aspx.

"Annual Meeting of the Benevolent Society." *Sydney Gazette*, 3 June 1830, 2.

"Appendix A: Diploma of the University of Göttingen." *SMH*, 4 August 1849, 4.

Australian Competition & Consumer Commission. "A.C.C.C .Proposes Surgical College Reform to Help Address Surgeons Shortage." news release, 2003, https://www.accc.gov.au/media-release/accc-proposes-surgical-college-reform-to-help-address-surgeons-shortage.

"Australie: le 'Dr de la Mort' Condamné." *Le Figaro*, 1 July 2010.

"Benevolent Society: Account of the Late Anniversary Meeting." *Sydney Monitor*, 18 June 1834, 4.

Bhattacharya, Astha. "The Alarming Rise in Violence against Doctors in India and Its Immediate Solution." *Jurist*, 26 July 2021.

Bonner, Raymond. "Deaths and a Doctor's Past Transfix Australians." *The New York Times*, 19 June 2005.

Chandler, Jo. "Dr Jayant Patel Is Being Investigated over the Deaths of 87 Patients in a Public Hospital in Country Queensland." *The Age*, 28 May 2005.

Colvin, Mark. "Queensland to Review Overseas-Trained Doctors." ABC Radio National, 13 April 2005.

"Death from Chloral." *Brisbane Courier*, 22 November 1898.

"Death of Dr. Lapierre." *Kyabram Union*, 19 January 1894.

"Death of Dr. O'Reilly." *Kyneton Observer*, 20 July 1867.

Dhillon, Amrit. "Doctors in India Strike over Violent Attacks by Patients' Families " *The Guardian*, 17 June 2019.

"Distressing Fatal Accident." *Sydney Morning Herald*, 22 June 1886.

Dudley, Hugh. "Professor Critical of Australian Doctors." *Canberra Times*, 11 December 1972, 3.

Editorial. "Medibank Mark II." *SMH*, 29 September 1976, 6.

"Deaths." *Illustrated Sydney News*, 5 November 1853, 6.

Foley, Meraiah. "Inquiry into Australia's 'Dr Death'." *Irish Examiner*, 23 May 2005.

Haikerwal, Mukesh. "Observations from an Overseas Trained Doctor." Australian Press Club, 20 July 2005.

Halpin, Tony, David Brown, and Daniel McGrory. "Ex-KGB Spy 'Was Poisoned in Hotel'." *The Times (UK)*, 8 December 2006.

"Intercolonial Arrivals and Departures." *Hobart Mercury*, 10 December 1877.

"Malaysian Riots: Forces Impose Calm on Capital." *Canberra Times*, 19 May 1969, 5.

"Mc Laurin." *The Argus*, 26 July 1884.

"Notice." *Gympie Times and Mary River Mining Gazette*, 10 July 1884.

"Obituary: Emeritus Prof Hugh Dudley, Surgeon Who Set up World-Class Medical School." *The Scotsman*, 15 July 2011.

Parnell, Sean, and Tony Koch. "Coroner Probe in 'Dr Death' Scandal." *The Australian*, 15 April 2005.

Rajghatta, Chidanand. "Tale of Two Patels: One's a Lifesaver, the Other's Dr Death." *Times of India*, 21 April 2005.

Roxon, Nicola. "Registration, Accreditation and Support Processes for Overseas Doctors " news release, 25 November 2010, https://parlinfo.aph.gov.au/parlInfo/download/media/pressrel/398250/upload_binary/398250.p

df;fileType=application/pdf#search=%22registration%20processes%20and%20support%20for%20overseas%20trained%20doctors%22.

Sala, George Augustus. "The Land of the Golden Fleece: Marvellous Melbourne." *The Argus*, 8 August 1885, 5.

"Sharp Rise in TB Cases in Victoria." *Canberra Times*, 5 June 1980, 7.

Smith, Bridie. "Physician's Working Life Spent Cleaning and Selling Petrol." *The Age*, 22 July 2004.

Supreme Court. "Re Parte Dr Fattorini." *SMH*, 20 April 1849, 2.

"Surgeon Accused." *The Times (London)*, 6 August 2005.

"Sydney Eesti Arst: Dr S Perendi Lôpetas Ülikooli [Sydney Estonian Doctor: Dr S Perendi Graduates from University]." *Meie Kodu (Sydney)*, 20 May 1954, 1.

"Sydney Dispensary." *Sydney Gazette*, 7 August 1830, 3.

"TB Spreading in Destitute in Sydney and Melbourne." *Canberra Times*, 16 November 1982, 3.

"The Death of Dr. Pattinson: The Inquest." *Mount Alexander Mail*, 14 March 1864.

The Telegraph (Brisbane), 26 September 1888.Thomas, Hedley. "The Deadly Legacy of Dr Patel." *The Courier-Mail*, 13 April 2005.

Thomas, Hedley. "The Deadly Legacy of Dr Patel." *The Courier-Mail*, 13 April 2005.

———. "Why Didn't They Check?" *The Courier-Mail*, 13 April 2005.

"Town Talk." *Geelong Advertiser*, 28 January 1878.

Whiting, Kenneth. "P.M. Inherits Old Problems: Political, Racial Unrest in Malaysia." *Canberra Times*, 21 January 1976, 6.

Wijesinha, Sanjiva. "Australians See Dr Death in Every Overseas-Trained Doctor." *The Age*, 14 June 2005.

"William James Gray." *The Argus*, 17 May 1899.

Parliamentary Debates

Barton, Edward. *Commonwealth Parliamentary Debates, House of Representatives*. 7 August 1901.

Commonwealth Parliamentary Debates, 1901-1980, http://historichansard.net/

Commonwealth Parliament, Votes and Proceedings, 1901-2016, https://www.aph.gov.au/Parliamentary_Business/Chamber_documents/HoR/Votes_and_Proceedings/votes

Copeland, Stuart. *Queensland Parliamentary Debates*. 22 March 2005.

Fitzsimons, Herbert. *NSW Parliamentary Debates, Legislative Assembly*. 4 August 1938.

Heffron, Robert. *New South Wales Parliamentary Debates, Legislative Assembly*. 14 July 1938.

James, Walter. *Western Australia Parliamentary Debates, Legislative Assembly*. 15 November 1894.

McGirr, James. *New South Wales Parliamentary Debates, Legislative Assembly*. 14 July 1938.

NSW Legislative Council, Votes and Proceedings, https://www.parliament.nsw.gov.au/hansard/pages/home.aspx?tab=Browse&s=1

NSW Parliamentary Debates, Legislative Assembly. 26 March 1973.

Richardson, John. *Western Australia Parliamentary Debates, Legislative Assembly*. 15 November 1894.

Ridge, Keith. *Western Australia Parliamentary Debates, Legislative Assembly*. 7 September 1976.

Scott, Bruce. *Commonwealth Parliamentary Debates, House of Representatives*. 18 October 2010.

Sholl, Robert. *Western Australia Parliamentary Debates, Legislative Assembly*. 15 November 1894.

Victorian Parliamentary Debates, Legislative Assembly, https://www.parliament.vic.gov.au/hansard/historical-hansard.

Secondary Sources

Books and Journals[4]

Ackerknecht, Erwin H. "Medical Education in Nineteenth Century France." *Journal of Medical Education* 32, no. 2 (1957): 148-53.

Adams, Tracey L. "Self-Regulating Professions: Past, Present, Future." *Journal of Professions and Organization* 4, no. 1 (2017): 70-87.

Aidani, Mammad. "Iranian Poetic Testimonies of Revolution, Trauma and Displacement." *Australian Feminist Studies* 26, no. 69 (2011): 335-47.

Alltree, David. *The Leaving of Liverpool: Medical Migration to Western Australia*. Guildford, WA: Vineyard Publishing, 2008.

Anderson, Warwick. "Disease, Culture and History." *Health and History* 1, no. 1 (1998): 30-34.

Arnold, PC, and DE Lewinsohn. "Motives for Migration of South African Doctors to Australia since 1948." *Medical Journal of Australia* 192, no. 5 (2010): 288-90.

Arnold, Peter. *A Unique Migration: South African Doctors Fleeing to Australia.* Seattle, WA: CreateSpace, 2011.

Australian Competition & Consumer Commission and Australian Health Workforce Officials' Committee. *Review of Australian Specialist Medical Colleges: Report to Australian Health Ministers*. Canberra: Commonwealth of Australia, 2005.

Australian Medical Association, South Australian Branch. *The South Australian Branch of the Australian Medical Association: A Centenary History*. Adelaide: SA Branch of AMA, 1979.

Backhouse, James. *A Narrative of a Visit to the Australian Colonies*. London: Hamilton, Adams and Co., 1843.

Balint, Ruth, and Zora Simic. "Histories of Migrants and Refugees in Australia." *Australian Historical Studies* 49, no. 3 (2018): 378-409.

Bashford, Alison, and Stuart Macintyre. *The Cambridge History of Australia*. Cambridge: Cambridge University Press, 2013.

Bates, Barbara. *Bargaining for Life: A Social History of Tuberculosis, 1876-1938*. Philadelphia: Pennsylvania University Press, 1992.

[4] If there are more than six authors to a work, the first six are listed followed by *et al.*

Belich, James. *Replenishing the Earth: The Settler Revolution and the Rise of the Anglo-Celtic World, 1783-1939*. Oxford: Oxford University Press, 2009.

Bennett, Scott. *McCall, Sir John 1860-1919)*. Australian Dictionary of Biography. National Centre of Biography, Australian National University, https://adb.anu.edu.au/biography/mccall-sir-john-7299, published first in hardcopy 1986, accessed online 3 September 2021.

Berkowitz, Edward D. "The Historian as Policy Analyst: The Challenge of HEW." *The Public Historian* 1, no. 3 (1979): 17-25.

Bhattacharyya, Anusuya, Sarma Phulen, Harish Kumar, Bikash Medhi, Kasturi Bhattacharjee, Harsha Bhattacharjee, *et al.* "Doctor of Medicine and Diplomate of National Board Courses in India—Issues and Equivalence: A Comparative Analysis." *Innovare Journal of Medical Sciences* 8, no. 1 (2020): 1-7.

Biggs, Amanda. *Medicare—Background Brief*. Canberra: Parliament of Australia, 2004.

Bird, S Dougan. *On Australasian Climates and Their Influence on the Prevention and Arrest of Pulmonary Consumption*. London: Longman [etc.], 1863.

Birrell, Bob. "Hunger Strikes and the Accreditation of Overseas Trained Doctors in Australia." *People and Place* 5, no. 4 (1997): 53-58.

Birrell, Bob, and Lesleyanne Hawthorne. "Medicare Plus and Overseas-Trained Medical Doctors." *People and Place* 12, no. 2 (2004): 84-100.

Birrell, Bob, and Andrew Schwartz. "Accreditation of Overseas Trained Doctors: The Continuing Crisis." *People and Place* 14, no. 3 (2006): 37-47.

Birrell, Robert J. "Australian Policy on Overseas-Trained Doctors." *Medical Journal of Australia* 181, no. 11-12 (2004): 635-39.

Blacket, RB. "Foreign Medical Graduates. The Experience of the Australian Medical Examining Council and the Australian Medical Council, 1978-1989: Implications for Medical Immigration and the Medical Workforce." *Medical Journal of Australia* 153, no. 3 (1990): 125-32.

Blainey, Geoffrey. *A History of Victoria*. Cambridge: Cambridge University Press, 2013.

———. *Odd Fellows: A History of IOOF Australia*. North Sydney: Allen & Unwin, 1991.

———. *The Rush That Never Ended: A History of Australian Mining*. Parkville, Vic.: Melbourne University Press, 1963.

Bodvarsson, Örn B, and Hendrik Van den Berg. *The Economics of Migration: Theory and Policy*. 2nd ed. New York: Springer, 2013.

Bohra-Mishra, Pratikshya, and Douglas S Massey. "Individual Decisions to Migrate During Civil Conflict." *Demography* 48, no. 2 (2011): 401-24.

Borrie, WD. *The European Peopling of Australasia: A Demographic History, 1788-1988*. Canberra: Australian National University, 1994.

Bowden, Keith. *Doctors and Diggers on the Mount Alexander Goldfields*. Maryborough, Vic.: Hedges and Bell, 1974.

Boxall, Anne-Marie, and James Gillespie. *Making Medicare: The Politics of Universal Health Care in Australia*. Sydney: UNSW Press, 2013.

Boyatzis, Richard E. *Transforming Qualitative Information: Thematic Analysis and Code Development*. Thousand Oaks, Calif.: Sage Publications, 1998.

Bozorgmehr, Mehdi, and Georges Sabagh. "High Status Immigrants: A Statistical Profile of Iranians in the United States." *Iranian Studies* 21, no. 3-4 (1988): 5-36.

Braudel, Fernand. "La Longue Durée." *Annales: Histoire et Sciences Sociales* 13, no. 4 (1958): 725-53.

———. *La Méditerranée et le Monde Méditerranéen à L'Époque de Philippe II*. Paris: A Colin, 1949.

Breen, Kerry J. "National Registration Scheme at 5 Years: Not What It Promised." *Australian Health Review* 40, no. 6 (2016): 674-78.

Breen, K, I Frank, and T Walters. "Australian Medical Council: A View from the Inside." *Internal Medicine Journal* 31, no. 4 (2001): 243-48.

Breen, Kerry, and Kym Jenkins. "Australia's Health Ministers Ignore Concerns About Mandatory Reporting of Unwell Doctors." *BMJ Opinion*, June 10, 2019.

Breier, Mignonne, and Angelique Wildschut. *Doctors in a Divided Society: The Profession and Education of Medical Practitioners in South Africa*. Cape Town: HSRC Press, 2006.

Brown, Isaac Baker Jr. *Australia for the Consumptive Invalid: The Voyage, Climates, and Prospects for Residence*. London: Robert Hardwicke, 1865.

Brown, Keith. "Surgeons in Exile at Botany Bay, 1770-1816." *Bulletin of the Postgraduate Committee in Medicine University of Sydney* 7, no. 1 (1951): 1-18.

Bryan, Cyril. "The Earliest Medical History of Australia." *Journal and Proceedings of the Western Australian Historical Society* 2 (1933): 47-58.

Bryder, Linda. "'A Health Resort for Consumptives': Tuberculosis and Immigration to New Zealand, 1880-1914." *Medical History* 40, no. 4 (1996): 453-71.

———. "History of Medicine in Australia and New Zealand." In *The Oxford Handbook of the History of Medicine,* edited by Mark Jackson. Oxford: Oxford University Press, 2012 (online version). http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199546497.001.0001/oxfordhb-9780199546497-e-017

Burke, Edmund. *Thoughts on the Cause of the Present Discontents*. London: printed for J. Dodsley, in Pall-Mall, 1770.

Caldwell, JC. "Population." In *Australians, Historical Statistics*, edited by Wray Vamplew, 23-41. Broadway, NSW: Fairfax, Syme & Weldon Associates, 1987.

Cameron, Charles A. *History of the Royal College of Surgeons in Ireland and the Irish Schools of Medicine*. 2nd ed. Dublin: Fannin & Company, 1916.

Carter, David J. "Correcting the Record: Australian Prosecutions for Manslaughter in the Medical Context." *Journal of Law and Medicine* 22 (2015): 588-609.

Castles, Ian. *Year Book Australia 1994*. Canberra: Australian Bureau of Statistics, 1994.

Castles, Stephen. "Understanding Global Migration: A Social Transformation Perspective." *Journal of Ethnic and Migration Studies* 36, no. 10 (2010): 1565-86.

Chapman, HS. *Parliamentary Government; or Responsible Ministries for the Australian Colonies*. Tasmania: Pratt and Son, 1854.

Chen, Lincoln, Timothy Evans, Sudhir Anand, Jo Ivey Boufford, Hilary Brown, Mushtaque Chowdhury*, et al.* "Human Resources for Health: Overcoming the Crisis." *Lancet* 364, no. 9449 (2004): 1984-90.

Christianson, Sven-Åke, and Martin Safer. "Emotional Events and Emotions in Autobiographical Memories." In *Remembering Our Past: Studies in Autobiographical Memory*, edited by David C. Rubin, 218-43. New York: Cambridge University Press, 1996.

Clark, George. "History of the Royal College of Physicians of London." *British Medical Journal* 1, no. 5427 (1965): 79-82.

Clarkson, Chris, Zenobia Jacobs, Ben Marwick, Richard Fullagar, Lynley Wallis, Mike Smith, *et al*. "Human Occupation of Northern Australia by 65,000 Years Ago." *Nature* 547, no. 7663 (2017): 306-10.

Coghlan, Timothy A. *A Statistical Account of the Seven Colonies of Australasia, 1897-8*. Sydney: Government Printer, 1898.

Cohen, Jordan J. "The Role and Contributions of IMGs: A U.S. Perspective." *Academic Medicine* 81, no. 12 Supplement (2006): S17-S21.

Coleman, James S. "The Study of Social Organizations with Survey Methods." *Human Organization* 17, no. 4 (1958): 28-36.

"Conference Re Friendly Societies and the Medical Profession." *Intercolonial Medical Journal of Australasia* 3, no. 11 (1898): 675-83.

Copeman, WSC. *The Worshipful Society of Apothecaries of London: A History 1617-1967*. Oxford: Pergamon Press, 1967.

Cotton, Richard Payne. "Consumption and Climate." *British Medical Journal* 1, no. 838 (1877): 67-68.

Coxwell, CF. "A Study of Phthisis Mortality in Victoria." *Australian Medical Journal* 15, no. 4 (1893): 185-206.

Crawford, Robert. "Ignoble but Lucrative: Quacks, Ads, & Regulation." Journal of Australian Studies 36, no. 1 (2012): 29-47.

Creswell, Clarendon Hyde. *The Royal College of Surgeons of Edinburgh: Historical Notes from 1505 to 1905*. Edinburgh: Oliver and Boyd, 1926.

Crouch, C Stanton. "Friendly Societies and the Australian Profession." *Journal of the American Medical Association* 71, no. 15 (1918): 41.

Crowther, WELH. *Crowther, William Lodewyk (1817-1885)*. Australian Dictionary of Biography. National Centre of Biography, Australian National University, https://adb.anu.edu.au/biography/crowther-william-lodewyk-3297 , published first in hardcopy 1976, accessed online 3 September 2021.

Cullen, William. *Synopsis Nosologiae Methodicae* 3rd ed. Edinburgh: Publisher not identified, 1769.

Cummins, CJ. *A History of Medical Administration in New South Wales, 1788-1983*. North Sydney: New South Wales Health, 1979.

Cunningham, Peter. *Two Years in New South Wales: A Series of Letters Comprising Sketches of the Actual State of Society in That Colony, of Its Peculiar Advantages to Emigrants; of Its Topography, Natural History, &c. &c.* Vol. 1, London: Henry Colburn, 1827.

Daniel, Thomas M. "The History of Tuberculosis." *Respiratory Medicine* 100, no. 11 (2006): 1862-70.

Davies, Geoffrey. "Queensland Public Hospitals Commission of Inquiry Report." Brisbane: Queensland Government, 2005, available at http://www.qphci.qld.gov.au/final_report/Final_Report.pdf.

Demy-Geroe, Michael Steven. "Commission of Inquiry No. 1 of 2005, Medical Board of Queensland, Annexure Mdg-3." http://www.qphci.qld.gov.au/pdf/BHCI_Exhibit24-00.pdf.

Dew, Harold R. "Developments in Undergraduate Medical Education in Australia." *Medical Journal of Australia* 1, no. 1 (1951): 35-40.

Dewhurst, Neil G, Chris McManus, Jennifer Mollon, Jane E Dacre, and Allister J Vale. "Performance in the MRCP(UK)Examination 2003–4: Analysis of Pass Rates of UK Graduates in Relation to Self-Declared Ethnicity and Gender." *BMC Medicine* 5, no. 8 (2007): 1-8.

Digby, Anne. *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*. Cambridge: Cambridge University Press, 1994.

Dingwall, Helen. *'A Famous and Flourishing Society': The History of the Royal College of Surgeons of Edinburgh 1505-2005.* Edinburgh: Edinburgh University Press, 2005.

Dingwall, HM. "The Triple Qualification Examination of the Scottish Medical and Surgical Colleges, 1884-1993." *Journal of the Royal College of Physicians of Edinburgh* 40, no. 3 (2010): 269-76.

Doherty, Ralph L. *Australian Medical Education and Workforce into the 21st Century: Committee of Inquiry into Medical Education and Medical Workforce*. Canberra: AGPS, 1988.

Dorigo, Guido, and Waldo Tobler. "Push-Pull Migration Laws." *Annals of the Association of American Geographers* 73, no. 1 (1983): 1-17.

Dove, N. "Can International Medical Graduates Help Solve Canada's Shortage of Rural Physicians?". *Canadian Journal of Rural Medicine* 14, no. 3 (2009): 120-22.

Duckett, SJ. "Chopping and Changing Medibank." *Australian Journal of Social Issues* 14, no. 3 (1977): 230-43.

Duckett, Stephen, and Sharon Willcox. *Australian Health Care System*. 5th ed. Sydney: Oxford University Press, 2015.

Duplain, Raymond C. "Elites in the Colony and State of Victoria 1860-1939: A Prosopographical Analysis." PhD, Deakin University, 1994.

Durey, Angela. "The Changing Face of Rural General Practice: An Ethnographic Study of General Practitioners and Their Spouses." PhD, Edith Cowan University, 2005, https://ro.ecu.edu.au/theses/61.

Durkheim, Émile. *Le Suicide: Étude de Sociologie*. Paris: Félix Alcan, 1897.

Duszczyk, Maciej, and Kamil Majuszczyk. "Labour Market Security and Migration-Related Decisions: Theoretical Background." In *Why Do People Migrate? Labour Market Security and Migration Decisions*, edited by Maciej Duszczyk, 25-66. Bingley, UK: Emerald Publishing, 2019.

Dyason, Diana. "The Medical Profession in Colonial Victoria, 1834-1901." In *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, edited by Roy Macleod and Milton Lewis, 194-216. London: Routledge, 1988.

———. "Professional Self Respect." *Australian Medical Journal*, no. 3 (1870): 81-82.

Earles, Melvyn P. "The Introduction of Hydrocyanic Acid into Medicine: A Study in the History of Clinical Pharmacology." *Medical History* 11, no. 5 (1967): 305-13.

Editorial. "A Committee on Overseas Professional Qualifications." *Medical Journal of Australia* 1 (1969): 863-64.

———. "Mr William Thomson FRCS Ed." *Australian Medical Journal* 5, no. 7 (1883): 315-21.

Elkin, AP. *Aboriginal Men of High Degree*. 2nd ed. St Lucia, Qld: University of Queensland Press, 1977.

Elliott, SL, and ND Yeomans. "Future Directions of Medical Education in Australia." *Internal Medicine Journal* 33, no. 8 (2003): 360-61.

Eulner, Hans-Heinz "Historische Aspekte zu Aktuellen Fragen des Medizinstudiums." *Medizinhistorisches Journal* 3, no. 3 (1968): 180-94.

Evans, Robert G. "The Transformation of Australian Hospitals between the 1940s and the 1970s." *Health and History* 7, no. 2 (2005): 101-25.

Eyal, Nir, and Samia A Hurst. "Physician Brain Drain: Can Nothing Be Done?" *Public Health Ethics* 1, no. 2 (2008): 180-92.

Fairchild, Henry Pratt *Immigration: A World Movement and Its American Significance*. New York: Macmillan, 1925.

Fenton, James. *A History of Tasmania from Its Discovery in 1642 to the Present Time*. Hobart: J Walch and Sons, 1884.

Fenton, James Jemison. *Victorian Year-Book, 1895-8*. Melbourne: Government Printer, 1901.

Ferguson, John. *A Prosopography to the Poems of Juvenal*. Bruxelles: Latomus, 1987.

Fitzgerald, John. *Big White Lie: Chinese Australians in White Australia*. Sydney: University of NSW Press, 2006.

Fitzpatrick, David, Patrick Comber, and Edward Comber. "'An Outside Part of the World': Patrick and Edward Comber, 1862-92." In *Oceans of Consolation: Personal Accounts of Irish Migration to Australia*, edited by David Fitzpatrick, 230-48. Ithaca, NY: Cornell University Press, 1994.

Foucault, Michel. *Naissance de la Clinique*. Paris: Presses Universitaires de France, 1963.

Fourcroy, Antoine-François. "Décret des Comités d'Instruction Publique et de Salut Public sur l'Établissement d'une École Centrale de Médecine à Paris, Montpellier et Strasbourg." *Archives Parlementaires de la Révolution Française* 102 (2012, reprint of 1794), no. 1 (1794): 401-03.

Fowler, James K. "The Colonial Medical Service as a Career." *Lancet* 194, no. 5009 (1921): 729-34.

Fox, Theodore. "The Antipodes: Private Practice Publicly Supported." *Lancet* 281, no. 7286 (1963): 875-79.

Freud, Sigmund. *Das Ich und Das Es: Gesammelte Werke*. Psychoanalytic Electronic Publishing, 1923. http://www.pep-web.org/document.php?id=gw.013.0237a&type=hitlist&num=18&query=fulltext1%2Cgesammelte+werke+XIII%7Czone1%2Cparagraphs%7Czone2%2Cparagraphs%7Csort%2Cauthor%2Ca#hit1.

Gandevia, Bryan. *An Annotated Bibliography of the History of Medicine in Australia*. Sydney: Australian Medical Publishing Co., 1955.

———. "The Contribution of Doctors to Early Australiana." *Journal of the American Medical Association* 196, no. 1 (1966): 183-86.

———. "The Pattern of Australian Medical History." *Proceedings of the Royal Society of Medicine* 50 (1957): 591-98.

———. *Thomson, William (1819-1883)*. Australian Dictionary of Biography. National Centre of Biography, Australian National University. http://adb.anu.edu.au/biography/thomson-william-4718/text7823, published first in hardcopy 1976, accessed online 2 August 2020.

Garces-Ozanne, Arlene, Ameline Yow, and Rick Audas. "Rural Practice and Retention in New Zealand: An Examination of New Zealand-Trained and Foreign-Trained Doctors ". *New Zealand Medical Journal* 124, no. 1330 (2011): 14-23.

Gardner, Lyndsay. *Royal Children's Hospital, Melbourne, 1870-1970*. Parkville, Vic.: The Hospital, 1970.

Geary, Laurence M. "The Scottish-Australian Connection 1850-1900." In *The History of Medical Education in Britain*, edited by Vivian Nutton and Roy Porter, 51-75. Amsterdam: Rodopi, 1995.

Geffen, Laurence. "A Brief History of Medical Education and Training in Australia." *Medical Journal of Australia* 201, no. 1 (2014): S19-S22.

———. *Assuring Medical Standards: The Australian Medical Council 1985-2010*. Kingston, ACT: Australian Medical Council, 2010.

Geyer-Kordesch, Johanna, and Fiona Macdonald. *Physicians and Surgeons in Glasgow: The History of the Royal College of Physicians and Surgeons of Glasgow, 1599-1858*. London: Hambledon Press, 1999.

Gibson, Peter. "Scottish Emigration to Australia, 1788-1939." *Descent* 30, no. 2 (2000): 81-88.

Geary, Laurence M. "The Scottish-Australian Connection 1850-1900." In *The History of Medical Education in Britain*, edited by Vivian Nutton and Roy Porter, 51-75. Amsterdam: Rodopi, 1995.

Gilchrist, Ebenezer. *The Use of Sea Voyages in Medicine*. London: Millar, Wilson and Durham, 1756.

Gill, JCH. "Jean Baptiste Charles Lamonnerie Dit Fattorini, Late of Port Macquarie, NSW." *Royal Historical Society of Queensland* 9, no. 2 (1971): 134-67.

Gillespie, James A. *The Price of Health: Australian Governments and Medical Politics 1910-1960*. Cambridge: Cambridge University Press, 1991.

Girdwood, Ronald H. "Three Hundred Years of the Royal College of Physicians of Edinburgh." *British Medical Journal* 283 (1981): 651-54.

Golder, Hilary. *Politics, Patronage and Public Works: The Administration of New South Wales, 1842-1900*. Vol. 1, Sydney: University of NSW Press, 2005.

Goodman, David. "The Goldrushes of the 1850s." In *The Cambridge History of Australia*, edited by Alison Bashford and Stuart Macintyre, 170-88. New York: Cambridge University Press, 2013.

Goodwin, Craufurd D. "British Economists and Australian Gold." *Journal of Economic History* 30, no. 2 (1970): 405-26.

Green, Alix R. History, *Policy and Public Purpose : Historians and Historical Thinking in Government*. London: Palgrave-Macmillan, 2016.

Green, David G. "The 1918 Strike of the Medical Profession against the Friendly Societies in Victoria." *Labour History* 46, no. 1 (1984): 72-87.

Green, David G, and Lawrence G Cromwell. *Mutual Aid or Welfare State: Australia's Friendly Societies*. Sydney: Allen & Unwin, 1984.

Gregory, Alan. *The Ever Open Door: A History of the Royal Melbourne Hospital 1848-1998*. South Melbourne: Hyland House, 1998.

Guthrie, Douglas. "On Writing a History of Medicine." *International Record of Medicine and General Practice Clinics* 169, no. 11 (1956): 695-702.

Hagen-Zanker, Jessica. "Why Do People Migrate? A Review of the Theoretical Literature." Graduate School of Governance Working Paper No. WP002: Maastricht University, 2008.

Hahnemann, Samuel. *Organon der Heilkunst*. Dresden: Arnoldischen Buchhandlung, 1829.

Haines, Robin F. "Therapeutic Emigration: Some South Australian and Victorian Experiences." *Journal of Australian Studies* 16, no. 33 (1992): 76-90.

Han, Gil Soo, and John S Humphreys. "Overseas-Trained Doctors in Australia: Community Integration and Their Intention to Stay in a Rural Community." *Australian Journal of Rural Health* 13, no. 4 (2005): 236-41.

Harris, Anna, and Marilys Guillemin. "Notes on the Medical Underground: Migrant Doctors at the Margins." *Health Sociology Review* 24, no. 2 (2015): 163-74.

Harris, Mark F, and Nicholas A Zwar. "Reflections on the History of General Practice in Australia." *Medical Journal of Australia* 201, no. Suppl. 1 (2014): S37-40.

Harrison, Edward. *An Address Delivered to the Lincolnshire Benevolent Medical Society at Their Anniversary Meeting in 1809, Containing an Account of the Proceedings Lately Adopted to Improve Medical Science, and an Exposition of the Intended Act for Regulating Medical Education and Practice*. London: R. Bickerstaff, 1810. https://play.google.com/books/reader?id=Rah9HNz6FogC&hl=en_US&pg=GBS.PP5.

Hart, PR, and CJ Lloyd. *Lyons, Joseph Aloysius (Joe)(1879-1939)*. Australian Dictionary of Biography. Canberra: Australian National University, 1986.

Haszler, Charles. "The New Australian Doctors in New Guinea." *Papua and New Guinea Medical Journal* 10, no. 2 (1967): 35-41.

Hatton, Timothy J. "Emigration from the United Kingdom to the United States, Canada and Australia/New Zealand, 1870–1913: Quantity and Quality." *Australian Economic History Review* 61, no. 2 (2021): 136-58.

Hawthorne, L. "The Question of Discrimination: Skilled Migrants' Access to Australian Employment." *International Migration (Geneva, Switzerland)* 35, no. 3 (1997): 395-419.

Hawthorne, Lesleyanne. "International Medical Migration: What Is the Future for Australia?". *Medical Journal of Australia Open* 1, no. Suppl. 3 (2012): 18-21.

———. "The Scale and Nature in Recent Years of the Foreign-Born and Foreign-Trained Medical and Health Workforce Developed in Australia." In *Migration of Health Workers: WHO Code of Practice and the Global Economic Crisis*, edited by Amani Siyam and Mario R. Dal Poz, 109-32. Geneva: World Health Organization, 2014.

Hawthorne, Lesleyanne, Bob Birrell, and Doris Young. *The Retention of Overseas Trained Doctors in General Practice in Regional Victoria*. Melbourne: Rural Workforce Agency, Victoria, 2004.

Hawthorne, Lesleyanne, Graeme Hawthorne, and Brendan Crotty. *The Registration and Training Status of Overseas Trained Doctors in Australia*. Parkville, Vic.: The University of Melbourne, 2007.

Hayter, Henry Haylyn. *Victorian Year Book for 1879-80*. Melbourne: Government Printer, 1880.Health Division Headquarters. *Displaced Persons Professional Medical Register*. Geneva: International Refugee Organization, 1949.

Heil, Matthäus. *Prosopography*. New York: Oxford University Press, 2011. doi:10.1093/obo/9780195389661-0077.

Hirst, John. *Sense and Nonsense in Australian History*. Melbourne: Black Inc. Agenda, 2009.

Hiscock, Peter. *Archeology of Ancient Australia*. London: Routledge, 2008.

Holborn, Louise W. *The International Refugee Organization, a Specialized Agency of the United Nations: Its History and Work 1946-1952*. London: Oxford University Press, 1956.

Holloway, SWF. "The Apothecaries' Act, 1815: A Reinterpretation." *Medical History* 10, no. 2 (1966): 107-29.

———. "The Apothecaries' Act, 1815: A Reinterpretation." *Medical History* 10, no. 3 (1966): 221-36.

Horan, John. *Devine, Sir Hugh Berchmans (1878-1959)*. Australian Dictionary of Biography. National Centre of Biography, Australian National University, https://adb.anu.edu.au/biography/devine-sir-hugh-berchmans-5969, published first in hardcopy 1981, accessed online 19 January 2022.

Howard, Martin R. *Napoleon's Doctors: The Medical Services of the Grande Armée*. Stroud (England): Spellmount, 2006.

Howitt, William. *Land, Labour, and Gold: Two Years in Victoria with Visits to Sydney and Van Diemen's Land*. Vol. 1, London: Longman, Brown, Green, Longmans, and Roberts, 1858.

Hughes, J Estcourt. *A History of the Royal Adelaide Hospital*. Netley, SA: Board of Management of the Royal Adelaide Hospital, 1967.

Hughes, Robert. *The Fatal Shore: The Epic of Australia's Founding*. New York: Vintage Books, 1988.

Hunter, Thelma. "Pressure Groups and the Australian Political Process: The Case of the Australian Medical Association." *Journal of Commonwealth & Comparative Politics* 18, no. 2 (1980): 190-206.

Iredale, Robyn. "Luring Overseas Trained Doctors to Australia: Issues of Training, Regulating and Trading." *International Migration* 47, no. 4 (2009): 31-65.

Jacyna, Stephen. "Robert Carswell and William Thomson at the Hôtel-Dieu of Lyons: Scottish Views of French Medicine." In *British Medicine in an Age of Reform*, edited by Roger French and Andrew Wear, 110-35. London: Routledge, 1991.

Jennings, Reece. "The Medical Profession and the State in South Australia, 1836-1975." MD, University of Adelaide, 1998.

Jewkes, Rachel, and Naeema Abrahams. "The Epidemiology of Rape and Sexual Coercion in South Africa: An Overview." *Social Science & Medicine* 55, no. 7 (2002): 1231-44.

Johnson, Terence J, and Marjorie Caygill. "The British Medical Association and Its Overseas Branches: A Short History." *The Journal of Imperial and Commonwealth History* 1, no. 3 (1973): 303-29.

Jones, Hermann Johnston. "Ocean Voyages in Pulmonary Phthisis." *British Medical Journal* 1, no. 2036 (1900): 47.

Karabell, Zachary. "'Inside the US Espionage Den': The US Embassy and the Fall of the Shah." *Intelligence and National Security* 8, no. 1 (1993): 44-59.

Karenberg, Axel. "Retrospective Diagnosis: Use and Abuse in Medical Historiography." *Prague Medical Report* 110, no. 2 (2009): 140-45.

Kaul, Man Mohini. "The Indian Diaspora in Australia and New Zealand: Challenges and the Way Forward." *Diaspora Studies* 2, no. 2 (2009): 187-201.

Kaushik, Manas, Abhishek Jaiswal, Naseem Shah, and Ajay Mahal. "High-End Physician Migration from India." *Bulletin of the World Health Organization* 86, no. 1 (2008): 40-45.

Keats-Rohan, KSB. "Prosopography and Computing: A Marriage Made in Heaven." *History and Computing* 12, no. 1 (2000): 1-11.

Keetley, Charles Bell. *The Student's and Junior Practitioner's Guide to the Medical Profession*. London: Baillière-Tindall, 1885, available at: https://wellcomecollection.org/works/wpcu2c2v.

Kenny, Lucy M, and Richard A Bryant. "Keeping Memories at an Arm's Length: Vantage Point of Trauma Memories." *Behaviour Research and Therapy* 45, no. 8 (2007): 1915-20.

Kent, Athol, and Marietjie De Villiers. "Medical Education in South Africa—Exciting Times." *Journal of Continuing Education in the Health Professions* 29 (2007): 906-09.

Kidd, Michael R, and Felicity Braun. *Problems Encountered by Overseas-Trained Doctors Migrating to Australia*. Canberra: AGPS, 1992.

Kilgour, James. *Effect of the Climate of Australia Upon the European Constitution in Health and Disease*. Geelong, Vic: William Vale, 1855.

Kitchin, Rob, Cian O'Callaghan, and Justin Gleeson. "The New Ruins of Ireland? Unfinished Estates in the Post-Celtic Tiger Era." *International Journal of Urban and Regional Research* 38, no. 3 (2014): 1069-80.

Klein, Douglas, Marianna Hofmeister, Jocelyn Lockyear, Rodney Crutcher, and Herta Fidler. "Push, Pull, and Plant: The Personal Side of Physician Immigration to Alberta, Canada." *Family Medicine* 43, no. 3 (2009): 197-201.

Klingler, Corinna, and Georg Markmann. "Difficulties Experienced by Migrant Physicians Working in German Hospitals: A Qualitative Interview Study." *Human Resources for Health* 14 (2016): 57-69.

Knibbs, GH. *Official Year Book of the Commonwealth of Australia, Containing Authoritative Statistics for the Period 1901-1909*. Melbourne: McCarron, Bird and Co., 1910.

Koch, Robert. "Die Ätiologie der Tuberkulose." *Berliner Klinische Wochenschrift* 19, no. 15 (1882): 221-30.

Kumar, Rishi. "Indian Medical Graduates in New Zealand: Does Anyone Win?". *Postgraduate Medicine* 97, no. 1147 (2021): 275-79.

Kunz, Egon F. "Some Basic Determinants of Post-War Refugee Naturalisations in Australia." *Australian and New Zealand Journal of Sociology* 7, no. 2 (1971): 38-57.

———. *The Intruders : Refugee Doctors in Australia*. Canberra: Australian National University Press, 1975.

Labonté, Ronald, and Ted Schrecker. "Globalization and Social Determinants of Health: The Role of the Global Marketplace (Part 2 of 3)." *Globalization and Health* 3, no. 6 (2007): 1-17.

Langton, Marcia. "Traditional Aboriginal Healing Practice." In *The Art of Healing: Australian Indigenous Bush Medicine*, edited by Jacqueline Healy, 1-6. The University of Melbourne: Medical History Museum, 2018.

Last, JM. "Migration of British Doctors to Australia." *British Medical Journal* 2, no. 5359 (1963): 744-45.

Laurence, Caroline. "Overseas Trained Doctors in Rural and Remote Australia: Do They Practise Differently from Australian-Trained Doctors?" PhD, University of Adelaide, 2007.

Lawrence, Susan C. "Private Enterprise and Public Interests: Medical Education and the Apothecaries' Act, 1780-1825." In *British Medicine in an Age of Reform*, edited by Roger French and Andrew Wear, 45-73. London: Routledge, 1991.

Lee, Everett S. "A Theory of Migration." *Demography* 3, no. 1 (1966): 47-57.

Lendon, AA. *Jubilee of the Medical School, 1885-1935*. Adelaide: Hassell Press, 1935.

Lewis, Milton. "Medicine in Colonial Australia, 1788–1900." *Medical Journal of Australia* 201, no. 1 (Suppl.) (2014): S5-S10.

Lipner, Rebecca, Hao Song, Thomas Biester, and Robert Rhodes. "Factors That Influence General Internists' and Surgeons' Performance on Maintenance of Certification Exams." *Academic Medicine* 86 (2011): 53-58.

Lishman, Val. "Val Lishman." In *The Leaving of Liverpool : Medical Migration to Western Australia*, edited by David Alltree, 144-74. Guildford, W.A.: Vineyard Publishing, 2008.

Littré, Émile, and Charles-Philippe Robin. *Dictionnaire de Médecine, de Chirurgie, de Pharmacie, des Sciences Accessoires et de L'art Vétérinaire de P.H. Nysten* 12th ed. Paris: J B Baillière, 1855.

Lloyd, Peter. "The Evolution of Tariff Protection and Wage Protection in the Late Colonies and Early Federation." *Economic Papers* 36, no. 4 (2017): 459-76.

Loudon, ISL. "A Doctor's Cash Book: The Economy of General Practice in the 1830s." *Medical History* 27 (1983): 249-68.

Louis, Winnifred R, Richard N Lalonde, and Victoria M Essex. "Bias against Foreign-Born or Foreign-Trained Doctors: Experimental Evidence." *Medical Education* 44, no. 12 (2010): 1241-47.

Louw, JH. "A Brief History of the Medical Faculty, University of Cape Town." *South African Medical Journal* 56, no. 22 (1979): 864-70.

Lyons, Mary Ann. "The Role of Graduate Physicians in Professionalising Medical Practice in Ireland, c. 1619-54." In *Ireland and Medicine in the Seventeenth and Eighteenth Centuries*, edited by James Kelly and Fiona Clark, 17-38. London: Routledge, 2010.

MacDonald, John S, and Leatrice D MacDonald. "Chain Migration, Ethnic Neighborhood Formation and Social Networks." *The Milbank Memorial Fund Quarterly* 42, no. 1 (1964): 82-97.

Machiavelli, Niccolò. *Discorsi sopra la prima Deca di Tito Livio*. 1531. https://it.wikisource.org/wiki/Discorsi_sopra_la_prima_Deca_di_Tito_Livio/Libro_terzo/Capitolo_43.

Macintyre, Stuart. *A Concise History of Australia*. Cambridge: Cambridge University Press, 1999.

———. *Australia's Boldest Experiment: War and Reconstruction in the 1940s*. Sydney: New South, 2015.

Macintyre, Stuart, and Sean Scalmer. "Colonial States and Civil Society, 1860-90." In *The Cambridge History of Australia*, edited by Alison Bashford and Stuart Macintyre, 189-217. New York: Cambridge University Press, 2013.

Mackay, E Alan. "Medical Practice During the Goldfields Era in Victoria." *Medical Journal of Australia* 2 (1936): 421-28.

Martin, Susan. "South Australia and the Great Depression." *Cabbages and Kings* 23 (1995): 10-20.

Mathew, John. "The Peopling of Australia." *Nature* 62, no. 1614 (1900): 549-50.

Maya, Margarita López. "Venezuela: The Political Crisis of Post-Chavismo." *Social Justice* 40, no. 4 (2014): 68-87.

McCalman, Janet. *Sex and Suffering: Women's Health and a Women's Hospital: The Royal Women's Hospital, Melbourne 1856-1996*. Carlton, Vic.: Melbourne University Press, 1998.

