



# The Intruders

Refugee doctors in Australia

Egon F. Kunz

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Refugee doctors  
in Australia

Egon F. Kunz

Australian National University Press  
Canberra 1975

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# Preface

The story of the doctors displaced by World War II who, though not quite uninvited, appeared as unwanted intruders on the Australian medical scene, originally formed part of a major research project dealing with the occupational integration of tertiary educated former displaced persons in Australia.

Though during the 1950s as a contemporary witness I became aware of gross dissatisfaction among the refugee doctors. I was not convinced of the seriousness of their case until I began research on what was intended to be no more than a minor chapter in a major study. Then interviews with both Australian and former D.P. doctors, the reading of documents, and finally the discovery of the Andrew Memorandum, which put much of the unrelated evidence and many of the previously uncorroborated opinions in perspective, convinced me that here was a story which, in order that it should never happen again, must be told. However, to be believed, it had to be told in detail and with full documentation. Hence the present book.

Many people helped me with information. Dr H. G. Andrew, now a resident of England, a man of goodwill and kindness, and Dr J. T. Gunther, who retired from his many distinguished posts in Papua New Guinea, both played important roles in shaping the doctors' story and gave useful interviews. Others who helped were mainly practising doctors and it may not be in their interests that their names should be revealed. However, I record my tribute to two great medical immigrants to Australia who passed away before completion of the MS. Dr Charles Haszler, formerly of Port Moresby, and Dr Geza Santow of Sydney. Dr Haszler was able to corroborate and amplify much of the information supplied by Drs Andrew and Gunther, while Dr Santow's keen interest in the project opened up many leads and led to a number of valuable introductions.

Sources included a wide variety of printed books, journals, newspapers and Parliamentary debates of Australia and the various

States, as well as original manuscripts and public archives. Of the latter, extensive use was made of the archives of the Department of Immigration held in Canberra and the archives of the Department of Labour and National Service, kept in Melbourne. In addition International Refugee Organization (I.R.O.) archives in the Archive de France, Paris, and the privately held archives of the Unregistered Doctors' Association (U.D.A.) in Melbourne were found to hold pertinent answers to some questions. I record my grateful pleasure at the decision which permitted, in the public interest, the publication of government archives though they had not quite passed the thirty years barrier.

Though the scope of the inquiry broadened as the doctors' story took on a separate entity, and led to substantially wider investigations than originally planned, the sample used for the major study and consisting of displaced persons on nominal rolls of twelve chartered I.R.O. ships has been also utilised. This sample, yielding twenty-three doctors and twenty-five medical students, was used both to supply statistical support and as a lead to case histories. When quoted in the text, sample subjects are identified by their respondent numbers. Many people willingly helped with interviews, and their names are usually given in the text or in the references. However, some, particularly doctors, preferred to remain anonymous; in this case they are shown by initials.

Finally I record my indebtedness to Dr C. A. Price and Professor L. F. Crisp of the Australian National University who read the MS. and made many useful suggestions, and to Mrs Christine Bloem, Research Assistant of the Department of Demography, for her patient checking of the text and references. Though they improved considerably the final product, they are not to be held responsible in any way for the views expressed, nor for the faults which, in spite of their attention, may still survive in the text.

Canberra, 1974

E. F. K.

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*Figure drawn by the Cartographic Office, Department of Human Geography, Australian National University*

# Introduction

Events of World War II and its aftermath created an unprecedented dislocation of the population of Europe. Some twelve million people became homeless. Most of these were ethnic Germans expelled or fleeing from the east, while a much smaller number were Jews who survived the concentration camps of Germany. There was, however, a third type of refugee: former citizens of eastern European countries whom the war or subsequent political events had displaced and who, because of political changes, were unwilling to return to their countries of origin. This group of homeless people, about two million in all, became displaced either during the war, or else fled westward a few years later when local communists, under the umbrella of Soviet troops, took charge of their homelands. Though their histories varied greatly, they were a distinct group and, unlike the Germans or Jews, were seeking refuge from political changes and not from ethnic persecution.

The International Refugee Organization (I.R.O.) was created to care for the non-German refugees, most of whom lived amid war-devastated ruins on the fringes of the disorganised German economy. In addition to providing for their shelter and day-to-day existence, the I.R.O. had the task of defusing the politically explosive refugee situation by reducing the concentration of refugees, mainly through repatriation but also through schemes of re-settlement in countries supporting the I.R.O. The motives of these receiving countries were mixed: human charity and compassion, political expediency, and the need for labour to undertake schemes of development, all played a part. As a result, about one million refugees were re-settled in over twenty countries. Australia, by admitting some 170,000 'D.P.s' (Displaced Persons), as these refugees were called, became one of the most prominent countries of re-settlement, running second only to the United States of America.

The arrival of these eastern and central European refugees, most of whom until their embarkation lived in the I.R.O. camps of war-

torn Germany and Austria, was made possible by the implementation of a new Australian immigration policy. This took shape between 1945-7 in reaction to the Japanese wartime advance towards the coasts of Australia. The Australian people and government became acutely aware of their vulnerability in facing a powerful enemy with a population of little over seven million. Another factor favouring a policy of large-scale immigration was the realisation that any program of economic development would be handicapped by a labour force which, because of the low birth rate of the Depression, was on the point of decline. Hence the Calwell immigration policy: that migration should proceed at the rate of one per cent a year (about 70,000 persons in 1945) for as long as necessary.

When the new policy of national growth was first conceived the extent of the post-war refugee problem, particularly the immensity of displacement of the population from Soviet occupied Central and Eastern Europe, was not yet known. However, it was inevitable that the new Australian immigration policy, envisaging an aggressive recruitment of Europeans, should eventually be matched with the Western Powers' desire to eliminate the politically dangerous problem of the displaced persons. Moreover, both Australia and the I.R.O. shared a sense of urgency which gave impetus to the scheme and kept it moving.

Consequently, it was during the ever accelerating growth of the Displaced Persons Scheme that immigration and integration policies and procedures were hammered out and the new Australian Department of Immigration began to learn its difficult trade. Moreover, the mounting tide of displaced persons forced Australians, formerly used mainly to British customs and ways, to deal with non-British Europeans of a very great quantity and variety; so much so that the challenge which their existence presented could not be ignored for long. At the same time it turned out to be the displaced persons' unenviable lot, and unsolicited role, to become the human guinea pigs on whom was tested the social and political feasibility of the government's intention to maintain a large-scale non-British European immigration.

Other overseas countries conducted their immigration programs mainly through private employers. The Displaced Persons migration scheme introduced by the Australian government, however, was

completely government sponsored and, because the need for a labour force for development programs was so great, provided that all able-bodied males (and also women with no dependants) should sign a contract agreeing to remain for two years in the employment found for them by the Australian government and not to change this employment during that period without the consent of the Department of Immigration. Because after the war there was a great shortage of unskilled labour, the initial placings mostly ranged from factory hands producing essential goods (mainly building materials, rubber, cars and foodstuffs) and as unskilled or semi-skilled employees with public utilities such as railways, main road departments, and water and sewerage establishments. Humanitarian motives were also involved, especially on the part of those Australians who felt themselves to be sharing in a great 'international rescue operation' of those whose lives had been shattered by the war, who were living in camps in countries of temporary refuge and whose main desire was to have a chance to build new lives in conditions of security and peace.

Although the introduction and the absorption of displaced persons into Australian society gave rise to vigorous public discussion at that time in parliaments, press and radio, and the various facets of their re-settlement became the subject of a number of valuable studies, a thorough evaluation of the characteristics and careers of the D.P.s, and their effect on Australian society, has not yet been undertaken. Nevertheless it seems that, on the whole, Australia's displaced persons scheme was a highly successful operation mutually beneficial both to Australia and to the overwhelming majority of the arrivals. Although they had left their countries of birth as unwilling refugees, and had to abandon all or most of their possessions, there can be little doubt that in the long run most benefited by their transfer to the secure and free environment of Australia. This was particularly so with those of lesser skill and lower education, who lost little but gained much by exchanging the living standard which was the part of the low income group Eastern Europeans for Australia's high minimum wages, better housing and an incomparably healthier style of life.

Research based on a large sample of former displaced persons shows that about 70 per cent of the adult male displaced persons who disembarked in Australia had no more than eight years of

formal education. Accepting as inevitable the personal costs of broken family ties, and their severance from the communities, languages and traditions of the past, few of these lower educated refugees, and perhaps even not many of another 10 per cent of settlers whose formal education was below matriculation standard on arrival, had cause for dissatisfaction. Indeed it is likely that many would gladly admit that their erstwhile misfortune opened the door to a life style which they could hardly have envisaged before.

In contrast the higher educated refugees, those who had invested most during their early life, left most behind and had therefore most to regain. Because they were fleeing from newly established regimes which ostensibly acted for the proletariat, the refugees had a high proportion of the well educated among them. No less than one-fifth of the adult male displaced persons arriving in Australia had already matriculated in their countries of birth, and half of these were either graduates of universities or university students on arrival.

Arthur Calwell, the architect of the scheme, as Minister for Immigration, took great pains to consult the trade unions so that their fear of competition from newcomers might be allayed. A trusted Labor Party politician, he used his persuasive power to secure support for his immigration program from those parts of the Labour and Trade Union movement which had traditionally opposed immigration; in particular he consulted them about the number of skilled and unskilled immigrants required to fill known vacancies, so that the union movement need not fear any trade would be subjected to undue competition from newcomers.

In the event, of all the displaced persons introduced through the scheme, it was not those with blue collar occupations but those professionally qualified in various non-British universities who faced the most serious difficulties after arrival in Australia. Holding university degrees of which the Australian professions and public knew little or nothing, their struggle for recognition and their successes and failures illustrate the problems faced by immigrants and host society alike, when new types of immigrants are introduced in large numbers into a community accustomed to ethnic homogeneity and cultural conformism. Part of the difficulty lay in the fact that Calwell had so concentrated on winning the trade

unions that he gave no thought to the need for ensuring that the Australian professions approved of the arrival of professionally qualified refugees; the requirement that all D.P.s should agree to work where directed for two years probably blunted a sense of urgency here.

Doctors of medicine among the displaced persons were not the only professional group which had difficulties in obtaining recognition in Australia. Engineers, if qualified at a university, fared best and were given instant recognition by the Institution of Engineers, Australia. Teachers, if able to speak fluent English, were on the whole welcome, and graduates of science often found good openings. The organisations of dentists, veterinarians, pharmacists, and architects, however, all pursued exclusionist policies to varying degrees. But dentists, veterinarians and pharmacists were rare among D.P.s and architects, though in most states formally debarred, had no difficulty in establishing themselves as builders or developers.

Doctors were not only numerous and had few satisfying alternatives, but their fellow refugees depended on them. During their early years in Australia not many refugees needed the services of veterinary surgeons, economists, etc., and even if some did, few would have insisted that these should be given by a compatriot. Even the debarring of dentists caused less bad feeling among the D.P.s, partly because few knew of a compatriot dentist among the refugees, and partly because relations with dentists seldom depended as much on the understanding of language, customs and shared values as did the relationship between doctor and patient. The taking away of their doctors, however, was an unexpected blow.

In addition the doctors' story had certain unusual features, not the least of which was the anomaly connected with their recruitment in Europe. Moreover, their confrontation with the powerfully organised Australian medical profession became a political issue, and remained for over a decade the subject of widespread controversy and press comment. It is not surprising, therefore, that during the 1950s, the handling of the displaced doctors' bid for recognition became in the eyes of many of their fellow immigrants the touchstone on which the genuineness of the host society's goodwill might be tested. Retrospectively, the doctors' story pro-

vides one of the most poignant chapters of Australia's great immigration experiment.

Frequent references have been made in the text to the professional organisation of medical practitioners in Australia. Originally known as the British Medical Association (B.M.A.) in Australia, this association was renamed on 1 January 1962 'the Australian Medical Association (A.M.A.). Though not strictly correct, to ensure uniformity on all occasions except in quotations the current name or abbreviation has been used, irrespective of whether the matter discussed referred to the period before or after 1962.

# 1 Recruitment of refugee doctors for Australia

Among the millions of refugees of post-war Europe, there were many doctors. By the end of 1947, the number of medical practitioners displaced by events of the war and its consequences was estimated by the I.R.O. as over two-and-a-half thousand. Renewed refugee movements in 1948 and 1949, originating mainly from Hungary and Czechoslovakia, swelled this number ultimately to almost three thousand.

Because many of these doctors had lost not only their material possessions during the war, but also their diplomas and identity papers, the I.R.O. established a special screening and identification procedure to verify their credentials. Two boards were established: one in the British zone of Germany under the presidency of a former professor of the University of Riga (Latvia) and the other in the U.S. zone, headed by a former professor of the University of Szeged (Hungary). The applicants were required to appear before the screening boards presenting proofs of identity and qualifications. Reference to former medical registers or affidavits by former teachers or fellow graduates of known integrity were also used. If an authentic original diploma did not exist, the board subjected the candidates to examination, including clinical examination for specialists.<sup>1</sup>

Once the board was satisfied the I.R.O. issued a 'certificate of professional status' and the name of that doctor was included in the *Professional Medical Register* published by the I.R.O.'s Health Division. In the words of the division, the accuracy of claims of those appearing in the register 'has been confirmed and cross-checked, and their qualifications should be recognised even in those cases where they are unable to produce the nominal diplomas of graduation'.<sup>2</sup>

The certification of doctors was in line with the continued

1. L. W. Holborn, *The International Refugee Organization*, London, Oxford University Press, 1956, p.304.

2. *IRO Professional Medical Register*, Geneva (n.d.), p.3.



efforts of the I.R.O. to gain recognition for the medical graduates displaced by the war and its aftermath, and to find suitable employment for them in the countries of re-settlement. As early as September 1947 the I.R.O. presented to the Interim Commission of the World Health Organisation a memorandum on displaced persons medical practitioners. The result was a resolution requesting governments to consider this question and to indicate conditions under which foreign doctors and dentists could be admitted to practice in their countries. In Australia the matter was handled by the Department of Health, then headed by Labor Senator N. E. McKenna; early in 1948 the department advised the W.H.O. through the Department of External Affairs that: 'under existing conditions, medical practitioners holding only foreign degrees would not be granted registration in Australia to practise their profession'.<sup>3</sup>

Neither did other countries prove much more helpful. Though doctors of medicine were able to emigrate to a number of countries and take their chances for their eventual registration as medical practitioners, only a few nations specifically sought the services of doctors or guaranteed professional employment on arrival. Thus, in spite of a Pakistani scheme for Army medical officers and some recruitment by the U.S. for doctors to serve in the Pacific Islands, or Norway's request for dentists, the future of the majority of medical and dental practitioners (by this time employed mostly in temporary hospitals and refugee camps) remained in great uncertainty.

The Department of Health's discouraging letter from Australia early in 1948 was later that year followed by a move from Canberra opening up at least a minor avenue of relief. The Department of Immigration through its representative in Europe, Brigadier F. G. Galleghan, Head of the Australian Military Mission in Germany, advised the I.R.O. that although under the laws of the States foreign academic qualifications were not recognised, and holders of foreign degrees were required to undergo university courses in Australia, the Medical Board of the Territory of Papua-New Guinea 'may register persons with the requisite qualifications to practise

3. Director-General of Health to Secretary, Department of External Affairs, 19 February 1948, Department of Immigration Corresp. File, CRS A434, item 50/3/12500. C.A.O. Canberra.

within the Territory, but such registration would not permit the person registered to practise within Australia should he later desire to do so'.<sup>4</sup>

In November 1948 Brigadier Galleghan received a memorandum from Dr H. G. Andrew, medical officer with the Australian Military Mission in Berlin.<sup>5</sup> Prompted by I.R.O. efforts to find a professional future for the displaced doctors and aware of the Chifley Labor Government's difficulties at home in establishing an Australian national health service in the face of a shortage of doctors and strong opposition by the A.M.A.<sup>6</sup> Dr Andrew referred to the existence of 2,700 qualified doctors of medicine among the D.P.s. These doctors, he stated: 'have been examined, screened, and registered, under rigid standards, by special Medical Screening and Registration Board initiated by the Health Division of the International Refugee Organization, and with the recognition of the World Health Organization' which establishes them as *bona fide* graduates in medicine from European schools and acceptable by nationality to Australia. Noting that the Commonwealth planned to introduce shortly an Australian National Health Service, and that to introduce this service the Commonwealth needed more doctors than were then available, or likely to qualify from Australian universities, he proposed that Australia should recruit the D.P. doctors in large numbers. The proposal envisaged either immediate employment in the medical profession or, until suitable vacancies in the profession were available, employment in the fringe areas of medicine for some period. Such placements, Andrew suggested, would be acceptable to many because the D.P. doctors' 'chief concern is not advantageous terms of appointment and special considerations, but simply to be allowed to migrate with their families, and additionally given a firm guarantee of "some kind of hospital work" '.

Linking the chances of the D.P. doctors ultimately with the proposed National Health Service, the memorandum proposed:

As all doctors so recruited as 'hospital workers' will hope for an

4. Galleghan to Assistant Director General, I.R.O. Berlin, 30 September 1948. IRO Archives: Australia; Archives de France, Paris.

5. Berlin Memo No. 120/48 1/152/33/1770. Memo to the Secretary, Department of Immigration, Department of Labour and National Service Correspondence, 1947-53. MT 72, File no. 49/23/431. C.A.O., Canberra.

6. Prior to January 1962 British Medical Association in Australia. For usage in text see Introduction on p.6.

eventual opportunity to 'graduate' from hospital worker to registered practitioner, it is suggested that no special time limit be placed on the contract for hospital work (either minimum or maximum); but that the Commonwealth review the position periodically in relation to the changing demands of the developing National Health Act. The rate of intake of recruits from civilian 'lay' ranks for employment as semi-skilled hospital workers would also influence the acceptance of D.P. doctors into the registered practitioner category.

The memorandum proposed further alternative avenues for using the skills of the 2,700 displaced doctors for the benefit of Australia. These included: 'if the Commonwealth does not agree to ultimate registration for unrestricted practice' the allocation of the displaced doctors into restricted practices in country areas or hospitals and the employment of those with recognised teaching ability in Australian university medical schools. Finally the memorandum suggested the use of the skills of the doctors, among whom there were 'several highly qualified men' in tropical medicine, malariology and parasitology, in New Guinea.

Naturally [went on the memorandum] they prefer to go as registered medical practitioners and to be allowed to practise their profession at once. However, they appreciate the present barriers to registration, and are more than willing to come to Australia provided . . . that eventually some consideration be given to their registration within a National Health Scheme, or other similar Health Service.

The memorandum concluded by repeating that the displaced doctors and their families, who represented a total of 8,000-10,000 persons and included a large proportion of children, were migrants of the highest order of great professional and personal integrity and had already proved their worth in international organisations. Also, they were immediately available. However, Dr Andrew warned that the United States wanted many of them and therefore Australia should quickly recruit them 'lest the best be lost to the U.S. and other countries'.

Forwarding the memorandum two days later to the Department of Immigration in Canberra, Brigadier Galleghan added a cautious

but practical covering note. The note is of interest, because while it reveals Galleghan's doubts about the eventual professional employment of doctors, it does not suggest that he communicated these doubts to his Chief Medical Officer, nor to officials of the I.R.O.<sup>7</sup>

the suggestion to recruit D.P. doctors as hospital workers, which is suggested by Dr. Andrew, is quite a good one. I know from my own experience how short the repatriation hospitals are of qualified medical orderlies and provided D.P. doctors are prepared to accept work of that nature I think their entry into Australia would be beneficial. The plan outlined by Dr. Andrew in his report has been proceeded with without prior conference with the IRO officials. IRO has a special division which deals with D.P.'s having professional qualifications and my experience is that they are thinking more in terms of placing all individuals as professionals and disregarding what the individual displaced doctor mostly desires, that is an opportunity to resettle in any capacity in a resettling country, particularly Australia. As a result of this idea I asked Dr. Andrew to make his survey without reference to the IRO authorities. I am sure that if approval is given to recruit these qualified men as hospital orderlies there would be no dearth of applicants and no embarrassment ensue from IRO. I make no comment regarding Dr. Andrew's proposal that these qualified medical practitioners may be used later in any Commonwealth National Health Service, nor can I comment as to the possibility of their subsequently being allowed to practice as medical practitioners in Australia.

As a result of Andrew's proposals and Brigadier Galleghan's covering note, hospitals throughout Australia were circularised about the chances of obtaining D.P. doctors as medical orderlies. Though widespread shortages of orderlies were reported from New South Wales, Victoria and Queensland, few hospitals were in a position to take advantage of the offer because of lack of accommodation. Some early doubts were expressed by the Department of Health in Western Australia on the wisdom of employing doctors

7. Galleghan to Secretary of Department of Immigration, Canberra. Berlin, 17 November 1948, Berlin Memo No. 120/48. Department of Labour and National Service Corresp. Ser., 1947-53. MT/72, File no. 49/23/431. C.A.O., Melbourne.

in a sub-professional capacity.<sup>8</sup> In Victoria, the manager of the Wangaratta District Base Hospital, who already had the experience of employing a D.P. doctor as an orderly, expressed quite definite views on the subject:

It would seem, from my observations, that there may be greater difficulty in Doctors reconciling themselves to a substantial change in status when employed in and about a Hospital.

Of 10 female D.P.'s employed at this Hospital the only one who has shown definite signs of difficult adjustment has been a Doctor, who, prior to her arrival in Australia, practised her profession for something more than 20 years.

She is at present employed as a Nurse Assistant in a female Public Ward. It is apparent from conversation with her that it is a source of constant distress to her that she is unable to practise her profession. She recognises that this is not possible in Australia. However I believe that the fact that she is employed in a Hospital ward may tend to aggravate a certain feeling of frustration from which she is understandably suffering.<sup>9</sup>

In the end N.S.W. requested twenty, Victoria two and Queensland thirty D.P. doctors as medical orderlies.<sup>10</sup>

The other main suggestion embodied in the memorandum, that of importing over 2,000 medical practitioners, as 'medical workers', to keep them in reserve in case of difficulties or shortages jeopardising a future National Health Scheme, did not receive departmental endorsement. That Canberra would not agree to the recruitment of D.P.'s 'for specific purposes', a formula which would bring the processing of doctors under the terms of the I.R.O. specialist scheme – with recruitment and eventual employment subject to approval and scrutinised by the I.R.O. – was already known to Galleghan and indicated in his note.

8. W.A. Department of Health, Department of Labour and National Service, File no. 49/23/431. C.A.O., Melbourne.

9. Manager, Wangaratta District Base Hospital to District Employment Officer, Wangaratta. Copy for Director of Employment, N.S.W. 2/5/1949. Department of Labour and National Service Corresp. Ser., 1947-53, MT 72, File no. 49/23/431. C.A.O., Melbourne.

10. Funnell to Secretary, Department of Immigration, 25/5/49. Department of Labour and National Service Corresp. Ser., 1947-53, MT 72, File no. 49/23/431. C.A.O., Melbourne.

Despite his knowledge here Galleghan does not seem to have moved to prevent Andrew going ahead with some of the proposals outlined in the memorandum. Doctors were approached for the New Guinea Scheme and through widespread interviews the coming National Health Scheme and the great shortage of doctors in Australia became common rumours in the camps and were passed on uncritically. I.R.O. officials of the middle level were induced to line up doctors of medicine for interviews with Australian missions, and the resulting I.R.O. letterheads lent further authenticity to the news spread by word of mouth. One doctor who later in Australia faced years of factory work, still has in his possession the German original of the following letter sent to him while working as a medical officer in an I.R.O. camp:<sup>11</sup>

Preparatory Commission  
INTERNATIONAL REFUGEE ORGANIZATION  
Headquarters Area Team 2  
LINZ AUSTRIA

Military Address:  
APO 174

Civilian Address:  
Zollamtstrasse 7.

8 February 1949.

Dr  
Camp 1001  
Wels.

SUBJECT: Your emigration to Australia.

As we have learnt that the Australian Selection Commission which is expected here on the 1st of March, will be interested in certain Doctors and Dentists, we will have the opportunity to introduce you to this Commission for the purpose of your emigration to Australia. In this case you must be agreeable to work for the first two years as an assistant in a laboratory or in a similar place, however you will have after these two years a very good chance to work fully in your own profession.

Should you agree with these proposals, please write us immediately so that we can undertake the necessary steps to introduce

11. U.D.A. Archives, Melbourne.

you to the Australian Commission. We believe that should you be accepted by the Commission, this proposal offers you an outstanding opportunity for your emigration and a happy re-settlement.

F.C. Bruhns  
Repatr. & Indiv. Resettl. Off.  
IRO.                      Area Team 2.

Towards the middle of 1949, running parallel with the New Guinea recruitment and the canvassing of possibilities under the impending National Health Service, a new doctors-for-Australia scheme was hatched in Europe. This time the terms were outlined in circulars distributed from I.R.O. Zone Headquarters to Area Resettlement Officers. The version here reproduced is a re-translation into English of a certified German copy obtained by a D.P. doctor in Germany and brought with him to Australia:

INTERNATIONAL REFUGEE ORGANIZATION  
US ZONE HEADQUARTERS  
APO 62                      US Army

Tel.  
Bad Kissingen 255 ext.51.

Resettlement Division  
RR/RJM/10/126  
6 September 1949

TO: Area Directors 1-8  
Attn: Resettlement Officers

Frankfurt    Amberg  
Nellingen    Augsburg  
Wuerzburg   Gauting  
Muenchen    Bremen

Subject: Australia – Medical practitioners.

1. We have been informed by Geneva, that directives have been made to engage D.P. doctors as escort medical officers on ships plying the Australian line. The Head of the Australian Mission notified us that Australia is ready to accept Refugee doctors and their families within the mass-programme, subject that they qualify within the normal selection standards and agree with the 2 years occupation plan.

2. It is understood that the medical practitioners on arrival in Australia, as far as possible will be allotted into appropriate occupations, either in Hospitals as laboratory assistants or similar jobs. During this work period the opportunity shall be given to refugee

doctors to prepare themselves for further studies and examinations so as to satisfy the requirements of the Australian medical authorities, in case they should settle as practising physicians.

3. Geneva is in charge of actions for the employment of medical practitioners for the duration of 21-22 voyages before their settlement in that country. Relatives may either stay in Italy until the doctor's last voyage, or may go with the first trip and wait for him there.

4. The US Zone has been allotted an initial quota of 18 doctors. You are asked to discuss this with every doctor who wishes to emigrate to Australia, and should any of them be interested to arrange for interview at the Resettlement Centre.

5. The Resettlement Centres are requested to notify our H.Q.s whenever such doctor has been accepted by the Mission, giving his name, members of his family, and also whether the family of the medical practitioner will accompany the doctor on his first trip.

6. Early action is requested, as Geneva presses for an increase in the number of physicians. It is understood that arrangements for the engagement by IRO will be completed only in Italy.

For the Chief of Operations  
ROBERT J. CORKERY  
Chief, Repatriation & Resettlement.<sup>12</sup>

By July 1949 enticing rumours disseminated among D.P. doctors on opportunities in Australia became so frequent that Geneva considered it necessary to intervene. Criticising the wording and contents of a circular letter calling for D.P. doctors to be employed en route to Australia with further possibilities in view after disembarkation, Dr L. Findlay, Chief Medical Officer of the I.R.O. British Commonwealth Resettlement Division pointed out that its terms, particularly in Paragraph 1, were 'rather general and not specific enough to be of interest to D.P. doctors'.

I have [wrote Dr Findlay] discussed it with Dr Kennedy while he was here with Dr Graham Andrew, the Chief Medical Officer of the Australian Mission. Unless there is some firm guarantee that doctors will be employed in various hospital appointments,

12. U.D.A. Archives, Melbourne.



even if not strictly professional ones, it will be difficult to circulate information of value to the doctors.<sup>13</sup>

Acting on the request of Dr Findlay, on 22 August the Health Division in Geneva included a discouraging phraseology in the relevant notice, and advised the area directors that:

phraseology which indicates that doctors should be required to work on the general labour market was inserted at the specific request of the British Commonwealth Division, Resettlement Division, who were transmitting their views to General Galleghan in Berlin.

Unofficially, the position remains that doctors will, so far as is possible, be given either medical work or para medical work on arrival in Australia. There is, however, no *guarantee* to this effect. It was to stress this fact that the discouraging phraseology employed was inserted.<sup>14</sup>

However, the recruitment campaign to obtain doctors for Australia continued for some time in the same way it had begun. Moreover, the circular letter to the area directors of the U.S. Zone was distributed from Bad Kissingen on 6 September – apparently just a few days too soon to insert the discouraging phraseology which, on 22 August, Geneva decided should be included in the text. As a result the main points of the memorandum, particularly those relating to a National Health Scheme and to laboratory-type employment during contract,<sup>15</sup> were well publicised throughout

13. Findlay to Health Division, I.R.O. H.Q. Geneva, 12/7/49. I.R.O. Archives, 49/4/Australia. Item 146. Archives de France, Paris.

