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**The Common-Health and Beyond:  
New Zealand Trainee Specialists in  
International Medical Networks, 1945-1975**

A Thesis

submitted in partial fulfilment  
of the requirements for the degree

of

**Doctor of Philosophy**

at

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by

**John Armstrong**



THE UNIVERSITY OF  
**WAIKATO**

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## *Abstract*

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In the two to three decades that followed World War Two, approximately three-quarters of all New Zealand doctors, and up to ninety per cent of New Zealand medical specialists, travelled overseas for the purposes of obtaining post-graduate experience and qualifications. This thesis uses oral interviews, quantification techniques, and a range of textual analyses to explore the form and function of this large-scale professional migration, and to capture the experiences of those doctors who participated in it.

The central argument of this thesis is that the careers of New Zealand specialists during this period cannot be understood without making reference to a complex and mutually influential international system of cultural and professional conventions, institutional rules, interpersonal networks, health related policies, and discursive formations. While powerfully centred on British medical norms and structures, this 'Common-health' system facilitated the transmission of people, ideas, technologies, and policies both within and between the nations of the British Commonwealth, in multiple directions by multiple means, and in doing so, was critical to the development of medical specialisation in the twentieth century.

For New Zealand's prospective specialists, the primary motivating force behind these migrations was the need to access populations that were large enough to facilitate specialist training. Britain's much larger population and the existence of a range of cultural and institutional commonalities, derived from nineteenth-century colonisation, made Britain the default destination for thousands of New Zealand trainee specialists during the second half of the twentieth century. However, while the Common-health system was a powerful facilitator of medical interaction and migration, it also functioned as a mechanism of exclusion that severely curtailed the ability of women doctors and those of non-European heritage to participate in professional medicine on their own terms. This

thesis examines this restrictive aspect of post-World War Two medical networks with relation to women by suggesting that traditional beliefs about the role of women in medicine, together with the strongly informal nature of many professional interactions, not only limited the overall participation of women doctors, but also conditioned their ability to access particular specialty fields. The thesis also examines the reconfiguration of these patterns of connection during the late 1960s and early 1970s, and in particular, the emergence of the United States and Australia as important venues for post-graduate training for New Zealand's prospective specialists.

## *Acknowledgements*

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the data entry and preliminary analysis of the 770 medical obituaries that provide much of the evidence for the chapters that follow, during a Summer Studentship programme in late 2009.

I could not have started this thesis, let alone finished it, without the doctoral scholarship provided by the University of Waikato. I must also thank Janice Smith, History Programme administrator, for presenting such a cheerful and helpful interface between students and University. Her approach has seen much stress avoided. The University librarians, and particularly those in the New Zealand Collection, have, as always, gone above and beyond the call of duty, as have their colleagues in the Waikato hospital library, the Hocken Library in Dunedin, and the Otago Medical School Library. My research has also been aided by Sue Johnston, Administration Assistant at the New Zealand Orthopaedic Association, Laura Foley and Fraser Faithfull at the Australian and New Zealand College of Anaesthetists, and unknown administrators at the Royal Australasian College of Physicians and the Urological Society of Australasia, all of whom provided me with useful research material, including free copies of their respective written histories.

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## *Preface*

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This thesis has its roots in a commissioned history of Waikato Hospital, New Zealand, that I completed between 2007 and 2009.<sup>1</sup> The process of researching and writing *Under One Roof* raised a number of thematic, conceptual, and methodological issues which could not be explored in the context of a commissioned history, but which, I felt, clearly warranted further examination. It is important therefore to begin this thesis with a brief outline of that earlier project in order to clarify the origins of its main concerns and approaches.

In July 2007, I was commissioned by the Waikato Health Memorabilia Trust to write an updated history of Waikato Hospital.<sup>2</sup> Over the course of the next two years, I conducted forty interviews with long-serving members of the hospital's staff, examined approximately twelve shelf-metres of hospital board minutes and other official reports, and read a large amount of secondary material related to the political, social, technical and economic contexts within which the institution had developed.

As the research continued, two major insights emerged that together form the conceptual basis of the current thesis. The first insight, derived primarily from the interviews, related to the crucial importance of personality and interpersonal

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<sup>1</sup> John Armstrong, *Under One Roof: A History of Waikato Hospital* (Hamilton: Half Court Press, 2009).

<sup>2</sup> A history of Waikato Hospital had been written in 1987 to mark the institution's centenary. See Dr Rex Wright-St Clair, *From Cottage to Regional Base Hospital* (Hamilton: W. Inkster and the Waikato Hospital Board, 1987). The commissioned history of Waikato Hospital itself arose from an earlier ten-week Summer Studentship project that I completed for the Waikato Health Memorabilia Trust in 2006. The Waikato Health Memorabilia Trust was established in 2005 to collect and preserve items associated with health care services in the Waikato region, and at Waikato Hospital in particular. The Studentship, carried out at the conclusion of my Honours year at the University of Waikato, had been established several years before as a partnership between the Trust and the University's History Department, with the notable support of the Department's Associate Professor Catharine Coleborne. Over the previous few summers, the Trust had employed a graduate of the History Department to carry out a specific research task. My task was to record interviews with twenty long-standing members of Waikato Hospital's staff, who had been identified and located by the Trust's Chairman, Dr Peter Rothwell. I would like to acknowledge the role of both Cathy and the Trust in laying the foundations for my research interest.

relationships in the functioning and development of a major hospital. Every significant development in Waikato Hospital's history had been driven by people who possessed personal qualities suited to facilitating change: determination, charisma, vision, and perhaps most importantly, the ability to inspire others. Many interviewees could recall specific, frequently informal, conversations that later proved to be the wellspring for major service developments, from the establishment of new clinical specialties to the restructuring of administrative systems. In every case, the extent and quality of interpersonal relationships was an important factor in determining whether a given project would proceed. Waikato Hospital's Superintendents relied on connections with their staff, with colleagues at other hospitals, and with officials at the Department of Health to bring about major structural changes, while the institution's doctors and nurses also relied on networks of relationships to establish or improve clinical services.<sup>3</sup> The implementation of official government policies, such as the health reforms of the early 1990s, were materially affected by the personalities of those charged with carrying them out. Particularly powerful personalities – both admirable and challenging – left indelible marks not only on the memories of their colleagues, but on the structure and functioning of the institution as a whole.

However, as the importance of personality and personal relationships in Waikato Hospital's history became increasingly apparent, it also became clear that these factors were not always adequately acknowledged in the existing historiography of New Zealand's medical services. While the 'doctor-historians' who were responsible for a significant proportion of that historiography were happy to single out noteworthy colleagues for praise, very few were willing to even hint at the shortcomings of their fellow doctors. On the other hand, work produced by professional historians tended to downplay the importance of interpersonal relationships, emphasising instead such contextual factors such as government policies, social attitudes, or economic conditions as drivers of change. In these works, those individuals who *were* highlighted tended to be prominent government figures or the leaders of professional medical organisations, who generated change primarily at the level of policy. Everyday interpersonal

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<sup>3</sup> External relationships were particularly important at Waikato Hospital, where practitioners endeavouring to establish new specialties often seek the approval and support of their colleagues at Auckland Hospital, a large and relatively nearby institution that had traditionally viewed Waikato as a junior neighbour not worthy of specialist services of its own.

relationships, it seemed, were crucial ‘on the ground’, but unevenly unacknowledged on the page.<sup>4</sup>

The second major insight also arose from oral interviews. The methodology employed during the interviews conducted for *Under One Roof* was modelled on the ‘life-narrative’ approach, which seeks, as much as is possible, to allow participants to shape the narrative of interviews themselves, rather than to have it shaped by the predetermined questions of the interviewer. This methodology can be revealing both in terms of the ways in which people choose to construct their narratives, and by providing a space in which interviewees can introduce ideas or themes that had not been considered by the interviewer.<sup>5</sup>

In the twenty-six interviews conducted with medical specialists in particular, the life-narrative approach proved fruitful.<sup>6</sup> In almost every interview, Waikato Hospital’s specialist doctors spoke about the experience of travelling overseas – usually to Britain – for post-graduate specialist training in the years prior to their employment at Waikato Hospital. For some doctors, discussing this experience took up a significant proportion of the interview, with one interviewee narrating his entire career in terms of the contrasts he had felt between his experiences training in Dublin during the late 1950s and his subsequent time in New Zealand. While post-graduate specialist training in the four decades following World War Two – when all of the interviewees were active – typically involved spending only two to four years overseas, usually at the very start of their careers, it was clearly a deeply formative experience for many doctors, in terms of their subsequent career trajectories and their professional identities.

Again, the significance of this theme only became apparent as I became aware of its relative absence in existing historical literature on New Zealand’s medical services. The written histories of New Zealand’s hospitals are invariably framed within the context of developments at the regional or national level, while work examining health policy also tends to be bounded in its concerns by New Zealand’s geopolitical borders. While all such work contains numerous discreet

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<sup>4</sup> This issue will be discussed in detail in Chapter 1: Conceptualising the Common-Health as a System: Historiography, Theory, and Method.

<sup>5</sup> Methodological and theoretical issues around the use of life-narrative approaches in the university context will also be discussed in Chapter 1.

<sup>6</sup> This number includes those interviews conducted for the previous Summer Scholarship project, mentioned in footnote 2 above. Overall, I conducted approximately fifty interviews for the oral history project and the subsequent book, thirty of whom were with medical practitioners.

references to international influences – economic, legal, scientific, social, and personal – few acknowledge the collective or cumulative importance of those international influences in the development of New Zealand’s medical services, choosing instead to subsume them within the metanarrative of *national* development. The notable exceptions to this rule can be found among the medical autobiographies written by New Zealand doctors. While most of these accounts are rich with international references, a few authors take an additional step and foreground the international aspects of their careers as a central theme in their life stories.

This second insight resonated particularly strongly due to my recent exposure as an undergraduate to the teaching and ideas of Peter Gibbons, a senior lecturer in history at the University of Waikato. Over the preceding few years, Peter had written a series of seminal essays highlighting the ways in which the idea of ‘the nation’ had shaped historical narratives in New Zealand, and by extension marginalised those members of New Zealand society – particularly Māori – whose histories did not align with the widely accepted, mainly Pākehā version.<sup>7</sup> In his essays, Peter had also suggested several possible alternatives to ‘the nation’ as an historiographical framework. One such alternative was to take a ‘world history’ approach: to ‘transform understandings of many supposedly locally centred events’ by foregrounding international systems, linkages, and flows.<sup>8</sup> Having recently experienced Peter’s teaching – which was deeply imbued with these ideas – it appeared to me that the strong international inflections that I was hearing in the narratives of my specialist interviewees both validated his assertion of the importance of international influences, and provided an opportunity to further explore the instrumentality of employing an international conceptual framework in a particular historical context.

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<sup>7</sup> See Peter Gibbons, ‘A Note on Writing, Identity, and Colonisation in Aotearoa’, *Sites*, volume 13 (1986), pp. 32-8, ‘Non-Fiction’, in *The Oxford History of New Zealand Literature in English*, ed. by Terry Sturm (Auckland: Oxford University Press, 1991), pp. 23-104, ‘Going Native: A Case Study of Cultural Appropriation in a Settler Society, With Particular Reference to the Activities of Johannes Andersen in New Zealand During the First Half of the Twentieth Century’, PhD Thesis, University of Waikato, 1992, ‘Cultural Colonization and National Identity’, *New Zealand Journal of History*, volume 36, number 1, (April 2002), pp. 5-17, and ‘The Far Side of the Search for Identity: Reconsidering New Zealand History’, *New Zealand Journal of History*, volume 37, number 1, (April 2003), pp. 38-49. Peter’s work will be discussed and contextualised in both the Introduction and in Chapter 1: Conceptualising the Common-Health as a System Historiography, Theory, and Method.

<sup>8</sup> Peter Gibbons, Personal Communication.

At its heart then, this thesis is an intentional attempt to harness these two insights to the task of re-considering one aspect of the history of New Zealand specialty medicine during the twentieth century: that of post-graduate specialist training. First, it seeks to frame the international aspects of New Zealand specialists' early careers and experiences not as contributing factors to the central story of an emerging and unique 'New Zealand medicine', but as the main story itself. Rather than describing New Zealand specialists within a national framework, it situates their early careers in the context of an international professional system, and examines that system from a New Zealand perspective. While the thesis does not consider in detail the international exchange of technical and scientific ideas, it does argue that New Zealand's medical specialists operated within a framework of professional training structures, qualifications, policy concerns, and interpersonal networks that were fundamentally international in nature.

Second, the thesis seeks to incorporate the experiences and agency of living, breathing, interacting doctors. Initially, this was motivated by a desire to ensure that the adoption of what is at one level a 'structuralist' international framework illuminated, rather than obscured, the experiences of the people who inhabited and constituted those structures. To that end, the thesis not only maps the structure of an international system of migrations, policies, and discourses, but also shows how that structure played out in the lives of the doctors who inhabited them. As the following chapters will show, it does so by demonstrating that informal, interpersonal relationships were no less critical to the foundation and maintenance of international medical systems than they were to the day-to-day functioning of Waikato Hospital. But it also argues that those interpersonal relationships were conditioned (if not necessarily determined) by a multiplicity of factors, including attitudes about gender and ethnicity, professional interests, institutional traditions, and the laws of national governments. Indeed, one of the main objectives of the thesis is to demonstrate the analytical value of conceiving of a particular set of values, policies, discourses, traditions, institutions, migrations, relationships and experiences as an interacting and dynamic system that operated both within and between nation states.

For the purposes of this thesis, I am calling this network the ‘Common-health’. In the Introduction that follows, I define the term more closely and outline the work that I intend the term to do.

## Introduction

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### *New Zealand Medical Specialists: An International Profession*

In the two to three decades that followed World War Two, approximately three-quarters of all New Zealand doctors, and up to ninety per cent of New Zealand medical specialists, travelled overseas for the purposes of obtaining post-graduate experience and qualifications.<sup>1</sup> This thesis argues that these migrations occurred within, and were shaped by, a complex and mutually influential system of cultural and professional conventions, interpersonal networks, institutional rules, health related policies, and discursive formations.<sup>2</sup> It suggests that the interplay of these factors shaped the development of medical specialisation in the Commonwealth, and in particular, the migration patterns and early career experiences of New Zealand medical specialists.

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<sup>1</sup> These figures are based on the database analysis of 770 obituaries published in the New Zealand Medical Journal between 1939 and 2008. Of the 597 obituaries of doctors born in New Zealand, 447, or 74.8%, mentioned either a specific overseas training programme or cited a post-graduate qualification that could only be obtained overseas. Of the 246 obituaries of New Zealand-born doctors identified as specialists, 219, or 89% mentioned overseas migration. The database will be discussed in detail later in this thesis.

<sup>2</sup> 'International' is but one of several terms that can be used to describe systems that cross national borders. While the term 'Common-health' has in part been coined to bring precision to the discussion, 'international' will be used in general discussion because of its versatility; it can refer to the interaction of sovereign nations, to networks of national organisations, and to the interactions of sub- or supra- national organisations across national borders. Several of the other possible terms have unhelpful associations; 'transnational', for example, is commonly assumed to refer to international networks of families of ethnically based communities who remain in contact after migration, typically assumed to be permanent. Similarly, 'multinational' is usually associated with large-scale institutions such as corporations or religions whose activities take place in multiple countries, while 'global' suggests a truly 'planetary' system. For fuller discussions of such terminology, see Alejandro Portes, 'Introduction: the Debates and Significance of Immigrant Transnationalism', *Global Networks: A Journal of Transnational Affairs*, volume 1, issue 3 (2001), pp. 181-194, and Alejandro Portes, Luis Eduardo Guarnizo and Patricia Landolt, 'The Study of Transnationalism: Pitfalls and Promise of an Emergent Research Field', *Ethnic and Racial Studies*, volume 2, number 22 (1999), pp. 217-37. For a discussion of such terms in the context of medical historiography, see Rosemary Stevens, 'International Medical Education and the Concept of Quality', *Academic Medicine*, volume 70, number 7 (Supplement, July 1995), p. S11.

In February 2007, I interviewed Dr James Faed, a cell-biologist and haematologist at Dunedin Hospital and senior lecturer in pathology at the Otago Medical School about his experiences obtaining post-graduate specialist training in Edinburgh between 1979 and 1981. During the course of the interview, Dr Faed received an urgent phone call from a colleague asking his advice about a patient. When the phone call ended, Dr Faed reflected – in the light of our previous conversation about international networks – that consultant medical practice relied entirely upon ‘knowing who to ring’; medical specialists can only function effectively within a broader network of professional relationships.<sup>3</sup> This thesis contends that the networks of relationships that underpinned the practices of New Zealand medical specialists during the second half of the twentieth century did not only operate at the institutional level, but were also international in scope. This was, in one important sense, a direct consequence of the nature of specialised medicine. Many areas of specialist practice – although by no means all – were, and are, devoted to treating relatively uncommon illnesses or conditions that manifest in only a small proportion of a population at any given time.<sup>4</sup> As specialisation began to challenge generalism as the dominant mode of medical practice in the two decades following World War Two, it became crucial for aspiring specialists to have access to a population large enough to provide the volume of ‘cases’ needed to make training and professional practice viable. In many specialist areas, New Zealand’s urban populations were simply not large enough to support specialist training, and were usually only just large enough to support small-scale private practise. For New Zealand doctors aspiring to train in such specialty areas, overseas travel was therefore practically obligatory. Sources suggest that during the 1960s, when post-graduate migration to Britain was at its peak, more than a fifth of New Zealand’s entire active medical workforce, and

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<sup>3</sup> Interview with Dr James Faed, 17 February 2011. The phrase ‘consultant’ practice is synonymous with senior specialist practice.

<sup>4</sup> Many surgical specialties and sub-specialties require access to large populations in order for practitioners to acquire and maintain the required manual skills. Specialty areas such as obstetrics or anaesthetics, on the other hand, can be taught in the context of much smaller populations; pregnancy, for example, is not a rare condition, while anaesthetics can be applied in a huge range of medical situations. The distinction between specialties on this basis is explored more fully in Chapter 6: A System of Exclusion.

more than one third of its hospital-based practitioners were working overseas, mostly in post-graduate training positions, at any given time.<sup>5</sup>

While any sufficiently large population centre could have met the training needs of New Zealand's aspiring specialists, the vast majority chose Britain, and London in particular, as their destination for post-graduate specialist training.<sup>6</sup> London's status as the most populous city in the world after World War Two was an important part of its attraction, as was the presence of a number of dedicated specialist hospitals. Of no less significance, however, were the strong historical relationships that existed between the New Zealand medical establishment and various British medical institutions, structures, and traditions – not to mention the broader cultural, legal, and linguistic heritage that Pākeha New Zealanders and British people shared. New Zealand's first European doctors were predominantly British-trained, and British medical education structures and traditions later came to underpin undergraduate medical teaching in New Zealand.<sup>7</sup> Many New Zealand doctors could trace and draw upon familial connections in Britain, and could access British organisations that had established branches in New Zealand, including banks, travel agencies, insurance companies, and a range of professional medical associations and organisations. Strong trade links between the two countries meant that transportation was relatively easily obtained. The overseas military service of at least one third of all practising New Zealand doctors during each of the twentieth century's world wars generated friendships with colleagues from Britain and other Allied countries.<sup>8</sup> Wartime friendships sometimes led to

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<sup>5</sup> In March 1969, the New Zealand Medical Register listed 4,435 doctors, of whom only 3,400 were described as active within New Zealand. The difference was accounted for in a 'medical manpower' survey the following year, which reported that 990 New Zealand graduates were working overseas. See 'Staff in Public Hospitals', *Appendices to the Journal of the House of Representatives*, 1970, volume 4, Section H-31, p. 58, and 'The Government's Answer', *New Zealand Medical Journal*, volume 69 (December 1970), pp. 405-6.

<sup>6</sup> Of the 307 obituaries that included the destination of their subject's post-graduate migration, 287, or more than 93%, specified England and / or Scotland. 264 of these specified England alone or England *and* Scotland, while only 24 specified only Scotland. The difference between England and Scotland as training venues is discussed in Chapter 3.

<sup>7</sup> The most comprehensive discussion on the origins of New Zealand's medical profession can be found in Michael Belgrave's "'Medical Men" and "Lady Doctors": The Making of a New Zealand Medical Profession, 1857-1941', PhD Thesis, Victoria University of Wellington, 1985.

<sup>8</sup> Data on the proportion of New Zealand doctors serving overseas during World War Two come from Sir Charles Hercus and Sir Gordon Bell, *The Otago Medical School Under the First Three Deans* (Edinburgh: Livingstone, 1964), p. 205. However, military medical service rates may have been much higher. According to A.D. Carbery's *The New Zealand Medical Service in the Great War, 1914-1918: Based On Official Documents* (Auckland: Whitcombe & Tombs, 1924), xii,

written exchanges and travel for both personal and professional reasons after the conflicts ended. Doctors from across the British Commonwealth invited each other to conferences, organised formal exchanges, and notified friends about the availability of both post-graduate training opportunities and permanent jobs.

While post-World War Two post-graduate migrations relied on historical professional and cultural connections, they also perpetuated them. For reasons discussed later in this thesis, New Zealand doctors who gained employment in Britain after World War Two often made positive impressions on hospital staff and administrators, easing the way for subsequent applicants. During the 1950s and 1960s, New Zealand doctors established strong peer-support networks in Britain, helping each other to find accommodation and to negotiate transport systems. They organised study groups for examinations, helped each other to find jobs in British hospitals, and their spouses organised child-care groups. They also gave each other invaluable social support during a busy and often stressful period of their professional and personal lives.<sup>9</sup>

### *The Historiography of New Zealand Medical Migration*

It is not surprising, then, to find that the autobiographies of at least two generations of doctors who worked in New Zealand are rich with references to international experiences and relationships. Many of those active before and during World War One, such as the English-born Dunedin surgeon Sir Francis Gordon Bell and the physician Bernard Myers, wrote of travelling to Edinburgh for all or part of their undergraduate education, of wartime service, and of

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“[t]hree hundred and eighty-five out of some seven hundred doctors embarked for service overseas as officers of the medical corps”, a migration rate of fifty-five per cent of all New Zealand doctors. However, Michael Belgrave’s thesis suggests that this figure is not definitive, as various sources give slightly different numbers of registered doctors. See Michael Belgrave, “Medical Men” and “Lady Doctors”, pp. 242–3. Analysis of the database of New Zealand medical obituaries compiled for this thesis shows that out of the 291 obituaries of doctors who graduated between 1923 and 1945, and who would therefore be of military age during World War Two, almost forty per cent (115) mentioned overseas war service.

<sup>9</sup> See Chapter 5 for discussion of support networks among New Zealand doctors and their wives working in Britain.

subsequent training opportunities in England and the United States.<sup>10</sup> The chapter titles of the New Zealand surgeon Sir Frederick Bowerbank's autobiography also point to a lifetime of professional travel, much of it related to his role as a medical administrator in two World Wars:<sup>11</sup>

*I Reach New Zealand*  
*Hospital Work in Egypt*  
*To England and Back*  
*Edinburgh and Home through America*  
*Overseas Tours Begin*  
*The Middle East, Italy and England*  
*The United States, Canada, Home Again*  
*Fiji and Japan*

Similarly, the chapter titles of the New Zealand obstetrician / gynaecologist and medical adventurer Dr Donald Matthews' aptly titled autobiography, *Medicine My Passport*, also suggest that international travel remained a part of many doctors' lives in the decades following World War Two:<sup>12</sup>

*Journey to Edinburgh – and Medicine*  
*Wavy Navy Doctor*  
*Slum Voyage [Discussing his experience as a ship's doctor]*  
*Postgraduate Life in London*  
*Doctor in West Africa*  
*South American Interlude*  
*Doctor in India*  
*Nepalese Interlude*  
*Doctor in the Himalayas*  
*My Last Indian Adventure*

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<sup>10</sup> Relevant chapter titles in Sir Francis Gordon Bell's autobiography, *Surgeon's Saga* (Wellington: A. H. & A. W. Reed, 1968), include 'Post-War London and Edinburgh', 'The Grand Tour' and 'Visits Abroad'. Similarly, Bernard Myers' *The Reminiscences of a Physician* (Wellington: A. H. & A. W. Reed, 1949) included chapters on 'England', 'A Children's Clinic in London', and a 'Lecture Tour in the USA'.

<sup>11</sup> See Sir Fred Bowerbank, *A Doctor's Story* (Wellington: Harry H. Tombs, 1958) and A. W. Beasley, 'Bowerbank, Fred Thompson – Biography', from *The Dictionary of New Zealand Biography, Te Ara: The Encyclopaedia of New Zealand*, URL: <http://www.TeAra.govt.nz/en/biographies/4b46/1>, accessed 16 July 2012.

<sup>12</sup> Donald Stafford Matthews, *Medicine My Passport* (London: George G. Harrap & Co, 1957).

While Drs Bowerbank and Matthews are perhaps extreme examples of medical mobility, my research suggests that it is impossible to find a twentieth century New Zealand medical biography or autobiography that does not refer to international travel or connections.<sup>13</sup>

This is also true for the few histories of medical organisations published in New Zealand. These invariably contain numerous references to the role of ‘parent’ or ‘sister’ organisations overseas, to visits by overseas luminaries, and to the influence of changing health-related policies in other countries. In part, this reflects the fact that many of the professional organisations that New Zealand doctors joined were themselves international in scope. In the context of New Zealand’s small national population, medical specialists had little choice but to affiliate at the regional (that is, Australasian) or international levels if they wished to make viable their collective professional activities, such as conference organisation, journal publication, or policy lobbying.<sup>14</sup>

The histories of New Zealand medical institutions are also full of international references.<sup>15</sup> While this theme will be discussed in more detail in the

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<sup>13</sup> This research has involved the examination of approximately thirty medical biographies and autobiographies, listed in the bibliography. The list does not cover every medical autobiography published in New Zealand, as some general practitioner autobiographies were not considered. But even books by general practitioners include references to international education, training, or travel.

<sup>14</sup> Histories of medical organisations or groups in New Zealand or Australasia include Mervyn J. Eadie’s *The Flowering of a Waratah: A History of Australian Neurology and of the Australian Association of Neurologists* (Sydney: John Libbey, 2000), Colin Hooker’s *Orthopaedics in New Zealand* (New Zealand Orthopaedic Association, 1996), Rowan Nicks’ *Surgeons All: The Story of Cardiothoracic Surgery in Australia and New Zealand* (Sydney: Hale & Iremonger, 1984), G. D. Phillips and R. V. Truhbuhovich, *Australian and New Zealand Intensive Care Society: A Record of Events, The First 25 Years: 1975-2000* (Melbourne: Australian and New Zealand Intensive Care Society, 2000), Sarah (Sally) Wilde’s, *Joined Across the Water: A History of the Urological Society of Australasia* (Melbourne: Hyland House, 1999) Gwen Wilson’s *One Grand Chain: The History of Anaesthesia in Australia, 1846-1962* (Melbourne, The Australia and New Zealand College of Anaesthetists, 1995), Ronald Winton’s *Why the Pomegranate: A History of the Royal Australasian College of Physicians* (Sydney, Royal Australasian College of Physicians, 1988), Josephine Wiseman’s *To Follow Knowledge: A History of Examinations, Continuing Education and Specialist Affiliations of the Royal Australasian College of Physicians* (Sydney: Royal Australasian College of Physicians, 1988), and Rex Wright-St Clair’s *A History of the New Zealand Medical Association: The First 100 Years* (Wellington: Butterworths, 1987).

<sup>15</sup> See, for example, John Angus, *A History of the Otago Hospital Board and its Predecessors* (Dunedin: Otago Hospital Board, 1984), John Armstrong, *Under One Roof, A History of Waikato Hospital* (Hamilton: Half Court Press, 2009), Laurie Barber and Roy Towers, *Wellington Hospital: 1847-1976* (Wellington: Wellington Hospital Board, 1976), F. O. Bennett, *Hospital on the Avon: The History of Christchurch Hospital, 1862-1962* (Christchurch: North Canterbury Hospital Board, 1962), Sir Charles Hercus and Sir Gordon Bell, *The Otago Medical School Under the First Three Deans* (Edinburgh: Livingstone, 1964), B. R. Hutchinson, *Green Lane Hospital: The First Hundred*

following section, a useful illustrative example is Dorothy Page's history of the Otago Medical School, which makes frequent references to the overseas origins and continuing loyalties of staff, to the influence of changing international standards and conventions, and to the difficulties that arose from the availability of better working conditions overseas.<sup>16</sup> In the case of medical education, the need to provide qualifications that would be recognised in overseas jurisdictions made international relationships of various kinds a central issue in policy formation.

### *Medical History and the Nation*

References to international connections and colleagues are ubiquitous in New Zealand medical autobiography and historiography. However, the significance of those references has been consistently understated.<sup>17</sup> I suggest that this is largely attributable to the widespread use of the nation-state as a conceptual, organisational, and narrative framework in much historical writing and thinking – including medical history and medical autobiography – prior to the social and cultural turns of the 1960s and 1970s, and indeed, after them.<sup>18</sup>

The German historian of national narratives, Stefan Berger, argues that in the European context, works of history designed to tell the story of a discreet nation – usually delineated in terms of a relatively identifiable ethnic group or groups – were produced as far back as the Middle Ages and the early modern

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*Years* (Auckland: Green Lane Hospital Centenary Committee, 1990), Jo Kellaway and Mike Maryan, *A Century of Care: Palmerston North Hospital, 1893-1993* (Double Bay, N.S.W.: Focus Books, 1993), and Craig Mackenzie, *Hospital in the Valley: The Story of Hutt Hospital* (Palmerston North: Dunmore Press, 1983).

<sup>16</sup> Dorothy Page, *Anatomy of a Medical School: A History of Medicine at the University of Otago, 1875-2000* (Dunedin: Otago University Press, 2008).

<sup>17</sup> I should note that for the purposes of this discussion I am defining 'medical history' as a field of study related to the activities and institutions of medical professionals. Health history, of which medical history is a subset, is a much wider field, encompassing topics such as epidemiological history, the history of disease, cultural histories of illness, and the histories of 'non-medical' health practitioners.

<sup>18</sup> For fuller discussions of the relationship between historical writing and the nation-state, see Joyce Appleby, Lynn Hunt and Margaret Jacob, *Telling the Truth About History* (New York: Norton, 1994), pp. 91-107, *Writing The Nation: A Global Perspective*, ed. by Stefan Berger (Basingstoke: Palgrave Macmillan, 2007), Stefan Berger, Mark Donovan, and Kevin Passmore, *Writing National Histories: Western Europe Since 1800* (London: Routledge, 1999). The origins of nationalist historical narratives will be discussed in Chapter 1: Conceptualising the Common-Health as a System Historiography, Theory, and Method.

period.<sup>19</sup> However, as the work of historians became professionalised during the late eighteenth and nineteenth centuries, historical scholarship achieved greater cultural authority and thus became more widespread as a political tool for the construction and reconstruction of national myths and identities, and for the legitimisation of sovereign state power.<sup>20</sup> Recognising this value, state governments and their agents became willing sponsors of historians' work. The symbiotic relationship between states and historians ensured that throughout the nineteenth and twentieth centuries, 'the nation' functioned as one of the central organisational structures not only of many official 'national histories', but of much historical writing in general. The narrative trajectories of countless biographical, institutional, social, and military histories were shaped by the trope of 'the rise of the nation', while the events they describe are routinely explained or justified in terms of the nation-state.

Medical history, which encompasses biographical, institutional, political, and social modes, has also been shaped by nation-centred discourses. In the New Zealand context, the titles of many early medical autobiographies – *Doctor in the Sticks*; *Stethoscope and Saddlebags*; *Back-Blocks Baby Doctor*; and *Doctor in the Mountains* – resonate with the popular national image of the pioneer and the 'man-alone', or in Dr Doris Gordon's case, the woman alone.<sup>21</sup> In 1950, the New Zealand-born surgeon and medical statesman, Sir Arthur Porritt, delivered a memorial oration for doctors killed during World War Two, in which he claimed that New Zealand national identity – defined in terms of the pioneering spirit and sporting and military values – served as a 'firm rock of faith' for doctors in times made unstable by war, depression, and 'moral and economic failing'.<sup>22</sup> Seventeen years later, while writing one of the earliest surveys of the history of New Zealand medicine, Porritt again drew upon common national myths when he noted that the

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<sup>19</sup> Stefan Berger, 'The Power of National Pasts: Writing National History in Nineteenth- and Twentieth-Century Europe', in *Writing the Nation: A Global Perspective*, ed. by Stefan Berger (Basingstoke: Palgrave Macmillan, 2007), p. 30.

<sup>20</sup> Berger, 'The Power of National Pasts', p. 33.

<sup>21</sup> D. A. Bathgate, *Doctor in the Sticks* (Auckland: Collins, 1972), Eleanor S. Baker McLaglan, *Stethoscope and Saddlebags: An Autobiography* (Auckland: Collins, 1965), Doris Gordon, *Back-Blocks Baby Doctor: An Autobiography* (London: Faber and Faber, 1955), and W. A. Anderson, *Doctor in the Mountains* (Wellington: A. W. & A. H. Reed, 1964). The central character of John Mulgan's *Man Alone* (London: Selwyn & Blount, 1939) has often been touted as the iconic New Zealand male: single, itinerant, resourceful, rurally based, and loyal.