———. *Vandemonians: The Repressed History of Colonial Victoria.* Carlton, Vic.: Miegunyah Press, 2021.

McCalman, Janet, and Rebecca Kippen. "Population and Health." In *The Cambridge History of Australia*, edited by Alison Bashford and Stuart Macintyre, 294-314. New York: Cambridge University Press, 2013.

McCoubrie, Paul. "Improving the Fairness of Multiple-Choice Questions: A Literature Review." *Medical Teacher* 26, no. 8 (2004): 709-12.

McCurley, James III. "The Historian's Role in the Making of Public Policy." *Social Science History* 3, no. 2 (1979): 202-07.

McGrail, Matthew R, John S Humphreys, Catherine M Joyce, and Anthony Scott. "International Medical Graduates Mandated to Practise in Rural Australia Are Highly Unsatisfied: Results from a National Survey of Doctors." *Health Policy* 108 (2012): 133-39.

McGrath, Pam. "Integration into the Australian Health Care System: Insights from International Medical Graduates." *Australian Family Physician* 38, no. 10 (2009): 844-48.

McKay, PT, and E Pickup. *The Parliament of Tasmania, 1856-1973*. Hobart: Govt. Printer, 1973.

McLean, Rick, and Jan Bennett. "Nationally Consistent Assessment of International Medical Graduates." *Medical Journal of Australia* 188, no. 8 (2008): 464-68.

McWhirter, Rebekah. "Smallpox and Vaccination in Tasmania." *Papers and Proceedings of Tasmanian Historical Research Association* (2009).

Medical Board of Queensland. *Register of Medical Practitioners, Queensland*. Brisbane: Medical Board of Queensland, 1975-1985.

Mejía, Alfonso. "Migration of Physicians and Nurses: A World Wide Picture." *International Journal of Epidemiology* 7, no. 3 (1978): 207-15.

Menzies, Lara, Susan Minson, Alexandra Brightwell, Anna Davies-Muir, Andrew Long, and Caroline Fertelman. "An Evaluation of Demographic Factors Affecting Performance in a Paediatric Membership Multiple-Choice Examination." *Postgraduate Medicine* 91 (2015): 72-76.

Mincer, Jacob. "Family Migration Decisions." *Journal of Political Economy* 86, no. 5 (1978): 749-73.

Mitchell, Ann M. *Watson, James Frederick (Fred) (1878-1945)*. Australian Dictionary of Biography. National Centre of Biography, Australian National University, https://adb.anu.edu.au/biography/watson-james-frederick-fred-9001/text15847, published first in hardcopy 1990, accessed online 14 November 2021.

Mody, Fallon Kiran. "Doctors Down Under: European Medical Migrants in Victoria (Australia), 1930-60." PhD, University of Melbourne, 2018.

———. "'The Intellectual Boys Are the Ones in a Mess': The Unregistered Doctors Association in Victoria, 1951-56." *Health and History* 17, no. 1 (2015): 17-36.

Monnais, Laurence, and David Wright. "Introduction." In *Doctors Beyond Borders: The Transnational Migration of Physicians in the Twentieth Century*, edited by Laurence Monnais and David Wright, 3-19. Toronto: University of Toronto Press, 2016.

Morrison, Andrew R. "Violence or Economics: What Drives Internal Migration in Guatemala?". *Economic Development and Cultural Change* 41, no. 4 (1993): 817-31.

Moullan, Yasser. "What Fundamentals Drive the Immigration of Medical Doctors?". In *High-Skilled Migration: Drivers and Policies*, edited by Mathias Czaika, 301-19. Oxford: Oxford University Press, 2018.

Mullan, Fitzhugh. "The Metrics of the Physician Brain Drain." *New England Journal of Medicine* 353, no. 17 (2005): 1810-18.

Mullaney, Susan. "The 1791 Irish Apothecary's Act: The First Nationwide Registration of Apothecaries in the British Isles." *Eighteenth-Century Ireland* 25 (2010): 177-90.

Murphy, John. *A Decent Provision: Australian Welfare Policy, 1870-1949*. Farnham, Surrey: Ashgate, 2011.

Nair, Balakrishnan R, Michael Hensley, Mulavana S Parvathy, Deborah M Lloyd, Brooke Murphy, Kathy Ingham, *et al*. "A Systematic Approach to Workplace-Based Assessment for International Medical Graduates." *Medical Journal of Australia* 196, no. 6 (2012): 399-402.

Nair, Balakrishnan R, Andrew M Searles, Rod I Ling, Julie Wein, and Kathy Ingham. "Workplace-Based Assessment for International Medical Graduates: At What Cost?". *Medical Journal of Australia* 200, no. 1 (2014): 41-44.

Nazarska, Georgeta. "Bulgarian Women Medical Doctors in the Social Modernization of the Bulgarian Nation State (1878-1944)." *Historical Social Research* 33, no. 2 (2008): 232-46.

Newman, Charles. *The Evolution of Medical Education in the Nineteenth Century*. London: Oxford University Press, 1957.

———. "The Hospital as a Teaching Centre." In *The Evolution of Hospitals in Britain*, edited by FNL Poynter, 187-205. London: Pitman Medical Publishing, 1964.

Nichol, W. "The Medical Profession in New South Wales, 1788-1850." *Australian Economic History Review* 24, no. 2 (1984): 115-31.

Nimmo, JA. *Health Insurance: Report of the Commonwealth Committee of Enquiry into Health Insurance*. Canberra: AGPS, 1969.

Norcini, John J, Linda L Blank, F Daniel Duffy, and Gregory S Fortna. "The Mini-CEX: A Method for Assessing Clinical Skills." *Annals of Internal Medicine* 138, no. 6 (2003): 476-81.

OECD. *Recent Trends in International Migration of Doctors, Nurses and Medical Students*. Paris: OECD Publishing, 2019. https://doi.org/10.1787/5571ef48-en.

Onyebuchi, A Arah, Uzor C Ogbu, and Chukwudi E Okeke. "Too Poor to Leave, Too Rich to Stay: Developmental and Global Health Correlates of Physician Migration to the United States, Canada, Australia and the United Kingdom." *Public Health* 98 (2008): 148-54.

Osler, William. *The Principles and Practice of Medicine*. New York: D Appleton and Co., 1892.

O'Sullivan, Belinda, Deborah J Russell, Matthew R McGrail, and Anthony Scott. "Reviewing Reliance on Overseas-Trained Doctors in Rural Australia and Planning for Self-Sufficiency: Applying 10 Years' Mabel Evidence." *Human Resources for Health* 17, no. 1 (2019): NA.

O'Sullivan, David M. *Bird, Samuel Dougan (1832-1904)*. Australian Dictionary of Biography. National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/bird-samuel-dougan-2996/text4383, published first in hardcopy 1969, accessed online 1 August 2020.

Palmer, George Rupert, and Stephanie Short. *Health Care and Public Policy: An Australian Analysis*. 3rd ed. South Yarra, Vic.: Palgrave Macmillan, 2014.

Pang, Tikki, Mary Ann Lansang, and Andy Haines. "Brain Drain and Health Professionals: A Global Problem Needs Global Solutions." *British Medical Journal* 324, no. 7336 (2002): 499-500.

Patton, Michael Q. *Qualitative Research and Evaluation Methods*. Thousand Oaks, Calif.: Sage Publications, 2002.

Pearn, John. "Forced Emigration, Favourable Outcomes." *Australian and New Zealand Journal of Public Health* 25, no. 5 (2001): 458-63.

———. "Surgeon-Superintendants on Convict Ships." *Australian and New Zealand Journal of Surgery* 66 (1996): 253-56.

Pensabene, TS. *The Rise of the Medical Practitioner in Victoria*. Canberra: Australian National University, 1980.

Peterson, M Jeanne. *The Medical Profession in Mid-Victorian London*. Berkeley, CA: University of California Press, 1978.

Phillips, Peter J. *Kill or Cure? Lotions, Potions, Characters & Quacks of Early Australia*. Adelaide: Rigby, 1978.

Population Studies Group. "Demographic Changes in the Northern Territory Following Cyclone Tracy (1974/5)." (2008). Published electronically 2008. https://www.cdu.edu.au/sites/default/files/research-brief-2008-18.pdf.

Powell, JM. "Medical Promotion and the Consumptive Immigrant to Australia." *Geographical Review* 63, no. 4 (1973): 449-76.

Poynter, John. *The Audacious Adventures of Dr Louis Lawrence Smith: 1830-1910*. Vol. 1, North Melbourne, Vic.: Australian Scholarly Publishing, 2014.

Price, Charles. "Immigration and Ethnic Origin." In *Australians, Historical Statistics*, edited by Wray Vamplew, 2-22. Broadway, NSW: Fairfax, Syme & Weldon Associates, 1987.

Price, Kim. *Medical Negligence in Victorian Britain: The Crisis of Care under the English Poor Law, C1834-1900*. London: Bloomsbury Academic, 2015.

Productivity Commission. *Australia's Health Workforce: Research Report*. Canberra: Commonwealth of Australia, 2005.

Proudfoot, Malcolm J. *European Refugees, 1939-52: A Study in Forced Population Movement*. London: Faber, 1957.

Ranke, Leopold von. *Geschichten der Romanischen und Germanischen Völker von 1494 bis 1535*. Vol. 1, Leipzig and Berlin: G.Reimer, 1824.

Rao, Jana. *A Surgeon & Consul General: A Migrant Experience*. Chennai, India: Notion Press, 2017.

Ravallion, Martin. "Ethnic Inequality and Poverty in Malaysia since May 1969. Part 1: Inequality." *World Development* 134, no. October (2020): 1-16.

Ravenstein, EG. "The Laws of Migration." *Journal of the Royal Statistical Society* 48, no. 2 (1885): 167-235.

Renfree, Nancy Swinburne. "Migrants and Cultural Transference: English Friendly Societies in a Victorian Goldfield Town." PhD, Latrobe University, 1983.

Richards, David. "Medical Convicts to New South Wales and Van Diemen's Land, 1788-1818." *Medical Journal of Australia* 161 (1994): 73-77.

Richards, Tom. "An Intellectual History of NUD*IST and NVivo." *International Journal of Social Research Methodology* 5, no. 3 (2002): 199-214.

Rimmer, William G. *Portrait of a Hospital, the Royal Hobart*. Hobart: Royal Hobart Hospital, 1981.

Risse, Guenter B. *Mending Bodies, Saving Souls: A History of Hospitals*. New York: Oxford University Press, 1999.

Roberts, MJD. "The Politics of Professionalization: MPs, Medical Men, and the 1858 Medical Act." *Medical History* 53, no. 1 (2009): 37-56.

Rogers, Marie G. "For the Good of Their Health: A Social History of Consumption, Victoria 1863-1900." MA, University of Melbourne, 1984

Royal College of Surgeons in London. "Regulations of the College of Surgeons, and Apothecaries' Company, Relative to the Admission of Members and Licentiates." *Lancet* 5, no. 108 (1825): 17-18.

Rubright, Jonathan D, Michael Jodoin, and Michael A Barone. "Examining Demographics, Prior Academic Performance, and United States Medical Licensing Examination Scores." *Academic Medicine* 94, no. 3 (2019): 364-70.

Rutland, Suzanne D. "Australian Responses to Jewish Refugee Migration before and after World War II." *Australian Journal of Politics and History* 31, no. 1 (1985): 29-48.

———. *The Jews in Australia*. Cambridge: Cambridge University Press, 2005. doi:10.1017/CBO9780511481277.

Rutledge, Martha. *Renwick, Sir Arthur (1837-1908)*. Canberra: Australian National University, 1976.

Sabbatani, Sergio. "Le Epidemie sul Mare: Odissee di Migranti del XIX Secolo." *Le Infezioni nella Storia della Medicina* 23, no. 2 (2015): 195-206.

Saedon, Habiba, MHM Saedon, and SP Aggarwal. "Workplace-Based Assessment as an Educational Tool." *Medical Teacher* 32, no. 9 (2010): e369-72.

Sager, Alex. "Reframing the Brain Drain." *Critical Review of International Social and Political Philosophy* 17, no. 5 (2014): 560-79.

Sandhu, Harbinder, Ann Adams, Laura Singleton, David Clark-Carter, and Jane Kidd. "The Impact of Gender Dyads on Doctor–Patient Communication: A Systematic Review." *Patient Education and Counselling* 76 (2009): 348-55.

Scalmer, Sean. "Containing Contention: A Reinterpretation of Democratic Change and Electoral Reform in the Australian Colonies." *Australian Historical Studies* 42, no. 3 (2011): 337-56.

Schmalz, Geoffrey CR. *Augustan and Julio-Claudian Athens: A New Epigraphy and Prosopography*. Leiden: Brill, 2009.

Scott, Mark, Anna Whelan, John Dewdney, and Anthony B Zwi. "'Brain Drain' or Ethical Recruitment? Solving Health Workforce Shortages with Professionals from Developing Countries." *Medical Journal of Australia* 180, no. 4 (2004): 174-76.

Scotton, RB. "Medibank 1976." *Australian Economic Review* 10, no. 1 (1977): 23-35.

Scotton, RB, and CR Macdonald. *The Making of Medibank*. Kensington, NSW: University of NSW, 1993.

Seale, John. "Medical Emigration from Britain, 1930-1961." *British Medical Journal* 1, no. 5280 (1962): 82-86.

Seggie, Janet L. "MB ChB Curriculum Modernisation in South Africa: Growing Doctors for Africa." *African Journal of Health Professions Education* 2, no. 1 (2010): 8-14.

Sen, Samita, and Anirban Das. "A History of the Calcutta Medical College and Hospital, 1835-1936." In *Science and Modern India: An Institutional History, C.1784-1947*, edited by Uma Das Gupta, 477-522. Delhi: Pearson Education, 2011.

Shaffir, William, and Robert Alan Stebbins. *Experiencing Fieldwork: An inside View of Qualitative Research*. Newbury Park: Sage Publications, 1990.

Sinclair, Hugh. "Foreword." In *The Worshipful Society of Apothecaries of London: A History 1617-1967*, edited by WSC Copeman, ix-x. Oxford: Pergamon Press, 1967.

Singer, Charles, and SWF Holloway. "Early Medical Education in England in Relation to the Pre-History of London University." *Medical History* 4, no. 1 (1960): 1-17.

Smallwood, Richard. "Foreword." In *Assuring Medical Standards: The Australian Medical Council 1985-2010*, vii-viii. Kingston, ACT: Australian Medical Council, 2010.

Smith, Adam. *An Inquiry into the Nature and Causes of the Wealth of Nations*. Edinburgh: Adam and Charles Black, 1863.

Smith, Barry. "Gullible's Travails: Tuberculosis and Quackery 1890-1930." *Journal of Contemporary History* 20 (1985): 733-56.

Smith, FB. "Curing Alcoholism in Australia, 1880s-1920s." *Journal of Australian Colonial History* 8 (2006): 137-58.

———. *Illness in Colonial Australia*. Melbourne: Australian Scholarly Publishing, 2011.

———. *The People's Health, 1830-1910*. London: Croom Helm, 1979.

Smith, Julian O. "The History of the Royal Australasian College of Surgeons, 1920-1935." *Australian and New Zealand Journal of Surgery* 41, no. 1 (1971): 1-19.

Solanki, Anjali, and Surender Kashyap. "Medical Education in India: Current Challenges and the Way Forward." *Medical Teacher* 36, no. 12 (2014): 1027-31.

Spradley, James P. *The Ethnographic Interview*. Long Grove, IL: Waveland Press, 1979.

Srole, Leo. "Community Institutions and Psychosocial Climate." In *Mental Health in the Metropolis: The Midtown Manhattan Study*, edited by Leo Srole, Thomas S Langner, Stanley T Michael, Marvin K Opler and Thomas AC Rennie, 104-24. New York: McGraw-Hill, 1962.

Starr, Fiona. "The 'Sydney Slaughter House': Convict Experience of Medical Care at the General 'Rum' Hospital, Sydney, 1816-1848." *Health and History* 19, no. 2 (2017): 60-89.

Stokes, Michèle. "A Measure of the Élite: A History of Medical Practitioners in Harley Street, 1845-1914." PhD, University of London, 2004.

Stone, Lawrence. "Prosopography." *Daedalus* 100, no. 1 (1971): 46-79.

Sumption, Madeleine, and Michael Fix. "Immigration and the Health-Care Workforce since the Global Economic Crisis: Overview." In *Migration of Health Workers: WHO Code of Practice and the Global Economic Crisis*, edited by Amani Siyam and Mario R. Dal Poz, 97-107. Geneva: World Health Organization, 2014.

Symes, Ronald. *The Roman Revolution*. Oxford: Oxford University Press, 1939.

Tam, Vivian, Jennifer S Edge, and Stephen J Hoffman. "Empirically Evaluating the WHO Global Code of Practice on the International Recruitment of Health Personnel's Impact on Four High-Income Countries Four Years after Adoption." *Globalization and Health* 12 (2016): 62-73.

Tavan, Gwenda. *The Long, Slow Death of White Australia*. Carlton North, Vic.: Scribe Publications, 2005.

Templeton, Jacqueline. *Prince Henry's: The Evolution of a Melbourne Hospital, 1869-1969*. Melbourne: Robertson & Mullens, 1969.

Terry, Daniel Robert. "Health and Wellbeing of International Medical Graduates: Acculturation into the Tasmanian Rural and Remote Context." PhD, University of Tasmania, 2014. https://eprints.utas.edu.au/21728/.

Thatcher, Charles. *Thatcher's Colonial Songster*. Melbourne: Charlwood & Son, 1865.

The Chicago Manual of Style. 17th ed. Chicago: University of Chicago Press, 2017.

The Future of General Practice (Issues Paper No. 3). Melbourne: National Health Strategy, 1992.

Thomas, Bryn, and Brian Gandevia. "Dr. Francis Workman, Emigrant, and the History of Taking the Cure for Consumption in the Australian Colonies." *Medical Journal of Australia* 2, no. 1 (1959): 1-10.

Thompson, Brian C. "Survival Rates in Pulmonary Tuberculosis." *British Medical Journal* 2, no. 4326 (1943): 721.

Thomson, Alistair. "Memory and Remembering in Oral History." In *The Oxford Handbook of Oral History*, edited by Donald A. Ritchie, 77-95. Oxford: Oxford University Press, 2011.

Thomson, Arthur. "History and Development of Teaching Hospitals in England." *British Medical Journal* 2, no. 5201 (1960): 749-51.

Thomson, Kathleen, and Geoffrey Serle. *A Biographical Register of the Victorian Parliament, 1859-1900*. Canberra: ANU Press, 1972.

Thomson, William. *On Phthisis and the Supposed Influence of Climate: Being an Analysis of Statistics of Consumption in This Part of Australia with Remarks on the Increase of That Disease in Melbourne*. Melbourne: Stillwell & Knight, 1879.

Thorowgood, John C. "Ocean Voyages in Pulmonary Phthisis." *British Medical Journal* 2, no. 2028 (1899): 1388.

Tiemersma, Edine W, Marieke J van der Werf, Martien W Borgdorff, Brian G Williams, and Nico JD Nagelkerke. "Natural History of Tuberculosis: Duration and Fatality of Untreated Pulmonary Tuberculosis in HIV Negative Patients: A Systematic Review." *PLOS One* 6, no. 4, e17601. doi:10.1371/journal.pone.0017601 (2011): 1-4.

Tirat, Jean-Yves. "Problèmes de Méthode en Histoire Sociale." *Revue d'Histoire Moderne et Contemporaine* 10, no. 3 (1963): 211-18.

Tomkins, Alannah. *Medical Misadventure in an Age of Professionalisation, 1780-1890*. Manchester: Manchester University Press, 2014.

Travers, Richard. "Dr David Hastings Young (1863–1926): A Peripatetic Practitioner." *Health and History* 19, no. 2 (2017): 134-61.

Unwin, Emily, Henry W Potts, Jane Dacre, Andrew Elder, and Katherine Woolf. "Passing MRCP (UK) Paces: A Cross-Sectional Study Examining the Performance of Doctors by Sex and Country." *BMC Medical Education* 18, no. 70 (2018): 1-9.

Van der Vleuten, CPM. "The Assessment of Professional Competence: Developments, Research and Practical Implications." *Advances in Health Sciences Education* 1, no. 1 (1996): 41-67.

Vernant, Jacques. *The Refugee in the Post-War World*. New Haven: Yale University Press, 1953.

Wakley, Thomas. "The Infamous Apothecaries' Act." *Lancet* 15, no. 383 (1831): 465-69.

Walker, Robin. "The Struggle against Pulmonary Tuberculosis in Australia, 1788–1950." Historical Studies 20, no. 80 (1983): 439-61.

Walker, Wal. *Jane and D'Arcy: Folly Is Not Always Folly*. Vol. 1, Sydney: Arcana Trust, 2017.

Wanna, John. *Defence Not Defiance: The Development of Organised Labour in South Australia*. Adelaide: Adelaide College of the Arts and Education, 1981.

Warner, John Harley. "The Idea of Science in English Medicine: The 'Decline of Science' and the Rhetoric of Reform, 1815-45." In *British Medicine in an Age of Reform*, edited by Roger French and Andrew Wear, 136-64. London: Routledge, 1991.

Watson, J Frederick. *The History of the Sydney Hospital from 1811 to 1911*. Sydney: WA Gullick, 1911.

Watt, George. "Remarks on Medical Education." *Glasgow Medical Journal* 4, no. 14 (1831): 149-64.

Weaver, John. "'A Glut on the Market': Medical Practice Laws and Treatment of Refugee Doctors in Australia and New Zealand, 1933-1942." *Australian and New Zealand Law and History E-Journal* 2 (2009): 1-38.

Wegge, Simone A. "Chain Migration and Information Networks: Evidence from Nineteenth-Century Hesse-Cassel." *Journal of Economic History* 58, no. 4 (1998): 957-86.

Weinbren, Dan, and Bob James. "Getting a Grip: The Roles of Friendly Societies in Australia and Britain Reappraised." *Labour History*, no. 1 (2005): 87-103.

Weisz, George. "The Emergence of Medical Specialization in the Nineteenth Century." *Bulletin of the History of Medicine* 77, no. 3 (2003): 536-75.

Wetli, Charles V, and Ronald K Wright. "Death Caused by Recreational Cocaine Use." *Journal of American Medical Association* 241, no. 23 (1979): 2519-22.

Wettenhall, Roland Seton. "The Influence of the Friendly Society Movement in Victoria, 1835-1920." PhD, University of Melbourne, 2019.

Wijnen-Meijer, Marjo, Sjoukje van den Broek, Franciska Koens, and Olle ten Cate. "Vertical Integration in Medical Education: The Broader Perspective." *BMC Medical Education* 20, no. 509 (2020): 1-5.

Willis, Evan. *Medical Dominance: The Division of Labour in Australian Health Care*. 2nd ed. Sydney: Allen & Unwin, 1989.

Winton, Ronald. *Why the Pomegranate? A History of the Royal Australasian College of Physicians*. Sydney: The Royal Australasian College of Physicians, 1988.

Wolf, Gabrielle. "Controlling the 'Invasion': The Commonwealth Alien Doctors Board and Medical Migrants in Australia, 1942-6." *NSW Law Journal* 45, no. 4 (2022): In press.

———. "Machinations of the British Medical Association: Excluding Refugee Doctors from Queensland's Medical Profession, 1937-1942." *American Journal of Legal History* 59 (2019): 513-41.

———. "Moritz Meyer and the Medical Board: Preventing Refugee Doctors from Practising Medicine in Victoria, Australia, 1937-1958." *Journal of Law and Medicine* 26, no. 1 (2018): 61-88.

———. "The Law and Politics of Registering Doctors: Lessons from New South Wales, 1937-42." *UNSW Law Journal* 43, no. 4 (2020): 1521-51.

World Health Organization. *WHO Global Code of Practice on the International Recruitment of Health Personnel*. Geneva: World Health Organization, 2010.

Wright, David, Sasha Mullally, and Mary Colleen Cordukes. "'Worse Than Being Married': The Exodus of British Doctors from the National Health Service to Canada, c. 1955-75." *Journal of the History of Medicine and Allied Sciences* 65, no. 4 (2010): 546-75.

Yeo, J Burney. "Sea Voyages and Phthisis." *Lancet* 142, no. 3661 (1893): 1089.

Yeomans, Neville D. "Demographics and Distribution of Australia's Medical Immigrant Workforce." *Journal of Migration and Health 5* (2022): 1-6, https://doi.org/10.1016/j.jmh.2022.100109.

Yeomans, Neville D, Jill Sewell, Philip Pigou, and Stuart F Macintyre. "Demographics and Performance of Candidates in the Examinations of the Australian Medical Council, 1978-2019." *Medical Journal of Australia* 214 (2021): 54-58.

Yeomans, Neville D, GP. Thompson, and Napier M Thomson. *Medical Careers in Australia*. 2nd ed. Surrey Hills, Vic.: Victorian Medical Postgraduate Foundation Inc., 1987.

Younghusband, W. "Appointment of Colonial Surgeon." *South Australian Register*, 11 November 1858, 3.

Zinn, Christopher. "Doctors Stage Hunger Strike in Australia." *British Medical Journal* 315, no. 7122 (1997): 315.

Websites

"A Cambridge Alumni Database: William Clark Haines." University of Cambridge, accessed 3 September 2021, https://venn.lib.cam.ac.uk/Documents/acad/2018/search-2018.html.

AHPRA. "Concerned About a Health Practitioner?" accessed 29 November 2021, https://www.ahpra.gov.au/Notifications/Concerned-about-a-health-practitioner.aspx.

AHPRA and National Boards. "English Language Skills." accessed 4 May 2022, https://www.ahpra.gov.au/registration/registration-standards/english-language-skills.aspx.

AMA South Australia. "Past Presidents of the BMA/AMA in South Australia." accessed 30 April 2022, https://sa.ama.com.au/past-presidents-bmaama-south-australia.

AMA Victoria. "History of AMA Victoria." accessed 30 April 2022, https://amavic.com.au/about-us/history.

Australian Bureau of Statistics. "Australian Demographic Statistics, Jun 2018." accessed 16 November 2020, https://www.abs.gov.au/ausstats/abs@.nsf/featurearticlesbyCatalogue/7A40A407211F35F4CA257A2200120EAA.

———. "Australian Statistical Geography Standard (ASGS): Volume 5—Remoteness Structure, July 2016." accessed 16 November 2020, https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/1270.0.55.005Main+Features1July%202016?OpenDocument.

———. "Census of Population and Housing, 1976." accessed 11 January 2022, https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2104.01976?OpenDocument.

———. "Census of the Commonwealth of Australia, 1947." accessed 18 December 2021, https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2109.01947?OpenDocument

———. "Migration, Australia, 2020." accessed 18 December 2021, https://www.abs.gov.au/statistics/people/population/migration-australia/latest-release.

Australian Government Department of Health. "Medicare Provider Number Restrictions." accessed 8 December 2021, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-pubs-mtrp-16-toc~work-pubs-mtrp-16-chapter-5~work-pubs-mtrp-16-chapter-5-medicare-provider-number-restrictions.

———. "Requirements for Practising Medicine in Australia." accessed 1 September 2021, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-pubs-mtrp-15-toc~work-pubs-mtrp-15-chap5~work-pubs-mtrp-15-chap5-rep.

———. "Summary Statistics, Remoteness Area." accessed 17 May 2022, https://hwd.health.gov.au/resources/data/summary-remote.html.

———. "The Australian Health System." accessed 8 December 2021, https://www.health.gov.au/about-us/the-australian-health-system.

Australian Medical Council Limited. "Accredited Medical Schools." accessed 7 November 2021, https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-primary-medical-programs/accredited-medical-schools/.

———. "Assessment and Accreditation of Specialist Medical Programs." accessed 24 November 2021, https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-specialist-medical-programs/.

———. "IMG Guides." accessed 3 July 2020, https://www.amc.org.au/publications/img-guides/.

———. "Overview of Assessment Pathways." accessed 15 September 2021, https://www.amc.org.au/assessment/pathways/overview/.

———. "Workplace Based Assessment (Standard Pathway)." accessed 24 November 2021, https://www.amc.org.au/assessment/pathways/standard-pathway/workplace-based-assessment-standard-pathway/.

Australian Medical Pioneers Index. "About AMPI." accessed 10 February 2019, http://www.medicalpioneers.com/about.htm.

Australian Prudential Regulation Authority. "Register of Private Health Insurers." accessed 8 December 2021, https://www.apra.gov.au/register-of-private-health-insurers.

"Australian Unity: Our Story." accessed 2 December 2021, https://www.australianunity.com.au/about-us/our-story.

Careers 360. "MBBS Admission in India." accessed 6 November 2021, https://medicine.careers360.com/articles/mbbs-admission-in-india.

Commonwealth Department of Health. "Assessment of Overseas Trained Specialists." accessed 2 November 2021, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-pubs-mtrp-13-toc~work-pubs-mtrp-13-5~work-pubs-mtrp-13-5-req.

"Csordas, Stefan Eugen (1920-2000)." accessed 26 January 2022, https://www.asap.unimelb.edu.au/bsparcs/biogs/P004784b.htm.

Department of Health [Cth]. "Medicare Provider Number Restrictions." accessed 6 January 2021, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-pubs-mtrp-13-toc~work-pubs-mtrp-13-5~work-pubs-mtrp-13-5-med.

ECFMG. "Epic: Source Verified Physician Credentials." accessed 24 November 2021, https://www.ecfmgepic.org/index.html.

"Medical Board of Australia." accessed 23 April 2020, https://www.medicalboard.gov.au/.

Medical Board of Australia. "Area of Need." accessed 4 January 2021, https://www.medicalboard.gov.au/registration/types/limited-registration/area-of-need.aspx.

———. "Competent Authority Pathway, 2019." accessed 12 January 2020, https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Competent-Authority-Pathway.aspx.

———. "Guide to the Specialist Pathway: Information for International Medical Graduates." accessed 29 November 2021, https://www.ahpra.gov.au/documents/default.aspx?record=WD20%2F30478&dbid=AP&chksum=VjXVXsLaw%2FAQ%2FgGuHMqI0g%3D%3D.

———. "Provisional Registration." last modified 2019, accessed 14 December 2021, https://www.medicalboard.gov.au/Registration/Types/Provisional-Registration.aspx.

———. "Registration Standards." accessed 13 September 2021, https://www.medicalboard.gov.au/registration-standards.aspx.

———. "Regulating Australia's Medical Practitioners." last modified 2019, accessed 20 September 2021, http://www.medicalboard.gov.au/.

———. "Standards, Reports and Resources." accessed 27 September 2021, https://www.medicalboard.gov.au/registration/international-medical-graduates/specialist-pathway/guides-and-reports.aspx.

"Medical Directory of Australia: About MDA Online." Australian Medical Publishing Company Pty Ltd, last modified 2020, accessed 23 April 2020, https://www.mdaonline.com.au/information/about.

Menzies Research Centre. "Ties That Bind." accessed 4 January 2022, https://www.menziesrc.org/news-feed/ties-that-bind.

National Health Practitioner Ombudsman. "Registration Complaints." accessed 14 March 2022, https://www.nhpo.gov.au/registration-complaints.

National Medical Commission (India). "List of Colleges Teaching MBBS." accessed 6 November 2021, https://www.nmc.org.in/information-desk/for-students-to-study-in-india/list-of-college-teaching-mbbs/.

Nature Index. "Institution Research Output Table." accessed 8 March 2022, https://www.natureindex.com/institution-outputs/generate/all/global/healthcare.

"Parliament of New South Wales, Former Members." accessed 23 July 2021, https://www.parliament.nsw.gov.au/members/formermembers/Pages/former-members.aspx.

"Parliament of South Australia: All Former Members." accessed 23 July 2021, https://www.parliament.sa.gov.au/en/Members/All-Former-Members.

Parliament of Tasmania. "The Parliament of Tasmania from 1856: Gamaliel Henry Butler." accessed 3 September 2021, https://www.parliament.tas.gov.au/history/members/butlerg269.html.

Parliament of Victoria. "Sir James Frederick Palmer." accessed 5 September 2021, https://www.parliament.vic.gov.au/about/people-in-parliament/re-member/details/24/760.

Parliament of Western Australia. "Biographical Register of Members of the Parliament of Western Australia." accessed 23 July 2021, https://www.parliament.wa.gov.au/parliament/library/MPHistoricalData.nsf/screenMemberBios.

"Queensland Parliament, Former Members Register." accessed 25 July 2021, https://www.parliament.qld.gov.au/Members/Former-Members/Former-Members-Register.

Oregon Medical Board. "Jayant M Patel, MD: Summary of Known Disciplinary Record." accessed 25 November 2021, http://www.oregon.gov/OMB/PDFforms/Patel.pdf.

"Population of Kununurra." accessed 20 September 2021, https://population.com.au/sa2/510011265.

RACGP. "The Pathway to Fellowship." accessed 8 November 2021, https://www.racgp.org.au/education/students/starting-the-gp-journey/the-pathway-to-fellowship.

Royal Australasian College of Physicians. "Overseas Trained Physicians (Australia)." accessed 18 April 2022, https://www.racp.edu.au/docs/default-source/overseas-specialists/specialist-assessment-of-overseas-trained-physicians-and-paediatricians.pdf?sfvrsn=cf612c1a_26.

———. "RACP Fellowship Training Pathways." accessed 8 November 2021, https://www.racp.edu.au/become-a-physician/training-pathways.

Royal Australasian College of Surgeons. "Guide to SET 2022: A Comparative Guide of Surgical Specialties and an Overview of Surgical Education and Training." accessed 8 November 2021, https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/guide-to-set.pdf?rev=ee91981c30e5449fa0ace0cc299676ff&hash=7BBE2898A51BDBE4213E5187C8DB3F92.

The New Zealand Official Year-Book 1893. "Death-Rates from Phthisis Per 10,000 Persons Living [Victoria] " https://www3.stats.govt.nz/New_Zealand_Official_Yearbooks/1893/NZOYB_1893.html#id344E848.

United Nations Statistics Division. "Countries or Areas / Geographical Divisions." accessed 18 April 2020, https://unstats.un.org/unsd/methodology/m49/.

APPENDIX

Appendix A: Supplementary tables

Appendix B: Sample pages from prosopography

Appendix C: Publications arising from thesis

Appendix A

Appendix Tables

Supplementary table 1: Australian Medical Acts and their Amendments, 1838-2010

Supplementary table 2: Recommendations from 'Lost in the Labyrinth' report (2012)

Supplementary table 3: IMGs registered in the colonial period by decade

Supplementary table 4: IMGs registered 1901-1984 in each state and territory (all countries)

Supplementary table 5: Country of origin and time of arrival for all IMGs in the MDA sample

Supplementary table 6: List of all participants in oral histories

Supplementary Table 1: Australian Medical Acts and their Amendments, 1838-2010

Colony, state or territory	Year	Name of Act or Amendment	Main change(s)
NSW	1838	Medical Witnesses at Inquests Act (1 Vict. No. 3)	Allowed coroners to require practitioners to attend inquests and perform autopsies
NSW	1838	Medical Witnesses at Inquests Act (2 Vict. No. 22)	Defined who was a legally qualified medical practitioner—for inquests and autopsies. Those eligible were: 'a Doctor or Bachelor of Medicine of some university' or licensed by 'some College of Physicians or Surgeons in Great Britain or Ireland or a Member of the Company of Apothecaries of London' or a Medical Officer of 'Her Majesty's Sea or Land Service.'
NSW	1845	Medical Witnesses at Inquests Amendment Act (9 Vict. No. 12)	Added Members of the Apothecaries Hall of Dublin as eligible for registration under the Act.
NSW	1855	Medical Practitioners Act 1855 (19 Vict. No. 17)	Extended registrable qualifications to any 3 or longer years medical course which gave degree or diploma allowing them to practise in that country.
NSW	1898	Medical Practitioners Act 1898 No. 26	Consolidates the previous acts (except the Port Phillip one (1844).
NSW	1900	Medical Practitioners Amendment Act No. 33	Only those registered by the Board could call themselves legally qualified medical practitioners; prescribed penalties.
NSW	1900	Medical Practitioners Acts Further Amendment Act 1900 No. 70	Provision to remove practitioners from register for 'infamous' professional conduct. Extended required period of study at a university from 3 years to 5.
NSW	1912	Medical Practitioners Act 1912 No. 29	Consolidated the 1898 and 1900 acts.
NSW	1915	Medical Practitioners (amendment) Act 1915 No. 33	Prohibited registration of German or Austrian subjects or graduates (only) from a German or Austrian university. Mentioned Australian universities for the first time. Graduates of other countries could only be registered now in NSW if there was reciprocity for those registered in NSW to practise in that other country without having to pass any examination.

NSW	1938	Medical Practitioners Act 1938 No. 37	Specifically recognised New Zealand as well as Australian medical degrees. Accepted graduates from a medical school in British Empire. Raised the bar very high for graduates from a country outside the Empire (required three years of study at University of Sydney medical school). Also applied a ceiling of 8/year for anyone not a 'natural-born British subject.'
NSW	1939	Medical Practitioners (amendment) Act 1939 No. 5	Governor and Minister could declare an 'area of need' for which some of conditions restricting IMGs from countries outside British Empire could be waived. Eligible for full registration if they held a 'regional certificate' for 5 years.
NSW	1945	Medical Practitioners (amendment) Act 1945 No. 11	Permits aliens who were registered to practise under the National Security regulations, to have full registration when the National Security (Alien Doctors) Regulations cease effect.
NSW	1850	Medical Practitioners (amendment) Act 1950 No. 29	Repealed the limit of 8 per year who were non-British born and qualified outside the British Empire.
NSW	1953	Medical Practitioners (amendment) Act 1953 No. 22	Minor amendment to the requirements for reciprocity if Sydney graduates wish to practise in a country from which an IMG applies for NSW registration.
NSW	1955	Medical Practitioners (amendment) Act 1955 No. 23	Introduced the Medical Examining Committee, to conduct examinations and assess English skills of IMGs given regional or area of need registration.
NSW	1956	Medical Practitioners (amendment) Act 1956 No. 14	Prohibited unregistered persons from treating several listed diseases.
NSW	1957	Medical Practitioners (amendment) Act 1957 No. 20	Gave the Minister power to issue a certificate of regional registration if the Board failed to do so itself. Required applicants to be domiciled in NSW.
NSW	1958	Medical Practitioners (amendment) Act 1958 No. 12	Governor can declare a country WAS part of the British Empire.
NSW	1963	Medical Practitioners (amendment) Act 1963 No. 22	Added University of NSW to list of NSW universities; deleted reference to British Empire; named in an attached Schedule all the universities and colleges whose qualifications were registerable. These were all in Australia, NZ, UK, Ireland,

			South Africa, Ceylon, Malta, and Hong Kong—but only Manitoba in Canada and Bombay in India.
NSW	1964	Medical Practitioners (amendment) Act 1964 No. 13	Minor changes to syntax re registerable qualifications; but added Singapore, Malaysia, and the Polish School of Medicine at University of Edinburgh.
NSW	1972	Medical Practitioners (amendment) Act 1972 No. 52	Amended composition of the Medical Board. Various amendments to the investigative and disciplinary functions of the Board. Allowed Minister to cancel a regional registration if person practised outside the designated region. Created a register of specialists. The amendments applied equally to IMGs and local graduates.
NSW	1981	Medical Practitioners (amendment) Act 1981 No. 55	Many drafting changes. Those relevant to who could be registered were: (i) University of Newcastle (NSW) added; (ii) important provision (see prosopography) was that those graduates from a school not in the Schedule (essentially British Commonwealth countries as in 1964 Act) who were not domiciled or practising medicine six months after being registered were to be removed from register.
NSW	1982	Medical Practitioners (amendment) Act 1982 No. 51	Alterations to provisions about conduct and other matters relating to disciplinary committees. No changes specifically about IMGs.
NSW	1983	Medical Practitioners (amendment) Act 1983 No. 41	No changes specifically affecting IMGs. Changes mainly concerned disciplinary procedures and committee, also fees payable.
NSW	1983	Medical Practitioners (further amendment) Act 1983 No. 177	Board can remove from register if practitioners not living in Australia nor practised in NSW for 'greater part' of previous 3 years.
NSW	1987	Medical Practitioners (amendment) Act 1987 No. 127	Replaced 'prescribed examination' by Board with 'obtained results satisfactory to the Board in an examination conducted by the Australian Medical Council' for those IMGs whose school not in the Schedule.

NSW	1992	Medical Practice Act 1992 No. 94	Just three main categories for general registration: (i) Australian and New Zealand graduates; (ii) IMGs who passed the AMC exams; (iii) those already registered in another Australian state or territory. Overseas specialists could be registered if the corresponding Australia specialist college recognised their qualifications and experience.
NSW	2000	Medical Practice Amendment Act 2000 No. 64	No changes specifically for IMGs. Detailed provisions for assessing impaired or unprofessional practitioners.
NSW	2008	Medical Practice Amendment Act 2008 No. 27	Further provisions for dealing with practitioners alleged to be underperforming or engaged in alleged misconduct.
NSW	2009	Health Practitioner Regulation National Law Act 2009 No. 86	Instituted the National Law, so medical registration became the responsibility of the newly created Medical Board of Australia. A state board was set up under the national framework, with the responsibility of managing disciplinary matters at a state level.
Van Diemen's Land (VDL)	1837	An Act to provide for the attendance of medical witnesses at inquests 1837 (1 Vict. No. 14)	Modelled on the Imperial Medical Witnesses Act 1836, and wording near identical to the NSW act of 1838.
VDL	1837	An Act to regulate the Practice of Medicine in this colony 1837 (1 Vict. No. 17)	Defined who could be registered in the colony. The Medical Council to decide whether the applicant was 'a Doctor of Medicine of some University'; or licensed by 'some College of Physicians or Surgeons'; or the London or Dublin Apothecaries' Societies. In addition, the Court of Examiners could issue letters testimonial for practice in VDL after examination by at least three members of the Court of Examiners. From 1840, letters testimonial could only be granted to locally trained practitioners after being apprenticed in the colony for at least five years then passing an examination (including in Greek and Latin) determined by the Court.
VDL	1840	An Act to amend an Act intituled An Act to regulate the Practice of Medicine in this colony 1840 (4 Vict. No. 24)	Those who had been practising in VDL prior to 1835 and not yet registered must submit to an examination.