14. I.R.O. Archives, 42/4/Australia. Item 182. Archives de France, Paris.

15. It was the Australian government's decision that prior to embarking all displaced persons should sign an undertaking to work in jobs provided for them by the Australian government. The 'contract' – as it was referred to by the immigrants themselves – did not specify the type of work the D.P. would have to undertake, and its interpretation became one of the controversial issues involved in the doctors' case. Its wording changed slightly with the passage of time. During the peak intake of D.P.s (1945-51) the following form was used:

Undertaking:

I hereby certify that the personal particulars supplied by me to the Australian Selection Officers are true in every respect and that I have made myself familiar with the conditions under which displaced persons can emigrate to Australia. I fully understand that I must remain in the employment found for me for a period of up to two

the hospitals and camp surgeries; some refugee doctors interpreted the information as meaning such things might possibly happen, others that they would very likely happen, and yet others that they were bound to happen.

Memories of this were still very clear some four years later when the doctors concerned, now in Australia, were asked to participate in a survey organised by the Unregistered Doctors' Association (U.D.A.) in Victoria. In addition to other relevant information the survey supplied the answers given in 1953 by some 200 former D.P. doctors to a U.D.A. questionnaire on what they remember being told by Australian authorities in Europe about their chances in Australia. The answers were as follows:<sup>16</sup>

- |   |     |
|---|-----|
| a) they will be employed as ships' doctors already on the run to Australia  | 3%  |
| b) they will be able to exercise their profession on arrival in Australia   | 10% |
| c) their abilities will be exploited through employment as laboratory-research assistants   | 7%  |
| d) they will be free to work as doctors after finishing the 2-years contract  | 21% |
| e) that to get the permission for practice repeating of 2 last years of clinics are necessary   | 1%  |
| f) that in the nearest future the medical law in Australia will be changed because of the very shortage [ <i>sic</i> ] of doctors and a new medical scheme will be introduced | 24% |
| g) no definite promise has been given of the situation in Australia described as difficult for doctors at the present time  | 33% |
| h) they have to go to Australia otherwise they lose the privileges of the D.P. Some people were put under pressure while waiting for the visa for the U.S.A.                  | 2%  |

The general trend of these answers coincides with replies received to questionnaires sent out two decades later for this study. Of the

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years and that I shall not be permitted to change that employment during that period without the consent of the Department of Immigration.

Full name (Blocks)  
Signature  
Date

16. U.D.A.: European doctors in Australia. MS. U.D.A. Archives, Melbourne.

thirteen doctors of the sample who answered the questionnaire, six stated that at the time of signing of the contract they were quite confident about being able to practise in Australia after the expiry of the contract. Three of the six also added that they were given verbal assurances to this effect. Of the five who expected to meet difficulties, two thought the difficulties would be less severe than they actually turned out to be. Two doctors did not answer the question.

Whatever credence one may give to replies supplied to a questionnaire by persons deeply involved and with a substantial stake in the issue, the very wording of the answers under a number of paragraphs, but particularly paragraph f, shows that the contents of the Andrew proposals were widely disseminated among the displaced doctors of Europe, and that quite a large number interpreted them as definite.

Conversations carried on between selection officers and the prospective immigrant at the interview which preceded the signing of the contract, and the interpretation given by the 'consul' to the words of the contract, naturally remained unrecorded.<sup>17</sup> However, the fact that according to the U.D.A. survey one-third of the doctors proceeding to Australia were well apprised of the difficulties which awaited them suggests that some conscientious selection officers often succeeded in counteracting misrepresentations and wishful thinking. The failure of other selection officers to explain the position clearly became in time the cause of much bitterness and misfortune.

How widespread the rumours on Australia's need for D.P. doctors and her willingness to accept them were, is indicated also by some surviving contemporary documents originating from outside the I.R.O. or D.P. camps.

Three weeks before Andrew put down on paper his report, the Director of the Foreign Office of the Austrian Medical Chambers,

17. In the lore of the displaced persons camps selection officers of visiting missions were referred to as 'consuls'. Some countries may indeed have used consular staff to select refugee immigrants, but the term was mostly a misnomer, and certainly so in the case of Australian selection officers, who were public servants responsible to the Department of Immigration. The designation 'consul' has nevertheless been used occasionally in the text, to serve as a reminder of how uninformed displaced persons were of facts closely connected with their choices or predicaments.

Dr E. Musil,<sup>18</sup> wrote to Sydney from Vienna, then the target point for neo-refugee movements, that the Austrian Medical Chambers had learnt that there was a shortage of physicians in Australia and that Austria could send abroad a number of well-trained physicians, general practitioners, specialists and medical investigators. The news later spread beyond Austria and Germany. In March 1950 the Medical Secretary of the A.M.A., Victorian Branch, wrote to the Department of Immigration in Canberra noting that, from a letter received from a foreign medical practitioner in Italy, he had gained 'the impression that some of those making enquiries have perhaps been misinformed, or have misunderstood what they have been told by officers of your Department stationed overseas' and therefore suggested that the Immigration Department in future refrain from giving information to medical graduates of foreign schools and refer them to the medical boards of the various States.<sup>19</sup>

In these circumstances it is not surprising that the Director General of Health of the I.R.O. requested General Lloyd, then stationed in Australia as Chief of the Australia and New Zealand Mission of the I.R.O., to protest in Canberra against misrepresentations made by Australian officials in Europe on the situation awaiting medical practitioners in Australia. T. H. E. Heyes, the Secretary of the Department of Immigration, refused to agree with the I.R.O.'s interpretation but subsequently wrote a strong memorandum to the Head of the Australian Mission in Berlin enclosing copies of summaries of State legislation covering registration of medical practitioners.<sup>20</sup>

The free rein given to rumours of Australia's need for and alleged willingness to absorb D.P. doctors lasted for eighteen months: from October 1948 to April 1950. Until August 1949, I.R.O. lent its

18. E. Musil, Director Foreign Office of the Austrian Medical Chambers, Wien, 25 October 1948. Department of Immigration Corresp. File, CRS A446, item 58/66376, pt 1. C.A.O., Canberra.

19. B.M.A. Victorian Branch to Secretary, Department of Immigration, 7 March 1950. Department of Immigration Corresp. File, CRS A446, item 58/66376, pt 1, no. 49/32367. C.A.O., Canberra.

20. Department of Immigration, Canberra, 17 April 1950 to Head of the Australian Military Mission, Berlin. Department of Immigration Corresp. File, CRS A446, item 58/66376, pt 1. C.A.O., Canberra.

letterheads and co-operation to help recruit doctors for Australia. However, following the intervention of Dr Findlay, I.R.O. co-operation in securing D.P. doctors for the Australian mass scheme receded, and apparently no more letters were sent to individual medical practitioners. Inferences which could be misconstrued as promises certainly ceased after April 1950 following the arrival of the Heyes memorandum at the Australian Mission.

But evidence gained from perusal of the I.R.O. and other archives corroborates the view expressed by contemporaries and witnesses, that neither those in charge of Australia's immigration effort nor the Department of Health and Social Services under Senator McKenna had any part in misleading the medical men among the D.P.s then in the camps of Europe. Rather to the contrary: in their discussions and correspondence with I.R.O. officials both the Minister of Immigration and his departmental head made no bones about their unyielding attitude to stand by the mass scheme and their unwillingness to be drawn into migration schemes which would involve guarantees.

In short, it appears that some Australian officials, acting at a distance of 14,000 miles from their home, went beyond the instructions issued to them. But it should also be noted that their claim that urgency was essential because these valuable people might be snapped up by the United States, does echo many contemporary statements made by both Arthur Calwell and T. H. E. Heyes. Also, to search for quality but not to give guarantees on any particular kind of employment, was in keeping with the Department of Immigration's determined policy not to bring displaced persons in through specialist schemes.

## 2 Background, numbers, arrival and reception

Whatever the displaced persons doctors were told in Europe, and whatever they may have expected during the long voyage across the Indian Ocean, the fact was that on their arrival at the reception centres only on rare occasions did anyone care much about their past qualifications, or their prevailing expectations. Indeed the background of higher qualified displaced persons, even the very number of engineers, architects, doctors and dentists among them, was initially of little interest and consequently remained for a while largely unknown.

This occurred despite the fact that educational and occupational information collected about every immigrant was handed over to the Australian Mission by the I.R.O. and together with the interviewing officer's summary, was shipped to Australia on the I.R.O. vessel concerned. These personal files, however, were not handed over to officers of the Department of Labour and National Service which allocated the D.P.s among employers. A similar fate met the I.R.O.'s *Professional Medical Register* which Galleghan told the I.R.O. was 'of not much value in Australia'.<sup>1</sup>

### Numbers

Because of this, statistics of skills on disembarkation in Australia were compiled from the occupational columns of the nominal rolls of the D.P. transport ships. Occupational descriptions in these lists were, however, unreliable: they depended to a large extent on the whim of the re-settlement officers of the assembly centres who originally drew up the information, and from whose lists the nominal rolls were compiled. Depending on the insistence of the immigrant, and the willingness of the resettlement officer to comply with the wishes of the refugee, or the instructions which the compilers may have received from I.R.O. staff or Australian

1. Galleghan to Director of Resettlement, I.R.O., 30/11/1948. 224/4/8, I.R.O. Archives: Australia; Archives de France, Paris.

selection officers, the occupations on the rolls presented a bewildering mixture of true past occupations, *ad hoc* occupations pursued in transit, occupations which the immigrant hoped to pursue on arrival, or unbroken pages of dittoes lined up under the omnibus term of 'labourer'.

Nevertheless there is some indication that doctors of medicine were more successful in retaining in the nominal rolls their occupational designations than other professionally qualified refugees. This may have been partly due to the fact that most of them practised until their embarkation and were known to the camp clerks as doctors. It may be also that doctors of medicine, more than other professionals, were convinced that they could continue their profession on arrival, and therefore were more successful in insisting on being described on the rolls as medical men. Thus of the sample of twenty-three doctors, seven were on the rolls described as doctors of medicine, one as a student, two as following white collar occupations and thirteen were listed as blue collar workers.

Because departmental statistics on the skills of displaced persons were at first based on the nominal rolls, the number of doctors among D.P.s was grossly underestimated, at any rate in the early statistics. However, by the end of 1949 it became known in Australia that there were some highly skilled professionals among the displaced persons, and that they might be of considerable importance to Australia; from then on new arrivals were asked to supply details of their professional backgrounds. At the same time a survey was undertaken to find out what qualifications were held by displaced persons already in Australia. This survey by April 1950 indicated the existence in Australia of 238 male and 50 female D.P.s who claimed to have medical qualifications.<sup>2</sup>

A later survey of 1 August 1951 by the Department of Immigration located 282 male and 86 female D.P. medical practitioners throughout Australia: a subsequent working paper referred to 287 males and 63 females.<sup>3</sup> Because these figures did not include those who died or departed after their arrival, nor those who had not then arrived, the total number of D.P. doctors arriving

2. Analysis of cards registered in Order No.1 of Classifications of Industries & Occupations, as at 15 April 1950, Department of Labour and National Service Corresp. File, 49/23/5630, MT 115. C.A.O., Melbourne.

3. Both papers in Department of Immigration Corresp. File, CRS A446, item 58/66376, pt 1. C.A.O., Canberra.

under the D.P. Scheme may be estimated as some 300 males and 70 females.

### Birthplace

Though the Department of Immigration eventually collected various statistics on doctors and other professional people it did not note their nationality or birthplace. However, the survey made by the U.D.A. in 1953 did show the birthplaces of some 200 then unregistered doctors in Australia, as did a special 1966 Census

Table 1: Country of birth of doctors of medicine (percentages)

	(a) Sample arrivals	(b) U.D.A. survey	(c) 1966 census
Bulgaria	4.3	—	0.7
Czechoslovakia	13.0	10.0	11.5
Estonia	4.3	3.0	5.0
Hungary	26.1	31.0	22.3
Latvia	4.3	21.0	12.9
Lithuania	17.4	11.5	4.7
Poland	13.0	9.0	24.8
Russia and Ukraine	0	10.0	11.5
Yugoslavia	0	0	6.5
Other	17.4	4.5	—
<b>Total</b>	<b>99.8</b>	<b>100.0</b>	<b>99.9</b>
<b>Numbers</b>	<b>23</b>	<b>230(?)</b>	<b>278</b>

a. Only males b. 1890-1930.

b. Data of 1953 based on both sexes. Includes only members of U.D.A. who were not employed as doctors at the time of survey. Birthplace groups with large female doctor proportions over-emphasised (Latvia).

c. Male 1947-54 arrivals surviving to and present in June 1966. Only registered

medical practitioners counted. Takes in both overseas and local graduates, including those who were only children on arrival. Through locally qualified second generation it possibly inflates figures for places of origin with larger families (Baltic countries, Poland). Inclusion of non-D.P. arrivals exaggerates birth groups with substantial non-D.P. inflow between 1947-54 (Polish Jews).



tabulation of medical practitioners in Australia who arrived between 1947 and 1954 (Table 1). These, with the sample, substantially agree that about one in four of the D.P. doctors were born in Hungary, but there is little agreement on other origins.

### Age

No reliable statistics were found on the age of the D.P. doctors. However, a combination of the ages of doctors obtained from the sample and information collected by the U.D.A. indicates that the vast majority of doctors were on arrival within the 28-48 age bracket.

### Qualifications

The doctors qualified in various universities and predictably an overwhelming proportion of them completed their university courses in the country of their birth. However, some, particularly younger ones, held degrees from Germany (U.D.A. survey 16.9 per cent) while again some others obtained additional post-graduate degrees outside their homelands while in transit.

### Family status

According to the sample fourteen of the doctors were single and another two were married without children when they left home. By the time of their arrival, however, sixteen were married. As many married in transit only, it is not surprising that almost half of the married doctors in the sample had no children on arrival. Of those with families, the modal number of children was two. No doctor in the sample had more than three children on arrival.

### Religion

Just under half the doctors, both in the sample and the U.D.A. survey, were Catholics. All others included in the sample stated their religion in the nominal rolls as Protestant or Orthodox; according to the U.D.A. survey, however, 2 per cent were Jewish.

Table 2: Types of employment of male D.P. doctors in Australia, 1948-51

Experience	No Medical Jobs Since Arrival				Mostly non- near medical employment (process worker etc.)		Total
	Had medical job sometime since arrival	No.	%	Mostly near medical employment (orderly etc.)	No.	%	
More than 3 years pre-war	10	9.8	52	51.0	40	39.2	102 35.5
Less than 3 years pre-war	27	14.6	73	39.5	85	45.9	185 64.5
<b>Total</b>	<b>37</b>	<b>12.9</b>	<b>125</b>	<b>43.6</b>	<b>125</b>	<b>43.6</b>	<b>287</b>

Source: Based on Department of Immigration survey.  
 Department of Immigration Corresp. File.  
 CRS A446, item 58/66376 pt 1. (November 1951).  
 C.A.O., Canberra.

### Past experience and interruptions to practice

Of the 287 male doctors whose records were checked by the Department of Immigration in 1951, 102 had at least three years' practice in medicine before the war began. The remaining 185 were relatively young and had either none, or less than three years pre-war experience (Table 2). The total experience of the D.P. doctors was naturally substantially more than this because in addition to pre-war practice most doctors gained varied and valuable experience during the war and during the years spent in transit. For example, three-quarters of doctors in the sample spent four years or more as medical officers in the armed forces, prisoner-of-war camps, D.P. camps and processing centres, or in the hospitals of occupied Europe. What is most remarkable is that of the twenty-three doctors in the sample twenty had not suffered interruption to their medical work during those troubled years, while of the remaining three, two experienced breaks of only two years or less. These findings corroborate the findings of the Department of Immigration, which showed that of those doctors who were already in practice for three or more years before the war, only 4 per cent had interruptions amounting to three years. Together they inevitably presage the conclusion that widespread and lengthy interruptions to professional careers for most medical men began with their arrival in Australia; a situation rather exceptional among D.P.s.

Not that there were none who had their doubts. When recalling their expectations before leaving Europe, of the thirteen who answered a questionnaire twenty years later, six stated that their lives in Australia had turned out to be no different than anticipated; four thought their lives had turned out to be worse and three thought they had turned out better. But survival in Australia possibly biased these results towards the successful, especially as many of the dissatisfied had left, a few committed suicide, while a number of the older and less successful had died in the two decades which had passed since arrival.

### Reception and allocation of jobs

But whatever promises they were given in Europe, or whatever fears they may have held, they certainly did not expect that when they

arrived in Australia they would encounter attitudes by reception staff which were, according to one doctor who later left Australia, 'full of prejudice, plainly hostile and purposely humiliating'. At Bonegilla, the District Controller Mr K., 'a war-time commandant of a P.O.W. Camp, addressing the new arrivals, repeatedly stated that all newcomers are labourers and all European professional degrees are in Australia of no value as such documents can be bought on the black market in Europe. Therefore there are no doctors among the newcomers'<sup>4</sup> In other camps the reception may have been kinder, but the outcome was nevertheless the same; the Employment Service allotted the vast majority jobs which had little or nothing to do with their qualifications. By November 1951, out of 287 male doctors known to the Department of Immigration, only 37 (12.5 per cent) had at some time since arrival held a medical appointment. About half of the remaining 250 were placed in jobs within the health field, mainly as hospital cleaners, orderlies or in rare cases laboratory assistants, while the other half were directed to general work, mainly in factories (Table 2).

#### Medical employment: prospects and difficulties

The factors which created difficulties for refugee medical doctors were manifold. First of all the Commonwealth initially insisted that doctors of medicine, like all other displaced persons, should be employed according to the needs of the economy, and this was seen, particularly in the early stages of the scheme, almost exclusively in terms of unskilled labouring jobs. Secondly, even if and when the Commonwealth or State authorities became convinced that a demand existed for these doctors as doctors, the statutory authorities concerned with registration and licensing of medical practitioners on the whole refused permission for them to practise. Thus the formula, which called for the use of the D.P.s' skills, in the case of doctors came to mean not employment in a medical capacity, but mostly assignment to hospitals as orderlies and cleaners. Such a course of action in the event seldom brought satisfaction either to the D.P. doctor, the hospital, or to the registered medical personnel who practised there.

4. Dobos, Charles Edward, M.D., statement, p.3. MS. U.D.A. Archives, Melbourne.

Perhaps more than other graduates, the D.P. medical practitioners lacked the necessary information and understanding of the Australian situation; many of them, confused by earlier promises, needed a considerable time before they were even able to find out how many of the apparent avenues of progress were closed to them. Most found the narrow path which could lead them out of their difficult situation only years after: for some this was too late.

It was not only that language was a barrier to those who did not speak it initially nor that distance inhibited communication for those placed far from the centres of affairs, though both of these factors undoubtedly did create difficulties during the first year for doctors in search of advice on their professional opportunities. As much as anything it was the maze of the federal system, to which they were newcomers, and the wide scope this provided for 'passing the buck' which confused them. Also these refugee doctors were not used to meeting pressure groups strong enough to defy governments, nor to governments willing to yield.

Some were convinced that their employment in camps as orderlies or medical assistants (though in fact they often performed full medical duties) was, as one doctor later recalled, 'a bad joke' which would expire with the two-year contract. He and his colleagues, said this doctor at an interview, still relied on what they had heard in Europe and were confident of their consequent automatic re-classification as professionals.<sup>5</sup> Others were astounded by the malevolence of the propaganda sustained against foreign doctors and stood bewildered when faced by the rudeness shown to them by some Australian colleagues.

Lost between Federal and State governments; puzzled by differing conditions laid down by the various States and universities; confused betwixt past promises and more recent realities, many foundered on the Scylla of easy hope or the Charybdis of despair.

Behind all the barriers raised, and determined in its opposition, stood the Australian Medical Association. Wielding great influence but declining commensurate responsibility, profoundly interested in rich monetary rewards for its members, its ethical standards and

5. Interview with Dr J.H.

actions became the most important influence shaping the lives and Australian careers of the D.P. doctors. Because of this, no study can be made of the D.P. doctors' predicament without examining the traditions, standards, practices and status of the Australian medical profession and the attitudes and actions of the Australian Medical Association towards doctors qualified at non-British universities.<sup>6</sup>

6. Medico-political activities to protect the general and social interest of the profession, particularly to resist attempts by successive governments to encroach upon what the A.M.A. regards as the exclusive professional domain of doctors, has been always considered the main purpose and function of the A.M.A. Its predecessor the B.M.A. in Australia successfully challenged governments on legislation it did not approve of, and through a policy of non-co-operation was able to dictate its terms. (Thelma Hunter, *The Politics of National Health*, Ph.D. thesis, Australian National University, 1969. Processed. Notably Chapter 3: *The Medico-Political Activities of the A.M.A.*, pp.63-6).

### 3 The Australian medical profession

The income and status enjoyed by the Australian medical practitioner are very high. Indeed, his situation in society is almost comparable to that of doctors in the U.S.A. The average Australian doctor certainly commands substantially higher financial rewards than his colleagues in Britain or the Continent of Europe do.

It is not unlikely that the status accorded to doctors in both the U.S.A. and Australia is the result of the decline of Christianity and the corresponding rise of material values in both countries. The spread of materialism with its exclusive emphasis on life this side of the grave has no doubt helped to raise human values in these new societies. It has also brought about a preoccupation with health and a willingness to pay money and to accord esteem to those professionally engaged in the maintenance of life.

In an effort to explain the extraordinarily elevated status enjoyed by the Australian medical profession Gandevia has pointed to four factors, arising specifically from Australian history.<sup>1</sup> First, suggests Gandevia, in the early convict days doctors of medicine were of great beneficial influence; in the harsh days of convict transportation ships' surgeons were safeguards against grosser abuses of inhumanity and brutality, and thus gained the respect and affection of the first settlers in the course of the long voyage. Secondly, through a dearth of those of the better class, the doctor of even average qualification was more educated than many with whom he mingled in the colony, and this automatically singled him out for leadership in community activities, politics and science. Thirdly, and most importantly, the great Australian distances meant isolation, often accentuated by flood, drought or bushfires, so that it was not a matter of 'which doctor?' but only 'the doctor'.

Finally [concludes Gandevia] virtually throughout the Nine-

1. Bryan Gandevia, Associate Professor, Division of Thoracic Medicine, University of New South Wales, is a noted Australian medical historian. His 'A History of General Practice in Australia' published in the *Canadian Family Physician*, October 1971, is the source of the quotations.

teenth century there was little or no intra-professional gradient, that is to say, almost all doctors were in general practice on a more or less equal footing. An inevitable result of emerging specialisation is that, in the public eye, there are doctors and better doctors, with pedestals of different heights.<sup>2</sup>

Analysis of the four factors enumerated by Gandevia suggests that the initial cause of the unusually high status accorded to men of medicine in Australia was the continuation of traditional attitudes which derived their origin from the peculiarities of Australian history. That these attitudes remained frozen, however, and did not develop into a more enlightened and more critical appreciation of the true values of medical practice, was the outcome of the more recent and conscious policies of the Australian medical profession; these policies, running counter to contemporary developments in medically advanced countries elsewhere in the world, succeeded in preserving a situation of undersupply and in retarding the growth of specialisation. The medical profession's success in resisting world-wide trends towards competition and specialisation was due to many factors. Among these the unsophisticated nature of the Australian clientele, and the determination of the well organised and disciplined profession to insulate this clientele from 'alien medical ideas', played as much part as Australia's geographical and intellectual isolation at the time, and the medical profession's ability to remain both the profiting practitioner and sole arbiter of its services and standards. In this context the almost indiscriminate exclusion of non-British graduates from its ranks was not only part of the important objective to keep its numbers low so that the question of 'which doctor?' would never arise, but was also a precondition of its continued power to resist the development of specialisation.<sup>3</sup>

The extent to which Australia was medically understaffed in the early 1950s is difficult to establish. A government survey prepared in 1950 indicated a ratio of 10.3 doctors for 10,000 people.

2. *Ibid.*

3. British graduates were free to practise under reciprocal arrangements which were on the whole favourable to Australian doctors. Immigration of British doctors was, prior to the introduction of nationalised medicine in Britain, negligible, while reciprocity permitted Australian doctors to obtain post-graduate training in Britain or to spend working holidays there.



However, because registration procedures in the 1950s did not demand yearly re-registrations, this estimate was qualified by the statement that information obtained from the various medical boards might include some doctors who were dead or no longer actively engaged in the profession. Moreover, it was possibly inflated by the registration of the same person in more than one State.<sup>4</sup> But, even accepting the ratio of 10.3 as a valid one, it fell well short of the United States ratio of 14, and trailed a number of other developed countries, including the United Kingdom, Iceland, Denmark and Canada. The seriousness of the situation was highlighted by 100 unfilled vacancies in that year in Commonwealth and State government services alone. There were also shortages of medical practitioners in many country areas.<sup>5</sup>

An earlier survey by the Department of Labour and National Service in 1950 suggested that even an expected increase from 10.3 to 10.8 by 1960 would bring about a change on paper only as real improvement would be contingent on existing conditions of medical and health services still prevailing in the following decade. Developments in preventive medicine, expansion of medical research and a widening of health services would bring about a further deterioration in the shortage of doctors which would by 1960 become 'more acute than at present'.<sup>6</sup>

Though aware of the impossibility of filling positions in health departments and hospitals, the Commonwealth government was apparently unable to discover the exact number of doctors practising in Australia, let alone reach an agreement with the A.M.A. on Australia's absorptive capacity for medical practitioners.<sup>7</sup> As an exasperated government official complained after years of negotiation: 'In the discussions with the B.M.A. agreement could not be reached even on such a fundamental fact as the number of doctors actually practising in Australia.'<sup>8</sup>

4. Immigration Planning Council. Confidential Report. Agendum no. 37/1951. Prepared for the meeting of 17/7/1951.

5. Ibid.

6. Department of Labour and National Service, Brief Review — Medicine. December 1950. D.14885. C.A.O., Melbourne.

7. Hugh R. G. Poate, 'The Capacity of the Medical Profession in Australia to Absorb new Members'. *Medical Journal of Australia*, vol.2, no.16, 17 Oct. 1953, pp.616-21.

8. Memorandum to Principal Research Officer (April 1953), Department of Immigration Corresp. File, CRS A446, item 58/66378, pt 2. C.A.O., Canberra.

## Under-specialisation

If the Commonwealth found it hard to assess the doctor/population ratio in 1950, it is even more difficult for someone twenty years later to estimate the extent of under-specialisation which then characterised the Australian medical profession and continued well into the 1960s. Wedded to a system dominated by general practitioners, the A.M.A. did not find it necessary to investigate the problem. On the contrary: in 1951 its Federal Council asserted that

the special geography of Australia, with relatively long distances from access to consultant practice, has established the need from the earliest days of settlement onwards for a high-grade general practitioner type. The systems of training in Australian Universities have been framed with respect to this need and any measure which provided for the Australian public an inferior type would be retrograde. In general it may be stated that the population distribution of Australia is such that specialist practice cannot be carried on economically except in the cities and larger country towns provided with base hospitals. It has further to be borne in mind that specialists cannot retain their necessary high standards unless remaining in constant contact with large medical centres. In view of these factors the specialist population in its present numbers with expected increases, is regarded as being adequate.

The requirements of numbers of medical practitioners in the future will therefore be concerned primarily with the available numbers of the high grade general practitioner type referred to above.<sup>9</sup>

Because in 1951 there were no post-graduate courses in medicine conducted by Australian universities, the 'high grade general practitioner type' referred to by the A.M.A. was often a doctor with basic medical training, who after some years of hospital and general practice experience became accustomed to look after his patients himself, and who frequently insisted on carrying out a wide variety of highly specialised and lucrative procedures which in most

9. Federal Council of the B.M.A. in Australia to Minister of Immigration. 13 June 1951. CRS A446, item 58/66376, pt 1. C.A.O., Canberra.

developed countries of the world were considered the preserve of specialists. This he did, not because of the 'special geography of Australia', as the A.M.A. Council asserted, but in spite of it. According to the 1954 Census nearly 80 per cent of the population lived in urban areas and 37.7 per cent in cities of 1½ million or over; thus revealing Australian society to be one of the most highly urbanised in the world.<sup>10</sup>

Determined to retain the old system so favourable to general practitioners, the A.M.A. did not until the mid-1960s publish information on just how much specialist service was carried out by general practitioners in Australia. It was only during the 1960s — when growing criticism from press and public, a changing power distribution within the profession, and fear of socialised medicine, made the A.M.A. change its traditionally pro-G.P. stance — that the organised profession began participating in the preparation and publication of studies, reports and articles which drew attention to the gross under-specialisation of Australian medicine.<sup>11</sup> The organised profession, which up till then vehemently defended the general practitioner's right to perform any operations and procedures for which he deemed himself qualified, began airing opinions formerly thought heretical in the artificially retarded climate of the Australian medical profession. Assuming its pro-specialist stance the A.M.A. set up a study group aimed at exposing under-specialisation and the intrusion of general practitioners into specialist areas. At the same time the *Medical Journal of Australia* opened its columns to similar surveys.