<sup>22</sup> Sir Arthur Porritt, 'Mars and Aesculapius: A New Zealand Memorial Oration', *British Medical Journal*, volume 2, number 4694 (23 December 1950), pp. 1438-40.

first European doctors had exhibited ‘sturdy individualism’ both in their professional lives and in their sporting achievements, and that the passing of certain parliamentary statutes legislating health policy in advance of Britain confirmed New Zealand as the social laboratory of the world. According to Porritt, the sound physical and mental health of New Zealanders was a product of their descent from ‘virile stock’, and their living ‘an essentially outdoor life’ bathed in ‘ample sunshine’.<sup>23</sup>

Such national myths proved remarkably durable. In 1984, the cardiologist and amateur historian, Rowan Nicks, wrote that Australasia’s first cardiologists were ‘young and vigorous’ men who worked hard to ‘blaze a trail through the forest of cardiovascular disease’.<sup>24</sup> Similarly, Dr Rex Wright-St Clair’s 1987 centenary history of the New Zealand Medical Association began by presenting the image of ‘rural practitioners riding to their patients on horseback, rain, hail or shine’ over the roughest terrain, fording rivers, and following tracks through bush, improvising splints for broken limbs, and operating on kitchen tables by candlelight.<sup>25</sup> Such images did not function as mere romantic decoration. For these historians – all of whom, it should be noted, were doctors – the story of an emerging national identity represented a useful framework upon which to construct and legitimise a supposedly unique professional identity. Rex Wright-St Clair, for example, argued that while ‘New Zealand medicine’ had started life as a transplanted outpost of British medicine, its practitioners had quickly organised themselves into a cohesive and distinct entity, eventually coming of age with the achievement of organisational and political autonomy, and a unique sense of ‘national identity’.<sup>26</sup> By the 1960s, according to Wright-St Clair, the political views of overseas doctors and administrators were largely irrelevant because New Zealand medicine had, by that stage, evolved to a point that it could, and should, be considered a unique and separate professional entity. His assertion that British connections no longer had ‘practical political advantages for New Zealand’

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<sup>23</sup> Sir Arthur Porritt, ‘The History of Medicine in New Zealand’, *Medical History*, volume 11, number 4 (October 1967), p. 341.

<sup>24</sup> Rowan Nicks, *Surgeons All: The Story of Cardiothoracic Surgery in Australia and New Zealand* (Sydney: Hale & Iremonger, 1984), p. 78.

<sup>25</sup> Rex Wright-St Clair, *A History of the New Zealand Medical Association: The First 100 Years* (Wellington: Butterworths, 1987), unpaginated dedication prior to foreword.

<sup>26</sup> Wright-St Clair, *A History of the New Zealand Medical Association*.

because ‘our government dealt with our Association and that was that’ can also be read as an expression of New Zealand exceptionalism, and even isolationism.<sup>27</sup>

The key point is that in each of these examples, and in many others, the use of narratives that foregrounded the emergence of distinctly ‘national’ characteristics or structures often resulted in international connections being downplayed or ignored. Despite the ubiquity of such references to international connections in New Zealand and Australasian medical historiography, international exchange is rarely explored as a historical theme in its own right. Instead, international connections tend to be subsumed within the meta-narrative of an emerging and evolving ‘New Zealand medicine’. Professor David Skegg’s prefatory recognition of Dorothy Page’s successes in placing the history of the Otago Medical School, with its myriad international references, ‘in the broader context of New Zealand’s social history’ inadvertently reflects this.<sup>28</sup> Similarly, while the short concluding chapter of Professor Mervyn Eadie’s history of the Australasian Association of Neurologists, *The Flowering of the Warratah*, seeks to understand the development of the specialty in Australasia relative to its evolution in Britain, the approach taken is strictly comparative; the differing rates of development are attributed entirely to the different economic and demographic conditions within the respective countries, and the influence of the many professional interactions that occurred between them is ignored.<sup>29</sup> Despite the title of Sally Wilde’s history of the Urological Society of Australasia – *Joined Across the Waters* – and the title of its opening chapter, ‘The International Context’, the book’s content and overarching narrative structure is very much limited to telling the story of the specialty’s development within a particular national context, or in

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<sup>27</sup> In a similar vein, his 1987 article summarising the history of the *New Zealand Medical Journal* argued that the period from 1886 to 1887 was significant for local medical professionals because it marked the ‘beginning of their self-identification as New Zealand doctors’. For Wright-St Clair, the establishment of the New Zealand Medical Association in 1886, the graduation of the first locally trained doctor in 1887, and the launch of the *New Zealand Medical Journal* that same year symbolised and confirmed the achievement of a distinctively ‘national’ medical culture. Rex Wright-St Clair, ‘The Early Years of the New Zealand Medical Journal, 1987-96’, *New Zealand Medical Journal*, volume 100 (14 October 1987), p. 622. The focus placed on the work of Dr Rex Wright-St Clair here is a reflection on his prolific output rather than any exceptional strain of medical nationalism in his work. As this *Introduction* has noted, the work of several other medically trained historians and commentators, including Sir Arthur Porritt and Douglas Robb, also regularly assumed the existence of a distinctly New Zealand medical culture.

<sup>28</sup> Page, p.7.

<sup>29</sup> Mervyn J. Eadie, , *The Flowering of a Waratah: A History of Australian Neurology and of the Australian Association of Neurologists* (Sydney: John Libbey, 2000).

that particular case, two national contexts.<sup>30</sup> Colin Hooker's history of New Zealand orthopaedics is so alive to the importance of international influences such that the book's overall national frame seems incongruous.<sup>31</sup> It is important to note that these observations are not intended to be critiques, but instead highlight the almost instinctive adoption of a conceptual framework in historical works that is often at odds with the realities of the subjects they describe. As Hooker's short chapter, 'New Zealand and World Orthopaedics' demonstrates, foregrounding international, rather than national developments is both possible and productive.<sup>32</sup> Gwen Wilson's *One Grand Chain, The History of Anaesthesia in Australia*, which consistently depicts Australian developments as a single node or case study within a wider, fundamentally international narrative of change, is perhaps the most notable, and certainly the most sustained, local example of this approach.<sup>33</sup>

#### *The 'Common-health' as an Alternative Historical Framework*

As mentioned in the Preface, my intention to explore the instrumentality of an international framework in this thesis has its origins in ideas explicated by the New Zealand historian, Peter Gibbons, in an influential series of essays written between 1986 and 2003.<sup>34</sup> In the last of those essays, 'The Far Side of the Search for Identity: Reconsidering New Zealand History', Gibbons proposes two possible alternatives to nation-centered historical narratives. First, he argues that New Zealand historians might take macro-historical or 'world systems' approaches that

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<sup>30</sup> Sarah (Sally) Wilde, *Joined Across the Water: A History of the Urological Society of Australasia* (Melbourne: Hyland House, 1999).

<sup>31</sup> Colin Hooker, *Orthopaedics in New Zealand* (New Zealand Orthopaedic Association, 1996)

<sup>32</sup> Hooker, pp. 167-75.

<sup>33</sup> Gwen Wilson, *One Grand Chain: The History of Anaesthesia in Australia, 1846–1962* (Melbourne, The Australia and New Zealand College of Anaesthetists, 1995).

<sup>34</sup> See *Preface*, footnote 7. In his 1992 PhD thesis, Gibbon acknowledged an intellectual debt to scholars of 'colonial discourse and the semiotics of conquest and colonisation; the cultural politics of representing traditional cultures; biculturalism; [and] matters of culture and identity.' Peter Gibbons, 'Going Native: A Case Study of Cultural Appropriation in a Settler Society, With Particular Reference to the Activities of Johannes Andersen in New Zealand During the First Half of the Twentieth Century', PhD Thesis, University of Waikato, 1992, p. iv. Foremost among the scholars Gibbons cites was the Palestinian literary theorist Edward Said, and in particular, his seminal 1978 study, *Orientalism* (London: Routledge & Kegan Paul, 1978). The relationship of Peter Gibbons' ideas to wider scholarship is acknowledged and discussed in more detail later in this *Introduction*.

foreground economic interactions between various urban centres, rather than between nation-states. Such approaches, Gibbons argues, might ‘transform understandings of many supposedly locally centred events, enabling us to see the extent to which they are responses to, and within, larger systems.’<sup>35</sup> Gibbons’ second alternative to nation-centred narratives is to use ‘micro-historical’ investigations of individuals or small communities in order to generate insights into the ‘attitudes, beliefs, mentality and values of communities or classes or local institutions’, thereby illuminating the ‘complex dialectics between person and society’.<sup>36</sup> He also notes that macro- and micro-historical approaches could be used in partnership, by examining the consumption and production patterns of individuals or small groups in order to map their involvement in long-distance systems of exchange.<sup>37</sup>

This thesis represents an attempt to place the individual experiences of New Zealand trainee specialists and the various structures within which they worked in the same analytical frame. To do this requires several apparent dualisms to be addressed and reconciled. The first of these is the classic historical dualism of structures and agents. The thoughts and actions of individual doctors were not determined by the infrastructures and environments they inhabited, but nor were they formed independently of those structures and contexts. The second dualism is that of the national and the international. While the chapters that follow argue that international networks underpinned specialist medical practice, they also acknowledge the instrumentality of economic factors, organisations, cultural traditions, and discourses as they manifested at the national, regional, and even institutional levels. To paraphrase the French sociologist of science, Bruno Latour, the international medical system was local at all points.<sup>38</sup> The corollary of this is that all localities were also influenced by their involvement in international systems. The final, related, and necessarily imprecise dualism addressed is that of the material and the cultural. The decisions of individual doctors and the policies

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<sup>35</sup> Gibbons, ‘The Far Side of the Search for Identity’, p. 41.

<sup>36</sup> Gibbons, ‘The Far Side of the Search for Identity’, p. 45.

<sup>37</sup> Gibbons, ‘The Far Side of the Search for Identity’, pp. 45-6.

<sup>38</sup> Bruno Latour, *We Have Never Been Modern*, translated by Catherine Porter (Cambridge, MA., Harvard University Press, 1993), p. 117. Cited by Warwick Anderson, ‘Introduction: Postcolonial Technoscience’, *Social Studies of Science*, volume 32, number 5/6 (October-December 2002), p. 649.

of their representatives were shaped by both cultural assumptions and economic conditions.

Fundamentally, the concept of the ‘Common-health’ used in this thesis is conceived as a mechanism for holding the local, international, individual, and structural aspects of professional medicine within the same analytical frame. It also acknowledges that international networks comprised both real-world ‘patterns of connection on the ground’ and discursive ‘ideologies of connection and community’.<sup>39</sup> Reconciling these various aspects, and their interactions, has required the adoption of a mixed methodology, and by extension, a theoretical foundation that combines the insights of several thinkers and their work. Unifying these various approaches, however, is an overarching analytic stance or principle best summarised by the term ‘perspectival dualism’, coined by the American social theorist Nancy Fraser. For Fraser, the concept of perspectival dualism represents an attempt to acknowledge the ‘interpenetration’ of cultural and economic aspects of human societies without losing sight of their ‘differentiation’.<sup>40</sup> In this thesis, Fraser’s core insight of ‘interpenetrating but differentiated’ serves as the key guiding principle in the selection of theories and methods, and in the interpretation and analysis of sources. Perspectival dualism is therefore the founding concept behind a ‘Common-health’ of medicine conceived as *simultaneously* international, national, and local, shaped by both individual agency and structural conditions, and manifesting in both ‘real-world’ exchanges and discourse-based ideologies.

While the particular ways in which various methods and theories have been marshalled to this end will be discussed in detail in the following chapter, it is important at this stage to note that the adoption of perspectival dualism has ultimately resulted in a particular conceptualisation of the Common-health: that it was a *system*. This is not meant to imply that the multiple connections that characterised professional medicine after World War Two were directed towards a specific end, but rather that the various components were *collectively* ‘interpenetrating but differentiated’. By conceiving the networks of interpersonal relationships, organisational linkages and medical discourses as a single, mutually

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<sup>39</sup> Peggy Levitt and Nina Glick Schiller, ‘Conceptualising Simultaneity: A Transnational Social Field Perspective on Society’, *International Migration Review* (volume 38, number 145 (Fall 2004)), p. 5.

<sup>40</sup> Nancy Fraser and Axel Honneth, *Redistribution or Recognition A Political-Philosophical Exchange* (London: Verso, 2003), pp. 63-4.

interpenetrating system, the thesis is better able to tease out the interactions that occurred both within and between these various modes of exchange.

From the outset, it must be emphasised that while the term Common-health is used to refer to an interconnected and mutually interacting network of cultural, political, professional, and interpersonal relationships, it is not intended to imply any easily demarcated cultural, geographical, or interpersonal space. While the term intentionally implies a strong association with the British Commonwealth, it does not refer exclusively to the activities of Commonwealth doctors working within the context of Commonwealth nations. The Common-health was shaped in powerful ways by migrations, laws, technologies and ideas originating from nations outside the British Commonwealth, as well as within.<sup>41</sup> Similarly, while I will use the term to refer to a particular set of traditions and cultural understandings, few, if any, of these were unique to the British Commonwealth. In addition, the particular characteristics of the Common-health changed over time, under the influence of factors that were not always under the control of the medical profession. Broader political, social, and economic changes influenced medical politics, training practices, and migration patterns. The following chapters acknowledge, where appropriate, the ‘unboundedness’ of what was a highly complex and far-reaching network of interactions and relationships.

The mutual interaction of the Common-health’s many components is perhaps a more useful defining characteristic than its ‘boundaries’. At one level, the Common-health comprised a network of interpersonal relationships and individual migrations. However, this network was conditioned and patterned by a range of factors including institutional and professional policies, economic pressures, social attitudes, cultural conventions, and the relative sizes of national and municipal populations. Together, these factors influenced the particular training institutions that New Zealand doctors chose in Britain, the distribution of doctors of different genders and ethnicities between institutions, and even between different medical specialties. What is more, all of these aspects of the Common-health system were deeply intertwined. A change to any one of them could

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<sup>41</sup> Germany and Japan, for example, became important suppliers of medical equipment during the post-World War Two era, while doctors from Continental Europe, South America, and South Asia also interacted with New Zealand doctors on a regular basis and through a variety of means. The changing relationship with the United States is explored in Chapter 7: The Fragmenting of the Common-health.

resonate throughout the system and lead to changes elsewhere. An adjustment to the pass-rate of an Australasian professional examination, for example, could, and did, have a profound influence on the volume and pattern of medical migration to Britain, while the invention of a new medical technique could alter the economics of a particular specialty to such a degree that opportunities were created for women practitioners where no such opportunity had existed before. It is in this sense that the ‘Common-health’ concept draws together individuals, structures, and discourses into a single framework for historical analysis.

Clearly, the concept of a ‘Common-health’ system generates associations with the Commonwealth system, and by extension, with British imperialism. This is also intentional, and is in part a reaction to nation-centred narratives that often depict British influence as little more than an unfortunate colonial backstory.<sup>42</sup> However, the emphasis that this thesis places on the relationship between British medical structures and the broader international ‘Common-health’ system should not be read as an assertion of the ‘centre and periphery’ model of colonial relations, which depicts social, political, and economic influence radiating unilaterally from the metropolitan centre to its passive and receptive colonies.<sup>43</sup> While the following chapters often highlight the penetration of British structures and ideas into the broader Common-health, they will also demonstrate that the rich and intimate connections that characterised the system transmitted people, ideas, and influence in multiple directions, by multiple means.<sup>44</sup> As a number of scholars have noted, this often resulted in ostensibly ‘British traditions’ being strongly

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<sup>42</sup> Pocock suggested that the work of the New Zealand historical nationalist, Keith Sinclair, was in part a reaction to Britain’s turning away from its former colonies and towards Europe. ‘Being denied his inheritance [by Britain’s joining the EEC], [Sinclair] denied that he ever had one.’ J. G. A. Pocock, *The Discovery of Islands* (Cambridge: Cambridge University Press, 2005), p. 21. Sinclair’s most influential works included *A History of New Zealand* (Harmondsworth: Penguin, 1959); *A Destiny Apart: New Zealand’s Search for National Identity* (Wellington: Allen & Unwin, 1986); *The Native Born: The Origins of New Zealand Nationalism* (Palmerston North: Massey University, 1986); and *The Oxford Illustrated History of New Zealand*, ed. by Keith Sinclair (Auckland: Oxford University Press, 1990).

<sup>43</sup> Trevor M. Simmons’ review article, ‘Conceptualizing the Geography of Empire’, *Journal of Historical Geography*, volume 37, number 1 (January 2011), pp. 127-30 provides a very useful brief survey of the historiography of the concept of ‘centre and periphery’ in the colonial context.

<sup>44</sup> This does not suggest that British doctors necessarily *invented* these ‘British’ medical traditions. Investigating the roots of these ideas is beyond the scope of this thesis. Comprehensive examinations of ‘the roots of medicine’ can be found in Roy Porter, *The Greatest Benefit to Mankind* (London: Fontana, 1999 [first published 1997]), and Lawrence Conrad, et al, *The Western Medical Tradition : 800 B.C.-1800 A.D.* (Cambridge: Cambridge University Press, 1995).

shaped by activity in the colonies.<sup>45</sup> In addition, while long lasting networks of interaction certainly ensured that commonalities existed between ‘metropole’ and ‘periphery’, *variations* also developed as ideas and structures were applied in different political and cultural settings at different times.<sup>46</sup> To assert that Britain had an important, or even central, place in the Common-health medical system is therefore not to deny the myriad ways in which the resulting interactions shaped British medicine. Indeed, reconceptualising the development of specialised medicine across the Common-health as the outcome of a system of international exchange inflected with British norms and traditions might represent a useful starting point for a re-evaluation of the ways in which extra-local norms and traditions have shaped, and continue to shape, health-service delivery in ‘post’ colonial societies.

In 1972, the sociologists of the British medical profession, Terence Johnson and Marjorie Caygill, felt justified to argue that ‘at various points in the historical development of the [medical] profession any distinction between the

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<sup>45</sup> See Warwick Anderson, ‘Postcolonial Histories of Medicine’, in *Locating Medical History: The Stories and Their Meanings*, ed. by Frank Huisman and John Harley Warner (Baltimore: Johns Hopkins University Press, 2004), pp. 462-82, ‘How’s the Empire? An Essay Review’, *Journal of the History of Medicine and Allied Sciences* volume 58, number 4 (2003), pp. 459-465, and ‘Introduction: Postcolonial Technoscience’, *Social Studies of Science*, volume 32, number 5/6 (October-December 2002), pp. 643-658. Other notable examples include David Arnold, *Imperial Medicine and Indigenous Responses* (Manchester: Manchester University Press, 1988), Tony Ballantyne, *Orientalism and Race: Aryanism in the British Empire* (Basingstoke: Palgrave, 2002), Roy MacLeod, ‘On Visiting the “Moving Metropolis”: Reflections on the Architecture of Imperial Science’, in *Scientific Colonialism: A Cross-Cultural Comparison*, ed. by Nathan Reingold and Marc Rothenberg (Washington: Smithsonian Institution Press, 1987), pp. 219-49, Roy MacLeod and Milton Lewis, eds, *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London: Routledge, 1988), and Douglas M. Haynes, ‘Victorian Imperialism in the Making of the British Medical Profession’, in *Decentering Empire: Britain, India and the Transcolonial World*, ed. by Durbha Ghosh and Dane Kennedy (Hyderabad: Orient Longman, 2006), pp. 130-56, and Alan Lester, ‘Imperial Circuits and Networks: Geographies of the British Empire’, *History Compass*, volume 4, number 1 (January 2006), pp. 124-41.

<sup>46</sup> The New Zealand historian, Derek Dow, has noted that British medicine evolved in social conditions and historical circumstances radically different to those encountered in nineteenth-century New Zealand. In addition, the dissatisfaction which motivated at least some migrants to leave Britain was likely to result in an unwillingness to perpetuate certain aspects of British society. See Derek Dow, ‘Springs of Charity?: The Development of the New Zealand Hospital System, 1876-1910’ in *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, ed. by Linda Bryder (Wellington: Bridget Williams, 1991), pp. 44-5. Deborah Gordon makes a similar point in her study of the cultural aspects of western medicine. She stresses that identifying a set of foundational ideas and beliefs should not imply that ‘western medicine’ is monolithic. Rather, she argues that it is instead comprised of a multiplicity of biomedicines, differing along economic, national, regional, and ethnic lines. See Deborah R. Gordon, ‘Tenacious Assumptions in Western Medicine’, in *Biomedicine Examined* ed. by Margaret M. Lock and Deborah R. Gordon (Dordrecht: Kluwer Academic Publishers, 1988), p. 22.

profession in Britain and overseas, while geographically significant, was in a number of ways socially unreal.<sup>47</sup> While this claim clearly supports my contention that the New Zealand and British medical establishments were parts of a single system, it also risks overstating these commonalities by assuming that medicine throughout the Commonwealth was a simple geographic extension of British medical culture and structures. While useful as a corrective against claims of national distinctiveness, this is perhaps to err too far in the other direction. Not only does it risk overlooking important differences that existed between the various parts of the Commonwealth, but it also risks obscuring significant variations between and within the nations, localities, institutions, and social groups that together constituted 'Britain' in the period under discussion. With this in mind, this thesis does not endeavour to summarise 'British values' or 'British medical values' in an ethnographical or psychological sense. While the thesis uses terms such as 'Britain' and 'British' frequently, I have endeavoured to limit their use, respectively, as a signifier of geographical location and as a referent to aspects of society or professional organisation that might be considered as generally stable or universal across most of the British Isles. More often, however, the topics under discussion require more careful contextualisation, and where this is the case, the particular national, regional, or institutional setting will be used. In terms of national contexts, the thesis focuses mainly on England and Scotland, as these had the strongest influence over professional medicine in New Zealand. Drilling down, other discussions are framed in terms of the relationship between London institutions and their regional counterparts, or between particular kinds of institution within London.

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<sup>47</sup> In 1968, between 22,000 and 24,000 members of Britain's health workforce were from overseas and the majority were from the Commonwealth. Of these, approximately 5,500 were doctors holding training appointments in hospitals. Terence J. Johnson and Marjorie Caygill, *Community in the Making: Aspects of Britain's Role in the Development of Professional Development in the Commonwealth* (London: Institute of Commonwealth Studies, University of London, 1972), p. 33.

## *Structure of the Thesis*

With these conceptual foundations in mind, the remainder of this Introduction will outline the content and purposes of the seven substantive chapters that comprise this thesis. Chapter 1: ‘The Common-Health as a System: Historiography, Theory, and Method’, is largely devoted to mapping out the theoretical positions that this thesis uses to engage with each of the three dualisms discussed above. Understanding and representing the relationships between localities and wider extra-local networks, between individuals and structures, and between material and cultural systems together account for a significant mass of historical scholarship, and a significant proportion of current scholarly debate. Chapter 1 surveys those aspects of these debates that relate to the concept of the Common-health, to the selection of sources, and to the design and implementation of the research methodologies that are used to analyse and interpret those sources. Overall, the adoption of perspectival dualism as an underlying analytic position has necessitated a mixed methodology that includes the analysis of oral interviews, the textual analysis of autobiographies, government reports, professional surveys, and institutional histories, and the qualitative and quantitative analysis, using a computerised database, of 770 obituaries published in the *New Zealand Medical Journal* between 1939 and 2008.

Chapter 2: ‘The Origins of the Common-health’ outlines the origins and development of those aspects of British professional medicine that later became important features of the Common-health system.<sup>48</sup> As is the case with this thesis’ attempt to map the Common-health itself, this chapter’s exploration of the system’s origins is less an exercise in definition than of articulating complexity.

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<sup>48</sup> It is acknowledged that the phrase ‘regular medicine’ is loaded and therefore contested. However, there is no uncontroversial alternative. ‘Conventional’ has similarly hegemonic connotations, ‘Western’ medicine ignores the profound influence of non-European practitioners, and ‘allopathic’ medicine is often perceived to be pejorative by ‘regular’ practitioners. On the other hand, terms such as ‘alternative’, ‘complementary’, and ‘irregular’ tend to define particular practices in relation to a normative ‘regular approach’. In the context of this thesis, the ‘medical profession’ refers to doctors working within ‘conventional’ regulated professional frameworks. For discussions on the terminology of medical practice, see Roberta Bivins’ ‘Introduction’ in *Alternative Medicine?: A History* (Oxford: Oxford University Press, 2007), pp. 1-40, and Bivins, ‘Histories of Heterodoxy’, in *The Oxford Handbook of the History of Medicine*, ed. by Mark Jackson (Oxford: Oxford University Press, 2011), pp. 578-97. In the New Zealand context, see Joanna Bishop, ‘The Role of Medicinal Plants in New Zealand’s Settler Medical Culture, 1850s-1920s’, PhD Thesis, University of Waikato, forthcoming.

To this end, it argues that ‘British medicine’ was actually far less unified and homogeneous than the term implies. Important differences existed between Britain’s various national medical establishments, between hospital-based doctors and general practitioners, between doctors working in urban and provincial settings, and between physicians and surgeons. These differences manifested in the form of income discrepancies, differing educational approaches and emphases between countries and institutions, varying attitudes to medical specialisation, and in a rigid occupational hierarchy that gave immense power to a numerically small group of elite practitioners: the London-based physicians.

In Chapter 3: ‘The Development of the Common-health’, I suggest that the dynamic and often competing blend of personal and collective interests that characterised British medicine contributed directly to its internationalisation, and thus to the development of the Common-health system. From the mid-nineteenth century, domestic conditions and an expanding Empire together encouraged thousands of British doctors to move overseas. British professional organisations, institutional systems, clinical standards, and medical qualifications were also transmitted, in various forms, to the colonies. Soon after, Britain in turn became a destination for colonial subjects seeking undergraduate medical education.<sup>49</sup> Then, in the four years from 1914 to 1918, the unprecedented migration of thousands of already-qualified doctors from around the world to Britain transformed and revitalised interaction between British and colonial medical personnel and structures, most significantly by stimulating the development of Britain’s previously limited structures for post-graduate training. When World War Two generated another surge of medical migrations, Britain was much better prepared, and quickly became a hub for post-war specialist training across the Commonwealth. Through this process, the Common-health system was born.

Chapter 4: ‘New Zealanders in the Common-health’ considers the interaction of New Zealand medical structures and the Common-health system, with particular regard to the effects of that interaction on medical migration patterns. The chapter suggests that those interactions were such that many aspects of New Zealand’s domestic medical structure might be usefully reconceptualised

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<sup>49</sup> For a discussion of the close relationship between New Zealand and British health and medical education systems, see Dow, ‘Springs of Charity?’, pp. 44-5, and Page, *Anatomy of a Medical School*, particularly Chapter 2, ‘An Outpost of Edinburgh’, pp. 25-33.

as extensions or parts of the broader Common-health system. The motivations and patterns of New Zealand's domestic medical migration had much in common with international patterns, while expectations and conventions originating in the British system influenced the ability of New Zealand doctors to enter and negotiate the Common-health network. Chapter 5: 'The Migration Experience' extends this discussion by examining the experiences of New Zealand doctors who travelled to Britain during the 1950s and 1960s, when the Common-health system was operating at its peak. Chapter 5 considers migrants' objectives, discusses some of the challenges that New Zealand doctors faced while trying to meet those objectives, and examines the informal, interpersonal relationships that both facilitated migration and helped migrants to deal with the challenges that arose. The chapter concludes with a discussion of the ways in which the 'outsider' status of some New Zealand doctors, in the contexts of both New Zealand undergraduate education and British post-graduate training, seemed to contribute to their professional success, rather than to the professional marginalisation that might be expected.

Together, Chapters 1 to 5 of this thesis serve to outline the development of the Common-health system, and to highlight the ways in which that system facilitated migration and promoted the careers of New Zealand specialist doctors. Chapter 6 explores the ways in which the Common-health system functioned as a mechanism for exclusion, or at least, for heavily prescribed forms of inclusion. For women doctors and those of non-white ethnicity, the deep interrelation of cultural norms, individual attitudes, professional structures, and employment opportunities functioned as powerful inhibitors of professional choice. The chapter begins with a discussion of the ways in which those white, male doctors who identified themselves as outsiders, considered in Chapter 5, still managed to access and utilise the informal networks that were so vital to establishing specialist careers. It then surveys the participation of women in medicine, paying particular attention to the ways in which traditional attitudes about women doctors influenced their ability to form the informal relationships that facilitated access to Common-health training structures, to migrate, and by extension, to forge careers in specialised medicine.

Chapter 7 discusses the ways in which the Common-health system changed and 'fragmented' during the 1960s and 1970s. This chapter suggests that

many of those processes and factors that contributed to the development of a heavily Anglo-centric Commonwealth system up to World War Two, and to its continuing operation for twenty years afterwards, also contributed to the decentralisation of Britain in that system, and, from a New Zealand point of view, to a more multilateral system in which the United States and Australia became prominent. Chapter 7 also looks at some of the ways in which leading doctors in Britain and New Zealand attempted to preserve international connections in the face of fragmenting political and professional systems.

Together, the following chapters map the form and function of an international system that, during the three decades that followed World War Two, influenced the careers of New Zealand medical specialists far more than any national professional structures, policies, or organisations. New Zealand medical graduates drew upon international interpersonal networks to access overseas specialist training opportunities, pursued overseas post-graduate qualifications, and developed long-lasting relationships with colleagues and institutions from all over the world. Personal, professional, and institutional conventions and hierarchies, often of British origin, influenced their selection of specialty fields and shaped their subsequent career trajectories. By evaluating a range of historical sources through a range of analytical and interpretive methodologies, this thesis brings into focus a complex system of international exchange, and takes a first step towards the re-evaluation of New Zealand medical history through an international, rather than national, lens.



## *Chapter 1*

### *The Common-Health as a System: Historiography, Theory, and Method*

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Fundamentally, the ‘Common-health’ concept is an acknowledgement of the complexity of human societies and historical change. As discussed in the Introduction to this thesis, the concept represents an attempt to bring within one analytical frame the actions and experiences of individual people and the many structures within which they operate: institutional, social, professional, legislative, economic, and cultural. It also acknowledges the complex interaction of local and international conditions and events.

This chapter outlines some of the historiographies and theories that have contributed to the Common-health concept, and which underpin the ways in which that concept has functioned as a tool for analysis and interpretation in this thesis. It also makes a case for the value of the Common-health concept by highlighting some of the shortcomings in the existing medical historiography. The concept of the Common-health system is but one of a series of ‘models’ that have attempted to conceptualise the international movements and activities of Commonwealth doctors during the nineteenth and twentieth centuries. I suggest that all of these models have been associated with particular historiographical emphases and methodological approaches. Further, I suggest that these conceptualisations and approaches have contributed to particular characterisations of the medical profession. This chapter begins with a brief review of some influential models of international connection and their associated historiographical emphases, before considering the ways in which these models have framed and represented medical practitioners as a group. The first part of this discussion focusses on work which has examined colonial scientific networks, as

these have served as the main frame of reference for the study of international medical relationships and movements in the nineteenth century. It then reviews the literature on medical migration, which is a leading field of research into international relationships and movements in the twentieth century.

The chapter then discusses some of the theoretical underpinnings of the Common-health concept, with a view to clarifying the ways in which it seeks to address some of the shortcomings discussed in the opening section. The most influential ideas in this regard are those which grapple with the complex interconnectedness of historical actors and factors. The work of the French sociologist and social theorist, Pierre Bourdieu, for example, has proved useful for conceptualising the connections between individuals and the structures within which they interact, and for imagining social formations beyond national borders. The final section of this chapter describes the ways in which these ideas have influenced the selection of sources that this thesis draws on to describe the various aspects of the Common-health system, and also the particular methodologies and forms of analysis that have been used to interpret them.

### *Medical Imperialism*

Until the middle decades of the twentieth century, most works of medical history produced in the Anglophone world emphasised the achievements of a few eminent physicians, framed within metanarratives of an inexorably advancing medical enterprise.<sup>1</sup> In the historiographical sub-field of imperial medicine, this metanarrative typically led to the portrayal of colonial medical services as exemplars of metropolitan beneficence, providing ‘modern’ health-care services to colonists while simultaneously civilising colonised peoples.<sup>2</sup> The biographies

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<sup>1</sup> A valuable survey of the historiography of imperial medicine is provided in Warwick Anderson’s chapter, ‘Postcolonial Histories of Medicine’, in *Locating Medical History: The Stories and Their Meanings*, ed. by Frank Huisman and John Harley Warner (Baltimore: Johns Hopkins University Press, 2004), pp. 462-82.

<sup>2</sup> Indicative examples include H. Harold Scott, *The History of Tropical Medicine*, 2 vols. (Baltimore: William and Wilkins, 1939-42), Charles Morrow Wilson, *Ambassadors in White: The Story of American Tropical Medicine* (New York: Henry Holt, 1942), Michael Gelfand, *Tropical Victory: An Account of the Influence of Medicine on the History of Southern Rhodesia 1890 – 1923* (Cape Town: Juta & Co, 1953), and Paul Russell, *Man’s Mastery of Malaria* (London: Oxford University Press, 1955).

of prominent colonial doctors and the histories of institutions such as the British School of Tropical Medicine regularly framed the activities of their subjects as triumphs of the humanitarian spirit, or of western scientific medicine in general.<sup>3</sup> While these themes were typical of much historical scholarship at the time, the tendency of medical historians to focus on elites and narratives of progress was perhaps accentuated by the fact that a significant proportion of those writers were themselves medical practitioners.<sup>4</sup>

This metanarrative of progress was tied to a particular conception of the nature of international relationships. In 'The Spread of Western Science', published in 1967, George Basalla argued that scientific influence radiated outwards from metropolitan centres to their colonial peripheries, in a pattern analogous to the spokes of a wheel.<sup>5</sup> Basalla's model characterised the development of colonial science as progressive; initially, colonies inherited science carried out in the metropole, then served as sites for scientific research directed from the metropole, before reaching a 'mature' state in which science was carried out locally in response to local imperatives.<sup>6</sup> While Basalla's model referred to the spread of science generally, rather than of medicine specifically, its inherent assumption of progress was the same as that which underpinned those histories that depicted British medicine as a progressive force. At the same time, its emphasis on the development of 'national science' reflects the historiographical tendency to describe the development of medicine in the context of particular national settings.<sup>7</sup>

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<sup>3</sup> Biographical examples include Howard Kelley, *Walter Reed and Yellow Fever* (New York, McClure, Phillips and Co., 1906), Ronald Ross, *Memoirs, with a Full Account of the Great Malaria Problem and its Solution* (London: J. Murray, 1923), Victor Heiser, *An American Doctor's Odyssey: Adventures in Forty-Five Countries* (New York, W. W. Norton, 1936). More general examples include H. Harold Scott, *A History of Tropical Medicine* (Williams and Wilkins: Baltimore, 1939), J. S. Boyd, 'Fifty Years of Tropical Medicine', *British Medical Journal*, volume 1, number 4644 (7 January, 1950), pp. 37-43, Michael Gelfand, *Tropical Victory: An Account of the Influence of Medicine on the History of Southern Rhodesia, 1890-1923* (Juta: Cape Town, 1953), Philip Manson-Bahr, *The History of the School of Tropical Medicine in London, 1899-1940* (London: School of Hygiene and Tropical Medicine, 1956).