VDL	1842	An Act to amend and consolidate the laws now in force in this island regulating the practice of medicine therein 1842 (6 Vict. No. 2) (VDL)	‘Grandfathered' those already registered prior to date of this act. Court of Examiners to approve the 'course of education' of those apprenticed in the colony before allowing them to take the examination for Letters Testimonial.
TAS	1867	Medical Practitioners Amendment Act 1867 (31 Vict. No. 4)	Made provision for medical practitioners to sell medicines or drugs more than two miles from their place of business.
TAS	1908	The Medical Act 1908 (8 Edw. VII No. 32)	Court of Examiners created by prior acts was abolished. Prescribed appointment of members and functioning of the Medical Council of Tasmania. Power to remove from register those convicted of a felony or judged guilty of infamous conduct. Those registered medically in another state, and had been a resident medical officer in a Tasmanian hospital for 6 months before this act could be registered. Listed registerable qualifications placed in Schedule 2: (i) Fellows, Members or Licentiates of Royal Colleges of Physicians of London, Edinburgh or Ireland; (ii) ditto for Royal Colleges of Surgeons of England, Edinburgh, Ireland or the Faculty of Physicians and Surgeons of Glasgow; (iii) Licentiates of the Apothecaries' companies of London or Ireland; (iv) degree in medicine or surgery 'of any University within the British dominions;' (v) persons already registered or entitled to be registered in Great Britain and Ireland; (vi) medical officers in the British sea or land service.
TAS	1918	The Medical Act 1918 (9 Geo. V No. 71)	A number of administrative changes to function of Council and its procedures. Added US medical graduates if from a school rated 'Class A by the Council on Medical Education and the American Medical Association' and licensed to practise in that US state.
TAS	1919	The Medical Act 1919 (10 Geo. V No. 48)	Only changes affecting licensing were addition of an appeal process for those refused registration, and allowing US graduates to have been registered in any US state.
TAS	1920	The Medical Act 1920 (11 Geo. V No. 9)	Added a statute of limitations for offences that allowed cancellation of registration.

TAS	1937	Medical Act 1937 (1 Geo. VI No. 53)	Restricted those who may be registered to 'British subjects'. Gave discretion to Medical Council to allow, as well as universities and colleges, 'other institutions recognised for that purpose' for training and examining doctors in the foreign country.
TAS	1951	Medical Act 1951 No. 26	Empowered the Medical Council (on Minister's recommendation) to approve further training under supervision in a hospital for applicants whose qualifications judged 'equivalent' to one of the British qualifications in the Schedule to the 1918 Act. At end of training period, Council may register practitioner with a special licence entitling them to call themself 'Tasmanian Licentiate in Medicine, Surgery or Medicine and Surgery.' Also restricted registration of those registered in another Australian state, but without the British qualifications in the Schedule, to maximum of four each year.
TAS	1954	Medical Act 1954 No. 6	Cap on number of TMLS licences amended to 2/year, ending in December 1959.
TAS	1955	Medical Act 1955 No. 10	Minor change to timing of the 10 capped TMLS licences.
TAS	1957	Medical Act 1957 No. 87	Council can confer provisional registration on doctors serving as resident medical officers in hospitals
TAS	1959	Medical Act 1959 No. 80	Schedule amended to list registerable qualifications: (i) Any university in Australia, England, Scotland, Wales or Ireland; (ii) members or licentiates of the Colleges of Medicine or Surgery in England, Scotland or Ireland, or Royal Faculty of Physicians and Surgeons in Glasgow; (iii) licentiates of Society of Apothecaries (London) or Apothecaries' Hall (Dublin). Those not listed in Schedule, but entitled to be registered in Britain, could be registered if they had been an HMO for 12 months in Tasmania, or practised in another state or country for 3 years. However, the Governor (on recommendation of the Council) could veto qualifications from another country that might be accepted in Britain. Applicants from non-British countries could apply for further training then have to pass an examination by examiners in an Australian university, at standard of its own graduates.
TAS	1961	Medical Act 1961 No. 12	No changes relevant to registration of practitioners.

TAS	1962	Medical Act 1962 No. 22	Medical Council could give provisional registration to non-British subjects with a medical qualification and who passed a qualifying examination so they could 'serve as a resident medical officer in an approved hospital'.
TAS	1963	Medical Act 1963 No. 91	Royal Faculty of Physicians and Surgeons of Glasgow renamed Royal College of Physicians and Surgeons of Glasgow.
TAS	1966	Medical Act 1966 No. 36	Number of limited registrations capped at two per year. Tightened conditions of practice for those on limited registration.
TAS	1968	Medical Act 1968 No. 52	Changed cap on annual number of limited registrations to 'such number as the Minister, after consultation with the Council, may determine'.
TAS	1972	Medical Act 1972 No. 30	Replaced 'British subject' with 'person' wherever it appeared in the Act.
TAS	1973	Medical Act 1973 No. 61	Listed the recognised qualifications as medical degrees from any university in Australia, New Zealand, UK and Ireland, plus the British and Irish licentiateships as listed before. However, the governor, 'on recommendation of the Council' could declare any other qualification 'recognized ... for the purposes of this Act.'
TAS	1974	Medical Act 1974 No. 16	Very minor drafting change.
TAS	1977	Medical Act 1977 No. 98	Repealed the Schedule of recognised qualifications, replacing with 'those declared by the Governor on recommendation of the Council.’
TAS	1978	Medical Act 1978 No. 36	Council may give full registration to someone with limited registration if employer certifies nobody with full registration is available to take a position.
TAS	1982	Medical Amendment Act 1982 No. 40	Clarified that someone registered under the 1982 Chiropractors Act was not a physician or surgeon.
TAS	1983	Medical Amendment Act 1983 No. 37	Amendments to regulate the conduct of medical service companies.
TAS	1986	Medical Amendment Act 1986 No. 8	Amendment to allow podiatrists to administer local anaesthetics.
TAS	1988	Medical Amendment Act 1988 No. 33	Amended penalties under various sections of the Act.

TAS	1996	Medical Practitioners Registration Act 1996 No. 2	Those registerable now only: (i) graduates of an AMC-accredited medical school (i.e., medical schools in Australia and New Zealand), or (ii) those who had passed the AMC examinations.
TAS	2004	Medical Practitioners Registration Amendment Act 2004 No. 17	Various changes, not affecting IMGs.
TAS	2007	Medical Practitioners Registration Amendment Act 2007 No. 50	Minor drafting changes.
TAS	2010	Health Practitioner Regulation National Law Act 2010 No. 2	The mirror legislation enacted in each state to create AHPRA and the national registration framework for health practitioners.
NSW act governing VIC	1844	Medical Witnesses at Inquests Amendment Act (8 Vict. No. 8)	Created medical board for the District of Port Phillip, with same powers as the NSW Board
VIC	1862	Medical Practitioners Act 1862 (25 Vict. No. 158)	Amended the Imperial Act, Medical Act 1858 c. 90. Board could register: (i) anyone who was a legally qualified medical practitioner in England, Ireland or Scotland; (ii) foreign medical practitioners from any country who graduated from a medical course at least three years long. This act made it illegal for someone not registered in Victoria to pass themselves off as medically qualified and prescribed a penalty of up to 50 pounds.
VIC	1865	Medical Practitioners Statute 1865 (28 Vict. No. 262)	Registration limited to British subjects. Listed registerable qualifications in a Schedule: (i) Graduates from a British or Colonial university; (ii) Licentiates, Members or Fellows of the British or Irish colleges and faculties; (iii) London and Dublin Apothecaries societies; (iv) anyone registered in UK; (v) army and naval surgeons; (vi) any graduates from a 3-year course elsewhere 'who shall prove to the satisfaction of the board' the authenticity of his documentation.
VIC	1889	Medical Practitioners Act 1889 (53 Vict. No. 1041)	Removed registration requirement to be a British subject ('natural born or naturalised subject of Her Majesty').
VIC	1890	Medical Act 1890 (54 Vict. No. 1118)	Various administrative changes (including adoption of British Pharmacopeia) but no change to the eligibilities to registration in the 1865 Statute.

VIC	1906	Medical Act 1906 (7 Edw. No. 2069)	Two substantive changes affecting IMGs: (i) their medical course must be at least 5 years duration (not 3); (ii) graduates of non-British universities or colleges were not registerable unless there was reciprocity for Victorian registered practitioners to practise in that foreign country 'without further examination.'
VIC	1915	Medical Act 1915 (6 Geo. V No. 2695)	Added provision to register maximum of one person annually who had qualified at Boston Homeopathic Hospital or the New York Homeopathic Medical College, provided they worked for at least one year at the Melbourne Homeopathic Hospital.
VIC	1915	Medical Act 1915 No. 2 (6 Geo. V No. 2753)	Reduced the minimum length required of a foreign medical course from 5 years to 4 years.
VIC	1916	Medical Act 1916 (7 Geo. V No. 2825)	No changes affecting registration of IMGs.
VIC	1928	Medical Act 1928 (19 Geo. V No. 3730)	Reinstituted requirement medical course be at least 5 years.
VIC	1933	Medical Act 1933 (24 Geo. V No. 4131)	No changes affecting registration of IMGs.
VIC	1935	Medical Act 1935 (26 Geo. V No. 4289)	Minor change to how far in advance documents must be lodged.
VIC	1937	Medical Act 1937 (1 Geo. VI No. 4504)	No changes affecting registration of IMGs.
VIC	1938	Medical Act 1938 (3 Geo. VI No. 4617)	Recognised specifically (for first time) that those whose medical training was in Victoria were registerable (previously they came under ‘colonial’ medical schools). Medical training could be recognised if part of it occurred in a second country. Medical officers in 'His Majesty's Air Service' added to the other armed forces.
VIC	1946	Medical Practitioners Registration Act 1946 No. 5151	Full registration could be awarded to holders of a licence under the National Security (Alien Doctors) Regulations (National Security Act 1939-1943) if they were practising in Victoria 'in pursuance of such licence.'
VIC	1950	Medical Act 1950 No. 5498	Could be registered if part of their medical course completed in any country, so long as at least the last three years were in an Australian medical school.

VIC	1951	Medical (Temporary Registration) Act 1951 No. 5546	Temporary registration available to IMGs for 2 years (could be extended) for those coming to a teaching or research position in medicine.
VIC	1953	Medical (Registration) Act 1953 No. 5765	Modified the reciprocity clause from the 1906 and 1928 acts to state that if the other country required some 'further hospital experience' before giving full licensure to someone with medical registration in Victoria, that could be regarded as 'reciprocity'.
VIC	1956	Medical (Registration) Act 1956 No. 5965	Gave discretion to Board to register those not otherwise registerable who possessed 'medical or surgical knowledge experience and skill which in the opinion of the Board are of international standing or are such as to have special value to the people of Victoria'—and they had adequate English language skills and were of good character.
VIC	1957	Medical (Registration) Act 1957 No. 6084	Created the 'Foreign Practitioners Qualification Committee' for the purpose of 'the better examination of qualifications of foreign medical practitioners to practise ... in Victoria'. Five of the nine members were to be nominated and approved by the University of Melbourne, one of whom would be committee chair; four were to hold medical chairs in the Clinical Schools at Royal Melbourne, St Vincent's, Alfred, and Royal Women's Hospitals. The Committee was given wide discretion as to how it would conduct examinations for IMGs who were not graduates from Victoria or a country with which Victorian medical graduates had reciprocity to practise. Candidates had to be resident in Victoria for 3 years before they could apply.
VIC	1958	Medical Act 1958 No. 6309	Provided further details for the operation of the FPQC, but retained its flexibility to decide how it would conduct examinations.
VIC	1959	Medical Act 1959 No. 6528	No changes affecting registration of IMGs.
VIC	1960	Medical (Amendment) Act 1960 No. 6643	No changes affecting registration of IMGs.
VIC	1961	Medical (Amendment) Act 1961 No. 6837	A 'sunset' clause was inserted such that applications from IMGs who needed to gain registration via examination by the FPQC could only be considered up till 31 December 1964.

VIC	1964	Medical (Amendment) Act 1964 No. 7212	No changes affecting registration of IMGs.
VIC	1965	Medical (Foreign Practitioners) Act 1965 No. 7277	Allowed temporary registration for practitioners wanting to work in Victoria for 'postgraduate study.' The time IMGs had to be resident in Victoria before applying for assessment via the FPQC examination route was reduced from 3 years (1957 Act) to 3 months.
VIC	1966	Medical (Foreign Practitioners Qualification Committee) Act 1966 No. 7408	Amended the four designated members of the FPQC to be a Professor of Medicine, Professor of Surgery, Professor of Obstetrics & Gynaecology, and a Professor of Paediatrics of 'a Faculty of Medicine of a University of Victoria' [since Monash University had then been created].
VIC	1967	Medical (Foreign Practitioners) Act 1967 No. 7565	The limitation on applications to be examined by the FPQC beyond December 1964 was repealed.
VIC	1970	Medical Practitioners Act 1970 No. 8061	Redefined those eligible to be registered as— graduates from a medical course of five years or longer: (i} anywhere in Australia, New Zealand, Great Britain or Ireland; or (ii) who held the Foreign Practitioners Qualifications Committee's certificate; or (iii) possessed skills of international standing or that were of 'special value to the people of Victoria.' For the first time, registered practitioners had to apply annually for renewal and pay a fee.
VIC	1973	Medical Practitioners (Amendment) Act No. 8424	Provided for the appointment of a 'Hospitals Accreditation Committee' as a subcommittee of the Board, with the function of accrediting hospitals for HMO training and advising the Board accordingly.
VIC	1981	Medical Practitioners (Amendment) Act 1981 No. 9670	No changes affecting registration of IMGs. Changes mainly related to disciplinary procedures and managing impaired doctors.
VIC	1983	Medical Practitioners (Amendment) Act 1983 No. 9918	Replaced holding the FPQC certificate with the Australian Medical Examining Council's certificate for those not eligible for registration on the basis of Australian, New Zealand, British, or Irish qualifications.

VIC	1983	Medical Practitioners (Conditional Registration) Act 1983 No. 9948	Board could register a graduate who was from a country other than Australia, New Zealand, Britain, or Ireland 'where the Health Commission certifies to the Board that it is satisfied that the person will meet a special need for the provision of medical services to a particular ethnic community.'
VIC	1984	Medical Practitioners (Miscellaneous Amendments) Act 1984 No. 10072	No changes affecting registration of IMGs. Amended some of the previous provisions for handling professional misconduct.
VIC	1984	Medical Practitioners (Further Amendment) Act 1984 No.10132	Replaced pathway to registration by virtue of holding the AMEC certificate with being holder of 'a certificate of the Australian Medical Examining Council or the Australian Medical Council' [the AMC was created in that year].
VIC	1991	Medical Practitioners (Amendment) Act 1991 No. 52	Replaced graduates of a medical course 'in any State in Australia or in the Australian Capital Territory' with 'a graduate of a university, college or other body accredited by the Australian Medical Council'. [This included New Zealand since the AMC now accredited New Zealand as well as Australian medical schools].
VIC	1994	Medical Practice Act 1994 No. 23	General registration now available only to: (i) graduates from an AMC accredited medical school, who completed a 12-month approved internship; or (ii) a holder of the AMC certificate who had completed supervised training the Board considered equivalent to internship. Others could be registered to undertake training; to fill a teaching or research position; in specialties where their qualification recognised by the corresponding Australian college; or practise in areas of need on essentially a case-by-case basis.
VIC	1995	Medical Practice and Nurses Acts (Amendment) Act 1995 No. 49	Minor amendments, not affecting IMGs.
VIC	2009	Health Practitioner Regulation National Law (Victoria) Act 2009 No. 79	The mirror legislation enacted in each state to create AHPRA and the national registration framework for health practitioners.

SA	1844	An Ordinance to Define the Qualifications of Medical Practitioners in this Province for certain purposes 1844 (8 & 9 Vict. No. 17)	This first SA legislation provided for appointment of the South Australian Medical Board. Those eligible for registration were: (i) Doctor or Bachelor of Medicine of some University, or a Physician, or Surgeon, licensed or admitted as such by some College of Physicians or Surgeons in Great Britain or Ireland, or a Member of the Company of Apothecaries of London or Dublin', OR (ii) 'a regular Graduate in Medicine of some Foreign University which shall appear to the said Medical Board to be of sufficient credit and authority', OR (ii) 'a Medical Officer ... of Her Majesty's sea or land service.'
SA	1846	An Ordinance to Define the Qualifications of Medical Practitioners in this Province for certain purposes (Amendment) 1846 (10 Vict. No. 1)	Clarified (despite the 1844 Act seeming clear) that a Member of the Company of Apothecaries of London was to be deemed a legally qualified Medical Practitioner.
SA	1880	Medical Act 1880 (43 & 44 Vict. No. 193)	The eligible medical qualifications were now spelled out in a Schedule to this new act: (i) Fellow, Member or Licentiate of any of the medical or surgical colleges of England, Scotland and Ireland, and the two Apothecaries companies (London and Dublin); (ii) degrees in medicine and/or surgery from 'any chartered University in her Majesty's Dominions', (iii) any qualification that would allow the holder to be registered in the UK (Britain and Ireland); or (iv) 'Any qualification which would entitle the holder to practise in all branches of medicine in any foreign state, and also to hold medical Government appointments in such state.'
SA	1889	Medical Act Amendment Act 1889 (52 & 53 Vict. No. 471)	Eligible qualifications were rewritten in this amendment. They were now: (i) a medical qualification allowing the person to be registered in UK; (ii) a graduate of any medical school in Australasia; (iii) a medical qualification from 'any British colony or possession' which the Medical Board considered equal to one allowing the holder to be registered in the UK; or (iv) any person 'who proves to the satisfaction of the Board' they completed a course of at least four years in a British or foreign medical school that allowed them to practise in that country.

SA	1919	Medical Practitioners Act 1919 (10 Geo. V No. 1372)	This new act rewrote the qualifications that could be registered but did not essentially change them from the 1889 Act, except that a foreign medical course needed now to be at least five years duration, and 'not lower in standard than required in the State [SA]'.
SA	1921	Medical Practitioners Act Amendment Act 1921 (12 Geo. V No. 1495)	No changes affecting registration of IMGs.
SA	1946	Medical Practitioners Act Amendment Act 1946 (10 Geo. VI No. 41)	Permitted those 'alien doctors' who had been allowed to practise during the war under the National Security (Alien Doctors) Regulations (Cth.) to have full registration if they were practising in SA during October 1946 'as an employee of the State Government or otherwise.'
SA	1950	Medical Practitioners Act Amendment Act 1950 (14 Geo. VI No. 42)	No changes affecting registration of IMGs.
SA	1954	Medical Practitioners Act Amendment Act 1954 No. 5	No changes affecting registration of IMGs.
SA	1955	Medical Practitioners Act Amendment Act 1955 No. 41	Foreign graduates now needed to specifically have a British qualification (not just a qualification that would allow them to be registered in UK). Graduates from a country other than the UK or a 'British Dominion' could be registered provided the Board judged the course not lower in standard 'than that required in the State' and the country granted reciprocity to those registered in SA.
SA	1966	Medical Practitioners Act Amendment Act 1966 No. 60.	Added requirement that graduates from a country other than UK or a British Dominion must have performed competently as a resident medical officer in 'one or more approved institutions' or had experience judged by Board as equivalent.
SA	1970	Medical Practitioners Act Amendment Act 1970 No. 62	No changes specifically affecting registration of IMGs.
SA	1971	Medical Practitioners Act Amendment Act 1971 No. 68	No changes specifically affecting registration of IMGs.

SA	1976	Medical Practitioners Act Amendment Act 1976 No. 58	No changes specifically affecting registration of IMGs.
SA	1983	Medical Practitioners Act 1983 No. 25	New act, fully rewritten. Who could be registered now were only those who 'have prescribed qualifications and experience'. The SA act was entirely opaque as to what those were. Minutes of Medical Board 17 June 1982 noted that the Board had received details of the amendments to the act, but those details were not minuted. One of the 'prescriptions' must have been a residence in Australia one, since s.34(6) allowed for reinstatement under certain conditions if 'registration has been suspended [due] failure to reside in the Commonwealth'.
SA	1986	Medical Practitioners Act Amendment Act 1986 No. 110	No changes specifically affecting registration of IMGs.
SA	1988	Medical Practitioners Act Amendment Act 1988 No. 43	No changes specifically affecting registration of IMGs.
SA	2004	Medical Practice Act 2004 No. 53	Like the 1983 act, this new act simply said those who may be registered have qualifications 'approved or recognised by the Board for the purposes of registration'. That is, no details were given in the Act about who might be registered.
SA	2010	Health Practitioner Regulation National Law (South Australia) Act 2010 No. 5	The mirror legislation enacted in each state to create AHPRA and the national registration framework for health practitioners.
NSW act governing QLD	1838	Medical Witnesses at Inquests Act (2 Vict. No. 22)	Defined who was a legally qualified medical practitioner—for inquests and autopsies. Those eligible were: 'a Doctor or Bachelor of Medicine of some university' or licensed by 'some College of Physicians or Surgeons in Great Britain or Ireland or a Member of the Company of Apothecaries of London' or a Medical Officer of 'Her Majesty's Sea or Land Service.'
QLD	1861	Medical Act 1861 (25 Vict. No. 5)	No changes to list of registerable qualifications.

QLD	1867	Medical Act 1867 (31 Vict. No. 33)	Specified process for appointing Queensland Medical Board and its composition. Eligibility for registration broadened greatly to now include those who successfully completed a three-year medical course in any country, which entitled them to practise in that country (as well as British naval or army medical officers).
QLD	1925	The Medical Act of 1925 (16 Geo. V No. 24)	This new act specified those who could be registered: (i) medical graduates from an Australian or New Zealand medical school; (ii) those registered under the UK Medical Act; or (iii) graduates of a five-year medical course elsewhere, allowing them to practise medicine in that country—provided that anyone qualified to practise in UK or Ireland could also practise in that third country (reciprocity provision).
QLD	1932	The Medical Act Amendment Act 1932 (23 Geo. V No. 33)	No changes affecting registration of IMGs.
QLD	1933	The Medical and Other Acts Amendment Act 1933 (24 Geo. No. 31)	No changes affecting registration of IMGs.
QLD	1935	The Medical Acts Amendment Act 1935 (26 Geo. V No. 5)	No changes affecting registration of IMGs.
QLD	1939	The Medical Act of 1939 (3 Geo. VI No. 10)	Added the requirement that applicants must have served 12 months as a resident medical officer in an approved hospital, or had practised for at least three years in a state or country outside Queensland. Exemptions from this were available to those coming to perform approved teaching or research.
QLD	1940	The Medical Act Amendment Act of 1940 (4 Geo. VI No. 21)	Those whose degree was not from an Australian university or registerable in Britain were no longer eligible during the war, until such time as the Governor in Council reinstated the original provision.
QLD	1946	The Medical Acts Amendment Act of 1946 (10 Geo. VI No. 27)	No changes affecting registration of IMGs.
QLD	1955	The Medical Acts Amendment Act of 1955 (4 Eliz. II No. 27)	Reinstated the possibility of registering doctors who were trained outside Australia, New Zealand, or registerable in Great Britain or Northern Ireland,

			provided that: their medical course was at least 5 years, the standard was at least equal to that of the University of Queensland degree, The Board approved the course, the course was recognised by the Governor-in-Council as qualifying them to practise in that third country, and they had served as an RMO for 12 months or practised for at least three years in a 'State or Country outside Queensland.'
QLD	1963	The Medical Acts Amendment Act of 1963 No. 9	South African degrees were recognised specifically, rather than just potentially under the third group of the earlier acts.
QLD	1966	The Medical Acts Amendment Act of 1966 No. 23	No changes specifically affecting registration of IMGs.
QLD	1968	The Medical Acts Amendment Act of 1968 No. 53	Republic of Ireland degrees specified for the first time in a Queensland act.
QLD	1969	Medical Act Amendment Act 1969 No. 3	Revised provisions re autopsies and anatomical dissection. No changes affecting registration of IMGs.
QLD	1973	Medical Act and Other Acts (Administration) Act Amendment Act 1973 No. 2	No changes specifically affecting registration of IMGs.
QLD	1973	Medical Act Amendment Act 1973 No. 30	Added requirement that those who qualified elsewhere than Australasia, UK, Ireland or South Africa must pass examinations (oral and clinical) held by the Professors of Medicine, Surgery and Obstetrics & Gynaecology at University of Queensland. The Board could waive this for some with specialist qualifications.
QLD	1976	Medical Act Amendment Act 1976 No. 4	Acceptable qualifications now listed in a Schedule. Eligible degrees were from medical schools in Australia, New Zealand, Britain, Ireland, Canada, South Africa, Singapore and Hong Kong. All others were required to pass examinations 'conducted by examiners approved by the Board' at a standard equal to that in 'any university in Queensland.' There were exemptions for some with specialist qualifications.
QLD	1978	Medical Act Amendment Act 1978 No. 85	No changes affecting registration of IMGs.

QLD	1979	Medical Act Amendment Act 1979 No. 34	This amendment limited registration to one year for those whose qualification was from one of the countries in the Schedule. To remain registered, they must prove that by the end of that year they were practising in Queensland.
QLD	1980	Medical Act Amendment Act 1980 No. 7	Added an additional requirement for those qualified in a country not in the Schedule: to have successfully completed the equivalent of an Intern year in a hospital approved by the Board.
QLD	1981	Medical Act Amendment Act 1981 No. 37	No changes specifically affecting registration of IMGs.
QLD	1981	Medical Act and other Acts Amendment Act 1981 No. 76	Amended recognised qualifications to those 'set out in regulations'—i.e. they were no longer spelled out in the amended act.
QLD	1984	Medical Act Amendment Act 1984 No. 20	No changes specifically affecting registration of IMGs.
QLD	1987	Medical Act Amendment Act 1987 No. 24	No changes specifically affecting registration of IMGs.
QLD	2001	Medical Practitioners Registration Act 2001 No. 7	General registration now available only to: (i) graduates from an AMC accredited medical school (i.e., an Australian or New Zealand school), or (ii) those who had passed the AMC examinations; or (iii) had another qualification prescribed 'under a regulation for this section'. S.135 provided for the Minister to declare an area of need, and if so for the Board to make a determination about whether the person has 'a medical qualification and experience the board considers suitable for practising the profession in the area.'
QLD	2005	Medical Practitioners Registration Amendment Act 2005 No. 30	No changes specifically affecting registration of IMGs.
QLD	2009	Health Practitioner Regulation National Law Act 2009 No. 45	The mirror legislation enacted in each state to create AHPRA and the national registration framework for health practitioners.
WA	1869	Medical Ordinance 1869 (33 Vict. No. 8)	Created the Medical Board of Western Australia. Those registerable were practitioners who could be registered in UK under Imperial Act 21 & 22 Vict. C. 90 1858, i.e., graduates of a UK or Irish medical school or licentiate etc. of any UK or Irish medical or surgical college, or LSA (Lond) or LAH (Dublin).

WA	1894	Medical Act 1894 (58 Vict. No. 36)	Those registered under the 1869 Ordinance were to be transferred to the new Medical Register required under this 1894 Act. Eligible now for registration were those under the 1858 Imperial Act, plus those with a medical degree from a British or Colonial University; anyone registered as a medical practitioner in United Kingdom of Great Britain and Ireland; or medical officers of 'Her Majesty's Sea or Land Service'; and was 'of good fame and character.'
WA	1940	Medical Act Amendment Act 1940 (4 & 5 Geo. VI No. 51)	If a region or hospital were declared by the Governor an area or institution of workforce need, the Board could issue regional certificates. To be eligible, an IMG must have (i) completed a five-year medical course which allowed them to practise in 'some part of the British Empire or some other country'; (ii) had experience the Board considered 'necessary for the proper provision of medical and surgical attention for the inhabitants of the proclaimed regions'; and (iii) served as a junior resident medical officer for at least three months in a hospital approved by the Minister. Those who had served at least 7 years with a regional certificate could then be given full registration at the discretion of the Minister.
WA	1945	Medical Act Amendment Act 1945 (9 & 10 Geo. VI No. 22)	Eligible qualifications for registration rewritten as: (i) graduate of a medical school in Australia or New Zealand; (ii) registered or able to be registered in Great Britain and Northern Ireland; (iii) graduate of a medical course of at least five years elsewhere which the Board considered 'not inferior to [that of] the University of Sydney, Melbourne, Queensland or Adelaide.'
WA	1946	Medical Act Amendment Act 1946 (10 Geo. VI No. 8)	Those licensed under the National Security (Alien Doctors) Regulations of the Commonwealth could have time spent practising under those regulations counted towards the seven-year period specified under the 1940 Act.
WA	1950	Medical Act Amendment Act 1950 (14 Geo. VI No. 21)	Semantic changes only in the definition of service in an area of need.
WA	1952	Medical Act Amendment Act 1952 (1 Eliz. II No. 65)	Full registration could be awarded to those holding a regional certificate after they served three years in the region, if they passed an examination by examiners appointed by the Board.

WA	1955	Medical Act Amendment Act 1955 (4 Eliz. II No. 10)	No changes specifically affecting registration of IMGs.
WA	1956	Medical Act Amendment Act 1956 (5 Eliz. II No. 35)	All the British and Irish qualifications which were registerable were now put in a Schedule to the Act. The Board could accept qualifications other than those (and the Australian degrees) if it considered the standard not lower than that of the Western Australian medical school [which commenced in 1957].
WA	1961	Medical Act Amendment Act 1961 (10 Eliz. II No. 42)	Gave the Board the power to register practitioners solely to engage in teaching or research, or to undertake postgraduate study in the state.
WA	1966	Medical Act Amendment Act 1966 No. 43	Amendments relating to impaired practitioners. No changes specifically affecting registration of IMGs.
WA	1968	Medical Act Amendment Act 1968 No. 19	Medical practitioners with visiting armed forces could be registered in WA.
WA	1975	Medical Act Amendment Act 1975 No. 19	Two new medical schools in UK (Newcastle--on-Tyne and Dundee) added to list of approved universities in the Schedule.
WA	1976	Medical Act Amendment Act 1976 No. 70	A person could be removed from the register if they had not commenced practise in the State within 6 months of being added to the Register.
WA	1979	Medical Act Amendment Act 1979 No. 56	Eligible qualifications now listed as those from medical schools in Australia, New Zealand, the UK, and Republic of Ireland. Other graduates now needed to pass the examinations held by the Australian Medical Examining Committee.
WA	1981	Medical Amendment Act 1981 No. 28	Exempted the need to pass the AMEC exams for some psychiatrists trained in UK, Canada, Ireland or South Africa
WA	1985	Medical Amendment Act 1985 No. 70	Examination by the Australian Medical Examining Council now replaced by Australian Medical Council.
WA	1988	Medical Amendment Act 1988 No. 45	No changes specifically affecting registration of IMGs.
WA	1991	Medical Amendment Act 1991 No. 29	No changes specifically affecting registration of IMGs.

WA	1994	Medical Amendment Act 1994 No. 67	The recognised qualifications changed to only: (i) medical degree from an Australian or New Zealand medical school; or (ii) those who had passed the AMC examinations.
WA	1996	Medical Amendment Act 1996 No. 38	Those who could be registered must be (i) Australian permanent residents or having taken steps toward that, and (ii) practising medicine in Australia or having taken steps to prove they intended to.
WA	2000	Medical Amendment Act 2000 No. 48	Board could register people with experience in General Practice outside Australia if they would practise in rural or remote areas of the State for at least five years. If they were not an FRACGP at the time of registration, they must become one within two years.
WA	2006	Medical Amendment Act 2006 No. 49	No changes specifically affecting registration of IMGs.
WA	2008	Medical Practitioners Act 2008 No. 22	Gave the Board some flexibility to determine that other medical examinations IMGs had passed were 'substantially equivalent' to those held by the AMC.
WA	2010	Health Practitioner Regulation National Law (WA) Act 2010 No. 35	The mirror legislation enacted in each state to create AHPRA and the national registration framework for health practitioners.
ACT	1930	Medical Practitioners Registration Ordinance 1930 No. 13	Created the Medical Board of the ACT, chaired by the Director-General of Health. Those eligible for registration must be: (i) 'of good fame and character'; (ii) holder of a degree in 'medicine or surgery' from any Australian or New Zealand university; or (iii) registered in the UK or possessing 'a qualification entitling him to be registered' in UK. The duration of medical study had to be at least 5 years.
ACT	1931	Medical Practitioners Registration Ordinance 1931 No. 7	Trivial drafting changes to 1930 Ordinance.
ACT	1933	Medical Practitioners Registration Ordinance 1933 No. 23	Minor amendments, not affecting IMGs.

ACT	1939	Medical Practitioners Registration Ordinance 1939 No. 2	Specified that a foreign medical degree must be from a country in the British Empire or, if not, from one that gave full reciprocity to medical practitioners registered in any Australian State or Territory to practise in that overseas country without further examination.
ACT	1950	Medical Practitioners Registration Ordinance 1950 No. 4	Minor amendment, not affecting IMGs.
ACT	1954	Medical Practitioners Registration Ordinance 1954 No. 9	'British Empire' replaced by 'Queen's dominions'. Twelve months' experience as a medical officer or equivalent required before registration.
ACT	1956	Medical Practitioners Registration Ordinance 1956 No. 5	No changes specifically affecting IMGs.
ACT	1958	Medical Practitioners Registration Ordinance 1958 No. 13	No changes specifically affecting IMGs.
ACT	1962	Medical Practitioners Registration Ordinance 1962 No. 2	Added a further group eligible for registration: those who had completed the last three years of an Australian medical course [these were usually medical graduates from a country whose qualifications did not allow them registration in an Australian State, but were offered chance to complete an Australian degree].
ACT	1963	Medical Practitioners Registration Ordinance 1963 No. 3	No changes specifically affecting IMGs.
ACT	1964	Medical Practitioners Registration Ordinance (No. 2) 1963 [No. 1 of 1964]	No changes specifically affecting IMGs.
ACT	1967	Medical Practitioners Registration Ordinance 1967 No. 14	Allowed temporary licensing for teaching or research purposes.
ACT	1967	Medical Practitioners Registration Ordinance (No. 2) 1967 No. 15	No changes specifically affecting IMGs.
ACT	1969	Medical Practitioners Registration Ordinance 1969 No. 21	Added one additional member to the Board.

ACT	1970	Medical Practitioners Registration Ordinance 1970 No. 34	Changes only to fees and expenses for Board activities.
ACT	1973	Medical Practitioners Registration Ordinance 1973 No. 44	Changed name of the Canberra teaching hospital.
ACT	1976	Medical Practitioners Registration (Amendment) Ordinance 1976 No. 40	Minor change to Board governance.
ACT	1978	Medical Practitioners Registration (Amendment) Ordinance 1978 No. 43	A schedule of all the UK and Irish qualifications eligible for registration now appended to the Act. They were covered by the previous blanket description but now spelled out. [Perhaps for clarity about several new UK universities].
ACT	1979	Medical Practitioners Registration (Amendment) Ordinance 1979 No. 38	Minister given power (on recommendation by the Board) to gazette additional medical qualifications (outside the schedule). Board could also require written and/or clinical examinations
ACT	1980	Medical Practitioners Registration (Amendment) Ordinance 1980 No. 47	Amendments only to composition and governance of the Board.
ACT	1981	Medical Practitioners Registration (Amendment) Ordinance 1981 No. 48	Amendments only to composition, governance, and operations of the Board.
ACT	1982	Medical Practitioners Registration (Amendment) Ordinance 1982 No. 30	Provided that those not otherwise eligible for registration [because not from an approved country] could be registered as an 'eminent person …[if] the reputation and status of the applicant in the medical profession are such that it would be in the public interest and of benefit to the medical profession.'
ACT	1982	Medical Practitioners Registration (Amendment) Ordinance (No. 2) 1982 No. 41	No changes specifically affecting IMGs.
ACT	1984	Medical Practitioners Registration (Amendment) Ordinance 1984 No. 13	No changes specifically affecting IMGs.
ACT	1985	Medical Practitioners Registration (Amendment) Ordinance 1985 No. 13	No changes specifically affecting IMGs.

ACT	1987	Medical Practitioners Registration (Amendment) Ordinance 1987 No. 57	Amended those eligible to graduates of the British, Irish and New Zealand universities and colleges in the Schedule, and covered the Australian medical schools with the phrase 'qualifications recognised by the Australian Medical Council.'
ACT	1993	Medical Practitioners Registration (Amendment) Act 1993 No. 21	The changes meant that only two groups were now eligible for general registration: (i) a graduate of an Australian or New Zealand medical school; (ii) a person who had passed the AMC examinations. Board could give temporary registration to others for the purpose of postgraduate training; for teaching and research; overseas-trained specialists who were recognised by an Australian college; or those who would be approved to work in an area of unmet need.
ACT	1997	Medical Practitioners Registration (Amendment) Act 1997 No. 109	No changes affecting IMGs. Amendments only to the composition of the Board.
ACT	2002	Medical Practitioners (Maternal Health) Amendment Act 2002 No. 26	No changes affecting IMGs. Amendments only concerned conduct of abortions.
ACT	2010	Health Practitioner Regulation National Law (ACT) Act 2010 No. 10	The mirror legislation enacted in each state and territory to create AHPRA and the national registration framework for health practitioners.
NT	1935	Medical Practitioners Registration Ordinance 1935 No. 1	Created the Medical Board of Northern Territory. Those eligible for registration were: (i) graduates of Australian or New Zealand medical schools; (ii) those registered, or holding a qualification entitling them to be registered, under the Medical Acts of the UK.
NT	1945	Medical Practitioners Registration Ordinance 1945 No. 5	No changes affecting IMGs.
NT	1957	Medical Practitioners Registration Ordinance 1957 No. 4	Allowed registration of practitioners who qualified in a country outside the British Empire provided the medical course was of at least 5 years and the country where it took place allowed practitioners registered in Australia to practise without further examination (reciprocity clause).
NT	1962	Medical Practitioners Registration Ordinance 1961 [No. 3 of 1962]	No changes affecting IMGs.

NT	1963	Medical Practitioners Registration Ordinance 1962 [No. 5 of 1963]	No changes affecting IMGs.
NT	1971	Medical Practitioners Registration Ordinance 1971 No. 31	No limitation on countries outside Australia where the medical qualification could be obtained, but Board to determine (by examination if necessary) that the standard was equal to that of an Australian graduate.
NT	1972	Medical Practitioners Registration Ordinance 1972 No. 73	Board chair permitted to give provisional registration in circumstances he/she considered uncontroversial.
NT	1976	Medical Practitioners Registration Ordinance 1976 No. 67	Board may now require an IMG to 'satisfy it that he has taken up or intends to take up residence in the Territory'.
NT	1980	Medical Practitioners Registration Act 1980 No. 45	No changes affecting IMGs.
NT	1983	Medical Practitioners Registration Amendment Act 1983 No. 26	No changes affecting IMGs.
NT	1984	Medical Practitioners Registration Amendment Act 1984 No. 29	No changes affecting IMGs.
NT	1993	Medical Practitioners Registration Amendment Act 1985 No. 3	Those eligible for registration amended to the following: (i) graduates of an AMC accredited medical school (i.e., any of those in Australia or New Zealand); or (ii) IMGs who passed the AMC examinations.
NT	1995	Medical Act 1995 No. 5	Conditional registration could be granted for those seeking postgraduate training in the Territory.
NT	2010	Health Practitioner Regulation (National Uniform Legislation) Act 2010	The mirror legislation enacted in each state and territory to create AHPRA and the national registration framework for health practitioners.

Supplementary Table 2: Recommendations from 'Lost in the Labyrinth' report (2012)*

No.	Recommendation
1	AMC take steps to assist IMGs experiencing difficulties and delays with primary source verification.
2	AMC take action to increase the availability of the Australian Medical Council Structured Clinical Examination (SCE) so that those making a first attempt at the examination be accommodated within six months of their initial application.
3	AMC publish detailed information on its website outlining the processes for determining the allocation of places for the Structured Clinical Examination (SCE). The information should explain prioritisation, the purpose and operation of the standby list and provide up-to-date information on waiting times for undertaking the SCE.
4	AMC provides a detailed level of constructive written feedback for candidates who have undertaken the Australian Medical Council's Structured Clinical Examination.
5	Council of Australian Governments include workplace-based assessment (WBA) pathway for international medical graduates on its health workforce agenda in order to extend endorsement from state and territory governments and increase the availability of host sites nationally.
6	Medical Board of Australia in conjunction with the Australian Medical Council, commission an independent evaluation of the workplace-based assessment (WBA) model. The evaluation should incorporate a cost benefit analysis of WBA, and encompass the views of all stakeholders, including international medical graduates, clinical assessors and host institution administrators. The outcomes of the evaluation should be made public.
7	The Australian Government Department of Health and Ageing and Australian Medical Council, in consultation with the Joint Standing Committee on Overseas Trained Specialists and the specialist medical colleges: • publish agreed definitions of levels of comparability on their websites, for the information of international medical graduates (IMGs) applying for specialist registration; • develop and publish objective guidelines clarifying how overseas qualifications, skills and experience are used to determine level of comparability; • develop and publish objective guidelines clarifying how overseas qualifications, skills and experience are taken into account when determining the length of time an IMG needs to spend under peer review; and • develop and maintain a public dataset detailing the country of origin of specialist pathway IMGs' professional qualifications and rates of success.
8	Specialist medical colleges adopt the practise of using workplace-based assessment (WBA) during the period of peer review to assess the clinical competence of specialist international medical graduates (IMGs) in cases where applicants can demonstrate that they have accumulated substantial prior specialist experience overseas. As part of the WBA process the specialist medical colleges should make available the criteria used to select WBA assessors. Specialist medical college examinations should only be used as an assessment tool where specialist IMGs are recent graduates, or where deficiencies or concerns have been identified during WBA.
9	All specialist medical colleges consult with the Australian Medical Council to ensure each college undertakes a consistent three-stage appeals process, incorporating the following: • an automatic right for an international medical graduate (IMG) to undertake the next stage of appeal, following completion of each preceding appeal; • the option for the IMG to retain an advocate for the duration of any appeal process to an Appeals Committee, including permission for that advocate to appear on the IMG's behalf at the appeal itself; and • the capacity to expand membership of the Appeals Committee to include an IMG who holds full membership of the relevant specialist college, but has no involvement with the decision under review.
10	The Committee recommends that the specialist medical colleges undertake the following steps to ensure international medical graduates (IMGs) are aware of their right of appeal regarding

	their application for specialisation: • publish information regarding their appeals process in a prominent place on their website, including information regarding each stage of the appeals process, timelines for lodging appeals and the composition of Appeals Committee membership; and • ensure that IMGs are informed of their right to appeal when any decision is made regarding their application, with information regarding their right to appeal a particular decision provided in writing on the same document advising the IMG of the decision made regarding their application.
11	The Australian Health Ministers Advisory Council, in conjunction with the Australian Government Department of Health and Ageing and the National Health Practitioner Ombudsman, develop and institute an overarching, independent appeals mechanism to review decisions relating to the assessment of clinical competence to be constituted following an unsuccessful appeal by an international medical graduate to the Appeals Committee of a specialist medical college.
12	Health Workforce Australia, in consultation with state and territory health departments, the Medical Board of Australia, specialist medical colleges and other key stakeholders, investigate options to ensure equitable and fair access to clinical supervision places for international medical graduates. Consideration should include establishing designated supervised placements for international medical graduates in teaching hospitals or similar settings.
13	Australian Medical Council, the Medical Board of Australia and specialist medical colleges collaborate to develop a process which will allow semi or recently retired medical practitioners and specialist practitioners to maintain a category of registration which will enable them to work in the role of a clinical supervisor.
14	Health Workforce Australia provide support under the Clinical Supervision Support Program to promote the innovative use of new technologies to increase clinical supervision capacity, particularly for medical practitioners who are employed in situations where they have little or no access to direct supervision.
15	Prior to undertaking practise in an area of need position or regional, rural, remote position with indirect or limited access to clinical supervision, international medical graduates (IMGs) be placed in a teaching hospital, base hospital or similar setting. Within this setting IMGs could be provided appropriate supervision for a defined period to further establish their clinical competency and assist with their orientation to the Australian health care system.
16	Health Workforce Australia ensure aspects of cross-cultural awareness and communication issues are key components in any guidelines, educational materials or training programs that are developed to support enhanced competency of clinical supervisors.
17	The Medical Board of Australia/Australian Health Practitioners Registration Agency (MBA/AHPRA) provide more information on the Pre-Employment Structured Clinical Interview (PESCI). At a minimum this information should outline: • the criteria used to determine the need for an IMG to undertake a PESCI assessment; and • criteria for accreditation of PESCI providers. • details of the PESCI assessment process including: o the composition of the interview panel, the criteria used for selecting panel members and their roles and responsibilities; o the format of the interview and the aspects of skills, knowledge and experience that will be assessed; o criteria for assessment and mechanisms for receiving feedback; and o the process for lodging and determining an appeal against the findings of a PESCI assessment. This information should be easily located on the MBA/AHPRA website and provide links to relevant information on PESCIs that is available on the websites of Australian Medical Council accredited PESCI providers.
18	All Pre-Employment Structured Clinical Interview (PESCI) assessments be video-recorded and a copy of the video-recording be provided to the applicant for the purpose of providing appropriate feedback on the assessment and as a record should an international medical graduate wish to appeal the outcome of a PESCI.