Thus in a survey published in the *Medical Journal of Australia*, Adams asserted that in the late 1960s in western Sydney, well within the metropolitan area, one-quarter of the surgery performed in private hospitals, and one-half of the surgery performed in public

10. Comparison with other nations shows that Australia in 1954 was in urbanisation ahead of Canada, U.S.A., Belgium, Denmark, France, Italy, the Netherlands, Norway, Sweden, U.S.S.R., Japan and Argentine, and second only to the United Kingdom. (Peter Hall, *The World Cities*. London, Weidenfeld and Nicolson, 1966, table 3, p.18).

11. Between 1947 and 1965 the proportion of G.P.s among the registered medical practitioners fell from 79 per cent to 44 per cent (A.M.A. Study Group on Medical Planning, *General Practice and its Future in Australia*. Report No.1 [1971], p.14). The consequent *volte face* by the A.M.A. to support specialisation as indiscriminately as it resisted it previously brought about a wide split in the profession and the formation of the break-away General Practitioners Society.

hospitals, was carried out by general practitioners.<sup>12</sup> Another survey published by the *Journal* revealed that most Australian general practitioners regularly carried out surgical procedures which four-fifths of their British colleagues would consider it improper to handle.<sup>13</sup> The same survey found that in 1965-6 82 per cent of general practitioners sampled in New South Wales attended confinements, including 73.4 per cent of the general practitioners who lived in the metropolitan area. A special significance is lent to this latter figure by the survey's findings that half of the metropolitan general practitioners who reported attending confinements had only intermittently secured obstetric cases and had attended during the twelve months covered by the survey one to twenty-five confinements each.

General practitioners could have had even less experience in handling major surgery. Nevertheless many performed such highly specialised procedures (see Table 3) notwithstanding the fact that 80.5 per cent in the sample doing so did not possess a higher degree.<sup>14</sup> After decades of proclaiming the Australian medical system, dominated as it was by the general practitioner, superior to any other medical system in the world, the A.M.A.'s own Study Group on Medical Planning reached the conclusion that 'the performance of the Australian health service system appears to be lagging compared with other countries of similar development' and the Australian age-specific mortality rates bear this out.<sup>15</sup>

The facts and figures collected by the profession reveal the backwardness of the Australian medical system as it was in the late 1960s, and not ten to fifteen years earlier when the displaced persons doctors arrived. 'Up to the early years after the Second World War', states Andersen, 'it has been generally assumed that general practitioners were much more active in surgery than they are today.'<sup>16</sup>

12. A. Adams, *et al.*, 'Medical Care in Western Sydney. A Report on the Utilisation of Health Services by a Defined Population'. *Medical Journal of Australia*, vol.1, no.10, 6 March 1971, p.511.

13. N. A. Andersen, 'An Assessment of the Structure of General Practice in New South Wales, Report of a Survey'. *Medical Journal of Australia, Supplement*, vol.2, no.12, 30 November 1968, p.160.

14. *Ibid.*, pp.161,162.

15. A.M.A. Study Group on Medical Planning, *op. cit.*, pp.18-19.

16. Andersen, *op. cit.*, p.160.

Held back for decades by the vested interests of medical under-specialisation, Australian medicine was considered by overseas experts to be in a primitive stage, indeed not yet to have passed the first phase of development.

This first phase [T. McKeown wrote], is characterised by the fact that a doctor with general responsibilities provides specialized services, sometimes of diverse kinds, for which he may lack formal training, although not experience. In such circumstances the dividing line between general and specialist practice is inevitably blurred. The two classes of doctors are not distinguished clearly by the nature of their work, or by their prestige or income.

This was the position everywhere in the recent past, when medical knowledge was not extensive enough to make it essential for a doctor to devote himself exclusively to a field of work if he was to become competent in it. It is also the position in large

**Table 3: Frequency of operations performed by general practitioners**

Procedure	Percentage of doctors performing the operation
Uterine curettage	72.4
Closed fracture reduction	65.5
Appendicectomy	61.0
Tonsillectomy, adenoidectomy	60.8
Hernial repair	51.0
Anal surgery (haemorrhoids, fissure)	44.5
Hysterectomy	29.3
Compound fracture reduction	24.8
Other traumatic surgery	22.7
Cholecystectomy	21.6
Miscellaneous	18.6

Source: Andersen, op. cit., p.161.

parts of the world today, where medical services are at a primitive stage and one doctor may have to serve many thousands of people. . . Moreover it is sometimes necessary for the doctor to accept a similar role in thinly populated outlying areas of developed countries, although improved transport should soon make it unnecessary for him to attempt the heroic procedures which may be unavoidable in Central Africa.

But with the increasing complexity of medicine it is patently unsatisfactory to retain this type of practice in urban and most rural areas of the advanced countries, indeed in any place where it is possible to offer something better. . . It is therefore remarkable that what may be described, not unfairly, as the primitive form of medical practice has been retained in countries with a high standard of living, which have long passed the stage when it was necessary. In Australia, for example, a significant proportion of the major surgery in large cities is still performed by general practitioners.<sup>17</sup>

### Professional attitudes

The unusually high status and esteem accorded to doctors, reinforced by the absence of effective competition and the discouragement of specialisation, and a subdued and uncritical public, in turn created a medical profession which at its best prided itself on its self-reliance, on its ability to cope single-handed with all types of medical problems, and on its capacity to assume leadership in sundry affairs. These factors, however, fostered the development of a medical Jack-of-all-trades attitude in the context of which the ability to cope, if necessary, was turned into a right to perform complex medical tasks and operations even if better qualified practitioners were available.<sup>18</sup> They inevitably led to an over-prevalence of 'commercialists' among the Australian medical profession, and to undue emphasis on maintaining codes and practices of conduct which would minimise competition, safeguard the rights of the general practitioner and, if possible, compensate him

17. T. McKeown, *Medicine in Modern Society*. London, Allen & Unwin, 1965, p.170.

18. On the dangers inherent in a system where under-specialisation is combined with the incentive of fee for service see Sir Theodore Fox, 'The Antipodes: Private Practice Publicly Supported' in *Lancet*, vol.1, 20, 27 April 1963, pp.875, 933 *et seq.*

for the loss of a patient. The result was a situation where, according to a distinguished critic,

. . . doctors may manipulate the lives of their patients in order to line their pockets or in which they work in concert, not necessarily to provide the best service or free choice by the patient but to sustain a mutually self-supporting situation in which the patient is but a pawn.<sup>19</sup>

Some leaders of the medical profession realised that, as the uniquely lucrative and satisfying situation for the Australian doctor was largely the result of scarcity of medical practitioners and absence of an intra-professional hierarchy, the preservation of financial and status standards in the 1950s rested on the preservation of scarcity and the retardation of specialisation. The arrival of the European medical practitioners presented threats in both respects. First, their registration would have meant a step towards alleviating the scarcity. Second, refugee doctors came from more advanced 'second stage' areas and contained a higher proportion of specialists among their ranks; consequently their absorption in the medical structure would have resulted in a further move to specialisation at the expense of the general practitioner.

It is not suggested that all medical practitioners in Australia saw the issues as clearly as that, or that all who opposed the registration of the displaced persons doctors did this from selfish reasons. But as a young, locally-born doctor explained, Australian medical men had been brought up and reared in Australian medical faculties where, insulated from all but select British medical lore, their minds were imbued with the belief that 'Continental medicine was little better than witchcraft'.<sup>20</sup> After reading some of the statements of the time, one feels that these leaders were believed by at least some doctors. Indeed it is hard to escape the notion that the Australian medical profession developed in its isolation a paranoid state which

19. Hugh Dudley, Foundation Professor of Surgery at Monash University, Victoria, *Australian Broadcasting Commission Guest of Honour Talk*, 10 December 1972. Among earlier criticisms of the commercial nature of the Australian medical scene see W. Osler, 'British Medicine in Greater Britain' in *Aequanimitas with Other Addresses*. London, Lewis, 1925; and 'Conversation with a Surgeon' (Professor Jack Marshall), *Bulletin*, Sydney, 1 February 1964.

20. Interview with Dr X.Y.

was fostered for the benefit of the profession both by its A.M.A. leaders and, at least until the mid-1960s, by many of its academic peers. Also, long, unchallenged decades of commercialised medicine developed a state of mind where 'medical standards' became synonymous with financial and status standards, and 'medical ethics' primarily a term defining professional codes of solidarity. However sweeping and general it may sound, one cannot but feel that there is much truth in the observation of an Australian doctor interviewed on the issue: 'the Australian doctors' first loyalty is to the profession, while the European doctors' is to the patient'. If true, awareness of it may indeed have lain behind the often repeated but always vague charges that European doctors had 'different medical ethics' and would cause a 'lowering of existing Australian medical standards'.

#### Attitudes to earlier intruders: refugee doctors of the 1930s

The situation presented to the Australian medical profession by the arrival of the displaced persons doctors was not entirely new. Among the refugees who had come to Australia from Hitler's Europe in the late 1930s there were over fifty medical practitioners. Their arrival, at a time when many Australian doctors were serving in the armed forces, gave rise to strong opposition by local medical practitioners against their registration. The resulting campaign, in which many participated and from which few (mainly foreign-born or Jewish doctors) dissented, was waged both in the daily press and in the official journal of the A.M.A. The campaign's tone was set by no less a person than the President of the Australian Medical Association in New South Wales, who declared that 'every effort to safeguard the interest of Australian and British doctors and the interest of their British families . . . was . . . worthy of support'.<sup>21</sup> The meaning of 'every effort' became clear from a leader in the *Sydney Morning Herald* which alleged that the President of the A.M.A. in N.S.W. 'has cast completely unwarranted slurs on the honesty of refugee doctors'. In the view of the *Sydney Morning Herald* the A.M.A. 'has in fact done the medical profession a grave disservice by its over-jealous attempts to conserve its sectional interest'.<sup>22</sup>

21. *Sydney Morning Herald*, 27 November 1939, p.5, col.6. Letter to Editor.

22. 7 December 1939, p.8, col.4. Leader.



The castigation by a leading newspaper well known for its sympathetic leanings towards the business and professional classes did not, however, succeed in restraining the vehemence of the campaign. A fortnight later the *Medical Journal of Australia* published a letter from a Sydney member which, coming six months after the welcome offered to refugee colleagues by the *Journal of the Institution of Engineers*, contrasted sharply with the humanitarian attitudes and the intellectual integrity shown by the engineers.<sup>23</sup> And, just as the article of the *Journal of the Institution of Engineers* presaged a fair deal not only towards the refugees from Hitler's expansion but also to the refugees who were to arrive a decade afterwards, the letter by Dr W. Maxwell presaged the attitude which the medical profession was to hold towards the refugees of both pre-war and post-war Europe. Though written against the mostly Jewish refugee doctors of 1939, the letter contained in embryonic form most of the lines of attack, tone and methods which leading members of the Australian medical profession were to use ten years later against the non-Jewish D.P. doctors.

Sir: In a time of national crisis we as a profession are engaged in attempting to safeguard the welfare of those of us who will make sacrifices to serve. The object is worthy, and is one pursued otherwise by certain reputable private firms.

But at this very time there arises a clamour that refugee aliens be registered ostensibly to serve outback centres where after paying living and professional expenses the incumbent will find himself in the affluence of less than the basic wage.

Firstly, Sir, are these refugees trained to our standards in general medical work? Also, will they stay in these unattractive locations? I am sure not. And, will the administration of the machinery devised to keep them there succeed or not suffer from being tampered with? Again I am sure not. The present agitation will again raise its head to grant further licence, or else the newcomers themselves will deliberately circumvent the restrictions in some other way. Indeed, I would ask, how many cases have already arisen in which these aliens have flouted the law by surreptitious practice?

23. E. F. Kunz, 'The Engineering Profession and the Displaced Person Migrant in Australia'. *International Migration*, 1969, 1-2, pp.22-33.

Plain language, Sir! But not as strong as that of our own nationals returning from service to the fields of their lives' work only to find the alien entrenched. And the newcomer? Is he a superman, and are we out of date, incompetent, and fools? If so, then all England and America are likewise fools. I have no doubt that in pressing their claims the aliens will stress this very point: to the layman, as a matter of course, but even to our profession, and with an effrontery that is un-British.

Impudence implies dishonesty. These men come from Vienna mostly, and, I presume, with passports. Can their identity be definitely established, and if so, the authenticity of their diplomas also? I am sure not, especially as their country of origin is under foreign rule. Are there not in the numbers of the refugees those who are not what they profess to be, and who have shamelessly made use of philanthropic organisations to escape the consequences of political debacles in their homelands?

The Press has taken up the cudgels on behalf of the refugee doctors. Why? It has been stated that the Medical Board will be requested to give an early decision. Why? Have they been impressed by claims which many of us have reason to believe are exaggerated and spurious? I wonder has any parliamentarian been hoodwinked to the degree of allowing himself to be treated by these people, even though he knows that he is flouting the law! In my time I remember that revisions have been sought for the *Medical Act* on two occasions; in each instance a parliamentarian has cited the case of a quack who performed a cure of a relative when registered practitioners had failed. Is lay judgement supreme? I do not suggest that the Medical Board can be dominated in this matter; but a statement has appeared in the Press that the Board has been requested to expedite its decisions. I am not aware of the personnel of the Board, but I suspect strongly that their hesitancy may have its origin in some of the doubts expressed by myself.

I believe I know the technique of these alien people. One will be introduced by a friend 'on a friendly visit', and will forthwith insinuate himself into a home and a family's confidence. Is this playing the game? Decidedly not — at least in the light of British standards. Why, then, this urge to introduce alien practitioners who every knowledgeable person knows full well are possessed

of what may be termed eastern European standards of ethics? Our profession will not benefit, nor the public. All will suffer.

I hope the profession will take cognizance of this matter. Laymen are so likely to be cozened and misled, their intellectual standard notwithstanding, where medical matters are concerned. And I hope, though vainly I am sure, that the lay Press may copy this letter.

Yours, etc.  
W. Maxwell

141 Macquarie Street  
Sydney

November, 29, 1939<sup>24</sup>

24. *Medical Journal of Australia*, vol.26, no.23, 16 December 1939, p.919. 'The Refugee Doctors', letter by W. Maxwell.

## 4 The struggle for recognition

The system and power structure of medical registration in Australia

For the newly arrived doctor the Australian medical scene presented a confusing picture. First, he had to realise that medical legislation, including the registration of medical practitioners, was primarily a State matter, and that promises he may have thought he had received in Europe from servants of the Federal government might be shrugged off with unconcern in the capital cities of the States. Once he realised this he had then to make himself familiar with the triangular power structure of the Australian medical world: the medical registration boards, the universities and the Australian Medical Association.

The situation for the uninitiated was further confused by the fact that Australia was divided into six States and two Territories. Each State and Territory had its own medical legislation under which a registration board controlled the admission of medical practitioners in that particular State. The practice of medicine, and the use of the title 'doctor' by unregistered persons, was punishable by law.

Registration in one State or Territory, however, did not entitle a practitioner to registration in another State or Territory, and though certain principles behind the laws dealing with the registration of medical practitioners were common, there were also many minor but nevertheless important differences.

The registration boards had drawn up lists of medical qualifications acceptable for registration in their State or Territory without further examination. These invariably included all Australian qualifications, and qualifications obtained in Britain, the Republic of Ireland or New Zealand. Qualifications obtained at other Commonwealth universities, including those obtained from the universities of Britain's African, Asian and American territories, were in the 1950s almost without exception recognised by all State registration boards in Australia.

Because degrees granted by Australian medical schools almost automatically entitled their holder to initial registration, the admission policies of universities played an important part in regulating both the quality and quantity of medical practitioners; in this sense universities held the second position of power in medical politics.

The third point of the triangle was occupied by the Australian Medical Association. Though the A.M.A. disclaimed any power or responsibility for recognising foreign degrees, it did make repeated and very clear pronouncements against the registration of foreign doctors. Moreover, it set up at least one committee (Feb. 1951) specifically 'to inquire into the need for and the practicability of recognition of the medical qualifications of foreign migrants'. This 'Migrant Doctors Committee', unlike the professional engineers' committee, did not include any migrants and reported that the Australian universities could fill the need for the next five to ten years. It also stated that the standard of education of the foreign doctors was not equal to that of Australian universities.<sup>1</sup>

Precisely because it had no constitutional responsibility in the registration of medical practitioners, the A.M.A. felt free to act as a trade union denying alternatives to its consumers. Also, unlike the registration boards and universities (which were more circumscribed by their charters and functions), the A.M.A. used its unfettered freedom, high status and ample finance to command considerable publicity to further its closed shop policies. Even more importantly, the A.M.A. exerted powerful influence over the registration boards and medical schools, partly through its official representatives and partly by overlapping membership; its pronouncements did in fact become guidelines for these bodies. Any liberalisation in the registration of foreign practitioners in the post-war period was achieved only in the face of bitter and sustained rearguard action by the A.M.A.

### **Admission to registration through re-qualification at an Australian university**

In addition to graduates of certain specified universities, registration

1. *Medical Journal of Australia*, vol.2, no.10, 17 October 1953, p.609.

laws as a rule provided for registration of graduates from other universities if the person concerned was of 'international standard' or had 'special knowledge or skill'. Such registration was, however, given very sparingly. New South Wales, for example, the most populous State, between 1950 and 1954 registered only four doctors under this section.<sup>2</sup> It is unlikely that these included any D.P. doctors.

Although there were certain exceptions, registration in the early 1950s for most D.P. doctors could be obtained only after a repeat study at an Australian university. Consequently, after having made the round of the various registration bodies, the doctors' next step was to familiarise themselves with the regulations and admission requirements of the medical faculties of the various Australian universities.

In the early 1950s four of the six Australian universities then in existence—Melbourne, Sydney, Adelaide and Queensland—offered full courses in medicine. Had they wished, these could have helped solve the problem of registration by awarding *ad eundem gradum* degrees, that is, by granting an applicant a local degree of the same rank as that which he had obtained in his original university in Europe. During that period, however, no Australian university conferred *ad eundem gradum* degrees on foreign medical graduates.<sup>3</sup>

To obtain a degree in Australia, therefore, foreign medical graduates had to attend lectures and pass examinations either at Sydney, Melbourne, Adelaide or Brisbane. Job placements, and the restricted facilities in Brisbane, led most medical graduates wishing to requalify to approach the universities of Melbourne, Sydney or Adelaide. Each of these set a different admission standard. The universities of Sydney and Adelaide required the passing of the third year examination (that is, mainly the academic years) after which they could enrol for the fourth year course (the first of the clinical years) and progress by examination to the fifth and sixth year courses. Melbourne's demands were more exacting: foreign graduates in medicine usually had to pass the first year examination

2. Eric Hilder, 'One Hundred and Twenty Years of Medical Registration in New South Wales, 1838-1958. Compiled from the records of the New South Wales Medical Board'. Sydney, 1959. Processed, p.43.

3. Letters from the Registrars of the universities of Melbourne, Sydney, Adelaide and Queensland.

and proceed from there to the next five years of the course. In some cases the annual examination for Sub-division IIA (second year) was used as a qualifying test: in this case the foreign doctor had only to pass the four remaining years. In addition to the qualifying examination he had to pass a test in English, and give evidence of permanent residence in Victoria.<sup>4</sup>

Admission to medical faculties was also subject to quota: it was the relative good fortune of the D.P. doctors that in the early 1950s the quota was not stretched by locally matriculated applicants. Nevertheless there were other quotas which limited foreign practitioners. In New South Wales Section 17(1)C of the Medical Practitioners Act, 1838-1938 stated that foreign graduates successfully completing the last three years at the University of Sydney could be included in the Register, provided no more than eight such doctors would be so registered in any one year. The problem created by the 1938 Act became obvious in 1949-50. In 1949 thirteen foreign doctors completed the last three years of the Sydney course and a ballot had to be held to decide which eight of the thirteen should be registered. The impasse could have been solved by the University of Sydney granting its own degrees to them all. This, however, the university was not prepared to do, and insisted that degrees could be awarded only to those who completed at least four years of the medical course at Sydney.

Reviewing the issue, the Senate of the university discussed the matter in March 1950. At this meeting strong support was shown in favour of granting degrees to all foreign doctors who successfully completed the last three 'clinical years' at Sydney; the vote, however, was tied, and finally resolved in the negative by the casting vote of the Chancellor Sir Charles Bickerton Blackburn, a surgeon, and a lifelong member of the A.M.A.\* As the *Sydney Daily Telegraph* noted in a leader entitled 'We Aren't Playing the Game with

4. Ibid.

\* After this volume went to press, the *Sydney Morning Herald* reported that in February 1974 the Senate of the University of Sydney had reversed its decision made twenty-four years earlier, and had begun notifying foreign doctors who had completed the last three years of the course before 1957 that they may apply for the usual Bachelor of Medicine-Bachelor of Surgery degree. The last batch of foreign doctors who responded received their degrees in August 1974. Quoting a Polish born general practitioner the article attributed the university's change of heart to the dean of the Medical School, Professor David Maddison, noting that it was largely due to him that this injustice was rectified. ('Graduate waits for 23 years'. *Sydney Morning Herald*, 31 August 1974.)

D.P. Doctors', four out of the nine who voted against the resolution were members of the medical profession.

The seven excluded doctors [went on the *Daily Telegraph*] will now have to wait until next year's ballot . . . Australia has no surplus of doctors and we should help newcomers to use their special skills as quickly as possible. To demand three years' re-schooling and then add the risk of a lottery for the right to practise is asking too much . . . the quota system smacks unpleasantly of the closed shop for Australian-trained doctors. The Australian public is entitled to freedom of choice.<sup>5</sup>

Other newspaper comments were also critical both of the vote and the legislation which provided for the quota.

As a whole [said the *Sydney Morning Herald* in a leader] Australia's treatment of alien doctors has been grudging. The Federal Government has encouraged their admission, along with other European migrants; but the States have been restrictive to a point well exceeding a proper regard for the preservation of professional standards.

The *Sydney Morning Herald* congratulated the McGirr government of N.S.W. for its intention to remove the quota from the Act.<sup>6</sup> The section was in the event omitted from the Act on 27 October 1950.

Although the doctors involved in the ballot of 1950 were not D.P.s but the tail-end of earlier arrivals, the press, government and public viewed the issue as one primarily affecting D.P. doctors.

Despite this early difficulty with the quota, New South Wales, through the three-year course at Sydney University, still offered the best chances for a D.P. doctor to requalify, even if the qualification left him without a local degree and entitled him to practise only within the boundaries of New South Wales. Compared particularly with the University of Melbourne, Sydney's terms were preferable. 'The only kindness I received from the University of Melbourne', wrote Respondent 248, who eventually requalified

5. 8 March 1950.

6. 27 October 1950.



through a three-year course at Sydney University, 'was their advice: Leave Victoria'.

Between 1946 and 1957 114 foreign graduate doctors successfully completed examinations for the fourth, fifth and sixth year at Sydney University – two of these also completed second year, and therefore were awarded local degrees of Bachelor of Medicine and Bachelor of Surgery. At the University of Melbourne between 1947 and 1960, twenty-four former graduates graduated after completing five, or four years of re-study. Figures for the University of Adelaide and the University of Queensland are less certain, but it may be presumed that Adelaide trailed Melbourne, while apparently few qualified at Brisbane.

Because the statistics available for Sydney, Melbourne and Adelaide cover periods before the arrival of the D.P. doctors, and because there were always a few non-D.P. doctors graduating during the peak years of D.P. graduation, the figures are no more than a generous ceiling of possible D.P. graduations or, in the case of Sydney, requalifications for Section 17(1)C of the Act. The approximate D.P. requalifications through universities are shown in Table 4; the 97 requalifications suggest that some 29 per cent of the 300 male D.P. doctors gained registration by this method.<sup>7</sup> This closely approximates the sample of twenty-three doctors, seven of whom gained registration by completing a course at an Australian university.

Requalification through attending university courses and passing examinations provided the safest way to re-enter the profession. The alternative was to await changes in State legislation, though this entailed a substantial risk. In the individual cases where this hope was realised it did in the end result in a longer break in professional practice than requalification by university course.

Re-enrolment, however, was by no means easy, and the chances were further limited by the individual circumstances of the D.P. doctor. Medicine was taught only during the day, and full-time attendance was unavoidable. The course was expensive, scholarships were almost non-existent, and the financial hardship which a family had to undergo while the head of the family was studying

7. This calculation is based on the assumption that all the 300 male doctors, and half of the estimated 70 female doctors, sought registration (97:335-0.2895).

was considerable. Also immigrants were more than anyone else disadvantaged by the taxation laws, which gave tax relief for the father if his child attended university, but not if he himself was the student.

On rare occasions a doctor could secure a personal loan or a scholarship from a business firm—an example of each was reported by doctors in the sample. But the majority of those re-qualifying at universities had to rely on part-time or week-end earnings or employment between terms, and on the earnings of their wives. Some were able to secure permanent shift work, like Respondent 248 who completed his course at Sydney University while employed full-time as a roster clerk at a bus depot.

The ages of those requalifying through a university course varied greatly. Those in the sample were between 30 and 46 on arrival, indicating perhaps that the youngest age group, those who just qualified overseas, were not well represented among the students. Most of the requalifiers were married, some with families of 1-3 children.

Table 4: Qualification for registration by completing a course of at least 3 years at an Australian university

All foreign doctors and D.P. doctors

(a)	(b)	(c)	(d)
University	Period for which data available	Number of foreign medical graduates who completed medical course	Estimated D.P. content of (c)
Sydney	1952-57	98	70
Melbourne	1947-60	24	12
Adelaide	1949-57	15	9
Queensland	—	12	6
<b>Total</b>		<b>149</b>	<b>97</b>

Source: Sydney and Melbourne: letters from registrar. Adelaide: Estimate based on *News*, Adelaide, 4 January 1957, reporting the graduation of 13 former doctors. Queensland: estimate.

Re-entering university involved certain strains and stresses, especially after years away from university life while practising medicine. Many felt humiliation in being forced to sit with young students, while others felt the absurdity of being taught by persons who sometimes knew less about the subject than they did themselves; an apt illustration here is the story of a D.P. doctor correcting his Australian examiner's quotation from the text book which the D.P. had himself written some fifteen years ago. On the other hand, though it was difficult to study afresh those subjects which had little relevance to practice, or had been forgotten through years of intensive specialisation, the D.P. doctor on the whole had a great advantage over the young undergraduate, because he had performed most of the procedures which undergraduates knew only from description.

Those who chose to seek registration through re-study at an Australian university did so mainly between 1951 and 1956. Before 1951 most doctors were still under contract, and though occasionally the Department of Labour and National Service did approve transfers to facilitate studies, such approvals were not always forthcoming.<sup>8</sup> When questioned on this in Parliament, Harold Holt, as Minister for Immigration, explained that 'the fact that registration upon the completion of a three years course is confined to New South Wales considerably restricts the number of displaced person doctors who would be able to undertake such a course'. However, he declined to give any undertaking that doctors under contract would be allocated to Sydney to facilitate their enrolment at Sydney University.<sup>9</sup> Contract placements alone, therefore, did prevent some doctors from commencing studies on arrival: however, postponement of study was inevitable to those with less than fair knowledge of English on arrival: the sample findings suggest that well over half of the doctors fell into this group.

### Admission to registration through service in New Guinea

By accepting appointment to Papua New Guinea some of the D.P.

8. Examples of both approvals and refusals of applications for transfer by doctors to enrol appear in A.N.U. Department of Demography File PLF, Case Documents F. 22. 4.