<sup>4</sup> For a useful discussion on this topic, see John C. Burnham, 'A Brief History of Medical Practitioners and Professional Historians as Writers of Medical History', *Health and History*, volume 1, number 4 (1999), pp. 250-73.

<sup>5</sup> George Basalla, 'The Spread of Western Science', *Science*, volume 15 (1967), pp. 611-21.

<sup>6</sup> Jan Todd, *Colonial Technology: Science and the Transfer of Innovation to Australia* (Cambridge: Cambridge University Press, 1995), pp. 7-8.

<sup>7</sup> The particular nature of the relationship between historiography and models of connection is considered in the Conclusion to this thesis.

Beginning with the work of Henry Sigerist in the late 1930s, but increasingly from the late 1960s, historians with formal academic training, rather than medical training, broadened the scope of medical history and began to take a less adulatory approach to examining the profession. Rather than focussing on the lives and work of prominent practitioners, professional historians emphasised the social role and status of the medical profession as a whole, or wrote about the institutions in which they worked. Some historians began to look beyond practitioners as the main subjects of medical history, investigating topics such as the epidemiology and social effects of diseases, the evolution of public health measures, and the experiences of patients. As a consequence of this ‘social turn’ in medical historiography, professional historians began to interrogate the metanarrative of progress that had long characterised their discipline, noting, for example, the role that medical professionals had played in resisting the introduction of ‘socialised’ health systems, the subordination of ‘rival’ service providers such as midwives and nurses, and the ways in which their activities could harm, as well as help, individuals and communities.<sup>8</sup> Other scholars – often working in, or under the sponsorship of, newly independent nations – produced histories that foregrounded local agency in the development of public health programmes and institutions, while simultaneously downplaying the legacies of the departed colonising powers.<sup>9</sup>

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<sup>8</sup> Key examples of more socially oriented works of medical history or historiography include Roy Porter, ‘The Patient’s View: Doing Medical History From Below’, *Theory and Society*, 14 (1985), Howard S. Becker, *Boys in White: Student Culture in Medical School* (New Brunswick: Transaction Books, 1977 (first published 1961)), Gesler, William M., *The Cultural Geography of Health Care* (Pittsburgh: University of Pittsburgh Press, 1991). For work in the New Zealand context, see *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, ed. by Linda Bryder (Wellington: Bridget Williams, 1991) was a key example of the social history approach to medical history in New Zealand. Derek Dow’s *Safeguarding the Public Health: A History of the New Zealand Department of Health* (Wellington: Victoria University Press in association with the Ministry of Health, 1995) is also an example of social history, to the degree that it discusses the social context within which the New Zealand public health system has evolved.

<sup>9</sup> Examples of the first kind include Ann Beck’s *A History of the British Medical Administration of East Africa* (Cambridge, Mass.: Harvard University Press, 1970), Nancy Gallagher’s *Medicine and Power in Tunisia 1780-1900* (Cambridge: Cambridge University Press, 1983), David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993), and *Disease in African History: An Introductory Survey and Case Studies*, ed. by Gerald W. Hartwig and K. David Patterson (Durham, North Carolina: Duke University Press, 1978). Histories of developments in newly independent nations include Ralph Schramm, *A History of Nigerian Health Services* (Ibadan: Ibadan University Press, 1971), *Nigerian Pioneers of Modern Medicine: Selected Writings*, ed. by Adelola Adeyoye (Ibadan University Press, Ibadan, 1977; and Ahmed Bayoumi, *The History of Sudan Health Services* (Nairobi: Kenya Literature Bureau, 1979).

This growing emphasis on social factors and local contexts, and the related interrogation of ‘progressivist’ historical narratives that occurred during the 1960s and 1970s, was again related to changing conceptualisations of international scientific and medical exchange.<sup>10</sup> Before this time, Basalla’s ‘modernisation model’ had been attractive because it both reinforced and reflected the dominant historiographical narratives of nation-building.<sup>11</sup> However, by the 1980s, scholars such as Roy Macleod were recognising that Basalla’s wheel metaphor oversimplified colonial relationships by overlooking the influence of local colonial administrators, subjects, and conditions. Macleod argued that colonial relationships were never as linear as the ‘metropole to periphery’ model implied, but were instead closer in character to the multi-centred structure and shifting centres of imperial Rome.<sup>12</sup> As an alternative, Macleod proposed the notion of a ‘moving metropolis’ to highlight both the dissemination of authority around the colonies, and the agency of local actors. Writing about the structures of colonial science in which he specialised, MacLeod argued that colonial linkages were characterised by the ‘considerable circulation of scientists and administrators among widely dispersed colonial worlds’, who communicated through personal visits, periodicals, and commodity exchanges.<sup>13</sup>

In the 1980s and 1990s, historians of colonial medicine began to produce work that foregrounded the medical profession’s contribution to the process of colonisation. Focussing in particular on encounters between Western doctors and indigenous peoples, or, conceived at another level, between Western medical paradigms and ‘non-Western’ cultures, these studies argued that the importation

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<sup>10</sup> In the section that follows, the emphasis is generally on scientific, rather than explicitly medical international relationships. The relevance of models of *scientific* networks derives from the fact that medicine is often, if not universally, portrayed as a scientific enterprise. Medical professionals often based their claims for autonomy and professional status on the scientific nature of medical practice, although, as will be discussed in the next chapter, these were often tempered by apparently contradictory claims that medicine’s status arose instead mainly from the humanist qualities of its practitioners. These differences notwithstanding, the discussion assumes that similar conceptualisations of international relationships underpinned the work of historians of imperial science and of imperial medicine.

<sup>11</sup> Roy MacLeod, ‘On Visiting the “Moving Metropolis”’: Reflections on the Architecture of Imperial Science’, in *Scientific Colonialism: A Cross-Cultural Comparison*, ed. by Nathan Reingold and Marc Rothenberg (Washington, D.C.: Smithsonian Institution Press, 1987), p. 226.

<sup>12</sup> MacLeod, ‘On Visiting the “Moving Metropolis”’, pp. 217-49.

<sup>13</sup> See also MacLeod’s ‘Introduction’, *Osiris*, 2nd Series, volume 15, *Nature and Empire: Science and the Colonial Enterprise* (2000), pp. 1-13. Warwick Anderson notes that the phrase ‘moving metropolis’ was originally coined by the imperial historian, W. K. Hancock.

of western medical models and practices into colonial settings had not always been beneficial, but had often led to the suppression of indigenous health practices, sometimes to the detriment of indigenous health and broader social structures. Histories of ‘colonial medicine’ began to acknowledge the ways that indigenous peoples had resisted the imposition of foreign medical ideas and methods.<sup>14</sup>

Once again, these ideas were connected to changing conceptualisations of international relationships. In the early 1990s, historians Paolo Palladino and Michael Worboys argued that historians of imperial science could no longer take for granted the idea that science was an instrument of civilisation and enlightenment, wielded and shaped solely by colonising powers. They argued that historians needed to acknowledge the degree to which the development of science was influenced by the ‘historical and cultural heritage of both the imperialists and the indigenes.’<sup>15</sup> Similarly, in 2000, Roy MacLeod argued that the ‘traffic of ideas and institutions has always been reciprocal’, not only between Europeans at home and overseas, but between Europeans and indigenous peoples.<sup>16</sup> Ann Laura Stoler took these ideas further when she challenged colonial historians to examine the ‘overlapping and cross-cutting circuits of persons and policies that make their way from metropole to centre and the other way around . . . as well as those that connected metropolitan centres, cut along horizontal axes within colonised regions, and produced circuits of knowledge that traversed imperial borders and were not confined by them’.<sup>17</sup>

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<sup>14</sup> The two most influential early examples were Roy MacLeod and Milton Lewis's *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London: Routledge, 1988), and David Arnold's *Imperial Medicine and Indigenous Responses* (Manchester: Manchester University Press, 1988). Important later contributions were made in Philip Curtin, *Death by Migration: Europe's Encounter with the Tropical World in the Nineteenth Century* (Cambridge: Cambridge University Press, 1989), *Western Medicine as Contested Knowledge*, ed. by Andrew Cunningham and Bridie Andrews (Manchester: Manchester University Press, 1997), Deborah Dupton, *Medicine as Culture*, 2<sup>nd</sup> edn (London: Sage, 2003) *Cultures of Empire: Colonizers in Britain and the Empire in the Nineteenth and Twentieth Centuries: A Reader*, ed. by Catherine Hall (Manchester, St. Martin's Press, 2000), W. F. Bynum, *The Western Medical Tradition: 1800-2000* (Cambridge: Cambridge University Press, 2006) and *Health, Disease and Society in Europe, 1800-1930*, ed. by Deborah Brunton (Manchester: Manchester University Press, 2004).

<sup>15</sup> Paolo Palladino and Michael Worboys, ‘Science and Imperialism’, *Isis*, volume 84, number 1 (March 1993), p. 102.

<sup>16</sup> Roy MacLeod, ‘Introduction’, p. 8 (see footnote 13 above).

<sup>17</sup> Ann Laura Stoler, *Carnal Knowledge and Imperial Power: Race and the Intimate in Colonial Rule* (Berkeley: University of California Press, 2002), p. 210.

Overall, the development of models of international interaction over the last forty years can be summarised as a shift from linear relationships through which influence travelled in one direction, to multi-centred networks characterised by exchanges in all directions.<sup>18</sup> In one respect, the notion of a Common-health of medicine is a continuation of this trend, as it also views influence travelling in multiple directions by multiple means. However, the Common-health concept differs slightly from these earlier models, to the extent that the connections and exchanges that constitute it are conceived as a system, rather than a network. This differentiation is not presented here as a radical departure from previous models, but is instead an attempt to highlight a particular conception of the ways in which Commonwealth doctors, institutions, professional bodies, cultural conventions, and a range of other factors, interacted.<sup>19</sup> I suggest that the metaphor of the network, or alternatively, the web, brings potentially misleading connotations of linearity and directionality; people and information travel between particular points, and the ‘influence’ of those movements travels with them. Studies of medical migration, for example, usually restrict their analyses to the effects of movements at the points of departure and arrival, and often, to only one of these. The systemic approach instead views ‘influence’ as non-linear and more diffuse, manifesting in a range of legal, economic, social, and personal changes, in both the receiving and sending societies, and in other parts of the system. This is not to say that that the system was ‘perfect’, in the sense that every action had ramifications across the entire system. However, the conceptualisation of Commonwealth medical networks in systemic terms does generate valuable insights into the complex and multi-layered nature of international relationships, and the diverse ramifications of their effects.

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<sup>18</sup> Roy MacLeod, ‘Introduction’, p.1 (see footnote 13 above).

<sup>19</sup> Palladino and Worboys, for example, made a similar claim when highlighting the ways in which so-called ‘cores’ and ‘peripheries’ in fact influenced each other. Nathan Reingold and Marc Rothenberg came even closer to an assertion of systemic relationships when they noted that ‘understand[ing] science fully requires an understanding of the ecology of its environment.’ Nathan Reingold and Marc Rothenberg, ‘Introduction’, in *Scientific Colonialism: A Cross-Cultural Comparison*, ed. by Nathan Reingold and Marc Rothenberg (Washington, D.C.: Smithsonian Institution Press, 1987), citation 31, p. xii. In New Zealand, Tony Ballantyne advocated for what can be viewed as a systemic model when he challenged historians to ‘move beyond the nation-state as the organising unit for the writing of the history of imperialism [and to replace it with] a multi-site imperial history that uses webs as its organizing analytical metaphor, an approach that views empires as integrative structures that knit, often forcibly, previously disparate and unconnected points together into a shared space.’ Tony Ballantyne, *Orientalism and Race: Aryanism in the British Empire* (Basingstoke, Hampshire: Palgrave, 2002), p. 194.

A much more important difference between the Common-health concept and earlier models is their respective portrayal of medical professionals. The American historian of colonial medicine, Douglas Haynes, has argued that the increasingly critical nature of colonial medical historiography has contributed to the essentialisation of the medical profession.<sup>20</sup> Because such work tends to focus on the negative outcomes of the profession's activities, 'colonial medicine' has come to be understood as work fundamentally oriented to the task of colonisation, with its practitioners cast firmly as perpetrators.<sup>21</sup> While such research leaves little doubt that the activities of medical professionals *did* contribute to the process of colonisation, it may also overestimate the degree to which the activities of doctors in colonial settings were 'geared to the needs of Empire', rather than to their own personal or collective professional ends.<sup>22</sup>

Treating the medical profession as an undifferentiated collective with common motivations underestimates its heterogeneous and even fragmentary nature. In the nineteenth century, surgeons, physicians, and apothecaries competed for patients, occupational status, and autonomy, despite the often overlapping nature of their work.<sup>23</sup> The rise of the hospital in the late nineteenth century and the development of medical subspecialisation during the first half of the twentieth resulted in the profession becoming even more strongly demarcated, both organisationally, and in terms of the range of practice or individual practitioners. Hospital-based specialists and community-based general practitioners undertook significantly different post-graduate training, inhabited very different occupational spaces, and carried out very different kinds of work,

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<sup>20</sup> Douglas M. Haynes, 'Victorian Imperialism in the Making of the British Medical Profession', in *Decentring Empire: Britain, India and the Transcolonial World*, ed. by Durbha Ghosh and Dane Kennedy (Hyderabad: Orient Longman, 2006), pp. 130-56.

<sup>21</sup> In the 'Introduction' to *Disease, Medicine and Empire*, for example, Roy MacLeod argues that the historiography of imperial medicine consists of the 'histories of medical regimes as participants in the expansion and consolidation of political rule'. MacLeod, *Disease, Medicine and Empire*, p. 2. It should be noted that the image of a unified profession was also actively supported by medical spokespeople striving to present a united voice in various political debates.

<sup>22</sup> This is not to suggest that medical practice in Britain's colonies was driven entirely by individual or professional self-interest. Rather, it is an assertion of the diversity of professional and personal motivations that underpinned the work and decisions of medical practitioners. The phrase 'geared to the needs of Empire' is taken from Terence J. Johnson and Marjorie Caygill, *Community in the Making: Aspects of Britain's Role in the Development of Professional Development in the Commonwealth* (London: Institute of Commonwealth Studies, University of London, 1972), p. 303.

<sup>23</sup> P. W. J. Bartrip, *Mirror of Medicine: A History of the BMJ, 1840-1990* (Oxford: Oxford University Press, 1990), p. 5.

as, indeed, did practitioners *within* particular specialties, who were often in direct competition. Writing in the 1970s, the sociologist of medicine, Eliot Freidson, characterised professional medicine as a collection of ‘warring factions each struggling for jurisdiction and control over various areas of work.’<sup>24</sup> Michael Belgrave’s observation that the New Zealand medical profession ‘was more of an abstraction than a social reality’ in the nineteenth century could also be applied to the twentieth.<sup>25</sup>

Haynes also argues that the tendency to focus on the effect that colonial medicine had on patients has contributed to a lack of research into the ramifications of colonial practice for the medical profession itself. He argues that much of the scholarship on medical professionalisation in Britain, for example, has ignored the imperial context entirely, and has thus portrayed professionalisation as a process that was shaped almost exclusively by domestic events and conditions.<sup>26</sup> The Common-health concept explicitly foregrounds the movements, motivations, and experiences of individual doctors as critical factors in the development of specialised medicine. As discussed in the Preface to this thesis, individuals and interpersonal relationships were at least as influential in the development of medical services as formal health-related policies and laws.

Over the last forty to fifty years, medical history, like many other social sciences, has been reformed under the influence of the civil rights and women’s liberation movements and the increased demographic diversity of its practitioners, and has become much more attuned to the experiences of marginalised members of human societies.<sup>27</sup> The American medical historian Robert Baker has

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<sup>24</sup> Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (New York: Aldine, 1970), p. 16.

<sup>25</sup> Michael Belgrave, ‘“Medical Men” and “Lady Doctors”: The Making of a New Zealand Medical Profession, 1857-1941’, PhD Thesis, Victoria University of Wellington, 1985, p. 60.

<sup>26</sup> Haynes, ‘Victorian Imperialism’, p. 133.

<sup>27</sup> New social history is a broad field, but is generally characterised by its emphasis on the lives of ‘ordinary’ people in society, and particularly on marginalised groups such as women, children, and ethnic minorities. Its practitioners foreground both broad social processes and structures using quantitative demographic analysis and other macro-level techniques, and also the lives and experiences of ordinary people, accessed through the analysis of sources such as diaries and oral interviews. Useful surveys of the development and methods of social history include *Theory, Method, and Practice in Social and Cultural History*, ed. by Peter Karsten and John Modell (New York: New York University Press, 1991), *New Methods for Social History*, ed. by Larry Griffin and Marcel van der Linden (New York: Cambridge University Press, 1998), Miles Fairburn, *Social History: Problems, Strategies and Methods* (New York: St. Martin's Press, 1999), Geoff Eley, *A Crooked Line: From Cultural History To The History Of Society* (Ann Arbor: University of Michigan Press, 2005).

summarised the ‘social turn’ as a change whereby social scientists stopped writing about what was right with society and began to discuss what was wrong with it.<sup>28</sup> In the field of academic history, one consequence of this change has been the adoption of a more critical approach to assessing the influence of those social elites – politicians, military figures, and doctors – who had previously dominated the written historical record. This change in focus has not only been true in historical examinations of colonial medicine performed in the nineteenth century, but is also evident in the literature on human migration during the twentieth.

### *Migrations*

Physical migration has been a part of many doctors’ lives during the twentieth century. Doctors moved in huge numbers during each of the century’s two world wars, both for the purpose of military service and as refugees. After World War Two, improved transportation technologies allowed doctors to move in pursuit of professional opportunities facilitated by rapid economic growth and the expansion of technical medical knowledge. The introduction of Britain’s National Health Service in 1948 led to large numbers of British doctors travelling to less regulated and better remunerated Western jurisdictions, primarily in North America. As this thesis will demonstrate, large numbers of Commonwealth doctors migrated in pursuit of post-graduate training and qualifications during the three decades that followed World War Two.

However, the growing historical interest in the experiences of marginalised peoples since the 1960s has meant that the movement of medical professionals and other skilled workers is often overlooked within the broader migration literature. By far the greater part of research conducted on twentieth century migration has focussed on the movements of marginalised groups, such as refugees and labour migrants. A useful illustrative example of this tendency can be found in the *Cambridge World Survey of Migration*, in which only one chapter out of ninety-five discusses a group who have *not* been subject to marginalisation,

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<sup>28</sup> *The Codification of Medical Morality: Historical and Philosophical Studies of the Formalisation of Western Medical Morality in the Eighteenth and Nineteenth Centuries, Volume Two: Anglo-American Medical Ethics and Medical Jurisprudence in the Nineteenth Century*, ed. by Robert Baker (Dordrecht: Kluwer Academic Publishers, 1995), p. 8.

either in their communities of origin or in their ‘host’ societies.<sup>29</sup> Tellingly, the one exception to this rule describes its subject – the migration of skilled workers – as an ‘invisible phenomenon’.<sup>30</sup> The chapter’s author, Allan M. Findlay, argues that this invisibility refers in part to the fact that professional migrants were often not as easily identifiable as groups marginalised by poverty, gender, age or ethnic background. He also argues that professional migrants are invisible in the literature because their movements ‘pose no threat in terms of perceived social and economic burdens for the sender and host societies’.<sup>31</sup>

The social turn has also shaped research on the migration of doctors during the twentieth century. During the 1950s, the emigration of British doctors began to represent a serious challenge for the new nationalised system, which generated primarily sociological research into the so-called ‘brain drain’ phenomenon.<sup>32</sup> However, migration *into* Britain soon began to attract attention as doctors from low income Commonwealth countries such as India and Pakistan moved to Britain in large numbers to take advantage of the vacancies that medical emigration was creating.<sup>33</sup> A similar pattern emerged in New Zealand, as growing numbers of locally trained doctors sought temporary training or permanent work opportunities overseas, to be replaced by overseas-trained practitioners from low income countries. Initially, research into these movements focussed on their repercussions for receiving countries. However, in the late 1960s and early 1970s,

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<sup>29</sup> *The Cambridge Survey of World Migration*, ed. by Robin Cohen (Cambridge: Cambridge University Press, 1995). An indicative sample includes Ong Jin Hui’s chapter ‘Chinese indentured Labour: Coolies and Colonies’, Robert Scally’s ‘The Irish and the Famine Exodus’, Shubi Ishemo’s chapter ‘Forced Labour and Migration in Portugal’s African Colonies’, and Helmut Loinskandl’s ‘Illegal Migrant Workers in Japan’. The few entries which do not study marginalised groups do not study specific groups at all, but focus instead on theoretical or thematic approaches or policy topics: Roger Daniels compares international immigration policies, Daniél Joly brings a similar approach to asylum policies, Ewa Morawska explores a regional-system approach in her investigation of East European migration, and Giovanna Campani considers migration through the lens of gender.

<sup>30</sup> Allan M. Findlay. ‘Skilled Transients: The Invisible Phenomenon?’, in *The Cambridge Survey of World Migration*, pp. 515-22

<sup>31</sup> Findlay, p. 515.

<sup>32</sup> See David Wright, Nathan Flis and Mona Gupta, ‘The ‘Brain Drain’ of Physicians: Historical Antecedents to an Ethical Debate, 1960–79’ in *Philosophy, Ethics, and Humanities in Medicine*, 2008, volume 3, number 24, pp. 24-42 of online version, URL: <http://www.peh-med.com/content/3/1/24>, accessed 21 August 2009, and Judith Fortney, ‘Immigrant Professionals: A Brief Historical Survey’, *International Migration Review*, volume 6, number 1 (Spring 1972), pp. 50-62.

<sup>33</sup> ‘Low income country’ is the currently accepted term for countries previously described as ‘developing’ or ‘third world’. See World Bank, ‘How we Classify Countries’, URL: <http://data.worldbank.org/about/country-classifications>.

led by the European trained health economist Oscar Gish, research began to highlight the ethical problems associated with wealthy nations receiving doctors from countries that could not afford to lose them.<sup>34</sup>

Research into this aspect of twentieth century medical migration is entirely justified by its potential ramifications for the health-care capabilities of low income countries.<sup>35</sup> However, it has also meant that the movement of doctors from high income countries in the years after World War Two has received comparatively little academic scrutiny. This is particularly true for the New Zealand context, where the importance of international movements in the careers of New Zealand specialists stands in stark contrast to the amount of research, historical or otherwise, concerning those movements.<sup>36</sup> Much of the New Zealand scholarship on post-World War Two medical migration focusses on issues around workforce depletion and the integration of migrants coming *into* New Zealand, and focusses almost exclusively on contemporary, rather than historical, movements.<sup>37</sup>

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<sup>34</sup> Wright, Flis and Gupta, pp. 24-42. Important articles by Gish included 'Overseas-Born Doctor Migration 1962-66', *British Journal of Medical Education*, volume 5, number 2 (June 1971), pp. 92-109, 'British Immigration, 1955-1968', *International Migration Review*, volume 3, number 1 (Autumn 1968), pp. 19-37, and 'Commonwealth Medical Immigrants', *Lancet*, volume 2, number 7567 (7 September 1968), pp. 566-67.

<sup>35</sup> Rather than citing a small selection of the many examples of research into medical migration from low income countries, I refer the reader to the extensive references listed in Wright, Flis and Gupta (footnote 32 above).

<sup>36</sup> Much of the extant scholarship focuses on the experiences of immigrant doctors to New Zealand during the period of formal colonisation, or on the influence of their primarily Scottish educations on the development of health services in New Zealand. See James Beattie, 'Natural History, Conservation and Scottish-trained Doctors in New Zealand, 1790-1920' (forthcoming). References to the immigration of doctors to New Zealand can be found in several early medical biographies such as Sir James Elliott's *Scalpel and Sword* (Sydney: Angus & Robertson, 1936) and Bernard Myers' *The Reminiscences of a Physician* (Wellington: Reed, 1949). Short references also exist in Rex Wright-St Clair's *Medical Practitioners in New Zealand, 1840 to 1930* (Hamilton: Self Published, 2003) and Robert Valpy Fulton's succinctly titled *Medical Practice in Otago and Southland in the Early Days: A Description of the Manner of Life, Trials, and Difficulties of Some of the Pioneer Doctors, of the Places in Which, and of the People Among Whom, They Laboured* (Dunedin: Otago Daily Times, 1922). See also Bob McKerrow's *Ebenezer Teichmann: Pioneer New Zealand Mountaineer, Explorer, Surgeon, Photographer and Conservationist: Cutting Across Continents* (New Delhi: Tara-India Research Press, 2005), and Gerda Elizabeth Bell's *Ernest Dieffenbach: Rebel and Humanist* (Palmerston North: Dunmore Press, 1976).

<sup>37</sup> Examples of such work in the New Zealand context include Edward Miller, et al, 'Emigration of New Zealand and Australian Physicians to the United States and the International Flow of Medical Personnel', *Health Policy*, volume 43, issue 3 (March 1998), pp. 253-70, J. Barnett, 'Geographical Impacts of Restricting Foreign Medical Immigration: A New Zealand Case Study, 1976-87' in *Social Science & Medicine*, volume 33 (1991) pp. 459-70, Steven Lillis, Ian St George, Ruth Upsdell, 'Perceptions of Migrant Doctors Joining the New Zealand Medical Workforce', *New Zealand Medical Journal*, volume 119, number 1229 (17 February 2006), R. Kearns, J. Myers and

Further, the tendency to treat the medical profession as a single, homogeneous collective, as discussed above, has contributed to a general failure to acknowledge important demarcations within the profession, and the effects of those demarcations on migration experiences and patterns. Most research investigates what might be called ‘career’ migrations, or movements undertaken by fully qualified doctors in pursuit of new jobs.<sup>38</sup> Movements carried out for other purposes, such as the pursuit of post-graduate training and qualifications, have received far less attention. There has also been little differentiation between general practitioners and hospital-based doctors, between the practitioners of different specialties, or between doctors of different genders. Later chapters will demonstrate that these differences could have a profound effect on migration patterns and experiences, and on subsequent career trajectories.

Finally, the essentialisation of the medical profession, together with the tendency to focus on the motivations and experiences of migrant doctors from low income countries, has sometimes led to a failure to differentiate between doctors from different high or mid-income countries. David Smith’s comprehensive 1978 survey of medical migrants working in Britain’s National Health Service, for example, routinely grouped doctors from New Zealand, Australia, South Africa, Canada and Rhodesia (now Zimbabwe) under the blanket term ‘white Anglophone’ doctors.<sup>39</sup> In Smith’s work, this led to generalisations that obscured important differences between doctors from those countries. For example, Smith

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V. Adair, ‘What Makes ‘Place’ Attractive to Overseas-Trained Doctors in Rural New Zealand?’, *Health and Social Care in the Community*, volume 14 (2006), pp. 532-40.

<sup>38</sup> Important historical work on permanent medical migration of ‘Anglophone’ doctors in the Common-health context includes L. Hogg, ‘Migration of a Professional Class: Case Study of Scottish-trained Doctors Who Have Emigrated to the Greater Wellington Area (BA Thesis, Victoria, 1981), Sarah (Sally) Wilde, ‘Practising Surgery: A History of Surgical Training in Australia, 1927-1974’, PhD Thesis, University of Melbourne, 2003, David Wright, Sasha Mullally, and Mary Colleen Cordukes, ‘“Worse than Being Married”: The Exodus of British Doctors from the National Health Service to Canada, c. 1955–75’, *Journal of the History of Medicine and Allied Sciences*, volume 65, number 4 (October 2010), pp. 546-575, and Wright, Flis and Gupta. For work on undergraduate migration, see I. Wotherspoon, ‘“The Most Powerful Medical Magnet in Europe”: Edinburgh University’s Medical School and the Overseas World, 1880-1914’, *Journal of the Royal College of Physicians of Edinburgh*, volume 34, number 2 (2004), pp. 153-59.

<sup>39</sup> David J. Smith, *Overseas Doctors in the National Health Service* (London: Policy Studies Institute, 1980), pp. 8-10, 36. In part, this grouping likely derives from the small number of ‘Anglophone’ doctors working in the British health service compared to ‘non-white’ doctors. Smith’s survey found that seventeen per cent of all overseas doctors and twenty per cent of hospital-based doctors practising in England in 1977-8 came from the Indian sub-continent, while doctors from New Zealand, Australia, South Africa, Canada and Zimbabwe together made up only three per cent.

concluded that the relatively low proportion of Anglophone doctors who sat formal College examinations while in Britain suggested that their main motivation was to have a leisurely ‘Grand Tour’ type experience, in contrast to the more focussed professional motivations of doctors from India, Pakistan, and the Middle East.<sup>40</sup> But this conclusion failed to acknowledge important differences between so-called ‘Anglophone’ countries. Several interviewees for this thesis expressed the opinion that New Zealand doctors were more highly motivated than most of their ‘Anglophone’ colleagues, due mainly to the personal and financial costs of travelling literally half way around the world.<sup>41</sup> The low examination rates also reflect the fact that by the 1970s, New Zealand doctors were generally more interested in accruing practical experience in British hospitals than in securing post-graduate qualifications.<sup>42</sup> Another critical point of difference between most Anglophone countries and New Zealand was the small population of the latter, which had ramifications for the style of undergraduate teaching available in its medical school, for the viability of its specialist training schemes, and for the country’s ability to employ specialists once they were trained and qualified. Treating Anglophone doctors as a single group almost certainly obscures important differences between other Anglophone countries also.

Through its investigation of a small subset of twentieth century medical migrants, that is, New Zealand doctors travelling for post-graduate training and qualifications, this thesis seeks to explore some of these hitherto overlooked variations, and to contribute to a more nuanced understanding of medical migration in general. The adoption of an international frame, and the related contention that the medical profession was in many ways fundamentally international, does not imply that medicine or its practitioners were the same across the globe, or even across the particular network under discussion. While mechanisms of international exchange operated within and through interpersonal networks and institutions, they were also influenced by the particular regional, national, or local contexts within which their colleagues and their institutions worked. Factors such as population size and distribution, economic conditions,

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<sup>40</sup> Smith, *Overseas Doctors in the National Health Service*, p. 36.

<sup>41</sup> Canadian doctors, for example, had a reputation for taking an almost cavalier approach to their examination preparation in Britain. Personal communication, name withheld by request.

<sup>42</sup> This change is discussed in detail in Chapter 7: The ‘Fragmenting’ of the Common-health, 1965-75.

institutional rules, and the backgrounds and personalities of individual practitioners all contributed to the form and function of international medical exchange. Indeed, in many ways, the Common-health system *was* the interaction of local factors.

*Pierre Bourdieu: Theories of Integration*

In 2005, the New Zealand-born imperial historian, J. G. A. Pocock, called for historians to consider the relationships between individuals, organisations, and the particular nation-states within which they are situated, framed within a broader ‘archipelago’ or ‘star-cluster’ of connected national histories.<sup>43</sup> Two years later, the Canadian historians Sasha Mullally and David Wright called for researchers on medical migration to augment ‘the analysis of macro-data, broad trends, and policy documents’ that typifies such studies with approaches that considered the ‘individual and group experiences’ of physicians.<sup>44</sup> In effect, these calls are very similar to Peter Gibbons’ suggestion, discussed above, that ‘micro’ and ‘macro’ level studies be used, singly or in partnership, as an alternative to nation-based analytical and narrative frames.

Fundamentally, the ‘Common-health’ concept is a shorthand term for the complex international system of interpersonal relationships, professional organisations, discourses and policies that has emerged from a research programme based on these ideas; the Common-health concept is the outcome, and not the starting point, of this thesis. As such, the Common-health concept therefore reflects the theoretical models that I have used throughout this research project to conceptualise, identify, and communicate the complex interaction of the system’s many ‘components’. As discussed in the Introduction, the underlying analytical principle of this thesis is the idea that the various aspects of international professional exchange were deeply interconnected, but not mutually reducible, an idea best summarised by Nancy Fraser’s concept of of ‘perspectival

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<sup>43</sup> J. G. A. Pocock, *The Discovery of Islands* (Cambridge: Cambridge University Press, 2005), pp. xi, 19, 42-3.