19	The Medical Board of Australia, as part of its current review of the utility and portability of Pre-Employment Structured Clinical Interview, include broader consideration of its utility as an assessment tool, particularly its application to international medical graduates who have already practised in Australia for a significant period of time under Limited Registration.
20	The Medical Board of Australia provide an opportunity for interested parties, including international medical graduates, to provide input into its current review of the utility and portability of Pre-Employment Structured Clinical Interviews. To promote transparency, the Medical Board of Australia should also provide regular updates on the review on its website, and at the conclusion of the review publish its findings
21	The Medical Board of Australia review whether the current English Language Skills Registration Standard is appropriate for international medical graduates. The review should include consideration of: • whether the International English Language Testing System and Occupational English Test scores required to meet the English Language Skills Registration Standard is appropriate; and • the basis for requiring a pass in all four components in a single sitting.
22	The Medical Board of Australia negotiate with providers of the International English Language Testing System and Occupational English Test with a view to requiring that detailed, qualitative written feedback on each component of the English Language test be provided in writing to international medical graduates to enable identification of areas of deficiency which may be rectified.
23	The Medical Board of Australia extend the period of validity for English language proficiency test results as prescribed by the English Language Skills Registration Standard to a minimum period of four years.
24	The Medical Board of Australia/Australian Health Practitioners Registration Agency provide the Australian Government Department of Immigration and Citizenship with direct access to information on its registration database as necessary to determine granting of a visa for employment purposes.
25	The Australian Government Department of Health and Ageing produce and publish on its website a comprehensive guide detailing how District of Workforce Shortage (DWS) status is determined and how it operates to address issues of medical practitioner workforce shortages. The guide should include detailed information on the following: • the methodology of DWS determination; • frequency of DWS status review; and • criteria for benchmarking of appropriate workforce levels.
26	The Australian Government Department of Health and Ageing consult with state and territory government departments of health to agree on nationally consistent and transparent approach to determining Area of Need (AoN) status based on agreed criteria. Consideration should also be given to improving the alignment between the AoN and Districts of Workforce Shortage.
27	The Department of Health and Ageing, in association with Health Workforce Australia, examine options for a planned, scaled reduction in the length of the 10-year moratorium so that it is consistent with the average duration of return of service obligations that apply to Australian graduates of Bonded Medical Places. Workforce modelling should be used to determine the implications for workforce preparation, transition, training and distribution. The outcomes should be made publicly available.
28	The Medical Board of Australia/Australian Health Practitioner Registration Agency, Australian Medical Council and specialist medical colleges, publish data against established benchmarks on their websites and in their annual reports, on the average length of time taken for international medical graduates to progress through key milestones of the accreditation and registration processes. Information published on websites should be updated on a quarterly basis.
29	AHPRA's annual report, with respect to the functions carried out by the MBA must also include a number of other key performance indicators providing further information to IMGs. In the Committee's view, these indicators must include (but should not be limited to): • the country of initial qualification for each IMG applying for Limited Registration; • the number of complaints and appeals which are made, investigated and resolved by IMGs to AHPRA, the AMC and specialist medical colleges; and

	• the number and percentage of IMGs undertaking each registration pathway (including workplace-based assessment) and their respective pass and failure rates for: o Australian Medical Council Multiple Choice Question Examination; o Australian Medical Council Structured Clinical Examination; o AHPRA's Pre-Employment Structured Clinical Interview (PESCI); o the MBA's English Language Skills Registration Standard; o other MBA Registration Standards including Criminal History Registration Standard; and o processes of specialist medical colleges including college interviews, examinations and peer review assessments.
30	Where an international medical graduate considers that the processes prescribed under the National Registration and Accreditation System have placed them at a significant disadvantage compared to their circumstances under the processes of former state and territory medical boards, that the Medical Board of Australia investigate the circumstances and, if necessary, rectify any registration requirements to reduce disadvantage. The process and procedure for review should be clearly outlined. Any review should be conducted in a timely and transparent manner.
31	The Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency ensure that computer-based information management systems contain up-to-date information regarding requirements and progress of individual international medical graduate's assessment, accreditation, and registration status to enable timely provision of advice.
32	The Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency implement appropriate induction and ongoing training for all employees responsible for dealing with inquiries. This training should include among other things, an understanding of the overall system of accreditation and registration so that referrals to other organisations can be made where necessary.
33	The Medical Board of Australia, in conjunction with the Australian Medical Council and specialist medical colleges, develop a centralised repository of documentation supplied by international medical graduates (IMGs) for the purposes of medical accreditation and registration. The central document repository should have the capacity to: • be accessed by relevant organisations to view certified copies of documentation provided by IMGs; • be accessed by relevant organisations to fulfil any future documentary needs for IMGs without the need for them to resubmit non time-limited documentation multiple times; • form a permanent record of supporting documentation provided by IMGs; and • comply with the Australian Government's Information Privacy Principles and Privacy Act 1988 (Cth).
34	The Medical Board of Australia/Australian Health Practitioner Registration Agency, the Australian Medical Council, and specialist medical colleges consult to develop consistent requirements for supporting documentation wherever possible. These requirements should be developed with a view to further reducing duplication by preventing the need for international medical graduates (IMGs) to lodge the information more than once and in different forms and formats. This documentation should form part of an IMG's permanent record on a central document repository.
35	The Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Registration Agency amend requirements so that Certificates of Good Standing provided by past employers remain valid for a period of 12 months, noting the following: • where there is a period of greater that three months since the last Certificate was issued, applicants must certify that they have not been employed in medical practice during that period; or • where applicants have been employed in medical practice since issuing of the last Certificate, additional Certificate(s) of Good Standing must be provided. Certificates of Good Standing should also be available on a central document repository.
36	Specialist medical colleges should consult with one another to establish a uniform approach to the fee structure applied to international medical graduates (IMGs) seeking specialist accreditation in

	Australia. This fee structure should be justified by the provision of clear and succinct fee information published on the Australian Medical Council and relevant college's websites, itemising the costs involved in each stage of the process. IMGs should be informed about possible penalties which may be applied throughout the assessment process.
37	The Medical Board of Australia/ Australian Health Practitioner Registration Agency, the Australian Medical Council and specialist medical colleges review the administrative fees and penalties applied throughout the accreditation and assessment processes to ensure that these fees can be fully justified in a cost-recovery based system.
38	The Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency increase awareness of administrative complaints handling and appeal processes available to international medical graduates (IMGs) by: • prominently displaying on their websites information on complaints handling policies, appeals processes and associated costs; and • ensuring when IMGs are advised of adverse outcomes of any review, that the advice contains information on the next step in the appeal process.
39	The Medical Board of Australia extend the obligations it applies to employers, supervisors and international medical graduates in its *Guidelines – Supervised practice for limited registration* to include a commitment to adhere to transparent processes and appropriate standards of professional behaviour that are in accordance with workplace bullying and harassment policies.
40	Health Workforce Australia, in consultation with key stakeholders, develop and implement a program of orientation to be made available to all international medical graduates (IMGs) and their families to assist them with adjusting to living and working in Australia. In addition to detailed information on immigration, accreditation and registration processes, the program should include: • accommodation options, education options for accompanying family members, health and lifestyle information, access to social/welfare benefits and services, and information about ongoing support programs for IMGs and their families; • information on Australia's social, cultural, political and religious diversity; and • an introduction to the Australian healthcare system including accreditation and registration processes for IMGs, state and territory health departments and systems along with Medicare. An integral part of the orientation program should be the development of a comprehensive package of information which can be accessed by IMGs and their families prior to their arrival in Australia.
41	Health Workforce Australia, in consultation with key stakeholders, develop a nationally consistent and streamlined system of education and training supports for international medical graduates. The consultation should include specific consideration of the following: • strategies for facilitating access for IMGs working in regional, remote and rural locations, including: o the potential for the innovative use of new technologies including tele/video-conferencing and internet; o the adequacy of locum relief where IMGs need to be absent from their practice to access education support; and o the adequacy of financial assistance for IMGs who need to travel to access educational and training supports. • strategies for extending eligibility to educational and training support programs to temporary resident IMGs seeking full registration in Australia and permanent residency; and • the financial and resource implications associated with providing wider access to educational and training supports.
42	Health Workforce Australia, in consultation with key stakeholders, develop a cohesive and comprehensive system of ongoing support options for IMGs and their families as an integral part of its National Strategy for International Recruitment. Such a system should include at a minimum, a particular emphasis on the educational needs of children, along with support and employment prospects for spouses.
43	Health Workforce Australia (HWA), as part of its National Strategy for International Recruitment program, examine options for establishing a one-stop shop for international medical graduates

	(IMGs) seeking registration in Australia. Serious consideration should be given to the feasibility of providing an individualised case management service for IMGs. In developing the most suitable model for such a service, HWA should consider the proposed scope of this service and the range of assistance provided, having regard to available resourcing.
44	The Australian Government Department of Health and Ageing expand the DoctorConnect website to include a register of support services available to IMGs in the various agencies around Australia, including information on: • details of location; • eligibility; • duration and timing; • cost; and • whether the program is available electronically/remotely.
45	The Australian Government Department of Health and Ageing provide a telephone help line to answers questions and provide clarification on information provided on the DoctorConnect website.

*Edited slightly, mainly by removing phrase 'The Committee recommends ...' from start of each recommendation.

House of Representatives Standing Committee on Health and Ageing. *Lost in the Labyrinth: Report on the Inquiry into Registration Processes and Support for Overseas Trained Doctors,* (Canberra: Commonwealth of Australia, 2012), xx-xxxiii.

Supplementary Table 3: IMGs registered in the colonial period by decade

A: New South Wales

Country	1831-40	1841-50	1851-60	1861-70	1871-80	1881-90	1891-1900	Total	%
Austria	0	0	0	1	0	0	1	2	0.1
Canada	0	0	0	0	3	8	9	20	1.0
Chile	0	0	0	0	0	0	1	1	0.0
Denmark	0	0	1	0	1	0	0	2	0.1
England	101	102	113	81	97	201	138	833	41.1
France	0	0	2	3	1	5	3	14	0.7
Germany	0	0	7	4	6	15	11	43	2.1
Greece	0	0	0	1	0	0	0	1	0.0
Hungary	0	0	0	1	0	0	0	1	0.0
Ireland	1	6	15	22	51	140	54	289	14.3
Italy	0	0	1	0	3	3	4	11	0.5
Malta	0	0	0	0	0	1	0	1	0.0
Netherlands	0	0	1	2	0	0	0	3	0.1
Norway	0	0	0	0	0	1	0	1	0.0
Poland	0	0	0	0	0	0	1	1	0.0
Scotland	69	55	53	39	80	258	189	743	36.7
Switzerland	0	0	1	0	0	0	0	1	0.0
Ukraine	0	0	0	0	0	0	1	1	0.0
USA	0	0	0	2	13	19	23	57	2.8
Totals	171	163	194	156	255	651	435	2025	100.0

B. Queensland

Country	**1851-60**	**1861-70**	**1871-80**	**1881-90**	**1891-1900**	**Total**	**%**
Belgium	0	0	0	1	0	1	0.2
Canada	0	1	0	3	3	7	1.1
England	1	53	42	100	55	251	40.4
France	0	0	0	1	1	2	0.3
Germany	0	9	8	5	1	23	3.7
Greece	0	1	0	0	0	1	0.2
Hungary	0	1	0	0	0	1	0.2
Ireland	1	9	19	58	25	112	18.0
Italy	0	0	1	2	0	3	0.5
Russia	0	0	0	0	1	1	0.2
Scotland	0	25	21	86	80	212	34.1
Switzerland	0	1	0	0	0	1	0.2
USA	0	0	2	4	0	6	1.0
Totals	2	100	93	260	166	621	100.0

C. South Australia

Country	1841-50	1851-60	1861-70	1871-80	1881-90	1891-1900	Total	%
Austria	1	0	0	0	0	0	1	0.2
Canada	0	0	0	0	1	2	3	0.6
Czechoslovakia	0	0	0	0	0	1	1	0.2
Denmark	1	0	0	0	0	0	1	0.2
England	34	29	11	25	43	22	164	30.5
France	1	0	0	1	0	0	2	0.4
Germany	6	8	2	3	4	3	26	4.8
Ireland	1	4	5	13	33	15	71	13.2
Italy	0	0	0	1	1	0	2	0.4
Not recorded*	1	4	0	1	0	0	6	1.1
Scotland	18	27	31	54	60	63	253	47.1
USA	1	1	1	1	1	2	7	1.3
Totals	64	73	50	99	143	108	537	100.0

*Names and years of registration are noted in register, but not where or when these IMGs qualified.

D. Van Diemen's Land/Tasmania

Country	1831-40	1841-50	1851-60	1861-70	1871-80	1881-90	1891-1900	Total	%
Canada	0	0	0	0	0	0	2	2	0.5
England	3	44	34	23	30	39	28	201	47.5
France	0	1	0	0	0	0	0	1	0.2
Germany	0	3	0	0	0	1	1	5	1.2
Ireland	1	2	4	0	6	19	14	46	10.9
NR*	3	15	1	0	0	0	0	19	4.5
Scotland	3	26	10	3	15	37	53	147	34.8
USA	0	0	0	0	0	2	0	2	0.5
Totals	10	91	49	26	51	98	98	423	100.0

*NR=Not recorded: a miscellaneous group where names recorded in register and minutes but not country of an overseas qualification. Five had been awarded 'Letters Testimonial of Van Diemen's Land Medical Council', two were military surgeons (the Act automatically made them registerable), two were marked 'Examination by the Board', and others had no explanation recorded.

E. Victoria

Country	1841-50	1851-60	1861-70	1871-80	1881-90	1891-1900	Total	%
Austria	0	0	2	0	0	0	2	0.1
Belgium	0	0	1	0	1	1	3	0.1
Canada	0	2	2	3	9	5	21	1.0
Czechoslovakia	0	0	1	0	0	0	1	0.0
Denmark	0	0	0	0	2	0	2	0.1
England*	9	257	150	92	159	66	733	35.7
France	0	0	4	1	1	3	9	0.4
Germany	0	12	7	6	13	6	44	2.1
Greece	0	1	0	0	0	0	1	0.0
India	0	0	0	0	1	0	1	0.0
Ireland	3	53	42	46	116	27	287	14.0
Italy	0	2	2	0	2	2	8	0.4
Netherland	0	0	1	0	0	0	1	0.0
Not recorded†	36	137	0	0	0	0	173	8.4
Peru	0	0	0	1	0	0	1	0.0
Scotland	11	168	93	84	232	144	732	35.7
Switzerland	0	0	0	0	1	0	1	0.0
Turkey	0	1	0	0	0	0	1	0.0
USA	0	8	7	7	5	4	31	1.5
Totals	59	641	312	240	542	258	2052	100.0

*John William Springthorpe qualified MB (Melb) and MRCS (England) in the same year (1881).
†In the first fourteen years of the Port Phillip District/Victorian Medical Boards, the country of qualification was often not recorded in the register or minutes. Most are likely to have trained in Britain.

F. Western Australia

Country	1861-70	1871-80	1881-90	1891-1900	Total	%
Canada	0	0	0	2	2	0.9
England	9	4	10	65	88	39.6
Germany	0	0	0	2	2	0.9
Ireland	0	1	12	28	41	18.5
Not recorded*	8	1	2	2	13	5.9
Scotland	3	2	15	53	73	32.9
USA	1	0	0	2	3	1.4
Totals	21	8	39	154	222	100.0

*Declaration that he was practising in the colony before 1 July 1869 (7); no details recorded (2).

Supplementary Table 4: IMGs registered 1901-1984 in each state and territory (all countries)

A: New South Wales

Country	1901-10	1911-20	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Afghanistan	0	0	0	0	0	0	0	1	1	2	0.02
Argentina	0	0	0	0	0	0	0	1	1	2	0.02
Austria	1	0	0	3	10	15	11	3	0	43	0.51
Azerbaijan	0	0	0	0	0	1	0	0	0	1	0.01
Bangladesh	0	0	0	0	0	0	1	9	2	12	0.14
Belgium	1	0	0	0	0	0	1	1	0	3	0.04
Bolivia	0	0	0	0	0	0	0	1	0	1	0.01
Bosnia	0	0	0	0	0	0	1	0	0	1	0.01
Bulgaria	0	0	0	0	0	1	0	3	1	5	0.06
Burma	0	0	0	0	0	0	7	45	3	55	0.66
Cambodia	0	0	0	0	0	0	0	2	0	2	0.02
Canada	3	2	0	0	1	0	20	123	10	159	1.90
Ceylon*	0	0	0	0	1	6	28	250	7	292	3.49
Chile	0	0	0	0	0	0	0	4	0	4	0.05
China	0	0	0	0	0	1	0	10	0	11	0.13
Czechoslovakia	0	0	0	0	3	22	15	25	5	70	0.84
Denmark	0	0	0	0	0	0	0	8	1	9	0.11
East Africa	0	0	0	0	0	0	0	1	0	1	0.01
Egypt	0	0	0	0	0	0	11	61	8	80	0.96
England	103	95	55	28	89	270	517	821	209	2187	26.2
Estonia	0	0	0	0	0	6	3	1	0	10	0.12
Fiji	0	0	0	0	0	0	0	1	0	1	0.01
France	1	1	0	1	4	2	4	3	1	17	0.20
Germany	16	1	0	1	7	22	11	10	3	71	0.85
Greece	0	0	1	0	0	3	3	2	0	9	0.11
Hong Kong	0	0	0	1	2	4	52	502	3	564	6.75
Hungary	0	0	0	0	5	40	36	10	0	91	1.09
India	0	0	0	0	1	1	131	656	42	831	9.95
Indonesia	0	0	0	0	0	0	0	2	2	4	0.05
Iran	0	0	0	0	0	0	0	1	0	1	0.01
Iraq	0	0	0	0	0	0	0	2	0	2	0.02
Ireland	38	41	13	8	22	67	65	209	28	491	5.88
Israel	0	0	0	0	0	0	0	8	1	9	0.11
Italy	11	3	0	0	3	13	12	11	0	53	0.63
Japan	0	0	0	0	1	0	0	0	0	1	0.01
Korea	0	0	0	0	0	0	1	0	0	1	0.01
Latvia	0	0	0	0	0	9	3	0	0	12	0.14
Lebanon	0	0	0	0	0	0	1	4	1	6	0.07
Lithuania	0	0	0	0	0	3	1	0	0	4	0.05
Macedonia	0	0	0	0	0	0	0	3	0	3	0.04
Malaya†	0	0	0	0	0	3	10	256	2	271	3.24
Malta	0	0	0	0	0	7	1	9	0	17	0.20
Mexico	0	0	0	0	0	0	0	1	0	1	0.01

N. Ireland	0	0	3	1	5	17	20	36	9	91	1.09
Netherlands	0	0	0	0	1	5	3	5	1	15	0.18
Pakistan	0	0	0	0	0	0	31	87	4	122	1.46
Papua New Guinea	0	0	0	0	0	0	0	3	0	3	0.04
Philippines	0	0	0	0	0	0	2	35	1	38	0.45
Poland	1	0	0	0	5	31	27	23	2	89	1.07
Portugal	0	0	0	0	0	0	0	2	0	2	0.02
Rhodesia	0	0	0	0	0	0	0	4	0	4	0.05
Romania	0	0	0	0	2	6	8	5	0	21	0.25
Russia	0	0	0	0	1	2	2	0	1	6	0.07
Scotland	148	121	67	43	45	116	180	246	58	1024	12.3
Serbia	0	0	0	0	0	2	2	4	0	8	0.10
Singapore	0	0	0	0	2	1	14	391	3	411	4.92
Slovakia	0	0	0	0	0	0	0	1	0	1	0.01
Slovenia	0	0	0	0	0	0	1	0	0	1	0.01
South Africa	0	0	0	0	1	36	88	676	41	842	10.1
Spain	0	0	0	0	0	0	3	2	1	6	0.07
Sudan	0	0	0	0	0	0	0	3	0	3	0.04
Sweden	0	0	0	0	0	0	0	17	3	20	0.24
Switzerland	2	0	0	0	0	3	6	5	0	16	0.19
Taiwan	0	0	0	0	0	0	0	3	0	3	0.04
Turkey	0	0	0	0	0	0	0	2	0	2	0.02
Uganda	0	0	0	0	0	0	2	18	1	21	0.25
Ukraine	0	0	0	0	1	2	2	1	0	6	0.07
Uruguay	0	0	0	0	0	0	0	0	1	1	0.01
USA	3	1	1	0	0	1	39	70	6	121	1.45
USSR	0	0	0	0	0	0	5	3	4	12	0.14
Vietnam	0	0	0	0	0	0	0	0	3	3	0.04
Wales	0	0	0	0	0	8	9	13	4	34	0.41
Yugoslavia	0	0	0	0	0	4	5	10	0	19	0.23
Totals	328	265	140	86	212	730	1395	4724	473	8355	

Not included are 38 where neither the Register nor Board Minutes list qualifications and where or when obtained. Three registered in 1955 were annotated section 17(1)(b) so were probably British or Irish graduates; 8 in 1947 were under section 17B (registered aliens); 17 between 1950 and 1955 were under section 17(1)(c) ('not being part of the British Empire'); and 10 lacked any details beyond names. *Name changed to Sri Lanka in 1972; †name changed to Malaysia in 1963 (applies also to listing in the following sub-tables).

B. Queensland

Country	1901-10	1911-20	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Algeria	0	0	0	0	0	0	1	0	0	1	0.1
Burma	0	0	0	0	0	0	0	1	**0**	1	0.1
Canada	3	2	1	0	0	1	0	50	0	57	2.9
Ceylon	0	0	0	0	0	2	0	18	2	22	1.1
Czechoslovakia	1	0	0	0	1	2	1	0	0	5	0.3
Egypt	0	0	0	0	0	0	1	0	0	1	0.1
England	54	52	23	17	23	134	195	356	22	876	44.9
Finland	0	0	0	0	0	0	0	1	0	1	0.1
France	0	1	0	0	0	0	0	0	0	1	0.1
Germany	6	2	0	0	0	1	0	1	0	10	0.5
Greece	0	0	0	0	0	0	1	0	0	1	0.1
Hong Kong	0	0	0	1	0	0	0	19	0	20	1.0
Hungary	0	0	0	0	0	1	2	0	0	3	0.2
India	0	0	0	0	1	1	1	10	0	13	0.7
Iran	0	0	0	0	0	0	0	0	1	1	0.1
Iraq	0	0	0	0	0	0	0	1	0	1	0.1
Ireland	20	17	10	6	4	13	5	124	5	204	10.5
Italy	10	2	9	18	2	1	0	0	0	42	2.2
Japan	0	1	0	0	0	0	0	1	0	2	0.1
Malaya	0	0	0	0	0	0	0	7	1	8	0.4
Malta	0	0	1	1	0	0	0	0	0	2	0.1
N. Ireland	0	0	0	1	3	8	7	22	1	42	2.2
Netherlands	0	0	0	0	0	1	2	2	1	6	0.3
Not recorded*	0	0	0	0	0	0	0	12	0	12	0.6
Pakistan	0	0	0	0	0	0	1	4	0	5	0.3
Poland	1	0	0	0	0	0	0	0	0	1	0.1
Romania	0	0	0	0	0	0	0	2	0	2	0.1
Scotland	84	75	31	25	10	48	72	134	9	488	25.0
Singapore	0	0	0	0	0	0	0	16	1	17	0.9
South Africa	0	0	0	0	0	1	6	72	3	82	4.2
Spain	0	0	0	0	0	0	0	1	0	1	0.1
Sweden	0	0	0	0	0	0	0	1	0	1	0.1
UAE	0	0	0	0	0	0	1	0	0	1	0.1
USA	0	0	0	0	0	1	0	2	0	3	0.2
USSR	0	0	0	0	0	2	0	0	0	2	0.1
Vietnam	0	0	0	0	0	0	0	2	0	2	0.1
Wales	0	0	0	0	0	2	3	8	0	13	0.7
Totals	179	152	75	69	44	219	299	867	46	1950	

*No country of origin entered in minutes/register for 12 IMGs in 1970s—recorded only as 'AMEC certificate'.

C: South Australia

Country	1901-10	1911-20	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Bangladesh	0	0	0	0	0	0	0	1	0	1	0.03
Belgium	1	0	0	0	0	0	0	0	0	1	0.03
Brazil	0	0	0	0	0	0	0	1	0	1	0.03
Burma	0	0	0	0	0	0	1	5	3	9	0.27
Canada	1	0	0	1	0	1	3	18	9	33	0.98
Chile	0	0	0	0	0	0	1	0	0	1	0.03
Czechoslovakia	0	0	0	0	0	0	2	1	0	3	0.09
Denmark	0	0	0	0	0	0	0	1	1	2	0.06
Egypt	0	0	0	0	0	0	0	4	1	5	0.15
England	19	19	26	19	16	118	142	259	80	698	20.80
France	0	0	0	0	0	1	0	0	1	2	0.06
Germany	1	3	0	0	0	0	3	0	2	9	0.27
Greece	0	0	0	0	0	0	0	0	1	1	0.03
Hong Kong	0	0	0	0	0	0	6	360	6	372	11.08
Hungary	0	0	0	0	0	0	1	3	1	5	0.15
India	0	0	0	0	0	3	47	297	17	364	10.85
Indonesia	0	0	0	0	0	0	0	1	3	4	0.12
Iraq	0	0	0	0	0	0	0	0	2	2	0.06
Ireland	11	7	3	3	3	12	13	54	5	111	3.31
Italy	0	0	0	5	2	1	0	3	1	12	0.36
Japan	0	0	0	0	0	0	0	3	0	3	0.09
Lebanon	0	0	0	0	0	1	0	0	0	1	0.03
Libya	0	0	0	0	0	0	0	0	2	2	0.06
Malaysia	0	0	0	0	0	0	0	341	2	343	10.22
Malta	0	0	0	0	0	1	3	10	0	14	0.42
N. Ireland	0	0	0	0	0	10	11	4	1	26	0.77
Netherlands	0	0	0	0	0	0	1	3	2	6	0.18
Nigeria	0	0	0	0	0	0	0	1	0	1	0.03
Pakistan	0	0	0	0	0	0	4	26	3	33	0.98
PNG	0	0	0	0	0	0	0	3	3	6	0.18
Peru	0	0	0	0	0	0	0	1	0	1	0.03
Philippines	0	0	0	0	0	0	0	6	1	7	0.21
Poland	1	0	0	0	0	0	0	0	3	4	0.12
Portugal	0	0	0	0	0	0	0	1	0	1	0.03
Rhodesia	0	0	0	0	0	0	0	1	0	1	0.03
Romania	0	0	0	0	0	0	0	1	0	1	0.03
Russia	0	2	0	0	0	0	0	0	0	2	0.06
Scotland	33	28	17	22	6	44	51	82	14	297	8.85
Singapore	0	0	0	0	2	0	4	432	2	440	13.11
South Africa	0	0	0	0	0	3	17	339	5	364	10.85
South Korea	0	0	0	0	0	0	0	0	1	1	0.03
Spain	0	0	0	0	0	0	0	2	1	3	0.09
Sri Lanka	0	0	0	0	1	1	2	53	4	61	1.82
Sweden	0	0	0	0	0	0	1	2	3	6	0.18
Switzerland	0	0	0	0	0	0	0	1	3	4	0.12

Thailand	0	0	0	0	0	0	4	6	1	11	0.33
Uganda	0	0	0	0	0	0	0	1	0	1	0.03
Uruguay	0	0	0	0	0	0	0	2	0	2	0.06
USA	7	6	0	0	0	0	4	15	14	46	1.37
USSR	0	0	0	0	0	0	1	1	0	2	0.06
Vietnam	0	0	0	0	0	0	0	7	4	11	0.33
Wales	0	0	0	0	0	5	2	8	1	16	0.48
West Indies	0	0	0	0	0	0	0	1	0	1	0.03
Yugoslavia	0	0	0	0	0	0	0	1	0	1	0.03
Zambia	0	0	0	0	0	0	0	1	0	1	0.03
Totals	74	65	46	50	30	201	324	2363	203	3356	

An additional two IMGs were registered in 1946 without record of qualifications or country, labelled 'Pursuant to Medical Practitioners Act Amendment Act 1946'.

D. Tasmania

Country	1901 -10	1911 -20	1921 -30	1931 -40	1941 -50	1951 -60	1961 -70	1971 -80	1981 -84	Total	%
Afghanistan	0	0	0	0	0	0	0	1	0	1	0.1
Austria	0	0	0	0	1	0	0	0	0	1	0.1
Bangladesh	0	0	0	0	0	0	0	2	0	2	0.1
Bosnia-Herzegovina	0	0	0	0	0	0	0	0	1	1	0.1
Burma	0	0	0	0	0	0	0	3	0	3	0.2
Canada	0	1	1	0	1	1	1	15	5	25	1.8
Ceylon	0	0	0	0	0	0	1	19	2	22	1.6
Czecho-slovakia	0	0	0	0	0	2	0	2	0	4	0.3
Egypt	0	0	0	0	0	0	0	3	0	3	0.2
England	33	19	12	12	20	86	136	173	22	513	37.9
France	0	0	0	0	0	0	0	1	0	1	0.1
Germany	1	0	0	0	1	5	0	0	2	9	0.7
Hong Kong	0	0	0	0	0	1	3	9	2	15	1.1
Hungary	0	0	0	0	0	2	0	0	1	3	0.2
India	0	0	0	0	0	1	12	103	5	121	8.9
Indonesia	0	0	0	0	0	0	0	0	1	1	0.1
Ireland	10	5	8	2	3	10	15	49	5	107	7.9
Italy	0	0	1	0	3	2	0	1	0	7	0.5
Kenya	0	0	0	0	0	0	0	1	0	1	0.1
Latvia	0	0	0	0	0	2	0	0	0	2	0.1
Malaya	0	0	0	0	0	0	1	3	0	4	0.3
Malta	0	0	0	0	0	0	1	0	0	1	0.1
N. Ireland	0	0	0	0	1	6	6	7	1	21	1.6
Netherlands	0	0	0	0	0	0	0	2	0	2	0.1
Pakistan	0	0	0	0	0	0	0	19	0	19	1.4
Papua New Guinea	0	0	0	0	0	0	0	2	1	3	0.2
Poland	0	0	0	0	0	1	0	2	2	5	0.4
Scotland	46	32	14	17	9	47	87	59	14	325	24.0
Singapore	0	0	0	0	0	0	3	1	0	4	0.3
South Africa	0	0	0	0	0	2	8	43	50	103	7.6
Sudan	0	0	0	0	0	0	1	0	0	1	0.1
Switzerland	0	0	0	0	0	0	0	0	1	1	0.1
USA	2	1	2	0	0	0	0	1	2	8	0.6
Wales	0	0	0	0	0	0	6	4	0	10	0.7
Yugoslavia	0	0	0	0	0	0	1	0	1	2	0.1
Zambia	0	0	0	0	0	0	0	0	1	1	0.1
Totals	92	58	38	31	39	168	282	525	119	1352	100

Not included are six who had country of initial training omitted from register/minutes: 3 awarded Tasmanian Licentiate in Medicine or Surgery (TLMS), 1 admitted under Sec 13(2) of the 1908 Act, 1 with no notation, and 1 having passed the Victorian Foreign Practitioners Qualifying Examination (1974).

E. Victoria

Country	1901-10	1911-20	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Argentina	0	0	0	0	0	0	0	2	0	2	0.1
Austria	0	0	0	0	8	9	3	2	1	23	0.6
Bangladesh	0	0	0	0	0	0	0	1	1	2	0.1
Belgium	0	0	0	0	0	0	0	0	1	1	0.0
Bulgaria	0	0	0	0	0	0	0	1	0	1	0.0
Burma	0	0	0	0	0	0	2	3	0	5	0.1
Canada	2	1	1	1	0	0	0	4	2	11	0.3
Ceylon	0	0	0	0	0	3	36	65	11	115	2.9
Chile	0	0	0	0	0	0	1	0	0	1	0.0
China	0	0	0	0	0	0	1	0	0	1	0.0
Czecho-slovakia	0	0	0	0	0	1	4	1	2	8	0.2
Denmark	0	0	0	0	0	0	1	0	0	1	0.0
Egypt	0	0	0	0	0	0	4	10	5	19	0.5
England	59	57	41	25	82	301	396	450	236	1647	41.9
Fiji	0	0	0	0	0	0	0	4	0	4	0.1
France	0	0	0	0	1	0	1	0	1	3	0.1
Germany	6	0	0	0	6	10	1	3	3	29	0.7
Greece	1	0	0	0	0	1	0	3	2	7	0.2
Hong Kong	0	0	0	0	0	1	53	105	4	163	4.1
Hungary	0	0	0	0	1	11	6	2	3	23	0.6
India	0	0	0	0	0	7	141	193	22	363	9.2
Indonesia	0	0	0	0	0	0	0	2	1	3	0.1
Iran	0	0	0	0	0	0	0	0	1	1	0.0
Iraq	0	0	0	0	0	0	0	1	0	1	0.0
Ireland	14	19	8	6	13	43	35	111	32	281	7.2
Israel	0	0	0	0	0	0	1	0	0	1	0.0
Italy	5	2	6	27	0	1	2	3	0	46	1.2
Latvia	0	0	0	0	0	6	4	1	0	11	0.3
Lithuania	0	0	0	0	1	2	0	0	0	3	0.1
Macedonia	0	0	0	0	0	0	0	1	1	2	0.1
Malaya	0	0	0	0	0	3	21	21	4	49	1.2
Malta	0	0	0	0	0	2	8	2	1	13	0.3
N. Ireland	0	0	0	1	4	18	12	27	5	67	1.7
Netherlands	0	0	0	0	0	0	2	4	0	6	0.2
Pakistan	0	0	0	0	0	2	5	8	3	18	0.5
Papua New Guinea	0	0	0	0	0	0	0	4	0	4	0.1
Philippines	0	0	0	0	0	0	2	0	0	2	0.1
Poland	0	0	0	0	2	2	6	4	5	19	0.5
Portugal	0	0	0	0	0	0	0	0	1	1	0.0
Rhodesia	0	0	0	0	0	0	0	1	0	1	0.0
Romania	0	0	0	0	0	0	1	2	1	4	0.1
Russia	0	0	0	0	0	2	0	1	4	7	0.2
Scotland	107	71	57	27	43	101	114	126	63	709	18.0

Singapore	0	0	0	0	0	1	35	28	2	66	1.7
South Africa	0	0	0	0	0	12	35	36	13	96	2.4
Sweden	0	0	0	0	0	0	0	3	0	3	0.1
Switzerland	1	0	0	0	0	3	0	0	0	4	0.1
Taiwan	0	0	0	0	0	0	0	1	0	1	0.0
Turkey	0	0	0	0	0	0	1	2	0	3	0.1
Uganda	0	0	0	0	0	0	0	0	1	1	0.0
Ukraine	0	0	0	0	0	1	0	0	0	1	0.0
Uruguay	0	0	0	0	0	0	0	1	0	1	0.0
USA	12	4	1	0	0	0	0	4	1	22	0.6
USSR	0	0	0	0	0	0	0	4	2	6	0.2
Vietnam	0	0	0	0	0	0	0	1	8	9	0.2
Wales	0	0	0	0	0	6	6	15	8	35	0.9
Yugoslavia	0	0	0	0	0	1	1	0	1	3	0.1
Totals	207	154	114	87	161	550	941	1263	452	3929	

*12 IMGs in 1970s had country of origin omitted in register—recorded only as 'AMEC certificate'.

F. Western Australia

Country	1901-10	1911-20	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Austria	0	0	0	0	4	3	1	0	0	8	0.3
Bangladesh	0	0	0	0	0	0	0	1	0	1	0.0
Bulgaria	0	0	0	0	0	1	0	0	1	2	0.1
Burma	0	0	0	0	0	0	1	5	2	8	0.3
Canada	0	0	0	0	1	1	1	7	0	10	0.3
Ceylon	0	0	0	0	0	0	0	16	0	16	0.5
Czechoslovakia	0	0	0	0	0	1	0	1	0	2	0.1
Denmark	0	0	0	0	0	0	0	0	2	2	0.1
Egypt	0	0	0	0	0	0	0	2	0	2	0.1
England	45	32	29	23	52	155	216	414	123	1089	36.8
Fiji	0	0	0	0	0	0	0	1	0	1	0.0
France	0	0	0	0	0	1	0	0	0	1	0.0
Germany	0	0	0	0	2	1	0	1	0	4	0.1
Hong Kong	0	0	1	0	0	2	8	221	1	233	7.9
Hungary	0	0	0	0	0	3	1	0	0	4	0.1
India	0	0	1	0	1	2	3	30	4	41	1.4
Indonesia	0	0	0	0	0	0	0	0	2	2	0.1
Ireland	20	16	12	2	13	23	34	105	18	243	8.2
Italy	0	1	2	3	0	0	0	0	1	7	0.2
Japan	1	2	2	0	1	0	0	1	0	7	0.2
Latvia	0	0	0	0	0	3	0	0	0	3	0.1
Lithuania	0	0	0	0	0	0	1	0	0	1	0.0
Malaya*	0	0	0	0	0	1	0	145	1	147	5.0
Malta	0	0	0	0	0	0	1	5	0	6	0.2
N. Ireland	0	0	0	0	0	12	6	15	3	36	1.2
Netherlands	0	0	0	0	0	0	1	1	1	3	0.1
Philippines	0	0	0	0	0	0	0	1	0	1	0.0
Poland	0	1	0	0	0	1	0	1	0	3	0.1
Rhodesia	0	0	0	0	0	0	0	2	0	2	0.1
Scotland	59	35	20	14	35	67	77	145	41	493	16.6
Singapore	0	0	0	0	0	3	1	428	4	436	14.7
South Africa	1	0	0	0	0	5	14	78	3	101	3.4
Switzerland	0	0	0	0	0	0	0	1	0	1	0.0
USSR	0	0	0	0	0	1	0	0	0	1	0.0
USA	0	0	0	0	0	0	4	10	4	18	0.6
Wales	0	0	0	0	0	4	5	13	5	27	0.9
Totals	126	87	67	42	109	290	375	1650	216	2962	100

*One qualified when country was Malaysia. Country not recorded for one IMG registered in 1951.

G. Australian Capital Territory

Country	1921-30	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Total	%
Canada	0	0	0	0	1	0	0	1	0.3
Czechoslovakia	0	0	0	0	0	1	1	2	0.5
Egypt	0	0	0	0	0	0	1	1	0.3
England	2	1	2	17	48	93	32	195	49.0
Germany	0	0	0	0	0	0	3	3	0.8
Hong Kong	0	0	0	0	2	10	1	13	3.3
India	0	0	0	0	0	2	7	9	2.3
Ireland	2	0	0	0	7	23	4	36	9.0
Malaysia	0	0	0	0	0	8	2	10	2.5
N. Ireland	0	0	0	2	5	3	1	11	2.8
Scotland	1	3	0	5	17	31	8	65	16.3
Singapore	0	0	0	0	0	18	0	18	4.5
South Africa	0	0	0	1	3	20	2	26	6.5
Sri Lanka	0	0	0	0	0	1	6	7	1.8
Switzerland	0	0	0	0	0	0	1	1	0.3
Uganda	0	0	0	0	0	0	1	1	0.3
Vietnam	0	0	0	0	0	0	1	1	0.3
Wales	0	0	0	0	0	1	0	1	0.3
Totals	5	4	2	25	83	210	69	398	

H. Northern Territory

Country	1931-40	1941-50	1951-60	1961-70	1971-80	1981-84	Totals	%
Argentina	0	0	0	1	0	0	1	0.2
Austria	0	0	0	0	0	1	1	0.2
Burma	0	0	0	0	7	1	8	1.2
Cambodia	0	0	0	0	1	0	1	0.2
Canada	0	0	0	1	12	1	14	2.2
Ceylon	0	0	0	1	89	2	92	14.2
Czecho-slovakia	0	0	0	0	1	0	1	0.2
Denmark	0	0	0	0	3	0	3	0.5
Egypt	0	0	0	1	5	1	7	1.1
England	1	9	25	31	56	16	138	21.3
Germany	0	0	0	0	4	0	4	0.6
Greece	0	0	0	0	1	0	1	0.2
Hong Kong	0	0	0	4	7	0	11	1.7
Hungary	0	0	0	0	1	0	1	0.2
India	0	0	0	17	150	7	174	26.8
Indonesia	0	0	0	0	2	0	2	0.3
Iran	0	0	0	0	1	0	1	0.2
Iraq	0	0	0	0	1	0	1	0.2
Ireland	0	4	5	4	16	2	31	4.8
Italy	0	0	0	0	2	0	2	0.3
Kenya	0	0	0	0	2	0	2	0.3
Malaya	0	0	0	2	13	0	15	2.3
Mexico	0	0	0	0	1	0	1	0.2
N. Ireland	0	0	2	1	2	2	7	1.1
Netherlands	0	0	0	0	1	0	1	0.2
Pakistan	0	0	0	1	7	0	8	1.2
Philippines	0	0	0	0	10	0	10	1.5
Papua New Guinea	0	0	0	0	3	0	3	0.5
Poland	0	0	0	0	4	1	5	0.8
Scotland	0	4	11	16	21	8	60	9.2
Singapore	0	0	0	2	9	0	11	1.7
South Africa	0	0	1	4	9	3	17	2.6
Sweden	0	0	0	0	2	0	2	0.3
Switzerland	0	0	0	0	2	0	2	0.3
Taiwan	0	0	0	0	1	0	1	0.2
USA	0	0	0	0	5	0	5	0.8
Uzbekistan	0	0	0	0	1	0	1	0.2
Wales	0	0	1	2	1	0	4	0.6
Totals:	1	17	45	88	453	45	649	

Supplementary Table 5: Country of origin and time of arrival for all IMGs in MDA sample

Country*	Years first registered in Australia							Region
	1961-1970	1971-1980	1981-1990	1991-2000	2001-2010	2011-2020	Total	
China	0	0	2	9	25	3	39	
Hong Kong	0	6	1	4	0	2	13	
Total:	0	6	3	13	25	5	52	Eastern Asia
Russia	0	1	1	4	20	2	28	
Romania	0	0	0	4	11	1	16	
Poland	1	0	2	6	4	0	13	
Ukraine	0	0	0	1	10	1	12	
Total:	1	1	3	15	45	4	69	Eastern Europe
Egypt	0	0	6	22	23	8	59	Northern Africa
Canada	0	1	0	2	4	2	9	Northern America
Philippines	0	1	0	7	33	3	44	
Myanmar	0	0	0	2	25	9	36	
Malaysia	0	3	0	1	5	6	15	
Singapore	0	7	0	0	2	0	9	
Total:	0	11	0	10	65	18	104	South-eastern Asia
India	3	21	11	42	230	56	363	
Sri Lanka	1	1	6	11	47	28	94	
Bangladesh	0	0	1	5	53	8	67	
Pakistan	0	1	0	3	36	16	56	
Iran	0	0	1	1	32	12	46	
Total:	4	23	19	62	398	120	626	Southern Asia
Serbia	0	0	0	4	7	1	12	Southern Europe
South Africa	0	12	12	24	80	12	140	
Nigeria	0	0	0	0	15	5	20	
Zimbabwe	0	0	0	3	9	2	14	
Total:	0	12	12	27	104	19	174	Sub-Saharan Africa
United Kingdom	1	26	37	62	149	51	326	
Ireland	0	3	5	10	24	8	50	
Total:	1	29	42	72	173	59	376	UK & Ireland
Iraq	0	0	0	7	26	8	41	Western Asia
Germany	0	0	1	6	19	1	27	
Netherlands	0	0	1	1	6	3	11	
Total:	0	0	2	7	25	4	38	Western Europe
All others*	4	0	7	32	77	24	144	
Total all regions:	10	83	94	273	972	272	1704	

*sum of remaining 56 countries that each contributed <0.5% of the IMGs in the random sample. UK & Ireland are in the UN Northern Europe region, but separated out because of the special treatment those countries enjoyed. Some graduates from elsewhere in Northern Europe were in the sample but each contributed <0.5% so included in the 'all others' group.