9. Holt in reply to Sheehan, 1 November 1950. Australia: *House of Representatives, Debates*, vol.210, p.1767.

doctors were able to bypass the lengthy process of requalification through universities. Appointment to the Health Department of Papua New Guinea as medical officers not only gave the most challenging opportunity to D.P. doctors to follow their professions, but also gave the Commonwealth the best use of the doctors' talents. Because it was beneficial to both sides, the Papua New Guinea D.P. doctor project became one of the outstanding success stories of the D.P. scheme.

The opportunity to go to New Guinea was the outcome of the severe shortage of medical graduates in Australia, which enabled doctors to stay in the larger cities and avoid both distant locations and salaried situations.

When the army withdrew and civil administration resumed on the mainland of New Guinea in July 1946, there were only two doctors left in Papua and six in the Territory of New Guinea.<sup>10</sup> These doctors were far from enough even for the needs of the white population of the Territories, and with the increasing pressures on Trust Territories foreshadowed by the Trusteeship Council the government realised that the establishment of a proper medical service must be its primary aim in New Guinea. Towards the end of 1945 the senior medical position of the Territory became vacant, and early in 1946 the Secretary of the Department of Territories offered the position of Director of Public Health to Dr J. T. Gunther. After a tour of New Guinea, Dr Gunther accepted the appointment, so to become the man on whose shoulders fell the responsibility of creating a modern medical service, one which could not only bring New Guinea from stone-age to modern European medical standards, but could also stand up to the scrutiny of international agencies and missions. To do this Dr Gunther needed doctors. In the initial stages he advertised in Australia and the United Kingdom but could find no-one willing to go to New Guinea. About this time, Dr Graham Andrew of Adelaide, who worked as an U.N.R.R.A. medical officer in Europe, came back to Australia, and spread the news of the high quality of the D.P. doctors in Europe.<sup>11</sup> He was particularly impressed by a medical unit of Hungarian doctors

10. R. F. R. Scragg, "The Medical Profession in Papua and New Guinea, 1884-1984". *Papua and New Guinea Scientific Society, Annual Report and Proceedings*, 1964.

11. Dr Andrew, after this visit to Australia, returned to Germany again, to become medical officer with the Australian Military Mission there. (See p.9 above).

working under him in Hospital Föhrenwald, near Munich, and suggested during his stay in Australia that these might be of use to fill shortages in Australia. Though Dr Gunther had no experience of European qualifications, he kept an open mind on the issue, and when he found it impossible to recruit anyone else, he proposed their employment to his superior.<sup>12</sup>

Dr Gunther in a taped interview recollected the decision in the following words:

As I remember it, somewhere around late 1948 or early 1949, following a discussion between myself and the Administrator, Col. Murray, we wrote to Australia suggesting that New Australian doctors who were known to be in Australia and were cutting sleepers, digging potatoes, or working in factories and foundries, or in fact doing anything but medicine, should be employed in New Guinea as part of their compulsory service, which was an obligation to the Australian Government. J. K. Murray would have written ordinarily to the Secretary, but he may have written straight to Minister Ward. Any case, the reply came back that no doctors were available for New Guinea until they had completed their compulsory service, whatever that might be . . . I do not know who that reply came from. It could have come from Tasman Heyes, or Arthur Calwell. My guess is that it came from Nutt, Heyes' second in charge . . . who was an old type public servant who would apply the letter of the law, and could well have advised Calwell, and Calwell reported to Ward, and so on. This remained the situation for a few months, and we tried again. This time there was ready acceptance, and I am absolutely certain that to-day Arthur Calwell would like to think it was his idea. When I say, he would like to think it was his idea, I mean I heard him on this subject very often, how

12. 'The population was so neglected both by the Japanese and by the allies, that the sickness in New Guinea after the war had to be seen to be believed . . . we just had to get more skilled medical persons. From my point of view I would have taken them from anywhere. I suppose it is natural, that I would have preferred Australians, because I knew their standards, I knew how they were trained, they had no language difficulties . . . I had no knowledge of the standards of their medical schools in Europe and I assumed that some of them were as good or better than anything we had in Australia. Naturally, some schools were well known to us. Vienna was one. But pre-war, in Australia graduates of Vienna could not be employed until they had done three years at an Australian university. This is nonsense, but not always thought so.' (Dr Gunther in a taped interview.)

he and I brought great benefit to New Guinea by using D.P. doctors. I have never tried to check with him exactly what his part in it was, but I personally know, that all of a sudden, virtually out of the blue, I was told that I could, if I wished, recruit displaced person doctors who were then available in Australia.

Working from lists supplied by the Department of Health and the Department of Immigration, he met a number of doctors in immigration camps, including the batch of Hungarian doctors recommended by Dr Andrew – this group arrived by I.R.O. transport *Nelly II* in Melbourne and were sent from there to Bonegilla. After interviewing doctors in various places and rejecting only a few of the applicants, Dr Gunther selected thirty-five medical officers, twelve Hungarians, nine from the Baltic countries, eight from Poland, five from Czechoslovakia and one from Yugoslavia.

Their recruitment went not without opposition, notably from Dr Metcalfe, Commonwealth Director General of Health. Dr Gunther recalls his dealings with this senior medico as follows:

Dr Metcalfe . . . was very much opposed to the employment of New Australians in New Guinea, on the ground, I suppose, that once they were employed there that was the thin edge of the wedge, and they could get into Australia . . . he said to me: 'You are doing a great disservice to Australia'. This upset me greatly, I took great umbrage over it, I went to Minister Ward and complained bitterly about it. My understanding is that he took up the matter with Mr Chifley, the Prime Minister, who told McKenna to keep Metcalfe out of New Guinea medical services. I therefore had no more dealing personally with Metcalfe.

About two years later two more Hungarians and one German joined the service, and later still four more Hungarians, two Romanians, and two from Czechoslovakia. Other migrant groups who were not refugees were also represented, though to a minor extent only.

The people recruited at later stages were partly to augment the service and partly to replace doctors who for either family or health reasons had to leave New Guinea. Later the Hungarian Revolution of 1956 and the crisis in Czechoslovakia in 1968 added refugees of new vintages.

The assembly of the original contingent was not easy. Doctors were not infrequently assigned to jobs in distant locations in Australia and time elapsed before an interview could be arranged. It was not until 15 December 1949 that the first batch of doctors was given the green light to proceed to Mosman, New South Wales, to the Australian School of Pacific Administration where they underwent special training in the anthropology and geography of New Guinea, Australian law and administration, tropical living and English. After a three-month course there the medical officers went to Port Moresby without their families, for a further month's introductory course. By 15 April 1950 they had been posted to different stations, some of them to areas where they became the first ever medical officers in the history of New Guinea.

Owing largely to the work of the D.P. doctors the service succeeded in establishing itself. Hospitals were built and diseases were brought under control. Moreover, as it became known in Australia that New Guinea could provide both facilities and opportunities for young doctors interested in an exciting and varied medical practice, gradually more Australian doctors joined the service. Nevertheless, in 1967 twenty-two foreign doctors were still in New Guinea, including eight of the original group. This indicates that, though D.P. doctors may have gone there mainly through sheer necessity and non-acceptance in Australia, many of them became deeply involved in work and opportunities in New Guinea and chose to make their careers there.

Dr Charles Haszler, a Hungarian D.P. doctor, who was in the first batch of D.P. doctors to arrive and who ended his New Guinea career eighteen years later as First Assistant Director of Public Health, has summed up the contribution and achievement of the New Australian doctors of Papua New Guinea. He points out that their coming enabled the Administration to extend medical attention to a great number of people, to set up a network of medical officers, and to initiate the first major health program in New Guinea. They took part in the early stages of the TB campaign. They organised vaccination campaigns, assessed the health situation and reported to Headquarters about it, thus improving the health conditions of both natives and non-natives. The yaws campaign, the initial work on leprosy, malaria and kuru were done by D.P. doctors. They also did much in the early stages of the maternal and child

health care program. Above all their presence gave a feeling of security to people living at out-stations.

With the passing of time administrative responsibilities were also shouldered by them, some being appointed as regional medical officers when these positions were created. By 1969, in the higher echelons of the department, there were two New Australian Assistant Directors, two New Australian regional medical officers, one senior specialist, and a number of other specialists.

By 1970 almost all the first group of D.P. doctors had retired from the service, and with their departure there came to an end a whole era of the health services in Papua New Guinea. This era was characterised by a more sophisticated hospital service, the gaining of the confidence of the population, the commencement of some health schemes and preventive measures, and the inauguration of a complete medical training system for Papua and New Guinea.<sup>13</sup>

Thus, about forty displaced person doctors, who were not allowed by the medical registration and training authorities in Australia to practise medicine in Australian cities, were able in one of the least developed areas of the world to make substantial contributions to the establishment of a modern health service. Constituting some 12 per cent of the total D.P. doctor intake, these willing and fortunate men gave the Australian government a chance to stand up with honour under the eyes of governments and organisations only too willing to criticise Australia's treatment of Papua New Guinea.

Speaking of their qualifications, ethics and performance, Dr Gunther, who more than anyone else deserves credit for the introduction of the New Guinea service, said in an interview:

These people came from different countries and different traditions and their qualifications did differ. I think I can say that Hungarians were the best . . . They were outstanding. They would be good doctors anywhere . . .

Perhaps it is unfair to say, as we did not have many, but the Ukrainians were the least well trained.

Apart from this exception I could not think of any others

13. C. Haszler, 'The New Australian Doctors in New Guinea'. *Papua and New Guinea Medical Journal*, vol.10, no.2, June 1967, pp.35-42.



who would not fit in the spectrum of qualities which the Australian doctors have—from very good to very bad.

There would have been no real medical service in New Guinea in the 1950s if these people had not had good qualifications and had not gained local experience. Their work performance on the whole was good. Naturally we had some bad ones. We had some bad Australians; we had some very bad Englishmen, whom we imported specially from England a little later on in the 1950s . . .

The ethical standards of the D.P. doctors were as high as anybody's. There were one or two who complained about conditions, but I do not think that had anything to do with ethics . . . But probably because of their situation, and their inability to work anywhere else except back in their own country, they were better doctors and gave a better service than others who were free to go.

Summarising . . . I had no more difficulty with the ethics and work performance of the D.P. doctors than I would have had with the same number of Australians.

If anything the New Australians were more amenable and easier to deal with.

In the early stages, two D.P.s claiming to be doctors were noted by their colleagues as being unqualified, and were sent back to the mainland. They were the only D.P.s employed as doctors who were not certified by the I.R.O. Medical Boards. This brought home the value of the until then disregarded *Professional Medical Register* of the I.R.O. To avoid a repetition from then on, only D.P. doctors whose names appeared in this *Register* were contracted.

The refugees, who during these formative years made up the majority of doctors in New Guinea, left lasting marks on the health services of the Territory. In addition, the *Papua and New Guinea Medical Journal* in its early years had hardly an issue without their contributions in it, and when the Medical Society of Papua New Guinea was formed in 1964, a Hungarian-born surgeon, Dr C. Haszler, became its first president. The vagaries of historical events and the operation of medical exclusiveness in Australia, which led these New Australian doctors to New Guinea, provided there for them a most satisfactory and happy professional life. Moreover, most of the New Guinea doctors had to endure only a

few months working in factories, or as medical orderlies, cleaners etc. on the mainland before being 'rescued' for tropical service; they therefore avoided much of the humiliation meted out to their colleagues by the Australian medical profession.

In interviews these doctors nearly always spoke with pleasure about the years spent in New Guinea; there from the first they were accepted as professional men alike by the Australian population, the Administration and naturally by the natives, and were accorded the dignity denied their colleagues in Australia. One wonders how successful a medical scheme could have been developed to serve the Aboriginal people, had their colleagues been given the same chance further south in the Wide Brown Land.

### **The battle for admission under State legislations**

The Commonwealth's power to register doctors in peace time was limited to the Australian Capital Territory, the Northern Territory and Papua New Guinea. Those who wished to practise in the States without completing a course at an Australian university had to approach the relevant State authorities. The States, as mentioned earlier, each had separate legislation which specified conditions for the registration of foreign qualified medical practitioners. The fragmentation provided by the federal system added to the confusion of the newcomers and made their task extremely difficult. At the same time it favoured the organised profession which, being familiar with the federal system, could utilise its weaknesses to its advantage.

### *Efforts to block the registration of foreign doctors*

The difficulties which the D.P. doctors faced in the various States were partly due to the laws relating to the registration of foreign practitioners, and partly to the fact that the interpretation of the various State Acts relating to the practice of medicine was invariably entrusted to the relevant medical boards. Though the compositions of these boards varied from State to State, their membership as a rule was made up entirely of doctors one of whom was the official representative of the State Branch of the A.M.A. Legislation employing phrases such as 'special knowledge', 'international standing', 'standing no less than the university of the state', etc.

gave ample scope to the profession to enforce restrictive practices.

On the whole, it was the general policy of the boards to keep silent concerning the way they arrived at their decisions. The A.M.A. had, however, no inhibitions on making its stand clear. Its opposition to liberalisation of registration laws and practices as well as its prejudices were disseminated widely through their spokesmen in parliaments and the daily press and it has been alleged that a fighting fund was collected among members in the early 1950s to keep foreign qualified doctors unregistered.<sup>14</sup>

From the arguments presented for public consumption it is plain that the campaign was conducted with intolerant and emotional undertones designed to arouse xenophobia and a mistrust and fear of the foreign doctor. This lengthy and bitter activity relied largely on the dogmatic repetition of certain statements and accusations which fell roughly under the following nine headings:

1. *Absorptive capacity*: The absorptive capacity of the Australian medical profession is already stretched.
2. *Australia does not need specialists*: All European doctors are specialists who specialise from the earliest part of their study and therefore are unable even to attend a confinement. Consequently they are not suited to Australia where, because of local conditions, general practitioners are needed who can perform all types of medical tasks.
3. *Qualifications*: The medical qualifications of European graduates are low.
4. *The ethics* of European doctors are 'different', 'doubtful', 'not proper'.
5. *The lowering of standards*: The acceptance of foreign graduates 'will lower Australian standards which are the best in the world'. It is the duty of the Australian medical profession to safeguard these standards and not to 'let loose' medical practitioners used to the lower standards of the Continent.
6. *Australian registration practices are in line with those of other*

14. The fighting fund was reported to have been established soon after the arrival of D.P. doctors in Australia. Although no written evidence of this fund was found after the lapse of twenty years, the fund's existence was mentioned in an interview by a foreign qualified doctor who has recently retired after a very distinguished medical career. He attributed the chance of his being a recipient of the letter soliciting donations to such a fund to his early reputation, his rather English sounding name, and to the high position which he at that time held at the local branch of the A.M.A.

*developed countries:* Doctors not registered in Australia would be barred elsewhere too.

7. *Reciprocity:* Because the countries from which the displaced person medical practitioners come do not offer reciprocity to Australian doctors it is unreasonable for these doctors to expect registration in Australia.

8. *Language:* It is essential that a doctor and patient should thoroughly understand each other. The imperfect knowledge of English which foreign doctors possess makes them dangerous to the patients.

9. *Congregating in cities:* The European practitioners if allowed to practise would congregate in the cities.

Today most of these arguments would be recognised by the average Australian newspaper reader as rather specious. But in the early post-war years the medical profession, trusting in the unquestioned authority it traditionally had commanded, judged them to be useful tools in the formation of public opinion. Influential connections and financial resources were utilised, and the medical profession was able to mobilise members of medical boards, colleagues who held seats in parliaments, sympathising doctors in the upper hierarchies of the public services, members of medical faculties and sundry members of the A.M.A. who held positions of importance and influence in the community.

In view of the well-known shortages of doctors, and repeated requests by country hospitals for D.P. doctors, the greatest problem was that of convincing governments and public that there were already sufficient medical practitioners in Australia. Methods to achieve this included: propagation of a low doctor/patient ratio; use of this hypothetical ratio as a guide irrespective of uneven population and doctor distribution within the State; calculation of medical manpower from registers which included multiple registrations as well as names of inactive or dead doctors; the use of minimum figures in population projections but of maximum estimates for the output of local graduates.

It is helpful here to compare contemporary calculations made by medical boards and A.M.A. officials with a since published and thorough demographic study of medical manpower during the period; this shows that statements in the 1950s given for public consumption, or in answer to government inquiries, were both

confusing and sometimes misleading.<sup>15</sup>

The attacks against graduates of European medical schools on the basis that 'they are all specialists' were particularly inappropriate. These statements were not only untrue, but were aimed at denigrating foreign doctors exactly in that area of their medical background where they were clearly ahead and better qualified than many of their locally qualified counterparts; the statements were also dangerous to good medicine, because they were intended to encourage the retention of an outdated system which permitted general practitioners to perform complex specialist procedures.

The anachronistic A.M.A. defence of a 'high-grade general practitioner type'<sup>16</sup> did not, however, constitute the whole of the argument. By innuendo or outright misstatement the idea was spread that European specialists, who usually spent two or three additional years specialising after they had completed their first degree, were less qualified than an Australian G.P. who did the equivalent of first degree only. Statements like 'in most European countries the medical student specialised from his second year and became a pathologist, bacteriologist, obstetrician and so on',<sup>17</sup> no matter how absurd, were hard for the D.P. doctors to counter at a time when most were working shifts in factories, lived in rented rooms, had no journals or funds at their disposal and were unfamiliar with the finer points of the English language.

It is certainly true that qualifications and standards of Australian and European medical graduates did differ. First, students in Australia and Europe entered university at different ages, in possession of different levels of high school education, and the average age of 17 for matriculants in Australia in the 1950s was less than Europe's 18 or over.<sup>18</sup> Undergraduate medical courses were on the whole the

15. The study of Scotton (R. B. Scotton, 'Medical Manpower in Australia, 1933-1965', *Medical Journal of Australia*, vol.54/1, no.19, 12 May 1967, p.986) has shown that in 1952 the all-doctors/patient ratio in Australia was around 1:1,000 (it fell from 1:1,141 in 1947 to 1:979 in 1954). Dr Collins, President of the A.M.A., assured the Minister for Immigration in July 1951 that a ratio of 11.2 per 10,000 (1:893) would be reached soon without registration of foreign doctors, because 'it is estimated that the outgoings from Australian universities will overtake the deficiency by 1952 at the latest'. (Federal Council of the B.M.A. in Australia to Minister for Immigration, 13 June 1951. Department of Immigration, Corresp. File, CRS A446, item 58/66376, pt 1. C.A.O., Canberra.)

16. Federal Council of the B.M.A. in Australia to Minister for Immigration, op.cit.

17. *Advertiser*, Adelaide, 7 November 1950.

18. The German language periodical *Der Anker*, published in Sydney, made among others the following observation on the different preparation of Australian and German doctors.

same length, but the period of study behind any doctor – Australian or European – depended partly on the doctor's age, because both Australian and European universities lengthened their medical courses between 1900 and 1945 from 4 to about 6 to 6½ years. Though medical curricula were to a large extent alike, local variations were inevitable.

Overseas qualifications also differed from one to the other. The qualifications of the refugee doctors were not 'European' but Hungarian, Czech, Polish, Latvian, Yugoslav or Russian etc. As was later found by some experienced observers, Hungarians and perhaps Czechs turned out to be better trained than others, Polish and Baltic graduates had about the same level of training as Australians, while those qualifying in some Russian or Ukrainian institutions were less well trained.<sup>19</sup> Ukrainians and Russians, however, constituted less than 6 per cent of the D.P. doctor intake, and an independent and impartial examination system could have sorted out the lower qualified from their ranks. The campaign, however, insisted that all foreign graduates were of doubtful standard, and never gave a hint that, while some might be of lower standard, more were as well qualified as, or better qualified than the Australian 'high-grade general practitioner'.

Even vaguer were the accusations about the ethics of foreign doctors. Such charges already figured prominently in the literature against foreign doctors written during the late 1930s. Dr Maxwell in his letter to the *Medical Journal of Australia* in 1939 made much of 'what may be termed Eastern European standards of ethics' and used with free abandon expressions like 'flouting the law', 'surrep-

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The latter covered not only German but most other European doctors:

1. The general education of Australians is based on specialisation from an early age. In Europe, matriculation subjects are compulsory. Australian elective system means that there are doctors who have never studied geography, history, foreign languages, Latin, psychology or logic . . . Moreover, Australians can matriculate as early as the age of 16, while in Europe the age of matriculation is between 18 and 19 years. (Note: In the 1960s Australian high-school education was extended in most States by one year to bring it closer to world standards.)

2. The practical experience in Australia for a doctor is only one year in a hospital of over 60 beds. In Germany it is two years, and this in an accredited hospital, which has more beds, more doctors, and consequently provides a wider experience in problems and solutions.

The article concludes: 'The Australian student learns more about less, the German less about more, and is ahead two years in general knowledge.' (*Der Anker*, no.45, 1956:1).

19. Interviews with Dr J. Gunther, Dr G. Andrew and Dr X.Y. of Sydney.

titious practice', 'quack', 'effrontery', 'impudence', 'dishonesty', 'spurious' and 'exaggerated claims' – all these without introducing one shred of evidence.<sup>20</sup> Some of these terms may have been aroused by anti-Semitism, as the pre-war arrivals were mainly Jewish. The overwhelmingly Christian post-war D.P. doctors, however, were exposed to similar accusations. For example, in 1950 in Melbourne, it was reported that a 'senior medical man' warned that the 'government should be careful to insist on maintaining a high standard of both knowledge and ethics'.<sup>21</sup> Such statements obliquely casting slurs on European doctors were by no means infrequent and cropped up in the most unlikely places, as long as there was a doctor in the house. So in 1953 a Dr Mowatt used his position of a representative of the Queensland New Settlers' League to impede the successful settlement of doctors by asserting that 'although European schools of medicine are old and well established, their ethical outlook is vastly different to those of Britain'.<sup>22</sup>

The sting of these derogatory statements was enhanced by their vagueness, suggesting different interpretations to different people. Their likely message to the Australian doctor was perhaps that the foreign doctor could not be trusted in such professional relations as referral agreements, fee splitting, or cover-up in the case of a mistake. The same message to the prospective patient would have given rise to the notion that there was perhaps something unethical about the doctor-patient relation of these foreign practitioners and therefore they should not be 'let loose' on the unsuspecting Australian public.

Embittered about these unsupported and hurtful charges a group of foreign doctors wrote:

The ethics of the medical profession throughout the world date back to the Greek Hypocrates, and his oath is obeyed by the medical profession everywhere. No one can show that the Victorian Medical profession maintains a higher standard with regard to this oath than their overseas colleagues . . . watching the care of sick in Australia from different points of view, we

20. *Medical Journal of Australia*, vol.26/2, no.23, 16 December 1939, p.919.

21. *Herald*, Melbourne, 24 August 1950.

22. *Mercury*, Hobart, 24 January 1953.

do not consider the approach to the patients being here more ethical than anywhere else.

Financial standard . . . is one standard in which the local medical profession is definitely superior and we can assume that the non-registration of the alien doctors must be due to the non-compliance with this standard. Presumably these alien doctors lower the standard by treating the patient as a human being, and not a number (of guineas) to be dispensed with as swiftly as possible.<sup>23</sup>

Closely related to the issue of standards was the assertion that the doctors who were refused registration in Australia would not be registered in other countries either. While it was true that in most countries organisations connected with medical services were vigilant in keeping out the unqualified, and that medical associations in many countries endeavoured to restrict competition, the organised profession in Australia raised more barriers against refugee doctors than medical professions in other countries. For example in England and on the Continent, though a foreign doctor could not work in general practice on his own without registration, and formal recognition by the State (nostrification) was sometimes difficult, he could work in various hospitals and institutions.

In the United States of America, which accepted the largest number of displaced persons, foreign doctors were permitted to work as interns or residents in hospitals. No registration was required for such positions and hospitals in the post-war years were actively advertising for foreign graduates. Registration was necessary only if the doctor wished to set up private practice. In some States registrations were relatively easy to obtain, with or without examination, but in others, particularly in the South and in the West, serious obstacles were put in the way of applicants.<sup>24</sup> Nevertheless, irrespective of his chances of entering private practice — and some may not have desired to do this — the D.P. doctor in the United States could, almost from his arrival, begin work as an

23. U.D.A. 'Considerations Regarding Foreign Trained Doctors, Their Treatment, by The Medical Board of Victoria and by Members of the B.M.A. in This State'. MS. U.D.A. Archives, Melbourne, pp.6-7.

24. Alex M. Burgess, 'Resettlement of Refugee Physicians in the United States', *New England Journal of Medicine*, vol.247, 18 September 1952, pp.419-23.



intern or resident in a hospital. Also, if he wished later to enter private practice, he could achieve this ambition with relative ease, at least in some of the States.<sup>25</sup> Consequently, the assertions that Australian conditions of registration were no different from those in other developed countries were without foundation.

The most cogent and least hurtful argument used against the D.P. doctors was that, because registration authorities in the countries where these doctors qualified would not grant reciprocity to Australian graduates, it was unrealistic for them to demand the right to practise in Australia. This argument was met by the Department of Immigration with two counter arguments. First, the D.P. wave was a unique occurrence, and both the limited and finite numbers involved and the international interest attached to solving the refugee problem warranted a special approach. Secondly the doctors came as part of an immigration program which was bringing in over a million non-British potential patients to Australia; the exceptional intake and the special language needs and social customs and attitudes of the newcomers warranted the registration of numerous doctors of the same language and social background.

It was in this context that the language argument used against the immigrant doctors became a reversible weapon. Insistence on a good knowledge of English was a sensible precondition of practice in Australia. But the demand for good English, in order that the doctor would not misunderstand his patient, could be applied in reverse, as a basic human right of an immigrant to be treated by a doctor who understands him. It is unreasonable – commented the *Sun News Pictorial* in Melbourne – ‘to bring tens of thousands of potential patients from abroad and deny them the services of doctors familiar with their languages and problems’.<sup>26</sup>

The last argument, that on congregating in the cities, was

25. On changes in the intern system after 1958 see U.S.A. Council of International Affairs. *The International Migration of Talent and Skills; Proceedings of a Workshop and Conference*. Washington, Dept of State, 1966, pp.124-8, 142.

In addition to state registration, doctors could be licensed to practise through passing the examinations of one of the specialty boards, or to obtain the coveted National Board certificate which permits physicians to practise in any of the States of the U.S.A. However, Kosa has found that considerably fewer foreign-trained physicians than American-trained held these certificates in 1967, suggesting that ‘foreign training constitutes a handicap to the physician practising in the United States’. (John Kosa, ‘The Foreign Trained Physician in the United States’, *Journal of Medical Education*, vol.44, no.1, January 1969, pp.46-51.

26. 24 October 1951.

conjectural, because the profession was not to know where the D.P. doctors would settle, if and when allowed to practise. It was perhaps based on the experiences with pre-war registered foreign doctors, among whom there were a larger proportion of specialists, and who therefore may have preferred to live in larger cities.

However, considering that only rarely could an Australian doctor be found to undertake work in New Guinea, or to serve with an Antarctic expedition, and considering that many country areas on the mainland were without doctors, the A.M.A. membership was the least qualified to complain about unwillingness to go to distant areas. As it turned out D.P. doctors were by no means reluctant to live away from the cities. To be sure, initially their registrations often tied them to distant locations, but the fact that many remained there after their term expired indicates that some were less city-bound than doctors in the host society.

In summary it seems that the purpose of the publicity campaign was not only to exclude foreign doctors from practice but to discredit them, to instil a fear and mistrust of the foreigner so that public support might be marshalled against those State governments tempted to liberalise the laws or practices governing the registration of foreign graduates.<sup>27</sup> It was in keeping with the A.M.A. Federal Council's expressed policy, 'that under no circumstances should registration be liberalised unless with the proviso that the foreign graduate should complete at least the last three years' study in medicine at an Australian University and satisfy the University examiners'.<sup>28</sup>

As a ritualistic extension of this stand, occasionally suggestions were made that the Federal government, which introduced these immigrants into Australia, should pay for their re-qualification at an Australian university.<sup>29</sup> This suggestion, though it had the

27. The methods used by the A.M.A. in its campaign differed little from those which the organised profession used a few years earlier to fight the Labor Government's social security proposals, and which in the words of Professor Crisp both surprised and appalled Prime Minister Chifley: 'continued defiance of enacted law . . . misrepresentation, half-truth and downright untruth put about by certain Federal Councillors and other B.M.A. spokesmen and champions who were . . . by virtue of their offices in a position where they could not but know the true facts'. (L. F. Crisp, *Ben Chifley*, London, Longmans, 1960, p.317).