<sup>44</sup> Sasha Mullally and David Wright, ‘La Grande Séduction: The Immigration of Foreign-Trained Physicians to Canada, c. 1954-74’, *Journal of Canadian Studies*, volume 41, number 3 (Fall 2007), p. 19.

dualism'. For the purposes of this thesis, the most valuable existing model for the application of Fraser's principle is found in the work of French sociologist and social theorist Pierre Bourdieu. Fundamentally, Bourdieu's work represents an attempt to investigate individuals and their social contexts without reducing one to the other.<sup>45</sup> The theoretical formulation that Bourdieu proposes to achieve this involves several key concepts interacting within a particular 'generative' relationship, the most important of which are the *habitus* and the *social field*.<sup>46</sup>

The *habitus* refers to the complex set of values, preferences, beliefs, fears, desires and prejudices – conscious, subconscious, and unconscious – that 'dispose' an individual to behave in certain ways. A person's habitus is formed partly under the influence of formal and semi-formal teaching over the course of his or her life, but also by their informally absorbing social and cultural norms. Bourdieu viewed this latter process as a more important method of habitus formation, because those aspects of an individual's personality that are absorbed and developed unconsciously are less easily accessible to self-reflection than are conscious thoughts, with the result that the behaviours they produce are less amenable to being controlled or changed.<sup>47</sup>

However, this does not mean that the habitus determines an individual's behaviour. While people are disposed to act in certain ways by their particular attitudes and beliefs, the decisions that they make are also shaped by their position within a range of social structures, or *social fields*. Bourdieu does not conceive these as 'domains' or easily defined spaces, but as dynamic structures consisting

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<sup>45</sup> Although Bourdieu emphasised the application of theory over theory as an end in itself, several of his publications explored the theoretical aspects of his work in detail. Useful examples include *Outline of a Theory of Practice*, translated by Richard Nice (Cambridge: Cambridge University Press, 1977), *Reproduction in Education, Society and Culture*, with Jean-Claude Passeron (London: Sage, 1990 [first published in French, 1970]), *In Other Words: Essays Toward a Reflexive Sociology* (Cambridge: Polity, 1990), *Language and Symbolic Power* (Cambridge: Polity, 1991), *The Logic of Practice*, translated by Richard Nice (Cambridge: Polity, 1992), and *Practical Reason: on the Theory of Action* (Cambridge: Polity Press, 1998). Valuable secondary works on Bourdieu's theory include *An Introduction to the Work of Pierre Bourdieu: The Practice of Theory*, ed. by Richard Harker, Cheleen Maher and Chris Wilkes (Basingstoke: MacMillan, 1990), Richard Jenkins, *Pierre Bourdieu* (London: Routledge, 2002 [first published 1992]), *Bourdieu: A Critical Reader*, ed. by Richard Shusterman (Oxford: Blackwell, 1999), 'Theorising Practice', in *Understanding Bourdieu*, ed. by Jen Webb, Tony Shapiro and Geoff Danaher (Crow's Nest, New South Wales: Allen and Unwin, 2002), pp. 45-62, and Peter Jackson, 'Pierre Bourdieu, the "Cultural Turn" and the Practice of International History', *Review of International Studies*, volume 34 (2008), pp. 155–181.

<sup>46</sup> Harker, Maher and Wilkes describe Bourdieu's central thesis as 'generative structuralism', in reference to the 'mutual penetration of objective and subjective structures' that characterises his work. Harker et al, pp. 3, 15.

<sup>47</sup> Jenkins, p. 165.

of related sets of positions within a relatively autonomous social world, related to each other by particular expectations, customs, and rules.<sup>48</sup> The field of professional medicine, for instance, comprises positions for practitioners, patients, researchers, teachers, students, and administrators, all of which have particular expectations, rules, or customs attached to them. Importantly, it was Bourdieu who insisted that research into social formations should begin with an empirical investigation of particular practices, and should only then attempt to delineate the extent and character of the social field within which those practices occur.<sup>49</sup> Bourdieu does not suggest that any social formations ‘discovered’ through this method are any more objectively real than those previously identified. Rather, he argues that this theoretical and empirical approach supports researchers to minimise the extent to which their work perpetuates preconceptions associated with existing social formations, such as the nation.<sup>50</sup> As alluded to above, the social field concept and its associated methodological sequence has provided the template upon which the Common-health system has been constructed as an alternative to nation-centred analytical and narrative frames.

For Bourdieu, human behaviour is the outcome of habitus-bearing individuals participating, negotiating, and strategizing in the context of the many social fields that they occupy: families, professions, artistic communities, religions, and others. He also argues that this interplay constitutes and reconstitutes the habitus and fields themselves: individuals are constantly reshaped by their immersion in social fields, and they in turn transform social fields ‘as world[s] of meaning’.<sup>51</sup> Bourdieu’s conception of society, therefore, can be seen as an exemplar of Fraser’s concept of ‘interpenetrating but differentiated’. While acknowledging that individuals and their social contexts are not the same phenomenon, he insists that it is impossible to analyse one without making reference to the other. Individual minds and their surrounding structures – cultural, social, economic, and discursive – are understood to be mutually constitutive and inseparable.

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<sup>48</sup> Harker et al, p. 8.

<sup>49</sup> Harker et al, p. 15.

<sup>50</sup> Jen Webb, Tony Shapiro and Geoff Danaher, *Understanding Bourdieu* (Crows Nest, Australia: Allen and Unwin, 2002), pp. 45-62.

<sup>51</sup> Harker et al, p. 170.

While habitus and social fields are the main two concepts in Bourdieu's theoretical formulation, several other conceptual tools are required before the theory can do the work demanded of it. One of these is the idea of *capital*, which Bourdieu defines as 'all things, material and symbolic . . . that present themselves as rare and worthy of being sought after in a particular social formation.'<sup>52</sup> Capital can therefore take many forms, from material and economic assets to forms of 'cultural capital' such as intelligence, the ability to articulate ideas, or familiarity with technical language, the mastery of which enables a person to succeed within a particular social field. Bourdieu also suggests that the power of a given form of capital increases in proportion to the ease with which it can be 'converted' into other forms *within* a social field, or 'transposed' *between* social fields.<sup>53</sup> In the field of specialised medicine, for example, medical knowledge has value not only because it can help patients, but because it can be converted into financial capital through lucrative hospital appointments or successful private practices, or transposed into political influence through public comments on health policy. In this regard, the most valuable form of capital is the *symbolic*, which is, in effect, capital manifesting in a disguised form. Material wealth, for example, can appear in the form of an individual's accent, physical carriage, and personal 'style'. The value of symbolic capital is that it often retains potency across many social fields.<sup>54</sup> Bourdieu claims that symbolic capital allows those who possess it to represent their own values and preferences as 'natural', thereby ensuring their acceptance by other participants in the social field.<sup>55</sup>

For the purposes of this thesis, the value of the concept of capital is twofold. First, it facilitates an awareness of motivations for medical migration beyond the economic, thereby avoiding economic reductionism in source analysis and interpretation. Secondly, it enables a more nuanced understanding of the ways in which various actors and organisations within the Common-health system accessed, accumulated and retained various forms of capital, including specialised knowledge, personal contacts, professional autonomy, social status, and institutional power, among many others.

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<sup>52</sup> Pierre Bourdieu, *Outline of a Theory of Practice* (Cambridge: Cambridge University Press, 1977, published in French 1972), p. 178.

<sup>53</sup> Harker et al, p. 13-14, and Jenkins, p. 78.

<sup>54</sup> Harker et al, p. 13-14.

<sup>55</sup> Harker et al, pp. 13-14, and Jackson, pp. 165-71.

Perhaps the most useful aspect of Bourdieu's formulation is that his ideas about the interaction of habitus, social fields, and capital are not presented as a rigid template into which data should be entered in pursuit of a particular 'answer', but instead represent a set of conceptual tools designed to explore the complexity of human societies.<sup>56</sup> For this reason, the following chapters make no attempt to use Bourdieu's terminologies to describe the ways in which the social backgrounds of doctors influenced their career paths, or to tease apart the changing distribution of various forms of capital in particular professional settings over time. Nonetheless, these concepts serve as the theoretical basis for the Common-health as an analytical frame. The following chapters reflect Bourdieu's awareness of the unboundedness of social fields, their intersections, the influence of doctors' personalities, and the constant negotiation that occurs between people and their surroundings. Bourdieu's ideas also help to clarify the particular processes that lead to both historical change and historical continuity. If, as Bourdieu suggests, social formations are sustained by the accumulation of capital, then the corollary must be that formations change as the many things that doctors valued shift within and between them.<sup>57</sup>

### *Sources and Methodology*

To borrow the phraseology of sociologists Peggy Levitt and Nina Glick Schiller, the Common-health system comprised both connections 'on the ground', such as personal friendships, institutional ties, and the international branches of professional organisations, and 'ideologies of connection' such as shared professional beliefs and conventions, and common policy goals.<sup>58</sup> In order to acknowledge all of these aspects, and their interaction, this thesis uses a mixed methodology to examine a broad range of historical sources, including New Zealand medical autobiographies and biographies, governmental and professional medical workforce surveys, institutional and organisational histories, New

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<sup>56</sup> Harker et al, p. 3.

<sup>57</sup> Jackson, p. 171.

<sup>58</sup> These phrases come from Peggy Levitt and Nina Glick Schiller, 'Conceptualising Simultaneity: A Transnational Social Field Perspective on Society', *International Migration Review* (volume 38, number 145 (Fall 2004), p. 5.

Zealand medical obituaries, journal articles and editorials, recorded interviews, and personal letters.<sup>59</sup>

Michel Foucault, the French social philosopher and historian, stated that ‘whenever, between objects, types of statement, concepts, or thematic choices, one can define a regularity (an order, correlations, positions and functionings, transformations), we will say that we are dealing with a discursive formation.’<sup>60</sup> Together, the written texts and spoken testimonies in which medical professionals from New Zealand and Britain referred to some aspect of international professional exchange represent the primary site of analysis for this thesis. These texts provide useful information about the workings of the Common-health, including quantitative data about the numbers of New Zealand specialists who travelled overseas, their destinations, the duration of their visits, and the outcomes of their overseas travel in terms of the attainment of specialised experience, formal qualifications, membership of professional associations, or affiliations with overseas hospitals. They also provide insights into the motivations, meanings, and consequences of medical migration for individual doctors, for their families, for professional bodies, and for the structure of the medical profession as a whole.

Crucially, this discursive formation can also provide insights into the various contexts – social, economic, cultural, political, and personal – within which they were produced.<sup>61</sup> In this regard, the discursive analysis of various medical texts complements Bourdieu’s formulation, which foregrounds the relationship between individual subjectivities and social structures, by providing insights into *collective* perceptions and understandings of the form and function of international medical structures. This is important because collective perceptions and characterisations had immense political instrumentality, and as such, played

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<sup>59</sup> The relatively recent appearance of specialised medicine meant that it did not figure prominently in any survey of the New Zealand medical workforce until 1968, when the establishment of a public subsidy for specialist medical treatment made it necessary to create a specialist register.

<sup>60</sup> Michel Foucault, *Archeology of Knowledge*, trans. A. M. Sheridan Smith (New York: Pantheon Books, 1972), p. 38. Foucault’s definition suggests that no discourse exists objectively, waiting to be found or identified. Instead, discursive formations are constituted by their selection for the purpose of addressing a particular research problem.

<sup>61</sup> Ove K. Pedersen, ‘Discourse Analysis’, Working paper No. 69, International Centre for Business and Politics, Copenhagen Business School (2009), unpaginated. Accessed online at URL: <[openarchive.cbs.dk/bitstream/.../WP%20CBP%202009-65.pdf?...1Similar](http://openarchive.cbs.dk/bitstream/.../WP%20CBP%202009-65.pdf?...1Similar)>, 28 June 2012.

a significant role in the development of the Common-health system over time, at all of its various levels.

The remainder of this chapter describes the various sources used in this thesis, outlines the ways in which they have been analysed and interpreted, and considers their limitations.

### *Published Sources*

Perhaps the key methodology employed in the research for this thesis has been the re-evaluation of various published works relevant to post World War Two New Zealand medical migration for the insights that they can provide into international patterns, structures, and relationships. As discussed in the Introduction, reading the autobiographies of New Zealand medical practitioners and the histories of New Zealand medical institutions and organisations through an international lens leaves no doubt about the scale and importance of international connections. In several cases, the evidence for this is apparent in the titles and cover images of the books concerned. The autobiographies of Donald Matthews and Sir Douglas Robb, entitled *Medicine My Passport* and *Medical Odyssey* respectively, are the most obvious examples of this, while Sarah Wilde's history of the Urological Society of Australasia, *Joined Across the Waters*, is perhaps the drollest.<sup>62</sup> The cover image of Gwen Wilson's history of Australian anaesthesia, *One Grand Chain*, also highlighted international connections by depicting a golden chain looping between New Zealand and Australia, before heading off the back cover in a north-westerly direction, presumably towards the United Kingdom (See Figure 1 below).

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<sup>62</sup> Donald Stafford Matthews, *Medicine My Passport* (London: George G. Harrap & Co, 1957), Sir Douglas Robb, *Medical Odyssey: An Autobiography* (Auckland: Collins, 1968), Sarah (Sally) Wilde, *Joined Across the Water: A History of the Urological Society of Australasia* (Melbourne: Hyland House, 1999), and Gwen Wilson, *One Grand Chain: The History of Anaesthesia in Australia, 1846–1962* (Melbourne, The Australia and New Zealand College of Anaesthetists, 1995). Also notable is Rex Wright-St Clair's biography of Sir David Monro, *Thoroughly a Man of the World* (Christchurch: Whitcombe and Tombs, 1971).

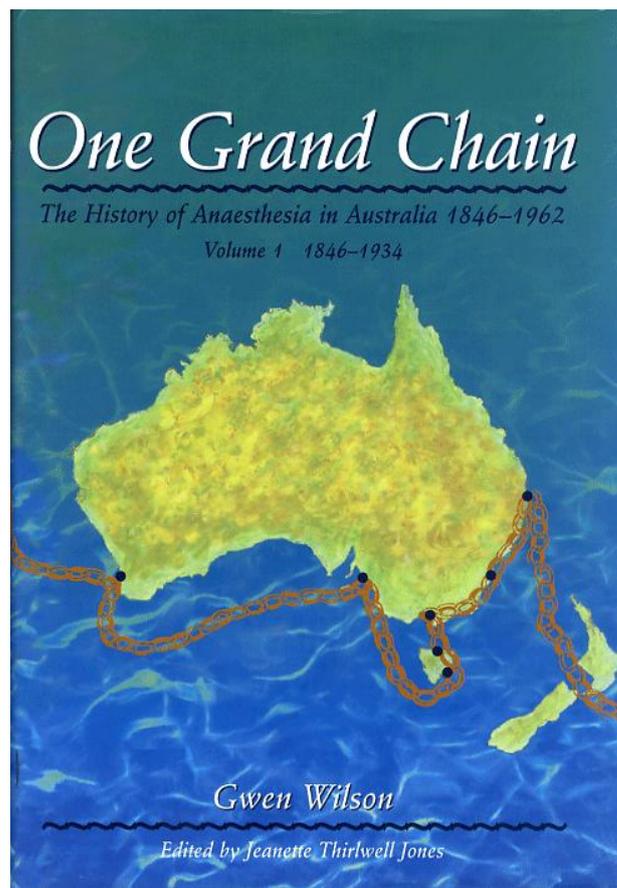


Figure 2: Front Cover, Gwen Wilson, *One Grand Chain: The History of Anaesthesia in Australia, 1846–1962* (Melbourne: Australia and New Zealand College of Anaesthetists, 1995).

The text of such works also demonstrates the enormous variety and ubiquity of international connections. The published histories of New Zealand, Australian, or Australasian medical associations and societies tend to emphasise formal connections, such as the often complex links between local organisations and ‘parent’ British bodies, or the organisation of ‘official’ visits, conferences, and exchange programmes.<sup>63</sup> Less overt references can be found in membership

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<sup>63</sup> Examples beyond those cited in the previous note include Colin Hooker’s *Orthopaedics in New Zealand* (Wellington: Orthopaedic Association of New Zealand, 1996), and Rex Wright St Clair’s *A History of the New Zealand Medical Association; The First 100 Years* (Wellington: Butterworths, 1987), Ronald Winton’s, *Why the Pomegranate: A History of the Royal Australasian College of Physicians* (Sydney, Royal Australasian College of Physicians, 1988), Josephine Wiseman’s *To Follow Knowledge: A History of Examinations, Continuing Education and Specialist Affiliations of the Royal Australasian College of Physicians* (Sydney: Royal Australasian College of Physicians, 1988), and Mervyn J. Eadie’s *The Flowering of a Waratah: A History of Australian Neurology and of the Australian Association of Neurologists* (Sydney: John Libbey, 2000).

lists, which sometimes provide information about post-graduate qualifications and the institutions at which they were obtained, and in references to the dissemination of medical technology between countries. The autobiographies of individual New Zealand doctors tend to contain fewer references to formal modes of connection, but are often rich with references to informal professional friendships, often maintained over very long periods of time and over long distances.<sup>64</sup> These autobiographies also contain valuable clues about the specific ways in which international relationships and experiences influenced their authors' subsequent careers.

Medical journals represent the other main source of information about the structure and operation of the Common-health system. Medical journals represented – and continue to represent – one of the main conduits for the international exchange of ideas in the field of medicine. During the post-World War Two period, major journals such as the *Lancet*, the *British Medical Journal*, and the *New England Journal of Medicine* had significant international readerships. Many smaller specialist journals also had international audiences. During the period that this thesis examines, many specialist fields were still becoming established, with the result that the number of specialists working in any one country was often small. In order to generate the professional interactions required to share ideas, develop new approaches, and to promote professional interests, specialists often formed associations and journals with regional, rather than national foci.<sup>65</sup>

Much of the content of these medical journals was scientific in character, describing new innovations in diagnosis and treatment. However, this thesis focuses primarily on their 'non-scientific' content, and in particular on items that provide insights into the structure and operation of the Common-health system.<sup>66</sup>

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<sup>64</sup> While this is true for both the autobiographies of New Zealand specialists and general practitioners, references to international connections among the latter group tend to be the result of migration for the purposes of receiving undergraduate education, rather than post-graduate specialist training. The reasons for this are discussed in Chapter 3: The Development of the Common-health.

<sup>65</sup> In Australasia, a number of specialty journals appeared in the years following World War Two, in the sub-disciplines of surgery, medicine, radiography, ophthalmology, psychiatry, and obstetrics and gynaecology.

<sup>66</sup> In part, this is because the contention that medical science was international in nature is largely self-evident and requires no academic verification. This is not to claim that science was acultural and as such unaffected by the particular national settings within which it was pursued.

This narrowed focus still leaves for consideration an enormous range of topics, discussed in a number of discursive modes. Lead articles and editorials, policy statements, surveys, reader correspondence, and contributions from non-medical figures such as government ministers all spoke to debates about immigration policies, overseas working conditions, medical education and post-graduate training standards, ‘medical manpower’ shortages, and proposals to expand or alter various ‘nationalised’ health services. When analysed through an international lens, it is clear that international factors such as practitioner mobility were central to all of these debates.<sup>67</sup>

This thesis focuses primarily on material published in the *New Zealand Medical Journal* and the *British Medical Journal*, but also draws on topical journals such as the *British Post-Graduate Journal* and the *Journal of Medical*

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Discussions about the influence of place or culture on scientific enquiry can be found in works such as David N. Livingstone’s *Putting Science in Its Place: Geographies of Scientific Knowledge* (Chicago: University of Chicago Press, 2003), Timothy Lenoir’s *Instituting Science: The Cultural Production of Scientific Disciplines* (Stanford: California University Press, 1997), Sarah Franklin’s ‘Science as Cultures, Cultures of Science’, *Annual Review of Anthropology*, volume 24 (1995), pp. 163-84, S. Harding’s ‘Is Science Multicultural? Challenges, Resources, Opportunities, Uncertainties’, *Configurations*, volume 2, number 2 (Spring 1994), pp. 301-30, and Adi Ophir and Steven Shapin’s ‘The Place of Knowledge: A Methodological Survey’, *Science in Context*, volume 4, number 1 (1991), pp. 3-21. For discussions about the relationship between culture and medical science, see Christopher Lawrence, ‘Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914’, *Journal of Contemporary History*, volume 20, number 4 (October 1985), pp. 503-520, Ronald Numbers and John Harley Warner, ‘The Maturation of American Medical Science’, in *Scientific Colonialism: A Cross-Cultural Comparison*, ed. by Nathan Reingold and Marc Rothenberg (Washington: Smithsonian Institute Press, 1987), pp. 191-216, and William A. Glaser, *Social Settings and Medical Organisation: A Cross National Study of the Hospital* (New York: Atherton Press, 1970).

<sup>67</sup> During the late-nineteenth and early twentieth centuries, such debates covered issues such as the terms of employment for lodge practice, statutes against irregular practice, prospects for remuneration or general work conditions, and overall recommendations about whether migration was advisable under the prevailing conditions. Examples relevant to New Zealand include ‘The Prospect of Medical Practice in New Zealand and Australia’, *British Medical Journal*, volume 2, number 1288, (5 September 1885), pp. 455-464, ‘To Those Going To the Colonies’, *British Medical Journal*, volume 2, number 1677, (10 December 1892), p. 1323, ‘Friendly Societies in New Zealand’, *British Medical Journal*, volume 1, number 1747, (23 June 1894), p. 1370, ‘Medical Legislation in New Zealand’, *British Medical Journal*, volume 1, number 2161, (31 May 1902), p. 1352-3, and ‘New Zealand’, *British Medical Journal*, volume 2, number 2439, (28 September 1907), pp. 847-8. For examples of internationally orientated content in the latter part of the twentieth century, see ‘Specialists’ Register and Consultation Benefit in New Zealand’, *British Medical Journal*, volume 4, number 5678, (1 November 1969), pp. 290-2, D. S. Cole, ‘Post-graduate Medical Education: The Graduate Phase in New Zealand’, *New Zealand Medical Journal*, volume 78, number 496, (8 August 1973), pp. 118-24, ‘Medical Manpower in Australia’, *New Zealand Medical Journal*, volume 84, number 577, (8 December 1976), pp. 427-32, ‘Editorial: Too Many Doctors in Australia?’, *New Zealand Medical Journal*, volume 90, number 639, (11 July 1979), pp. 14-15, and ‘Editorial: The NHS in Britain Under Review’, *New Zealand Medical Journal*, volume 90, number 643, (12 September 1979), pp. 197-8.

*Ethics*, and specialty Australasian journals such as the *Australia and New Zealand Journal of Surgery* and the *Australia New Zealand Journal of Obstetrics and Gynaecology*. Although these publications together represent only one small ‘branch’ of the broader Common-health system in terms of their geographic location, they all functioned as conduits for a range of issues with origins and ramifications well beyond Australasia and Britain. The decision to focus on journals from one geographical branch therefore does not diminish the ability to re-imagine the broader Common-health system, but arguably strengthens it by highlighting the presence of internationally oriented content in small, ostensibly ‘national’ publications.

### *Recorded Interviews*

As noted in the Preface, this thesis project arose from earlier research into the history of Waikato hospital, and specifically from a series of twenty-six recorded interviews with specialists who had worked in that institution for large parts of their careers. Those interviews were conducted using a ‘life narrative’ methodology, designed to provide participants with the freedom to dictate the course and structure of their interviews by raising, suppressing, or emphasising those aspects of their experience that were most significant to them. In theory, this approach provides interviewees with greater freedom to shape their narratives than is the case in interviews arranged around a set of pre-determined questions. By extension, the creation of interviewee-led narratives also provides the researcher with greater opportunities to identify and consider the importance of various contextual factors, by noting the degree to which they are emphasised in, or excluded from, interviewee narratives.<sup>68</sup>

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<sup>68</sup> For a discussion of life narrative methodology, see Valerie J. Janesick, *Oral History for the Qualitative Researcher: Choreographing the Story* (New York: Guilford Press, 2010), *The Oral History Reader*, ed. by Robert Perks and Alistair Thomson (New York: Routledge, 2006), Alessandro Portelli, *The Battle of Valle Giulia: Oral History and the Art of Dialogue* (Madison, Wis.: University of Wisconsin Press, 1997), particularly section 1, pp. 3-88, Appendix 1 of Alistair Thomson’s *Anzac Memories: Living With the Legend* (Melbourne: Oxford University Press, 1994), pp. 225-39, *Methods of Life Course Research: Qualitative and Quantitative Approaches*, ed. by Janet Z. Giele and Glen H. Elder Jr. (London: Sage, 1998), and Donald Ritchie, *Doing Oral History: A Practical Guide*, Second Edition (New York: Oxford University Press, 2003).

In practice, however, it is impossible for any interviewer to avoid exercising some form of influence over the form and structure of the interviews they conduct. Pierre Bourdieu has argued that all interviews are conducted within a constructed ‘postulate of meaning’ that varies according to a range of factors, including the interview setting, the nature of the relationship established between the interviewer and the interviewee, and the relative ‘social position and trajectory’ of participants.<sup>69</sup> Social anthropologist and oral historian Elizabeth Tonkin makes a similar point when she argues that ‘one cannot detach the oral representation of pastness from the relationship of teller and audience in which it was occasioned.’<sup>70</sup> In the initial Waikato hospital project, for example, all interviewees were aware that the institutional focus of the project required them to speak primarily about their professional lives. However, they were also assured that the project aimed to incorporate biographical details, and were therefore encouraged to discuss their careers within the wider context of their personal and family lives. It was with this understanding that many doctors spoke about aspects of their lives outside of Waikato hospital, such as their experiences travelling overseas to secure post-graduate training and qualifications.

The intellectual rationale behind the life narrative methodology has proved much more difficult to sustain in the current thesis project. This is due to the combined effects of a more focussed research topic and the more stringent requirements for informed consent associated with research in the University environment. To satisfy these requirements, all participants were informed in advance about the scope, purposes, and methods of the research project. While this is a necessary and valuable exercise, it all but negated the possibility of obtaining interviewee-led narratives using themes that diverged far from those that had been suggested during the consent process. For this reason, several of the life narrative interviews conducted during the Waikato Hospital history project have been re-analysed, with the interviewees’ permission, for use in this thesis. Four participants in the original project were also re-interviewed, while ten new interviews were conducted with doctors from other parts of New Zealand.<sup>71</sup> In

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<sup>69</sup> Pierre Bourdieu, ‘The Biographical Illusion’, in *Identity: A Reader*, ed. by Paul du Gay, Jessica Evans, and Peter Redman (London: Sage, 2000), p. 300.

<sup>70</sup> Elizabeth Tonkin, *Narrating Our Pasts: The Social Construction of Oral History* (Cambridge: Cambridge University Press, 1992), p. 2.

<sup>71</sup> The selectivity of the interviewee sample used here is discussed in final section of this chapter.

total, this thesis draws upon twenty-two interviews with doctors who travelled overseas for post-graduate training during the three decades that followed World War Two.<sup>72</sup>

Each ‘set’ of interviews – and indeed every participant – required different approaches in terms of the kinds of questions that were asked and the subsequent analysis of the resulting testimonies. Of those doctors who had already participated in the Waikato hospital project, specific questions were asked about aspects of their initial interviews that were of particular relevance for the thesis. However, several of those ‘repeat’ participants had found that the initial interviews had stimulated memories that they were eager to recount. These interviews were largely participant-led, and often provided valuable additional insights. Interviews with new participants also varied from person to person, but were in general more interactive than those conducted under the life narrative methodology. While all new interviewees were given freedom to shape their narratives, direct questions were also used to extract additional detail and meaning from the participants’ own statements.

Techniques of analysis also varied according to the structure of the interview. All interviews were analysed, in part, in what historian Michael Roper describes as the ‘reconstructive’ mode, to find information about each doctor’s migration experiences and their interactions with various international networks and relationships.<sup>73</sup> I also used more ‘interpretive’ discursive analysis techniques to examine the ways in which they characterised themselves and their profession, structured their narratives, assigned causation to particular events or attributes. However, I tended to use this approach more circumspectly in those interviews

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<sup>72</sup> New Zealand historian Dorothy Page generously provided some excerpts from interviews she conducted during her research for *Anatomy of a Medical School: A History of Medicine at the University of Otago, 1875-2000* (Dunedin: University of Otago Press, 2008). As this material did not figure strongly in my subsequent analyses, I do not discuss it here.

<sup>73</sup> The historian, Michael Roper, used these terms to describe different ‘periods’ of oral history methodology: up until the 1970s, oral accounts tended to be used by historians as unproblematic sources of ‘factual evidence’ (the reconstructive mode), whereas recent practice acknowledges – and makes use of – the inherent subjectivity of spoken accounts (the interpretive mode). See Michael Roper, ‘Oral History’, in *The Contemporary History Handbook*, ed. by Brian Brivati, Julia Buxton and Anthony Seldon (Manchester: Manchester University Press, 1997), p. 346. While I acknowledge the problems of taking spoken accounts at face value, it also seems clear that not all spoken content is *inherently* problematic: the ‘reconstructive’ mode of analysis continues to have value. These ideas are discussed in more depth by Anna Green and Kathleen Troupe in ‘Oral History’, *The Houses of History*, ed. by Anna Green and Kathleen Troupe (Manchester: Manchester University Press, 1999), pp. 230-52.

where interviewer questions played a larger part in framing the narrative. Mainly, this is because I felt that drawing conclusions about the relationship between an individual's statements or silences and the trajectories of their careers was both methodologically problematic and ethically dubious when those silences and statements arose in response to questions arising directly from my research agenda.<sup>74</sup>

### *Obituary Database*

Obituaries do not only report the 'fact' of someone's death. They also represent useful 'potted histories' of their subjects' lives, often including information about family backgrounds, places of birth and schooling, career changes, hobbies, and personal qualities. But, as an 'idealised account of a citizen's life . . . for public consumption', the obituary also provides insights into the particular qualities that are valued by those commemorating the deceased.<sup>75</sup> Medical obituaries therefore represent an important source for information about the lives of individual doctors, and about the discourses of self-characterisation that were used to define the profession as a whole.

This thesis draws upon a database analysis of 770 *New Zealand Medical Journal* obituaries; half of all obituaries published in that *Journal* between January 1939 and December 2008. This research method was initially made viable by Dr Basil Hutchinson's bibliographical database, compiled in 2003 and updated in 2008, which provides references for all 1,805 obituaries published in the *New Zealand Medical Journal* since its inception in 1887.<sup>76</sup> The final sample of 770

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<sup>74</sup> This is not to say that such interviews did not offer any insights into the ways in which doctors conceptualised themselves and their profession; all participants contributed in this regard. Rather, it reflects my general discomfort about claiming knowledge of an interviewee's inner processes. On two occasions, I contacted interviewees again to gauge their responses to interpretations I had made. Both were favourable, and the resulting conversations were as valuable as the interviews themselves.

<sup>75</sup> Janice Hume, *Obituaries in American Culture* (Jackson: University Press of Mississippi, 2000), pp. 11-13.

<sup>76</sup> This database greatly alleviated the time-consuming task of locating obituaries by browsing individual issue indexes. Initially, Dr Hutchinson's database was intended to reference only those articles and obituaries related to anaesthesia in New Zealand since the *Journal's* inception in 1887. He later expanded this original project into a bibliographical database of all obituaries published in the *Journal* before 2005. The database was updated again in 2008, producing a list of

obituaries was the result of several decisions about the appropriate study period and the volume of analysis that was feasible within the project's time constraints. While the thesis started as an exploration of post-World War Two medical migration, it soon became clear that the movement of New Zealand doctors *during* World War Two had played a critical part in establishing post-war patterns, with the result that obituaries published after the start of 1939 were included.<sup>77</sup> For logistical reasons, I then decided to analyse fifty per cent of the 1,508 post-1939 obituaries, achieved by ordering all references chronologically and selecting every second obituary for analysis.<sup>78</sup>

As expected, this selection strategy excluded roughly half of the one hundred obituaries of women doctors published after 1939, leaving only fifty-six to be analysed. However, the importance of gender as a category of analysis in this thesis made it necessary to augment this small sample by re-including the forty-six women excluded by the initial selection process. These supplementary cases were not reintroduced into the total 770-strong sample, but were instead placed in a separate database populated solely by the one hundred post-1939 obituaries of women doctors.<sup>79</sup> The use of two separate databases enables the thesis to draw upon the largest possible sample of women's obituaries without compromising the main database's numerical proportionality, and by extension, its ability to generate findings about the profession as a whole.

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1,805 references to the obituaries of 1,697 men and 107 women. The combined total men's and women's obituaries add up to less than the total number of listed references because one male doctor is listed under two names: Dr K. V. V. Satyanarayana and Dr K. V. V. S. Murty.

<sup>77</sup> It was not until the second year of this research that an anonymous commentator on a submitted journal article pointed out the importance of World War One medical migration. While this did inspire additional research into this aspect of twentieth century medical migration, time constraints meant that I was unable to retrospectively include and analyse post 1914 obituaries in the database.

<sup>78</sup> I used this selection method to ensure that the final sample could reflect as 'even' a distribution across the time period as possible. The chronological selection criterion was also designed to avoid distortions that may have arisen by selecting the sample of the basis of doctors' names; it was possible, for example, that such an approach might have generated a bias towards doctors whose names began with common prefixes such as 'Mc' or 'Mac'. In the event, Dr Hutchinson's database contained a number of errors which made it difficult to locate the obituaries concerned without going back to the original sources. Due to time constraints, I decided that the approximately twenty missing obituaries, which were scattered relatively evenly throughout the time period, would not be replaced. As a result the final database sample represents slightly less than fifty per cent of the 1,508 post-1939 obituaries published in the *New Zealand Medical Journal*.

<sup>79</sup> The seven obituaries of women doctors published in the *NZMJ* before World War Two were still excluded.

Most of the obituaries published in the *New Zealand Medical Journal* during this period followed a relatively common template, containing similar kinds of information, often in a similar order. These characteristics reflect traditional obituary formats, and – at least in recent years – prescriptive guidelines about the specific form and content of obituaries submitted to the *New Zealand Medical Journal*.<sup>80</sup> Most of the *Journal*'s obituaries begin by recording their subject's place of birth, the professional background of their parents, and the schools they attended during childhood. Most go on to note the medical school at which the doctors trained, and the hospitals in which they worked as house-officers. Usefully for this thesis, a large number then outline their subjects' overseas post-graduate experience, before describing their subsequent careers in New Zealand. Most obituaries conclude with a discussion of the personal qualities of their subjects, both in direct terms, such as 'humble', 'kind', or 'tough', and through references to the kinds of activities that the doctors were involved in outside of their professional lives, such as work in community organisations, involvement in church or sporting clubs, artistic endeavours, scientific interests, and a range of informal leisure pursuits such as gardening, boating, or reading. Most medical obituaries end with an acknowledgement of the deceased doctor's spouse and children.