Supplementary Table 6: List of all participants in oral histories

Inter-view No.	Pseudonym	Country of birth	Sex	How recruit-ed*	Date of interview	Where inter-viewed	How inter-viewed	Year born	Country of medical degree	Year of degree	Year of arrival	Year regist-ered	Registration status 2021
1	Maria López	Cuba	F	CS	14.03.18	VIC	FACE	1949	Venezuela	1977	2014	NR	NR
2	Annika Schmid	Germany	F	CS	14.03.18	VIC	FACE	1951	Germany	1977	1985	1987	GP specialist
3	Shamim Mahmud	Bangladesh	M	CS	14.03.18	VIC	FACE	1979	Bangladesh	2002	2005	2018	General
4	Rahul Mangal	India	M	CS	14.03.18	VIC	FACE	1989	Malaysia	2012	2015	2018	General
5	Priya Datta	India	F	CS	14.03.18	VIC	FACE	1989	India	2012	2017	2018	General
6	Walid Mostafa	Egypt	M	CS	24.03.18	VIC	AUDIO	1984	Egypt	2007	2014	NR	NR
7	Bahiri Khadami	Iran	M	CS	28.03.18	VIC	FACE	1964	Samoa	2012	2017	2017	General
8	Vani Gokhale	India	F	CS	28.03.18	VIC	FACE	1991	India	2015	2016	2018	General
9	Daniela Almeida†	Venezuela	F	CS	28.03.18	VIC	FACE	1991	Venezuela	2013	2014	2020	Limited
10	Erfan Mazdani	Iran	M	CS	28.03.18	VIC	FACE	1989	Iran	2016	2017	2019	General
11	Sanjana Chopra	India	F	CS	02.04.18	NSW	VIDEO	1965	India	1987	2015	2016	General
12	Shailja Chaturvedi†	India	F	SB	10.04.18	NSW	AUDIO	1945	India	1967	1970	1970	Retired psychiatrist
13	Asad Tehrani	Iran	M	CS	11.04.18	VIC	FACE	1989	Iran	2013	2017	2018	General
14	Shreya Dayal	India	F	CS	11.04.18	VIC	FACE	1965	India	1989	2012	NR	NR
15	Latoya Khouri	Iraq	F	CS	11.04.18	VIC	FACE	1988	Irak	2012	2016	2019	General
16	Anna Antonova	Russia	F	CS	11.04.18	VIC	FACE	1975	Russia	1999	2007	NR	NR
17	Deepak Mukherjee	India	M	CS	25.04.18	NSW	AUDIO	1988	Russia	2012	2017	2021	Provisional
18	Emina Shehu	Albania	F	CS	02.05.18	VIC	FACE	1974	Albania	1998	2008	NR	NR

19	Faiza Qazi	Pakistan	F	CS	02.05.18	VIC	FACE	1986	Pakistan	2011	2014	2020	NR
20	Jose Hurtado	Colombia	M	CS	02.05.18	VIC	FACE	1990	Columbia	2014	2016	2019	General
21	Artur Hakobyan†	Armenia	M	CS	16.05.18	VIC	FACE	1981	Armenia	2004	2015	NR	Returned home
22	Shirisha Tamang	Nepal	F	CS	16.05.18	VIC	FACE	1984	Nepal	2009	2017	2020	General
23	Somaye Paria	Iran	F	CS	16.05.18	VIC	FACE	1989	Iran	2014	2016	2019	General
24	Nabilah Reddy	Malaysia	F	CS	16.05.18	VIC	FACE	1980	Indonesia	2007	2013	2013	FRACGP 2021
25	Karolina Wiśniewski	Poland	F	SB	24.05.18	TAS	AUDIO	1978	Poland	2003	2010	2012	Paediatrics
26	Anjali Nair	India	F	CS	30.05.18	VIC	FACE	1981	India	2005	2017	2019	General
27	Niharika Thapa	Nepal	F	CS	13.06.18	VIC	FACE	1989	Bangladesh	2014	2017	2019	General
28	Mohammad Dekhordi	Iran	M	CS	13.06.18	VIC	FACE	1974	Iran	2002	2012	NR	NR
29	James Phillips	England	M	RAND	25.06.18	NSW	AUDIO	1953	England	1978	1987	1987	Physician
30	Franchesca Rodriguez	Ecuador	F	CS	27.06.18	VIC	FACE	1989	Ecuador	2015	2016	2019	General
31	Rakesh Madan	India	M	CS	27.06.18	VIC	FACE	1975	India	1999	2005	NR	NR
32	Shivangi Das	India	F	CS	27.06.18	VIC	FACE	1985	Kenya	2010	2017	2020	General
33	Nina Kovačević	Yugoslavia	F	CS	03.07.18	VIC	AUDIO	1964	Yugoslavia	1988	2004	2019	Provisional
34	Rebecca Strutt†	England	F	RAND	03.07.18	NSW	AUDIO	1967	England	1991	1993	1993	Palliative Medicine
35	Penelope Roberts	England	F	RAND	04.07.18	VIC	FACE	1958	England	1981	1989	1989	Paediatrics
36	William Pietersen	South Africa	M	RAND	17.07.18	VIC	VIDEO	1950	South Africa	1981	2007	2007	Retired anaesthetist
37	Elizabeth Morris	Australia	F	SB	03.08.18	NSW	AUDIO	1987	Ireland	2017	2017	2017	General
38	Magdy Eskander†	Egypt	M	Newsp.	08.08.18	VIC	FACE	1946	Egypt	1976	1988	NR	NR
39	Sherif Sarraf	Egypt	M	CS	11.06.19	VIC	FACE	1965	Egypt	1988	2013	2019	General

40	Kalasia Naufahu	Tonga	F	CS	11.06.19	VIC	FACE	1986	China	2017	2019	NR	NR
41	Valentina Alonso	Argentina	F	CS	11.06.19	VIC	FACE	1971	Argentina	1996	2011	NR	NR
42	Rosa Mendoza	Philippines	F	CS	11.06.19	VIC	FACE	1988	Philippines	2014	2019	2020	Provisional
43	Tau Dhakal	Nepal	M	CS	18.06.19	VIC	FACE	1990	Nepal	2016	2016	2020	General
44	Chaaran Malhotra	India	M	CS	18.06.19	VIC	FACE	1993	India	2017	2018	NR	NR
45	Aisha Shirazi	Pakistan	F	CS	18.06.19	VIC	FACE	1992	Pakistan	2016	2017	2020	General
46	Jaamini Tuli	India	F	CS	25.06.19	VIC	FACE	1983	Russia	2009	2017	2020	General
47	Vlado Nikolić	Yugoslavia	M	CS	25.06.19	VIC	FACE	1969	Yugoslavia	1995	2016	2020	Limited
48	Ayomide Okonkwo	Nigeria	F	CS	25.06.19	VIC	FACE	1988	Nigeria	2017	2019	NR	NR
49	Boris Ivanov	Russia	M	CS	29.06.19	VIC	FACE	1974	Russia	1997	2012	2014	General
50	Livia Morecroft	South Africa	F	SB	19.07.19	VIC	FACE	1958	South Africa	1981	2003	2003	Physician & Dermatol.
51	Suresh Varadarajan†	India	M	SB	24.07.19	VIC	FACE	1964	India	1988	1990	1993	Physician
52	Xiu-ying Wang	China	M	CS	31.07.19	VIC	FACE	1982	China	2006	2015	2016	Physician
53	Sean Murphy	Ireland	M	RAND	20.08.19	QLD	VIDEO	1978	Ireland	2003	2004	2004	Emergency Medicine
54	Mary O'Shea	Ireland	F	RAND	28.08.19	WA	AUDIO	1973	Ireland	1998	2008	2011	GP specialist
55	Jana Rao†	India	M	SB	30.08.19	VIC	FACE	1939	India	1960	1969	1969	Retired surgeon
56	Nuwan Bandara	Malaysia	M	RAND	19.06.20	QLD	VIDEO	1970	Malaysia	1995	2005	2004	Neonatologist
57	Hansie Le Grange	South Africa	M	RAND	23.06.20	WA	VIDEO	1968	South Africa	1968	1996	2006	General practice
58	Radeyah Hadi	Iraq	F	RAND	23.06.20	NSW	AUDIO	1963	Iraq	1987	1993	1998	Psychiatry
59	Jeremy Vassy	Australia	M	RAND	25.06.20	NSW	VIDEO	1985	England	2010	NA	2013	Neurologist
60	Yiu-po Soo	Malaysia	M	RAND	17.07.20	NSW	VIDEO	1945	Malaysia	1972	1977	1975	Haematologist

61	Hans Weber	Germany	M	RAND	30.07.20	QLD	VIDEO	1971	Germany	1998	2000	2009	Respiratory medicine
62	Daneen Muthalaly	India	F	RAND	03.08.20	ACT	VIDEO	1982	India	2005	2007	2008	Haematologist
63	Bridget Smith	England	F	RAND	04.08.20	NT	VIDEO	1988	England	2015	2018	2018	General
64	Chandresh Balakrishnan	India	M	RAND	05.08.20	NT	VIDEO	1968	India	1991	2003	2004	Respiratory medicine
65	Iwona Mrowka†	Poland	F	RAND	09.08.20	NSW	VIDEO	1960	Poland	1986	1989	1997	General practice
66	Antony Jose	India	M	RAND	12.08.20	TAS	VIDEO	1978	India	1999	2018	2018	Neurology under sup.
67	Thomas Schulz	Censored‡	M	RAND	28.08.20	VIC	VIDEO	1961	Censored‡	1993	2013	2013	General
68	Prisha Sharma	India	F	RAND	18.09.20	VIC	VIDEO	1968	England	1992	1996	1997	Gastroenterologist
69	Surjan Kohli	England	M	RAND	25.09.20	VIC	VIDEO	1972	England	1996	2011	2010	Orthopaedic surgery
70	Dr X‡	Censored**	F	SB	06.10.20	VIC	VIDEO	1963	Censored**	1992	2012	2013	Censored**
71	Roger Jones	England	M	RAND	08.10.20	VIC	AUDIO	1979	England	2003	2012	2004	General practice
72	Lawrence Frederiks	South Africa	M	RAND	09.10.20	NSW	VIDEO	1955	South Africa	1978	1986	1986	Neonatology
73	Ram Verosha	South Africa	M	RAND	14.10.20	VIC	VIDEO	1946	South Africa	1975	1978	1984	Specialist GP
74	Alicja Robertson	Poland	F	RAND	17.10.20	VIC	VIDEO	1961	Poland	1987	1988	1995	General practice
75	Peter Visser	South Africa	M	SB	27.04.21	VIC	VIDEO	1947	South Africa	1971	1979	1980	Retired radiologist
76	Vivaan Kumar	India	M	RAND	08.08.21	QLD	VIDEO	1972	India	1999	2006	2006	Nephrology
77	Blessica Ramos	Philippines	F	RAND	10.08.21	QLD	VIDEO	1961	Philippines	1986	2007	2007	General practice
78	Sabir Kumi	Ghana	M	SB	11.08.21	VIC	VIDEO	1980	China	2013	2016	2020	General practice
79	Ashal Weerasinghe	Sri Lanka	M	RAND	12.08.21	NSW	VIDEO	1961	Sri Lanka	1986	2009	2009	Cardiology
80	Madhab Begum	Bangladesh	M	SB	15.08.21	NSW	VIDEO	1983	Bangladesh	1983	1985	1987	Gastroenterology
81	Anadia Malik	Pakistan	F	SB	15.08.21	NSW	VIDEO	1978	Pakistan	2002	2012	2018	General

82	Roger Smit	South Africa	M	RAND	17.08.21	SA	VIDEO	1956	South Africa	1980	2001	2001	General practice
83	Ishaan Varma	India	M	RAND	19.08.21	NSW	VIDEO	1969	India	1992	2006	2006	Medical Administration
84	David Lloyd	England	M	RAND	19.08.21	WA	VIDEO	1975	Wales	1998	2010	2000	Anaesthesia
85	Binita Dalal	India	F	SB	23.08.21	VIC	VIDEO	1974	India	1997	2011	2011	Obstetrics & Gynae.
86	David Evans	South Africa	M	SB	22.09.21	VIC	VIDEO	1946	South Africa	1970	1978	1978	Physician/Nephrology
87	Sanura Shaheen	Egypt	F	SB	19.11.21	VIC	FACE	1978	Egypt	2001	2010	2011	Rehabilitation medicine

*CS=criterion sampling, SB=snowball, RAND = random, newsp.= newspaper article, FACE = in person, NR = not registered.
†Own name, not a pseudonym.
‡Western European country, obscured at participant's request because of ongoing apprehension about AHPRA victimization.
**Participant wanted gender, and pseudonym that might indicate their country of origin, obscured (see text for reasons).

Appendix B

Sample pages from the prosopography of each state and territory[1]

The entire prosopography is hosted at https://figshare.com,
with DOI:10.26188/19729972.

Notes re missing data

In the early years of some states, certificate numbers were not assigned, and other states (e.g., Queensland and Tasmania) changed their numbering system subsequently. Those registered in the old register of the Port Phillip District/Victoria were assigned numbers, but the numbering started again in the new Victorian register from 1862 (by 1863, 354 of the original practitioners were no longer registered). To avoid confusion for those who appeared in both registers, only the numbers assigned to them in the new register are given in the prosopography. It should be noted, too, that difficulty reading the handwriting in the registers will sometimes have led to errors in the database.

The Victorian old and new registers in the 1840s to 1850s frequently omitted qualifications, listing only names and dates registered; most of these qualifications can be presumed to have been obtained in Great Britain (because of the Medical Acts that limited who could be registered at that time). The New South Wales' data on IMGs' qualifications and years conferred are missing in both the register and Board minutes for certain periods in the twentieth century (see Methods section for the prosopography in Chapter 5). These were also omitted in some registers (e.g., TAS and WA) for practitioners who were licensed after they proved they had been practising in the colony prior to the formation of the Board or Council; or having passed examinations conducted by the Board/Council; or (after 1978) by the Australian Medical Examination Council. Notations to this effect are made in the database when they occurred.

For abbreviations of qualifications, please see Glossary in Front Matter.
NR = No entry in that field in either Medical Board Register or Minutes.
Obsc. = obscured

[1] Only the left side of the spreadsheet, showing the first registerable qualification for each, is shown here since it would otherwise be too wide to fit on a landscape page.

New South Wales: Medical Board Registrations to 1984 (sample page)

Certif-icate no.	Year registered	Last name	Other names	Qualification 1	University qual 1	Country qual 1	Year qual 1
1	1838	Clark	George Thomas	LSA *Lond*		England	1827
2	1838	Swaine	Spelman R	MRCS *Lond*		England	1835
3	1838	Dowe	Joshua	MD	Glasgow	Scotland	1836
4	1838	Stewart	Bute	MD	Edinburgh	Scotland	1816
5	1838	Ellis	James	RN surgeon—see notes		England	1813
6	1839	Martin	Samuel Macdonald	MD	Glasgow	Scotland	1835
7	1839	Macfarlane	John	MD	Glasgow	Scotland	1837
8	1839	O'Brien	Bartholomew	MD	Glasgow	Scotland	1833
9	1839	Bennett	George Thomas	MRCS *Lond*		England	1828
10	1839	Lloyd	Humphrey Thomas Lewis	LSA *Lond*		England	1826
11	1839	Nind	Isaac Scotlandt	LSA *Lond*		England	1820
12	1839	Nicholson	Charles	LRCS *Edin*		Scotland	1832
13	1839	Wallace	Francis Lascelles	MD	Edinburgh	Scotland	1831
14	1839	Cullen	Phibbs White	MRCS *Lond*		England	1834
15	1839	A'Beckett	Arthur Martin	MRCS *Lond*		England	1838
16	1839	Schouler	Arthur	LFPS *Glasg*		Scotland	1830
17	1839	Moran	Francis	MD	Edinburgh	Scotland	1820
18	1839	Savage	Arthur	RN Surgeon	Country deemed England	England	NR
19	1839	Dobio	John	RN Surgeon	Country deemed England	England	NR
20	1839	Brown	William	MD	Glasgow	Scotland	1832
21	1839	Glennie	Henry	MRCS *Edin*		Scotland	1830
22	1839	Hope	Robert Cuthbertson	MD	Edinburgh	Scotland	1834
23	1839	Huffington	Arthur	MRCS *Lond*		England	1831
24	1839	Cobb	Law Blaxland	MRCS *Lond*		England	1838

Tasmania: Medical Council Registrations to 1984 (sample page)

Certif-icate no.	Year registered	Last name	Other names	Qualification 1	University qual 1	Country qual 1	Year qual 1
III 1143	1977	Aaron	John	MBBS	London	England	1955
	1893	Abbott	Thomas Eastoe	LSA *Lond*		England	1880
III 1174	1977	Abdulla	Jamal	MB BCh	Natal	South Africa	1968
	1893	Adams	George Thomas Cooke	LRCP LRCS *Edin* LFPS *Glasg*		Scotland	1892
	1903	Addison	Ernest Joseph	LRCP LRCS *Edin*		Scotland	1902
III 389	1971	Agarwal	Shyam Sunder	MBBS	Osmania	India	1968
	1846	Agnew	James William	MRCS *Eng*		England	1838
III 579	1973	Agrawal	Harish Chandra	MBBS	Lucknow	India	1964
III 79	1967	Ahmed	Nazir	MBBS	London	England	1955
III 747	1974	Ahsan	Shakira	MBBS	Punjab	Pakistan	1967
II 634	1953	Ainslie	Margaret Grace	LAH *Dublin*		Ireland	1952
81 1702	1981	Aitken	Alastair William	MB ChB	Glasgow	Scotland	1971
Old 108	1922	Aitken	Gilbert Elliot	LRCP LRCS *Edin* LFPS *Glasg*		Scotland	1907
83 1920	1983	Aleem	Abdul	MBBS	Bombay	India	1969
III 77	1967	Ali	Mirghani Yousif	MBBS	London	England	1952
II 1322	1965	Allen (née Colledge)	Monica Ann	LRCP *Lond* MRCS *Eng*		England	1961
	1877	Allnutt	Willliam	LSA *Lond* MRCS *Eng*		England	1870
	1905	Allport	Evett Gordon	MRCS *Eng*		England	1901
	1900	Allwork	Frank	LSA *Lond*		England	1881
	1898	Alsop	Thomas Osmond Fabian	MB ChM	Edinburgh	Scotland	1874
III 997	1976	Ameer	Mohamed Farook M.	MBBS	London	England	1971
III 623	1973	Amin	Meenakshi Ambalal	MBBS	Madras	India	1970

Victoria: Medical Board Registrations to 1984 (sample page)

Certif-icate no.	Year registered	Last name	Other names	Qualification 1	University qual 1	Country qual 1	Year qual 1
6208	1948	Colville	James Robertson	LRCP *Lond* MRCS *Eng*		England	1929
17429	1979	Condon	Richard Anthony	MB BCh BAO	Dublin	Ireland	1970
8574	1958	Connell	Helen Margaret	MBBS	London	England	1945
8328	1957	Connell	Norman Charles	LRCP *Lond* MRCS *Eng*		England	1945
2658	1909	Connolly	Henry Albert	MD ChM	Ontario	Canada	1908
7960	1956	Connon	Aileen Forsyth	MB BCh BAO	QU Belfast	N. Ireland	1954
10473	1965	Connor	Frank	MB ChB	Manchester	England	1948
1030	1882	Connor	Samuel	MD	Queens	Ireland	1881
956	1880	Conradi	Sigmund	MD	Leipzig	Germany	1863
1894	1893	Cook	Edmund Alleyne	LFPS *Glasg*		Scotland	1880
9518	1962	Cook	George Edward	MB ChB	Witwatersrand	South Africa	1943
1919	1894	Cook	Henry William James	MB ChB	Durham	England	1891
1859	1893	Cook	James	LRCP LRCS *Edin*		Scotland	1892
8751	1959	Cook	Peter	MBBS	London	England	1953
14180	1973	Cook	Thomas Albert	MB ChB	Manchester	England	1959
726	1873	Cooke	John	MRCS *Eng*		England	1873
	1859	Cooke	Samuel H	MD	Glasgow	Scotland	1839
3137	1916	Cooke	Stephen Harold	LRCP *Lond* MRCS *Eng*		England	1914
2518	1907	Cookinkam	Frank Hillman	MD	Hahnemann Homeopathic Coll, Chicago	USA	1906
3312	1918	Cookson	Reginald George	LRCP *Lond*		England	1887
	1853	Coombe	Robert Gordon	MD		NR	NR
615	1853	Cooper	Charles	MRCS *Eng*		England	1835
19119	1982	Cooper	Harris	MBBS	London	England	1938

South Australia: Medical Board Registrations to 1984 (sample page)

Certif-icate no.	Year registered	Last name	Other names	Qualification 1	University qual 1	Country qual 1	Year qual 1
6112	1976	Eid	Ahmad Kamal	MB ChB	Leeds	England	1966
8927	1981	Eirew	Rosalind Cecilia	MBBS	Manchester	England	1962
226	1875	Elam	Shrofield	LSA *Lond*		England	1871
275	1879	Elcum	Charles Frederick	LSA *Lond* MRCS *Eng*		England	1839
3431	1963	Eldred	Doreen	MB ChB	St Andrews	Scotland	1960
9271	1983	Elinder	Leif Richard	MD	Stockholm	Sweden	1972
501	1893	Elliot	Frederick John	MRCS *Eng*		Scotland	1879
319	1882	Elliott	Charles Henry	MRCS *Eng*		Scotland	1858
7859	1978	Ellis	Peter Stephen Joseph	MB ChB	Cambridge	England	1975
4663	1971	Ellis-Jones	Richard Michael	MBBS	London	England	1969
370	1885	Ellison	Frederick William	LSA *Lond* MRCS *Eng*		England	1878
153	1863	Ellison	Samuel K	MRCS *Eng*		Scotland	1862
188	1870	Elphick	Edward	LSA *Lond*		England	1868
2154	1951	Elphinstone	John Joseph	MB ChM	Aberdeen	Scotland	1932
4239	1969	Elsner	Elizabeth Fuller	MD	Yale	USA	1948
8766	1981	Elvin	Norman Anthony	MB *BCh*	Durban	South Africa	1954
268	1879	Ely	John James	LSA *Lond*		England	1853
9532	1984	Emerson	David James Macglashan	MBBS	London	England	1972
3207	1961	Emmerson	Edgar Newton	LRCP *Lond* MRCS *Eng*		England	1942
191	1871	Engelhart	August	MD	Giessen	Germany	1870
9252	1983	England	Ronald Melvin	MD	Ottawa	Canada	1976
7498	1977	Erskine	David Orr	MBBS	London	England	1973
3178	1961	Erskine	Douglas James	MB ChB	Edinburgh	Scotland	1950
521	1894	Erson	Edward George	LRCP *Edin*		Scotland	1876
88	1853	Esan	Hermann CF	MD	Göttingen	Germany	1851

Queensland: Medical Board Registrations to 1984 (sample page)

Certif-icate no.	Year registered	Last name	Other names	Qualification 1	University qual 1	Country qual 1	Year qual 1
5775	1970	Jones	Hugh Idris	LRCP *Lond* MRCS *Eng*		England	1962
91	1869	Jones	James Aberdeen	LRCP LRCS *Edin*		Scotland	1869
773612	1977	Jones	John Graham	MB ChB	Sheffield	England	1975
1145	1913	Jones	John Henry	LRCP *Lond* MRCS *Eng*		England	1899
761020	1976	Jones	Richard Harries	LRCP *Lond* MRCS *Eng*		England	1973
95	1870	Jones	Richard Theophilus	LRCP LRCS *Edin*		Scotland	1869
400	1888	Jones	Walter William Stockton	LRCS *Ireland*		Ireland	1881
513	1892	Joscelyne	Arthur Edwin	LSA *Lond*		England	1888
191	1880	Joseph	Joshua Raphael	LSA *Lond*		England	1870
921	1908	Junk	David	MB BCh BAO	Ireland	Ireland	1886
4599	1963	Justine	Michael Paul	LRCP *Lond* MRCS *Eng*		England	1945
752171	1975	Kamitakahara	Ernest George	MD	Toronto	Canada	1971
782216	1978	Kanagarajah	Muttiah	MBBS	Ceylon	Ceylon	1954
714	1901	Kane	Francis William	LRCP LRCS *Edin* LFPS *Glasg*		Scotland	1889
629	1898	Kane	Robert English	LRCP LRCS *Edin*		Scotland	1886
790669	1979	Kasan	Pravin Naran	MB BCh	Witwatersrand	South Africa	1972
6064	1971	Kask	Endel	LM	Stockholm	Sweden	1949
753863	1976	Kassim	Rashid	LRCP LRCS *Ireland*		Ireland	1975
5299	1967	Kaye	Alice Marion	LRCP *Lond* MRCS *Eng*		England	1931
3761	1957	Kaye	David Alexander Gordon	LRCP *Lond* MRCS *Eng*		England	1943
381	1887	Kealy	Joseph Patrick	LRCS *Ireland*		Ireland	1880
2779	1947	Kearns	Daniel Philip	MB BCh BAO	QU Belfast	N. Ireland	1943
6617	1973	Keating	Mary Josephine	LRCP LRCS *Ireland*		Ireland	1958
791161	1979	Keays	Anthony Clairmonte	MB BCh	Witwatersrand	South Africa	1968
337	1885	Kebbell	Charles	MRCS *Eng*		England	1881

Western Australia: Medical Board Registrations to 1984 (sample page)

Certif-icate no.	Year registered	Last name	Other names	Qualification 1	University qual 1	Country qual 1	Year qual 1
1583	1952	Lubbe	Thies Richard	MD	Hamburg	Germany	1937
5488	1977	Luck	Derek James	MB ChB	Liverpool	England	1969
604	1920	Lucraft	Harry Stephenson	MB ChB	Edinburgh	Scotland	1919
3433	1971	Lui Chan	Wai Ying	MBBS	Hong Kong	Hong Kong	1963
1788	1955	Lumsden	Ian James Michael	MB ChB	Edinburgh	Scotland	1945
6030	1979	Luntz	Chaem Hymie	MB BCh	Witwatersrand	South Africa	1956
6589	1982	Lyall	Thomas	MBBS	Aberdeen	Scotland	1936
1453	1950	Lynch	George Martin Anthony	MB ChB	Glasgow	Scotland	1944
2426	1963	Lynch	Kennedy John Basco	MB ChB BAO	Natl U	Ireland	1958
2174	1959	Lynch	Patrick Thomas Desmond	MB ChB BAO	Natl U	Ireland	1936
2278	1961	Lyon	Michael Andrew Chisholm	MBBS	London	England	1956
2052	1958	Lyons	Edward David	MB BCh	Witwatersrand	South Africa	1950
841	1929	Lyster	Arthur Edward	LSA *Lond*		England	1883
5181	1976	Ma	Edward Yat Tai	MBBS	Hong Kong	Hong Kong	1972
2645	1966	MacIntosh	John	MB ChB	Edinburgh	Scotland	1951
6236	1980	MacAdam	Douglas Brobner	MB ChB	Cambridge	England	1959
301	1905	Macarthur	John Hardie	MB ChM	Glasgow	Scotland	1893
173	1898	Macaulay	Samuel	LRCP *Edin* LFPS *Glasg*		Scotland	1880
228	1901	MacColl	Donald Stuart	MB ChM	Glasgow	Scotland	1886
52	1894	Macdonald	Archibald	MD	Pennsylvania	USA	1848
4404	1975	MacDonald	Mary	MB ChB	Edinburgh	Scotland	1959
3318	1971	Macdonald	Neal Ross	MB ChB	Edinburgh	Scotland	1968
3601	1972	Macdonald	Peter Alexander Cameron	MBBS	London	England	1967
4405	1975	MacDonald	Robert Ewen Munn	LRCP LRCS *Edin* LFPS *Glasg*		Scotland	1959
6015	1979	Macdougall	Colin Neil	MB ChB	Birmingham	England	1973

Australian Capital Territory: Medical Board Registrations to 1984 (sample page)

Certif-icate no.	Year registered	Last name	Other names	Qualification 1`	University qual 1	Country qual 1	Year qual 1
1619	1983	Mecham	Rachel Elizabeth	MBBS	London	England	1972
61	1950	Merory	Paul Heinz	LRCP *Lond* MRCS *Eng*		England	1947
927	1976	Meyhandan	Thadshayani	LRCP LRCS *Ireland*		Ireland	1962
928	1976	Meyhandan	Vallipuram	MBBS	Malaya (Singapore)	Malaysia	1961
749	1974	Mickleburgh	Walter Edward	MB ChB	Aberdeen	Scotland	1953
575	1971	Middlemiss	Thomas	MB ChB	Edinburgh	Scotland	1960
632	1972	Miller	Norman Eric	MB ChB	Manchester	England	1968
624	1972	Milner	Gerald	MB ChB	Manchester	England	1959
118	1957	Mims	Cedric Arthur Chetwynd	MBBS	London	England	1952
767	1974	Mitchell	Catherine Hutcheon	MB ChB	Aberdeen	Scotland	1945
1393	1980	Moran	Kieran Thomas	MB BCh BAO	Dublin	Ireland	1972
1090	1977	Mulvany	Mary Philomena	MB BCh BAO	Ntl. U Ireland	Ireland	1939
1063	1977	Mulvany	Stanley Michael Nicholas	MB BCh BAO	Ntl. U Ireland	Ireland	1972
604	1971	Munro	Kathleen May Hart	MB ChB	Glasgow	Scotland	1964
892	1975	Munro-Ashman	Donald	LRCP *Lond* MRCS *Eng*		England	1939
879	1975	Munro-Ashman	Elizabeth Julie Erika	MB BCh	Oxford	England	1960
1304	1979	Nadanachandran	Myurathy	LRCP *Lond* MRCS *Eng*		England	1976
498	1970	Nelson	Godfrey Thomas	MB BCh BAO	Dublin	Ireland	1951
848	1975	Ng	Yiu Kwan Jason	MBBS	Hong Kong	Hong Kong	1973
1770	1984	Nithianandan	Ponniah	MBBS	Ceylon	Sri Lanka	1976
1771	1984	Nithianandan	Sulochana	MBBS	Ceylon	Sri Lanka	1976

Northern Territory: Medical Board Registrations to 1984 (sample page)

Certif-icate no.	Year registered	Last name	Other names	Qualification 1	University qual 1	Country qual 1	Year qual 1
869	1974	Tint	Khin	MBBS	Rangoon	Burma	1954
1167	1977	Tolhurst	Helen Mary	MB BCh BAO	Dublin	Ireland	1975
957	1975	Tooray [*obsc*.]	Muthuthantirige Kalanasiri Ranjith	MBBS	Ceylon	Ceylon	1967
1305	1979	Tozer	Ralph Arthur	MB ChB	Aberdeen	Scotland	1958
180	1956	Traini	Megan	MBBS	Liverpool	England	1951
1142	1977	Underwood	Thirugnanasuntharan	MBBS	Ceylon	Ceylon	1960
593	1971	Uy	Cresencjiana Beceril	MD	Philippines	Philippines	1966
933	1975	Van den Driesen	Geoffrey Richard Lloyd	MBBS	Ceylon	Ceylon	1962
953	1975	Varma	Jaydev Ramchodji	MBBS	Bombay	India	1965
960	1975	Veerabangsa	Ahamed	MBBS	Ceylon	Ceylon	1969
1050	1976	Veerapathiran	Subramania Pillai	MBBS	Madras	India	1962
852	1974	Veeravahu	Mylveganam	MBBS	Ceylon	Ceylon	1969
891	1974	Veeravahu	Rakneswery [obsc.]	MBBS	Ceylon	Ceylon	1969
873	1974	Victor	Paul Robert	MD	Ottowa	Canada	1971
1000	1975	Vignarajah	Subramaniam	MBBS	Ceylon	Ceylon	1965
625	1972	Vignesvaran	Rasiah	MBBS	Madras	India	1968
1184	1977	Vijayakumar	Kandasamy	MBBS	Ceylon	Ceylon	1971
1183	1977	Vijayakumar (née Subramaniam)	Chitra Devi	MBBS	Ceylon	Ceylon	1971
438	1969	Vilskai	Mumtaz	MBBS	Gujarat	India	1967
779	1974	Vohra	Shiv Lal	MBBS	Delhi	India	1964

Appendix C

Peer reviewed papers arising from thesis[1]

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Appendix C1:

Yeomans, Neville D. "A dangerous migration: early mortality in immigrant doctors in colonial Victoria." *Health and History* 22, no. 2 (2020): 67-84.

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[1] 'Author Accepted' versions for the first one, since the candidate has assigned copyright to the journal publisher. The papers in Appendices C2-3 are the published versions, with permission from publisher (John Wiley and Sons). Appendix C4 is also the published version, since the copyright is mine.

A Dangerous Emigration: Early Mortality in Immigrant Doctors in Colonial Victoria

George Glendinning graduated MB ChM from Edinburgh in 1874, aged nineteen or twenty. He probably practised in Scotland for a year, then travelled to Melbourne where he was registered by the Medical Board of Victoria on 4 August 1876.[1] After a short stint as a House Surgeon at Melbourne's Alfred Hospital, he set up practice in 1877 in the nearby city of Geelong. Within twelve months, at the age of twenty-four, he was dead. The death certificate stated the cause as phthisis (tuberculosis), its duration eighteen months, and haemoptysis (coughing of blood) as a preterminal event.[2] The *Geelong Advertiser* reported:

> Being in delicate health, suffering from phthisis, he came to this colony and settled in the Inverleigh district, near to Geelong, where he soon made himself a favorite, but he afterwards came to Geelong and commenced to practise his profession ... A violent cold, which he caught a few weeks ago, settled upon his chest, and during his illness he burst a blood vessel, which hastened death.[3]

The *Advertiser* continued:

> The funeral of the late Dr. Glendinning took place yesterday afternoon. The mournful cortége [*sic*] was a long one, the deceased gentleman's remains being followed to their last resting-place in the New General Cemetery by nearly the whole of the medical profession of the district, together with many of the leading townspeople.[4]

The story does not quite end there. The previous month, on 10 December at Scots' Church in Melbourne, George had married the eighteen-year-old Mary Buntin.[5] She arrived in Melbourne only eight days earlier, from Glasgow on the *Loch Tay*; and

1 Victorian Public Records Office (hereafter VPRO): Medical Register, Medical Board of Victoria, VPRS16394/P1, vol. 2, 1862-1949 (hereafter Medical Register), certificate no. 823.

2 George Glendinning, death certificate, 26 January 1878, file no. 1739/1878, Births, Deaths and Marriages Victoria (hereafter BMDV), copy in possession of author. This was source of all other death certificates, unless otherwise indicated.

3 "Town Talk," *Geelong Advertiser*, 28 January 1878, 2.

4 *Ibid*., 29 January 1878, 2.

5 George Glendinning and Mary Grant Buntin, marriage certificate, 10 December 1877, 4664/1877, BDMV.

because of the very short time between her arrival and marriage, it can be presumed they had known each other in Scotland before George set out for Australia.[6]

Mary's widowed mother, Annie Buntin, had accompanied her on the *Loch Tay*, but died at sea on 14 November. The ship's surgeon certified the cause as 'stricture of bowel' of duration 'three weeks.'[7] There is no record that autopsy was performed and, at Annie's age of forty-seven, malignancy of the bowel would be unusual, so it is quite likely the cause of the stricture was tuberculosis of the small intestine. She was buried with her intended son-in-law in Geelong (*Image 1*).

Place Image 1 about here

Image 1. Tombstone; grave of Dr George Glendinning and Mrs Annie Buntin, Geelong Western Cemetery, location WST-PRES-01-807-0002. Photograph by author.

Having lost both her new husband and her mother, Mary had little reason to stay. She was the sole beneficiary of George's estate of over a thousand pounds,[8] and departed for London on the Lusitania in March 1878.[9] In July 1881, she married again, to the Reverend Martin Lewis.[10] But just six years later, she died in Bournemouth with her husband at her side, at the age of twenty-eight. The cause was *phthisis pulmonalis*, which her doctor certified had been present for five years.[11] Quite likely she contracted it earlier than that, and her mother and George Glendinning would have been obvious sources. The disease that killed so many in the nineteenth century world had claimed another young victim.

We can surmise from the above, though without advantage of correspondence or other direct evidence, that George Glendinning contracted tuberculosis in Scotland –

6 Mary Buntin, Inwards Unassisted Passengers to Victoria, Loch Tay, Fiche 355, p. 2; "Intercolonial Arrivals and Departures," *Hobart Mercury*, 10 December 1877, 2.
7 Annie Buntin, death certificate, 14 November 1877, 12834/1877.
8 VPRO: Probate and Administration Files (hereafter Probate), VPRS28/P2, unit 73, item 17/081.
9 VPRO: Outward Passengers to Interstate, U.K. and Foreign Ports, VPRS948/P1, March 1878, p.1.
10 "Rev Martin Lewis DD, 1856-1938," Ancestry.com.au, https://www.ancestry.com.au/family-tree/person/tree/83027844/person/38469091229/facts?_phsrc=rDz884&_phstart=successSource (accessed 20 June 2020).
11 Mary Lilias Grant Lewis, death certificate, December 1887, General Register Office (UK), Christchurch, Hants, vol. 02B, p. 408, with author.

likely contributed to by his occupation as a doctor – and decided to emigrate to Australia in the hope that the change of climate would promote a cure. This theme of 'therapeutic emigration' will be taken up later.[12] We can assume that George and Mary became engaged in Scotland, arranging for her to follow him to Australia to marry; and it does not need much imagination to guess that they hoped the health of Mary's mother would benefit as well.

George Glendinning's early demise, after leaving Scotland to practise medicine in Australia, is not unique. This paper explores the deaths of a group of other medical immigrants who were registered in the colony of Victoria and died soon after arriving. It argues that, while many of these immigrants may have faced similar health risks had they stayed in their home country, their decision to migrate was an inauspicious one.

Causes of the Early Deaths of Immigrant Doctors

From the register of licensed medical practitioners maintained by the Medical Board of Victoria, details of all who obtained their primary medical qualification overseas during the years 1861-1900 were extracted. Those registered during this period, and then removed from the register within three years due to death, were retrieved and a cause sought.[13] Of the 1352 overseas-trained doctors entered on the register, seventy-five (5.5 percent) died within this three-year window.[14] All were male and all but four obtained their qualification in the United Kingdom. Five were actually born in Australia, but received their medical education in Britain; although not immigrants, they are included

Place Table 1 about here

Table 1. Categories of death in seventy-five overseas-trained doctors who died ≤3 years from the year of registration in colony of Victoria. SD = Standard Deviation.

12 Robin F. Haines, "Therapeutic Emigration: Some South Australian and Victorian Experiences," *Journal of Australian Studies* 16 (1992): 76-90, 76; Linda Bryder, "'A Health Resort for Consumptives': Tuberculosis and Immigration to New Zealand, 1880-1914," *Medical History* 40 (1996): 453-71, 453.

13 Prior to 1861, the clerk(s) who maintained the register inconsistently recorded removal of practitioners and reasons. Hence, records earlier than 1861 were ignored. During the period thus studied (1861-1900), 454 graduates from Australian universities were excluded.

14 All but one of the overseas-trained doctors were male. The woman was Emma Constance Stone, an Australian who travelled to Canada and UK to qualify.

with the others because of their shared medical training and lived environment prior to their death. The causes of death were ascertained in most instances from death certificates, and in the remainder from reports of inquests or death notices. *Table 1* lists the causes grouped by major categories.

Tuberculosis

The most frequent cause was tuberculosis, accounting for more than a quarter of these early fatalities. Death certificates variously stated *phthisis*, *phthisis pulmonalis*, *phthisis pulmonale* and *phthisis pulmonales.*[15]

A further three may have been due to tuberculosis but misdiagnosed. Anatole Lapierre qualified MD in Paris c. 1865 and was registered in Victoria in 1891.[16] His death three years later was certified due to 'acute enteritis' (inflammation of the small intestine).[17] No autopsy was performed, and his obituary in the *Kyabram Union* told a rather different story:

> Anatole Francois Lapierre, M.D., [died] after being confined to his bed for nearly three months ... but medical skill proved powerless to prevent a fatal termination to his illness, acute enteritis and chronic peritonitis being the cause of death. Dr Lapierre was a native of Paris ... During the Franco-German War he accompanied the French troops as surgeon, on their disastrous campaign, and rendered great service to many of his countrymen. Not being over robust of constitution, he some three years ago determined to see whether the climate of Australia would agree with him better than that of his beloved France.[18]

As with Annie Buntin, this narrative, with its long duration of illness, strongly hints at the diagnosis of intestinal tuberculosis.

Two other deaths might have been tubercular, though the evidence is weaker. Alexander Barker was not an immigrant. He was born in Wannon, Victoria, and like a number of colonial Australians, travelled to Scotland to study medicine.[19] He qualified

15 While most UK graduates were required to have studied some Latin, this variety of diagnoses suggests a loose attention to its grammar.