28. Federal Council of the B.M.A. in Australia to Minister for Immigration, op.cit.

29. Dr L. J. A. Parr, *N.S.W. Legislative Assembly*, 31 March 1955, p.3666. Similar suggestions were frequently made by officials of the A.M.A. in various States and given occasional press publicity.

appearance of reasonable constructiveness, neglected some of the salient issues, notably that most D.P. doctors were already well qualified, and that even if given scholarships some would not be able to use them on account of age or family responsibilities. In short, the proposal was strong on politics but weak on humanity: it was based on the foreknowledge that governments could not afford to offer scholarships to immigrants as long as Australian students had to pay their way through universities, and it neglected the fact that many fellow-Australians in country districts were in pressing need of resident medical help.

### Efforts to gain registration for D.P. doctors

Refugee doctors were obviously grossly handicapped in fighting the medical profession, especially soon after arrival. They were not only penniless but were under contract to the government and for two years had no right to refuse jobs allotted to them. As their job postings strewed them over the continent, their dispersal made the exchange of information or organised effort very difficult.

Not surprisingly, therefore, the first voices on behalf of the foreign doctors were not those of the doctors themselves but of Australians sympathetic to their predicament. As early as September 1949 Kim Beazley, the Federal Member for Fremantle, put a question on behalf of a Lithuanian doctor resident in Western Australia,<sup>30</sup> and thereafter kept the question alive, not only at Question Time in Parliament<sup>31</sup> but also in correspondence with the Minister for Immigration. He was one of the few parliamentarians who went further than demanding local registration for foreign doctors, and argued that the system of local registration for a foreign doctor 'is scientifically indefensible. If he is capable of treating people in a given area he is capable of treating them anywhere'.<sup>32</sup>

Intermittent interest was also shown at Question Time in Canberra by other parliamentarians in the early 1950s. On the whole the Minister for Immigration, Harold Holt, gave stereotype answers explaining that medical registration was a State matter,

30. *Australia: House of Representatives, Debates*, 30 September 1949, vol.204, p.778.

31. *Australia: House of Representatives, Debates*, 16 November 1951, vol.215, p.2213.

32. Beazley to Holt, 8 February 1950, *op.cit.*

that the problem was complex, being part of the wider issue of foreign professional qualifications, and that the Immigration Planning Council was conferring on the matter with representatives of the A.M.A.<sup>33</sup>

The first sign of an organised approach by the foreign doctors themselves came from South Australia where about twenty of them banded together under the leadership of a Dr Charles Gaal and in July 1950 approached the Department of Immigration. Their memorandum, which included a reiteration of the alleged promises, reads in part:

The Australian Authorities in Europe promised that we would be allocated appropriate positions according to our qualification. We were told also that if we are not allowed to work as medical officers to start we would be placed in scientific laboratories and other suitable jobs. Nobody thought in Europe that this 'suitable job' will be the duties of a medical orderly, nurse or wardsman. It seems paradoxical enough that while Australian doctors are eager to go to European Universities to brighten their medical knowledge and experience, the graduates of these Universities are not allowed to work as doctors in Australia. After many years training and experience in medical professions we have to work as plain workers here . . .

According to South Australian laws a European migrant doctor would not be able to resume his profession before the elapse of 6 years: 2 years as manual worker under the Government contract; ½ a year in preparation for the examination in anatomy, physiology and 3½ years of studies for the requalification.<sup>34</sup>

Although the South Australian D.P. doctors were able to command a measure of local publicity, political conditions under the almost interminable reign of Thomas Playford's Liberal government condemned them to wage a battle, which, if not completely

33. E.g. Holt to Beazley, 23 May 1950. *Australia: House of Representatives, Debates*, vol.208, p.3666; Holt to Sheehan, 1 November 1950, *ibid.*, vol.210, p.1767; the Minister for Immigration, through Senator Spicer to Senator Wedgwood. *Senate*, 8 November 1950.

34. Dr Gaal to the Department of Immigration, 20 July 1950, Adelaide. Department of Immigration Corresp. File, CRS A445, item 179/10/6, 20 July 1950. C.A.O., Canberra.

lost, turned out to be a very long siege. Their leader, Dr Gaal, who arrived in Adelaide in the middle of 1949, was himself registered only nineteen years later, in 1968.

These South Australian D.P. doctors were, however, able to obtain the help of the local Good Neighbour Council and although those on the council were unable to put pressure on the South Australian government, they exerted pressure in the Federal sphere.

The most significant grouping of foreign doctors emerged in Victoria, a year after the South Australian doctors began to band together. The first meeting of the Unregistered Doctors Association was held in Melbourne on 21 July 1951, under the leadership of Dr W. Didzys, Dr S. Weiner, Dr E. Paulikovics and Dr E. M. Miglic. The U.D.A. began its work by establishing a verification process which included the checking of the I.R.O. medical certificate, and the sighting of other relevant documents, as well as the U.D.A.'s own investigation of the applicant's professional background through correspondence and contacts. After establishing its membership file the U.D.A. was able to survey the extent of the problem and to compile statistical data on foreign doctors in Australia. In addition to contacting both Australian authorities and individuals who might be helpful in furthering their cause, they also collected information from overseas to facilitate the further migration of doctors to areas where their qualifications would be recognised. Asking a fair deal only for the properly qualified, the U.D.A. issued bulletins to its members, prepared submissions in which it countered the charges levelled against the qualifications and ethical standards of European doctors and generally kept the problem of foreign doctors alive.

As time went on the U.D.A. obtained the help of a number of generous Australian supporters including some influential journalists; of these John Hetherington became one of their most outspoken helpers. Gradually a small band of sympathising Australian doctors gathered around the leaders of the U.D.A.; these helped by creating intermediate, rehabilitating positions disguised as technical or research work, and by offering encouragement and help. A now highly respected, but in those days unregistered doctor, wrote about these Australian colleagues: 'No change could have ever been achieved without this numerically small, but vital group of men of integrity within the Australian profession itself. The sad fact that

an acknowledgement of their help could embarrass them even in 1973, is, on the other hand a proof of lingering "professional" prejudices'.<sup>35</sup>

The U.D.A. also gained the support of the St Thomas More Society in Melbourne, which till the end remained the only Australian medical group ever fully endorsing their cause. Due partly to the efforts of the U.D.A. and the Good Neighbour representatives from South Australia, the Third Australian Citizenship Convention (which met in Canberra from 29 January to 1 February 1952) passed a resolution about easing the registration of foreign doctors. Though earlier Citizenship Conventions had called for the recognition of foreign professional degrees and diplomas, this was the first time that a convention had passed a resolution dealing specifically with the recognition of medical qualifications. The resolution in paragraph 42 stated:<sup>36</sup>

That while recognising that medical standards in Australia must be maintained, Convention urges –

- (a) that every possible assistance should be given to skilled medical men to engage in their profession;
- (b) that the Commonwealth and State Governments be asked to determine the future of medical men brought to Australia under any of the assisted migration schemes;
- (c) that the Commonwealth and State Governments be requested to establish a small Committee of suitable medical men to examine each case individually and to arrive at definite conclusions in each case; and
- (d) that similar action be taken with regard to dentists and veterinary surgeons.

The resolution of this convention was forwarded to the Immigration Planning Council.

The Immigration Planning Council had since its second meeting in February 1950 concerned itself with the problems of the various professions among immigrants.<sup>37</sup> At its third meeting a month

35. Dr Y.Z., letter to E.F.K. 31.7.73.

36. Department of Immigration, *Report of Proceedings of Australia's Third Citizenship Convention*, Canberra, 1952, p.32.

37. Immigration Planning Council, 2nd Meeting, 8/2/1950. Minutes no.16.

later it had agreed that it would be desirable to invite senior executives of certain professional organisations to meet them in frank and open discussion.<sup>38</sup>

Although an invitation was extended to Dr A. J. Collins, President of the Federal Council of the A.M.A., by the third meeting in March, it was not until the eighth meeting in July that A.M.A. representatives attended. At this meeting, the Federal President Dr Collins opposed the liberalisation of existing registration laws and practices. Basing his views on his own personal experience and observations he asserted that European doctors receive a basic training different from that received by Australian doctors, that European doctors specialise from the fourth year, and that many were comparatively untrained in various aspects of their profession, particularly in obstetrics. Finally, he claimed that in his experience the three years of study demanded by the New South Wales statute from foreign doctors at Sydney University 'is not too much'.

Adding to the President's points Dr H. R. Grieve, Executive Member of the A.M.A. and a member of the Medical Board of N.S.W.,<sup>39</sup> warned that 'whatever is done in relation to the foreign doctors already in Australia will provide a pattern for the future'. He also stated that anticipated local output of graduates plus the expected intake of British doctors would 'adequately meet the needs of Australia's expanding population during the next ten years'. (This was a different conclusion from that reached by the Department of Labour and National Service.) Dr Grieve concluded by suggesting that the Federal government might assist foreign doctors to become eligible for registration by subsidising their three years' training at the university.

Dr Hunter, Secretary of the A.M.A., noted that 'experience has shown that foreign graduates prefer city practices and are extremely reluctant to undertake or remain in practice in sparsely populated regions'.<sup>40</sup> Nevertheless, the meeting agreed to set up a special sub-

38. Third Meeting, 28/3/1950. Minutes no.37.

39. Dr Grieve was also a member of the A.M.A. Council of several years standing. At the end of the 1930s he served on the A.M.A.'s National Health Insurance Committee, which put the profession's view before a Royal Commission inquiring into health insurance. By a judicious combination of manoeuvring and stalling the committee succeeded in having the issue shelved. (Hunter, *Politics of National Health*, pp.73-5). Sir (Herbert) Ronald Grieve is now the President of the Medical Benefit Fund of Australia.

40. Immigration Planning Council, Eighth Meeting, 17/7/1951. Minute no.131.

committee. The A.M.A. in October 1950 advised the minister that a special committee comprising Sir Victor Hurley, Dr A. J. Collins (then Vice-President), Dr Grieve and Dr A. E. Lee, University of Queensland, had been established to investigate problems connected with the absorption of foreign medical practitioners, particularly in the light of the absorptive capacity of the Australian medical profession.

The negotiations of the Immigration Planning Council with the Australian Medical Association brought into being a series of well-prepared statistics on the absorptive capacity of the medical profession all of which were in turn rejected by the A.M.A. Committee. The proceedings also resulted in the collection of valuable information on the number of unregistered foreign doctors and in the compilation of notes on existing State legislations relating to foreign medical practitioners. However, all the efforts of the Department of Immigration foundered on the unyielding attitude of the A.M.A. representatives. Delaying its final answer for over a year, the A.M.A. eventually summarised it in a letter sent on behalf of its Federal Council to the Minister for Immigration on 13 June 1951. Not in the least hesitant to influence registration policies in Australia, the A.M.A.'s letter was in essence a compendium of the points voiced by restrictionist doctors, registration boards and universities, and in no unclear terms stated that 'The Council is . . . of the opinion that under no circumstances should registration be liberalised unless with the proviso that the foreign graduate should complete at least the last three years' study in medicine at an Australian University and satisfy the University examiners'.<sup>41</sup> Because during the subsequent discussions the A.M.A. remained completely committed to its policy of restriction, the Department of Immigration in 1953 suggested that the negotiations with the A.M.A. should be discontinued.<sup>42</sup> From then on, the matter gradually dropped from the agenda of the council.

Though the efforts of the Immigration Planning Council on behalf of foreign doctors remained unproductive they were not without some influence on events. The prolonged negotiations gave to some of the foreign doctors and their supporters a genuine hope

41. Federal Council of the B.M.A. in Australia to Minister for Immigration, *op.cit.*

42. Memorandum. Principal Research Officer, 2 April 1953, Department of Immigration Corresp. File, CRS A446, item 58/66378, pt 2. C.A.O., Canberra.



that a change in policy might be at hand; the mere fact that the A.M.A. was willing to discuss the matter with the Immigration Planning Council over such a long period suggested that the D.P. doctors had a strong case and that the A.M.A. was fighting a rear-guard action by stalling. The negotiations certainly enabled the Minister for Immigration to answer questions in Parliament by routine answers on the complexity of the problem and on the present detailed examination given by the Immigration Planning Council.

In 1953 the Secretary of the U.D.A. attended the Citizenship Convention in Canberra and submitted proposals for the solution of the migrant doctor problem. The proposals in brief were the following:

1. Constitution of an organizing authority (Federal) to prepare a plan of resettlement of immigrant doctors;
2. Revision of propaganda methods used in Europe;
3. Abolition of rehabilitation by means of repeated study, which is usually an unnecessary hardship and overburdens the universities. A year's clinical work under supervision should be followed by an appropriate examination;
4. Permitting a quota of one doctor per 1,000 immigrants to enter the country;
5. Employment of doctors in reception centres;
6. Compilation of a Federal file of professional people (e.g. Professional Medical Register of I.R.O.) and a service for verification and translation of documents.<sup>43</sup>

These proposals, though both responsible and realistic, remained unsuccessful. Nevertheless the work of the U.D.A. as well as the work of the Adelaide doctors and other scattered groups did in time result in a more sympathetic press.<sup>44</sup>

43. This wording follows the version published in *The Australian and New Zealand General Practitioner*, 15 May 1954. MS. variants in the U.D.A. Archives, although they differ in the order of points, and occasionally in text, on the whole convey the same message.

44. Some of the immigrant organisations conducted their own campaigns. Because Hungarians were the most numerous amongst the D.P. doctors and most of them were living in N.S.W., the Council of Hungarian Associations in New South Wales was particularly active on their behalf, and between 1952-5 conducted an extensive correspondence with N.S.W. State politicians. (Cf. the council's file on doctors held by the Editor of the *Ausztráliai Magyarok*, Sydney.)

Not only did such important newspapers as the *Sydney Morning Herald*, the *Age*, and the *Argus* grow gradually in favour of the D.P. doctors but they also received the backing of the *Australian and New Zealand General Practitioner*, a publication at loggerheads with the Australian Medical Association and therefore more open to their cause. Commenting on the U.D.A. proposals the journal noted that the A.M.A. has repeatedly stated that it cannot and will not initiate any move in the matter:

. . . whilst this washing of hands may be correct from a formal viewpoint and is also in the interests of its members it can hardly satisfy those whose consciences may be a little uneasy in the matter, nor the unregistered doctors themselves, who rightly ask that their claims be at least investigated . . .

Among these claims is the rather startling statement that many of them were attracted to Australia under false pretences, and that they were given the impression, fostered officially by migration authorities, and documents that there would be few obstacles in the way of their practising medicine in Australia. This suggestion of breach of faith or contract certainly demands verification . . .

Certainly there is little in their listed proposals that even the most conservative elements of the Australian profession could object to, and the least that we can do is, by an official enquiry, commission or other means, properly and fairly to consider them.<sup>45</sup>

In the event the problem was, though belatedly, tackled by the States, not by the Commonwealth. And although the Commonwealth did put the issue on the agenda of various Premiers' Conferences from 1950 onwards, there is a clear indication that whatever changes occurred did not arise from Commonwealth representations, but from changing political power within the States.

In this respect the resolution of the A.L.P. Federal Conference of 1953 was probably of the greatest importance. The resolution directed Labor governments to break the A.M.A. stranglehold on the health services, so that those with proved qualifications could

45. *The Australian and New Zealand General Practitioner*, 15 May 1954.

ease the shortage of doctors, particularly in country areas.<sup>46</sup> This resolution came as a welcome guidance for Labor Ministers of Health in various States who, like their Liberal or Country Party counterparts, had the extremely difficult task of supplying doctors for country areas and filling the salaried positions in State medical departments and in hospitals. With this political lever behind them, some of them were stirred to action.

Depending on the political party in power and the particular degree of shortage facing each State, the chances which a foreign practitioner had to become registered varied from State to State. Nevertheless, even where registration was made possible for foreign graduates, either strict quota or residential qualifications were also applied; therefore at no time could a situation develop where registration in a State became so easy as to promote a rush of unregistered medical practitioners from other States. Because of the great differences between States the situation in each through the years from 1948 to the 1960s will be sketched in detail, beginning with the States where the registration of foreign practitioners became feasible relatively early.

#### *Western Australia*

Originally conceived as a war measure, an amendment to the Medical Act of Western Australia provided that the Governor could declare as a special 'region' any district without adequate medical services, and could also declare as an 'auxiliary service' any hospital or health agency which lacked adequate medical manpower. The medical board could then select a doctor holding a foreign degree to serve as a Junior Resident Medical Officer to an approved hospital for at least three months. If the responsible medical officer at the hospital then granted him a 'Certificate of Competency' he was appointed to the 'region' or 'auxiliary service' for one year. Practice was restricted to this particular 'region' or 'auxiliary service' and the licence was renewable every year. Up to the beginning of 1950 all former country regions were filled by practitioners registered in the normal way. During 1949, however, because of the short supply of Junior Resident Medical Officers at the Fremantle Hospital, two displaced person doctors were registered in these vacancies tem-

46. *Herald*, Melbourne, 12 December 1955. Column by E. W. Tipping.

porarily. These appointments proved so successful that others were registered in some other 'regions' and 'auxiliary services'. Doctors who practised for seven years in a 'region', or three years in an 'auxiliary service' became eligible for full registration in the State.

Although Western Australia was the first of the States to employ D.P. doctors without forcing them to undergo a local course in medicine, the opportunities for foreign doctors remained limited to periodic vacancies in 'regions' and 'auxiliary services'. Apart from securing the services of doctors in these unattractive positions, the attitude of the registration board remained 'utterly negative', as the Member for Fremantle, Kim Beazley noted in a letter to the Minister for Immigration.<sup>47</sup> Nevertheless, because of the extensive sparsely populated areas of the State, and the late establishment of a full medical course at the University of Western Australia, restricted registrations were relatively numerous, and became periodically available until the early 1960s.

The principal part of the Medical Act, however, was changed neither by the various Liberal-Country League governments nor during the Labor government's six years' rule between 1953 and 1959. The Western Australian Act consequently has retained a paragraph which excludes from registration properly qualified and otherwise acceptable medical practitioners, unless the countries of their origin offer reciprocal rights of registration to Australian doctors.

### *Tasmania*

Tasmania under the Labor Cosgrove government had already in 1951 made amendments to the Tasmanian Medical Act. These amendments aimed partly at clearing the way for registering foreign doctors who had requalified at an Australian university by completing at least the final three years. This was necessary because Tasmania had no medical faculty and, being short of doctors, wished to attract medical practitioners who had completed the last three years at the medical schools of the mainland. The Act stipulated that persons so registered would have to remain in the Tasmanian State Medical Service for at least five years. A more

47. Beazley to Holt. 8 Feb. 1950. Department of Immigration Corresp. File, CRS A445, item 179/10/6. C.A.O., Canberra.

important amendment of the Act provided for the granting in 1952 and 1953 of special licences to a total of ten approved applicants who had (a) undergone supplementary training by serving twelve months in a Tasmanian hospital; (b) passed an examination by recognised medical school examiners. Those obtaining these special licences were restricted to practising in areas designated by the Minister for Health. The licence was renewable each year, but after five years the licensee became eligible to practise anywhere in the State provided that he was then a British subject.

In July 1951 the Minister for Health, Dr Turnbull, stated that the State would register five doctors in each of the following two years; four of these in each year would be general practitioners and one a specialist in either psychiatry or tuberculosis.

Although Tasmania was distant from the States where most of the displaced person doctors lived, as soon as the news spread throughout the nation more than fifty alien doctors (including non-D.P.s) applied for registration;<sup>48</sup> Dr Turnbull was reported to have said that among the applicants were a number with 'splendid qualifications, and the task of making a selection would be difficult'.<sup>49</sup>

The Tasmanian experiment drew comments from other States. Noting that non-British doctors could serve in specified parts of Western Australia, the *Bendigo Advertiser*<sup>50</sup> commented that the West had both overcome the desperate need for doctors in outback areas and provided its migrant doctors with a very fair grounding in Australian conditions. Tasmania had gone a step further. While showing the right way, 'the plan falls short only in its limitation of numbers. These plans could be applied to Victoria with very good results and would go a long way to relieving a situation which, because of insufficient facilities and space, our universities will never be able to remedy'.

At the 1952 examination two of the three doctors presenting themselves for examination were failed. In 1953 four doctors were passed. Commenting on the 1953 examinations, Dr Turnbull said 'the standard shown by two of the four doctors successful . . . was well above that required of Australian doctors. The average standard

48. *Mercury*, Hobart, 19 July 1951. 'Alien Doctors Seek to Enrol'.

49. *Mercury*, Hobart, 25 July 1951. 'Six Alien Doctors Soon'.

50. 22 September 1951.

of the four was much higher than that shown last year'.<sup>51</sup> After passing the examinations the doctors spent their five years in State government posts, and thereafter were permitted to practise anywhere in the State.

### *New South Wales*

Following the success of the Tasmanian scheme and the decision of the A.L.P. Conference of 1953, efforts were made in other States to introduce similar laws and to use displaced person doctors to alleviate the drastic shortage of doctors in country areas and hospitals. In March 1955, on the recommendation of Health Minister O'Sullivan, the New South Wales Labor government presented a Bill which provided that foreign doctors selected by the medical board, and approved by the Sydney University examiners, be authorised to practise in specified places and under conditions to be prescribed. The Bill further provided that after five years of licensed practice they would have the right to full registration.

The Bill went through the Parliament without being strongly contested by the opposition. The only speaker criticising the Bill was Dr Parr, Liberal member for Burwood, a medical practitioner and a member of the Australian Medical Association. Dr Parr opposed the legislation and after claiming that the profession had never shown any dislike to qualified men who came from other countries and wished to practise medicine in Australia, continued:

However, we have an extremely high standard, which has taken our graduates into the foremost positions in the world; men of capacity, of brilliance and great learning. Having such a great record and tradition behind it, the profession has always been determined that it will safeguard the standard of medicine in this State and the Commonwealth as best it can, and give the people the very best service. This bill does justice to a large number of men who have had to leave their own lands and come to this country . . . Hon. members must remember that the standards of medical practice in Europe are vastly different from our own. I have learnt from many medical men from other countries the conditions of practice overseas. Many of their

51. *Advocate*, Burnie, Tas. 8 October 1953.

graduates, after leaving hospitals, went out as practitioners without ever having opened an ordinary abscess or attended a confinement.<sup>52</sup>

During the debate members on both sides of the House admitted that there was a substantial shortage of medical practitioners in both country and State hospitals and the figure of fifty vacancies in New South Wales was mentioned by one speaker.

The Bill inserted paragraph 21 B into the Medical Act. Under this paragraph, during two examinations held in 1955 and 1956 altogether twenty doctors were passed, and forty failed. Of the latter three failed in both years. It is not clear how many of those sitting for the examinations were former D.P.s. However, because twenty-five of the doctors submitting themselves to the examination were born in countries from which displaced persons were drawn, and ten of these passed, the passing rate of the displaced persons appears to have been better than the average of those who sat for the examinations under the Act.<sup>53</sup>

In March 1956, W. F. Sheahan, the former Attorney-General, in a re-shuffle of the N.S.W. State Cabinet, was appointed Minister for Health. Sheahan, a man well known for his strong convictions and indomitable character, immediately set out to see that obstructions preventing the provision by the Health Department of doctors for hospitals and country areas would be eliminated, and that at the same time fair treatment would be given to foreign doctors.

Hoping that he would be able to sway the majority of the State health ministers to act in unison, he brought up the question at the State Health Ministers' Conference in Hobart early in 1957. This meeting, which had Sheahan's proposal on its agenda as one of its most important topics, was all but ignored by the Federal Minister for Health (Dr Cameron), who paid the conference only an unscheduled visit of a few hours. Unsuccessful in convincing other State ministers to act, Sheahan returned to Sydney and decided to make New South Wales the first State which would give not only a *de jure*, but also a *de facto* chance to well qualified doctors among the migrants. 'What is the use of having the brother-

52. *N.S.W. Legislative Assembly, Debates*, 31 March 1955, p.3664.

53. Hilder, 'One Hundred and Twenty Years', pp.66-8.

hood of men as an ideal if we are not prepared to consider foreign doctors human beings. This matter should be approached not with frivolity or prejudice, but with common sense and justice' said Sheahan in the Parliament some weeks after his return, when introducing the Medical Practitioner Amendment Bill of 1957.<sup>54</sup>

Justifying the need for a new Bill only two years after the earlier amendment, Sheahan referred to the fact that the medical board and the examination committees were frustrating the work of the Medical Act. This, Sheahan said, they did by misinterpreting paragraph 17(2), (the 'specialist section') as if it was intended to refer to specialists of exceptionally high reputation only, and by setting under paragraph 26(1) unreasonable examination standards.

I said to them, 'You tell me the universities that you say are not of the status or the standard of the University of Sydney. I will be very much obliged if you will give me that information, for then I shall know, how to act'. Frankly, no one at the deputation was willing to give me that information . . . I for one would never subscribe to the opinion, which has been expressed publicly, that some of the greatest universities in Europe are inferior to the Sydney University.<sup>55</sup>

The debate followed mainly political lines; the leader of the N.S.W. Country Party, Colonel Bruxner, a close associate of the Federal leader of the Country Party, Sir Earle Page, the Federal Minister for Health, was chief spokesman for the opposition to the Bill. If his utterances sounded strange to some, they were no doubt received with the enthusiastic support of the medical profession in Australia.

My colleagues and I will be quite fair, always provided that the Minister has no intention of lowering the standard of medical service in this country, which is not exceeded anywhere else in the world.

. . . I have heard suggestions that there are in this country men with degrees in medicine and surgery far superior to those granted by our own University of Sydney who are not allowed to prac-

54. *N.S.W. Legislative Assembly, Debates*, 27 March 1957, p.4140.

55. *Ibid.*, 2 April 1957, pp.4286-7.



tise. Of course, that is ridiculous nonsense! I hate to hear even a suggestion that any medical school surpasses our own University of Sydney, which has produced some of the greatest and most progressive men in the medical world who are leaders in their own spheres . . .

. . . Those of us who have seen the practical work of the . . . [Bush Nursing Association] in country districts would prefer the service of a highly qualified nursing sister to those of a doubtfully competent doctor.<sup>56</sup>

The Bill, with the full support of the Labor Party, was finally passed, giving the Minister for Health authority to override the recommendations of his medical board in registering foreign doctors for practice in New South Wales.

Sheahan justified the legislation partly by the frustrations which he had experienced from his own medical board, composed solely of doctors, and partly by referring to the high quality of service given by refugee doctors already registered. After reading praises of foreign doctors from country hospital boards Sheahan significantly noted:

I might add, also, that during all the stress that we have experienced, and all the propaganda in certain places, not one complaint has been received by my department from one region where these doctors are practising, nor has there been any complaint about those who are employed in our public institutions.<sup>57</sup>

The introduction of the Medical Practitioners Bill of 1957 in the New South Wales Parliament, and its successful passing into law, was the most important event in the long drawn-out battle to break the medical profession's opposition to the recognition of foreign medical qualifications in Australia. It was a personal victory for Sheahan and it signified at least in New South Wales a reversal of the situation: the accused, defenceless and humiliated foreign medical practitioners, were given a chance, while their all-powerful persecutors in the medical and examination boards were publicly marked as unreasonable and selfish, and were divested of the power

56. *Ibid.*, 27 March 1957, p.4135.

57. *Ibid.*, 2 April 1957, p.4281.

to prevent the newcomer from competing against them.

That this change could come about was due to a number of factors of which not the least was the strong character of the minister. But through increased foreign travel, and through the grudging registration of a limited number of doctors, more and more Australians became exposed to foreign medical practitioners and realised that the statement repeated *ad nauseam* by the A.M.A., that only Australian or British doctors were good doctors, was absurd. In this respect, the very overstatement and hard-heartedness of the campaign backfired on the medical profession. Also, as the needs of country areas became better known, the registration board's unco-operative attitude became less tolerated by the press, the general public and by hospital boards in need of staff.

The sympathy and emotions aroused by the arrival of new waves of Hungarian refugees in the months following November 1956 may also have had their effect: certainly the doctors among them were the first beneficiaries of the N.S.W. Amendment Act of 1957.

### Queensland

Because of the very evident shortage of doctors in Queensland, the Labor government of Vincent Gair had little difficulty in amending the State's Medical Act in 1955. Also, because the amendment allowing a more liberal registration of foreign practitioners was part of a major revision of the Act, which extended to such controversial issues as the notification of suspected abortions, opposition to the Bill concentrated mainly on issues away from the registration of foreign qualified doctors. The Bill, assented to in November 1955, provided for the registration of doctors from universities other than those listed in the Act, provided that the persons had studied for at least five years at a university of no less standing than that of the University of Queensland, and had undergone an examination in medicine, surgery and obstetrics by examiners appointed from Queensland University. The examination committee was empowered to recommend either immediate registration, rejection or, if it found the candidate's knowledge sufficient but that he had been out of touch with medicine for too long, a twelve months' hospital appointment under supervision.