After carrying out some preliminary analyses, a database was constructed using the ACCESS program to enable the quantitative analysis of the obituary sample. The database contains sixty-six data fields on twenty-three different aspects of obituary content, listed next page:<sup>81</sup>

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<sup>80</sup> The *New Zealand Medical Journal*'s website provides six criteria for medical obituaries. These are date of birth, date of death, qualifications and honours (and years, if known), details of family surviving the deceased, details of the author of the obituary notice (occupation and city/town), and 'the person's professional achievements, best personal qualities, and (if possible) their interests and pastimes including club and society memberships.' URL: <http://journal.nzma.org.nz/journal/obituaries.html>, accessed 11 September 2012. Correspondents at the *Journal* were unable to specify whether such guidelines had always been in place.

<sup>81</sup> For analytical purposes, several categories had to be divided into multiple fields; for example, 'post-graduate destination' was divided into sub-fields with separate discrete values for 'England', 'Scotland', 'United States', 'Australia', and 'Other'.

Name  
Gender  
Place of Birth (New Zealand or Overseas)  
Year of Birth  
Year of Death  
Secondary Schooling  
Parent's Profession  
Medical School  
Year of Graduation  
Military Service (Yes/No)  
Overseas Training (Yes/No)  
Venue for House-Officer Training  
Venue for Overseas Post-graduate Training  
Duration of Overseas Post-graduate Training  
Names of Professional Mentors Mentioned  
Marital Status  
Parental Status  
Main Place of Employment in New Zealand  
Specialty  
Overseas Qualifications / Year of Qualifications  
Non-Medical Interests  
Character Description  
Involvement in Medical Organisations (political or Professional)

The database was used to provide simple descriptive statistics – such as frequency distributions, measures of central tendency and variation – and also to cross-tabulate value counts of different fields against each other to discover likely correlations between variables. Counting references to overseas migration, to specific overseas venues, or to overseas qualifications has been a central tool in creating an overall picture of post-World War Two migration patterns, while the cross-tabulation of the various fields has allowed a more nuanced picture to be formed, by considering, for example, the ways in which the gender and social backgrounds of doctors influenced migration patterns and the selection of specialties. Detailed descriptions of the specific statistical techniques used are included where appropriate in the following chapters.

Obituaries therefore provide an almost unique opportunity to map quantitative patterns alongside qualitative descriptions. While New Zealand historians such as Michael Belgrave have made creative use of official New Zealand Medical Registers, the qualitative aspects of medical obituaries makes them better suited to the multiple objectives of the present thesis.<sup>82</sup>

### *Notes on Source Selection*

Together, these interviews, published life stories, obituaries, and items of journal content represent the main primary source material for this thesis. These ‘sets’ of sources have been augmented by several ‘one off’ sources, including a series of guidebooks about post-graduate travel published informally by the Dean of the Otago Medical School between 1958 and the mid-1980s, and an invaluable collection of approximately three hundred personal letters written by the New Zealand ophthalmologist Dr Colin Fenton while living and training in Britain between late 1954 and late 1960.

Yet these sources together represent only a fraction of the material that could have been examined in an attempt to understand the form and function of the Common-health system. The thesis does not refer in detail to parliamentary debates on legislative issues surrounding medical migration, and makes only minimal use of the administrative records of medical institutions or professional organisations. In addition, the relatively late development of specialist medicine in New Zealand means that there is very little data available on the distribution of specialists within New Zealand, or on their overseas movements, before the mid-1960s.<sup>83</sup> The first formal register of New Zealand specialists only appeared in

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<sup>82</sup> Despite their comprehensive coverage, and aside from the useful information they provide about post-graduate qualifications, Medical Registers contain little else of real relevance to this study. Another potentially useful set of sources are the application forms for specialist registration collected and stored by the New Zealand Medical Council since 1968. These forms include detailed information about the post-graduate training venues, duration, and experience of almost every New Zealand specialist active at, and since, 1968. However, accessing these records in any useful number proved prohibitively expensive, which was unfortunate given their potential historical value.

<sup>83</sup> David Smith made a similar point about specialist records in Britain, while David Wright, Sasha Mullally, and Mary Colleen Cordukes note the scarcity of official records on migration into

1968, when the establishment of a specialist ‘benefit’ or government subsidy made it necessary to identify formally those doctors who were recognised as specialists.<sup>84</sup>

The process whereby various historical sources were selected or omitted from consideration in this thesis must be taken into account during analysis, particularly when specific findings are extrapolated into generalised statements about the profession as a whole. A potential distortion is the over-representation of prominent or successful doctors in obituaries, autobiographies, and within the interviewed group. However, consideration of the various sources suggests that this is not as significant an issue as might be anticipated: while medical biographies do typically discuss prominent practitioners, New Zealand medical autobiographies represent a broad cross section of practitioners, from medical leaders with state honours to provincial general practitioners, and from a range of social and familial backgrounds. The analysis of these works takes such variance into account, and indeed has been aided by the contextual information that it provides. The use of autobiographies does not appear to distort findings in any particular direction.

In her 2007 study of the use of the obituary as a form of collective memory, Bridget Fowler argues that the chances of any given person receiving an obituary rested primarily on their ‘talent’ or their ‘class origins’.<sup>85</sup> However, Fowler’s study was based on an analysis of obituaries published in leading newspapers such as the *Guardian*, *The Times*, *Le Monde*, and the *New York Times*. It is not surprising that obituary space in such publications is usually devoted to prominent members of society. In comparison, the obituaries published in a specialised professional publication such as the *New Zealand Medical Journal* are much more likely to be representative of its general readership, particularly given New Zealand’s small domestic population. An analysis of the obituaries published in the *New Zealand Medical Journal* between 1969 and 1979 suggested that about fifty-six per cent of all doctors who die in New Zealand each

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Canada. See Smith, *Overseas Doctors in the National Health Service*, p. 4., and Wright, Mullally, and Cordukes “‘Worse than Being Married’”, p. 558.

<sup>84</sup> Before World War Two, the vast majority of hospital-based doctors were either general surgeons or general physicians. While some were recognised to have ‘special interests’, it was relatively rare for doctors to devote themselves entirely to a particular sub-field.

<sup>85</sup> Bridget Fowler, *The Obituary as Collective Memory* (New York: Routledge, 2007), pp. 8-9.

year receive an obituary.<sup>86</sup> The *Journal*'s only 'selection' criteria for publishing obituaries were that their subjects must have been qualified medical doctors who trained or worked in New Zealand.<sup>87</sup> The chances of receiving an obituary in the *New Zealand Medical Journal* therefore appear to be governed less by achievement or status than by peer esteem, and in particular 'the willingness of someone who knew [the deceased] to write one'.<sup>88</sup> The high degree of representativeness of New Zealand medical obituaries is supported by the close conformity of the rates of specialisation of doctors in the database sample – approximately forty per cent – compared to that of the profession as a whole in New Zealand. However, the proportion of women doctors' obituaries in the database – approximately seven per cent – is notably lower than the rate of women doctors who were graduating from medical school in New Zealand at any point after World War Two.<sup>89</sup> Low rates of obituaries for women possibly reflect the concentration of many New Zealand women medical graduates in government-sponsored positions such as the New Zealand School Medical Service, which were generally low status positions in the medical hierarchy, and typically afforded fewer opportunities for peer interaction than did hospital practice, and even some urban general practice. With this in mind, the low rates might be read as evidence for one of the core conclusions of this research project: that women doctors in the period studied were primarily marginalised through informal means, such as exclusion from social events and informal networks of interpersonal relationships. The proportionately lower number of obituaries for women might well be another manifestation of this. As noted above, the creation and use of a second, female-only database is designed to compensate, as far as is possible, for distortions in this particular sample.

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<sup>86</sup> 'Index of Obituaries of Women Practitioners', in *Women Doctors in New Zealand: Historical Perspectives, 1921-1986*, ed. by Margaret Maxwell (Auckland: IMS, 1990), p. 197. 491 names were removed from the medical register due to death during these ten years, while 278 obituaries were published.

<sup>87</sup> The *New Zealand Medical Journal* also publishes some obituaries of doctors who trained in New Zealand but subsequently worked overseas. Brennan Edwardes, Production Editor for *New Zealand Medical Journal*, personal communication.

<sup>88</sup> Professor Ross Lawrenson, Head of the Waikato Clinical School, personal communication.

<sup>89</sup> Between the mid-1930s and the mid-1970s, the number of women among new medical graduates in New Zealand hovered between ten and fourteen per cent. After that, it rose significantly, to twenty-five per cent by the end of the 1970s to almost forty per cent by the end of the 1980s, to more than half by the end of the century.

The final issue to be addressed around source selection and possible bias is the selection of interviewees. In the initial Waikato hospital history project, selection was influenced by seniority and longevity within the institution, by accessibility, and by a desire to secure testimonies from people across the institution, including doctors, nurses, engineers, dieticians, and managers. Among doctors, the same desire for representativeness led to the selection of practitioners who had worked in a range of specialty areas. When the thesis project began, four participants in the earlier project who had spoken in detail about their post-graduate migration experiences were approached and asked to participate again. All agreed.<sup>90</sup> Another doctor from Waikato hospital who had not been involved in initial hospital history project, the endocrinologist Associate Professor John Conaglen, also volunteered to be interviewed. Methods used to secure interviewees from outside the Waikato region included following up word-of-mouth recommendations, placing advertisements in the Otago Medical School Alumni magazine, and distributing flyers at a reunion of the residents of Knox College, one of the Otago Medical School's main halls of residence. The organisers of two other smaller Otago graduating-class reunions were also contacted, and notices were distributed to their mailing lists. All notices asked for expressions of interest from New Zealand-born doctors who had carried out post-graduate training in Britain between 1945 and 1985.

As a result, sixteen doctors made contact with me expressing a willingness to be interviewed. Interestingly, five of these were New Zealand-born and trained doctors who are now resident in the United States. Although I was keen to interview these doctors, the logistical challenges involved could not be resolved, with the exception of Dr Quentin Durward, a New Zealand-trained neurosurgeon based in South Dakota, who was interviewed during a trip back to New Zealand. One Auckland-based doctor changed his mind about participating after being sent information about the objectives of the research, which he thought were 'too political'. I was later interested to hear another interviewee speculate that my interest in informal networks would probably limit responses from doctors in Auckland (New Zealand's largest city), who he described as 'sensitive' to insinuations that appointments in that city's major hospitals were made more on

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<sup>90</sup> These 'return' participants were Dr Peter Rothwell, Dr Colin Hooker, Dr Peter Stokes, and Dr Martin Wallace.

the basis of personal connections than clinical expertise or qualifications. I later interviewed one retired Auckland-based doctor after making a direct approach. Other potential ‘geographical’ biases arose from the fact that I did not interview any doctors from Christchurch, New Zealand’s third largest city, due to funding limitations and the effects of two major earthquakes that occurred during the preparation of this thesis. Funding issues also meant that none of the doctors interviewed came from one of New Zealand’s provincial cities or larger towns, as no more than one person from any one place expressed interest. Regrettably, this made it difficult to justify travelling long distances to conduct a single interview.<sup>91</sup> As a result, all nine ‘new’ New Zealand-based interviewees came from either Wellington or Dunedin. Of the sixteen original respondents, only one was a woman, and that interview was not conducted due to her subsequent unavailability. To compensate for this, I made contact with a number of women specialists whose overseas training met the study’s criteria. Again, personal circumstances meant that only two interviews could be arranged, with cardiologist Dame Norma Restieaux, and academic pathologist Professor Barbara Heslop.

As suggested by their titles, both of these women had attained significant prominence in their respective fields. Several of the male interviewees had also attained leadership positions; Dr Graham Hill was Professor of Surgery at the University of Auckland, Dr David Stewart was Head of the Health Sciences Division of Otago University, Dr John Conaglen is currently Associate Professor of Medicine at the Auckland School of Medicine, Dr Peter Rothwell is an ex-President of the Australasian Thoracic Society and John Sands College Medal recipient, and Dr Colin Hooker served as President of the New Zealand Orthopaedic Association in 1984 and 1985. It is difficult to ascertain whether the high personal profiles of these interviewees had any material effect on the content of their testimonies. Clearly, their success reflects personal attributes that may not have been found in every medical graduate, and may have contributed to a different experience of international interpersonal networks than others. This is an important issue in relation to the objectives of this thesis, and is therefore considered in some detail in Chapter 5: The Migration Experience. In the context

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<sup>91</sup> The small number of responses from doctors outside New Zealand’s largest cities may partially reflect the overall distribution of specialists in New Zealand, which is strongly inclined towards the larger cities, and weaker collegial networks among retired doctors in small towns.

of the present discussion, however, it is enough to note that the interviews of these doctors did not depart in any notable way from those of participants who had not elected to pursue academic medicine or leadership positions, and indeed, were sufficiently different from each other, in terms of their experiences and narrative structures, to dispel the idea that they were in some way unique.

Overall, these issues, together with the small sample size, means that these interviews cannot be interpreted as representative of New Zealand medical migrants as a group. Initially, I had hoped to speak with doctors from both gender groups, from a range of specialties and cultural backgrounds, and with different marital and parental statuses from across the time period. As noted above, this was not achieved. In addition, my initial assumption that the Common-health system served mainly to facilitate, rather than to *limit* participation in specialised medicine meant that I did not consider interviewing non-specialists for insights into the reasons why they became non-specialists. I hope to address these shortcomings in future research. However, the richness of the testimonies that have been gathered here demonstrates the immense potential that oral history techniques have to provide insights into aspects of medical migration and international exchange that cannot be accessed through documentary sources. Along with the other qualitative techniques described in this chapter, they represent a vital element of a research programme explicitly designed to acknowledge the deep interaction of social structures and the people who inhabit them.



## *Chapter 2*

### *The Origins of the Common-Health*

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During the second half of the twentieth century, New Zealand specialists functioned within an occupational space that was powerfully international in nature. Medical knowledge, technology, politics, and discourses were all shaped by events and conditions manifesting within and across multiple national jurisdictions. Together, the volume and complexity of these connections was such that it is possible to conceive professional medicine as a global phenomenon, in the sense that very few societies, if any, were wholly disconnected from it. However, as discussed in the previous chapter, this did not mean that professional medicine was globally homogeneous. Conditions within particular local, national, or regional jurisdictions led to specific patterns of organisation and modes of practice, while pre-existing social and cultural contexts shaped the ways in which those patterns and practices developed.

This chapter maps out the origins of some of the structures and conventions that later came to underpin that ‘branch’ of the Common-health medical system that connected New Zealand medical specialists to British colleagues, institutions, and organisations. It traces the ways in which the interaction of social, economic, and professional factors in Britain, over a long period of time, created conditions that enabled Britain to become an important international hub for post-graduate medical training during the middle decades of the twentieth century. At one level, those conditions derived from the hierarchical structure of British professional medicine, and from the sophisticated system of formal organisations that served both to support and to challenge that hierarchy. Evolving over centuries, this structure came to play a crucial part in shaping twentieth-century migration patterns and migrant experiences. The chapter therefore outlines the development

of those aspects of this structure most relevant to twentieth-century migration: the Royal Colleges of medicine and surgery, the British Medical Association, and most importantly, the British medical education system. This chapter also outlines the development of specialist medicine in Britain, both in terms of institutional development and professional attitudes. In doing so, it provides a historical and conceptual foundation for Chapter 3, which considers the ways in which the various structures, organisations, and attitudes considered here were later *internationalised* to form the basis of the Common-health system of medical exchange.<sup>1</sup>

### *The Development of Professional Structures in British Medicine*

The process of professionalisation was complex and multifaceted. Sociologists and historians alike have traced the many ways in which certain occupational groups have gained control over the regulation of their work and the people who are allowed to perform it. In the field of medicine, often highlighted as the ‘classic’ professional group, this has involved the establishment of formal organisations, education standards, ethical guidelines, and the creation of particular kinds of relationships with state authorities, allied health workers, patients, and the public.<sup>2</sup>

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<sup>1</sup> The following discussion is not meant to suggest that these structures and conventions were necessarily *invented* by British doctors. As Roy Porter and others have shown, many of the underlying values and assumptions of Western medicine, including those of the British medical establishment, can be traced back to antiquity and the beliefs of Hippocrates and Galen. Investigating the roots of these ideas, and indeed the various routes for their transmission, is beyond the scope of this thesis. The most comprehensive survey of the origins of ‘Western’ medicine remains Roy Porter’s *The Greatest Benefit to Mankind* (London: Fontana, 1999 (first published 1997)). See also Irvine Loudon, *Western Medicine: an Illustrated History* (Oxford: Oxford University Press, 1997), Lawrence Conrad, et al, *The Western Medical Tradition: 800 B.C.-1800 A.D.* (Cambridge: Cambridge University Press, 1995)

<sup>2</sup> Valuable studies of the process of professionalisation include Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd Mead & Company, 1970), Freidson, *Professional Dominance: The Social Structure of Medical Care* (New York: Aldine, 1970), Noel Parry and José Parry, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (London: Croom Helm, 1976), Magali Sarfatti Larson, *Rise of Professionalism: A Sociological Analysis* (Berkeley: University of California Press, 1977), *Sociology of the Professions: Lawyers, Doctors, and Others*, ed. by Robert Dingwall and Philip Lewis (London: MacMillan, 1983), Toby Gelfand, ‘The History of the Medical Profession’, in *The Companion Encyclopaedia of the History of Medicine*, Volume 2, ed. by W. F. Bynum and Roy Porter (London: Routledge, 1993), pp. 1119-50, Keith M. Macdonald, *The Sociology Of The Professions* (London: Sage, 1995). In the context of New Zealand medicine, the most thorough treatment is Michael Belgrave’s PhD

While all aspects of professionalisation are important, the following section focuses primarily on those aspects that are most relevant to post-World War Two British post-graduate training structures, and by extension, the migration of New Zealand doctors.

Although the mechanisms of professionalisation are relatively clear, there is much debate about the motivations behind it. Prior to the 1960s, most sociologists, following the work of Talcott Parsons, portrayed professional groups as ‘honoured servants of the public need’, whose efforts to control their occupational spaces were understood as a welcome countermovement to the invidious spread of free market philosophies and practices.<sup>3</sup> However, as part of the broad re-evaluation of elite agency that emerged across the social sciences during the late 1960s, a new generation of sociologists began to take a more critical view. Eliot Freidson highlighted the ways in which professional groups used their status to influence relevant government policy; Terence Johnson examined the relationships between professionals and various economic and political elites; while Magali Larson viewed professionalisation as an aspect of the development and maintenance of class systems.<sup>4</sup>

Common to all these approaches is the idea that professionalisation was driven by a desire for autonomy. According to Freidson, professions are effectively defined by their efforts to control the ‘content and terms of their work’, to obtain ‘positions of legal or political privilege’, to act as gatekeepers, or to ‘control the production and application of knowledge’.<sup>5</sup> The following discussion follows this convention to the extent that it views the pursuit of autonomy as a key part of the process of professionalisation. However, it is critically important to make a distinction between the desire for autonomy and the pursuit of self-interest. Often, the re-evaluation of elite agency that characterised the ‘social turn’ in academic history has resulted in critiques that interpret professional medical

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thesis, “‘Medical Men’ and “Lady Doctors”: The Making of a New Zealand Medical Profession, 1857-1941’, PhD Thesis, Victoria University of Wellington, 1985.

<sup>3</sup> *The Codification of Medical Morality: Historical and Philosophical Studies of the Formalisation of Western Medical Morality in the Eighteenth and Nineteenth Centuries, Volume Two: Anglo-American Medical Ethics and Medical Jurisprudence in the Nineteenth Century*, ed. by Robert Baker (Dordrecht: Kluwer Academic Publishers, 1995), p. 8.

<sup>4</sup> Eliot Freidson’s chapter, ‘The Theory of the Professions: State of the Art’, in *Sociology of the Professions: Lawyers, Doctors, and Others*, ed. by Robert Dingwall and Philip Lewis (London: MacMillan, 1983) provides a useful survey of the sociological literature on professionalisation.

<sup>5</sup> Freidson, *Professional Dominance*, pp. 135-7.

activity as a means to secure the economic or status positions of practitioners. As the American historian and bioethicist Robert Baker has noted, such conclusions typically require the expressed intentions of practitioners – which typically frame arguments for autonomy in terms of the need to maintain clinical or ethical standards – to be interpreted either as contrivances designed to conceal the pursuit of economic or social self-interest, or otherwise discounted altogether.<sup>6</sup> In reality, it is difficult for the historian to gauge whether a given claim for autonomy was motivated at the time by self-interest or by a genuine concern for the well-being of patients and the viability of medicine as a valuable human enterprise. While the following discussion does touch upon this question, its primary purpose is to provide an historical account of the structures, conditions, and discourses that developed in Britain as a consequence of the pursuit of professional medical autonomy, regardless of its motivations.

The historian of medicine, Roy Porter, argues that the initial impetus for the formal organisation of medicine in Britain emerged from the rapid population growth that occurred in Britain and the rest of Western Europe, starting in the twelfth century. As populations grew in these areas, the demand for health-care services grew with them, and increasing numbers of people began to derive at least part of their incomes from meeting that demand. Over the following three to four centuries, the proliferation of people selling health care services of various kinds led to efforts to regulate who could, and who could not, legitimately claim to work as healers.<sup>7</sup>

The limitations of medical knowledge prior to the early sixteenth century meant that claims for legitimacy often rested as much on social position, the ability to exercise discretion – or the capacity to draw upon the tools of rational thought and natural philosophy when discussing and treating illness – as it did on the ability to restore good health.<sup>8</sup> In Britain, those healers who had trained in one of

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<sup>6</sup> Baker, 'Introduction', in *The Codification of Medical Morality*, p. 9.

<sup>7</sup> Porter, *The Greatest Benefit to Mankind*, pp. 113-20.

<sup>8</sup> Peter Bartrip, *Mirror of Medicine: A History of the BMJ, 1840-1990* (Oxford: Oxford University Press, 1990), p. 5. The medical historian, Reginald Magee, notes the contrast between the intensity of university medical education programmes and the relative inadequacy of the medical knowledge imparted. A medical degree at Oxford, for example, took a minimum of fourteen years to acquire, and included a four-year Bachelor of Arts degree, taught and examined exclusively in Latin; a Master's Degree in natural philosophy, geometry, metaphysics, optics,

the few universities established during the period therefore held a distinct advantage in the struggle for legitimacy, and by extension, for professional control.<sup>9</sup> Despite their limited ability to make the sick better, the claim that ‘learned physicians knew the reasons for things’ by virtue of their broad, classical university education enabled such doctors to establish and maintain valuable relationships with wealthy upper-class patients, due in large part to contemporary ideals about the value of the ‘broadly cultured’ gentleman.<sup>10</sup> The 1518 Charter of the Royal College of Physicians of London (later England) referred to this ideal when it insisted that internal medicine should be practised only by ‘those persons that be profound, sad [i.e. serious], and discreet, groundedly learned, and deeply studied in physic.’<sup>11</sup> More than two hundred years later, in 1772, the Scottish physician and writer, James Makittrick, claimed that ‘no science requires so extensive a knowledge of what is called general learning than physic’.<sup>12</sup> The same idea continued to have currency at the start of the twentieth century, when William Osler – celebrated by many doctors as the archetypal physician – stated that ‘in no profession does culture count so much as in medicine’.<sup>13</sup>

Over time, those physicians who had gained access to wealthy patients by virtue of their university credentials appropriated other upper-class values and customs as they strove to maintain those relationships. Physicians may not have been able to cure their wealthy patients, but they could soothe and reassure them by presenting themselves as detached and discreet, trustworthy, wise, and

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physics and history; a medical Bachelor’s Degree of three years consisting mainly of the study of ancient medical authors; and a four year Doctor’s Degree during which the candidate was required to teach the whole book of Galen in a series of formal lectures. At the end of fourteen years, the candidate would be considered ‘well learned’, but would have had no exposure to any patient. Reginald Magee, ‘Medical Practice and Medical Education 1500-2001: An Overview’, *Australia and New Zealand Journal of Surgery*, volume 74 (2004), pp. 272-6.

<sup>9</sup> Teaching at Oxford University began during the late eleventh century, while the University of Cambridge had its roots in an association of scholars formed in 1209.

<sup>10</sup> Porter, *The Greatest Benefit to Mankind*, p. 114, and Gelfand, ‘The History of the Medical Profession’, p. 1121.

<sup>11</sup> William Munk, *The Roll of the Royal College of Physicians of London*, six volumes (London: Royal College of Physicians, 1878) volume 1, p. 8. Cited in Christopher Lawrence, ‘Medical Minds, Surgical Bodies, Corporeality and the Doctors’, in *Science Incarnate: Historical Embodiments of Natural Knowledge*, ed. by Christopher Lawrence and Steven Shapin (Chicago: University of Chicago Press, 1998), p. 161.

<sup>12</sup> James Makittrick, *Commentaries on the Principles and Practice of Physic* (London, 1772), p. xvii. Cited in Lawrence, ‘Medical Minds, Surgical Bodies’, p. 161.

<sup>13</sup> Sir William Osler, *Student Life*, ed. by Richard Verney (Edinburgh: E. and S. Livingstone, 1960), p. 113, cited in Lawrence, ‘Medical Minds, Surgical Bodies’, p. 161.

paternalistic.<sup>14</sup> They were also careful, despite their professional aspirations, to assume a posture of disinterest in financial matters, similar to those supposedly held by the propertied classes. In upper-class nineteenth-century British society, it was generally accepted that having access to independent wealth derived from land and property eliminated the need to fabricate or deceive. To appear financially disinterested was therefore to appear trustworthy. According to the geographer of science, David Livingstone, the association between honesty and class position also meant that anyone aspiring to produce scientific work was wise to ‘adopt the civil conventions of the gentility’.<sup>15</sup> The Royal College of Physicians made the appearance of financial trustworthiness a matter of policy in 1886, when it forbade its members from advertising, engaging in trade, dispensing medicines, or working in partnerships with chemists or other doctors.<sup>16</sup> On the surface, it appears that such injunctions must have left few viable opportunities for physicians to earn a living. Yet, by abstaining from surgery and trade, physicians simultaneously aligned themselves with the intellectual values of their elite clients *and* cemented their position at the top of the medical hierarchy by leaving their competitors to perform work which reinforced their more marginalised social positions.<sup>17</sup>

The social status that came with formal education and gentlemanly manners allowed ‘society’ physicians to dictate the terms of professional regulation. From at least the early fifteenth century, attempts to regulate the profession were justified in terms of the need to protect the public from unsafe medical practitioners. One of the earliest recorded attempts to petition the Crown

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<sup>14</sup> Larson, *Rise of Professionalism*, pp. 21-2.

<sup>15</sup> The corollary of this was that those who were clearly motivated by the need to make money, such as the working and merchant classes – or in the field of medicine, some surgeons, most apothecaries and all irregular practitioners – were thereby assumed to be inherently untrustworthy. David N. Livingstone, *Putting Science in Its Place: Geographies of Scientific Knowledge* (Chicago: University of Chicago Press, 2003), p. 104.

<sup>16</sup> D. W. Carmalt-Jones: *A Physician in Spite of Himself*, ed. by Brian Barraclough (London: Royal Society of Medicine Press, 2009), p. 80. Again, it should be noted that such conditions did not apply in other jurisdictions. In Italy, for example, no such proscription against advertising existed, and in the United States, making money was considered positively admirable. See Parry and Parry, pp. 29-30.

<sup>17</sup> The New Zealand medical historian, Michael Belgrave, notes that the aspiration of nineteenth century doctors to upper class status was partially hampered by the traditional and deep-seated association between aristocracy and land ownership. See Belgrave, “Medical Men” and “Lady Doctors”, p. 128. Roy Porter notes physicians were often careful to defer to their social superiors, sometimes allowing both their diagnoses and their treatments to be guided by the preferences of their clients. Porter, *The Greatest Benefit to Mankind*, p. 286.

for the right to regulate medicine was made in 1421 by a group of London physicians who argued that unregulated medical work was resulting in ‘great harm and [the] slaughter of many men’.<sup>18</sup> The preamble of the first British Act of Parliament intended to regulate medical practice, the 1511 Medical Act, argued that the actions of ‘ignorant persons’ who were causing ‘grievous hurt, damage, and destruction of many of the King’s liege people’ necessitated legislation.<sup>19</sup> Similarly, the 1518 incorporation of the Royal College of Physicians of London, which arose as a consequence of the 1511 Act, aimed to confer upon its Fellows the authority to protect the ‘rude and credulous populace’ of the City of London from fraudulent practitioners.<sup>20</sup>

While such claims are difficult to reconcile with the very limited therapeutic capacity of even the most prestigious doctors at this time, it does not necessarily follow that expressions of concern for the public’s safety were disingenuous. However, it seems clear that public health was not the only stimulus for professional organisation. In the case of London’s Royal College of Physicians, for example, the stated desire to protect the ‘rude and credulous populace’ from fraudulent practitioners must be considered alongside the fact that the vast majority of the city’s population had little choice *but* to seek them out. Most of the College’s Fellows made comfortable livings tending to the health needs of London’s upper classes, and while from the sixteenth century many senior practitioners donated time to charitable voluntary hospitals, there was little incentive for them to provide treatment in a private capacity to patients who could not afford to pay. Restricting access to irregular practitioners, and also to the non-university trained apothecaries and barber-surgeons, therefore did little to improve

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<sup>18</sup> Cited in John Raach, ‘English Medical Licensing in the Early Seventeenth Century’, *Yale Journal of Biological Medicine*, volume 16, number 4 (March 1944), p. 274.

<sup>19</sup> Cited in F. N. L. Poynter, ‘The Influence of Government Legislation on the Evolution of Medical Practice in Britain’, in *The Evolution of Medical Practice in Britain*, ed. by F. N. L. Poynter (London: Pitman Medical Publishing, 1961), p. 6.

<sup>20</sup> The Royal College of Physicians was granted the right to oversee medical practice within a seven mile radius of the City of London. Rosemary Stevens, *Medical Practice in Modern England; The Impact of Specialisation and State Medicine* (London: Yale University Press, 1966), pp. 12-3. Much of the early historiography of medical professionalisation accepted at face value the justifications espoused by those doctors who eventually came to constitute the ‘regular’ medical profession. John Raach’s 1944 essay on sixteenth century medical regulation, for example, argued that the earliest attempts to regulate practice aimed to ‘oversee the health of London’s population’ and to ‘rid the country of the quacks who infested it’. Raach, ‘English Medical Licensing in the Early Seventeenth Century’, pp. 272, 274. See also F. N. L. Poynter, *The Evolution of Medical Practice in Britain*, pp. 5-16.

the health status of London's general population but did much to relieve elite physicians of unwanted competition.<sup>21</sup>

The early emphasis on broad formal university education and upper-class values as the markers of the legitimate medical practitioner had implications for those healers whose treatments were more manual in character. While leading physicians characterised themselves as intellectuals whose diagnoses and prescriptions were backed by the authority of higher learning and experience, surgeons were viewed (at least by physicians) as the purveyors of a less intellectual and more 'manual' approach to healing, while apothecaries (the forerunners of modern general practitioners and pharmacists) were seen as little more than 'shop-keeping' dispensers of dubious remedies.<sup>22</sup> To a large extent, this characterisation of elite medical practice as an intellectual, rather than manual exercise can be seen as part of the leading physicians' attempts to align themselves – socially, behaviourally, ethically, and philosophically – with the upper classes whose patronage they were striving to secure. Yet these socially determined delineations failed to acknowledge the degree to which the day-to-day work of the various practitioners overlapped. As a result, they also created tensions as the members of each group attempted to either defend or expand their particular professional territories. Physicians, appealing to the values of the upper classes, derided the manual aspect of the surgeon's craft and the trade aspect of the apothecary's. Surgeons railed against the inefficacy of 'hands off' physicians and the dangers of the 'part-time' surgery of apothecaries, while the apothecaries appealed for the right to diagnose and treat less well-off patients, in addition to fulfilling their traditional role as dispensers of medicine.<sup>23</sup>

The establishment of formal organisations, or 'corporations', was a key strategy in the pursuit of professional autonomy for all of these groups. The Royal Colleges of Physicians of Ireland and Edinburgh, established respectively in 1654 and 1681, sought to emulate their London predecessor by promoting the interests of physicians within their jurisdictions. In 1617, apothecaries ceded from the Mystery of Grocers and became, by Royal Charter, the Worshipful Society of Apothecaries of London. While this was designed to distinguish apothecaries from

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<sup>21</sup> Stevens, *Medical Practice in Modern England*, pp. 12-3.

<sup>22</sup> Evidence of the division of healers into physicians, surgeons and apothecaries can be found as early as the ninth century. See Gelfand, p. 1120.

<sup>23</sup> Bartrip, *Mirror of Medicine*, p. 5.

their non-medical shop-keeping colleagues, it was also an assertion of their right to diagnose and prescribe medications without first consulting a physician.<sup>24</sup> Similarly, the establishment of the first Royal College of Surgeons, in Edinburgh in 1778, followed by equivalent bodies in Ireland in 1784 and in London in 1800, were declarations of the growing status of surgery, and of surgeons, compared to the historically preeminent physicians. This was due in large measure to the rising social status of British voluntary hospitals during the seventeenth and eighteenth centuries, which had emerged to fill the gap in health-care provision left by the dissolution of the monasteries in the early sixteenth century.<sup>25</sup> Such institutions provided a constant stream of patients for surgeons to practise on, and more intensive nursing care than could be provided by individual surgeons. Together, this enabled more adventurous, and eventually more successful, surgical treatments.

While the members of each of these professional medical organisations cited the well-being of their patients as a paramount motivation for their establishment, it is clear that such organisations also served to formalise and institutionalise the competing professional aspirations of their respective members. Each organisation promoted the credibility of its licentiates by ‘officially’ recognising their competence and character, and promoted their business interests by restricting the members of other Colleges from practising within their jurisdictions. Many also strove to limit the opportunities for ‘irregular’ healers to provide alternative services.<sup>26</sup>

By the early nineteenth century, however, the Royal Colleges could no longer claim to represent the interests of the medical profession as a whole. The

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<sup>24</sup> Apothecaries were recognised as a distinct occupational group within the Company of Grocers by James I in 1607. An independent body was established ten years later, under the title of the Masters, Wardens, and Society of the Art and Mystery of the Apothecaries of the City of London. Porter, *Greatest Benefit to Mankind*, p. 194.