16 His qualification is listed as Officier de Santé (dated 1879), but this is almost certainly incorrect, since he would have been aged thirty-four at that time, and his obituary indicates he 'had extensive practice in France's gay capital' before serving in the Franco-Prussian war.

17 Anatole Francois Lapierre, death certificate, 16 January 1894, 2425/1894.

18 "Death of Dr. Lapierre." *Kyabram Union*, 19 January 1894, 2.

19 TS Pensabene, The Rise of the Medical Practitioner in Victoria (Canberra: Australian National University, 1980), 63-4; Laurence M Geary, "The Scottish-Australian Connection 1850-1900," in The

in 1891, returned to Melbourne in 1892 and died the following year. His death certificate gave the cause as 'bronchitis (18 mo.) and gangrene of lung (4 d.).'[20] There was no autopsy, and the long duration of illness, which preceded his voyage to Melbourne, is again compatible with pulmonary tuberculosis. William Rowe qualified in Ireland in 1861, registered in Victoria in 1865 and died the following year. The cause was recorded as 'epileptic apoplexy', of duration ten months, and again no autopsy was performed.[21] Tubercular meningitis might have been responsible, though it would have been unusual to survive so long.

The mortality rate for tuberculosis in the immigrant doctors is difficult to calculate, or at least the problem is what denominator to use for the purpose. Using the number of doctors *newly* registered in each decade, I calculated that the annual mortality from tuberculosis in this group ranged from 320 to 973 per 100,000. If the denominator is instead the *total* number of international graduates on the register each decade, the annual rates are a little lower (*Table 2*).[22] All twenty-one with definite tuberculosis were younger than forty-five when they died. From several sources, we can calculate the mortality rates in the whole Victorian population, in the age group twenty to forty-five where that breakdown is available, or for the whole population if not.[23] These are shown

Place Table 2 about here

Table 2. Tuberculosis mortality/100,000 p.a. in overseas-trained doctor group versus whole of Victoria
**all age groups combined, not just 20-45; ** greater Melbourne only; Method 1: denominator = those newly registered during decade; Method 2: denominator = total on the register during the decade.*

History of Medical Education in Britain, edited by Vivian Nutton and Roy Porter (Amsterdam: Rodopi, 1995), 59.

20 Alexander Scot Barker, death certificate, 2 July 1883, 8810/1883.

21 William Babington Rowe, death certificate, 22 May 1866, 5163/1866.

22 Data for the denominators in these calculations were extracted from the author's unpublished prosopography of Australia's immigrant medical practitioners.

23 CF Coxwell, "A Study of Phthisis Mortality in Victoria," *Australian Medical Journal* 15 (1893): 185-206, 197; Henry Haylyn Hayter, *Victorian Year Book* (Melbourne: Government Printer, 1873), 94; *ibid.*, *Victorian Year Book for 1879-80* (Melbourne: Government Printer, 1880), 159; James Jemison Fenton, *Victorian Year-Book, 1895-8* (Melbourne: Government Printer, 1901), 730; FB Smith, *Illness in Colonial Australia* (Melbourne: Australian Scholarly Publishing, 2011), 118; *The New Zealand Official Year Book 1893*, "Death-Rates from Phthisis Per 10,000 Persons Living [Victoria]," https://www3.stats.govt.nz/New_Zealand_Official_Yearbooks/1893/NZOYB_1893.html#id344E848 (accessed 21 July 2020).

for comparison in *Table 2*. While the number of immigrant doctors is small, and they were selected because they died soon after arrival, their mortality does appear to have been higher than for the general population.

Suicide and drug overdosage

Suicides and overdoses were the second highest causes of early death, when four likely or possible suicides are added to the five for whom coronial juries recorded this verdict. The definite cases were Andrew Alexander ('Exhaustion due to refusal to take food'), Thomas Andrews ('Cut his throat when of unsound mind from excessive drinking'), John Gibson ('Suicide by prussic acid'), Henry Hobbs ('Haemorrhage from self-inflicted wounds whilst labouring under temporary insanity') and Robert Sinclair ('Poison. Prussic acid (self-administered)'). Four of five were unmarried, with ages ranging from twenty-six to fifty-four.[24]

The four other deaths occurred in circumstances where the evidence given at inquests suggested suicide was possible, yet juries opted for accidental death – an issue I take up later. Edward Colden was reportedly 'accidentally drowned ... while bathing.'[25] He had been resident surgeon at the Beechworth Lunatic Asylum, having registered in Victoria in 1877, married Mary Gennell the next year, and died in January 1879.[26] Surprisingly, there is no mention of a wife in any of the depositions or the press reports. One witness stated: 'he was a man of very intemperate habits.' Others gave evidence he was 'in a state of intoxication' at 8.30 am in the bar of the local hotel, then seen later sitting on the edge of a water hole. He asked two passing boys to take off his socks (which they did), then his trousers (which they refused). When next seen he had drowned. While this may indeed have been accidental, in a setting of equivocal marital status, lack of friends and sustained heavy drinking, intentional drowning is conceivable.

24 Andrew Alexander, death certificate, 22 January 1871, 2221/1871; Robert Duffy Sinclair, death certificate, 21 August 1892, 9977/1892; VPRO: Inquest Deposition Files (hereafter Inquest), VPRS24/P0, unit 481, item 1885/458; *ibid.*, unit 344, item 1878/558; *ibid.*, unit 277, item 1872/837.

25 Inquest, VPRS24/P0, unit 386, item 1879/119.

26 Medical Register, 854; Edward Colden and Mary Agnes Laura Gemmell, marriage certificate, 30 March 1878, 21/1878, BDMV.

In 1864, the jury at the inquest of Robert Pattinson unanimously concluded that he 'came to his death from accidentally taking an overdose of prussic acid as a sedative, administered by himself.' A bottle was found by his body, and his organs at autopsy smelled strongly of prussic acid (bitter almonds).[27] Hydrocyanic acid is a potent poison, though it was used during the nineteenth century in small doses as a sedative.[28] Pattinson, who qualified four years earlier in England,[29] would almost certainly have known the danger of overdose, thus to conclude his death was accidental appears risky.

Waldemar Roeckel qualified in London in 1874, registered in Victoria in 1892 and died two years later.[30] The cause was certified: 'by misadventure, having taken an overdose of cocaine by injection which produced asphyxia.' However, the inquest was told he had been in bed all day in a hotel in Ballarat, then sent a waiter to a chemist for some cocaine. The chemist deposed that Roeckel had stayed at the hotel on several weekends in the previous eighteen months, and that he had previously supplied him with the drug. Dr Herman Lawrence told the inquest that Roeckel worked with him as an assistant in Melbourne, and he had counselled him several times to abstain from cocaine use. On this last occasion, the packet from the chemist contained 30 grains (almost 2 gm), about 4-5 times a lethal dose if all taken at once.[31] A constable who attended the scene reported that a number of photographs, some letters and a syringe were laid out on the bed near the body. The autopsy revealed eighteen puncture marks on the right side of the chest and more on the right forearm.[32] This mode of seemingly frenzied administration, and the memorabilia arrayed around the body, do suggest an intentional death.

Henry Armstrong's death in 1861 was labelled 'Laudanum overdose while suffering delirium tremens.' His widow, Emily, gave evidence that he had 'been moving

27 "The Death of Dr. Pattinson: The Inquest," *Mount Alexander Mail*, 14 March 1864, 3.
28 Melvyn P Earles, "The Introduction of Hydrocyanic Acid into Medicine: A Study in the History of Clinical Pharmacology," *Medical History* 11 (1967): 305-13, 311-2.
29 Medical Register, 316.
30 *Ibid.*, 1786.
31 Charles V Wetli and Ronald K Wright, "Death Caused by Recreational Cocaine Use," *Journal of American Medical Association* 241 (1979): 2519-22, 2522.
32 Inquest, VPRS24/P0, unit 632, item 1894/1194.

about from one diggings to another ... [and] drinking hard. After each fit of drinking he used to get attacks of temporary insanity and try to destroy himself.' On the day he died, he had been drinking heavily for three days. He told his wife 'that he should cut his throat', whereupon she removed 'a razor that was near him'. She left him for a time but when she returned, he said to her: 'I have done it Emily.' An empty bottle marked tincture of opium was found by his bed, and the doctor who performed the autopsy noted that the stomach contained 'fluid which smelt very strongly of opium.'[33] It is difficult to regard this as an accidental death, even though the jury refused to use the word *suicide*. As a commentary on how women who suffer domestic violence so often forgive the perpetrator, Emily wrote:

> The deceased was very violent when he was in liquor, not alone with me but with every body. He has often struck me when drunk. I would be afraid to tell him of it when he was sober as it would cause him to fret very much. When he was sober he was a kind good husband. It was his straightened [*sic*] circumstances that first made him take to drink.[34]

Two more doctors (both single) died from drug overdoses, deemed accidental at inquest, but perhaps incorrectly. Charles Drinkwater died in 1889, from 'Failure of the heart's action, probably caused by the inhalation of chloroform.'[35] His inquest heard he suffered from neuralgia, had seemed well when last seen on the night he died, and that a bottle containing chloroform was found in the room with his body. Dr Francis Keyes performed the autopsy and, on what reads as rather flimsy evidence, concluded that 'The heart was one that would fail were any sudden strain put upon it.'[36]

The other to die from a drug overdose was Stanley Roome. The inquest recorded: 'The cause of his death was an over-dose of morphia self-administered but not intentionally.'[37] A colleague gave evidence that Roome took morphine in excessive doses, and others reported that he was suffering severe stomach cramps on the evening he died (likely narcotic-withdrawal symptoms). His overdose may indeed have been accidental.

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33 *Ibid.*, unit 103, item 1861/1033.
34 *Ibid.*
35 Charles Drinkwater, death certificate, 31 August 1889, 10781/1889.
36 Inquest, VPRS24/P0, unit 551, item 1889/1167.
37 *Ibid.*, unit 594, item 1892/320.

Sepsis and other infections

Not surprisingly in an era before antibiotics, some succumbed to other bacterial infections: four from typhoid, three from streptococcal septicaemia or probable meningitis, and three from pneumonia.[38] Others were diagnosed with influenza and one may have had viral encephalitis, judging by his symptoms.[39]

Another four died from kidney disease. None had an autopsy and we can only speculate about the precise diagnosis. However, considering their young age (twenty-nine to thirty-three), an infective agent may have been the culprit. Two certificates specified Bright's disease, which was recognised then and now to be a consequence of streptococcal infections;[40] and the information provided about the other two suggested they also had an acute or chronic form of the same disease.[41]

Other causes of death

The remainder died from a variety of causes. Three were from accidents. William O'Reilly fell from a horse, and William Gray was 'accidentally shot.'[42] George Lawrence's death was certified: 'Acute alcoholic poisoning.' However, he was seen to be very drunk, then brought unconscious to the Melbourne Hospital where the doctor who performed the autopsy appears not to have appreciated the significance of the discovery, when he opened the skull, of 'a large quantity of blood effused between the

38 Death certificates: Patrick Doyle, 14 April 1889, 7756/1889; George Slator, 23 June 1867, 6371/1867; Henry Wilkinson, 9 May 1866, 6401/1866; Thomas Dawson Moore, 30 December 1888, 15355/1888; John Fulford, 22 January 1887, 3483/1887; Samuel Blount, 19 October 1871, 8416/1871; Charles Clark, 21 June 1873, 3012/1873; Edwin Alfred Cormack, 24 May 1901, 5655/1901; "The Death of Dr. Horace Grattan Kelly," *Town Talk (Melbourne)*, 10 June 1898, 14; "James Hamilton Wilson," *The Australasian*, 6 December 1879, 28.

39 "Dr. Thomas James Barr," *Leader (Melbourne)*, 5 April 1890, 30; Death certificates: William Marshall Taylor, 16 June 1893, 6398; John Lyman, 2 September 1870, 7127/1870

40 Death certificates: William Walsh, 12 September 1873, 7690/1873; Francis Wingrove, 28 May 1892, 8117/1892; William Osler, *The Principles and Practice of Medicine* (New York: D Appleton and Co., 1892), 741.

41 James Peter Hill, death certificate, 8 April 1864, 3364/1864; James Robert Gillespie, death certificate, 27 February 1866, Births Deaths Marriages and Divorces Queensland, District of Ipswich, 620, with author.

42 "William James Gray," *The Argus*, 17 May 1899, 1; "Death of Dr. O'Reilly," *Kyneton Observer*, 20 July 1867, 2.

pia mater and the brain.'[43] Those findings suggest Lawrence had fallen and hit his head while drunk, causing a subdural haemorrhage (bleeding between the brain and the skull) that was the actual cause of death.

Three were certified as liver disease – two with cirrhosis, the third with 'hepatitis' of three months duration. In the second half of the nineteenth century, the likely underling cause in all would be chronic alcohol excess.[44]

Six died from heart disease. This was an older group, as would be expected. Autopsies were performed in only two; in the rest the diagnosis was a clinical one. James Figg and Frederick Burkitt's deaths were attributed to 'valvular heart disease.'[45] Rheumatic heart disease (causing valvular disease in young to mid-life) was common at the time. The physical signs of this were well known in the late nineteenth century so the doctors attending Figg and Burkitt were probably well trained to make the diagnosis.[46] The nature of the heart disease in the other four is less clear.[47]

The final group were certified as dying from either 'apoplexy' or 'serous apoplexy.' One of the first to define what physicians meant by apoplexy was William Cullen, who, using the Latin of educated practitioners of physic of his day, defined it as 'Soper profundissimus cum stertore vel sonora respiratione [deepest sleep with snoring or noisy breathing].'[48] Émile Littré and Charles-Philippe Robin gave a more detailed definition in 1855:

> An illness characterised by a sudden spontaneous paralysis – more or less complete, more or less extensive, more or less persistent – of consciousness and movement;

43 Inquest, VPRS24/P0, unit 175, item 1866/604. A subdural haemorrhage is usually a consequence of head trauma, resulting in blood accumulating between the brain and the overlying dura mater, which compresses the brain, often fatally unless treated.

44 The 'hepatitis' diagnosis was a clinical one. A plausible cause, based on the prevalence of alcoholism would be alcoholic hepatitis.

45 Death certificates: James Carnegie Figg, 1 May 1886, 7816/1886; Frederick William Burkitt, 21 December 1891, 17483/1891.

46 Osler, 273, 602-19.

47 Christopher Sharp, death certificate, 28 April 1864, 6421/1864; Inquests: VPRS24/P0, unit 625, item 1894/381; VPRS24/P0, unit 303, item 1874/127; "William Ray," *Ballarat Courier*, 14 June 1875, 2.

48 William Cullen, *Synopsis Nosologiae Methodicae* (3rd ed. Edinburgh: Publisher not identified, 1769), 47.

> paralysis produced in most cases by an effusion of blood into the cerebral membranes, ventricles, or the substance of the brain itself (my translation).[49]

This would now be called a stroke, due to either haemorrhage into some part of the brain, as Littré and Robin described, or interruption of cerebral blood flow by a clot or other obstruction of a cerebral artery.

However, in these doctors diagnosed with apoplexy, the term was clearly used more loosely. Only one had an autopsy: John Boxwell died aged thirty-one from 'Pulmonary appoplexy [*sic*] with consequent regurgitation of venous blood into heart.'[50] The autopsy description was brief in the extreme. Although the practitioner provided no evidence, he may have thought Boxwell died from a pulmonary embolus (clot of blood lodging in the pulmonary artery).[51] In the other six, it was a clinical diagnosis, without inquest or autopsy.[52]

Deaths in the final group were labelled 'serous apoplexy' – a diagnosis used not infrequently in the nineteenth century, and which appears to have been something of a catch-all for mainly sudden death without a very clear cause.[53] Two of these had autopsies, which were unable to explain the sudden deaths (though one recorded 'gin-drinker's liver' as perhaps an incidental finding).[54] The other two diagnoses were made clinically, without an inquest or further details.[55]

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49 Émile Littré and Charles-Philippe Robin, *Dictionnaire de Médecine, de Chirurgie, de Pharmacie, des Sciences Accessoires et de L'Art Vétérinaire de P.H. Nysten,* 12th ed. (Paris: J B Baillière, 1855), 95.

50 John Henry Boxwell , death certificate, 29 April 1876, 4344/1876.

51 Inquest, VPRS24/P0, unit 342, item 1876/390.

52 Death certificates: Sigmund Conradi, 18 May 1882, 5528/1882; James Leahy, 27 May 1870, file no, 5085/1870; George Milner Cole, 5 May 1884, 7575/1884; John Adam Swindells, 14 November 1892, 15107/1892; George Spearman, 12 August 1869, 7325/1869; "Mc Laurin," *The Argus*, 26 July 1884, 1.

53 William Cullen, *First Lines of the Practice of Physic*, Vol. 1 (Worcester, Mass.: Isaiah Thomas, 1790), 317; James Copland, *A Dictionary of Practical Medicine*, Vol. 1 (Boston: Lilly, Wait, Colman and Holden, 1834), 79; William Boyd Mushet, *A Practical Treatise on Apoplexy (Cerebral Hemorrhage), Its Pathology, Diagnosis, Therapeutics, and Prophylaxis, with an Essay on So-Called Nervous Apoplexy, on Congestion of the Brain and Serous Effusion* (London: John Churchill and Sons, 1866), iii-iv, 134-8.

54 Death certificates: Stewart Cowper, 7 June 1866, 3154/1876; Joseph Davidson, 2 October 1862, 7777/1862.

55 Death certificates: Joseph Magee, 7 June 1866, 5477/1866; Henry Francis McGrath, 20 July 1877, 9808/1877.

The Controversy about the 'Beneficial' Australian Climate

Tuberculosis was greatly feared in the nineteenth century. As Barry Smith writes: 'there was a lot of it about and Violetta and Mimi notwithstanding, it was not a gentle way to die.'[56]

A prevalent view at the time was that Australasia was a safer place for consumptives, and migrating from Britain might facilitate a cure.[57] Bryn Thomas and Bryan Gandevia refer to southern Australia as 'a haven of hope to the phthisical.'[58] Robin Haines writes about 'therapeutic emigration', noting the emergence of 'invalid' or 'hospital' ships in the second half of the century.[59] But this was not without risks: some consumptive emigrants died during the long journey, reminiscent of the fate of George Glendinning's prospective mother-in-law. Linda Bryder, writing about a similar immigration to New Zealand, describes that country in the late nineteenth century as a 'Health Resort for Consumptives.' However, the confined quarters on board ship posed a risk that healthy passengers would actually *contract* it en route.[60] Bryder examines the age distribution of immigrants who died within one year of arrival: nearly three-quarters of adults were aged between twenty and thirty-four, similar to the medical immigrants in this paper.[61] Most if not all of them would have been infected before they emigrated, based on an average interval of three years between disease onset and death.[62]

The idea that climate might be important is an old one. In 1756, Ebenezer Gilchrist wrote about the sea voyage for consumption as 'a grand remedy of antiquity':

56 Barry Smith, "Gullible's Travails: Tuberculosis and Quackery 1890-1930." *Journal of Contemporary History* 20 (1985): 733-56, 734.

57 JM Powell, "Medical Promotion and the Consumptive Immigrant to Australia," *Geographical Review* 63 (1973): 449-76; Robin Walker, "The Struggle against Pulmonary Tuberculosis in Australia, 1788–1950," *Historical Studies* 20 (1983): 439-61, 441.

58 Bryn Thomas and Brian Gandevia, "Dr. Francis Workman, Emigrant, and the History of Taking the Cure for Consumption in the Australian Colonies," Medical Journal of Australia 2 (1959): 1-10, 2.

59 Haines, 76-90

60 Bryder, 462.

61 *Ibid.*, 465.

62 Edine W Tiemersma et al., "Natural History of Tuberculosis: Duration and Fatality of Untreated Pulmonary Tuberculosis in HIV Negative Patients: A Systematic Review," *PLOS One* 6, no. 4, e17601. doi:10.1371/journal. pone.0017601 (2011): 1-13, 9-10.

> It has been chiefly in consumptive cases that I have recommended sailing; to the cure of which it seems altogether suited; and as no adequate remedy has yet been discovered, this encourages and justifies a serious trial of it, in this particular distemper, so frequent and fatal in Great Britain.[63]

By the nineteenth century, with the opening up of the antipodean colonies, others began to take up the theme. In 1827, Peter Cunningham wrote:

> The extraordinary healthiness of the climate of New South Wales must be of no trifling important in the eyes of a European ... the European phthisis is uniformly cured or at least relieved by a removal hither, if easily resorted to.[64]

The most influential of these proponents of therapeutic migration seems to have been Samuel Dougan Bird, an English physician whose own tuberculosis became apparent about 1860. Following the then fashionable advice, he travelled twice to Melbourne where he eventually settled and recovered.[65] Bird became a passionate advocate for the benefit of the antipodean climates and the long sea voyage – where the patient 'is exposed to the complete and continuous alterative of constantly breathing the pure, stimulant, ozoniferous, and yet soothing air of mid-ocean.'[66]

Others followed suit, but cautioned against sending patients with advanced disease for fear they die on the journey and suffer, as Isaac Brown writes, 'many sorrowful partings, and the separation from spiritual communion with those nearest and dearest, which in this fatal type of the disease is the only consolation left.'[67]

On the other hand, two in particular argued against the notion that the Australian climate offered any benefits to consumptives. In 1855, James Kilgour wrote a book in

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63 Ebenezer Gilchrist, *The Use of Sea Voyages in Medicine* (London: Millar, Wilson and Durham, 1756), 44.

64 Peter Cunningham, *Two Years in New South Wales: A Series of Letters Comprising Sketches of the Actual State of Society in That Colony, of Its Peculiar Advantages to Emigrants; of Its Topography, Natural History, &c. &c.* (Vol. 1, London: Henry Colburn, 1827), 183-4.

65 David M O'Sullivan, *Bird, Samuel Dougan (1832-1904)*, Australian Dictionary of Biography, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/bird-samuel-dougan-2996/text4383, published first 1969 (accessed online 1 August 2020).

66 S Dougan Bird, *On Australasian Climates and Their Influence on the Prevention and Arrest of Pulmonary Consumption* (London: Longman [etc.], 1863), 25, 116-7.

67 Isaac Baker Brown Jr., *Australia for the Consumptive Invalid: The Voyage, Climates, and Prospects for Residence*, (London: Robert Hardwicke, 1865), 27; Richard Payne Cotton, "Consumption and Climate," *British Medical Journal* 1, no. 838 (1877): 67-68, 67; John C Thorowgood, "Ocean Voyages in Pulmonary Phthisis," *British Medical Journal* 2 (1899): 1388, 1388; J Burney Yeo, "Sea Voyages and Phthisis," *Lancet* 142 (1893): 1089, 1089.

which he argued that far from benefiting tuberculosis, it must instead be 'extremely *favourable* [my emphasis] to its origin and growth.'[68]

Perhaps the most important dissenter to the dogma that the climate was beneficial was William Thomson. Thomson was surgeon-in-charge of many passenger ships sailing between England and foreign ports and had heard 'about the good repute Australian climates were rapidly gaining for their supposed salutary influence, especially over phthisis.' He began practice in Victoria in 1854 and saw many cases of the disease. This led him to a detailed assessment of mortality statistics in the colony. He notes that, in 1876-77, just under a quarter of those who died from phthisis were born in Australia; and of those born overseas, ninety percent had lived in Victoria for five or more years (implying they contracted it there).[69] His strident questioning of the dogma that the climate was beneficial led him into conflict with the Victorian medical establishment, including the *Australian Medical Journal*, of which he had been editor.[70] After his death in 1883, his obituarist refers to his tempestuous and argumentative relationship with the Medical Society of Victoria and the *Journal*, but also pays tribute to Thomson's advocacy for a germ aetiology of tuberculosis, three years before Robert Koch presented his elegant experiments to the Berlin Physiological Society.[71] Koch had not only identified the bacteria in tuberculous organs but cultured them and proved they reproduced the disease in experimental animals – 'Bazillen nicht nur Begleiter des tuberkulösen Prozesses, sondern die Ursache desselben sind' [the bacilli are not only companions of the tuberculous process, but the cause of it (my translation)].[72] Of course, even knowledge that the disease was an infection would not necessarily negate warmer

68 James Kilgour, *Effect of the Climate of Australia Upon the European Constitution in Health and Disease* (Geelong, Vic: William Vale, 1855), 11-17.

69 William Thomson, *On Phthisis and the Supposed Influence of Climate: Being an Analysis of Statistics of Consumption in This Part of Australia with Remarks on the Increase of That Disease in Melbourne* (Melbourne: Stillwell & Knight, 1879), vi-vii, 3-50.

70 Bryan Gandevia, *Thomson, William (1819-1883)*, Australian Dictionary of Biography, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/thomson-william-4718/text7823, published first 1976 (accessed online 2 August 2020); Smith, 119-124.

71 "Mr William Thomson FRCS Ed." *Australian Medical Journal* 5 (1883): 315-21, 315-6, 318.

72 Robert Koch, "Die Ätiologie der Tuberkulose." *Berliner Klinische Wochenschrift* 19, no. 15 (1882): 221-30, 442.

climates helping recovery; Bryder mentions there were still proponents for that early in the twentieth century.[73]

Suicide and Alcohol Abuse in the Medical Immigrants

The second most common cause of death in these doctors was by their own hand. I remarked earlier that some were certified as accidental, though the evidence seems suggestive of suicide. Timothy Coghlan notes in 1898 the 'growing disposition ... of coroners' juries to attribute [charitably] to accident what is really the result of an impulse at self-destruction'; Alannah Tomkins, in her aptly titled chapter *Despairing doctors*, notes a similar practice in nineteenth century Britain.[74] It is hard to calculate an accurate mortality rate for the immigrant doctors, but using the more conservative of the methods described above, their suicide rate may have been around 120 per 100,000 p.a. This is somewhat higher than the 93 and 31 per 100,000 estimated by Coghlan and JJ Fenton for the whole population.[75] Tomkins found that suicide accounted for almost three percent of all deaths in practitioners under the age of forty-four.[76] It was responsible for an even higher proportion (twelve percent) of the deaths described in this paper.

What factors may have driven these, mostly young, professionals to suicide? Financial insecurity may have played some part. Probate records could be retrieved for five, all of whom died intestate.[77] The mean value of their estates was £48; and for two with estates of £20 or less, there would have been little in reserve for contingencies. Tomkins also found impending financial failure to be a quite common precipitant in her British study.[78]

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73 Bryder, 457.

74 Timothy A Coghlan, *A Statistical Account of the Seven Colonies of Australasia, 1897-8* (Sydney: Government Printer, 1898), 117; Alannah Tomkins, *Medical Misadventure in an Age of Professionalisation*, 1780-1890 (Manchester: Manchester University Press, 2014), 236.

75 Coghlan, 116-7; Fenton, *Victorian Year-Book, 1895-8,* 74,748.

76 Tomkins, 232.

77 Probate: VPRS28/P1, unit 9, item 4/684; VPRS28/P2, unit 9, item 10/162; *ibid.*, unit 51, item 14/807; *ibid.*, unit 346, item 50/034; *ibid.*, unit 393, item 56/020.

78 Tomkins, 250.

Notably, two-thirds of those who suicided were single, and the wife and children of another were still in England.[79] Émile Durkheim's classic studies in nineteenth century France showed that unmarried males aged thirty to fifty were three times more likely to suicide than married men: 'la vie de famille y agit très différément sur le suicide.'[80] Loneliness might have been common in those who came out by themselves to practise in an unfamiliar country; more than half of these doctors who suicided did so within a year of arrival. David Fitzpatrick writes that 'many nineteenth century emigrants ... found Australia a harsh and hostile environment ... their letters home, when preserved, provide invaluable testimony to the personal costs and pains entailed by migration.'[81]

Alcohol probably contributed to the death of more than ten percent of this group of immigrant doctors. Four who committed suicide were reported to drink very heavily, and had been doing so around the time they died. Others died from or with alcoholic liver disease or alcohol-related trauma. Alcohol is often the refuge of the disillusioned and the despairing. Timothy Coghlan reports that, in 1896, there were 47,578 arrests in Victoria for drunkenness.'[82] James Backhouse travelled extensively in Australia in the 1890s, where he notes that 'drunkenness and debauchery' were 'awfully prevalent.'[83] At a time when doctors still prescribed alcohol for various ailments,[84] too many fell victim to their own remedy.

79 Probate: VPRS28/P2, unit 51, item 14/807.

80 Émile Durkheim, *Le Suicide: Étude de Sociologie* (Paris: Félix Alcan, 1897), 183, 203. 'Family life affects very differently [the risk of] suicide (my trans.)'

81 David Fitzpatrick, Patrick Comber and Edward Comber, "'An Outside Part of the World': Patrick and Edward Comber, 1862-92," in *Oceans of Consolation: Personal Accounts of Irish Migration to Australia*, edited by David Fitzpatrick, 230-48 (Ithaca, NY: Cornell University Press, 1994), 230.

82 Coghlan, 112.

83 James Backhouse, *A Narrative of a Visit to the Australian Colonies* (London: Hamilton, Adams and Co., 1843), 332, 413.

84 FB Smith, "Curing Alcoholism in Australia, 1880s-1920s." *Journal of Australian Colonial History* 8 (2006): 137-58, 142-3.

Conclusion

One of the challenges of researching deaths, in any era, is the accuracy of death certificates. From comments made above, it will be clear that the pathological expertise of some doctors who performed autopsies was questionable. Nineteenth century medical education in Britain generally assured anatomical knowledge, but training in pathology and understanding of diseases was still in evolution.[85] For most of these doctors who were diagnosed by their contemporaries with phthisis, the conclusion was very likely correct. The features of that disease were characteristic and well known. Similarly, there should be little doubt about those certified as suicide – the second main theme to emerge from these histories. However, for others I have often applied retrospective diagnosis – a risky process that Axel Karenberg writes should be 'used [only] in the form of an historical interpretation within a certain historical context, [when] it can be a valuable historical method.'[86]

This compilation of case histories paints a picture of the burden of illness that afflicted some of Victoria's earliest doctors, though it should be noted that these early deaths were much in the minority. Many more survived this arbitrary three-year window, often continuing to practise for decades in an era when mean life expectancy was little more than fifty years. But, for those featured here, it was in truth a dangerous migration.

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Acknowledgments

The author thanks Laureate Professor Emeritus Stuart Macintyre AO and Professor Janet McCalman AC for their encouragement to undertake this research, and their insightful suggestions and commentary on the manuscript.

Appendix C2:

Yeomans, Neville D, Jill Sewell, Philip Pigou, and Stuart Macintyre. “Demographics and Performance of Candidates in the Examinations of the Australian Medical Council, 1978-2019.” *Medical Journal of Australia* 214 (2021):54-58.

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Med J Aust 2021; 214 (2): 54-58; doi: 10.5694/mja2.50800.

Demographics and performance of candidates in the examinations of the Australian Medical Council, 1978–2019

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doi: 10.5694/mja2.50800

Australia has relied, for most of its history, on international medical graduates (IMGs) to supplement its workforce. Since 1978, IMGs applying for general registration to practise in Australia have usually needed to pass the examinations of the Australian Medical Examining Council, or since 1986, its successor, the Australian Medical Council (AMC). The AMC provides several pathways to registration by the Australian Health Practitioner Regulation Agency (AHPRA). The route now termed "the standard pathway" consists of a two-part assessment including a multiple choice question (MCQ) examination followed by a clinical examination. While most IMGs are required to pass both examinations, since 2007, IMGs who qualified in the so-called competent authority countries (the United Kingdom, Ireland, the United States and Canada) have usually not been required to sit these examinations.[1]

The examinations have sometimes provoked controversy and political responses in various forms.[2–4] Partly in reaction to these, but mainly through an internal process of continuous improvement, their formats have been adapted considerably over the 42-year period. The MCQ examination assesses "basic and applied medical knowledge across a wide range of topics," and since 2000, its pass mark has been set using item response theory.[5,6] The original clinical examination used short cases and viva voces; in 2004, this was replaced by a 16-station objective structured clinical examination (OSCE). The standard of both examinations is set at that "of newly qualified graduates of Australian medical schools who are about to commence intern training".[6]

The last account of the demographic features of candidates attempting the examinations and their performance was provided in 2010.[5] Now, a decade later, there have been striking changes in both these parameters, which we document and evaluate in this article. A further aim was to identify some demographic or candidate factors that might influence examination success.

Source of data

De-identified information about candidates who took the MCQ and clinical examinations of the Australian Medical Examining Council and AMC, from their inception in 1978 until October 2019, were provided by the Council. It included the country and year of primary medical qualification, gender, year of birth, years of first attempt and success, and number of attempts for each candidate.

From this information, we calculated the numbers of candidates, numbers of attempts, the success rate per attempt, and the proportion eventually achieving success each year. To examine the contributions of individual countries, results were aggregated into decades. Countries of training were also consolidated into regions, according to the United Nations geographical regions report, last updated in 1999 (Supporting information, table 1).[7]

Ethics approval was obtained from the University of Melbourne Human Research Ethics Committee (ID: 1750338.3).

Demographic features of candidates

Over the 42-year period, a total of 35 699 candidates from 153 countries sat the MCQ examination, 16 588 (46.7%) of whom were female (Box 1). The median age of all candidates at their first MCQ attempt was 32 years (interquartile range [IQR], 28–37 years; range, 20–73 years). The clinical examination was attempted by 20 494 candidates. Their demographic features were similar to that of the candidates for the MCQ.

Box 1 shows the number of candidates for the MCQ and clinical examination for the top ten countries of primary medical qualification at each examination. The data for countries grouped by UN region are provided in the online Supporting information, table 1, and data for candidates from all individual countries (except those with very few candidates) are provided in the online Supporting information, table 2. South Asia was the region contributing most candidates, with just under half the total — predominantly graduates from India, Pakistan and Sri Lanka. Next in order were those from South-East Asia and North Africa.

Candidate performance

From a low base until about the year 2000, there was a marked increase in candidates attempting each examination, reaching a peak in 2009 for the MCQ and 4 years later for the clinical examination (Box 2 and Box 3). Although the candidate numbers declined slightly after these peaks, they remained almost fourfold higher than in 2000.

The pass rate at each attempt in the MCQ examination fluctuated, with most year-to-year variations not reaching statistical significance. However, overall pass rates per attempt increased over time, from a low of 28% in 1987 to a high of 66% in 2018. Some candidates showed great persistence: 86 attempted the examination ten or more times.

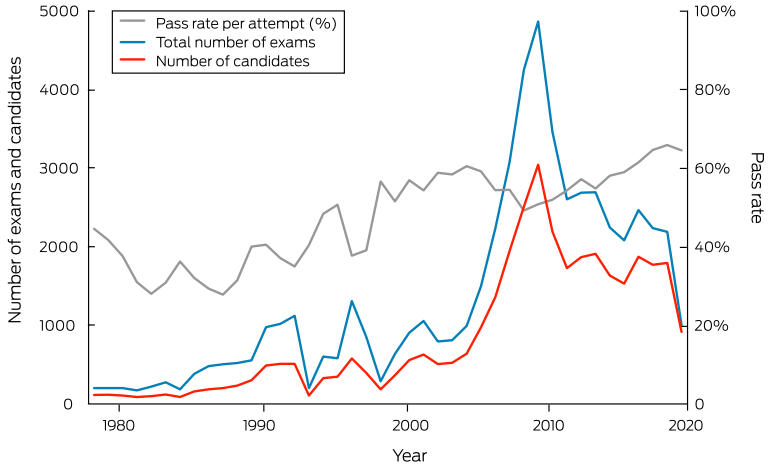
As with the MCQ examination, the pass rate in the clinical examination increased between the 1980s and the 2000s, reaching a peak of 64% in 2007. However, between 2011 and 2012 it fell by more than 10%, followed by a further decline; and for the past 5 years (excepting 2019 when data were incomplete), it

1 Multiple choice question (MCQ) and clinical examinations: numbers of candidates, top ten countries*

Country of training	1978–1989	1990–1999	2000–2009	2010–2019	Total
MCQ examination					
India	351	496	2619	2483	5949
Pakistan	32	113	1007	1838	2990
Sri Lanka	159	246	1005	1394	2804
Egypt	179	356	375	1171	2081
Bangladesh	16	99	777	1107	1999
Iran	32	34	664	1197	1927
Philippines	83	182	646	714	1625
China	4	219	641	745	1609
Myanmar	21	66	485	772	1344
Iraq	8	160	420	602	1190
Total all countries	1864	3859	12 722	17 254	35 699
Clinical examination					
India	190	392	1059	2074	3715
Sri Lanka	101	194	399	960	1654
Pakistan	13	59	342	1168	1582
Bangladesh	7	53	483	831	1374
Iran	8	27	263	688	986
China	0	109	398	475	982
Egypt	78	296	195	375	944
Myanmar	5	45	175	661	886
Philippines	11	104	198	507	820
Iraq	2	85	303	358	748
Total all countries	897	2588	5806	11 203	20 494

* By total number of candidates. Data are listed by the year each candidate first attempted the examination. Many candidates made multiple attempts. International medical graduates trained in the United Kingdom and Ireland were exempted from the Australian Medical Council examinations by most states until 1992. Since 1997, few candidates from the competent authority countries (UK, Ireland, Canada and the United States) were required to take the examinations. ◆

2 Number of candidates and success rate per attempt in the multiple choice question examinations since 1978, and total number of attempts by candidates each year*



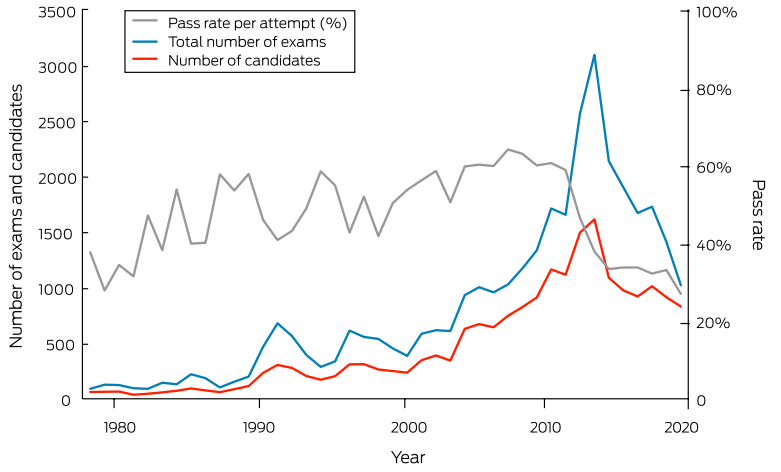
* Data for 2019 truncated at October. ◆

has remained just above 30%. Nevertheless, most candidates who persevered managed to pass after one or two further attempts. As with the MCQ, there were a few who found it much more difficult. Five or more attempts were made by 621 candidates (3.0%), 144 of whom have not yet succeeded.

Pass rates by individual country are provided in the Supporting information, table 3.

In the MCQ, during the past three decades, women had a higher pass rate per attempt and overall, although the magnitude of the difference (about 3%) was small (Box 4). In the clinical examination since 1990, women had both a higher pass rate

3 Number of candidates, success rate per attempt and total attempts in the clinical examinations since 1978, and total number of attempts by candidates each year*



* Data for 2019 truncated at October. ◆

and fewer attempts. In the most recent decade, the difference in pass rates was substantial (+12%).

Box 5 and Box 6 show the pass rates in the MCQ and clinical examinations, respectively, graphed against candidates' age and the interval (recency) since their medical graduation. There was a marked decline in success with both increasing age and interval since graduation; this was more marked in the clinical examination. While the number of candidates who were 55 years or older was small (245; 1.2% of total), their pass rate was one-third that of candidates aged 20–29 years, and only 45% of the older group eventually passed.

Commentary

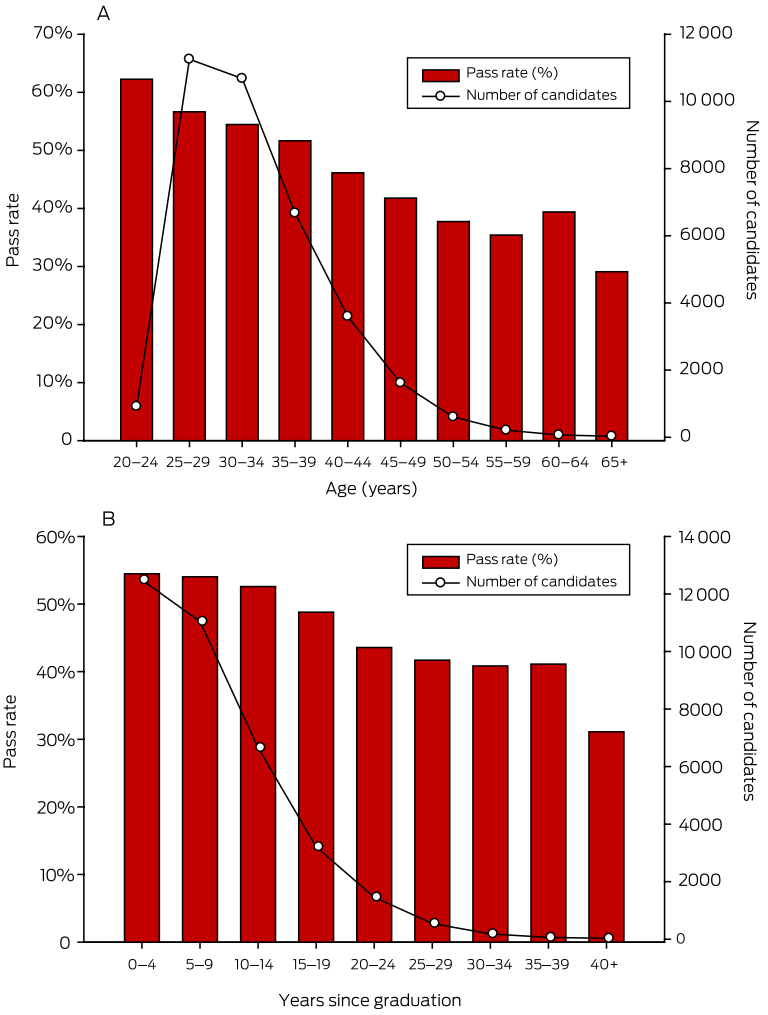
Before 2000, the number of IMGs attempting AMC examinations annually was usually less than 300 and never exceeded 600. However, between 2000 and 2018, candidate numbers increased more than threefold to an annual mean of 1003 during a period when the number of all Australians born overseas increased only from 4.5 to 7.3 million.[8] Some factors likely to have contributed to the increase in candidates were removal in 1998 of the requirement to be an Australian citizen, and offering the computer-delivered MCQ examination from 2005 in several centres outside Australia. A further increase in candidates for the MCQ examination resulted from the 2006 decision by the Council of Australian Governments that all IMGs with limited or temporary registration with the individual state medical boards should pass that examination. The peak in attempts at the clinical examination in 2013 followed the establishment of the National Registration and Accreditation Scheme

4 Influence of gender on examination success*

Period	Gender	*N*	Total attempts	Total passes	Mean (SD) attempts	Pass total (%)	Pass/attempt (%)
MCQ examination							
1978–1989	Female	568	1299	412	2.29 ± 1.84	72.5%	31.7%
	Male	1142	2431	817	2.13 ± 1.68	71.5%	33.6%
1990–1999	Female	1691	3279	1434	1.95 ± 1.57	84.8%	43.7%
	Male	2164	4275	1729	1.98 ± 1.71	79.9%	40.4%
2000–2009	Female	5438	8666	4813	1.59 ± 1.14	88.5%	55.5%
	Male	7287	11846	6192	1.63 ± 1.32	85.0%	52.3%
2010–2019	Female	8891	12238	7378	1.38 ± 0.86	83.0%	60.3%
	Male	8365	12041	6845	1.35 ± 0.85	81.8%	56.8%
Clinical examination							
1978–1989	Female	257	503	233	1.96 ± 1.58	90.7%	46.3%
	Male	543	1085	471	2.00 ± 1.47	86.7%	43.4%
1990–1999	Female	1156	2037	1084	1.76 ± 1.07	93.8%	53.2%
	Male	1432	2917	1243	2.04 ± 1.35	86.8%	42.6%
2000–2009	Female	2636	3662	2428	1.39 ± 0.82	92.1%	66.3%
	Male	3170	5036	2772	1.59 ± 1.08	87.4%	55.0%
2010–2019	Female	6150	9802	4535	1.59 ± 1.03	73.7%	46.3%
	Male	5053	9184	3132	1.82 ± 1.30	62.0%	34.1%

MCQ = multiple choice question; SD = standard deviation. * The Australian Medical Examining Council did not list candidates' gender in a few instances during the first decade. ◆

5 Australian Medical Council multiple choice question (MCQ) examination, 1978–2019: pass rates versus (A) age and (B) recency (interval since graduation) in the year when candidates first attempted the MCQ (all countries combined)*



Spearman rank order correlation: **(A)** $r = -0.964$, $P < 0.001$; **(B)** $r = -0.983$, $P < 0.001$. ◆

in July 2010 and the requirement that limited registrants (non-specialists) demonstrate progress towards full registration (including passing the AMC clinical examination where applicable).