The number of D.P.s registered under the Act is not known. Because only a few D.P. doctors lived in Queensland by the end of

1955, and because by the time the Act was passed similar provisions of the N.S.W. Act of 1955 made migration to the north unnecessary for those who had not requalified through completing university courses, it is thought that only a handful of former D.P. doctors became registered under the provision of this Act. There was one in the sample of twenty-three who did so.

### *Victoria*

The fact that Victoria was their point of arrival in Australia turned out to be rather unfortunate for many D.P. doctors. Not only did Melbourne University offer re-qualification for foreign medical graduates on conditions more stringent than other universities, but the Liberal-Country Party government in Victoria, and the strongly entrenched exclusivist Victorian Medical Board, went to extremes in interpreting the Act so as to frustrate registration of foreign practitioners.

An indication of the bias with which the Victorian Medical Board defended its closed shop system was a statement by its Chairman, Sir John Newman-Morris,<sup>58</sup> in which he described Victoria's 1:1,100 doctor:patient ratio as satisfactory.<sup>59</sup>

In spite of some early but inconclusive efforts made in 1951 by W. Fulton, the Minister for Health in MacDonal's Country Party government,<sup>60</sup> in spite of frequent newspaper publicity about the needs for doctors in country areas, and in spite of the work of the Melbourne based U.D.A. in arousing the conscience of the press, no changes were contemplated in Victoria in the Act or in its working until late 1956.

Between 1952 and 1955 John Cain's Labor government succeeded to the Treasury benches. Although Cain had criticised the previous government for not easing the registration of doctors, his Minister for Health, W. P. Barry, did not improve the situation. The first change in Victoria came in May 1956, after Tasmania, Queens-

58. Sir John Newman-Morris was an outstanding medical politician, who personified the triangular power structure of the A.M.A. in Australia. He was not only President of the Medical Board in Victoria but for over 15 years Chairman of the Council of the A.M.A. He was also a member of the Council of Melbourne University and its Deputy Chancellor in 1951.

59. *Advocate*, Innisfail, Queensland, 3 August 1950. 'No Urgent Need for Migrant Doctors'.

60. *Argus*, Melbourne, 25 October 1951. 'Inquiry Ordered on Doctors'.

land and New South Wales had all to varying degrees liberalised the admission of foreign practitioners. The passing of the Alien Doctors Act by the Bolte government provided for the registration of graduates of any university who 'possess the 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'.

The Bill, heralded as a significant innovation which would open the door to foreign practitioners,<sup>61</sup> turned out to be one of the most farcical and heartbreaking exercises in the history of foreign medical registration in Australia. After receiving 102 applications in writing, and procrastinating for over five months, the medical board, without granting interviews, advised 94 of the 102 applicants that they were found unacceptable. Significantly, the eight doctors who were registered were in no dire need of registration as they all held research or teaching appointments and none of them wished to engage in private practice.<sup>62</sup>

Embittered by the high-handed action of the medical board, the U.D.A. issued the following statement:

The doctors, trained elsewhere than in Australia and countries without reciprocity agreements, looked forward to a settlement, assimilation and citizenship in a free country with possibilities for them and their families . . . We expected a larger horizon and more understanding from our own professional group – we are amazed how shortsighted they are. After all you cannot develop a country only with muscles. The greater part of the migrant doctors are Australian Citizens. That does not mean that they are settled and assimilated.

There is much talk about a '*second generation of migrants becoming true Australians*' . . . Our fantasy simply fails to visualize a child becoming a happy and loyal citizen, in full knowledge that his parents are being humiliated because it happened that that were not trained in Australia. We doubt whether Australian parents would allow their children to assimilate in another country under similar circumstances.

. . . Intolerance will not lead to the settlement of a foreigner.

61. *Herald*, Melbourne, 17 April 1956.

62. *Herald*, Melbourne, 15 November 1956.

A university graduate cannot compete with a trained workman and here his fellow professionals are completely cutting him off from the field in which he could do his best. It is an indirect punishment for these men to find themselves confronted with jobs, situations and surroundings completely strange to their backgrounds and education.

We therefore feel that the Medical Board of Victoria has been more than unreasonable and has definitely not used its discretion. Therefore we trust that our energetic Government will find a satisfactory way to undo a very grave injustice, both to the alien doctors and the people of Victoria.<sup>63</sup>

Public opinion was expressed in the writing of a popular columnist:

I'm not becoming unduly ruffled about the stiffly-starched, B.M.A. dominated Victorian Medical Board.

But I join the hundreds of thousands of rebels who say there should be a curb on this tight little coterie's activities . . . Consider this incredible sequence of events:—

The Commonwealth immigration policy has brought us many doctors with European training. Some are graduates of world-famous universities.

But the British Medical Association — tightest union in the country, many people say — has set its face sternly against accepting foreigners, except on almost impossible conditions.

Last year the State Government realised the absurdity of a virtual blanket ban and passed legislation designed to ease the way for alien doctors . . . but apparently didn't realise how swiftly the B.M.A.-sponsored members of the . . . authority would seize upon loose wording in the act . . .

There is clearly a shortage of doctors in Australia.

Scores of country towns have no medical service because Australian graduates are disinclined to leave the cities.

Suburban residents are short of doctors and public hospitals have inadequate medical staffs.

63. Considerations Regarding Foreign Trained Doctors; Their Treatment by the Medical Board of Victoria and by Members of the B.M.A. in this State. MS. U.D.A. Archives, Melbourne, pp.8-9.

But the Medical Board, with the clear backing of the B.M.A., is sticking sternly to its formula of rejection unless the letter of the law is met . . .

No one wants unskilled practitioners in Victorian consulting rooms, and it is obvious that aliens must have a thorough knowledge of the English language before being allowed to practise here. But the Medical Board's prohibitions are against the public interest.<sup>64</sup>

In the face of public outcry a new Act was drafted in 1957 under which foreign medical practitioners could be registered after passing examinations in medicine, surgery and obstetrics. The examinations, particularly in 1958 and 1959, were conducted in a way which ensured a very high failure rate; also examinees had to pass in all the three subjects in the same year, and no credits were given for passes in one or two subjects. There was at least one doctor who in each of three consecutive years was passed in two, but failed in one subject, in each year a different one, and consequently was not eligible for registration though by that time he had passed every subject twice.

However, the pass rates increased as time went on, and by 1960 more than half of those sitting for the examinations were granted registration. Examination at an advanced age in a foreign language, and after the substantial break in practice which migration to Australia involved, was not easy for all. The improvement in the pass rate was partly due to a group of Australian doctors who generously went to the help of the foreign medical practitioners by holding three-month courses for them at Prince Henry and Queen Victoria Hospitals. The courses concentrated on Anglo-Saxon terminology, on particular subjects favoured by Australian examiners, and on the latest developments missed by the doctors in their ten years away from the practice of medicine.

### *South Australia*

The number of doctors who arrived through Woodside Centre was estimated at no more than forty. Those who remained in South Australia had to fight the longest battle for their recognition.

64. *Sun*, Melbourne, 15 January 1957. R. Leonard, 'These Alien Doctors need Justice'.

The only way the Medical Board of South Australia, consisting of five doctors, would grant registration to a foreign medical practitioner was if he had passed through the last three-and-a-half years of the medical course at Adelaide University. This some of the doctors were able to do – the estimate on p.51 indicates that perhaps nine had done so – others were, however, held back by age, finance, or family commitments.

In 1955 the *Adelaide News* published a long article on the migrant doctors, reproduced the photographs of some and listed their occupations in Australia:

One man, a general practitioner, is a laborer in a shipyard at Port Adelaide.

A Latvian woman, a skin and V.D. specialist, is a cleaner at the University.

A Polish gynaecologist is a porter with the S.A. Railways.

A Latvian dermatologist is a clerk at a washing machine factory.

An Estonian woman doctor, a general practitioner and child specialist was a waitress for the S.A. Railways until she decided to stay at home.

A Polish doctor is a laborer at a textile factory.

A Lithuanian general practitioner who had specialised in tuberculosis is a truck driver for a Hindley Street furniture shop.

There are plenty more, like the Ukrainian doctor, an expert in forensic medicine who is a laborer at Holdens. They have all tried to get registration as medical practitioners in South Australia. They have been told they are not good enough. We won't recognise their qualifications.<sup>65</sup>

Their situation remained unchanged during the long rule of Playford's Liberal government.

One year after Labor taking office, the South Australian Parliament passed a Medical Practitioners' Amendment Act, which was assented to on 10 November 1966. The section dealing with registration of foreign practitioners closely followed the Victorian legislation, and incorporated the paragraph which required the foreign doctor to possess 'medical or surgical knowledge, experi-

ence 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 South Australia'.<sup>66</sup> This was the clause which had allowed such arbitrary interpretation by the Victorian board. In line with the second Victorian Act, it also set up a Foreign Practitioners' Assessment Committee to give guidance to the board. The law was introduced as a temporary measure, and its operations were to cease by the end of 1971.

Giving ample latitude to the board, and coming a decade after more liberal legislation in other States, the Bill was not opposed by the board nor by the S.A. Branch of the A.M.A.<sup>67</sup>

Also, coming so long after the arrival of the D.P. doctors, few of them were left in South Australia to take advantage of the new Act. This rather incongruous registration of a handful of D.P. doctors after they had been denied access to practice for some seventeen years, highlighted the absurdity of the situation. Truly, community interest, justice and common sense played a very small part in the recognition of foreign medical degrees under the various State laws of Australia.

### **Scientific and research appointments**

A handful of doctors, though forced to give up the practice of medicine, were able to utilise their knowledge by accepting appointments as research scientists with the CSIRO, the Australian Army and with various State research institutes.

The number of those who were able to obtain these satisfying positions was, however, small. It is estimated that perhaps ten former D.P. doctors – amounting to about 3 per cent of the intake – received such permanent appointments.

### **Appointment to the Australian National Antarctic Research Expedition**

To a handful of D.P. doctors who were forced into menial jobs in hospitals, or were working completely outside the medical field, a

66. Medical Practitioners (Amendment) Act 1966. Para.19(b).

67. S.A. *Parliament, Debates*, 17 September 1966.



chance for professional employment came through the advertisements of the Department of External Affairs for medical officers for its Antarctic (A.N.A.R.E.) stations.

For those eventually selected, the appointment heralded a year of professional employment, bringing with it opportunities to catch up with advances in medicine, to refresh unused skills and – when the year was over – to resume their former occupations as process workers, filing clerks or hospital orderlies. Because the appointments were for a year only, those who served in the Antarctic did not benefit from the legislations enacted in the mid-1950s in Queensland, New South Wales and Tasmania, which gave to those who completed five years in New Guinea the right to registration.

The work of the A.N.A.R.E. was controlled from Melbourne by the Department of External Affairs. In the 1950s there were two permanent research stations, one at Macquarie Island, and one at Heard Island; after 1954 the latter ceased to operate as a permanent Research station. Each year the staffs of the stations were relieved, and the new crew included a new medical officer for each station. Because few Australian doctors volunteered for service in Antarctica, up to the end of the 1950s the medical officers responsible for the health of scientists in the parties mostly came from the pool of unregistered D.P. doctors. With the coming of the 1960s, refugees of the Hungarian Revolution of 1956 gradually replaced the former D.P.s among the Antarctic medical officers.

In addition to filling the role of medical officers with the expedition, some D.P. doctors joined as weather observers. The appointments were generally successful and quite a number of the D.P. doctors were recalled to serve again. In this way, though probably no more than perhaps six D.P. doctors served in Antarctica, in years their cumulative service amounted to about double of their number.

On their return to Melbourne almost all of the doctors attempted to gain registration with the Victorian Medical Board, but each in turn fell foul of the extremely restrictive policies of the board, headed by Sir John Newman-Morris.

The careers of these Antarctic doctors are not without interest. A Czech doctor, who served two consecutive years at Heard Island, unable to secure registration on his return to Victoria, finally re-

qualified by passing through the course at the University of Sydney. A Ukrainian doctor who served at Heard Island in 1950 as a biologist and at Macquarie Island in 1954, worked between the two appointments in a non-professional capacity. A Hungarian doctor who was reduced to the position of male nurse until appointed medical officer at Macquarie Island in 1955, was given a clerical assistant's position on his return to Melbourne. With the 1956 Act operating he applied to the medical board in writing. Though an author of scientific papers on nutritional problems in the Antarctic, and on the zoology of Macquarie Island, he was duly notified in a carbon copy letter that 'the Board has decided not to grant you a certificate of qualification under the Act'. Recalled to Antarctica in 1957 he did a year's service there again, and on his return he sat for examinations under the 1958 Act but was failed in different subjects in turn for several years. Returning from a third spell as Medical Officer at Macquarie Island in 1959, he was finally passed in 1960.

A Czech doctor was similarly failed after his return as a successful medical officer with A.N.A.R.E. This doctor was accepted later by the New Guinea Health Department, and served the Commonwealth for many years, including another voluntary spell in Antarctica.

The case of the Antarctic medical officers more than anything else drew attention to the unfairness of the system, which on the one hand could recognise and use the qualifications of an immigrant to fill a most responsible, lonely medical post in a national undertaking of great importance, and on the other hand would deny his right to practise medicine on his return.

The press was not slow to realise the hypocrisy behind the situation. 'If European medical men can be entrusted with responsible Federal work, it is not logical', said the Melbourne *Herald* as early as 1950, 'to put special barriers around them in the States'.<sup>68</sup> A year later, when the news arrived that Dr Kostas Kalnenas, a Lithuanian doctor, had operated on the senior meteorologist at Macquarie Island, at least two Victorian newspapers again drew attention to the contradictions in the situation.<sup>69</sup>

68. 31 July 1950.

69. *Herald*, Melbourne, 3 January 1951. *Advertiser*, Bendigo, 1 January 1951.

Intermittently the issue of Antarctic doctors came to the fore as doctors arrived back in Melbourne to their hero's welcome and were blocked anew from local practice by the medical board. On one occasion a newspaper article noted that a doctor on his second return was not only refused registration, but was unable to obtain even a laboratory job in a hospital.<sup>70</sup>

On the whole, the path of the D.P. doctors from Antarctica led nowhere. Two of them were reported to have performed successful emergency operations while in their lonely outposts, but even this did not move the Victorian Medical Board nor the Federal government, which they served, but which lacked either the interest, willingness or power to help them after their return.

70. *Herald*, Melbourne, 14 November 1956.

# 5 Lost years and wasted lives

## Employment in the lower echelons of the health field

It was exceptional for D.P. doctors not to spend at least some time in non-professional employment following their arrival in Australia. Even the earliest appointees to New Guinea seldom escaped a spell at a factory workbench or in a camp surgery as medical attendants.

The types of menial jobs given to them split the doctors into two groups of almost equal size. About half worked at one time or another as hospital cleaners, sick-bed attendants, medical orderlies or medical assistants, while the other half were allocated labouring jobs in factories or with public utilities (see Table 5).

The allocation of foreign doctors into the non-professional echelons of the health field was the compromise outcome of the opposing interests of the Department of Labour and National Service and the various medical boards: the former wished to place D.P. doctors in employment related to their training, while the medical boards did their utmost to exclude them from professional practice. The result was hospital or surgery employment in a menial capacity. Although there was no distinction in wages or official status, there was a considerable difference between the work of a D.P. doctor as a medical orderly in a reception centre among his fellow immigrants, or his similar position in an outside hospital.

### *Medical orderlies in immigration centres*

On the whole, employment in immigration reception centres meant initially little change in professional activities. Given their inability to enter full professional practice, most doctors in the beginning preferred such jobs to the available alternatives.

Registered medical officers employed in immigration centres were poorly paid compared with incomes in the commercial area. Indeed the unattractive salaries ranging from £978 to £1,280 in

1950, were the subject of a question in the Federal Parliament.<sup>1</sup>

Not surprisingly, therefore, the camps were short of Australian applicants, and both the general behaviour and ability or willingness of some to perform their duties left much to be desired. Bonegilla in Victoria, for example, had only one Australian medical officer in mid-1949, at a time when the centre had a floating population of 1,000-2,000 migrants, each of whom had to be examined on arrival, and receive medication if ill. The Greta Centre in New South Wales had three Australian doctors in the 1950s. Both of these centres, as well as most others, were relying heavily on the work of the 'medical orderly' foreign doctors. Officially filling menial positions and receiving appropriately low wages, they examined all new arrivals and reported their findings to the Australian doctors. Although performing these and a variety of other medical duties gave the D.P. doctors a certain amount of satisfaction, their situation was equivocal. On the one hand they were asked to go beyond the duty of the medical orderly – indeed, at Bonegilla at least they were issued with stethoscopes so that they could examine the new arrivals and the sick. On the other hand they were ordered around by the nursing sisters who insisted that they should wash implements and clean floors.<sup>2</sup>

Because at least some of the registered doctors had chosen salaried appointments in the camps to escape hard work outside, the centres tended to be staffed by doctors who were rather atypical. These factors of counter-selection and the pitfalls inherent in the vaguely defined roles inevitably precipitated a difficult relationship between the Australian 'doctors' and foreign 'medical orderlies'.

The desire of the D.P.s to be treated by their own doctors, or at least to seek their second opinion, was an added cause of tension.

There were, however, exceptions. A young Australian doctor who took up his appointment straight after leaving university, recalled his cordial relations with the D.P. doctors, and how his work with the 'medical orderlies' opened his eyes to the value of the European doctors' experience and knowledge, and enabled him to cast aside the prejudices which he acquired through indoctrina-

1. Beazley to Page. *Australia: House of Representatives, Debates*, 21 March 1950, vol.206, p.931.

2. Dobos statement. MS. III/d. U.D.A. Archives, Melbourne.

tion during his studies.<sup>3</sup> Doctors like this young man were able to soften the impact of dependence and status loss which these older D.P. doctors had to endure. Perceptive and tactful doctors were, however, in the minority among camp appointees. There were apparently more who took advantage of the misfortunes of the foreign intruders and flaunted their superiority by reminding the D.P. doctors of their reduced status.

An order appropriately distributed helped to put the D.P. doctors in their proper places:

It has come to my notice that orderlies attached to your hospital are still being addressed as 'Doctor'. This is to be discontinued FORTHWITH. Disciplinary action will be taken against offenders.<sup>4</sup>

Dr Charles Dobos, a Hungarian physician specialist, who worked in 1949 as a 'medical orderly' until he left Australia, described in a farewell statement the attitude of a certain doctor in charge of an immigration centre:

The attitude of the Australian staff members towards migrant doctors was . . . purposely humiliating. Some examples:

. . . During a reception given by Dr X to some doctors . . . from the Commonwealth Health Department in Canberra . . . I was ordered by him to serve coffee to the guests. The doctors, accordingly, ignored my presence completely. Dr X insisted on calling me by the Christian name, like he did in case of every European doctor until Dr Y arrived and introduced the custom of calling us doctors again.

. . . One morning I witnessed Dr X coming into the dressing room, throwing his dirty socks into the wash basin and ordering the there present [D.P.] Dr S . . . 'little fellow, wash that!' – Dr X was at times extremely cruel and refined in methods of humiliating us, then again showed generosity and friendly manners.

Dr Dobos concluded his statement with praise for one local

3. Interview with Dr X.Y. of Sydney.

4. Beazley to Page. *Australia: House of Representatives, Debates*, 21 March 1950, vol.206, p.931.

doctor and strong criticism for the attitudes and medical ability of others; he then added:

I co-operated in the examination of the arrivals of more than 60 ships, amounting to about 50,000 people. Even if we were not accepted as doctors, we did the work of a doctor and our diagnoses, if not disfigured by a badly trained sister, were guides in further treatment or employment of migrants.

Our knowledge was exploited but not always used to the best by responsible authorities. And as a reward we met the hostility of the Australian medical staff, humiliation and degradation to the status of an orderly.

I believe there is no country in the free world treating a foreign doctor in that manner and depriving a migrant patient of a free choice of a doctor, a doctor whom he could trust. I found the attitude of the Australian medical staff towards European patients and doctors unprecedented.<sup>5</sup>

However strong the words of Dr Dobos sound, they are apparently true. Certainly, the authoritative recollections of Dr John Gunther, then Director of Public Health for Papua New Guinea, do nothing but corroborate them. Recalling his visit to the same immigration centre to interview doctors for New Guinea, Dr Gunther unexpectedly referred to Dr X and the atmosphere in the camp surgery.

It was a pleasant and unpleasant experience . . . Obviously the senior medical officer did not like the D.P. doctors in the camp . . . I demanded that I interview the New Australian doctors on my own, but when I produced my list Dr X asked me would I like him to note against each name what he thought of the particular person I was to interview. As I could see no harm in this I said 'Yes, I would'. Hereby hangs quite a tale.

Well, Dr C... had a big red mark against his name put there by Dr X who said C... was an alcoholic and whilst he was a good doctor nevertheless he was an alcoholic. He damned him by building him up as a good doctor and then saying he was an

5. Dobos statement, op.cit.

alcoholic and certainly we did not want any alcoholics in New Guinea. So I said to C... 'By the way Dr do you smoke much?' and he answered 'Oh, yes, 50 cigarettes a day or something like this' and I said, 'Do you drink?' and he said 'Oh, depends how much I can get' and I said 'Suppose it was unlimited'. 'Oh, I would drink anything; two bottles of whisky a day and if one can't get anything I don't drink, but I have always been able to get something.' He proudly told me of his drinking prowess and naturally I said we did not want him.

Apparently [later] he was told why he was not wanted and I got a letter from a Catholic bishop in Victoria, and I think also a letter from a leading Lutheran, saying that as far as they knew he was a teetotaler. So . . . as soon as I got these letters I asked that he be interviewed again. When I asked him why he had told me that he was a heavy drinker and a chronic alcoholic when he in fact was not, he said that Dr X had told him to make sure that when I asked him about drink he should tell me that he is a heavy drinker. 'You know, Gunther is a chronic alcoholic and he will not select anybody who does not drink'. So then I enquired as to why Dr X should be so objectionable and as spiteful as this. As I understand it, C... had dealt with a medical crisis in the ward one day as an orderly. He had been reprimanded by one of the sisters of the hospital and I think he had slapped her face, and he was in great disgrace.

Well, Dr C... was a good medical officer. It would have been sad if he had not been given a second chance. But this was the kind of man X was and this was the attitude of a lot of doctors to these people. I do not know why they would want to be as spiteful as that. But this is the attitude of a lot of doctors in Australia to Pakistanis and to Indians today . . .<sup>6</sup>

It was particularly unfortunate that relations between Australian 'doctors' and D.P. 'orderlies' in a large centre were like this at a time when one-third of the total D.P. intake passed through it; this not only affected the opinion of D.P. doctors concerning their Australian counterparts, but left lasting impressions in the minds of many of the immigrants.

6. Dr J. T. Gunther. Tape recorded interview.



Both Australian and foreign-born doctors later interviewed suggested that the situation faced by the 'medical orderlies' in this centre was not unique, and that there were in other centres some doctors who apparently enjoyed the humiliation of their helpless European counterparts.<sup>7</sup> There were exceptions, however, and in any event the situation of the foreign doctor working as medical orderly in a reception centre depended on the co-operation of the Australian doctor and matron, under whom he had to perform his duties. If they displayed goodwill the doctor, hoping for better things to come, put up with the situation. However, some found their position too incongruous and too humiliating, and preferred to work in factories rather than put up with unpleasant nurses and vindictive doctors.

Because of the ambiguity of their position some foreign doctors, particularly if they worked with a relatively congenial group, lost sight of the real implications of their situation. Being separated from the outside world, some thought their exploitation was part and parcel of the contract — 'a bad joke' as one doctor said — and believed that as they were in any case performing medical duties, at the end of their two years they would be free to practise outside provided they did not 'rock the boat'. Lulled by false hopes, these doctors did nothing to prepare for their future.<sup>8</sup> Others, less optimistic or less naive, with their eyes set on the date when their contract would expire, began preparing for a second migration.

Occasionally, however, a foreign doctor was posted to a small centre, to perform his duties there alone, theoretically as a medical orderly under the supervision of the G.P. in the nearby town. In these jobs, they had often a freer hand, and were less likely to be molested.

Coming from a large immigration centre such appointments could mean for the foreign doctor his first contact with a hard working country G.P. living far from the A.M.A. dominated capitals or from the failures who seemed to predominate among camp appointments. Such confrontations could open new vistas of human decency for the bewildered foreign doctor.

7. Interviews with former D.P. Dr L.H. of Sydney and Australian-born Dr X.Y. of Sydney, both of whom worked in a N.S.W. immigration centre in the early 1950s.

8. Dr L.H. of Sydney. Interview.

At Benalla I was the only 'medical orderly' and my 'boss', the Australian doctor, lived and worked in the town. From the first moment onwards he treated me as a colleague and a friend. He asked me to assist in his operations on the townsfolk, but insisted that I should operate on migrants in the camp, while he assisted. He was genuine, and often said how upset he was about the attitude of his colleagues. As far as I am concerned – he often said – you can stay here forever and share my practice; I have, as you see, too much to do and there are not enough doctors to come out here.<sup>9</sup>

Of the 300 male D.P. doctors who came to Australia up to perhaps 60 were engaged for some length of time as immigration centre medical orderlies. A survey by the Department of Immigration in November 1951 listed fifteen camp medical orderlies whose contract had already expired, but who, possibly for want of better opportunities, chose to remain in their positions in the immigration centres (see Table 5).

Most of those directed to work in immigration centres, however, spent only their contract period there. There were even some who after a few months in a centre proceeded to New Guinea or the Antarctic in full medical capacity.

As a transition into Australian surroundings, and as a period in which they could improve their English and pick up local medical angles, these appointments were not without value. Just how much good or bad the positions held for the doctors depended to a very large extent on the Australian doctors and nurses with whom they came into contact. The fact that there were some who chose to stay indicates that at some centres these relations were tolerable enough for the foreign doctor to think twice before facing the even colder realities of the outside world. Whether they were filling these positions willingly or unwillingly, there can be little doubt that the employment of D.P. doctors at the nominal salary of medical orderlies constituted one of the most obvious exploitations of D.P.s within the contract system.

#### *Menial health occupations outside immigration centres*

It will be remembered that the Andrew proposals were dealt with

9. Dr S.C. of Melbourne. Interview.

by the Department of Labour and National Service primarily as a suggestion to relieve shortages of medical orderlies in established hospitals. Brigadier Galleghan saw them also as such and made a special point about the shortage of medical orderlies in repatriation hospitals.

Although the first placements of the 300 male D.P. doctors are not known, it seems that on arrival about one in every three doctors was allocated to a hospital as an orderly, medical attendant or hospital cleaner. Of those in Victoria some were placed into hospitals as junior (untrained) nurses. To become a 'senior nurse' the D.P. doctor was required to pass a State examination. The level of this examination was naturally very much lower than that required for his original medical degree.

Unlike their colleagues in the immigration centres, doctors allocated to outside hospitals were not expected to perform medical duties. Their placement, nevertheless, was not without pitfalls. Recalling past experiences, many doctors described how patients sooner or later learned that the medical orderly or cleaner was a

**Table 5: Occupations of D.P. doctors who had completed their contract, and held no medical appointment since their arrival in Australia**

November 1951

Health field	Last known occupations		
		Outside health field	
Camp orderlies	15	Labourers, process workers	77
Hospital orderlies	45	Storemen and packers	4
Hospital cleaners	3	Salesmen	2
Lab. assistants,	13	Farmhand	1
X-ray assistants, asst. dispensers		Clerk	1
<b>Total health field</b>	<b>76</b>	<b>Total non-health field</b>	<b>85</b>

Source: Research Memorandum. Department of Immigration Corresp. File, CRS A446, item 58/66376, pt 1. C.A.O., Canberra.

doctor, and turned to them for advice concerning their conditions. Some were able to parry such questions; a few, however, succumbed to the temptation to help and unavoidably came into conflict with Australian doctors. Apart from understandable pride, it was the realisation of this danger which prompted some doctors to refuse work in hospitals, preferring general labouring in a factory, away from the health sphere.<sup>10</sup> Consequently the work of male nurse or orderly turned out to be transitory; certainly few remained medical orderlies after their contracts expired.