<sup>25</sup> Geoffrey Rivett, ‘Voluntary Hospitals’, in *The Development of the London Hospital System, 1823- 1982*. National Health Service Website, URL: [http://www.nhshistory.net/voluntary\\_hospitals.htm](http://www.nhshistory.net/voluntary_hospitals.htm), accessed 14 September 2007. No pagination.

<sup>26</sup> The implication that surgeons emerged as a separate professional group much later than physicians is misleading. Surgeons were established as an occupational group distinct from physicians as early as 1368, but only ended their traditional association with barbers in the eighteenth century. Similarly, the Company of Apothecaries, established in 1617, emerged from much older craft guilds that promoted the interests of spice vendors and shopkeepers. See Porter, *The Greatest Benefit to Mankind*, p. 119, and Stevens, *Medical Practice in Modern England*, pp. 12-3.

Industrial Revolution and the related growth of towns and cities in northern England, the western lowlands of Scotland, and in Northern Ireland made it much more viable for doctors to establish medical practices outside of London. The rapid growth of provincial practice led the London-based Royal Colleges to implement policies that were designed in large measure to preserve their members' privileged positions. In 1832, a group of 'provincial' English practitioners responded by establishing a body that would actively promote their interests. By the late nineteenth century, that body could legitimately claim to represent the interests of doctors across Britain, and by the middle of the twentieth century, to represent doctors across the British Commonwealth.

### *Medical Reform and the British Medical Association*

Royal Colleges of medicine and surgery emerged in major metropolitan areas and centres of vibrant intellectual activity such as London and Edinburgh because their substantial populations and plentiful links to Britain's aristocrats and landed gentry offered the most attractive, and therefore competitive, conditions for private practice.<sup>27</sup> London in particular provided unique opportunities due to both its large population and its high concentration of wealth. As a result, the earning capacity of London's elite practitioners was an order of magnitude larger than that of doctors in provincial or rural Britain. Anne Digby's investigation of nineteenth-century British medical incomes found that London's foremost urologist, Sir Henry Thompson, earned £8,000 per year at the height of his career in the late 1800s, while the surgeon and pathologist Sir James Paget earned up to £10,000 per year in the middle decades of the nineteenth century. Sir Astley Cooper, the vascular surgeon and anatomist, who also served one term as Vice-President of the Royal Society and two as President as of the Royal College of Surgeons in the early decades of the century, earned almost as much as these two combined, with an annual income at his professional peak of between £15,000 and £21,000. Leading provincial surgeons could not hope to match these incomes. Working

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<sup>27</sup> Such urban centres also hosted universities, which, as the main providers of formal medical education (as opposed to apprenticeship-style training) contributed to the high concentration of 'elite' practitioners. See Gelfand, p. 1124.

during the same period as Sir Astley Cooper, the highly regarded lithotomist and obstetrician John Green Crosse of Norwich earned, on average, slightly more than £2,000 per year for the duration of his twenty-three year career.<sup>28</sup>

London's general practitioners also earned more than their provincial counterparts, although not by as great a margin as their hospital-based colleagues. Irvine Louden's classic study of British general practice, *Medical Care and the General Practitioner*, found that 'country' general practitioners working during the first half of the nineteenth century earned in the region of £150 to £250 per year, while their colleagues in provincial towns earned about twice as much.<sup>29</sup> Digby's research shows that in the second half of the century, urban general practitioners earned approximately £600 per year on average, while the 'first class' practices – almost certainly situated in London – could earn between £1000 and £1,500 per year, and very occasionally more.<sup>30</sup>

While income discrepancies were largely the result of demographic distribution, the Royal Colleges accentuated those effects by regulating the number of doctors entering the profession. The Colleges also effectively dictated who could have access to the wealthiest families by conveying their prestigious Fellowship qualifications by nomination rather than by examination. Similarly, appointments to London's most prestigious voluntary hospitals, which increased doctors' social prestige and provided them with first-hand access to wealthy benefactors, were also controlled to a significant degree by the incumbent senior staff, who were invariably Members or Fellows of one or other of the Royal Colleges.<sup>31</sup> Access to the upper echelons of professional medicine was thus effectively monopolised by the Royal Colleges.

From the late eighteenth century, provincial practitioners began to campaign for greater levels of professional parity with their metropolitan colleagues. In their classic study of the 'rise' of the British medical profession, Noel and José Parry argue that the medical reform movement that culminated in the 1858 Medical Act emerged out of the 'wider political attack on privilege' that

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<sup>28</sup> Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720–1911* (Cambridge: Cambridge University Press, 1994), pp. 137-8.

<sup>29</sup> Irvine Louden, *Medical Care and the General Practitioner* (Oxford: Clarendon Press, 1986), p. 261.

<sup>30</sup> Digby, p. 144.

<sup>31</sup> Rivett, 'Voluntary Hospitals', no pagination.

characterised the radical movement of the late eighteenth century, which had in turn drawn philosophical impetus from the French Revolution.<sup>32</sup> In the field of medicine, this movement manifested as a sustained attack on the dominance of the Royal Colleges. By the early decades of the nineteenth century, large industrial cities and towns had emerged in the English North and Midlands and parts of Scotland and Northern Ireland, leading to an extension of commercial networks and transportation infrastructures. The changing structure of British society both increased the opportunities for doctors working in the provinces and reduced the appropriateness of the highly localised guild system out of which the Royal Colleges had emerged.<sup>33</sup> Together, the traditional localism of Britain's elite medical Colleges and a lack of cooperation *between* the profession's three main branches were creating problems for the medical profession as a whole, and by extension, for their patients. Twenty-seven different organisations had the right to issue medical licences, but no single body existed to take responsibility for overall standards.<sup>34</sup> Only one third of practising doctors possessed a diploma, and there was no single reliable list of medical practitioners. Most doctors had limited access to post-graduate training of any quality.<sup>35</sup> In addition, the local focus of the urban-centred Royal Colleges left medicine in the provinces almost completely disorganised.<sup>36</sup>

In the first decades of the nineteenth century, medical reformers began to argue that many of these problems could be addressed by creating a single medical register and establishing clear criteria for entry onto it, either by creating a single licensing body, or, as eventually happened, by creating a new body to monitor the activities of the various licensing organisations. Initially, such proposals were resisted by the Fellows and parliamentary supporters of the Royal College of Physicians of England in particular, who realised that standardising the means of entry into the profession would mean the end of their tenure at the top of the professional medical hierarchy, and would also limit their ability to control the

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<sup>32</sup> Parry and Parry, *The Rise of the Medical Profession*, pp. 106-7. For a useful survey of the background to the introduction of the 1858 Medical Act, see M. J. D. Roberts, 'The Politics of Professionalization: MPs, Medical Men, and the 1858 Medical Act', *Medical History*, volume 53 (2009), pp. 37-56.

<sup>33</sup> Parry and Parry, p. 104.

<sup>34</sup> It was still possible, for example, to simply buy a medical degree from the University of Glasgow well into the nineteenth century. Parry and Parry, p. 107.

<sup>35</sup> Stevens, *Medical Practice in Modern England*, p. 23.

<sup>36</sup> Parry and Parry, p. 107.

number of practitioners entering the profession.<sup>37</sup> It was largely due to the ongoing resistance of that College that sixteen different reforming Bills were introduced and rejected by Parliament over eighteen years before the Medical Act was finally passed in 1858.<sup>38</sup>

One of the key moments in the campaign for medical reform was the establishment, in 1832, of the Provincial Surgical and Medical Association. The Association was born in the boardroom of the Worcester Infirmary, where a group of fifty doctors led by Sir Charles Hastings met and resolved to establish an organisation ‘to protect the interests of provincial reputations . . . rights and claims.’<sup>39</sup> Although a later commentator argued that the Association’s strongly provincial focus reflected the belief that the London medical establishment was ‘strong enough to hold its own’, the related observation that London was ‘important enough to claim precedence over all other places in all professional matters’ foreshadowed the Association’s subsequent efforts to challenge the dominance of the London-based Colleges in many matters of medical policy.<sup>40</sup>

The successful sponsorship of the 1858 Medical Act was only the start of the Association’s work. In the second half of the nineteenth century, the organisation sought to improve the lot of the provincial and general practitioners by promoting a range of services including a medical defence fund for doctors facing litigation and an insurance scheme for those who fell ill. It sponsored agencies that oversaw the exchange of medical practices and established arbitration services for disputes over medical fees.<sup>41</sup> While the oligarchic Colleges continued to oversee clinical standards and codes of behaviour, the more openly ‘material’ concerns of Provincial Surgical and Medical Association had a much

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<sup>37</sup> Stevens, *Medical Practice in Modern England*, p. 23. The College changed its name from the Royal College of Physicians of London to the Royal College of Physicians of England in 1843.

<sup>38</sup> Parry and Parry, p. 117.

<sup>39</sup> Cited in ‘A Cursory Survey of the History of the British Medical Association from its Institution to the Present Time’, *British Medical Journal*, volume 1, number 1903 (19 June 1897), p. 1565.

<sup>40</sup> ‘A Cursory Survey’ (see footnote 39 above), p. 1565. Despite common perceptions, the Provincial Association did not only comprise general practitioners, but also included physicians and surgeons appointed to provincial hospitals. Neither did it campaign for the disestablishment of the Royal Colleges. Sir Charles Hastings insisted that the ancient corporations should continue to be ‘respected’, as long as they were willing to operate within a less hierarchical professional structure. Rather than ‘pulling the corporations down’ – the stated goal of the more radical Thomas Wakley, publisher of the campaigning medical journal the *Lancet* – Hastings strove to attain professional equality by pulling provincial practitioners up. Parry and Parry, pp. 128-9.

<sup>41</sup> James A. Gillespie, *The Price of Health: Australian Governments and Medical Politics, 1910-1960* (Cambridge: Cambridge University Press, 1991), pp. 168-9.

broader appeal, and contributed to a rapid expansion of its membership.<sup>42</sup> During the first ten years of its existence, the Association's membership grew from fifty to approximately 1,350. In 1853, the Association opened its membership to doctors practising in London, and three years later declared itself the representative body of the British medical profession as a whole, changing its name to the British Medical Association. By 1897, the Association's membership had increased to more than 17,000, or approximately three quarters of all British doctors, and had largely taken over responsibility for the professional interests of British medical practitioners.<sup>43</sup>

At the start of the twentieth century, the British Medical Association was the single most powerful medical organisation in Britain. Although it had no means to compel action from its members, the threat of expulsion and the resulting loss of access to its services was enough to ensure that members supported the Association in most matters of policy.<sup>44</sup> More important than coercion, however, was collective goodwill, cooperation, and peer esteem, which endowed the Association with significant power to influence the policies of other organisations and institutions, such as private insurance 'lodges' and hospitals.<sup>45</sup> The Association was also able to exert significant pressure on successive British governments in matters of health-related legislation.<sup>46</sup> By the middle of the twentieth century, the British Medical Association had evolved into what was in effect an international association that actively 'pursued policies of overseas

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<sup>42</sup> Stevens, *Medical Practice in Modern England*, p. 270.

<sup>43</sup> 'A Cursory Survey' (see footnote 39 above), p. 1566. The total physician population figure is calculated on the basis of the 1901 census, which recorded 22,698 physicians, surgeons, or general practitioners, of whom 212 were women. 'Life in Britain: Using Millennial Census Data to Understand Poverty, Inequality and Place: Doctors and Nurses', p. 3. URL: <[http://www.sasi.group.shef.ac.uk/research/life\\_in\\_britain/pdfs/Report\\_1\\_Doctors\\_and\\_nurses.pdf](http://www.sasi.group.shef.ac.uk/research/life_in_britain/pdfs/Report_1_Doctors_and_nurses.pdf)>, accessed on 11 October 2012.

<sup>44</sup> Milton Lewis and Roy MacLeod, 'Medical Politics and the Professionalisation of Medicine in New South Wales, 1850–1901', *Journal of Australian Studies*, volume 12, issue 22 (1988), p. 75.

<sup>45</sup> By publishing black-bordered 'warning notices' in its weekly journal, the *British Medical Journal*, the Association was able to effectively cut off the supply of medical professionals to workplaces that refused to provide the minimum standards. For an example, see 'Contract Medical Practice', *British Medical Journal*, volume 1, number 2305 (4 March 1905), p. 507, cited by Rex Wright-St Clair in *A History of the New Zealand Medical Association: The First 100 Years* (Wellington: Butterworths, 1987), p. 82.

<sup>46</sup> The classic study of this aspect of the BMA's work is Harry Eckstein's *Pressure Group Politics: The Case of the British Medical Association* (London: Allen and Unwin, 1960).

involvement or expansion'.<sup>47</sup> By doing so, the Association served as an important conduit for the transmission of medical ideas and policies around the Commonwealth.

The formation and development of the British Medical Association therefore represented a significant victory for a majority of medical practitioners who had previously been poorly represented by the Royal Colleges. Yet Britain's elite physicians and surgeons retained considerable power. By statute, nine of the twenty-three members of the General Medical Council – the body established to administer the register created by the 1858 Act – were to be nominated by the Royal Colleges. The Act made no provision for the election of general practitioners to the Council despite the prominent role that they played in its establishment. A further eight members were nominated by universities with medical faculties, such as Oxford, Cambridge, Aberdeen and St Andrews, while the remainder were appointed by the Crown. A last minute Amendment removed a clause from the proposed Bill which would have prevented the Crown from choosing members of Colleges as its appointees: a likely scenario given the close relationship between the ruling classes and elite College Fellows. As a result, at any given time, a significant proportion of the Council's members were affiliated with one of the Royal Colleges.<sup>48</sup> Through their membership of the General Medical Council, these preeminent doctors wielded significant influence in matters such as the oversight of admissions to the medical register, the de-registration of those found guilty of criminal acts or 'infamous conduct', and the monitoring of standards of professional training. Of particular relevance to post-World War Two medical migration patterns were the membership examinations administered by the various Colleges, which effectively functioned as post-graduate qualifications during that time. Together, these activities ensured that Britain's Royal Colleges continued to play an important role in the evolution and development of Britain's medical structures, and by extension, in the evolution of international medical migration in the twentieth century. The international

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<sup>47</sup> Terence J. Johnson and Marjorie Caygill, 'The British Medical Association and its Overseas Branches: A Short History', *Journal of Imperial and Commonwealth History*, volume 1, number 3 (May 1973), p. 303.

<sup>48</sup> This state of affairs was illustrated by the election of the President of the Royal College of Physicians, Sir Benjamin Brodie, as the inaugural Council's first president. Roberts, 'The Politics of Professionalization', pp. 49-51.

ramifications of College policies will also be explored more fully in the following chapters.

### *The Structure of British Medical Education and the Dominance of Generalism*

The British medical historian, Irvine Loudon, has stated that medical reform was, at its core, ‘not a reform of standards of care or ethical behaviour, but a profound restructuring of medical education and medical licensing.’<sup>49</sup> Of all the mechanisms that the British medical profession used to control and manage its members, such as codes of conduct, registration systems, hierarchical structures, and education systems, it was the latter that had the greatest influence over the structure and practice of medicine. Undergraduate education involved not only the transmission of clinical and scientific knowledge, but also the passing on of a particular set of attitudes about patients, colleagues, allied workers, and the State. The admission policies and on-going requirements of medical schools served as powerful gatekeeping mechanisms that determined not only the number of doctors entering the profession, but also contributed to the perpetuation of a particular demographic composition among medical students, in terms of their gender, ethnicity, and social backgrounds. After graduation, career paths were influenced by the relative prestige of the medical schools that doctors attended, and promotional opportunities, at least within the hospital system, were dictated by the ability to secure post-graduate qualifications. As later chapters will demonstrate, the establishment of informal relationships between teachers and their students was also an important first step towards accessing employment opportunities and post-graduate training, and sometimes in determining the particular specialties that recent graduates pursued.

Prior to the 1858 Medical Act, nothing reflected the fragmentary and often conflicted nature of the medical profession in Britain more than its education and training systems.<sup>50</sup> As noted earlier, twenty-seven different bodies were permitted to license doctors, including any British university with a medical faculty, six

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<sup>49</sup> Irvine Loudon, ‘Medical Education and Medical Reform’, in *The History of Medical Education in Britain*, ed. by Vivian Nutton and Roy Porter (Amsterdam, Atlanta: Rodopi, 1995), p. 229.

<sup>50</sup> For the purposes of this thesis, ‘education’ will be used to refer to undergraduate study while ‘training’ will be used when discussing post-graduate specialist or ‘vocational’ study.

Royal Colleges, the Faculty of Physicians and Surgeons of Glasgow, the London Society of Apothecaries, Dublin's Apothecaries Hall, and the Archbishop of Canterbury.<sup>51</sup> Undergraduate medical education and post-graduate training also differed in significant ways according to specific national contexts. In Scotland, undergraduate medical education was mostly provided in the university setting, and a medical degree served as a licence to practise. University-based teaching tended to emphasise general principles of investigation and reasoning that could then be applied to any particular medical problem. Scottish medical education also encouraged experimental research, and was generally more open to international ideas than was the case in English institutions.<sup>52</sup>

Medical education in England, by contrast, emphasised an experiential empiricist approach over theory, and valued the much more 'practical' orientation of its graduates. There were several reasons for this. To an extent, it reflected the historical emphasis, discussed above, that elite English physicians in particular had placed on a broad knowledge of literature, the arts, law, theology, history, geography, and appropriate gentlemanly virtues as part of their attempt to secure the patronage of wealthy patients.<sup>53</sup> Also, while most nineteenth-century English

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<sup>51</sup> The licensing bodies were listed in Schedule A of *The Medical Act, 1858*, p. 275. Text of the Act is available at URL:

[http://ozcase.library.qut.edu.au/qhlc/documents/qr\\_medi\\_medical\\_1858\\_21-22\\_Vic\\_c90.pdf](http://ozcase.library.qut.edu.au/qhlc/documents/qr_medi_medical_1858_21-22_Vic_c90.pdf), accessed 17 October 2012.

<sup>52</sup> It should be emphasised, however, that these national differences were not absolute, but were mitigated by the constant movement of personnel between English and Scottish medical institutions. Many Scottish student doctors, for example, would sit through the requisite years of medical tuition in a Scottish university only to leave before qualifying in order to seek an English qualification, thereby circumventing the rules of English Colleges which forbade Irish and Scottish licentiates from practising in the lucrative London market. At the same time, many prominent English doctors had taken advantage, at some point in their careers, of the high standard of education available in Scottish universities. Licentiates from England and Ireland were also forbidden to practise medicine in Scotland. See Lawrence, 'The Shaping of Things to Come'. For many of the smaller licensing bodies, examination fees represented such a significant portion of their income that they were willing to advertise on the basis of offering the easiest examinations. Arthur Thomson, 'History and Development of Teaching Hospitals in England', *British Medical Journal*, volume 2, number 5201 (10 September, 1960), p. 750.

<sup>53</sup> Christopher Lawrence, 'Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914', *Journal of Contemporary History*, volume 20, number 4 (October 1985), pp. 503-520. In her study of comparative international medical culture, the medical journalist Lynn Payer suggests that the reluctance of the British medical establishment to embrace specialisation can be attributed to a broader 'British conservatism', and in particular to the idea that the passions of the human body should be suppressed or denied. She argues that in the field of medicine, this denial of the body manifested as a reluctance to perform too many diagnostic tests on patients, as to do so might 'put ideas' into the minds of their patients. At the same time, however, the reluctance to investigate also limited the number of ideas that emerged in the minds of their doctors. Payer, p. 113.

physicians would probably have acknowledged the importance of scientific principles and research methods, the relative scarcity of applicable and effective scientific knowledge in the field of medicine at the time made them generally reluctant to frame the formulation of diagnoses and treatments as scientific activities. Instead, English gentleman physicians tended to promote and value personal observation backed by first-hand experience, and the sound personal judgement derived from a deep understanding of their fellow human beings, which was in turn derived from a broad, classical education. Generalisable, theoretical knowledge was of limited use, English physicians argued, because every individual patient was different.<sup>54</sup> Such ideas persisted well into the twentieth century. In 1900, the English physician, Philip Henry Pye-Smith, wrote that ‘we must never allow theories or even what appear to be logical deductions . . . to take the place of the one touchstone of practical medicine, experience.’<sup>55</sup> Writing of senior physicians that he had trained with during the 1940s and 1950s, the New Zealand paediatrician and author, Neil Begg, spoke admiringly of the ‘old-fashioned clinician whose whole life experience had enhanced the bedside skills of observant eyes, acute and educated hearing, and a sensitive and understanding touch’.<sup>56</sup> For Begg, the traditional ideal of broad learning had come to encompass the physician’s ‘whole life experience’, while the powers of clinical observation had been elevated to an almost superhuman sensory awareness. Scientific skills and knowledge barely warranted a mention.

Another important factor in the dominance of ‘practical’ knowledge was the setting of English medical education, which had traditionally occurred at the patient’s bedside, at first at home, and later in the hospital. While courses of formal tuition at Oxford and Cambridge universities had long provided the traditional route to elite medical status, the vast majority of practitioners learned their craft by attaching themselves to a senior colleague and learning ‘on the job’. As voluntary hospitals became increasingly important providers of health care services during the eighteenth century, it made sense to shift the location of this

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<sup>54</sup> Lawrence argues that a similar privileging of personal observation over scientific theory was apparent in other British professions, such as chemistry and engineering. See Lawrence, ‘Incommunicable Knowledge’, pp. 504-6.

<sup>55</sup> Philip Henry Pye-Smith, ‘Medicine as a Science and Medicine as an Art’, *Lancet*, volume 156, number 4014 (4 August 1900), p. 309.

<sup>56</sup> Neil Begg, *The Intervening Years: A New Zealand Account of the Period between the 1910 Visit of Halley’s Comet and its Reappearance in 1986* (Dunedin: John McIndoe, 1992), p. 42.

apprenticeship-style training from the private home to the hospital bedside. The move had several beneficial consequences. One was the ability to educate medical students in greater numbers than the traditional 'one-on-one' arrangements had done. The presence of large numbers of unpaid trainee doctors in hospital wards also increased the amount of care that the institutions could provide, while the payment of tuition fees to senior doctors represented a welcome source of income. Students also benefitted by becoming known to greater numbers of senior doctors, and to the hospital's administrators: a useful introduction when it became customary for teaching hospitals to appoint their honorary staff, and later, their paid staff, from the ranks of their own trainees. Over time, particular London hospitals, including Guy's, St Thomas's and St Bartholomew's emerged as preeminent teaching institutions. Their consultants were esteemed, their graduates well-regarded, and their standards of patient care, high.<sup>57</sup>

In addition, the status of these hospitals and their senior doctors limited the development of medical education in other institutions. The tuition fees and professional status associated with working in the teaching hospitals gave senior London doctors good reason to limit teaching opportunities elsewhere in England. As most of those senior doctors were also Members or Fellows of the Royal Colleges, they were eminently capable of protecting their privileged positions. One way to do this was to withhold recognition of rival hospitals hoping to initiate their own teaching programmes. While many voluntary hospitals had opened outside of London during the eighteenth and nineteenth centuries, the examiners of the various Royal Colleges, most of whom resided in London, declined to examine students who had trained in those institutions. Some Colleges even enacted provisions that made a period of study in a London hospital obligatory. Through such measures, London's elite practitioners limited the opportunities for medical education outside of London, thereby ensuring that a substantial proportion of it would be carried out in the hospitals in which they worked. Only after a Select Committee hearing in 1839 were the London schools compelled to

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<sup>57</sup> For a useful brief overview of the history of teaching hospitals, see Thomson, 'History and Development of Teaching Hospitals in England' (footnote 52 above). For a more detailed discussion, see *The History of Medical Education in Britain*, ed. by Vivian Nutton and Roy Porter (Amsterdam: Rodopi, 1995).

remove the obligation of students to serve a compulsory period of training in London.<sup>58</sup>

In terms of twentieth century medical migration, the most important consequence of delivering medical education in the hospital environment was the low regard for theoretical medicine, which had strong implications for the development of medical specialisation, and in turn, for the development of structures for post-graduate specialist training. Learning medicine in hospital wards, rather than in university lecture theatres, placed first-hand observation and ‘hands-on’ practice at a premium. During the nineteenth and early twentieth centuries, the consultants in London’s premiere teaching hospitals were generally too busy with their undergraduate responsibilities and clinical duties to devote time to running post-graduate programmes as well. At the same time, their strictly hierarchical staffing arrangements fostered neither the broad collegiality nor the culture of innovation that underpinned specialisation. As consultant posts only became available upon the death or retirement of incumbents, ‘junior’ doctors could expect to wait years, and sometimes decades, for opportunities for promotion. The intense competition for the few promotional opportunities that did arise tended to breed a culture of subservience, in which junior doctors were careful to comply with the methods of their seniors, thereby perpetuating out-of-date practices and stifling new ideas.<sup>59</sup> The suppression of innovation in turn limited the development of specialisation in Britain’s major hospitals.

Specialisation was also hindered by elite physicians’ suspicion of irregular practitioners, many of whom oriented their work towards treating particular body-parts or a particular set of symptoms. To endorse specialisation, therefore, would be tantamount to endorsing quackery.<sup>60</sup> During the first half of the nineteenth

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<sup>58</sup> Stevens, *Medical Practice in Modern England*, pp. 16-19.

<sup>59</sup> Stevens, *Medical Practice in Modern England*, pp. 26, 29. The New Zealand ENT surgeon, Patrick Eisdell Moore learned the weaknesses of Britain’s hierarchical hospital system first-hand after admitting his son for an acute ear infection in the 1950s. After admission, the senior physician – who was elderly and not familiar with recent advances in the discipline – misdiagnosed the condition and forbade the use of penicillin, which would have cleared the condition up rapidly. Both Eisdell Moore and the registrar recognised the mistake, but both were reluctant to countermand it. As a family member, Eisdell Moore was forbidden from providing treatment, while the registrar feared for his professional future. In the end, the situation was resolved when the senior physician went away for a weekend, providing his ‘junior’ staff with an opportunity to administer the necessary medication. Patrick Eisdell Moore, *So Old, So Quick* (Auckland: David Ling, 2004), pp. 239-40.

<sup>60</sup> Lawrence, ‘Incommunicable Knowledge’, pp. 512, 514.

century in particular, prominent British doctors also warned that ‘specialism’ ignored both the systemic nature of sickness and the status of the patient as a complete person. Some also argued that adopting the ‘narrow outlook’ that specialised medicine required was not only unbecoming of gentlemen, but risked creating in its practitioners a ‘cerebral lop-sidedness’.<sup>61</sup> Indeed, the undue reliance on quantitative measurement and pre-determined rules that specialisation was thought to require risked undermining the very ‘art’ of medicine itself.<sup>62</sup> English medical texts were often scathing about the French fondness for theory, and about the announcement of new therapeutic measures based on laboratory research rather than on clinical trials and the observation of patients.<sup>63</sup> The historian of medical specialisation, George Weisz, has also argued that many medical reformers resisted medical specialisation out of concern that it would lead to further professional fragmentation, thereby undermining their attempts to standardise registration and improve professional equality.<sup>64</sup>

While the Scottish medical establishment was generally more receptive to ideas from Continental Europe and the United States, and therefore less inimical to specialisation than the English, the professional influence of leading English practitioners and the structures of English medicine meant that specialised medicine developed much more slowly in Britain as a whole than in comparable jurisdictions.<sup>65</sup> As a case in point, Weisz notes that Britain’s highly fragmented professional structure, founded on multiple individual Colleges and self-governing charitable hospitals, was much less-equipped to support innovation and specialisation than was the more interconnected ‘community’ of institutions and practitioners that existed in France, where centrally funded hospitals were sufficiently large and well-resourced to sustain the appropriate segregation of patients; the necessary precursor of departmental subdivision. An 1814 report to the Administrative Council of Paris’ hospitals claimed that ‘every infirmity, every

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<sup>61</sup> Lawrence, ‘Incommunicable Knowledge’, p. 512.

<sup>62</sup> Robert G. Evans, ‘A Quest for Identity, Authority and Status: The Development of Paediatrics in Australia’, *Health and History*, volume 10, number 2 (2008), pp. 54-6.

<sup>63</sup> Payer, pp. 108-0.

<sup>64</sup> George Weisz, ‘The Emergence of Medical Specialisation in the Nineteenth Century’, *Bulletin of the History of Medicine*, volume 77, number 3 (2003), p. 562.

<sup>65</sup> Christopher Lawrence argues that this willingness to embrace new ideas from overseas was a defining feature of Scottish medicine. See ‘The Shaping of Things to Come: Scottish Medical Education 1700–1939’, *Medical Education*, volume 40, issue 3 (March 2006), pp. 212-218.

need, every stage of life has now, in Paris, institutions that are devoted to it'.<sup>66</sup> From the 1820s, it became customary also for senior Parisian doctors to join institutions such as the Paris Faculty of Medicine, the Sorbonne, the College de France, or the French Museum of Natural History. Weisz argues that the close professional interaction that occurred within such institutions provided a powerful model for collective medical research that further supported the development of specialisation.<sup>67</sup>

The example of urology provides a useful illustration of the contrasting fortunes of specialised practice in different national contexts. In France, urology was a well-established subspecialty of surgery as early as the 1850s. The first dedicated unit had been set up in Paris in 1829, and by 1851 the Paris medical directory listed ten private specialist urologists active in the city. In 1883, the first urological journal was established, and twenty years later, eighty-five specialist urologists were at work in Paris alone.<sup>68</sup> In the United States, high levels of philanthropic support also created conditions conducive to specialisation. The first dedicated genito-urinary service came into being at the Bellevue Hospital in New York in 1866, a national urological association was set up in 1887, and *The Journal of Cutaneous and Genito-Urinary Diseases* published its first number two years later.<sup>69</sup> While the establishment of American urological services lagged slightly behind developments in France, they predated urology in Britain by almost half a century. The Australian medical historian, Robert Evans, has suggested that the development of urology in Britain was hindered even more than other specialties because of its early association with venereology, which was viewed an unsuitable area of interest for doctors trying to exhibit gentlemanly values.<sup>70</sup> Whatever the reason, it was not until 1910 that Guy's Hospital in London opened Britain's first dedicated urological department, more than eighty years after the first French unit. Britain's first urological journal appeared in 1929,

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<sup>66</sup> *Rapport fait au Conseil général de hospices* (Paris: Imprimerie de Madame Huzard, 1816), p. 7, cited by Weisz, 'The Emergence of Medical Specialisation in the Nineteenth Century', p. 553.

<sup>67</sup> Weisz, 'The Emergence of Medical Specialisation in the Nineteenth Century', p. 567.

<sup>68</sup> Sir David Innes Williams, 'The Development of Urology as a Specialty in Britain', *British Journal of Urology, International Edition*, volume 84 (1999), p. 587.

<sup>69</sup> Williams, 'The Development of Urology', p. 587.

<sup>70</sup> Evans, 'A Quest for Identity', pp. 48-50.

and a national association was only established in 1946.<sup>71</sup> Misgivings about specialisation also contributed to the slow adoption of medical technology in Britain. Clinical tools that later proved indispensable, such as the stethoscope, the microscope, and the thermometer, were adopted much more slowly in Britain than they were in Continental Europe. Even the introduction of X-ray machines, with their clear diagnostic benefits, was limited by a widespread belief that operating such machines was ‘beneath’ qualified physicians, and should be instead the work of non-medically trained technicians.<sup>72</sup>

### *Resistance to Specialisation in Britain*

Together, these factors ensured that specialisation in England developed largely outside of the established medical system. The most important venues in this regard were the small, entrepreneurial specialist hospitals that began to appear in London during the middle decades of the nineteenth century. Some were established by ambitious young doctors unwilling to wait the necessary years for promotion in one of London’s established hospitals, and who chose to set up private outpatients’ clinics or dispensaries of their own as an alternative path to clinical and professional advancement.<sup>73</sup> Others were started by doctors who had struggled to find a place in established institutions due to their class backgrounds or nationalities.<sup>74</sup> Due in large part to the expansion of the British middle classes during the mid-1800s, many such enterprises proved to be viable and later developed into small specialist hospitals.<sup>75</sup> By 1850, London had thirty-nine

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<sup>71</sup> Williams, ‘The Development of Urology’, pp. 587-8. The establishment of urology would probably have been even slower were it not for Guy’s exceptional – by British standards – research culture. Staff included Richard Bright (Bright’s disease), Thomas Addison (Addison’s disease), and Thomas Hodgkins (Hodgkins’ disease). See Weisz, ‘The Emergence of Medical Specialisation in the Nineteenth Century’, pp. 549, 562-3.

<sup>72</sup> Lawrence, ‘Incommunicable Knowledge’, pp. 513-7

<sup>73</sup> Lindsay Granshaw, ‘Fame and Fortune by Means of Bricks and Mortar: The Medical Profession and Specialist Hospitals in Britain, 1800-1948’, in *The Hospital in History*, ed. by Lindsay Granshaw and Roy Porter (London: Routledge, 1989), p. 206.

<sup>74</sup> Weisz, ‘The Emergence of Medical Specialisation in the Nineteenth Century’, p. 566-7.