It is important to note that these data are specific to those sitting the AMC examinations. They give only a partial picture of medical immigration over this period. Firstly, they do not include IMGs who were registered as specialists by the various states, and subsequently by AHPRA on advice from specialist colleges. Secondly, until 1992 the Medical Acts in all Australian states allowed graduates from the UK (and usually Ireland) exemption from the need for further examination. For the next 15 years, generalists from those countries usually had to take the AMC examinations, but from 2007 they were again exempted (along with IMGs from Canada and the US) when the AMC introduced the competent authority pathway.

The overall success rate in the MCQ examination increased significantly from the 1980s. The AMC made several changes over that time to increase reliability and fairness. One was altering question types to formats less dependent on English language skill; another was publication of annotated question banks to assist candidates in their preparation.[5,6,9] From 2000, the pass mark has been set by criterion-referenced methodology. A further refinement from 2011 was administering the MCQ examination in computer-adaptive format, where the difficulty of items is adjusted in real time according to a candidate's performance, considered to increase fairness and precision.[10]

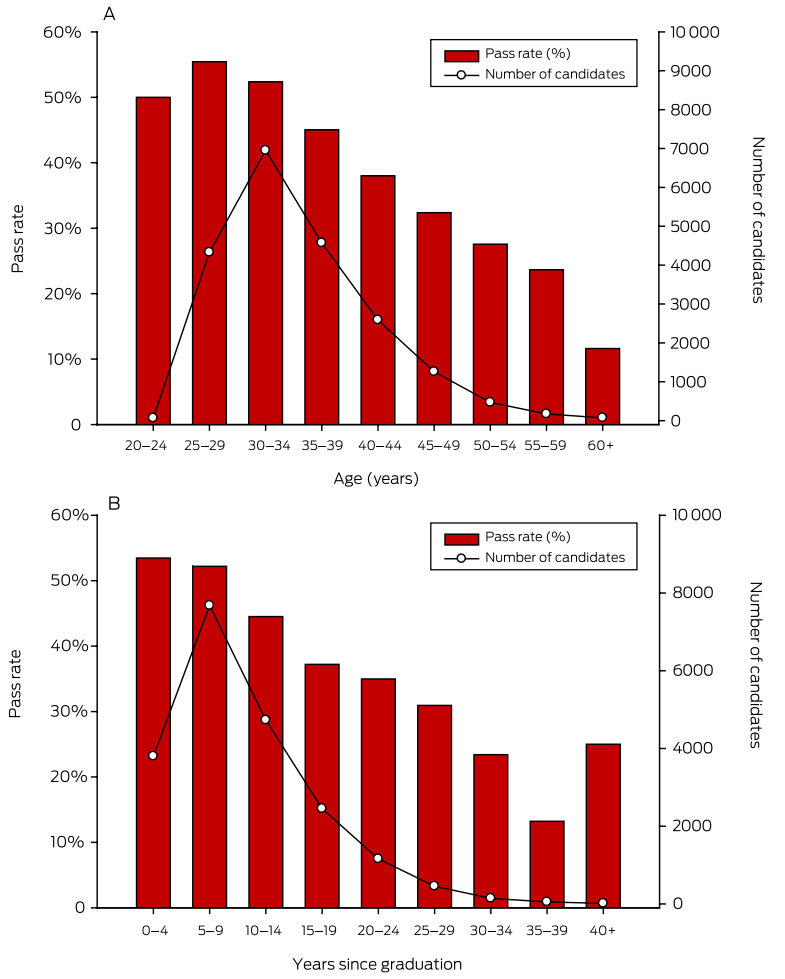
A factor likely to have contributed to the recent lower pass rate in the clinical examination (Box 3) is the removal of nearly all candidates from the competent authority countries. Up till 2009, UK graduates had the highest pass rate in this examination (Supporting information, table 3), and their removal from the pool would inevitably lower the overall rate. However, the decline since 2010 cannot be fully accounted for by this since competent authority candidates comprised less than 10% of the 2000–2009 total. Thus, other factors affecting the most recent cohorts of candidates (eg, the changing mix of parent countries) are likely to have contributed.

Many IMGs must often overcome hurdles less likely to be faced by those from competent authority countries. These include adapting to an unfamiliar health system, developing fluency in English, preparing for the examinations while under time pressure from short-stay visas, and needing to support themselves with sometimes long hours of work outside the health system.[11] It is possible, though, that changes in the format or content of the OSCE have also contributed.

The differences between the results for women and men in the MCQ should not be overplayed, since the magnitude was small. Others have found little gender effect in postgraduate written examinations in the UK and the US.[12,13]

However, the outperformance by women in the clinical examination, particularly in the past decade, is more striking. Those findings have been seen elsewhere. Women perform better than men in Step 2 of the United States Medical Licensing Examination.[14] Female overseas-trained doctors were twice as likely as males to pass the UK Federation of

6 Australian Medical Council clinical examination, 1978–2019: pass rates versus (A) age and (B) recency in year when the examination was first attempted*



* Spearman rank order correlation: **(A)** $r = -0.950$, $P < 0.001$; **(B)** $r = -0.950$, $P < 0.001$. ◆

Royal Colleges of Physicians' Practical Assessment of Clinical Examination Skills (PACES) at their first attempt.[15] The PACES examination has many similarities to the AMC OSCE, with communication skills important for both. Female superiority in patient–doctor communication has been documented previously,[16] and may partly explain the present findings.

That performance in the MCQ deteriorated with both age and time since graduation is not entirely surprising: the examination tests knowledge in all domains of medicine, including some of the basic sciences. The longer since these were studied, the more difficult it might be to pass questions based on them, especially for IMGs who had practised as specialists in their original country.

More unexpected was the much lower performance in the clinical examination by older candidates. Clinical experience might have been expected to give them an advantage, but this does not appear to have been generally so. We have been unable to find exactly comparable data from medical licensing examinations in other countries. A UK retrospective analysis observed that international graduates aged more than 37 years actually performed better in a postgraduate paediatric examination.[17] However, a US analysis noted a negative correlation between age when first certified by the American Board of Internal Medicine and the American Board of Surgery and subsequent success in maintenance of certification examinations.[18]

Since 1978, these examinations have played an important role in informing the credentialing of generalist IMGs by state medical boards and now the national board. This article has documented substantial changes over the four decades in the demography of candidates, and some factors that were associated with their success in the examinations. The information will be of interest to health planners, but more particularly to those IMGs who have passed through the process and others who are contemplating it. Many rural health services still struggle to meet their workforce needs and rely heavily on doctors who have migrated to practise medicine here.[19] Australia continues to owe a debt to its immigrant doctors.

Acknowledgements: We acknowledge the assistance of Kevin Ng and Prathyusha Sama, Senior Computer Programmer and Software Developer at the AMC, for programming to extract the de-identified data analysed in this article.

Competing interests: No relevant disclosures.

Provenance: Not commissioned; externally peer reviewed. ■

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References are available online.

1 Medical Board of Australia. Competent authority pathway [website]. AHPRA, 2019. https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Competent-Authority-Pathway.aspx (viewed July 2020).

2 Australian Government Publishing Service. Human Rights and Equal Opportunity Commission — annual report 1990–91. Canberra: Commonwealth of Australia; 1991. https://humanrights.gov.au/sites/default/files/Annual_Report_90-91.pdf (viewed July 2020).

3 Australian Competition and Consumer Commission and Australian Health Workforce Officials' Committee. Review of Australian specialist medical colleges: report to Australian Health Ministers. Canberra: Commonwealth of Australia, 2005.

4 House of Representatives Standing Committee on Health and Ageing. Lost in the labyrinth: report on the inquiry into registration processes and support for overseas trained doctors. Canberra: Commonwealth of Australia, 2012. https://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=haa/overseasdoctors/report.htm (viewed July 2020).

5 Geffen L. Assuring medical standards: the Australian Medical Council 1985–2010. Canberra, ACT: Australian Medical Council, 2010.

6 Australian Medical Council Limited. IMG guides. https://www.amc.org.au/publications/img-guides/ (viewed July 2020).

7 United Nations Statistics Division. Geographical regions 1999. https://unstats.un.org/unsd/methodology/m49 (viewed July 2020).

8 Australian Bureau of Statistics. Migration, Australia, 1993–2018 [Cat. No. 3412.0]. Canberra, ACT: ABS, 2018. https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3412.02017-18?OpenDocument (viewed July 2020).

9 Breen K, Frank I, Walters T. Australian Medical Council: a view from the inside. *Intern Med J* 2001; 31: 243–248.

10 McCoubrie P. Improving the fairness of multiple-choice questions: a literature review. *Med Teach* 2004; 26: 709–712.

11 Yeomans ND. They came to heal: Australia's medical immigrants, 1960 to the present [dissertation]. Melbourne: University of Melbourne, 2018: 120.

12 Dewhurst NG, McManus C, Mollon J, et al. Performance in the MRCP (UK) examination 2003–4: analysis of pass rates of UK graduates in relation to self-declared ethnicity and gender. *BMC Med* 2007; 5: 8.

13 Shellito JL, Osland JS, Helmer SD, Chang FC. American Board of Surgery examinations: can we identify surgery residency applicants and residents who will pass the examinations on the first attempt? *Am J Surg* 2010; 199: 216–222.

14 Rubright JD, Jodoin M, Barone MA. Examining demographics, prior academic performance, and United States Medical Licensing Examination scores. *Acad Med* 2019; 94: 364–370.

15 Unwin E, Potts HWW, Dacre J, et al. Passing MRCP (UK) PACES: a cross-sectional study examining the performance of doctors by sex and country. *BMC Med Educ* 2018; 18: 1–9.

16 Sandhu H, Adams A, Singleton L, et al. The impact of gender dyads on doctor–patient communication: A systematic review. *Patient Educ Couns* 2009; 76: 348–355.

17 Menzies L, Minson S, Brightwell A, et al. An evaluation of demographic factors affecting performance in a paediatric membership multiple-choice examination. *Postgrad Med J* 2015; 91: 72–76.

18 Lipner R, Song H, Biester T, et al. Factors that influence general internists' and surgeons' performance on maintenance of certification exams. *Acad Med* 2011; 86: 53–58.

19 McGrail MR, Russell DJ. Australia's rural medical workforce: supply from its medical schools against career stage, gender and rural-origin. *Aust J Rural Health* 2016; 25: 298–305. ■

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Supporting Information

Supplementary tables

This appendix was part of the submitted manuscript and has been peer reviewed.
It is posted as supplied by the authors.

Appendix to: Yeomans ND, Sewell JR, Pigou P, Macintyre S. Demographics and performance of candidates in the examinations of the Australian Medical Council, 1978–2019. *Med J Aust* 2020; doi: 10.5694/mja2.50800.

Table 1: Numbers presenting for MCQ examination by Geographical Region*

UN Geographical Region	1978-1989	1990-1999	2000-2009	2010-2019	Total
Northern Europe	23	376	540	152	1091
Eastern Europe	185	383	786	927	2281
Southern Europe	84	211	142	148	585
Western Europe	112	98	335	270	815
Eastern Asia	80	420	736	867	2103
South-Eastern Asia	257	355	1411	2097	4120
Southern Asia	597	1019	6263	8272	16151
Western Asia	48	250	639	1141	2078
Northern America	45	46	39	20	150
Latin America and Caribbean	7	8	70	139	224
South America	23	51	213	422	709
Northern Africa	183	390	468	1478	2519
Sub-Saharan Africa	182	175	832	1082	2271
Oceania	25	58	152	193	428

* Regions with less than 100 candidates excluded. Based on United Nations Statistics Division: Geographical Regions, 1999.

Countries contributing at least 100 candidates, listed by UN Statistics Division: Geographical Regions 1999 (https://unstats.un.org/unsd/methodology/m49):

- **Northern Europe:** Denmark, Estonia, Finland, Iceland, Ireland, Latvia, Lithuania, Norway, Sweden, United Kingdom.
- **Eastern Europe:** Belarus, Bulgaria, Czech Republic, Czechoslovakia, Hungary, Moldova, Poland, Romania, Russia, Slovakia, Ukraine, USSR.
- **Southern Europe:** Albania, Bosnia and Herzegovina, Croatia, Greece, Italy, Kosovo, Macedonia, Malta, Montenegro, Portugal, Serbia, Slovenia, Spain.
- **Western Europe:** Austria, Belgium, France, Germany, Netherlands, Switzerland.
- **Eastern Asia:** China, Hong Kong, Japan, Mongolia, South Korea, Taiwan.
- **South-Eastern Asia:** Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand, Viet Nam.
- **Southern Asia:** Afghanistan, Bangladesh, India, Iran, Nepal, Pakistan, Sri Lanka.
- **Western Asia:** Armenia, Azerbaijan, Bahrain, Georgia, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian Authority, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates, Yemen.
- **Northern America:** Canada, USA.
- **Latin America and Caribbean:** Antigua and Barbuda, Aruba, Barbados, Cayman Islands, Cuba, Curacao, Dominica, Dominican Republic, Grenada, Jamaica, Montserrat, Netherlands Antilles, Saba, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and The Grenadines, Sint Maarten, Trinidad and Tobago.
- **South America:** Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Uruguay, Venezuela.
- **Northern Africa:** Algeria, Egypt, Libya, Morocco, Sudan, Tunisia.
- **Sub-Saharan Africa:** Benin, Burundi, Cameroon, Democratic Republic of the Congo, Ethiopia, Gambia, Ghana, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Nigeria, Rwanda, Seychelles, Somalia, South Africa, South Sudan, Tanzania, Uganda, Zambia, Zimbabwe.
- **Oceania:** Fiji, Papua New Guinea, Samoa.

Table 2: MCQ examination data – all countries of training contributing at least 10 candidates*

Country of Training	1978-1989				1990-1999				2000-2009				2010-2019			
	No.	Mean tries	% pass overall	% pass per try	No.	Mean tries	% pass overall	% pass per try	No.	Mean tries	% pass overall	% pass per try	No.	Mean tries	% pass overall	% pass per try
Afghanistan	7	2.43	42.9	17.6	29	4.31	82.8	19.2	60	2.00	90.0	45.0	47	2.04	57.4	28.1
Albania					1	NR	NR	NR	5	2.20	80.0	36.4	4	NR	NR	NR
Argentina	5	2.80	60.0	21.4	5	2.40	80.0	33.3	25	2.24	92.0	41.1	25	1.12	84.0	75.0
Armenia									3	NR	NR	NR	16	1.63	68.8	42.3
Austria	3	NR	NR	NR	2	NR	NR	NR	29	1.31	79.3	60.5	19	1.47	84.2	57.1
Bahrain									3	NR	NR	NR	17	1.18	76.5	65.0
Bangladesh	16	2.81	75.0	26.7	99	2.32	85.9	37.0	777	1.64	93.4	56.9	1107	1.45	87.7	60.5
Belarus					1	NR	NR	NR	17	2.00	94.1	47.1	50	1.84	70.0	38.0
Belgium	8	2.75	75.0	27.3	2	NR	NR	NR	14	1.07	92.9	86.7	12	1.00	83.3	83.3
Bolivia	1	NR	NR	NR					3	NR	NR	NR	9	1.89	44.4	23.5
Bosnia and Herzegovina	3	NR	NR	NR	53	3.00	79.2	26.4	30	2.03	90.0	44.3	5	1.60	60.0	37.5
Brazil	5	2.80	80.0	28.6	9	2.33	77.8	33.3	43	1.70	86.0	50.7	173	1.35	80.9	60.1
Bulgaria	3	NR	NR	NR	17	2.29	52.9	23.1	54	2.20	79.6	36.1	11	1.45	72.7	50.0
Cambodia	2	NR	NR	NR	3	NR	NR	NR	6	1.50	83.3	55.6	3	NR	NR	NR
Canada	20	1.35	90.0	66.7	21	1.14	100.0	87.5	15	1.40	93.3	66.7	7	1.14	85.7	75.0
Cayman Islands									5	1.40	40.0	28.6	6	1.50	83.3	55.6
Chile	4	NR	NR	NR	7	1.43	71.4	50.0	5	1.00	100.0	100.0	12	1.08	83.3	76.9
China	4	NR	NR	NR	219	2.05	81.3	39.7	641	1.71	86.7	50.9	745	1.62	67.1	41.5
Colombia	1	NR	NR	NR	5	2.00	40.0	20.0	81	1.65	82.7	50.0	138	1.48	78.3	52.9
Croatia	13	2.69	46.2	17.1	31	2.42	83.9	34.7	11	2.55	90.9	35.7	2	NR	NR	NR
Cuba									5	2.20	80.0	36.4	22	1.45	68.2	46.9
Czech Republic					3	NR	NR	NR	17	1.89	70.6	37.5	11	1.18	63.6	53.9
Czechoslovakia	38	2.00	63.2	31.6	13	2.46	84.6	34.4	10	1.60	70.0	43.8				
Democratic Republic of the Congo									4	NR	NR	NR	18	1.78	50.0	28.1
Denmark	6	1.67	66.7	40.0	4	NR	NR	NR	5	1.20	80.0	66.7	12	1.33	91.7	68.8

Dominica					1	NR	NR	NR	1	NR	NR	NR	9	1.22	66.7	54.5
Dominican Republic	2	NR	NR	NR	2	NR	NR	NR	6	2.17	66.7	30.8	4	NR	NR	NR
Ecuador	1	NR	NR	NR	1	NR	NR	NR	8	1.75	87.5	50.0	7	1.43	57.1	40.0
Egypt	179	2.59	79.9	30.8	356	2.39	82.0	34.4	375	1.67	85.9	51.4	1171	1.23	82.7	67.0
El Salvador	1	NR	NR	NR	10	2.80	40.0	14.3	3	NR	NR	NR	4	NR	NR	NR
Ethiopia					5	1.40	100.0	71.4	14	1.07	85.7	80.0	19	1.16	78.9	68.2
Fiji	14	2.86	78.6	27.5	45	1.62	88.9	54.8	105	2.09	88.6	42.5	118	1.53	67.8	44.4
Finland	1	NR	NR	NR	4	NR	NR	NR	1	NR	NR	NR	5	1.00	100.0	100.0
France	11	2.64	45.5	17.2	6	1.33	33.3	25.0	14	1.29	92.9	72.2	26	1.23	92.3	75.0
Georgia					1	NR	NR	NR	2	NR	NR	NR	24	1.21	58.3	48.3
Germany	66	1.76	57.6	32.8	74	1.47	87.8	59.6	212	1.36	93.9	69.1	127	1.18	92.9	78.7
Ghana	1	NR	NR	NR					9	1.44	88.9	61.5	22	1.27	63.6	50.0
Greece	17	2.47	41.2	16.7	9	1.78	66.7	37.5	5	2.40	80.0	33.3	11	1.18	81.8	69.2
Grenada					4	NR	NR	NR	5	2.00	100.0	50.0	14	1.29	85.7	66.7
Guatemala	4	NR	NR	NR	1	NR	NR	NR	1	NR	NR	NR	7	1.71	42.9	25.0
Hong Kong	68	1.35	77.9	57.6	168	1.11	92.3	82.9	17	1.12	88.2	78.9	18	1.11	94.4	85.0
Hungary	19	2.58	63.2	24.5	27	2.48	66.7	26.9	22	1.77	90.9	51.3	26	1.35	69.2	51.4
India	351	2.15	74.6	34.7	496	1.92	85.5	44.6	2619	1.65	86.4	52.5	2483	1.42	80.0	56.3
Indonesia	13	1.69	61.5	36.4	15	2.40	53.3	22.2	69	2.30	76.8	33.3	121	1.77	62.0	35.0
Iran	32	2.03	65.6	32.3	34	1.76	79.4	45.0	664	1.45	90.5	62.3	1197	1.30	88.2	68.0
Iraq	8	1.50	37.5	25.0	160	1.73	91.9	53.3	420	1.35	96.2	71.3	602	1.28	90.2	70.2
Ireland					38	1.42	89.5	63.0	118	1.33	87.3	65.6	63	1.30	81.0	62.2
Israel	5	3.20	40.0	12.5	2	NR	NR	NR	4	NR	NR	NR	5	1.00	100.0	100.0
Italy	30	2.27	50.0	22.1	21	3.05	57.1	18.8	8	4.63	62.5	13.5	33	1.45	75.8	52.1
Jamaica	5	1.00	100.0	100.0					1	NR	NR	NR	9	1.00	88.9	88.9
Japan	1	NR	NR	NR	4	NR	NR	NR	10	1.40	80.0	57.1	31	1.19	87.1	73.0
Jordan					5	1.00	80.0	80.0	70	1.20	78.6	65.5	123	1.12	75.6	67.4
Kazakhstan					1	NR	NR	NR	12	1.75	83.3	47.6	19	1.47	52.6	35.7
Kenya					2	NR	NR	NR	22	1.55	81.8	52.9	61	1.30	67.2	51.9
Kuwait					8	1.13	62.5	55.6					5	1.00	100.0	100.0

Kyrgyzstan									3	NR	NR	NR	17	1.88	76.5	40.6
Latvia					2	NR	NR	NR	31	1.77	87.1	49.1	23	1.70	78.3	46.2
Lebanon	2	NR	NR	NR	8	1.38	75.0	54.5	16	1.31	93.8	71.4	21	1.48	90.5	61.3
Libya	2	NR	NR	NR	4	NR	NR	NR	14	1.50	71.4	47.6	48	1.44	83.3	58.0
Lithuania					4	NR	NR	NR	13	1.77	84.6	47.8	10	1.80	70.0	38.9
Macedonia	2	NR	NR	NR	17	4.29	70.6	16.4	25	2.64	88.0	33.3	10	2.00	70.0	35.0
Malaysia	32	1.38	81.3	59.1	12	1.08	75.0	69.2	108	1.51	75.9	50.3	385	1.25	83.4	66.9
Malta	1	NR	NR	NR	1	NR	NR	NR	11	1.18	100.0	84.6	9	1.11	100.0	90.0
Mauritius									3	NR	NR	NR	16	1.69	62.5	37.0
Mexico	7	2.00	57.1	28.6	5	2.40	20.0	8.3	13	1.69	53.8	31.8	31	1.45	64.5	44.4
Myanmar	21	2.05	66.7	32.6	66	2.44	80.3	32.9	485	1.37	91.3	66.7	772	1.22	86.8	71.0
Nepal					2	NR	NR	NR`	131	1.63	85.5	52.3	206	1.60	82.0	51.2
Netherlands	14	2.07	71.4	34.5	10	2.00	60.0	30.0	55	1.47	85.5	58.0	66	1.20	89.4	74.7
Nigeria	2	NR	NR	NR	9	1.33	77.8	58.3	242	1.79	75.6	42.2	487	1.50	68.0	45.4
Norway					1	NR	NR	NR	4	NR	NR	NR	6	1.00	100.0	100.0
Oman									3	NR	NR	NR	54	1.20	79.6	66.2
Pakistan	32	3.75	87.5	23.3	113	2.62	74.3	28.4	100 7	1.64	84.1	51.3	1838	1.35	80.0	59.4
Palestinian Authority									1	NR	NR	NR	12	1.08	91.7	84.6
Papua New Guinea	11	2.45	90.9	37.0	13	2.54	61.5	24.2	41	1.95	68.3	35.0	23	1.74	60.9	35.0
Peru	2	NR	NR	NR	15	2.20	66.7	30.3	26	1.54	84.6	55.0	20	1.45	65.0	44.8
Philippines	83	2.87	53.0	18.5	182	2.54	69.8	27.4	646	2.07	69.5	33.6	714	1.53	62.0	40.6
Poland	77	2.26	67.5	29.9	98	2.22	78.6	35.3	41	1.54	85.4	55.6	49	1.22	73.5	60.0
Romania	14	2.86	28.6	10.0	76	2.47	76.3	30.9	94	1.84	81.9	44.5	62	1.84	61.3	33.3
Russia					9	2.22	55.6	25.0	286	1.99	75.5	38.0	458	1.67	71.0	42.4
Saint Kitts and Nevis									7	2.86	100.0	35.0	30	1.53	60.0	39.1
Saint Lucia									3	NR	NR	NR	12	1.67	41.7	25.0
Samoa									6	1.50	83.3	55.6	52	1.65	88.5	53.5
Saudi Arabia									32	1.69	59.4	35.2	40	1.35	72.5	53.7
Serbia	7	3.00	57.1	19.0	73	2.15	76.7	35.7	60	2.53	81.7	32.2	27	2.00	74.1	37.0
Seychelles									3	NR	NR	NR	11	2.00	72.7	36.4

Singapore	36	1.36	75.0	55.1	10	1.30	90.0	69.2	14	1.07	92.9	86.7	26	1.12	92.3	82.8
Slovakia					3	NR	NR	NR	8	3.38	75.0	22.2	6	1.67	66.7	40.0
South Africa	164	1.41	82.9	58.6	148	1.25	88.5	70.8	400	1.17	93.8	80.1	302	1.19	86.4	72.7
South Korea	1	NR	NR	NR	11	1.45	90.9	62.5	51	1.61	74.5	46.3	43	1.35	86.0	63.8
Spain	8	3.75	87.5	23.3	4	NR	NR	NR	7	1.29	85.7	66.7	12	1.17	91.7	78.6
Sri Lanka	159	1.76	79.9	45.4	246	1.52	89.0	58.4	100 5	1.26	94.9	75.4	1394	1.18	91.0	76.9
Sudan	2	NR	NR	NR	24	2.00	91.7	45.8	77	1.94	77.9	40.3	254	1.27	75.2	59.1
Sweden	4	NR	NR	NR	6	1.33	66.7	50.0	4	NR	NR	NR	11	1.00	100.0	100.0
Switzerland	10	1.30	60.0	46.2	4	NR	NR	NR	11	1.45	63.6	43.8	20	1.00	90.0	90.0
Syria	12	3.08	100.0	32.4	36	2.56	`80.6	31.5	45	1.98	82.2	41.6	96	1.25	91.7	73.3
Taiwan	6	1.17	0.0	0.0	18	1.94	77.8	40.0	16	1.75	81.3	46.4	29	1.41	86.2	61.0
Tanzania	1	NR	NR	NR					10	2.00	40.0	20.0	17	1.59	47.1	29.6
Thailand	7	1.71	57.1	33.3	2	NR	NR	NR	19	1.53	73.7	48.3	20	1.20	90.0	75.0
Trinidad and Tobago									30	1.27	90.0	71.1	11	1.09	72.7	66.7
Turkey	21	2.33	76.2	32.7	29	1.83	75.9	41.5	18	1.72	94.4	54.8	32	1.28	81.3	63.4
Uganda	4	NR	NR	NR	1	NR	NR	NR	10	1.40	80.0	57.1	35	1.17	65.7	56.1
Ukraine					8	2.50	87.5	35.0	133	2.25	75.9	33.8	200	1.61	69.0	43.0
United Arab Emirates									14	1.71	71.4	41.7	64	1.25	85.9	68.8
United Kingdom	12	1.58	58.3	36.8	316	1.11	96.2	86.6	362	1.12	92.8	83.0	20	1.15	90.0	78.3
Uruguay	4	NR	NR	NR	8	2.13	87.5	41.2	6	1.33	83.3	62.5	1	NR	NR	NR
USA	25	1.24	72.0	58.1	25	1.12	92.0	82.1	24	1.17	87.5	75.0	13	1.23	92.3	75.0
USSR	34	3.44	41.2	12.0	128	2.60	65.6	25.2	124	2.24	85.5	38.1	26	1.92	73.1	38.0
Uzbekistan					1	NR	NR	NR	12	1.50	75.0	50.0	8	1.50	50.0	33.3
Venezuela					1	NR	NR	NR	11	2.09	90.9	43.5	31	1.71	58.1	34.0
Viet Nam	63	2.49	76.2	30.6	64	2.84	65.6	23.1	64	1.80	82.8	46.1	55	1.42	70.9	50.0
Yemen					1	NR	NR	NR	4	NR	NR	NR	28	1.11	53.6	48.4
Zambia	2	NR	NR	NR	3	NR	NR	NR	5	1.00	80.0	80.0	3	NR	NR	NR
Zimbabwe	7	1.57	71.4	45.5	6	1.33	100.0	75.0	101	1.33	95.0	71.6	69	1.25	85.5	68.6

*40 countries with <10 candidates in total omitted. NR=not reported when N<5, to maintain confidentiality.
IMGs trained in UK and Ireland were exempted from AMC examinations by most states until 1992. Since 2007, few candidates from the 'Competent Authority' countries (UK, Ireland, Canada, USA) were required to take the examinations.

Table 3: Clinical examination data – all countries of training contributing at least 10 candidates*

Country of Training	1978-1989				1990-1999				2000-2009				2010-2019			
	No.	Mean tries	% pass overall	% pass per try	No.	Mean tries	% pass overall	% pass per try	No.	Mean tries	% pass overall	% pass per try	No.	Mean tries	% pass overall	% pass per try
Afghanistan					13	2.38	100.0	41.9	54	1.83	85.2	46.5	32	2.81	40.6	14.4
Argentina	2	NR	NR	NR	3	NR	NR	NR	13	1.69	84.6	50.0	25	1.60	56.0	35.0
Austria	2	NR	NR	NR	1	NR	NR	NR	11	1.27	90.9	71.4	12	1.17	91.7	78.6
Bangladesh	7	1.86	85.7	46.2	53	2.26	94.3	41.7	483	1.81	85.5	47.2	831	1.93	61.0	31.6
Belarus									11	1.91	100.0	52.4	26	1.81	42.3	23.4
Belgium	3	NR	NR	NR	3	NR	NR	NR	5	1.20	100.0	83.3	10	1.80	60.0	33.3
Bosnia and Herzegovina	1	NR	NR	NR	13	2.15	92.3	42.9	46	1.50	93.5	62.3	5	1.60	80.0	50.0
Brazil	3	NR	NR	NR	8	1.38	75.0	54.5	11	1.18	90.9	76.9	86	1.45	68.6	47.2
Bulgaria	1	NR	NR	NR	8	1.75	100.0	57.1	28	2.04	82.1	40.4	19	2.00	89.5	44.7
Cambodia					4	NR	NR	NR	3	NR	NR	NR	3	NR	NR	NR
Canada	16	1.06	68.8	64.7	17	1.71	82.4	48.3	10	1.00	100.0	100.0	3	NR	NR	NR
Chile	2	NR	NR	NR	6	1.33	100.0	75.0	3	NR	NR	NR	8	1.25	75.0	60.0
China					109	1.95	91.7	46.9	398	1.48	95.5	64.4	475	1.70	69.7	41.0
Colombia	1	NR	NR	NR	1	NR	NR	NR	34	1.24	97.1	78.6	100	1.43	74.0	51.7
Croatia	3	NR	NR	NR	22	2.00	90.9	45.5	15	1.80	86.7	48.1	1	NR	NR	NR
Czech Republic									10	1.50	100.0	66.7	11	1.73	54.5	31.6
Czechoslovakia	17	2.06	88.2	42.9	14	2.07	92.9	44.8	6	2.17	83.3	38.5	2	NR	NR	NR
Denmark	4	NR	NR	NR	2	NR	NR	NR	3	NR	NR	NR	4	NR	NR	NR
Ecuador					1	NR	NR	NR	5	1.00	80.0	80.0	5	1.20	80.0	66.7
Egypt	78	2.92	96.2	32.9	296	2.34	92.9	39.6	195	1.59	86.7	54.3	375	1.66	63.5	38.3
Ethiopia					4	NR	NR	NR	10	1.50	100.0	66.7	11	1.45	54.5	37.5
Fiji	5	2.00	100.0	50.0	37	1.70	89.2	52.4	50	1.44	94.0	65.3	87	1.44	67.8	47.2
France	3	NR	NR	NR	4	NR	NR	NR	6	1.17	83.3	71.4	12	2.42	66.7	27.6
Germany	26	1.62	88.5	54.8	60	1.72	90.0	52.4	109	1.30	90.8	69.7	108	1.31	81.5	62.0
Ghana									5	1.60	100.0	62.5	11	1.36	54.5	40.0
Greece	5	2.80	60.0	21.4	4	NR	NR	NR	5	1.20	60.0	50.0	6	1.83	50.0	27.3

Grenada					3	NR	NR	NR	2	NR	NR	NR	9	1.78	44.4	25.0
Hong Kong	36	1.44	83.3	57.7	123	1.31	79.7	60.9	4	NR	NR	NR	7	1.29	85.7	66.7
Hungary	7	1.71	100.0	58.3	20	1.70	100.0	58.8	15	1.80	86.7	48.1	14	2.00	64.3	32.1
India	190	2.08	84.7	40.8	392	1.96	91.3	46.7	1059	1.44	88.1	61.3	2074	1.72	69.7	40.6
Indonesia	7	2.00	100.0	50.0	6	2.33	66.7	28.6	23	1.91	82.6	43.2	76	1.83	65.8	36.0
Iran	8	1.88	75.0	40.0	27	1.70	96.3	56.5	263	1.35	94.3	69.7	688	1.70	70.1	41.1
Iraq	2	NR	NR	NR	85	1.82	92.9	51.0	303	1.47	91.1	62.0	358	1.71	69.6	40.8
Ireland					26	1.23	92.3	75.0	65	1.15	90.8	78.7	33	1.21	75.8	62.5
Italy	9	1.78	88.9	50.0	11	3.00	81.8	27.3	7	1.71	85.7	50.0	13	1.69	53.8	31.8
Jamaica	5	1.20	80.0	66.7									6	1.00	66.7	66.7
Japan	1	NR	NR	NR	1	NR	NR	NR	2	NR	NR	NR	13	1.46	76.9	52.6
Jordan					4	NR	NR	NR	10	1.60	80.0	50.0	68	1.26	70.6	55.8
Kazakhstan					1	NR	NR	NR	6	1.33	100.0	75.0	8	1.13	75.0	66.7
Kenya					2	NR	NR	NR	8	1.00	100.0	100.0	27	1.56	70.4	45.2
Latvia					2	NR	NR	NR	10	1.00	90.0	90.0	26	1.58	73.1	46.3
Lebanon	1	NR	NR	NR	5	2.40	60.0	25.0	9	1.44	77.8	53.8	17	1.71	52.9	31.0
Libya	1	NR	NR	NR	2	NR	NR	NR	4	NR	NR	NR	23	2.00	60.9	30.4
Lithuania					2	NR	NR	NR	10	2.00	90.0	45.0	6	1.83	66.7	36.4
Macedonia	1	NR	NR	NR	9	2.00	100.0	50.0	18	1.83	83.3	45.5	9	1.33	77.8	58.3
Malaysia	22	1.41	63.6	45.2	10	1.50	80.0	53.3	15	1.27	100.0	78.9	216	1.50	74.5	49.7
Malta	1	NR	NR	NR	1	NR	NR	NR	5	1.40	100.0	71.4	9	1.22	77.8	63.6
Mexico	3	NR	NR	NR	1	NR	NR	NR	5	1.60	80.0	50.0	10	1.30	60.0	46.2
Myanmar	5	2.20	80.0	36.4	45	2.44	80.0	32.7	175	1.71	88.0	51.5	661	1.65	80.2	48.6
Nepal					1	NR	NR	NR	39	1.23	97.4	79.2	159	1.69	71.1	42.0
Netherlands	10	1.90	60.0	31.6	3	NR	NR	NR	26	1.19	92.3	77.4	46	1.43	84.8	59.1
Nigeria					6	1.33	66.7	50.0	68	1.63	88.2	54.1	226	1.97	59.3	30.1
Oman													14	1.43	57.1	40.0
Pakistan	13	1.38	76.9	55.6	59	2.00	91.5	45.8	342	1.58	89.8	56.7	1168	1.65	70.5	42.7
Papua New Guinea	5	1.20	100.0	83.3	11	2.91	81.8	28.1	17	2.00	70.6	35.3	18	2.33	50.0	21.4
Peru					9	2.11	88.9	42.1	5	1.40	80.0	57.1	24	1.38	79.2	57.6
Philippines	11	4.18	54.5	13.0	104	2.43	84.6	34.8	198	1.98	75.3	38.0	507	1.96	57.8	29.5

Poland	38	2.18	92.1	42.2	81	1.99	91.4	46.0	27	1.52	81.5	53.7	29	1.83	41.4	22.6
Romania	1	NR	NR	NR	49	2.29	79.6	34.8	60	1.47	90.0	61.4	35	2.09	42.9	20.5
Russia					9	2.11	88.9	42.1	116	1.40	94.8	67.9	278	1.90	62.9	33.2
Saint Kitts and Nevis									2	NR	NR	NR	11	1.36	54.5	40.0
Samoa									1	NR	NR	NR	35	1.80	51.4	28.6
Saudi Arabia													17	2.00	58.8	29.4
Serbia	3	NR	NR	NR	24	1.96	95.8	48.9	59	1.83	88.1	48.1	19	2.32	57.9	25.0
Singapore	22	1.32	90.9	69.0	10	1.50	100.0	66.7	5	1.00	80.0	80.0	14	1.14	78.6	68.8
Slovakia					1	NR	NR	NR	7	1.29	100.0	77.8	4	NR	NR	NR
South Africa	115	1.34	93.0	69.5	102	1.35	91.2	67.4	192	1.07	97.4	90.8	269	1.21	81.8	67.5
South Korea					8	3.13	87.5	28.0	13	1.85	61.5	33.3	24	1.83	41.7	22.7
Spain	1	NR	NR	NR	6	3.33	50.0	15.0	6	1.00	100.0	100.0	4	NR	NR	NR
Sri Lanka	101	1.92	77.2	40.2	194	1.93	92.3	47.9	399	1.38	91.7	66.5	960	1.53	75.6	49.4
Sudan					15	1.53	93.3	60.9	33	1.64	81.8	50.0	68	1.57	44.1	28.0
Sweden	2	NR	NR	NR	4	NR	NR	NR					5	1.00	80.0	80.0
Switzerland	6	1.50	83.3	55.6	2	NR	NR	NR	4	NR	NR	NR	10	1.60	90.0	56.3
Syria	5	1.80	100.0	55.6	22	2.50	90.9	36.4	29	1.86	89.7	48.1	42	1.69	52.4	31.0
Taiwan					11	1.55	63.6	41.2	6	1.33	83.3	62.5	20	1.60	50.0	31.3
Tanzania	1	NR	NR	NR					1	NR	NR	NR	9	2.33	55.6	23.8
Thailand	2	NR	NR	NR	4	NR	NR	NR	5	1.40	60.0	42.9	16	1.19	56.3	47.4
Trinidad and Tobago									11	1.27	81.8	64.3	19	1.47	84.2	57.1
Turkey	8	1.38	100.0	72.7	21	2.29	90.5	39.6	18	1.28	83.3	65.2	21	1.76	61.9	35.1
Uganda	1	NR	NR	NR	2	NR	NR	NR	6	1.50	100.0	66.7	16	1.75	81.3	46.4
Ukraine					6	1.00	100.0	100.0	50	1.50	92.0	61.3	126	2.00	61.1	30.6
United Arab Emirates									2	NR	NR	NR	32	1.53	46.9	30.6
United Kingdom	5	1.00	80.0	80.0	218	1.20	95.0	79.0	256	1.06	94.5	89.0	10	1.40	40.0	28.6
Uruguay	1	NR	NR	NR	8	1.63	100.0	61.5	3	NR	NR	NR	1	NR	NR	NR
USA	15	1.33	80.0	60.0	21	1.52	85.7	56.3	15	1.20	86.7	72.2	11	1.45	81.8	56.3
USSR	8	1.50	100.0	66.7	49	2.16	87.8	40.6	80	1.89	85.0	45.0	28	2.18	53.6	24.6
Uzbekistan									7	1.71	85.7	50.0	4	NR	NR	NR
Venezuela									7	2.57	100.0	38.9	16	1.81	62.5	34.5

Viet Nam	34	3.00	91.2	30.4	40	2.80	80.0	28.6	51	1.63	78.4	48.2	40	2.03	57.5	28.4
Zimbabwe	4	NR	NR	NR	6	1.50	100.0	66.7	49	1.14	93.9	82.1	67	1.60	73.1	45.8

*55 countries with <10 candidates in total omitted. NR=not reported when N<5, to maintain confidentiality. Exemptions from the clinical exam for many candidates from countries listed in footnote to Appendix 1.

Appendix C3:

Yeomans, Neville D, Ayaz Chowdhury, and Alan Roberts. “IMGs in Cul-de-sacs: ‘Lost in the Labyrinth’ Revisited?” *Medical Journal of Australia* 215 (2022): 553-5.

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International medical graduates (IMGs) in cul-de-sacs: "lost in the labyrinth" revisited?

IMGs face a series of obstacles to practise in Australia, which regulatory agencies should address

In 2018, international medical graduates (IMGs) made up 31% of the medical workforce.[1] Their contribution was recently acknowledged by the Secretary of the Commonwealth Department of Health:

> IMGs … are incredibly valuable in the Australian health workforce, and we would not be in the situation we are now, with a very good health system with very good health outcomes, without the extraordinary support that we've had from overseas-trained doctors. (Brendan Murphy, presentation at the Australian Medical Association Virtual National Conference, 29 July 2021; https://sa.ama.com.au/node/880)

The processes for evaluating the skills and competencies of IMGs before registration have been refined by the creation in 1984 of the Australian Medical Council (AMC),[2] and the agreement of the states in 2008 to cede their licensing roles to the national regulator, the Australian Health Practitioner Regulation Agency (AHPRA).[3]

In 2012, as a result of representations about difficulties IMGs had negotiating the pathways to registration, a milestone enquiry was held by the House of Representatives Standing Committee on Health and Ageing.[4] Their report, *Lost in the labyrinth*, made 45 recommendations, but many remain unaddressed.