### *Sub-professional work*

Some former 'medical orderlies' gained promotion to sub-professional employment; others arrived at the same type of employment from the factory floor or from railway yards. However, such positions were by no means easy to obtain, as doctors applying for work in hospital or X-ray laboratories as assistants were frequently rejected on the grounds that they were too highly qualified for such a position.<sup>11</sup>

In contrast to this negative attitude, there were sympathetic Australian doctors, who counteracted existing restrictions by creating positions disguised as technical or research work and used these for the rehabilitation of their foreign colleagues.<sup>12</sup>

Surveying the occupations of 161 doctors whose contracts had already expired the Department of Immigration found that 13 of them (8 per cent) were working at the turn of 1951 as laboratory assistants, assistant dispensers, bacteriologists, blood bank officers and health inspectors. (Sample: 4 per cent from 2nd to 5th year, 8 per cent in 6th year).

The number of those in these near-professional categories, however, remained fairly stationary, as new entrants from below were often compensated for by the loss of those who either became registered under various State laws, died, or left Australia.

### *Non-medical occupations*

The survey by the Department of Labour and National Service prompted by the Andrew proposals indicated not only that there

10. Interviews with Dr S.C., Dr S.W. and Respondent 809 of Melbourne.

11. Letter from Dr S.C. of Melbourne.

12. Letter from Dr S.W. of Melbourne.

was a great need for medical orderlies in hospitals, but also noted that many hospitals were unable to accept D.P.s for these positions because of shortage of accommodation.<sup>13</sup>

Consequently, almost half of the doctors on their arrival were placed in non-health occupations, mostly as railway labourers or process workers, or on occasions as cane cutters.

Their numbers came to be augmented by doctors who, having been appointed to hospitals or immigration centres as orderlies or cleaners, could not stand the emotional strain involved in their situation and secured a transfer; or else, if no longer under contract, left for a labouring occupation. Some chose labouring jobs so as to be able to work night shifts and attend universities, while others who obtained loans, or were living on their family's earnings, worked during university vacations to supplement their income.

As time passed, doctors from both the lower health and non-health occupation categories began to move out to become medical practitioners again through one of the avenues open to them; they either went to New Guinea, re-qualified through university courses or were registered when the State registration laws or practices allowed them to do so. Others gave up hope of full reinstatement and a few of these secured mostly sub-professional appointments as laboratory assistants or health inspectors. Others settled for jobs as salesmen, clerks, letter sorters, or storemen. Among the twenty-three medically qualified doctors of the sample there were two from the latter category but neither returned the questionnaire sent to them. When visited by an interviewer, one was not available and his wife, refusing to be drawn into conversation, firmly shut the door. Of Respondent 809, the interviewer reported:

His surname with the usual abbreviated title 'Dr' was on an enamel-plate, nailed to the door of his rented bedroom, in one of the older suburbs of Adelaide. The doctor, a Ukrainian born in Poland, had not returned the Questionnaire nor had he answered the reminder notices. I knocked on his door. He was forty-one when he arrived in Australia, and the years which had passed had not made him look any younger. Respondent 809

13. Secretary, Department of Labour and National Service to Secretary, Department of Immigration, 25 May 1949. Department of Labour and National Service Corresp. File, 49/23/43. C.A.O., Melbourne.

was an old bachelor, stocky, volatile, and not without a sense of humour. On being told the purpose of my visit he hesitated for a second. Then possibly because he heard the foreign accent in my voice he waved his arm wide and invited me to step into his home, a room filled with furniture, photographs and some books. – ‘We will talk my dear friend’ – he said as I sat down on an old armchair and looked around – ‘we will talk. No interview, just a friendly chat, so put away that biro’. He obviously enjoyed the company of an unexpected visitor with whom he could steal away the hours of the evening.

He told me that he held a degree from a Polish university and a post-graduate degree in Virology from a German university.

After his arrival he was sent to a hospital to work there as a cleaner. On one occasion there was only one doctor on duty, a young man straight out from university. Dr B saw that a patient in a critical condition was being given wrong treatment. He warned the young doctor that the patient was going to die. Not listened to, and his prediction proved, he was transferred to a mental hospital, again as a cleaner. There similar clashes occurred between him and the medical staff. They tried to get rid of him, he said, and offered him the chance to go to New Guinea and practise there. He refused: he could not leave his aged parents in Australia, neither could he take them to the tropics. So he became a storeman-packer with a Government department.

‘That’s all, and no postmortems please.’

‘You tell me this? Don’t we all learn from postmortems?’

‘Maybe. But the illness has been diagnosed and the epidemic is now almost under control. So what?’ – and he smiled.

I asked him about the couple of dozen medical books which stood on a shelf.

‘These books? I read them as a hobby now.’

There was no self-pity in his voice.

‘I told you, no interviews, no postmortems.’

He pointed to a small gas stove in the corner of his room and offered me a mug of instant coffee ‘for the road’.

The irretrievably lost

Exclusion from the practice of their profession, if based on the

argument of economic necessity to safeguard doctors already in business, would have been a blow in itself to the doctors from Europe, who were already committed to their profession and had accustomed themselves to a middle-class socio-economic status. But only rarely was this the sole argument used against their registration: the campaign waged against them concentrated more on convincing the public of the inferiority of the foreign doctors. Thus many of the newcomers felt that without ever intending to offend the Australian medical profession, they had become its special target for denigration.

They were also concerned that, with every passing month of non-professional employment, the 'discontinuation of medical activity will be the A.M.A.'s major argument against the concerned people when other accusations will prove to be false'.<sup>14</sup>

It is a sad fact emerging from this research that the barring of the D.P. doctors was indeed accompanied by many unnecessary, hurtful incidents, and while there were some doctors who gave a friendly hand to their European colleagues there were more who carried on in their individual sphere of influence the campaign against the intruders.

This psychological offensive against foreign doctors was clearly not restricted to medical misfits in the lower echelons of the health services. Even the Commissioner of Public Health in one of the States 'had the habit of greeting all applicants with a query: "What about my son who has just completed his Medical Course at an Australian University"'.<sup>15</sup>

Records of uncharitable attitudes shown towards the D.P. doctors are found not only in the farewell statements of those leaving Australia, but abound in government archives, daily newspapers and the Hansards of the Federal and State parliaments.

Reference has been made in previous chapters to some of these. But there were many more incidents which cut deep. Early in 1952 the Melbourne *Argus*, for example, reported the case of Dr Katilius, a Lithuanian medical practitioner of ten years standing, and an associate professor of medicine in his country. Dr Katilius, and his Latvian colleague, who were allocated to work as attendants at

14. U.D.A., European Doctors in Australia. MS. p.7. U.D.A. Archives, Melbourne.

15. Beazley to Holt, 8 February 1950. Department of Immigration Corresp. File, CRS A445, item 179/10/6. C.A.O., Canberra.

Ballarat Mental Hospital, bitterly complained that they were forbidden even to handle bandages. Katilius, who was reported to have been in charge of a 400 bed hospital in Germany, was refused permission to watch operations at the base hospital in order to study local procedure and techniques. 'I feel like crawling through the nearest keyhole out of Australia. I know my wife and child could get a better deal in America, and that's where we hope to be soon', reported the *Argus*.<sup>16</sup>

There were not only those who saw no other hope than further migration, some even demanded that the Commonwealth government deport them immediately back to Europe where, though not well paid, at least they worked in their profession.

In November 1950 Clyde Cameron, Labor member for Hindmarsh in South Australia, brought such a case before the Parliament on the adjournment:<sup>17</sup>

The matter that I bring to the attention of the Government now concerns a displaced person who has spent eighteen years of his life in universities and schools studying medicine, and who is now a qualified doctor in his own right. The name of this person is Vytautas Kilikonis. As a new Australian doctor he has been living in South Australia since he arrived in Australia, and has been employed in the capacities of a laundry man at the Bedford Park sanatorium, an unskilled labourer in another location, and for six months as an ordinary process worker employed at General Motors- Holden's Limited. This man is so completely disgusted with the treatment that he has received at the hands of the Government that he has written to me and asked that I request the Government to deport him and his wife back to Germany.

Although Harold Holt, then Minister for Immigration, was in the House, he took practically no part in the debate; the Hansard records only two interjections by him during the six-page long proceedings. The burden on the government side was carried by the Independent Member for the Australian Capital Territory,

16. *Argus*, Melbourne, 22 February 1952. 'Doctors, but Can't Watch'.

17. *Australia: House of Representatives, Debates*, 15 November 1950, vol.210, pp.2480-6.



Dr Nott, a medical practitioner. Typically, Dr Nott used the occasion not only to denigrate Dr Kilikonis but also to cast aspersions on all foreign doctors:

I cannot allow certain statements that were made by the person to whom the honourable member for Hindmarsh (Mr. Clyde Cameron) referred to go unchallenged. The honorable member did not give any indication whatever of the medical qualifications of that individual. When I was medical superintendent of the Canberra Community Hospital, scores of people who alleged that they were doctors passed through my hands both as patients and as persons who offered to assist in the medical work of that institution. I was impressed by the claims of only one of those individuals. I submitted his name to the previous Government and requested that he be appointed to the hospital staff as a clinical assistant. That request was rejected . . . the Government has the responsibility of appointing to its health services only men who possess qualifications of the standard that is accepted in this country. I do not desire to labour the matter. I believe that that poor, unhappy soul would feel much more contented in a concentration camp in Germany, and I recommend that the Minister accede to his request, and give him a one-way passage back to the land from which he should never have come.

### *Self-destruction*

If occurring in isolation the slights and uncharitable attitudes would have been dismissed probably by all as the manifestation of individual greed, uncouthness or intolerance. But news among educated displaced persons travelled fast as they read and discussed every news item about themselves in order to come to grips with their new surroundings. These made a stunning impact on many refugees; for some the trials and humiliations were just too much to bear. In 1952 the leaders of the U.D.A. saw the scene as

the pitiful picture of humiliation, of wastage of professional skill . . . cruel disheartening methods applied to European professional men . . . who came to Australia eager to contribute to development of this beautiful country, chosen for no other reason than love of freedom . . . persistently malicious and

cunningly generalised statements about the low standards of European Doctors . . .<sup>18</sup>

'The stiff opposition', wrote the U.D.A. a year later 'was at times so heart-breaking that many European doctors gave up their will to fight . . .'.<sup>19</sup>

On 22 January 1956 Dr L. Ogelsneff, a Russian graduate of the University of Bologna, who practised for ten years overseas before arriving in Australia, and who was employed as a male nurse in Lidcombe Mental Hospital in Sydney, battered his mother to death, and then fatally stabbed himself.

Newspapers in Sydney and Melbourne reported that the suicide was the fifth among New Australian doctors. The *Sydney Morning Herald* wrote:

The suicide of the fifth New Australian doctor barred from registration and practice seems to have pricked Sydney's conscience.

And it is a strong conscience. Many people are demanding a review of the official attitude to these doctors. More than 400 New Australian doctors have come to this country but only about 60 have been able to win recognition.

People are now asking whether it is not coldly inhuman to tell these people, usually penniless to go and complete the final three years of the medical course at a local university without any aid. How does the man live during that period?<sup>20</sup>

The popular Sydney columnist Eric Baume, himself a third generation descendant of a refugee of the 1848 revolutions of Europe, used even stronger words in his column 'Face the Facts':

Who sent him mad? You and I, I am afraid. We would not have cared less, that although a qualified surgeon, he could not practise here. You see, we were never refugees.

For we are the supermen, and only Sydney or Edinburgh or

18. *UDA Bulletin*, no.2, November 1952, p.3.

19. *UDA Bulletin*, no.3, November 1953, p.1.

20. 1 February 1956.

similar British schools can produce our medical prophets – or profits?

As an ordinary human being I feel ashamed of what we did to him in Australia and are doing to some refugees from communist tyrannies . . .<sup>21</sup>

Suicide was one of the possible ways of opting out from a game where the cards were stacked so heavily against the newcomer. Alcohol offered an alternative and there were a few who succumbed to it. Interviewed doctors told the story of one colleague, coming from a long line of distinguished medical men, who took to drink, and by the time he was offered a regional registration in New South Wales, was unable to take advantage of the chance. He died a few years later in *delirium tremens*.

While some fell into despair, apparently not one tried to profit from the opportunities wide open to them by their non-registration. A wide search of newspapers failed to find any instance of an unregistered D.P. doctor performing illegal abortions, though the temptations must have been great. The only reference to unregistered doctors and illegal abortion found seems to underline this: an Adelaide paper in 1951 reported the conviction of a woman who unsuccessfully solicited the help of an unregistered doctor for the termination of a pregnancy.<sup>22</sup>

#### *Further migration*

Not surprisingly, there were a number of doctors who were able to sum up the situation quickly and felt confident enough to prepare as soon as possible for a further migration. It is very likely that these doctors were not only the more active and more mobile, but were professionally the most qualified and least willing to put up with their humiliating lot; knowing their own value, they felt certain they would be able to secure professional openings in other countries. Such further migration, however, was by no means easy. Most would have gladly left for the United States where, as it was widely known, doctors were offered immediate hospital employment. However, displaced persons by their arrival in Australia

21. *Sun*, Sydney, 26 January 1956.

22. *Advertiser*, Adelaide, 29 September 1951.

became, in international refugee terminology, technically 'firmly resettled' and thus lost their former eligibility to fit into the U.S. displaced persons program. With national quotas already strained, those who belatedly put their names down at a consulate in Australia had to expect a waiting period of 2-6 years. Many could not contemplate a third, fourth or fifth uprooting after the passage of so many years. If advancing years did not, then their families' yearning for a home after years in camps stood in the way of some who contemplated a move. Still there were many who were able to surmount the difficulties and left Australia for the United States. There were others who went back to Germany, or to underdeveloped countries that were looking for doctors.

According to the sample, doctors were prominent among those professionally qualified D.P.s who left Australia at a very early stage. This underlines the earlier findings, that many genuinely felt that they had been misled, and as soon as they realised this, many made plans to leave Australia. Dr Kilikonis was not the only doctor who demanded that either the I.R.O. or the Australian government should pay for his repatriation. Writing in the *Age* in Melbourne in 1951 'A New Australian Doctor' said: 'If the Government will not, or cannot change this system then . . . New Australian doctors have no option than . . . ask the I.R.O. in Europe to transfer them to those countries which are willing to recognise their existing degrees . . .'<sup>23</sup>

It was partly for the purpose of further migration that the U.D.A. was formed, and during its existence the association collated data on admission procedures, particularly in the U.S.A., and supplied with information many doctors wishing to emigrate. As they stated in their bulletin:<sup>24</sup> 'We follow this logical policy: regain the status, to which . . . [by our] training and ability we are fully entitled, or leave the Country, whatever comes first.'

Dr Jozsef Incze, a Hungarian TB specialist, who was working as an orderly at Kalyra Sanatorium, Belair, South Australia and was described as a doctor of 'undeniable brilliance who would be useful in fighting TB in South Australia', was one of the first reported departures for the U.S.A., where he was offered a TB specialist

23. *Age*, Melbourne, August 1951.

24. *U.D.A. Bulletin*, no.3, 2 November 1953, p.1.

appointment.<sup>25</sup> Other Hungarian doctors to move to the U.S.A. as soon as their landing permits arrived included Drs Kovacs and Prockl, both of whom worked in Greta Immigration Centre as medical orderlies, and Dr Kaippel, who worked in factories until his departure. The Hungarian Dr Dobos, who was medical orderly in Bonegilla, and the Latvian Dr Bergs who worked as medical orderly in Greta, went back to Germany as soon as their contracts expired, and moved from there into medical work in the United States.<sup>26</sup> Dr Tomboly, another Hungarian, also left by 1954, while Dr Kölcze went about the same time to Canada, to practise there.<sup>27</sup> Dr Algirdas Brundza, described by the Lithuanian Society as Europe's leading brain specialist, left Melbourne in 1952 to resume his medical practice with the Ethiopian Health Department. From 1949 until his departure he worked as a railway storeman in Melbourne.<sup>28</sup>

Also among the early departures was Dr Kazys Katilius with his family. The Lithuanian associate professor, who was not permitted to watch an operation in Ballarat, after his contract expired resumed professional practice in the United States. Dr Vytautas Kilikonis, who worked in the first years of the 1950s in Adelaide as a labourer, and who, because of his demand for deportation, became the butt of Dr Nott's condescending insults in the Commonwealth Parliament, worked by the mid-1950s in Illinois where he was licensed as a specialist in ophthalmology.<sup>29</sup>

In 1956 the Melbourne *Herald* reported that Dr J. Novak, one of the doctors whose application was rejected without interview or explanation by the Victorian Medical Board, was offered a post at the world-famous Bellevue Medical Centre by its director when on a visit to Australia. Dr Novak left towards the end of 1956.<sup>30</sup> Dr Szeghy of the Royal Hungarian Medical Corps, who worked as a male nurse in Launceston in the early 1950s, and later as a pathology technician in New South Wales, waited until 1958 for

25. *Miner*, Broken Hill, 19 August 1950. Also U.D.A. Members' File, January 1954. Departures.

26. Information from Dr L.H. of Sydney.

27. U.D.A. Members' File, January 1954. Departures.

28. *News*, Perth, September 1952. Also U.D.A. Members' File, January 1954. Departures.

29. *American Medical Directory*, 25th ed., 1969.

30. *Herald*, Melbourne, 14 December 1956. 'In Black and White'

his entry visa, which enabled him to take up the position of Research Director at the Illinois State Hospital.<sup>31</sup>

Such and similar departures were numerous, and no complete list could or need be compiled; the foregoing is just an indication of the loss Australia suffered by the departure of foreign doctors at a time when many hospitals and country areas were without adequate medical manpower.

Some of the doctors who sought registration in Australia found that, even when they achieved this through completing local university courses, they were still discriminated against. A doctor, already well qualified in Europe, who spent some time with the New Guinea Health Department as a medical officer, but for family reasons returned to Australia before completing five years there, re-qualified through the three years' course at Sydney University, and registered in New South Wales. Nevertheless, he soon left for the United States, where he became director of a state medical teaching institute. In answer to a question, he wrote:

My experiences in New Guinea were very favorable and I enjoyed my two-year's stay there very much indeed. The foreign physicians were treated very properly and I know of nobody who would have complained.

During my stay in Sydney, I experienced considerable prejudice against foreign graduates and in my own opinion the A.M.A. is nothing more than a trade union. For quite some while I was affiliated with one of the University hospitals as Clinical Assistant, which means no salary and no privileges, but when the issue came up that I should have consideration for completion of my residency training in order to satisfy the requirements for the Royal College of Gynaecologists, I was denied the opportunity. As you must realize, I left Australia because I did not like the atmosphere in that country at that time.<sup>32</sup>

Just how many men with medical degrees left Australia to seek opportunities elsewhere is not known. However, there are indica-

31. Information from the late Dr G.S. of Sydney.

32. Letter from Dr L.H. from West Seneca, New York, 12 April 1972.

tions that the sample's breakdown, which shows 17.4 per cent as 'leavers' and 4.3 per cent as 'unknown', does not overestimate departures. The Department of Immigration's list of 161 D.P. medical practitioners who, after two years in Australia, still held no medical appointment by November 1951, checked against the *American Medical Directory* of 1969 shows that 22 of these 161 doctors were in 1969 working as medical practitioners in the United States of America. Pro rata addition of the D.P.s already in the medical profession when the list was compiled, and the addition of conservative estimates of untraced departures, suggest that the settler loss among qualified D.P. medical practitioners of that arrival cohort was no less than 18.7 per cent (see Table 6).

There is no reason to assume that the estimated 118 later arrivals of male doctors would have shown a different departure pattern; consequently it may be calculated that about one in five, i.e. approximately sixty of the male D.P. doctors recruited under the D.P. scheme for Australia, left later to live in other countries, particularly in the U.S.A. No record was found of any departure which did not result in the immediate professional employment of the D.P. in his new country of residence, irrespective of the length of time spent by the doctor in menial occupations in Australia.

#### *The balance sheet of wastage*

Non-recognition of their foreign degrees meant a personal tragedy to those doctors who could see no way to recovery. But non-recognition was a loss also to the Australian nation which during the 1950s was very short of medical practitioners.

While it is possible to estimate the number of D.P. doctors who were lost to Australia because of the exclusionist policies of the profession, it is impossible to put a figure on the loss of medical care, on the number of unnecessary deaths and the amount of avoidable suffering caused by their non-recognition, particularly in the country areas where they would gladly have gone to serve the nation. The throwing away of eighteen or more years of formal study which the doctors brought with them, and which was provided at the expense of other governments, the neglect to utilise their wide experience, skills, and challengingly different outlook, was in economic terms an expensive and wasteful folly.

Estimates introduced so far indicate that the sum of those who

Table 6: Departure of D.P. doctors from Australia (earliest arrival cohort, representing 67 per cent of the total doctor intake)

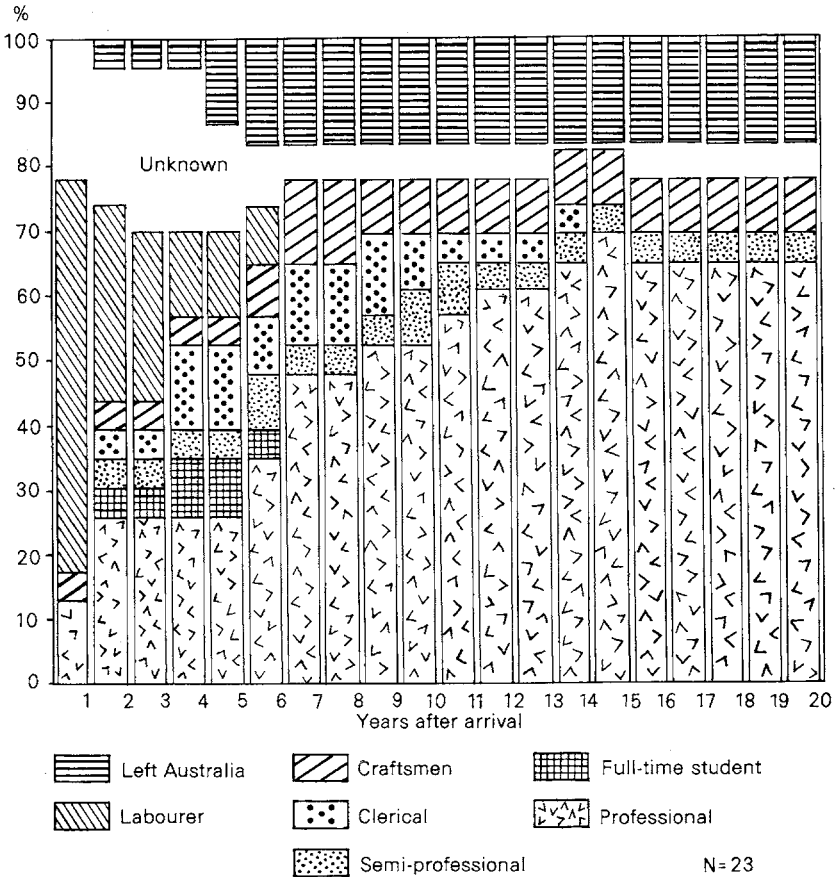
Universe	Numbers	Departure category	Numbers	Departing %
Department of Immigration list of non-practising doctors 2 years in Australia, 1951	161	Found in U.S. <i>Med. Dir.</i> 1969	22	
		Located in other countries	2	
		Estimated in U.S. but deceased prior to 1969	4	
		Estimated in other countries	4	21.1
Same arrival cohort, working as doctors (New Guinea, Antarctica, W.A.) by 1951	21	Estimated departures	2	9.6
		<b>Total arrival cohort</b>	<b>182</b>	<b>Total estimated departures</b>



left, suicided, or died before recognition, and those who never 'made it' in Australia's medical world, amounted to just one in three of the male doctors brought to Australia by the I.R.O. under the Commonwealth government's D.P. scheme. To these 100 male doctors we may add possibly some 55 of the 70 female doctors who arrived with them.

The loss cannot be measured, however, by the final outcome

**Figure 1: Graduates in medicine. Achieved occupational status in each of the first twenty years after arrival in Australia.**



alone. Only some of the forty doctors employed mainly by the Papua New Guinea Health Department and a few by the Western Australian government did not lose valuable years before recognition. Even if the doctor was registered at a later date the sum total of years lost through unnecessary university study by men already well qualified, and the periods spent in occupations such as orderlies, factory workers, clerks or salesmen, was considerable and can be quantified. What cannot be measured is the deterioration of the quality of medical knowledge and skill of these doctors through artificially induced long interruptions to their practice.

Figure 1 shows the year-by-year path to recognition of doctors in the sample. While the sample proved itself reliable in a number of respects, Figure 1 deals with small cells, and consequently cannot be taken to be more than a rough indication of the pattern. However, all the additional information which came to light has confirmed at least the main outlines shown in Figure 1. Altogether there can be little doubt that not only was the skill of one doctor among every three who disembarked from a D.P. vessel totally lost to Australia, but there is sufficient evidence to indicate that in addition about one in three of the remaining working years of those eventually registered were whittled away at unnecessary university courses and in menial occupations.

In numbers alone, therefore, the campaign of the A.M.A. against the D.P. doctors was not a complete victory. Nevertheless it did achieve, at a time when Australia's doctor:patient ratio was the lowest in its modern history, the elimination and repulsion, or at least neutralisation, of just over half of the available talents and skills which the displaced person doctors brought with them to Australia.

# 6 Medical students

## Numbers and background

If the twenty-five medical students aboard the twelve sample ships can be taken as an indication of their numbers in the total of the displaced persons intake, then there were perhaps 320 male medical students among the 170,000 displaced persons who arrived in Australia.

Because the history of each refugee vintage differed considerably, the age composition of the various nationalities was by no means the same. Thus refugees from Czechoslovakia, and to a lesser extent Hungary, had more young men of the university student age range among them than other refugee groups. It is not surprising, therefore, that the distribution of medical students among countries of origin did not match those of the elder graduate doctors. Reflecting clearly the predominance of Czechs and Hungarians in the younger age categories, nine of the medical students of the sample were born in Czechoslovakia, seven in Hungary, while the remaining nine of the sample came from other countries. All those in the sample were single on arrival.

About half of all students were neo-refugees from Czechoslovakia and Hungary, who left their countries after the communist takeover from 1947 onwards. The others were 'westwarder type' refugees, either forced to move from their countries of birth by the German Army or escaping in mass westward from the advancing Russian troops. Twelve per cent of those who answered a questionnaire had seen military service of up to one year. The rest did not serve during or after the war.

Half of those who answered the questionnaire did not study in transit, only in their country of birth; these were obviously the neo-refugees who spent only a short period between leaving their home and arriving in Australia. Roughly one in three of the refugee students continued in the countries of asylum (Germany, Austria etc.) the studies which they began at home. The remainder were

children of 'westwarders' who began university studies in transit. Nearly half of the students reported that they spoke good, or at least fair English, before leaving the Continent.

### Resumption of study

For most students, full-time study was not possible until they completed their two-year contract, which bound them to full-time labouring jobs and often kept them far from universities. Finance was also a considerable problem to most, as there were no Federal or State scholarship schemes launched to help D.P. students, nor were there sufficiently large national communities in Australia able to support their studies. Still, some were able to secure loans from Australian families who befriended them, or receive cadetships from companies. One former student in the sample was able to obtain a Mature Age Scholarship.

The extent to which universities recognised their earlier studies varied. With the exception of those demanding a formal examination in English, all other universities gave them full matriculation status. However, few received credits for the years completed in Europe and except for occasional exemption from first-year courses, all lost years by the change. Thus the cumulative loss of years caused by interruptions in Europe, and on board ship, and during contract, was accentuated by the partial or complete lack of recognition of years already completed.

Of the twelve former students who answered the questionnaire, nine had contacted Australian universities after their arrival. Six of these said that the universities gave them a fair deal, while three reported that the universities' attitude was either mediocre or unfair.

### Settler loss and mortality and occupational achievement

Of the twenty-five students who arrived, five left Australia and five could not be traced; most of the latter may be presumed to have left, making a departure rate of between one-fifth and two-fifths. If, as is likely, the rate was nearer two-fifths, then relatively more students left than medical practitioners; a likely possibility in view of their greater mobility. One of those who left did so after com-

pleting his medical course in Australia; he is now practising medicine in England.

None of the twenty-five students in the sample is known to have died during the twenty years following their arrival. One student who worked during the early years as a general labourer in the northern part of South Australia, lost his mental balance and has been since repeatedly confined in institutions.

Only seven of the twenty-five of the sample are known to have recommenced university courses in Australia, and in the end all these graduated. Five did so in medicine. One of these is now on the staff of a university. Of the two who switched faculties, one is now an accountant and the other a linguist with a university appointment.

Altogether, of the fifteen who are known to be still in Australia, the occupation of two is unknown, four are process workers, two are clerks, and one is in a semi-professional occupation. Four are doctors, and two are in other professions.