<sup>75</sup> As the new specialist institutions began to prosper, the elite physicians and surgeons that dominated the major teaching hospitals became concerned about the loss of ‘unusual’ patients, which limited the range of teaching that they could perform. By extension, it also limited their ability to extract tuition fees. See Weisz, ‘The Emergence of Medical Specialisation in the Nineteenth Century’, and Granshaw, ‘Fame and Fortune’, p. 206.

specialist dispensaries or hospitals, with a further sixteen opening in the city between 1860 and 1870.<sup>76</sup> Some, such as the Brompton Hospital for Consumption and Diseases of the Chest, the Free Cancer Hospital, the Great Ormond Street Hospital for Sick Children, and the National Hospital for Diseases of the Nervous System, subsequently evolved into world-renowned centres of excellence that attracted trainee specialists from around the world.<sup>77</sup>

By the end of the nineteenth century, the British medical establishment was finally coming to accept the value of medical specialisation. The worth of medical instruments such as the ophthalmoscope, the laryngoscope and the resectoscope had been proven, as had the need for dedicated practice in order to use such instruments effectively and safely. Those British doctors who had dedicated themselves to a limited range of procedures at an early stage soon campaigned for exclusivity in their particular occupational territories: it was not safe, argued specialist urologists, for example, for general surgeons to use resectoscopes only occasionally, as need arose.<sup>78</sup> British general physicians and surgeons began to cede, usually reluctantly, particular procedures and bodies of knowledge to their specialist colleagues, and specialist departments were established in which the appropriate patients, specialists, and their specialised equipment could be brought together. By the end of the nineteenth century, there were 128 specialist hospitals operating in England and Wales, and almost eighty-five per cent of the senior doctors working in London's major teaching hospitals held at least one additional appointment in a specialist hospital.<sup>79</sup> Societies and journals also began to appear to support practitioners in those early specialties. The first specialist organisation, the Ophthalmological Society, was established in 1881, and the *Journal of Laryngology and Otology* appeared in 1887. By 1905, Britain's General Medical Council officially recognised sixteen separate medical and surgical specialties.<sup>80</sup>

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<sup>76</sup> Parry and Parry, p. 140.

<sup>77</sup> Granshaw, 'Fame and Fortune', p. 201.

<sup>78</sup> Sally Wilde, 'See One, Do One, Modify One: Prostate Surgery in the 1930s', *Medical History*, volume 48, number 3 (1 July 2004), p. 361.

<sup>79</sup> 164 out of 195 senior hospital doctors held such dual appointments. Stevens, *Medical Practice in Modern England*, pp. 27-9.

<sup>80</sup> Stevens, *Medical Practice in Modern England*, p. 31.

Despite these developments, the crucial point is that medical specialisation in Britain lagged behind the Continent and the United States by several decades.<sup>81</sup> While differences in definition prior to World War Two make definitive comparisons of the numbers of specialists in various jurisdictions almost impossible, the consequences of historical attitudes about specialisation were discernible in other ways. Weisz has noted that the regulatory structure that surrounded specialist medicine in Britain during the twentieth century was unique to the degree that it generally strove to *increase* the number of specialists, rather than to limit it, as was the case in countries such as France, Germany, and the United States. For Weisz, British specialist shortage was the result of several factors, including the introduction of a nationalised health service in Britain after World War Two, the related lack of opportunities for specialists to generate income in the private sphere, and historical attitudes about specialisation.<sup>82</sup> Comparative studies of international clinical practice in the second half of the twentieth century have shown that British doctors working throughout the twentieth century did ‘less of nearly everything’.<sup>83</sup> On average, they performed less surgery than their European and American colleagues, prescribed fewer drugs, recommended lower daily intakes of vitamins, and requested a fraction of the diagnostic tests. British patients spent less time in doctors’ offices and underwent fewer physical examinations than their counterparts in Europe and the United States.<sup>84</sup> While these tendencies were doubtless the result of a range of factors, it seems reasonable to conclude that the widespread resistance to specialisation that characterised much of British medicine in the nineteenth and early twentieth centuries continued to resonate in the practices of doctors working in the later decades of the twentieth century.

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<sup>81</sup> See George Weisz, ‘Medical Directories and Medical Specialization in France, Britain, and the United States’, *Bulletin of the History of Medicine*, volume 71, number 1 (March 1997), pp. 60-66. Weisz notes several of the factors preventing specialisation among general practitioners, but these are outside the scope of this thesis.

<sup>82</sup> Weisz, ‘The Emergence of Medical Specialization in the Nineteenth Century’, footnote 140 (p. 575). The influence of Britain’s National Health Service on post-World War Two New Zealand medical migration is discussed in the following chapter.

<sup>83</sup> Payer, p. 101.

<sup>84</sup> Payer cites studies, for example, which found British doctors requesting approximately one-eighth the number of laboratory tests that Canadian doctors did, and prescribing half as many drugs as French and German doctors. For references to specific studies, see Payer, pp. 101-5.

One of the critical consequences of Britain's historical aversion to specialisation was that prior to the 1960s, almost no formally organised systems were developed there to foster or support post-graduate specialist training. Traditionally, Britain's Royal Colleges had controlled medical standards through the mechanism of their own notoriously difficult membership examinations, rather than by providing medical education and training. While this arrangement gave the Colleges the upper hand over the universities in terms of their ability to assert control over professional standards, it also meant that British post-graduate training had no central organising body, and was left entirely to individual institutions. It was not until the last third of the twentieth century that medical authorities began to institute formal training programmes for the attainment of specialist qualifications, or to stipulate the kinds of skills and experiences that specialists were expected to have. As a result, all specialised training up to the 1960s, and in some cases beyond, was obtained on an informal, ad hoc basis. Prospective specialists had to secure a job in a well-regarded specialist unit, and learn by observation and 'hands-on' practice. The quality of training was immensely variable, depending as it did on the level of resourcing in any given department, on the abilities of senior colleagues, and on those seniors' willingness to provide clinical opportunities. Often, trainees had to move between several jobs if they were to obtain the breadth of experience necessary for true competence.

Paradoxically, however, the almost total absence of formal specialist training systems was a vital factor in Britain's emergence as a global centre for post-graduate medical training in the years following World War Two. Whereas gaining entry into the numerically limited formal specialist training programmes that existed in the United States and Continental Europe was highly competitive, the informal, decentralised, job-based training structure that existed in Britain meant that every hospital job below the level of consultant was effectively a specialist training post. Despite their variable quality, the sheer volume of training opportunities proved critical as growing numbers of colonial and other 'foreign' doctors began to travel to Britain for post-graduate experience. At the same time, British medical organisations played a central part in determining the regulatory structures within which many overseas doctors worked. Across the British Empire, the international advocacy of the British Medical Association influenced working conditions, the examinations of Britain's Royal Colleges were recognised

as the passport to professional success, and attitudes to specialisation were transmitted and adopted. The following chapter discusses some of the ways in which these organisations and attitudes came to form the basis of an international system of medical exchange.



## Chapter 3

### *The Development of the Common-Health System: The New Zealand Perspective*

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The international system of relationships, organisations, laws, and conventions within which New Zealand medical specialists operated during the decades following World War Two was a direct descendant of a broader, and older, British Empire system. Through Britain's colonising project, New Zealand had imported British-trained doctors and established hospitals that largely followed the British model in terms of staffing systems, professional hierarchies, and beliefs about their proper role in society.<sup>1</sup> Concerns about 'pauperisation', or the creation of a morally destructive dependence on charity, for example, guided decisions about who could, and who could not receive treatment in New Zealand's earliest hospitals. The first four colonial hospitals, established in Auckland, Whanganui, New Plymouth and Wellington in 1847 were manifestations of a 'native policy' designed to introduce indigenous Māori to the benefits of European civilisation, and, following contemporary British conventions, could only be accessed by Europeans who were able to satisfy the Colonial Secretary that they were sufficiently poor, and sufficiently virtuous, to 'deserve' admission.<sup>2</sup> The policies of other health-related institutions, such as friendly societies and churches, also reflected British attitudes to illness and medical treatment, with many continuing to be governed by the constitutions of their British equivalents.<sup>3</sup>

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<sup>1</sup> Michael Belgrave, "'Medical Men' and 'Lady Doctors': The Making of a New Zealand Medical Profession, 1857-1941', PhD Thesis, Victoria University of Wellington, 1985, pp. 31-3.

<sup>2</sup> Iain Hay, *The Caring Commodity: The Provision of Health Care in New Zealand* (Auckland: Oxford University Press, 1989), p. 18.

<sup>3</sup> Belgrave, "'Medical Men' and 'Lady Doctors'", p. 32.

The provisions of the 1858 Medical Act applied across the British Empire, and it was not until 1905 that a degree from the University of New Zealand replaced British registration as the basic qualification for a medical career in New Zealand.<sup>4</sup> Even then, New Zealand's only medical school, in the city of Dunedin in the southern Otago region, had a curriculum closely modelled on British, and particularly Scottish, clinical and cultural norms. The membership examinations of Britain's Royal Colleges continued to function as important keys to professional success in New Zealand, while a range of British professional medical societies and associations influenced colonial working conditions and clinical standards through the establishment of overseas branches and the publication of journals in international editions.<sup>5</sup> Viewed alongside the 'patterns of social aspiration', Victorian values, and urban middle class growth-rates that were similar in both societies, it is easy to agree with historian Michael Belgrave that New Zealand's 'medical market' was an integral part of the British medical market 'until the Second World War, and possibly well beyond.'<sup>6</sup>

The first part of this chapter describes some of the ways in which various British medical structures and patterns 'found some colonial expression' during the nineteenth and early twentieth centuries.<sup>7</sup> It considers the migration of British doctors to the colonies, and the related establishment of British professional organisations overseas. For the purposes of this thesis, however, the most important mechanism of imperial medical connection was the extension of medical education structures, conventions, and values. In many ways, medical education and medical qualifications were the glue that bound the Common-health together. Professional migration could not occur without mutual recognition of overseas qualifications, and attempts to generate consistent clinical and institutional standards across the system relied on all practitioners having broadly

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<sup>4</sup> Britain's colonies were given the right to enact their own medical registration legislation in 1868. Belgrave, "Medical Men" and "Lady Doctors", pp. 48 (footnote 16), 66.

<sup>5</sup> For an interesting discussion about the influence of British organisations and standards on New Zealand medicine, see 'Editorial: The Future of Post-graduate Work in Obstetrics and Gynaecology', *New Zealand Medical Journal*, volume 44, number 240 (April 1945), pp. 67-8, which argued that a proposed obstetrics hospital in Auckland should 'be developed in a way acceptable to such overseas organisations as the Royal College of Obstetricians and Gynaecologists of Great Britain.'

<sup>6</sup> Belgrave, "Medical Men" and "Lady Doctors", pp. 31, 241.

<sup>7</sup> This phrase comes from Terence J. Johnson, 'Imperialism and its Professions: Notes on the Development of Professional Occupations in Britain's Colonies and New States' in *Professionalisation and Social Change*, ed. by Paul Halmos (University of Keele, 1973), pp. 285-6.

comparable levels of knowledge and ability. Therefore, this chapter first examines medical education from an ‘imperial’ perspective, beginning with a discussion of the role of Edinburgh University as one of the ‘great graduating and teaching bodies’ of the British Empire, and in particular, as a graduating body for a significant proportion of New Zealand’s earliest doctors.<sup>8</sup>

The second main section of this chapter explores an important shift in the educational relationship between Britain and New Zealand. Slowly, over the first half of the twentieth century, Britain’s role changed from being that of an important provider of undergraduate medical education to a hub for post-graduate training. Here, I demonstrate that this change was primarily a consequence of the century’s two world wars, each of which contributed, in slightly different ways, to the development of medical specialisation, specialist medical organisations, and medical migration patterns. Of particular importance were the numerous friendly relationships that developed between doctors from New Zealand, and elsewhere in the British Empire, through military service. These friendships formed the basis of an extensive and long-lasting interpersonal network of doctors that facilitated access to post-graduate training opportunities and jobs for thousands of Commonwealth doctors long after the conflicts ended. Chapters 4 and 5 suggest that the largely informal nature of the international medical system had a profound influence on the development of post-World War Two migration patterns, training opportunities, and certain medical specialties, and, critically, shaped the kinds of professional opportunities that were available to doctors of different genders, ethnicities, or social backgrounds. The final section of this chapter discusses the conditions that existed in Britain after World War Two to enable the large-scale migration of so many Commonwealth doctors in search of post-graduate training and qualifications. Together, the growing international demand for post-graduate training and Britain’s ability to supply it ensured that medicine in New Zealand and Britain remained, as Michael Belgrave speculated, closely integrated well beyond World War Two.

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<sup>8</sup> William Turner, Professor of Anatomy and Dean of the Faculty of Medicine at Edinburgh University, cited by Andrew Hull and Johanna Geyer-Kordesch, *The Shaping of the Medical Profession: The History of the Royal College of Physicians and Surgeons of Glasgow, 1858- 1999* (London, Continuum International Publishing Group, 1999), p. 26.

## *Colonial Expansion*

In the middle decades of the nineteenth century, Britain emerged as the world's leading colonial power. The massive growth of Britain's Empire during the second half of the century provided Britain's medical professionals with unprecedented opportunities to expand the bounds of their profession, both geographically and numerically.<sup>9</sup> At the most basic level, this imperial expansion generated a massive increase in the number of medical job opportunities that were available to British doctors, at a time when employment opportunities in Britain were becoming increasingly limited by the hierarchical and intensely competitive nature of domestic medical practice, even though the domestic population was increasing apace. Jobs in formal colonial medical services, in mines and plantations, in the overseas branches of British firms, or as private general practitioners in growing colonial settlements were particularly useful for provincial English doctors struggling against structural pay disparities, and for Irish and Scottish doctors who, before 1858, had been prevented by the regulations of the English Royal Colleges from practising in the more lucrative English market. Even after reciprocity provisions included in the 1858 Medical Act granted doctors from Scotland and Ireland the legal right to work in England, 'institutional racism', a lack of social networks, and limited access to capital perpetuated their exclusion.<sup>10</sup> Under such conditions, thousands of economically marginalised doctors chose to leave Britain and seek their futures in the lands of

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<sup>9</sup> In 1750, Britain was just one of five major European colonising powers. Together with Spain, France, Portugal, and the Dutch Republic, Britain strove to strengthen its economic position by establishing permanent trading posts and colonies in various parts of the world. A century later, the British Empire stood unrivalled, with vastly increased industrial capacity, clear maritime dominance, sophisticated trading mechanisms, and a network of overseas colonies that together covered one quarter of the earth's surface and included one quarter of the earth's population. The precise nature of the connections between the processes of imperialism and industrialisation remains contested. For some historians, the establishment of colonies in India during the earliest stages of industrialisation provides evidence that colonial holdings underpinned domestic growth through the provision of cheap raw materials. Others note that the massive extension of British colonies during the nineteenth century was built on the easy availability of credit and the purchasing power of British citizens, both of which were facilitated by a strongly industrialised British economy. See, for example, J. R. Ward, 'The Industrial Revolution and British Imperialism, 1750-1850', *The Economic History Review*, New Series, volume 47, number 1 (February 1994), pp. 44-65.

<sup>10</sup> Johnson and Caygill, 'The British Medical Association and its Overseas Branches', p. 304, and Douglas M. Haynes, 'Victorian Imperialism in the Making of the British Medical Profession', in *Decentring Empire: Britain, India and the Transcolonial World*, ed. by Durbha Ghosh and Dane Kennedy (Hyderabad: Orient Longman, 2006), p. 130.

the Empire. By the end of the century, almost one out of every five British Medical Association members was living and working overseas.<sup>11</sup>

Such medical migrations were also actively encouraged by British professional organisations and legislators. For the English Royal Colleges, whose long-standing gatekeeping policies were effectively outlawed in 1858, migration became an important mechanism for militating against excessive domestic competition and the concomitant lowering of medical incomes.<sup>12</sup> Membership of the English Royal College of Surgeons had long conferred the right to work not only in Britain, but also ‘elsewhere in the King’s domains’, with the result that RCS licentiates made up a significant proportion of colonial practitioners.<sup>13</sup> In 1886, the passing of the Medical Amendments Act further smoothed the path to the colonies by giving all doctors with a qualification recognised by the General Medical Council the automatic right to practise medicine anywhere in the British Empire.<sup>14</sup>

In effect, this measure further consolidated the social and economic positions of Britain’s medical elites by facilitating the migrations of many ‘excess’ doctors. Very few British medical migrants came from the upper echelons of the British profession. Michael Belgrave noted that of the 198 doctors registered in New Zealand in 1870, only eight practised under a license granted by the most prestigious British body, the Royal College of Physicians of England. Very few of New Zealand’s early medical registrants held the highly prestigious Fellowships of the British Colleges, and those that did tended to have attained them from one of the Scottish or Irish Colleges.<sup>15</sup> Indeed, the Australian doctor and historian Donald Simpson has suggested that the only thing that could compel

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<sup>11</sup> While some of these were overseas-born doctors who had joined local branches, Johnson and Caygill argue that many were British doctors who had emigrated. Johnson and Caygill, ‘The British Medical Association and its Overseas Branches’, p. 304.

<sup>12</sup> Noel Parry and José Parry, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (London: Croom Helm, 1976), p. 115.

<sup>13</sup> In the New Zealand context, for example, a qualification from the English Royal College of Surgeons remained the most common single basic qualification for practice until at least 1911. These qualifications included licences, Memberships, and, less frequently, Fellowships. See Belgrave, “‘Medical Men’ and ‘Lady Doctors’”, p. 98.

<sup>14</sup> Haynes, ‘Victorian Imperialism’, p. 151.

<sup>15</sup> Seventy-two of those registered in New Zealand in 1870 were members of the Royal College of Surgeons of London, forty-eight held diplomas from the London Society of Apothecaries, while Edinburgh’s Royal Colleges of Surgery and Physicians provided twenty and fourteen qualifications respectively. Only one doctor held a Fellowship of the Royal College of Surgeons of London. Belgrave, “‘Medical Men’ and ‘Lady Doctors’”, p. 96.

an established member of London's medical elite to migrate to the colonies was tuberculosis.<sup>16</sup>

However, there is little doubt that many 'rank and file' practitioners would have welcomed the passing of measures that facilitated migration. For doctors of Irish and Scottish descent in particular, work in the Empire represented an important vehicle for upward social mobility, and many embraced the opportunity created by the 1886 Amendment. By the end of the nineteenth century, these doctors formed a significant majority of many colonial medical services, including sixty per cent of the British Army's medical department, the same proportion of the Indian Medical Service, and seventy-nine per cent of the Royal Navy's medical staff.<sup>17</sup> Irish and Scottish doctors also became increasingly prominent in civilian practice after 1886. According to Michael Belgrave, thirty-eight per cent of New Zealand's medical workforce was Scottish-qualified in 1881, compared to forty-eight per cent who were practising with an English qualification.<sup>18</sup> However, just three years after the passing of the 1886 Act, the proportions were almost reversed, with Scottish-qualified doctors making up forty-four per cent of the New Zealand medical workforce, compared to English qualified at thirty-eight per cent.<sup>19</sup> The increase in the number of Scottish-qualified doctors working in New Zealand occurred despite the fact that New Zealand medical students were no longer compelled to travel overseas to complete their undergraduate degrees after 1883, when the Otago medical school began to offer a full course. Despite the growing prestige of Otago's degree, graduates of Scottish institutions, and in particular, Edinburgh University, continued to form

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<sup>16</sup> Donald Simpson, 'English Roots of Medical Education in Australasia: Kenneth F. Russell Memorial Lecture' in *Australia New Zealand Journal of Surgery*, volume 70 (December 2000), p. 846.

<sup>17</sup> Haynes, 'Victorian Imperialism', pp. 138-40. The statistics for the Army and the Indian Medical Service applied to all doctors employed during the period from 1860-1892, while the Navy statistics apply to all appointments made in the decade following 1870.

<sup>18</sup> Michael Belgrave's analysis of the 1870 New Zealand Medical Register showed that only nine of the 198 doctors registered in New Zealand at that time held qualifications from institutions outside the British Isles. Out of 332 doctors registered in New Zealand in 1881, 160 practised with an English qualification. Of these, only four were university degrees, with the remainder coming from the Company of Apothecaries (fifty-two), the College of Physicians (eleven), and the College of Surgeons (ninety-three). Belgrave, "'Medical Men" and "Lady Doctors"', pp. 96-8.

<sup>19</sup> Belgrave, "'Medical Men" and "Lady Doctors"', p. 98.

the largest single cohort of New Zealand practitioners until at least the First World War, when locally educated graduates finally surpassed them.<sup>20</sup>

*The Evolution of the 'Educational Common-health'*

The British Medical Association has often served as a case study of professional activity in the British imperial and Commonwealth contexts because it has been identified by both sociologists and historians as an exemplar of the British 'professional empire'.<sup>21</sup> The American historian, Douglas Haynes, for example, wrote that the British Medical Association was not a passive agent of colonial expansion, but instead 'leveraged its position as an imperial institution to defend the entitlement of British medicine in the world'.<sup>22</sup> Looking at the British Medical Association in particular, the sociologist, Terence Johnson, insisted that the organisation's extensive overseas activities were not merely the accidental by-products of a passive involvement in Britain's colonial project, but arose instead from intentional 'policies of overseas involvement or expansion'.<sup>23</sup> This characterisation might be partially attributed to the use of a social-scientific definition of 'professions' that invariably foregrounds the efforts of occupational groups to promote and protect the *material* interests of their members. Given the prominence of the British Medical Association in protecting the material interests of medical professionals working in both Britain and in colonial environments, the organisation's subsequent depiction as a classic imperial institution is reasonable.

However, the concept of professionalism has other dimensions beyond the material. Foremost among these is the close association between the concepts of professionalism and competence. It is almost axiomatic that professional practitioners pass through formalised courses of education and training, and that their subsequent work is monitored, even if only informally. When considered in the context of imperial medical professionalisation, the foregrounding of education, training, and the maintenance of standards brings into focus a range of other mechanisms by which British medical norms and structures were

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<sup>20</sup> Belgrave, "Medical Men" and "Lady Doctors", p. 98.

<sup>21</sup> Johnson and Caygill, 'The British Medical Association and its Overseas Branches', p. 303.

<sup>22</sup> Haynes, 'Victorian Imperialism', p. 151.

<sup>23</sup> Johnson and Caygill, 'The British Medical Association and its Overseas Branches', p. 303.

internationalised. The earliest migrations of doctors into Britain's colonies were predicated on the near-universal recognition of British medical training and qualifications, as were many early colonial registration schemes.<sup>24</sup> The subsequent establishment of colonial hospitals and medical schools required a system of clinical, operational, and educational standards to be established, which were also invariably British in origin. From the early decades of the twentieth century, the acceleration of medical specialisation contributed to a renewed emphasis on British post-graduate qualifications. While material interests and working conditions had been of primary concern to medical practitioners during the early, less-regulated phases of British expansion in many colonial societies, education, registration, and the maintenance of standards emerged as increasingly important considerations as those societies developed. The reciprocal recognition and standardisation of medical education and training formed an intrinsic part of the international medical network, serving as both a means and a purpose for on-going international interaction.

The educational dimensions of the Common-health evolved under the influence of a series of important historical developments. One was the changing status of British medical qualifications relative to those attained elsewhere; the evolving differential here was perhaps the prime factor in the evolution of medical migration patterns during the twentieth century. Another important factor was a general shift in the objectives of those migrants who travelled to Britain for medical education-related purposes. Up until the First World War, by far the majority of such migrants were students in pursuit of all or part of their undergraduate educations. During the interbellum period, increasing numbers of colonial doctors travelled to Britain for the purposes of attaining postgraduate training and qualifications, and this became normative in the decades following World War Two. The two other key factors in the development of the international medical network were the influence of global conflict, and the closely related acceleration of specialisation that characterised medicine in the twentieth century. Due to the complex interactions of these factors over time, the

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<sup>24</sup> The sole exception was Canada, where reciprocity broke down after the British General Medical Council refused to recognise all Canadian-trained doctors due to the uneven requirements of the various provinces. Canadian authorities refused to recognise British qualifications in turn. See Johnson and Caygill, 'The British Medical Association and its Overseas Branches', p. 318.

following section employs a roughly chronological framework to chart the evolution of medical education in the ‘Common-health’, as it was this aspect of medical interaction, more than any other, than underpinned the post-World War Two migration of New Zealand specialists.

Beginning in at least the eleventh century, a series of prominent European institutions and metropolitan centres achieved international recognition for their undergraduate medical teaching, attracting students from all over the world. The medical school at Salerno in southern Italy, generally regarded as the first institution of its type, drew students from across Europe from at least 1000CE, peaking in popularity during the middle years of the thirteenth century.<sup>25</sup> From the mid-sixteenth century, the focus shifted to northern Italy and the University of Padua, where an emphasis on practical anatomy attracted large numbers of students from as far afield as the British Isles.<sup>26</sup> Students from all over Europe and North America travelled to the University of Leiden in the Netherlands during the seventeenth and eighteenth centuries, initially attracted by the stellar reputation of its senior clinical lecturer, Hermann Boerhaave. From the eighteenth century, Edinburgh University hosted literally thousands of overseas students, many of whom came from either the United States or from one of Britain’s colonies.<sup>27</sup> From the mid-nineteenth century to the outbreak of the First World War, the State-sponsored clinics of Paris and various German universities also served as important destinations for international medical trainees. In the wake of Germany’s defeat and the concurrent reform of the American medical education

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<sup>25</sup> See ‘Salerno and the Beginnings of Modern Medical Education’, in *Medieval Medicine* by James J. Walsh (London: A. & C. Black, 1920), unpaginated online version, URL: <http://bookdome.com/history/Medieval-Medicine/Chapter-III-Salerno-And-The-Beginnings-Of-Modern-Medical-Education.html>, accessed 18 October 2011.

<sup>26</sup> For a survey of the international dimension of Padua’s history, see Cynthia Klestinec, ‘Medical Education at Padua: Students, Faculty, and Facilities’, in *Centres of Medical Excellence?: Medical Travel and Education in Europe, 1500-1789*, ed. by Andrew Cunningham, Ole Peter Grell, and Jon Arrizabalaga (Farnham: Ashgate, 2010), pp. 193-220. See also Douglas Guthrie, ‘The Influence of the Leyden School upon Scottish Medicine’, *Medical History*, volume 3, number 2 (April 1959), p. 108, URL: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1034462/pdf/medhist00179-0028.pdf>, accessed 18 October 2011.

<sup>27</sup> Helen Dingwall notes that many of these students attended Edinburgh for only a brief period, with a minority staying long enough to graduate. See Helen Dingwall, ‘The Importance of Being Edinburgh: The Rise and Fall of the Edinburgh Medical School in the Eighteenth Century’, in *Centres of Medical Excellence?: Medical Travel and Education in Europe, 1500-1789*, ed. by Andrew Cunningham, Ole Peter Grell, and Jon Arrizabalaga (Farnham: Ashgate, 2010), pp. 305-24.

system, the medical schools of Philadelphia and Johns Hopkins emerged as important international centres.<sup>28</sup>

The British medical historian, Rosemary Stevens, has observed that the ascendancy of these various educational centres invariably coincided with the economic and political statuses of their host jurisdictions.<sup>29</sup> Padua University prospered at a time when the Republic of Venice was prominent in European affairs; Leiden came to prominence at the height of the Dutch Republic, while the development of Edinburgh University into an international centre for medical education was inseparable from Scotland's integration into the realms of British imperial expansion after the Union of Parliaments in 1707. Growing national political or economic influence also contributed to the later emergence of medical teaching centres in Paris, Germany, and the United States.

Given this relationship between educational status on one hand, and political and economic prominence on the other, it is notable that very few undergraduate medical migrants travelled to England, even after London became the hub of the most expansive Empire in history. With the possible exception of the small private anatomy school established in London by John Hunter in 1764, no English institution attracted significant numbers of overseas medical students.<sup>30</sup> As discussed in the previous chapter, this was due in large part to the comparatively unstructured apprenticeship-style system that characterised undergraduate medical education in England. At the same time, access to the very few English universities that offered medical degrees was restricted by policies of exclusion, based primarily on religious affiliation.<sup>31</sup> Professional fragmentation, institutional rivalry, and later, a relatively undeveloped research culture also made England unattractive to overseas students.

By contrast, the Scottish system of university-based medical education, and the status of Edinburgh University in particular as Britain's leading medical teaching institution, attracted prospective doctors from all around the British

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<sup>28</sup> Stevens, 'International Medical Education', pp. s11-s18.

<sup>29</sup> Stevens, 'International Medical Education', pp. s11-s18.

<sup>30</sup> Sir D'Arcy Power, 'How Surgery Came to Australasia', Paper read at the opening of the Royal Australasian College of Surgeons, Melbourne, 1935, subsequently published in the *Australian and New Zealand Journal of Surgery*, volume 4, number 4 (April 1935), p. 368.

<sup>31</sup> See Thomas Neville Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945* (New York: Oxford University Press, 1995), pp. 14-16, 79, and Roy Porter, *The Greatest Benefit to Mankind: Medical History of Humanity from Antiquity to the Present* (London: Harper Collins, 1997), pp. 288-9.

Empire from at least the 1850s.<sup>32</sup> Edinburgh University had taught medicine from the early fifteenth century, and established a formal programme in 1726. While medical teaching in England during the nineteenth century revolved mainly around the most prestigious London hospitals and required students to pass an examination of one of the Royal Colleges before they could register, Edinburgh by that time provided ‘a complete, high standard, medical education [that led] to a [registerable] degree.’ Edinburgh also intentionally tailored its curriculum to meet the needs of doctors working in the colonies, offering courses on tropical medicine and even *ad hoc* courses on the medical needs of specific colonies.<sup>33</sup> By the middle of the nineteenth century, Edinburgh had become a byword for high quality medical education around the world, and by 1884, more than half of Edinburgh’s graduates were coming from countries other than Scotland, including England but also from Australasia, India, Canada and South Africa. By the early years of the twentieth century, the Dean of Edinburgh’s Faculty of Medicine, Sir William Turner, could describe his institution as one of the ‘great graduating and teaching bodies, not only for Scotland, but also . . . for the British Empire.’<sup>34</sup>

Edinburgh’s influence over medicine in the imperial context was vast.<sup>35</sup> The sheer number of Edinburgh graduates alone guaranteed its influence: between 1880 and 1914, approximately one quarter of the University’s 9,000 medical graduates subsequently worked overseas.<sup>36</sup> In addition, the status of Edinburgh’s medical degree ensured that many of those graduates achieved positions of responsibility in colonial hospitals, medical schools, and in health administration. As the following section illustrates, Edinburgh was also highly influential in the development of medical education in New Zealand.

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<sup>32</sup> Laurence M. Geary, ‘The Australian-Scottish Connection, 1850-1900’, in *The History of Medical Education in Britain*, ed. by W. F. Bynum and Roy Porter (Amsterdam, Georgia: Rolopi, 1995), pp. 52-3. Geary notes that Edinburgh had been an important venue for American and Irish students from the mid-eighteenth century, but that the establishment of medical schools in these ‘old colonies’ had diminished the flow of students.

<sup>33</sup> Andrew Hull and Johanna Geyer-Kordesch, *The Shaping of the Medical Profession: The History of the Royal College of Physicians and Surgeons of Glasgow, 1858- 1999* (London, Continuum International Publishing Group, 1999), p. 26. See also Bonner, *Becoming a Physician*, pp. 40-2.

<sup>34</sup> Sir William Turner, Professor of Anatomy and Dean of the Faculty of Medicine at Edinburgh University, 1903-1916, cited by Hull and Geyer-Kordesch, p. 26.

<sup>35</sup> *The Influence of Scottish Medicine*, ed. by Derek Dow (Carnforth; Lancs.: Parthenon, 1988), and Ian Wotherspoon, ‘“The Most Powerful Medical Magnet in Europe”: Edinburgh University’s Medical School and the Overseas World, 1880-1914’, *Journal of the Royal College of Physicians of Edinburgh*, volume 34, number 2 (2004), pp. 153-59.

<sup>36</sup> Wotherspoon, p. 155.

## *British Influences in New Zealand Medical Education*

Prior to the establishment of the Otago Medical School in 1875, all New Zealand doctors trained overseas, with the vast majority graduating from institutions in the British Isles.<sup>37</sup> For the first eight years of its existence, the Otago Medical School was not licensed to provide a full course, and its students were obliged to complete the final years of their degrees overseas, usually in Britain, and often at Edinburgh.<sup>38</sup> Even after Otago began to offer a complete medical curriculum in 1883, many of its students continued to leave part way through the course in pursuit of more prestigious British qualifications. Between 1883 and 1893, twenty-one Otago medical students stayed in Dunedin to complete the course, while sixty-five students left after one or two years in order to graduate in Britain.<sup>39</sup>

In the early decades of the twentieth century, the Otago Medical School established its credentials more firmly and began to retain most of its enrollees for the duration of the course. However, a significant proportion of those students were drawn from within the Otago region or neighbouring areas. British universities and medical schools continued to attract large numbers of students from more distant parts of New Zealand. The autobiographies of many doctors who chose to study at Edinburgh suggest that its degree, in particular, had an almost totemic status by the early decades of the twentieth century. The English-born surgeon, and later Chair of Surgery at the Otago Medical School, Sir Francis Gordon Bell, was attracted by the ‘fame of Edinburgh’s Medical School’ and its ‘powerful Scottish tradition’, while Donald Stafford Matthews chose Edinburgh on the strength of ‘[t]he story behind its great traditions, so deeply rooted in the life of the city and in the history of medicine.’<sup>40</sup> Although Fred Bowerbank

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<sup>37</sup> For a detailed description of the international origins of New Zealand’s early medical profession, see Belgrave, “‘Medical Men’ and ‘Lady Doctors’”, pp. 96-106.

<sup>38</sup> Wright-St Clair, *A History of the New Zealand Medical Association*, p. 34. The strength of the Otago Medical School’s early overseas influences is suggested in the title of Chapter 2 of Dorothy Page’s history of the Otago medical School: ‘An Outpost of Edinburgh’. See Dorothy Page, *Anatomy of a Medical School: A History of Medicine at the University of Otago, 1875-2000* (Dunedin: Otago University Press, 2008).

<sup>39</sup> See Page, p. 478, and R. G. Robinson, ‘The Otago Medical School, 1875-1975’, *British Medical Journal*, volume 1, number 5954 (15 February 1975), p. 379.