We acknowledge the very important role that the AMC and AHPRA play in helping keep Australian patients safe. But there need to be improvements. The AMC has made considerable efforts to improve the reliability and fairness of its examinations and to cope with the increased number of candidates who currently apply.[5] However, we call into question the restrictions imposed by AHPRA that continue to impede many IMGs applying by the standard pathway after their success in one or both AMC examinations (a written and clinical exam sequentially).

The evidence cited comes from oral histories of IMGs recorded during the past 3 years (Supporting Information). The research was approved by the University of Melbourne's Human Research Ethics Committee (approval No. 1750338.3). Participants have been de-identified, and each gave permission for the use of the material attributed to them.

Problems due to timing of limited or provisional registration

When an IMG passes the AMC's examinations, they are eligible for AHPRA to give them either limited or provisional registration so that they can obtain a year of supervised practice. The "catch 22", though, is that they must first get a job offer before AHPRA will process their application.[6] But hospitals and teaching general practices are likely to prefer to employ practitioners who are already registered, since there is sometimes a substantial delay between a hospital offering employment and AHPRA processing the registration. For example, a graduate with first class honours from an Irish medical school was offered an intern position at a major teaching hospital shortly after passing the AMC multiple choice question exam. It took 3 months for AHPRA to complete the documentation despite frequent telephone contact from the hospital, anxious to immediately fill its unexpectedly vacant position (IMG A). Another example is an experienced practitioner from a major western European city, who passed both AMC exams in 2020 but had to wait 6 months before a supervised position he obtained in a rural area of need was approved by AHPRA (IMG B). These are examples of IMGs who had their careers hindered by inefficient licensing procedures in spite of their success in obtaining job offers. These hurdles also have an impact on the operations of training sites, causing shortcomings in health care and educational attainments. Numerous IMGs simply cannot get a job offer, despite passing AMC exams many months or years earlier. Such delays have a momentous impact on the viability of medical registration, given their effect on the AHPRA requirement for recency of medical practice. One IMG followed her Australian husband from Serbia in 2004, escaping the consequences of the civil war, but her husband died a year after they arrived here, leaving her stranded with two young children. When they grew up, she had time to study for the AMC exams with the hope of resuming the career she loved. She passed the exams in 2017, but only received provisional registration in 2019 after several unsuccessful interviews (IMG C). Another IMG complained that jobs do come up unexpectedly but are rapidly filled up: "It is like a star falling" (IMG D).

Apart from producing anxiety and uncertainty, there is a financial burden:

> Even after clearing all this stuff [AMC exams] there are people who do not get a job even for the next one year. And that is a struggle; they run out of their savings. (IMG E)

Consequence of the requirement of recency of practice

AHPRA's recency of practice requirement is designed to ensure that practitioners' skills remain current. It requires that a practitioner work for a minimum of 152

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doi: 10.5694/mja2.51516

See Editorial (Douglas)

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hours per year (or pro rata over 3 years) within their scope of practice.[7] That skills decline when not used seems self-evident, although epistemological evidence for this in medicine is surprisingly scant. Pregnancy and child rearing sometimes make it hard for even Australian-trained doctors to meet the provision, but they at least have the chance to do so by working a day a week.

Restrictions related to recency of practice may affect particularly IMGs who have not yet obtained registration in Australia. For example, a young Indian graduate migrated with her Australian husband. It took a while for her to prepare for and pass the AMC examinations, but then needed to spend time looking after her new baby. By the time she was ready to look for the obligatory supervised job, her recency of practice had nearly expired:

> I am searching for jobs. Last year I was pregnant and couldn't do that. This year when I search for jobs, the "gap" is becoming a trouble. [Australia should] have some kind of bridging courses like the way nurses have … where you are guaranteed that after this step [the exams] you will be able to get into the medical workforce and work rather than just leave you hanging after doing the exams. (IMG F)

Others caught out in this way, often because of pregnancy, have had to return to their parent country to reinstitute their recency of practice (IMG G).

IMGs stranded by changed rules or procedures

A further difficulty that besets some IMGs is a sudden change of requirement, resulting in them having to start again, usually at additional expense. One IMG arrived in Australia in 2010 having been promised help to find a job in an area of need, only to be told that the program had changed (IMG H). Another got a job offer from a general practice, passed the Pre-employment Structured Clinical Interview (PESCI), but was instructed by AHPRA to start again because it had delayed the paperwork for 6 months, by which time the practice had been reclassified as no longer in an area of need. In other words, they had to find another job in an area of need, wait till a PESCI tailored to that position could be sat, and again pay the substantial PESCI fee. The authors note with considerable concern that some IMGs were so afraid of possible repercussions from AHPRA that they declined to be quoted in any way, even with the de-identification method we and the Journal have employed for the others cited in this article (correspondence on file with the authors).

Recommendations and conclusion

We believe the issues described above need to be managed. Firstly, IMGs who have passed both AMC examinations could be immediately provided with provisional registration by AHPRA (rather than waiting for the IMG to find a job), so hospitals or practices would have certainty they could employ them. There would be no risk they would practise without supervision since that is a condition of provisional registration. A variation on this might be that AHPRA delegates to teaching hospitals the ability to act as its agent to confer provisional registration (and then immediately notify AHPRA).

Another solution to consider is for the Commonwealth to provide funding to health departments for 3-month supernumerary bridging-course positions in emergency and general medicine for IMGs with the AMC certificate. This would increase their chance to win a subsequent supervised position to meet AHPRA's requirements, and help some who were at the limit of their recency situation. IMGs could be provided a loan to cover the cost to health departments of these bridging positions, possibly about $15 000–$20 000 based on costing of a similar program in 2014,[8] which would be repayable after they got a subsequent job. We argue this would be a small cost for the benefit it brings to both the health system and the IMG.

As regards the impact of rule changes, it seems more in the spirit of the Australian "fair go" to usually provide transitional arrangements rather than a sudden "dead end" for those who are already part way through a process when it changes.

Finally, the Victorian Government's recent announcement that it is bringing 350 overseas doctors and nurses to help with the coronavirus disease 2019 (COVID-19) pandemic deserves comment.[9] At the time of writing, some had already started. To us this seems poor policy, since there is already a substantial pool of qualified IMGs, most of whom are Australian permanent residents or citizens, who have completed all our requirements and are ready to be deployed for this purpose.

As we say at the outset, Australia owes a debt to its IMGs. The *Lost in the labyrinth* report suggested changes to how we manage the transition of an immigrant doctor to the Australian practice. Others have called for this too.[10-12] It is clear there is still work to be done.

Acknowledgements: We thank the de-identified IMGs who generously contributed their oral histories for this research. Neville Yeoman's research was supported by an Australian Government Research Training Program fee-offset scholarship, which waives fees during his PhD candidature. The funding source played no role in planning, study design, data collection, analysis or interpretation, reporting or publication of this work.

Competing interests: Alan Roberts is principal of an organisation that runs and charges a fee for training programs to assist IMGs to pass the AMC examinations. In that role, he often hears of difficulties they encounter with the processes required after they pass the examinations.

Provenance: Not commissioned; externally peer reviewed. ■

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1 Australian Government Department of Health. 2018 Doctors in focus. https://hwd.health.gov.au/resources/publications/factsheet-mdcl-2018-full.pdf (viewed Sept 2021).

2 Geffen L. Assuring medical standards: the Australian Medical Council 1985–2010. Canberra, ACT: Australian Medical Council, 2010.

3 Short SD, McDonald F. A national scheme for health practitioner registration and accreditation: the case of Australia. In: Short SD, McDonald F; editors. Health workforce governance: improved access, good regulatory practice, safer patients. London: Routledge, 2016: 185-204.

4 House of Representatives, Standing Committee on Health and Ageing. Lost in the labyrinth: report on the inquiry into registration

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processes and support for overseas trained doctors. Canberra: Commonwealth of Australia, 2012. http://www.cpmec.org.au/files/http___woparedaphgovau_house_committee_haa_overseasdoctors_report_combined_full_report1.pdf (viewed Mar 2018).

5 Yeomans ND, Sewell J, Pigou P, Macintyre S. Demographics and performance of candidates in the examinations of the Australian Medical Council, 1978–2019. *Med J Aust* 2021; 214: 54-58. https://www.mja.com.au/journal/2021/214/2/demographics-and-performance-candidates-examinations-australian-medical-council

6 Medical Board of Australia. Standard pathway [website]. https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Standard-Pathway.aspx (viewed Sept 2021).

7 Nair BRMedical Board of Australia: Registration standards [website]. https://www.medicalboard.gov.au/registration-standards.aspx (viewed Sept 2021).

8 Nair BR, Searles AM, Ling RI, et al. Workplace-based assessment for international medical graduates: at what cost? *Med J Aust* 2014; 200: 41-44. https://www.mja.com.au/journal/2014/200/1/workplace-based-assessment-international-medical-graduates-what-cost

9 Nair BRVic imports international doctors, nurses. *The Canberra Times* 2051; 25 Aug. https://www.canberratimes.com.au/story/7402609/vic-imports-international-doctors-nurses (viewed Sept 2021).

10 Zubaran C, Douglas S. Peers or pariahs? The quest for fairer conditions for international medical graduates in Australia. *Med J Aust* 2014; 201: 509-510. https://www.mja.com.au/journal/2014/201/9/peers-or-pariahs-quest-fairer-conditions-international-medical-graduates

11 Douglas S. The registration and accreditation of international medical graduates in Australia: a broken system or a work in progress? *People Place* 2008; 16: 28-40.

12 Breen KJ. National registration scheme at 5 years: not what it promised. *Aust Health Rev* 2016; 40: 674-678. ■

Supporting Information

Additional Supporting Information is included with the online version of this article.

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Supporting Information

Supplementary material

This appendix was part of the submitted manuscript and has been peer reviewed. It is posted as supplied by the authors.

Appendix to: Yeomans ND, Chowdhury A, Roberts A. International medical graduates (IMGs) in cul-de-sacs: "lost in the labyrinth" revisited? *Med J Aust* 2022; doi: 10.5694/mja2.51516.

Methodology

The research material in this paper is taken from 87 unpublished oral histories of international medical graduates (IMGs), compiled by one of the authors (NDY) over the period 2018 to 2021. They will subsequently be incorporated into a thesis for the Doctor of Philosophy, School of Historical and Philosophical Studies at The University of Melbourne.

The source of participants was as follows:

- 42 were criterion sampled; these were IMGs currently or recently attempting to pass AMC examinations, referred by co-author AR;
- 1 from a newspaper article reporting his difficulties getting registered in Australia;
- 30 sampled randomly from a larger random sample of 1704 IMGs listed in the online Medical Directory of Australia;
- 14 by the snowball method.[1]

Those reported in the present paper were chosen because their stories illustrate the particular types of difficulty experienced by IMGs which form the topic of the paper.

The mode of interview was face-to-face for 44, by videoconference for 32, and audioconference (Skype or telephone) for 11.

Having given informed consent, the interviews were audio-recorded, then transcribed by NDY.

Each of the IMGs whose oral history is cited in the present paper was sent a draft of the paper and then gave their emailed consent for us to use the material attributed to them.

Reference

1 Coleman JS. The study of social organizations with survey methods. *Human Organization* 1958; 17: 29.

Appendix C4:

Yeomans, Neville D. “Demographics and Distribution of Australia’s Medical Immigrant Workforce.” *Journal of Migration and Health* 5 (2022): https://doi.org/10.1016/jmh.2022.100109

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Journal of Migration and Health 5 (2022) 100109

Contents lists available at ScienceDirect

Journal of Migration and Health

journal homepage: www.elsevier.com/locate/jmh

Demographics and distribution of australia's medical immigrant workforce

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ARTICLE INFO

Keywords:
Medical migration
Source countries
Health system
Integration
Medical specialization

ABSTRACT

Background: International medical graduates (IMGs) have made important contributions to Australian healthcare since colonization. Recent published data have documented source countries and characteristics of IMGs undertaking the examinations of the Australian Medical Council. However, information about those currently practicing in Australia is limited.

Objective: To analyze a cross section of IMGs currently practicing in Australia to determine patterns of change in donor countries, other demographic characteristics, geographical locations, and their areas of specialization.

Methods: A random sample of all practitioners on a national database was interrogated for their country of first medical qualification. Those who qualified outside Australia were then analyzed for demographic variables such as age, gender, country of origin, and years of graduation and immigration. Their practice locations were matched to the Australian Bureau of Statistics geographical framework, and their specialties compared with those of a random sample of graduates from Australian medical schools.

Results: Over the approximately 60 years since those surveyed arrived in Australia, IMGs' countries/regions of origin have changed from mainly the UK and Ireland to Southern Asia, in line with demographic changes in Australia as a whole. Most arrived soon after graduation, and IMGs are twice IMGs as likely as local graduates to be working in a rural area of workforce shortage. Compared with local graduates, significantly more IMGs are working in general practice.

Conclusions: IMGs currently practicing in Australia make up a substantial proportion of the workforce and are more likely than local graduates to provide health services in regional and remote areas.

1. Introduction

Throughout its post-colonization history, Australia has relied to varying extents on overseas trained doctors for its medical workforce. During the nineteenth century, in an era when medical practitioners helped expand the perimeters of the British empire, most of Australia's immigrants received their medical training in Britain, with just a sprinkling of graduates coming from other European and North American medical schools. As the country became self-sufficient in medical training, after the opening of medical schools in most states, immigration of doctors became much less important during the first part of the twentieth century (Pensabene, 1980). Up till the 1950s, Australia limited the entry of many foreign nationals by the device of a dictation test administered by immigration officials at the port of entry (Jupp, 2018). This was often referred to as 'The White Australia Policy', and while the dictation test was abolished by legislation in 1956 (Migration Act 1956), it took about another decade for the gradual unwinding of this restrictive immigration policy (Immigration Restriction Act 1901; Tavan, 2005). The Medical Boards of the Australian states, and pressure groups such as the British Medical Association, went further by actively obstructing the registration of certain groups who had managed to arrive despite the immigration barrier – particularly Jewish and other refugee doctors before and during WWII (Winterton, 2005; Wolf, 2019; Kunz, 1975).

But workforce shortages, especially in rural areas, continued to drive medical immigration; by the latter part of the twentieth century the contributing countries had become much more numerous and varied, with an increasing proportion of IMGs coming from Southern Asia (Hawthorne and Birrell, 2002; Yeomans, 2018). Policy settings waxed and waned between the view that there was a doctor oversupply in the 1990s (Doherty, 1988; The Future of General Practice 1992; Australian Workforce Advisory Committee 2000) and an undersupply in the 2000s – the latter leading to a concerted effort to increase overseas recruitment. A text-analysis of over 600 press articles between 1996 and 2003 found 'drought', 'chronic' and 'doctor-starved' widely used in reference to medical workforce in rural communities (Han, 2010). At present, underserved communities are designated 'areas of need' to al-

Abbreviations: IMG, international medical graduates; AMC, australian medical council; MDA, medical directory of australia; AHPRA, Australian Health Practitioner Regulation Agency; MBA, Medical Board of Australia.

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https://doi.org/10.1016/j.jmh.2022.100109
Received 21 June 2021; Received in revised form 15 September 2021; Accepted 15 April 2022
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low faster-track routes to registration for practitioners willing to work in them (Medical Board of Australia 2018). Despite ethical concerns about wealthy countries 'stealing' medical graduates from poorer ones (Bradby, 2014), the reluctance of local doctors to work in rural and remote areas is one reason Australia is likely to rely on immigrant doctors for the foreseeable future (Hawthorne, 2012).

Currently, in line with the terminology in similar countries (Mullan et al., 1995; Eapen and Varghese, 2006), overseas-trained doctors in Australia are referred to as international medical graduates (IMGs), and this is what will be used in this paper. During the last thirty years, there have been several controversies about the treatment of IMGs. A hunger strike took place in 1997 in front of the New South Wales and Victorian Parliaments because the number of IMGs who could sit the registration examinations had been capped (Birrell, 1997). Fairer and less discriminatory treatment for IMGs was called for in a Human Rights and Equal Opportunities Commission report in 1991 (Human Rights and Equal Opportunity Commission 1991). In 2005, the Australian Competition and Consumer Commission inquired into how the specialist medical colleges dealt with applications by IMGs, focusing particularly on transparency and accountability (Australian Competition and Consumer Commission and Australian Health Workforce Officials' Committee 2005). It found both wanting and recommended improvements. Then in 2012, a standing committee of the Australian Government published the "Lost in the Labyrinth" report, which also criticized the processes for registration and support of IMGs (House of Representatives Standing Committee on Health and Ageing 2012).

IMGs currently practicing in Australia have negotiated different processes to achieve medical registration depending on when they arrived. Currently, most IMGs who seek registration in Australia are assessed via the Standard Pathway, administered by the Australian Medical Council (AMC), which requires them to pass two examinations then spend a year (sometimes more) in a supervised practice role. However, those seeking general (non-specialist) registration whose primary medical qualification was obtained in one of five countries with similar training and registration systems to Australia can apply via the Competent Authority Pathway, which exempts them from the AMC exams – sometimes a source of dissatisfaction for IMGs not thus exempted. Finally, those who were considered specialists in their home country can apply for registration by the Specialist Pathway, in which case their application will be dealt with by the relevant Australian specialist college (Australian Medical Council Limited 2021).

These political and cultural factors, plus oscillating workforce supply and demand, have acted to both attract and suppress medical immigration, as well as influence the pattern of donor countries over the last half century. The aim of this paper is to examine the current composition of the IMG workforce practicing in Australia and how and where it is distributed.

2. Methods

2.1. Research questions

This study asks, what is the composition of the immigrant medical workforce currently in Australia? Where did these practitioners come from, when did they arrive, and in what specialties and geographical locations are they working?

2.2. Statistical and demographic data

The data were obtained from the Medical Directory of Australia (MDA) – an online database that lists registered medical practitioners at no cost to them, but is accessible by subscription to other interested parties such as companies marketing pharmaceutical or other medical products (Medical Directory of Australia 2021). On 23 April 2020, the entire MDA dataset of 60,082 practitioners was downloaded into an Excel spreadsheet after entering in the last-name field the wildcard '*'. Using the Excel function '= RAND()', a random sample of 5926 (9.9%) was obtained. Each entry was then examined to determine where the practitioner's initial medical qualification was obtained, to categorize them as either an IMG or a graduate of an Australian or New Zealand medical school (the Australian Medical Council accredits the medical schools of both countries; thus, IMGs are graduates from elsewhere).

The entry was cross-checked from the website of the Medical Board to ensure the practitioner still had a current registration and sometimes to correct missing information about the country of their primary medical degree (Medical Board of Australia 2021). The Medical Board site could not be used as the primary source since it is not searchable without knowing a practitioner's last name. The checks led to the removal of 36 from the MDA sample because they were no longer registered. Thus, the final sample for analysis comprised 5890 medical practitioners who held a current licence to practice in April 2020.

The information extracted for each IMG in the sample included name, gender, year and country of graduation, and year they were first registered to practice in Australia. In addition, the specialty in which they were authorised to practice in Australia and their postal code of practice were recorded. The practice locations were then matched to one of the five geographical areas in the most recent Australian Bureau of Statistics classification: major cities, inner regional, outer regional, remote, and very remote (Australian Bureau of Statistics 2016). For comparison with the IMGs, a separate random sample of 1701 Australian graduates (matched to the number of IMGs in the primary sample) was drawn from the database, and their current postcodes and specialties recorded.

Medians and Interquartile Ranges (IQR) were used since data were often not Gaussian. The statistical significance of differences in frequencies was assessed using the chi square test, and differences in medians with the Mann-Whitney test. The level of significance was taken as $p \leq 0.05$.

2.3. Ethics approval

No individuals are identified in this paper; when numbers in any subsets were very small, the subset was omitted or amalgamated with others to preserve anonymity. The database the author constructed for this paper may be made available to other researchers on request. The research was approved by the University of Melbourne Human Research Ethics Committee (ID: 1,750,338.3).

3. Results

In this sample of just under ten percent of the practitioners in the MDA database, 1704 (28.8%; 95% confidence interval (CI) 27.6–30.0%) obtained their medical degree outside Australia. Of these, 36.0% were women, a slightly smaller proportion ($p<0.001$) than the 39.9% of females in the random sample of Australian graduates from the MDA. Fig. 1 shows the time that has elapsed since their medical graduation for women and men separately. The mode was 16–20 years for both, with medians (IQR) 25 (18–33) and 28 (20–36) years for women and men respectively ($p<0.001$). Fifty (2.9% of the sample) practicing in 2020 had graduated more than 50 years earlier. IMGs had usually migrated to Australia early in their careers, with most arriving and being licenced within ten years of their overseas qualification: for women, the median (IQR) interval between medical graduation and registration in Australia was 9 (5–14) years, minimally shorter than 10 (6–15) years for men ($p = 0.032$). (I discuss in Section 4.3 why the total numbers for IMGs who arrived within the last ten years are likely to be artificially low).

3.1. Countries of overseas medical qualification

The IMGs obtained their medical degree in a total of 82 countries. Those that contributed at least 0.5% each of the sample are listed

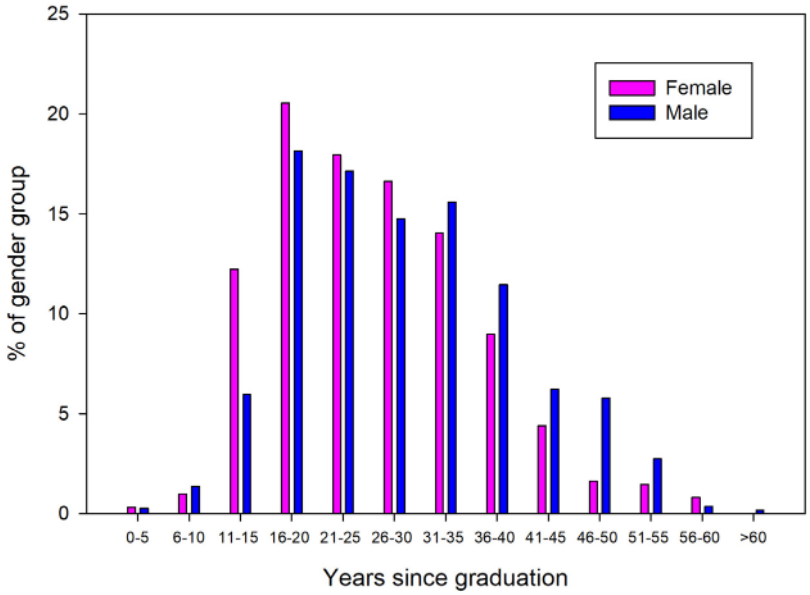

Fig. 1. Percent of each gender, currently practicing in 2020, by years since medical graduation. The low number in the 0–10 years interval is partly artefactual due to those who recently arrived and are still under supervision being under-represented in the MDA database. Medians: female 25 (18–33) y; male 28 (20–36 y); $p<0.001$ (Mann-Whitney test).

Table 1
Countries of training of IMGs practicing in Australia in 2020[a].

Country	N	%
India	363	21.30
UK	326	19.13
S. Africa	140	8.22
Sri Lanka	94	5.52
Bangladesh	67	3.93
Egypt	59	3.46
Pakistan	56	3.29
Ireland	50	2.93
Iran	46	2.70
Philippines	44	2.58
Iraq	41	2.41
China	39	2.29
Myanmar	36	2.11
Russia	28	1.64
Germany	27	1.58
Nigeria	20	1.17
Romania	16	0.94
Malaysia	15	0.88
Zimbabwe	14	0.82
Hong Kong	13	0.76
Poland	13	0.76
Serbia	12	0.70
Ukraine	12	0.70
Netherlands	11	0.65
Canada	9	0.53
Singapore	9	0.53

[a] From random sample of 10% of all IMGs listed in Medical Directory of Australia at April 2020. Table excludes countries contributing < 0.5% of the total sample of 1704 practitioners.

in Table 1. The major donor countries for those currently practicing in Australia are India, the United Kingdom and South Africa. When classified into United Nations (UN) geographic regions (Division UNS 2021), the main contributors are UK & Ireland, Southern Asia, Sub-Saharan Africa, South-eastern Asia and Eastern Europe. UK & Ireland are actually part of the UN Northern Europe division, but separated out here because of the preferential treatment now given to their graduates by the AMC and previously by State and Territory medical boards. Fig. 2 demonstrates how their relative contributions have changed over time. For those still practicing who were registered in Australia prior to 2000, the largest contribution came from UK & Ireland. But among IMGs who were first registered in the 2000s, Southern Asia is now the dominant source.

3.2. Geographical distribution of IMGs and local graduates

Compared with the random sub-sample of 1701 Australian graduates, the IMGs are nearly twice as likely to be practicing in outer regional and remote areas (8.7% of IMGs vs 5.2% of local graduates), and 2.5 times as likely to be in remote and very remote areas (1.5% vs 0.6%), though much the largest number are in major cities (Fig. 3). A marginally higher proportion of females than males are in the cities, but the gender differences were not statistically significant. Those practicing outside the major cities are more likely to be recent graduates. Fig. 4 shows the distribution of IMGs in the five geographical regions versus time since registration in Australia: 38.5% of those registered since 2010 are practicing in the regions compared with only 15.3% of those who were registered prior to 2000 ($p<0.001$).

3.3. Areas of specialization

A much larger proportion of IMGs are in general practice compared with the local graduates: 56% versus 37% (Table 2). In nine of the other specialty areas shown in the table, immigrants are significantly under-represented, often by a factor of more than two. Of the larger specialties, one where the difference (though still significant) is less marked is Internal Medicine, where 14.2% of the Australian graduates in the sample are in that specialty compared with 11.5% of IMGs.

4. Discussion

4.1. The demographics of the immigrant workforce

This random sample of IMGs practicing in Australia in 2020 reflects the waves of medical immigration to the country over the last 60 years. The shift in countries of origin, from mainly UK and Ireland in those who arrived before 1990, to mainly Southern Asia in the last twenty years, has been striking. But these changes in the countries of origin of IMGs reflect major changes in the composition of Australia's migrants generally over that period. Immigration policies that were widely criticized as racist have become more inclusive, perhaps in part as Australia has come to recognize that its social and economic destiny is linked more to its geographic region

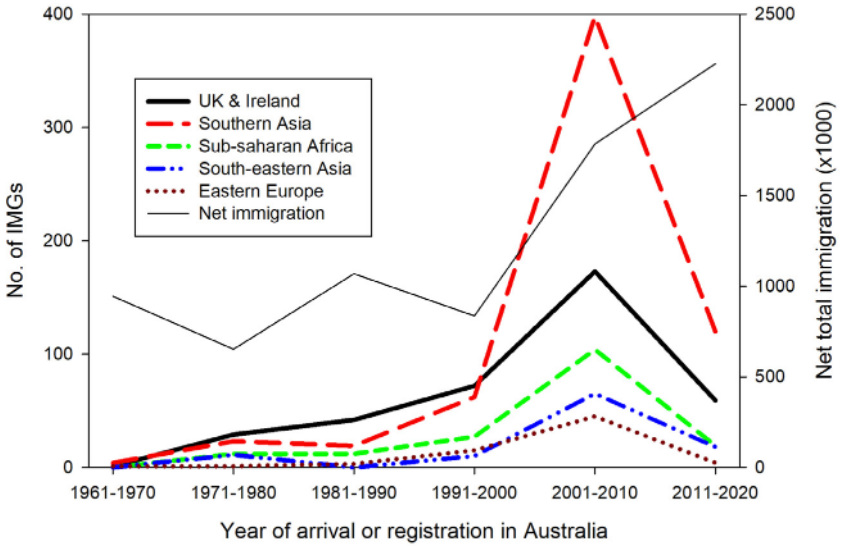

Fig. 2. UN geographic regions of origin of the IMGs practicing in 2020 versus year of registration. UK and Ireland are in the Northern Europe region, but plotted here by themselves because of the favoured registration status they have enjoyed from the Australian Medical Council and historical medical boards. See legend to Fig. 1 for explanation of the smaller totals in 2011–20. (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)

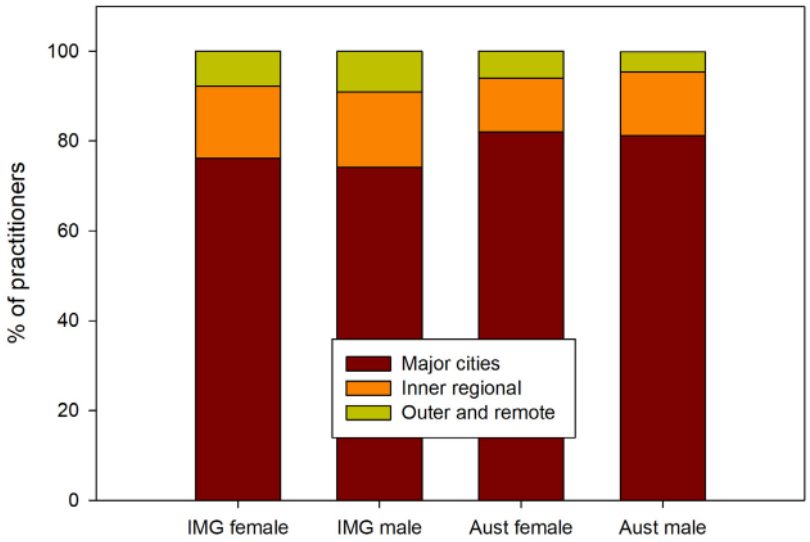

Fig. 3. Geographic place of practice of IMGs and local graduates in Australia in 2020, by Australian Bureau of Statistics (ABS) geographical regions. 'Outer' is sum of 'outer regional' plus 'remote' plus 'very remote' areas. IMGs vs Australian graduates, $p<0.001$ (chi square).

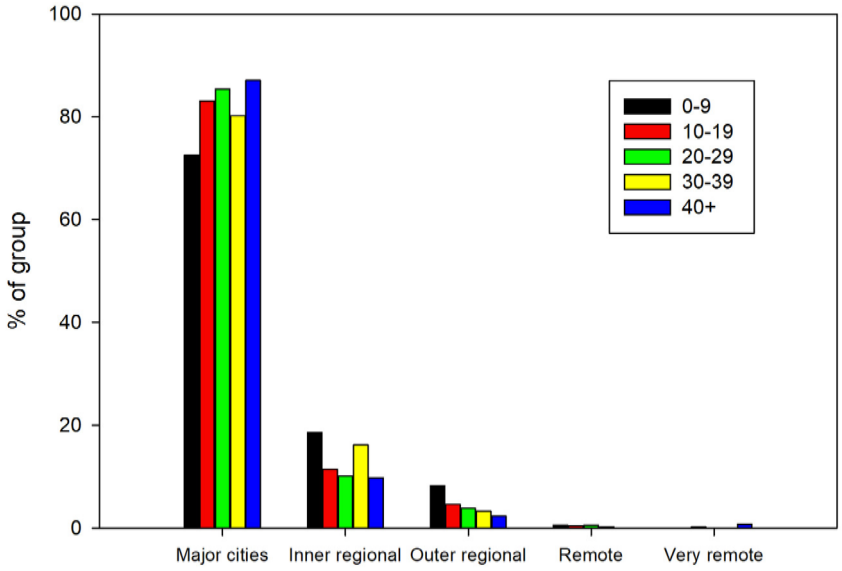

Fig. 4. Geographic place of practice of IMGs in Australia in 2020, by ABS geographical regions and time since first registered in Australia. (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)

Table 2
Numbers of IMGs and Australian Graduates practicing in each medical specialization or category in Australia in 2020.

	Number (%) in discipline		
Discipline	IMGs	Aust. Grads.	P value[a]
Alcohol & Drug Dependency	0	1 (0.1)	NA
Anaesthesia	65 (3.8)	123 (7.8)	<0.001
Dermatology	6 (0.4)	25 (1.6)	0.001
Diagnostic Radiology	30 (1.8)	50 (3.2)	0.031
Emergency Medicine	64 (3.8)	48 (3.0)	0.152
General Practice	953 (56.2)	587 (37.2)	<0.001
Genetics	1 (0.1)	1 (0.1)	NA
Intensive Care	30 (1.8)	24 (1.5)	0.497
Internal Medicine	196 (11.6)	241 (15.3)	0.023
Medical Administration	4 (0.2)	7 (0.4)	0.544
Medical Education & Research	4 (0.2)	12 (0.8)	0.079
Medical Officer	44 (2.6)	77 (4.9)	0.003
Medico-Legal Consulting	1 (0.1)	1 (0.1)	NA
Microbiology	2 (0.1)	3 (0.2)	NA
Obstetrics & Gynaecology	36 (2.1)	34 (2.2)	0.910
Occupational Medicine	3 (0.2)	4 (0.3)	NA
Ophthalmology	15 (0.9)	29 (1.8)	0.048
Paediatric Medicine	42 (2.5)	40 (2.5)	0.917
Palliative Medicine	3 (0.2)	3 (0.2)	NA
Pathology	10 (0.6)	28 (1.8)	0.005
Physical Medicine	1 (0.1)	0	NA
Psychiatry	83 (4.9)	65 (4.1)	0.156
Public Health	1 (0.1)	5 (0.3)	NA
Radiation Oncology	6 (0.4)	8 (0.5)	0.786
Rehabilitation	16 (0.9)	7 (0.4)	0.095
Sexual Health	3 (0.2)	0	NA
Sports Medicine	4 (0.2)	3 (0.2)	NA
Surgery	73 (4.3)	153 (9.7)	<0.001
Totals	1696	1579	

[a]chi square test; significant differences shaded; NA= not applicable due low numbers of expected frequencies in some cells.
Derived from random samples of each category of graduate in Medical Directory of Australia at April 2020. Doctors listed as 'in training' in the database have been omitted from this table (8 IMGs and 122 Australian graduates).

than to the 'old world' of its colonial origins. The proportion of Australia's population born overseas has increased from 10% at the end of WWII to 30% in 2019 (Australian Bureau of Statistics 2020). And in 2018–19,[1] the countries that made the largest contribution to the 160,323 new permanent migrants were India (21%), China (15%) and UK (9%). (Australian Government Department of Home Affairs 2019)[2] It is no surprise that Indian doctors are now the major contributor of IMGs to Australia. India has a large population, a robust medical education system, and many links with its diaspora in Australia that facilitate chain migration (Yeomans, 2018). India is also the biggest exporter of medical practitioners to USA and Britain (Kaushik et al., 2008).

However, it is perhaps surprising that only 2% of Australian IMGs were trained in China since, as mentioned, it is now the second largest migrant source overall. However, the number of Chinese medical migrants is beginning to increase: excluding Hong Kong, almost a thousand Chinese-trained doctors sat the AMC clinical exam between 2000 and 2018 (Yeomans et al., 2021). By contrast South Africa, which ranks third overall as country of origin for those IMGs currently practicing, provided only 2% of migrants in all categories in 2019. Medical migration from that country was prominent during the Apartheid period and up till about 2010 (Arnold, 2011), but seems to be now slowing.

[1] Data are available for 2019-20, but that period was impacted by the Australian border closure due to the COVID-19 pandemic.

[2] New Zealand is excluded here because the two countries have a freedom of movement agreement between them.

4.2. Practice locations and specialties of the immigrants

The finding that IMGs were more likely to be practicing in a rural or remote area of the country than the local graduates is no surprise. Indeed, as mentioned already, it is government policy. Visas and registration are more likely to be obtained if the immigrant goes to an area of need (Iredale, 2009). Another factor since 1997 has been a requirement for most IMGs to work in an area of workforce shortage for ten years before they can bill patients under the universal medical insurance (Medicare) scheme (Department of Health [Cth] 2009). Our findings are similar to those of O'Sullivan et al., who surveyed almost 20% of the practicing medical workforce in the period 2008–2013. Sixteen percent of their respondents were IMGs. And they found those practicing in small rural and remote areas in that period were about twice as likely to be IMGs compared with local graduates (O'Sullivan et al., 2019).

That those in the rural areas are younger is also not surprising. Some older IMGs would have started there then moved to a city, sometimes motivated by better opportunities for their children's education or work for a spouse, after having 'served their time' in a more remote area. The other notable aspect of the IMGs compared with the local graduates is the smaller proportion of them registered as specialists and their over-representation among general practitioners. A likely reason is the difficulty many who were specialists in their home country have in persuading the Australian specialist colleges to recognize their credentials.

4.3. Limitations of the data

The number of IMGs in the medical directory sample who were registered after 2011 is quite small. This is very likely to be artefactual, since many IMGs continued to sit and pass the AMC examinations during that final decade (Yeomans et al., 2021), although their number has fallen by about a half since 2009. The other reason for the lower numbers of IMGs in 2011–20 in the MDA database is probably that many are still in supervised positions – with the relevant specialty colleges, in mandated hospital medical officer positions after passing the AMC examinations, or in supervised general practice positions where they are not yet permitted to bill patients for private services in their own right. Thus, this paper concerns the distribution of the established medical workforce, not the total workforce that includes doctors still in supervised positions. A further limitation is that a small number of doctors who work solely in hospitals, without private practice, do not get listed in the MDA,

5. Conclusions and implications for policy

This paper provides up-to-date information about the demography of the immigrant doctors who are currently practicing in Australia, which will be of some value to health planners and likely to be of interest to prospective medical immigrants. These data confirm that IMGs are more likely than local graduates to provide medical services in rural and remote areas, though the cities continue to be a magnet for the majority. Australia is not alone in using IMGs to plug these healthcare gaps: Canada and New Zealand have relied on them for years (Pinsky, 2017; Dove, 2009; Lawrenson et al., 2016).

Funding

This work was supported by an Australian Government research scholarship.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

Arnold, P., 2011. A Unique Migration: South African Doctors Fleeing to Australia. CreateSpace, Seattle, WA.

Australian Bureau of Statistics. Australian statistical geography standard (ASGS): volume 5 - remoteness structure, July 2016. https://www.abs.gov.au/ausstats/abs@.nsf/mf/1270.0.55.005 (accessed 23 April 2021).

Australian Bureau of Statistics. Migration, Australia 2020. https://www.abs.gov.au/statistics/people/population/migration-australia/latest-release (accessed 1 May 2021).

Australian Competition & Consumer Commission and Australian Health Workforce Officials' Committee, 2005. Review of Australian Specialist Medical Colleges: Report to Australian Health Ministers. Commonwealth of Australia, Canberra.

Australian Government Department of Home Affairs. 2018-19 Migration program report 2019. https://www.homeaffairs.gov.au/research-and-statistics/statistics/visa-statistics/live/migration-program (accessed 16 March 2021).

Australian Medical Council Limited. Overview of assessment pathways [Available from: https://www.amc.org.au/assessment/pathways/overview/ (accessed 15 September 2021).

Australian Workforce Advisory Committee, 2000. Medical workforce planning in Australia. Aust. Health Rev. 23 (4), 8–26.

Birrell, B., 1997. Hunger strikes and the accreditation of overseas trained doctors in australia. People Place 5 (4), 53–58.

Bradby, H., 2014. International medical migration: a critical conceptual review of the global movements of doctors and nurses. Health (United Kingdom) 18 (6), 580–596.

Department of Health [Cth]. Medicare Provider Number Restrictions 2009. https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-pubs-mtrp-13-toc~work-pubs-mtrp-13-5~work-pubs-mtrp-13-5-med (accessed 30 May 2021).

Division UNS. Countries or areas /geographical divisions. https://unstats.un.org/unsd/methodology/m49/ (accessed 26 April 2021).

Doherty, R.L., 1988. Australian medical education and workforce into the 21st century: committee of inquiry into medical education and medical workforce. Canberra, AGPS,.

Dove, N., 2009. Can international medical graduates help solve canada's shortage of rural physicians? Can. J. Rural Med. 14 (3), 120–122.

Eapen, K., Varghese, J., 2006. New visa rules for imgs: cutting through the confusion. Br. Med. J 332, s191.

Han, G.S., 2010. International medical graduates in Australian news: a media narrative analysis. J. Heal. Organ Manag. 24 (3), 237–257.

Hawthorne, L., Birrell, B., 2002. Doctor shortages and their impact on the quality of care in Australia. People Place 10 (3), 55–67.

Hawthorne, L., 2012. International medical migration: what is the future for Australia? Med. J. Australia Open 1 (Suppl. 3), 18–21.

House of Representatives Standing Committee on Health and Ageing, 2012. Lost in the Labyrinth: Report on the Inquiry into Registration Processes and Support for Overseas Trained Doctors. Commonwealth of Australia, Canberra.

Human Rights and Equal Opportunity Commission, 1991. Annual Report 1990-91. AGPS, Canberra.

Immigration Restriction Act, (1901).

Iredale, R., 2009. Luring overseas trained doctors to australia: issues of training, regulating and trading. Int. Migration 47 (4), 31–65.

Jupp, J., 2018. An Immigrant Nation Seeks Cohesion: Australia from 1788. Anthem Press, London.

Kaushik, M., Jaiswal, A., Shah, N., Mahal, A., 2008. High-end physician migration from India. Bull. World Heal. Organ. 86 (1), 40–45.

Kunz, E.F., 1975. The Intruders: Refugee Doctors in Australia. Canberra. Australian National University Press.

Lawrenson, R., Reid, J., Nixon, G., Laurenson, A., 2016. The New Zealand rural hospital doctors workforce survey 2015. New Zealand *Med. J.* 129 (1434), 9–16.

Medical Board of Australia. Area of need 2018 https://www.medicalboard.gov.au/registration/types/limited-registration/area-of-need.aspx (accessed 4 June 2021).

Medical Board of Australia. https://www.medicalboard.gov.au/ (accessed 4 June 2021).

Medical Directory of Australia. https://www.mdaonline.com.au/ (accessed 2 January 2021).

Migration Act, (1956).

Mullan, F., Politzer, R.M., Davis, C.H., 1995. Medical migration and the physician workforce: international medical graduates and american medicine. JAMA 273 (19), 1521–1527.

O'Sullivan, B., Russell, D.J., McGrail, M.R., Scott, A., 2019. Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence. Hum. Resour. Health 17 (1) NA.

Pensabene, T., 1980. The Rise of the Medical Practitioner in Victoria. Australian National University, Canberra.

Pinsky, W., 2017. The importance of international medical graduates in the United States. Ann. Intern. Med. 166 (11), 840–841.

Tavan, G., 2005. The Long, Slow Death of White Australia. Carlton North, Vic., Scribe Publications.

The Future of General Practice (Issues Paper no. 3). Melbourne, national health strategy, 1992.

Winterton, P., 2005. Alien doctors: the western australian medical fraternity's reaction to European events 1930-50. Heal. History 7 (1), 67.

Wolf, G., 2019. Machinations of the british medical association: excluding refugee doctors from queensland's medical profession, 1937-1942. Am. J. Legal History 59, 513–541.

Yeomans, N.D., Sewell, J., Pigou, P., Macintyre, S.F., 2021. Demographics and performance of candidates in the examinations of the australian medical council, 1978-2019. Med. J. Aust. 214, 54–58.

Yeomans, N.D., 2018. They Came to Heal: Australia's Medical Immigrants, 1960 to the Present Thesis. University of Melbourne.