### **Possible factors of achievement and failure**

The background characteristics among those successful vary. In nationality the seven who received degrees were widely distributed: three Hungarians, one Czech, one Yugoslav, one Lithuanian and one Pole. This does not indicate that Czechs did not fare well — they predominate among the departures and among those who cannot be located. Neither is age an indication. However, there is some association between knowledge of English on arrival and later career. Those who spoke better English on arrival were more numerous among the 'achievers', the 'leavers' and the 'lost' categories, than among those who stayed and did not achieve professional status. It may be that greater fluency in English on arrival was indicative of drive and energy. It certainly facilitated orientation and shortened the time lapse before beginning local studies.

However, one post-arrival factor clearly had an important influence on the careers of these displaced students. Four of the five students who disembarked at Fremantle were among the seven who achieved professional status. Because of some slight unemployment in Western Australia at the time of their arrival, the provisions of the contract were not fully enforced and any student,

if supported by the family or if able to earn at week-ends or in term breaks, could attend university full time. Furthermore, study at the University of Western Australia was free in the early 1950s, and this was a help to displaced persons who on arrival could not afford fees. The teaching of medicine in Perth in the early 1950s, however, was restricted to the first two years of the course, and students had later to transfer to other States to obtain their degrees. By that time, not only was the two-year contract period over but students had also some chance to pick up scholarships or loans. The fact that four of the five Western Australian arrivals of the sample enrolled at the University of Western Australia and all eventually graduated, indicates not only the quality of the D.P. student intake but also pin-points factors which contributed in the other States to the ruin of many young careers.

On the whole the problems which foreign medical students faced on their arrival in Australia differed from those of their elders. First, the students did not become the target of hostile propaganda. Second, because they were younger and had fewer responsibilities, a return to university courses did not mean for them a loss of status; hence the repetition of some years of education hit them less hard. However, the repeated breaks from studies proved too much for some, and the enforcement of the contract undoubtedly became a final straw for many who could not further postpone the taking on of family responsibilities.

# 7 Pressures and principles

## Effect of the exclusion of doctors on the immigrants

### *Resentment felt by fellow immigrants*

In the exclusion of the D.P. doctors from the medical profession much more was involved than their own fate and the availability of their services to the Australian community. Other D.P.s were deeply shocked by the whole affair; some, indeed, developed quite hostile attitudes towards the land of their choice.

For most refugees, their arrival in Australia was seen as the latest move in a series of journeys which led through war, evacuation, P.O.W. camps, refugee compounds and processing centres. In all these places, distant from their homeland and in strange surroundings, they were able to speak to, confide in, and rely on doctors who were either compatriots or at least understood their languages and were fellow refugees and therefore understood and shared their human predicament. Also the doctors of Central Europe shared with other refugees a somewhat different tradition of doctor-patient relationship from that common in Australia; they had a more outgoing, more confiding approach to which Continental refugees were accustomed. At least to the D.P., it conveyed the message that the doctor cared.

The degrading of doctors was therefore not a matter affecting the doctors only, but was felt as a personal loss and an affront by a large proportion of the 170,000 refugees. It was a personal loss particularly for the lesser educated who, because of language difficulties, depended greatly on a doctor of their own nationality. It was an affront to all who thought that the humiliating treatment of the doctors by their Australian counterparts reflected Australian attitudes towards all immigrants.<sup>1</sup> The idea that human beings of all

1. In answer to the open-ended question 'Have you any comment on the problems other D.P. professionals, outside your field, had to face in Australia?', put to tertiary educated former refugees, the overwhelming majority mentioned the discrimination which the medical profession had to face after arrival. 'More than shocking', 'narrow-minded and stupid', 'very unfair' were some of the phrases used to describe the plight of the doctors.

nations suffer the same illnesses and respond to the same treatment was widespread, and medicine was considered by the refugees as an eminently international and transferable occupation. Though perhaps never verbalised, it was also strongly felt by many that, unlike law or certain forms of art, twentieth century medicine was the consummate achievement of scientists and medical men from many centuries and many nations. Therefore the debarring of their doctors from practice in Australia appeared to them not only a slight against their nations which gave medicine great men,<sup>2</sup> but filled them also with apprehension about the quality of medicine they could expect from doctors who apparently did not consider their craft heir to European traditions.

Thus to the painful problem of language which the debarring of their own doctors brought about,<sup>3</sup> was added resentment and distrust of Australian doctors. The immigrants were by no means convinced that their doctors were not allowed to practise because they were of lower standard than Australian doctors. On the contrary. The D.P.s were almost unanimous in their opinion that their doctors were excluded because they were better trained, more helpful and more compassionate, and consequently that their registration would result in a competition in which Australian doctors would lose. Hence displaced persons insisted on getting the second opinion of their 'medical orderlies' when still in camp and, even later, when already settled outside, there were many who travelled hours to distant suburbs to be examined and treated by a compatriot, or at least by a Continental doctor. It was well known that before D.P. doctors became registered, even strongly right-wing D.P.s made considerable efforts to be attended by the few pre-war foreign doctors who were often Jewish, rather than go to Australian doctors in their own suburb.

2. For example, Czechs justly pointed to Purkinje, who gave many of the concepts of physiology; the Poles to Mikulicz-Radecki who originated modern surgery, and the Hungarians to Semmelweiss, the founder of antiseptic medicine — medical giants, who originated still valid concepts and practices before there was even a medical school in Australia.

3. Even as late as 1953 at a Good Neighbour Council meeting in Melbourne 'a discussion on the question of European professional people started, after a New Australian lady stressed the ordeal of recently arrived female patients who, having once had the painful experience of explaining their discreet ailments to the local, English-only speaking doctor, are forced to abandon the visits, with detriment to their health'. (U.D.A. Secretary's Report, 1952-53, p.2.)



*Publicity given to the doctors' plight in the immigrant press*

The importance which fellow immigrants attached to the doctors' cause is indicated by the space given to it by the ethnic press. For example the German language papers, *Der Anker* of Sydney and *Neue Welt* of Melbourne, which were read by displaced persons of many nationalities, dealt with the issue almost constantly during the 1950s, devoting several front page articles denouncing the A.M.A.'s stand and discussing impending moves. Paying back the Australian medical profession for its slights to foreign doctors, the ethnic press seldom missed an opportunity to stress the shortcomings of Australian medical services and reports of incompetence among Australian doctors.<sup>4</sup> These articles, by reinforcing the feelings of resentment, must have had an unsettling effect on the immigrants throughout the 1950s. Thus the A.M.A.'s campaign against foreign doctors drove a wedge of distrust between newcomers and the host society. No other interpretation given to the two years' contract, and no other closed shop attitudes were so widely discussed among immigrants in conversation and their press. Although most immigrants realised that the campaign originated from the local medical profession and not from the government,

4. For example, the *Neue Welt* made a point of reporting on its front page departures of critically ill people to Europe to seek medical treatment there, and on such occasions always referred to the absurd situation that European graduates could not practise here. The *Neue Welt* was also only one of the many foreign language papers emphasising the contrast between the incompetence resulting in the 'dead man walking' case of Melbourne, and the non-registration of well-qualified foreign doctors. ('Der lebende Leichnam', *Neue Welt*, Melbourne, 30 August 1956).

Apprehensive about the future of doctors among the new arrivals from the 1956 revolution, the Sydney Hungarian *Becsülettelt* gathered together in an angry leader the reported blunders of Australian doctors:

'Most of them [doctor refugees of the 1956 revolution] have been sent into factories, while in other parts of the world their colleagues are already in hospitals. And at the same time, to fill the shortage, fifty English doctors will soon arrive in Australia. Only the doctors from behind the Iron Curtain have 'low' knowledge which does not reach the 'high' Australian standard, which supplies the 'best' doctors in the world. But it happens exactly here, that the sick person receives a petrol injection (and dies from it); that they leave a quarter metre of gauze in his abdomen and find the cause of his death only during the post-mortem; that they pierce the windpipe of a child but, 'so what, the doctor was young and yet inexperienced'; that they mix up blood-types during transfusion; that they issue a death certificate for the living, and to make things sure put him into the freezing chamber; that during an operation they mix up the bottles and the patient breathes death instead of oxygen; that they miss the vein when giving an intravenous injection, but all this is for nothing — for the Australian doctors — after all, science must have its martyrs.

'It's no use; what is permitted for the ox is not permitted for Jupiter.'

(Sydney, 15 June 1957, p.1. 'Ujabb magyar orvosok a kálvária útján — Hungarian doctors once again on their way to Calvary.)

the fact that the Department of Immigration was not able to intervene effectively to help the foreign doctors became a source of distrust between immigrants and the government, added considerably to the early tensions, and very likely contributed to settler loss among displaced person immigrants in the 1950s.

*The damage to Australia's reputation abroad*

Resentment against Australia's treatment of D.P. doctors did not stop at the D.P. press, nor did it end at the confines of the continental shelf. The hurt was so deep that many doctors felt that their treatment by their Australian colleagues should be told to the medical profession abroad. As a U.D.A. official wrote:

[Should we] leave this Country which offers us settlement on unacceptable terms, we have to clear our name from generalized accusations and inform the medical world about this hopeless aberration from traditional medical solidarity. That is our immediate program.<sup>5</sup>

By May 1952 at the Chicago meeting of the American Federation of International Institutes, Dr Alex Burgess named Australia as a country where 'there are 500 D.P. doctors, many of whom are specialists but none of whom . . . have been allowed to practise'.<sup>6</sup> 'It is pathetic', he continued, 'to think of a man who was a teacher and a leader of medicine in his own land doing unskilled labor for his living, but there are many instances of this in Australia . . .'.

The memorandum prepared by the departing Dr Dobos has already been quoted. There were also other doctors who were sufficiently enraged about their treatment to broadcast after their re-settlement abroad their views on the ethical and humanitarian standards of the organised medical profession in Australia, thus damaging Australia's reputation as a country of immigration for professionals.

By 1956, under the title *Statistical data and facts relating to the situation of immigrant doctors who are treated as white niggers in Australia*, a leaflet was published in the United States by a D.P.

5. *UDA Bulletin*, 3 November 1953, p.2.

6. A. M. Burgess, 'Resettlement of Refugee Physicians'. *New England Journal of Medicine*, vol.247, 18 September 1952, pp.419-23.

doctor who was forced to work in Australia as a process worker in a rubber factory before he could re-migrate to the United States of America and resume his medical career. The leaflet was published under the symbolic picture of five graves, an allusion to the five doctors driven to suicide in Australia. Whatever the exact text of this leaflet was, it certainly did little good for Australia's reputation as a country offering a chance for a new life and a fair deal to intending immigrants of higher education.<sup>7</sup>

### Foreign doctors and ministerial politics

#### *Harold Holt and the D.P. doctors*

Although statements made by various ministers in the Federal Parliament often emphasised that the registration of doctors was a matter for the States, D.P. doctors and their integration into the Australian occupational structure were in many aspects a Federal responsibility.

First, the D.P. refugees were assisted immigrants, coming to Australia as a result of Commonwealth recruitment, and the Federal government through its Department of Immigration was responsible for the smooth absorption of immigrants into the Australian community. Secondly, through representations made to it by individuals, interested bodies and through press reports, the Department of Immigration was aware of the fact that some of their servants in Europe were apparently going beyond their briefs, and that a proportion of the D.P. doctors was consequently induced to come to Australia by what seemed to be fairly definite promises relating to their professional future. Thirdly, the initial job-placement of the doctors, together with any subsequent changes of employment within the first two years, was under the joint control of the Department of Labour and National Service and the Department of Immigration. Fourthly, by the early 1950s it was becoming evident that the handling of the doctors' case would affect the smooth absorption of immigrants and could jeopardise Australia's

7. Search for a copy of this now almost twenty-year-old document remained unrewarded. Reference to the leaflet was made in its September 1956 issue of the Sydney *Becksülettel* which reproduced the distinctive illustration appearing on it, and gave a Hungarian summary of its contents. The title spelled out in the text is not definitive, as it is a re-translation of the Hungarian version printed in the article.

good name as a country of immigration.<sup>8</sup> Fifthly, both Harold Holt and his predecessor, Arthur Calwell, cultivated a public image presenting the Federal Minister for Immigration as a benevolent father figure assuring immigrants of fair and equal opportunities and encouraging them to stay permanently in Australia. Sixthly, though the registration of doctors in the six mainland States was a State matter, the Commonwealth had an unquestioned power to register them not only in Papua New Guinea and Antarctica but also on the mainland in the Australian Capital Territory and in the Northern Territory. Powers to register doctors under Federal jurisdiction for the armed services, and within immigration centres, could also have been explored.

Contemporary documents, however, clearly show that Harold Holt, who held the Immigration portfolio during the critical period from December 1949 to December 1958, paid no more than lip-service to the cause of the D.P. doctors. He did not appear to have taken much interest in his department's research findings and remained negative in the Parliament, apparently satisfied with the virtual shelving of the problem by the Immigration Planning Council. No documents or parliamentary evidence were found which would suggest that he was ever willing to become involved in a political fight against established medical interests.

It is true that the Immigration Planning Council may have begun its inquiries into foreign professional qualifications with the intention of achieving some liberalisation, or at least some rationalisation, of the laws and practices. It is evident, however, that once the council realised how adamant the A.M.A. was in its opposition, they accepted the role of the instrument which by protracted negotiation of the unnegotiable would win time, and justify the non-actions of the minister.

### *The role of Sir Earle Page*

There can be no doubt that had Harold Holt decided to press the

8. The effect of the continued exclusion on the wider ranks of immigrants was anticipated by the Department of Immigration by 1953. A departmental memo pressing for action noted: '... migrant doctors no doubt have a certain standing within their own national group. If their qualifications continue to be ignored on principle, these doctors are liable to become permanent malcontents and social misfits with corresponding effects on those fellow immigrants with whom they carry weight and influence'. (Memorandum. Principal Research Officer. 2.4.1953. Department of Immigratic Corresp. File, CRS A446, item 58/66378, pt 2. C.A.O., Canberra).

issue of foreign doctors he would have been on the loser's side and put his political career in jeopardy. His party leader, Prime Minister R. G. Menzies, had in early 1939 terminated for a time the anti-Labor coalition when he first resigned from its Cabinet, and then gained the Prime Ministership on the death of J. A. Lyons. He justified his resignation by his disagreement with the Lyons's Cabinet's dilatory attitude to the proclamation of the National Insurance Bill, and as a result seriously impaired his relations with Earle Page, then leader of the Country Party.

A surgeon, Page was a man clearly identified with the ideals and policies of the A.M.A. He was a man of strong views 'respected within the medical profession and was ever conscious and sympathetic to its point of view — a situation which was . . . not always conducive to speedy action in an area of policy allegedly close to his heart'.<sup>9</sup> His commitment to the cause of the A.M.A. gained for him from Prime Minister Chifley the epithet 'the agent in this Parliament of the British Medical Association'.<sup>10</sup>

Harold Holt was well aware that the Liberal-Country Party coalition regained the Treasury benches ten years later only because the differences between Menzies and Page had been patched up; he knew that Page, though no longer leader of the Country Party, was still its most senior and most powerful representative in the Cabinet and would brook no interference in matters of health, for which he chose to become the minister after the electoral victory.

Having made the difficult reconciliation with Page, it is unlikely that Menzies would have countenanced any proposal impinging on Page's portfolio, at any rate in such a way as to antagonise the arch-conservative doctor. Quite apart from inter-party strains in the Cabinet, the medical profession was a body strongly identified with the coalition parties by its strident and expensive campaign against the Chifley Labor government, 1945-9. For Holt to support the cause of three hundred foreign doctors — about whose background he knew little and who, to him, were just a small proportion of all the refugees coming to Australia — would have meant taking a great political risk without promise of ultimate success.

Thus, despite the efforts of some hard-working departmental

9. Hunter, *Politics of National Health*, p.37.

10. Speech in House of Representatives, 17 March 1949, reproduced in J. B. Chifley, *Things Worth Fighting For*. Melbourne, Melbourne University Press [1952], p.287.

officers, any Federal approach to the problem of D.P. doctors was from the outset doomed to be shelved because of contemporary political realities. Through Earl Page's professional allegiance and the intransigence of the A.M.A., the issue, however minor, could have erupted at any time into a political controversy endangering the future of the coalition.

The definite character of Page's stand is clear from his handling of two questions directed to him in Parliament by Kim Beazley. To avoid placing a lever in the hands of those who supported the registration of foreign doctors, Page, like some other A.M.A. spokesmen, did not refrain from gross inaccuracies or from misleading the Parliament. The first question was asked by Beazley on 8 March 1950.<sup>11</sup>

Mr BEAZLEY — I desire to ask the Minister for Health a question which arises from the fact that displaced persons with medical qualifications are being permitted by the Australian Government to practise in New Guinea. If it is a fact that these doctors are competent to practise amongst the European and native communities in New Guinea, why are they not permitted to practise in Australia as well? Will the Minister grant registration to suitably qualified foreign medical practitioners in the Australian Capital Territory and the Northern Territory? Does he intend to take any steps to persuade State Governments to grant registration to these immigrant doctors, since the Commonwealth has seen fit to recognize them as qualified to practise? In view of the fact that the registration laws of the States do not provide for an impartial scientific assessment of the content and status of foreign medical degrees, will the Minister request the States to place their registration laws on a scientific basis, uninfluenced by the trade union conceptions of the British Medical Association?

Sir EARLE PAGE — The honorable member's sneer at the British Medical Association is unjustified because the laws that govern the registration of doctors are State laws, made in many instances, by Labour governments without any pressure from

11. *Australia: House of Representatives, Debates*, 8 March 1950, vol.206, pp.492-3.

doctors. Those laws are uniform throughout Australia and, I think, throughout the British Empire insofar as they do not permit the registration of doctors from countries the governments of which do not recognize the medical degrees of Australian doctors. That has been the practice over many years and it has been enforced by all governments, irrespective of party. Certain doctors who have been permitted to practise in New Guinea have studied for three years at, I think, the University of Sydney, and have passed an examination. A small number of them were allowed to practise in New South Wales. The position is one which needs correcting on a world-wide scale for correction of only one anomaly could lead to the creation of bigger anomalies. However, I shall take up the question with the State governments to see whether anything can be done to improve the local position.

Page's answer was typical. Though Beazley explicitly asked whether he would consider registering these doctors in the Federal territories, where he, the Minister for Health, had the power to do so, Page simply ignored this relevant part of the question and preferred to speak about registration in the States. But when he did give answers, these were misleading: laws were not uniform in the States, even less in the British Empire; but admitting to variations would have given more force to the argument that the Federal government should act, at least in its own territories, by introducing yet another variant. The answer neglected to mention, for example, that foreign doctors in the United Kingdom were almost always permitted to work as *locum tenens* and in hospitals as *doctors*, and that there were British universities which, instead of demanding three years of re-study, accepted European degrees for admission to post-graduate studies. The statement that D.P. doctors already in New Guinea practised there by virtue of local study of three years and examinations passed at Sydney or any other Australian university was also utterly without foundation. It throws an interesting light on Page's technique to observe that he introduced both misleading statements with the meaningless caveat: 'I think'.

Two weeks later Beazley again questioned Sir Earle Page, this time about the employment of foreign doctors in immigration

centres:<sup>12</sup>

Mr BEAZLEY — My question to the Minister for Health arises from an advertisement by his department seeking the services of medical officers at immigration centres, and an order forbidding foreign medical officers serving as medical orderlies to be addressed as 'Doctor' . . . In view of the fact that medical officers are required urgently, will the Minister authorize immigrant doctors to practise among their co-nationals, bearing in mind that they did so in Europe and on shipboard, and that they enjoy the complete confidence of their own people?

Sir EARLE PAGE — Migrant camps are not controlled by the Department of Health. I have not yet had an opportunity to visit all of the migrant camps in this country, but in two of the camps that I have visited I noticed that migrant doctors, although not registered in Australia, were acting officially. I found that there was no difficulty so far as those doctors were concerned, and they were the only doctors practising there.

The Parliament was none the wiser from Page's answer, which effectively covered up the fact that the doctors were indeed paid as medical orderlies, and immigrants and staff alike were ordered not to address them as doctors.

These quotations have been introduced to show how strongly committed Page was to follow the A.M.A. line.<sup>13</sup> Only an understanding of Page's commitment and his powerful position in the Cabinet can explain Harold Holt's non-intervention in the cause of the doctors, including his very noticeable silence in the Kilikonis debate.

Although the registration of doctors was largely a State matter, had Dr Page not been such an important link in the chain holding the coalition together, Commonwealth leadership could have been assumed and liberalisation of the State Acts may well have been speeded up. Commonwealth authorities were free to register doctors in Commonwealth territories: indeed in areas outside the

12. *Australia: House of Representatives, Debates*, 21 March 1950, vol.206, p.931.

13. Further on Page's relations with the A.M.A. and his commitment to A.M.A. policies, see Thelma Hunter, *op.cit.* Particularly pp.31 ff.



Australian mainland the Department of Territories (in New Guinea) and the Department of External Affairs (in Antarctica) made sensible use of their talents. Had not the Minister for Health and his department so strongly followed the A.M.A.'s lines, a handful of doctors registered in the Australian Capital Territory and the Northern Territory as a start might have forced the States to follow suit. Federal registration for hospitals in the Australian Capital Territory, Alice Springs, Darwin, and perhaps special surgeries for Aborigines, were perfectly within the ambit of the Federal government and their registration to serve immigrants alone could also have been explored. Immediate appointment of a limited number of D.P. doctors in these areas would have had great psychological impact and would have speeded up the liberalisation process. This, however, was a possibility which neither Dr Page, Dr Metcalfe, nor the then Member for the Australian Capital Territory (1949-51), Dr Nott, wished to see.

In the two years' contract which all D.P. immigrants signed, the Department of Immigration had a powerful tool in its hands. With will and with imaginative actions to provide housing and surgery facilities, this contract could have been used both to provide medical services in distant areas and as an assurance to the A.M.A. to keep foreign doctors away from the cities.

Although Holt shied away from any debate on foreign doctors and excused inaction with statements on 'the complex nature' of the issue and the consideration being given to it by the Immigration Planning Council, there is evidence that he was well aware that because of the intransigence of the A.M.A., negotiations were almost certainly doomed to failure. The *Adelaide News* in an article entitled 'Australia Needs Migrant Doctors' reported Harold Holt's statement:

If the Commonwealth Government had experienced as little assistance with other sections of industry and the professions in their acceptance of new settlers, then there would have been much less industrial progress as a result of immigration.<sup>14</sup>

Significantly, Holt's quoted statement was made in February

1956, a few weeks after the retirement of Sir Earle Page from the Ministry. In mid-January 1956 a relatively junior politician, Dr D. A. Cameron, became the Minister for Health.

Morality in politics is one of the most difficult questions and it might be too much to demand that a minister champion a cause which would endanger his career, particularly if he was well aware that the cause in any case was doomed because of the superior forces against it. This consideration may excuse Harold Holt's non-action on the general problem of refugee doctors. It does not, however, excuse him permitting his department to use the skill and knowledge of foreign doctors in camps while treating them and paying them as medical orderlies. Neither do the Cabinet and the responsible ministers in it show up very well over taking advantage of the D.P. doctors' availability by utilising their knowledge and skills at Australian Antarctic stations, but washing their hands of them on their return.

Politics may be the science of exigencies but somewhere along the line morality, honour, ethical standards and the integrity of a nation must come into the picture. How far he can compromise these to survive is for the politician to judge. But those who watch him from the sidelines of the contemporary arena, or from the vantage point of history, cannot be denied the right to decide for themselves whether he has been found wanting.

# Epilogue

The events described in this study spanned twenty years, during which Australia's population grew from eight to twelve and a half million, and the number of medical practitioners from some 5,000 to about 14,000. The period saw not only a quantitative growth in all sectors of Australian life, but also a qualitative change in all aspects of Australian existence, including the embracing of new ideas, the widening of vistas and the reviewing, and even occasional rejection, of outmoded concepts.

The pathetic and tragic story of the D.P. medical practitioners will never be a proud chapter in Australia's post-war history. It has more elements of greed and folly than of the humanity and common-sense on which we pride ourselves. Although it came about as a part of the national vision of Calwell's immigration program, it contains more elements of narrow, petty politics in its details than do credit to the noble initial concepts.

Part of the tragedy lay in the refugee situation itself. Although over 80 per cent of the doctors practised medicine while in Europe, they were not immune from the pressures which were exerted on all refugees to leave their countries of asylum as quickly as possible. Whether these pressures manifested themselves in the political uncertainties of Europe during the months of the Berlin blockade, or in the rumours of withdrawal of I.R.O. support from those who would not emigrate, or in the warning of early cessation of the schemes, they were a powerful factor in hurrying the refugee into a decision to leave.<sup>1</sup> Had the pressures been less, and had there been no enticing hearsays about chances in Australia, many of the doctors would have waited a while longer in the refugee camps and hospitals of Europe, and could have gone to the U.S.A. or some other country where they could have continued their professional work. As it was, they signed up for Australia, and on their arrival

1. On the role which pressure plays in forcing the refugee to take a 'plunge' see E. F. Kunz, 'The Refugee in Flight: Kinetic Models and Forms of Displacement' in *International Migration Review*, vol.7, no.2, Summer 1973, pp.125-46.

were confronted by a spoilt, and at its organisational level, uncharitable profession, insular in outlook and ready to disclaim collegiality with doctors they did not invite. Never protesting against the increase in potential patients which the migration flow brought with it, they braced themselves to launch temporarily successful campaigns of falsification, stalling and political pressure to keep out the doctors among the immigrants. In this sense the refugee doctors, fleeing from a major injustice in Europe, became victims of a lesser but, from their point of view, equally tragic injustice in Australia. Though the long slow processes of human justice and decency eventually rectified much, numbers of doctors suffered long, in some cases irreparable, periods of discrimination, humiliation and professional and social damage.

Yet the story has its lessons. It shows that great national undertakings need national backing, and parliamentary votes alone do not guarantee this. It shows that a numerically insignificant but determined pressure group like the A.M.A., amounting to no more than perhaps 0.07 per cent of the population, if powerfully organised and sufficiently ruthless, can sabotage and discredit national and humanitarian projects.

It draws attention to the effect of distance which even in the age of modern communications lies between Australia and the other developed countries of the world; a distance which in periods of rapid thrusting towards maturity makes the nation vulnerable to uneven development, so that while some aspects of national life leap ahead, others can erratically stagnate if overlooked or held back by determined groups. It also emphasises the important role played by immigrants with different backgrounds in eliminating, or at least reducing, the effects of demographic and intellectual bottlenecks.

The story also has lessons pertaining to the study of immigration. It draws attention to the pitfalls surrounding recruitment, to the necessity for unemotional assessment of needs and to the importance of ever up-dated expert advice for the intending immigrant.

Above all, it illustrates that an immigration program is about human beings with potentials, and only an immigration scheme designed to provide for the realisation of these potentials can be ethically or economically justified.

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Dr Egon F. Kunz, a Senior Research Fellow in the Department of Demography, The Australian National University, is a social historian with a wide range of interests. He has compiled scholarly bibliographies, translated poetry and written literary and historical studies. For the past fifteen years he has been working on the subject of international migration, particularly on the development and patterns of refugee movements and integration of refugees into the host society. Since 1968 he has been in charge of a major research project analysing the occupational adjustment of the Displaced Persons who arrived in Australia between 1947 and 1954 with completed degrees or with some tertiary education. This book is one of the results of this project.



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Among the thousands of European refugees who arrived in Australia between 1947 and 1954 as immigrants assisted by the Australian Government were many highly qualified professionals. These included a number of doctors, whose fate is the subject of this book.

Misled by information given them in Europe, the majority of these men and women arrived expecting to continue their careers. But, faced with the implacable opposition of the Australian Medical Association and the indifference of the authorities, they found it impossible to obtain registration and most were forced to take jobs as hospital orderlies, cleaners, factory hands or labourers. This book examines the factors that led to the situation where, when there was an urgent need for medical practitioners in Australia, these qualified

people were denied the opportunity of using their skills.

The AMA emerges as the main obstruction in this affair but there is little to be said for the State and Commonwealth governments. The latter in particular, though quick to take advantage of the skills of these doctors in New Guinea and Antarctica, where Australian doctors were reluctant to go, did nothing to assist them to resume their careers in the mainland territories over which it had control.

Though eventually most refugee doctors were able to obtain registration in Australia, for some it came too late and the wasted years and loss of skill represented a great deprivation, both to the doctors and to Australian society. This book is an indictment of the short-sightedness of those who could have helped to avoid this waste of talent.

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