<sup>40</sup> Sir Francis Gordon Bell, *Surgeon’s Saga* (Wellington: A. H. & A. W. Reed, 1968), p. 207, and Donald Stafford Matthews, *Medicine My Passport* (London: George G. Harrap & Co, 1957), p. 25.

immigrated to New Zealand only after qualifying in medicine, his description of Edinburgh as ‘the great seat of culture of the north . . . more civilised than any other European countries, including England’ reinforces the image of Edinburgh as an important intellectual hub.<sup>41</sup> Bell also recalled that his decision to study at Edinburgh was shaped by childhood friendships with two practising doctors, both of whom were Edinburgh graduates, and both of whom were highly respected within their respective communities.<sup>42</sup> Given the number of Scottish graduates among New Zealand’s medical profession, it is likely that this form of informal, aspirational motivation was not unusual.

As a result of these factors, Edinburgh was very much ‘the Mecca for prospective medical students’ from New Zealand around the turn of the twentieth century.<sup>43</sup> The New Zealand physician, Sir Bernard Myers, recalled arriving in Edinburgh in 1894, to be ‘welcomed by Albert Orchard and other New Zealand students doing the medical curriculum.’ For Myers, the cohort of students from his home country was so extensive and visible that he claimed to ‘not feel lonely’ in what he described as a ‘New Zealand atmosphere’.<sup>44</sup> Nine years later, the New Zealand physician Dr Charles Hand-Newton recalled arriving at Edinburgh University to find an active network of ‘about seventy’ other New Zealand medical students.<sup>45</sup> In 1905, when Sir Francis Gordon Bell travelled from England to Edinburgh, sixteen New Zealanders also enrolled.<sup>46</sup> Michael Belgrave’s analysis of the New Zealand Medical Register shows that between 1881 and 1911, 457 doctors registered to practise in New Zealand with a Scottish qualification – the vast majority likely from Edinburgh – compared to 355 with English qualifications; 138 Otago degrees, and 92 Irish qualifications. The analysis of 770 obituaries published in the *New Zealand Medical Journal* since 1939 conducted as part of this thesis’ examination of post-World War Two migration suggests that

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<sup>41</sup> Sir Fred Bowerbank also noted Edinburgh’s relatively cheap living costs. See Sir Fred Bowerbank, *A Doctor’s Story* (Wellington: Harry H. Tombs, 1958), p. 18. See also Dr Wyn Beasley’s biography of Fred Thompson Bowerbank, available online from the Dictionary of New Zealand Biography in Te Ara - the Encyclopaedia of New Zealand, at: URL: <http://www.TeAra.govt.nz/en/biographies/4b46/1>, accessed 29 October 2012.

<sup>42</sup> Bell, p. 207.

<sup>43</sup> Francis Gordon Bell, ‘Period Piece: 1905-1910’, *University of Edinburgh Journal*, volume 20, number 3 (Spring 1962), p. 215, cited in Wotherspoon, p. 154.

<sup>44</sup> Bernard Myers, *The Reminiscences of a Physician* (Wellington: A. H. & A. W. Reed, 1949), p. 27.

<sup>45</sup> C. T. Hand-Newton, *A Physician in Peace and War* (Christchurch: N. M. Peryer, 1967), p. 1.

<sup>46</sup> Bell, p. 44.

almost sixty per cent of all New Zealand-born doctors who qualified overseas as late as 1938 did so at the University of Edinburgh.<sup>47</sup>

The persistence of high rates of undergraduate medical migration from New Zealand and other British colonies, even after the establishment of local medical schools, was an important factor for continuing interactions between colonial doctors and the British medical establishment. However, the colonial medical schools themselves also served as conduits for the transmission of ‘metropolitan’ influence by employing not only British personnel, but also British curricula, teaching methods, and clinical standards. This was, to a large extent, unavoidable, as it took time for colonial societies to establish the academic infrastructures, expertise, institutions, financial resources, and populations that were needed to facilitate medical education.<sup>48</sup> In these circumstances, the viability of colonial medical schools invariably relied on their ability to import and conform to the methods and standards of British institutions and organisations. The early survival of the Otago Medical School, for example, relied in large measure upon its achievement of official recognition from the University of Glasgow in 1876 and from the University of Edinburgh in 1878. Formal recognition from the English Royal Colleges of Medicine and Surgery came a decade later, and only then after the Medical School agreed to implement the four-year curriculum that had been recommended by the British General Medical Council. Thereafter, continuing recognition relied on the School’s ability to satisfy auditors sent by the Royal Colleges on an annual basis.<sup>49</sup>

The methods and philosophies of British-trained teaching staff also served to transmit British norms into colonial settings, less formally, but no less influentially.<sup>50</sup> While many colonial medical teachers were English born or trained, the international fame of Scottish medical education ensured that significant numbers of Scottish-trained doctors secured positions in the newly emerging colonial medical schools.<sup>51</sup> While the staff of the Otago Medical School

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<sup>47</sup> Of the 257 New Zealand-born doctors on the database who qualified before 1939, fifty-two graduated at a medical school other than Otago. Of these, thirty qualified at Edinburgh. No other single overseas medical school had more than two graduates.

<sup>48</sup> Wotherspoon, p. 153-5.

<sup>49</sup> Page, p. 13; Robinson, p. 379.

<sup>50</sup> See Johnson and Caygill, *Community in the Making*, p. xiv.

<sup>51</sup> Wotherspoon, p. 155. By 1959-60, almost two-thirds of the Members of the Edinburgh College of Physicians (1300 out of 2000) resided overseas. See also Bryan Egan, ‘Interpreting the Medical

included both English and Scottish doctors, Scottish influences tended to dominate. The memoirs of Dr D. W. Carmalt-Jones, Professor of Systematic Medicine at the Otago Medical School from 1919 to 1939, for example, made reference to the significant differences that he perceived between his own Oxford-derived, demonstration-centred approach to clinical teaching and the more theoretically oriented lectures of his Edinburgh-trained colleague, Dr Frank Fitchett.<sup>52</sup> Carmalt-Jones conceded, somewhat ruefully, that ‘the Edinburgh approach’ tended to dominate New Zealand medical teaching.<sup>53</sup> To an extent, this was because the more academic Scottish approach fitted Otago’s demographic circumstances better than the ‘hands-on’ approach preferred by many English educators. While the Otago region was home to one third of New Zealand’s European population at the time of the School’s founding in 1875, and Dunedin’s hospital had been the country’s largest, the end of the gold rushes that fuelled that early growth meant that the region’s population increased only slowly thereafter, relative to other parts of New Zealand. This in turn meant that the Otago Medical School faced a perpetual struggle to access the volume of ‘clinical material’ needed to provide hands-on clinical teaching, thereby reinforcing the ‘cultural’ inclination towards theoretical teaching that came with a largely Scottish-trained staff.<sup>54</sup>

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Culture’, in *New Perspectives on the History of Medicine: First National Conference of the Australian Society of the History of Medicine, 1989*, ed. by H. Attwood, R. Gillespie and M. Lewis (Melbourne: University of Melbourne, 1990), pp. 176-81.

<sup>52</sup> *D. W. Carmalt-Jones: A Physician in Spite of Himself*, ed. by Brian Barraclough (London: Royal Society of Medicine Press, 2009), pp. 129-31.

<sup>53</sup> Barraclough, pp. 129-31. The Australian medical historian Donald Simpson notes that while Dunedin and Sydney were also shaped predominantly by Scottish ideas, Melbourne and Adelaide were more closely aligned, respectively, with the London medical establishment and with Cambridge University. Simpson argues that the ‘Englishness’ of such colonial medical schools has been overlooked by historians who have mistakenly assumed that the ‘cultures’ of the medical schools were the same as those of their host universities, many of which were indeed heavily inflected by Scottish traditions and attitudes. For Simpson, the educational backgrounds of the medical schools’ foundation professors – many of whom had experience of English systems – were more influential than the cultures of the universities within which they worked. See Simpson, ‘English Roots of Medical Education in Australasia’, pp. 843-8.

<sup>54</sup> Belgrave, “Medical Men” and “Lady Doctors”, p. 113.

### *The Shift to Postgraduate Migration*

The emphasis on theory that characterised the first decades of undergraduate teaching at the Otago Medical School may have been a factor in the subsequent migrations of many New Zealand graduates. Prior to the 1940s, more than sixty per cent of New Zealand's population lived in rural areas or in settlements of fewer than one thousand people.<sup>55</sup> This meant that many New Zealand doctors worked in relative professional isolation, and therefore needed to develop practical skills in all branches of medicine, including surgery, anaesthetics, and obstetrics.<sup>56</sup> Many early Otago graduates were aware that their theoretically inclined educations had provided few practical opportunities, and in the absence of any formal post-graduate courses in medicine in New Zealand before 1911, chose to travel to Britain to round out this aspect of their training before embarking on their professional careers.<sup>57</sup> Thus, many of New Zealand's earliest 'post-graduate' medical migrants were not travelling to obtain specialist training, but to become more competent and useful general practitioners.<sup>58</sup> This is borne out by the obituary database findings that suggest that slightly fewer than ninety per cent of New Zealand-born general practitioners who qualified before World War One travelled overseas for some kind of post-graduate training. This was little different to the ninety-three per cent migration rate among doctors who were identified in their obituaries as specialists.<sup>59</sup>

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<sup>55</sup> Campbell Gibson, 'Urbanization in New Zealand: A Comparative Analysis', *Demography*, volume 10, number 1 (February 1973), p. 73.

<sup>56</sup> See Belgrave, "Medical Men" and "Lady Doctors", pp. 251-7 for a series of maps and tables summarising the distribution of New Zealand medical practitioners between 1881 and 1941.

<sup>57</sup> Thomas Frederick Corkill, 'New Zealand's Debt to British Obstetrics', *Journal of Obstetrics and Gynaecology of the British Commonwealth*, volume 68 (February 1961), p. 150. New Zealand's first post-graduate course was held by Sydney Taylor Champaloup in April 1911, and attracted an audience of eight. Rex Wright-St Clair, *An Exercise in Self Help* (Hamilton: Waikato Post-graduate Medical Society, c. 1994), pp. 15-6.

<sup>58</sup> Sir Francis Gordon Bell noted that higher qualifications were also of significant professional advantage for practitioners working in the increasingly competitive urban settings. Bell, p. 167.

<sup>59</sup> Because the database sample was designed primarily with a view to capturing information about post-World War Two migrations, its findings on pre-World War One statistics can only be suggestive. However, of the database's thirty-one New Zealand-born general practitioners who qualified in 1913 or earlier but survived to have their obituaries published after 1939, twenty-seven had either a British medical qualification that required a trip to Britain, or an explicit obituary reference to such a migration. Over the same period, fifteen out of sixteen specialists in the sample migrated. The database also suggests, on firmer statistical ground, that high rates of general practitioner migration continued until World War Two, with 166 of the 202 pre-1938 qualified GPs migrating (eighty-two per cent). This rate drops significantly after 1939, however,

By the start of the twentieth century, leading British medical figures began to suggest that a basic medical degree was no longer a sufficient basis upon which to found a life-long medical career. As medical knowledge became increasingly sophisticated and voluminous, it became clear that safe medical practice required the basic undergraduate education to be continually augmented by informal reading and formal postgraduate training. In 1903, Britain's *Royal Commission on Medical Education* (published as the Todd Report) stated that the objective of undergraduate medical education should no longer be to produce a 'finished doctor', but should aim instead to produce 'a broadly based man who can become a doctor by further training'.<sup>60</sup>

This was particularly true for the growing cohort of specialist doctors. Prior to the 1930s, almost all New Zealand doctors, both in general practice and in hospitals, were generalists. While some hospital-based doctors had 'special interests' in particular areas of medicine or surgery, it was very rare for New Zealand doctors to dedicate themselves to a single area exclusively.<sup>61</sup> For New Zealand's generalist hospital doctors, a short period in general practice following graduation was accepted as an adequate preparation for hospital work. However, as medical specialisation developed in the years following World War One, such apprenticeship-style preparations were no longer sufficient. More targeted post-graduate training was required. Yet, in New Zealand and in many other ex-colonies, it was not possible to provide anything but the most elementary specialist training. In New Zealand's case, the main reason for this was a very small and widely distributed domestic population. Many areas of specialist medicine – although, it is important to note, not all – were, and are, devoted to treating relatively uncommon illnesses or conditions that manifest in only a small proportion of a given population at any given time. New Zealand's urban

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when only ninety-one out of 157 GPs travelled overseas (fifty-eight per cent). For the purposes of this analysis, 'specialist' includes general physicians and general surgeons but excludes general practitioners and those whose area of practise was not identified in their obituaries.

<sup>60</sup>*Royal Commission on Medical Education* (London: HMSO, 1903), p. 23, cited in John Lister, *Postgraduate Medical Education* (London: Nuffield provincial Hospitals Trust, 1993), p. 2.

<sup>61</sup> Only a very few specialties were sufficiently advanced to offer their practitioners the option of full-time specialist practise. Not coincidentally, those specialties tended to be the ones that were most easily transferred into the private sector. Private patients tended to be much more willing to pay for an orthopaedic surgical procedure with a visible, tangible outcome than they were for a course of medication with slow or imperceptible results. Thus, orthopaedic surgeons, otolaryngologists, and ophthalmologists were among the earliest full-time specialists.

populations were simply not large enough to provide the volume of ‘cases’ that doctors needed to develop and maintain expertise, or to sustain viable private practices. Together, the lack of specialists and the lack of available patients made it practically impossible to establish specialised training programmes. At a time when the growing status of the Otago Medical School degree was lowering the rate of undergraduate medical migration to Britain, the growing emphasis on post-graduate training and New Zealand’s inability to provide it meant that international travel remained an integral part of the career experiences of most New Zealand doctors.

A critical moment in the shift from undergraduate to post-graduate migration came in July 1914, when the declaration of war set into motion an unprecedented wave of medical migration that would quickly transform specialised medicine, medical organisation, and the form and function of the entire Common-health system.

#### *War and the International Medical Network*

Interpersonal relationships, far more than formal institutionalised arrangements, were the lifeblood of the international medical network. While the pre-World War One migrations of some New Zealand doctors were supported by formal travelling scholarships and similar schemes administered by various professional bodies, institutions, national governments and international organisations, far more were organised informally, drawing on contacts made through family members based in Britain, or through senior medical colleagues who had studied or worked in Britain.<sup>62</sup>

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<sup>62</sup> An example of this was given in a 1935 paper on the development of surgery in Australasia. The article noted that ‘when a colleague applied for leave of absence and it was known that he was starting off for Europe, a friendly custom grew up of giving him a good send off’ at which advice and guidance was exchanged about the venues and people most likely to meet the particular doctor’s needs. After the doctor in question returned, a second gathering was organised at which information was passed on about both the clinical innovations that had been observed and any contacts that had been made of potential benefit to other prospective migrants. See Sir D’Arcy Power, ‘How Surgery Came to Australasia’, Paper read at the opening of the Royal Australasian College of Surgeons, Melbourne, 1935, subsequently published in the *Australian and New Zealand Journal of Surgery*, volume 4, number 4 (April 1935), p. 382. Informal networking is discussed in greater detail in Chapters 4, 5, and 6.

From 1914, the mass migration of New Zealand medical professionals overseas for the purpose of military service both disrupted and augmented this pattern. For the first time, large numbers of New Zealand doctors travelled not as medical students or recent graduates, but as fully qualified professionals. Wartime service generated an unprecedented number of interactions, both between the members of the New Zealand Expeditionary Force's Medical Corps and with doctors from other Allied countries. In this section, I argue that these wartime migrations provided a vital stimulus to the development of post-graduate structures in Britain, and formed the basis of an international network of interpersonal relationships that underpinned medical migration and post-graduate training structures for at least the next sixty years.

An anecdote recorded in the autobiography of the New Zealand surgeon, Arthur Eisdell-Moore, hints at both the extent of the international medical network during World War One, and the mobility of New Zealand doctors within it. In 1916, while stationed in Mesopotamia, Eisdell-Moore noticed a reference to an old friend in the pages of the *British Medical Journal*. He wrote a letter to his friend and posted it to the given address in Zanzibar, East Africa. By the time it arrived, his friend had moved, and the letter was forwarded first to England and then on to Shanghai in China, where it was finally received. The reply then took a similarly circuitous route, following Eisdell-Moore from Mesopotamia to India, Egypt, England, and New Zealand, before returning once again to England, where it found Eisdell-Moore engaged in postgraduate study in Bristol.<sup>63</sup>

While not all New Zealand doctors travelled this extensively during World War One, the sheer number who served overseas – according to some estimates, more than fifty per cent all doctors registered in the country at the time – generated unprecedented levels of interaction with overseas colleagues and institutions.<sup>64</sup> Some of those interactions developed into friendships, which in turn led to employment opportunities for New Zealand doctors when the conflict ended. After demobilisation, large numbers of New Zealand doctors made use of their wartime contacts to secure jobs in British or American hospitals, and to

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<sup>63</sup> Arthur Eisdell Moore, *Operation Lifetime: Memoirs of a New Zealand Surgeon* (Collins: Auckland, 1964), p. 24.

<sup>64</sup> For references on wartime migration rates, see footnote 8 of Introduction, pp. 9-10.

secure higher qualifications that were recognised throughout the Commonwealth, and increasingly, as semi-official markers of specialist status. Sometimes, departing New Zealand doctors were able to recommend other New Zealanders as their replacements, and over time, this developed into a form of professional ‘chain migration’.<sup>65</sup> Those doctors who chose to stay in Britain permanently also used their influence to facilitate subsequent ‘generations’ of New Zealand medical migrants.<sup>66</sup> Similar patterns seem to have developed among doctors from Canada, Australia, South Africa, and other Allied countries.<sup>67</sup>

The network of interpersonal relationships that developed between the doctors of the various Allied nations during World War One represents the single most important factor in the subsequent acceleration of medical specialisation within the Anglophone world. While most medical historians acknowledge the relationship between war and the development of medical specialisation in the twentieth century, almost all assume that the relationship revolves primarily around the creation of large numbers of casualties and the associated attempts to heal them. Historians note, for example, that orthopaedic surgery was ‘transformed’ during World War One from a discipline largely concerned with ‘knock-knees, flat feet and other congenital abnormalities’, to ‘a sophisticated branch of surgery’ through its attempts to deal with the unprecedented numbers of severe physical injuries.<sup>68</sup> Similarly, the proliferation of facial injuries that appeared as a consequence of trench warfare gave plastic surgeons both the clinical material and the motivation to develop a range of new and more sophisticated techniques.<sup>69</sup>

But not every specialty area was advanced by the exigencies of war, and some were positively inhibited. The British urologist and historian, Sir David Innes Williams, argues that both of the twentieth century’s world wars hindered the development of his discipline by diverting successive generations of urologists

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<sup>65</sup> Particularly useful examples of these phenomena are found in the autobiography of the New Zealand surgeon Sir Bernard Myers. Myers depicts the experience of war as a formative period in his professional life, leading to numerous professional relationships, and extensive international travel. See footnote 60 for reference.

<sup>66</sup> The following two chapters discuss this form of medical chain migration further.

<sup>67</sup> These relationships, however, are outside the scope of this thesis.

<sup>68</sup> Stevens, *Medical Practice in Modern England*, p. 41.

<sup>69</sup> An interesting and detailed contemporary summary of wartime medical advances can be found in ‘The President’s Address’, *New Zealand Medical Journal*, volume 45, number 245 (February 1946), pp. 201-12.

back into what was effectively general surgery.<sup>70</sup> The same thing occurred in other ‘non-military’ disciplines. The New Zealand ENT surgeon, Patrick Eisdell-Moore, echoed Williams when he suggested that medical science would have advanced more quickly *without* the interruption of war and the resultant displacement of thousands of potential medical specialists and researchers into primitive field hospitals and dressing stations. Although Eisdell-Moore was speaking about his perceptions of the Second World War, his observations remain applicable to the First.<sup>71</sup>

There is no doubt, however, that the process of specialisation, taken as a whole, accelerated after World War One, even in disciplines not directly ‘benefitted’ by the necessities of battle. I suggest that a key reason for this was captured in the observation, made by the prominent Australian war historian, C. E. W. Bean, that ‘[t]he lesson of the war was that by organisation you can do anything.’<sup>72</sup> After the war ended in late 1918, many doctors returned to their civilian work with a desire to implement the ‘lessons of medical control’ that they had learned while serving in the armed forces.<sup>73</sup> In Britain, perhaps the most visible manifestation of this was the proliferation of new specialist organisations. The rapid wartime development of orthopaedic surgical techniques, for example, was quickly followed by the formation in 1918 of the British Orthopaedic Association, by the formal recognition of orthopaedics as a separate specialty by the Royal Society of Medicine in 1922, and by the creation of the first specialised degree course at Liverpool University in 1924.<sup>74</sup> But formal organisation also occurred within less overtly ‘military-aligned’ specialties, including the British Association of Dermatologists in 1920, the Society of British Neurological

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<sup>70</sup> Sir David Innes Williams, ‘The Development of Urology as a Specialty in Britain,’ *British Journal of Urology, International Edition*, volume 84 (1999), p. 591. It is worth noting, however, that urological conditions were a perennial concern for military doctors, and that the official history of New Zealand’s wartime medical services included chapters devoted to ‘Diseases of the Testes’ and ‘Venereal Disease’. See Thomas Duncan MacGregor Stout, *War Surgery and Medicine*, part of *The Official History of New Zealand in the Second World War 1939–1945* (Wellington: Historical Publications Branch, 1954), available online at the New Zealand Electronic Text Collection, URL: <http://nzetc.victoria.ac.nz/tm/scholarly/tei-WH2Surg.html>, accessed 31 October 2012.

<sup>71</sup> Cited by his father, Eisdell Moore, *Operation Lifetime*, p. 182-3. Patrick Eisdell Moore returned from active service in World War Two repulsed by the suggestion that the experience of war could be in any way progressive.

<sup>72</sup> Cited in James A. Gillespie, *The Price of Health: Australian Governments and Medical Politics, 1910-1960* (Cambridge: Cambridge University Press, 1991), p. 57.

<sup>73</sup> Gillespie, p. 31.

<sup>74</sup> Stevens, *Medical Practice in Modern England*, p. 41.

Surgeons in 1926, The British Society of Pathologists in 1927, the British Paediatric Association and the British Tuberculosis Association in 1928, the British College of Obstetricians and Gynaecologists in 1929, and the Association of Anaesthetists of Great Britain and Ireland in 1932.<sup>75</sup> All of these groups played key roles in the subsequent evolution of their respective specialty areas through activities such as the organisation of regular meetings among their practitioners, the development of clinical and surgical standards, and the publication of journals. Perhaps their most important contribution, however, was the fostering of a sense of collective identity and purpose among their members, which often manifested as an eagerness to foster new doctors into the specialty.<sup>76</sup>

World War One also created a need to improve the organisation of British postgraduate training structures. Soon after the war began, London experienced a ‘peaceful invasion’ of doctors from the various Allied countries who were either passing through on duty or visiting during periods of leave.<sup>77</sup> Many of those doctors wished to take advantage of their time in the world’s most populous city, and sought opportunities to undertake some form of post-graduate training. However, despite London’s size and the sophistication of its medical services, formal post-graduate training opportunities were very limited. The only ‘programmes’ available prior to the war had been the informal gatherings held at the home of Dr Jonathon Hutchison on Wednesday afternoons from the early 1890s, and a handful of short courses run at various smaller London hospitals, including one established at the West London Hospital by Drs C. R. B. Keetley and L. A. Bidwell in 1893.<sup>78</sup>

It soon became clear that such limited facilities could not hope to meet the demands of overseas doctors. In response, a group of prominent London doctors, led by Sir John MacAlister, campaigned for an ‘emergency scheme’ that would expand and improve coordination between the existing post-graduate programmes. This culminated in the formation of the Fellowship of Medicine in

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<sup>75</sup> Founding dates are taken from the various association websites.

<sup>76</sup> This sense of ‘family’ was mentioned in several of the interviews conducted for this thesis.

<sup>77</sup> Herbert J. Paterson, ‘The Future of Post-Graduate Teaching in London’, *British Post-Graduate Medical Journal*, volume 5, number 59 (August 1930), pp. 184-5.

<sup>78</sup> For descriptions of London’s earliest post-graduate medical programmes, see Gordon Cook, *John MacAlister’s Other Vision* (Oxford: Radcliff, 2005), pp. 6-7, and Sir Francis Fraser, *The British Post-graduate Medical Federation: The First Fifteen Years* (London: Athlone Press, 1967), p. 3.

1918.<sup>79</sup> Britain's Minister of Health then assembled a panel of experts whose brief was to formalise post-graduate structures free of any university or government involvement. The panel recommended that the Fellowship of Medicine should merge with the Post-Graduate Medical Association that Professor William Osler had established in 1911, to create the Fellowship of Post-graduate Medicine.<sup>80</sup> Initially, the organisation aimed to help doctors who had spent long periods in the military to readjust to civilian practice. At the same time, however, Britain's leading medical figures recognised that the wartime influx of international doctors represented an opportunity to promote Britain as an important venue for post-graduate study. Up until his death in 1919, Osler in particular argued that London should grasp the opportunity to replace Vienna as the global Mecca for postgraduate medical students.<sup>81</sup>

From its inception, the Fellowship of Post-graduate Medicine was therefore strongly oriented to the development of specialist medicine not only within Britain, but across the British Empire. Osler himself argued that one of the organisation's core functions should be to encourage medical authorities to 'think about post-graduate education on an imperial scale'.<sup>82</sup> It was hoped that elevating London's status to that of a global centre for post-graduate medicine would promote 'goodwill and fellowship' between Britain and 'the great English speaking nation beyond the sea'.<sup>83</sup> However, achieving this would require significant improvements to London's existing post-graduate facilities. To this end, the Fellowship began to publish the *British Post-Graduate Medical Journal* in 1925, partly to provide a central source of information about Britain's scattered post-graduate opportunities.<sup>84</sup> The Fellowship's primary objective, however, was to campaign for the establishment of a centrally located institution in London devoted entirely to post-graduate medical teaching. Largely as a result of the Fellowship's lobbying, the idea found support in two prominent government

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<sup>79</sup> G. C. Cook, 'History of the Fellowship of Postgraduate Medicine', *British Postgraduate Medical Journal*, volume 81, number 961 (November 2005), p. 673.

<sup>80</sup> G. C. Cook, 'Dr D. G. James FRCP and the Fellowship of Postgraduate Medicine', *Postgraduate Medical Journal*, volume 79, number 928 (February 2003), p. 101.

<sup>81</sup> Charles Newman, 'A Brief History of the Postgraduate Medical School', *British Post-Graduate Medical Journal*, volume 42, number 494 (December 1966), pp. 738-740.

<sup>82</sup> Cited in Newman, 'A Brief History of the Postgraduate Medical School', pp. 738-740.

<sup>83</sup> Paterson, 'The Future of Post-Graduate Teaching in London', pp. 184-5 (see note 76).

<sup>84</sup> Sir William Hale-White, 'Foreword', *British Post-graduate Medical Journal*, volume 1, number 1 (October 1925), p. 1.

reports, the 1921 *Athlone Report into Post-Graduate Training* and the 1930 *Report of the [Government's] Postgraduate Medical Education Committee*. The latter report proposed the Hammersmith Hospital in Shepherd's Bush as the venue for the new Royal Post-graduate Medical School, and the institution opened in 1935.<sup>85</sup>

The development of specialist medical associations and the expansion of post-graduate teaching structures in the wake of World War One were critical to the subsequent acceleration of medical specialisation in Britain and across the British Empire. These developments provided an institutional framework for the hitherto informal network of inter-personal relationships, catalysing them into a powerful force for professional organisation and the development and dissemination of specialised medical knowledge. The network of enduring wartime relationships provided doctors from Britain's colonies and dominions with opportunities to access employment in Britain, while the emerging societies and post-graduate structures nurtured many of those medical migrants into specialist practice.

In a very short time, the main destination of medical migrants from Britain's ex-colonies and dominions shifted emphatically from the Scottish medical school to the English hospital. This change is discernible in the obituaries of New Zealand doctors active across this period. Among the forty-seven New Zealand-born doctors on the database who qualified in 1913 or earlier, twenty-five (fifty-three per cent) did so at a British medical school, with twenty-one (eighty-four per cent) of these graduating in Scotland. Of these forty-seven obituaries, eleven (twenty-three per cent) made explicit reference to service in a British hospital.<sup>86</sup> By contrast, of the 205 New Zealand-born doctors who qualified between 1914 and 1938, just twenty-five (twelve per cent) had qualified at a British medical school. However, almost three times that number mentioned service in at least one British hospital. Of those, almost eighty per cent had worked in an institution in London.<sup>87</sup> This figure is almost certainly a minimum,

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<sup>85</sup> Paterson, 'The Future of Post-Graduate Teaching in London', pp. 184-5.

<sup>86</sup> Two others qualified at the University of Melbourne's Medical School.

<sup>87</sup> A further ten doctors qualified from medical schools in Australia or Continental Europe. Fifty-four of these doctors mentioned service in two or more British hospitals.

as a further fifty-two obituaries referred to working in Britain without mentioning a specific hospital by name.<sup>88</sup>

I suggest that it was this shift, far more than the development of ‘battlefield medicine’, that drove the emergence of specialisation as the dominant mode of medical practice and organisation in the so called ‘settler societies’ of New Zealand, Australia, South Africa, and Canada. During the late 1920s and 1930s, each of these countries developed dedicated hospital departments and national associations in support of specialty medicine.<sup>89</sup> In Australia, for example, organised post-graduate training began when doctors returning from World War One also recognised a need to refresh their knowledge of medicine in a civilian context. Australia’s first post-graduate committee was established for this purpose in Melbourne in 1920, with others following at state and federal level. These committees organised refresher courses for general practitioners, helped recent graduates to prepare for examinations, organised visits by distinguished overseas practitioners, and helped doctors intending to travel overseas through their links with overseas groups such as the British Post-graduate Federation, the Edinburgh Postgraduate Board for Medicine, the World Health Organization in Geneva, the Nuffield Foundation in London and the Rockefeller Foundation in New York. The committees also helped prospective specialists travelling to Australia for professional training.<sup>90</sup> In New Zealand, any substantial post-graduate structures would not appear until the next world war.

Despite these measures, specialisation was not yet dominant. As mentioned above, most specialised work at this time was conducted as a ‘special interest’ by doctors who continued to work predominantly as general physicians

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<sup>88</sup> As late as 1978, three per cent of a sample of medical migrants to Britain cited links arising from war-time experience as a reason for their decision to travel to Britain for post-graduate study. David J. Smith, *Overseas Doctors in the National Health Service* (London: Policy Studies Institute, 1980), p. 35.

<sup>89</sup> The histories of New Zealand’s major hospitals provide the most useful references to the development of specialisation in the New Zealand context. See, for example, John Armstrong, *Under One Roof: A History of Waikato Hospital* (Hamilton: Half Court Press, 2009), Laurie Barber and Roy Towers *Wellington Hospital: 1847-1976* (Wellington: Wellington Hospital Board, 1976), Frank Bennett, *Hospital on the Avon: The History of Christchurch Hospital, 1862-1962* (Christchurch: North Canterbury Hospital Board, 1962), Basil Hutchinson, *Green Lane Hospital: The First Hundred Years* (Auckland: Green Lane Hospital Centenary Committee, 1990), and Craig Mackenzie, *Hospital in the Valley: The Story of Hutt Hospital* (Palmerston North: Dunmore Press, 1983).

<sup>90</sup> W. W. S. Johnston and R. R. H. Lovell, ‘Postgraduate Medical Education in Australia’, *British Postgraduate Medical Journal*, volume 38, number 440 (June 1962), pp. 323-8.

or general surgeons. Viable specialist practice required not only a doctor with the necessary expertise, but the support of colleagues who could appreciate its value and were willing to refer their patients. For many newly established specialists, this support was not forthcoming. Established generalists were often slow to accept the value of specialty practice, or were unwilling to forfeit aspects of their work that were enjoyable, or profitable, or both.<sup>91</sup> There was also a lingering intellectual resistance to the concept of specialisation from doctors who thought that it reduced patients to collections of body parts, and overlooked their status as complete human beings. Specialty medicine therefore evolved in bursts as various cultural, professional, and technological barriers were overcome.

World War One can therefore be seen as a necessary, but not sufficient development in the evolution of widespread and intensive medical specialisation. The twentieth century's first global conflict generated several important technological and procedural advances in medicine, but more significantly, set the organisational and structural scene for the subsequent emergence of specialisation as the dominant force in professional medicine. The next critical moment in this development came in 1939, when a second global conflict impelled a second wave of global medical migration. However, the thousands of overseas doctors who found themselves in London during and after the Second World War were met with much greater organisational, institutional, and attitudinal support for specialist post-graduate training than their predecessors had done. While this system was still less-well developed than those that were operating in parts of Continental Europe and North America, it represented a crucial catalyst for the development of specialist training in Britain, and for medical specialisation throughout the Commonwealth.

### *World War Two*

Like World War One, World War Two has also been identified by medical historians as a critical period for the evolution of specialisation. Historians have noted that disciplines such as orthopaedics and plastic surgery once again

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<sup>91</sup> Gillespie, p. 21.

developed a raft of new techniques in the attempt to deal with vast numbers of wartime casualties. In addition, new blood-transfusion techniques and the development of medicines such as the sulphonamides and penicillin proved widely applicable, enabling advances across a broad range of medical disciplines.<sup>92</sup>

While technical developments and narratives of progress continue to have a prominent place in the historiography of post-World War Two specialisation, a strong counterview is also discernible, most clearly in the autobiographies of doctors who served overseas. The reservations of Patrick Eisdell Moore regarding medical ‘progress’ during World War Two have already been discussed. The New Zealand veteran Dr Neil Begg recalled that his decision to remain in Britain after demobilisation was driven by a desire to ‘make up for the wasted years in the army’.<sup>93</sup> While Dr Donald Stafford Matthews conceded that military service had provided ‘a certain amount of practical experience’, his main memory of medical work in the Navy was one of a profound ‘mental hibernation’.<sup>94</sup> Matthews wrote that ‘too much of [the work] was hasty and casual’ and that leaving the Navy provided an opportunity to ‘pick up the threads’ of professional life, even if it meant doing so at ‘the very bottom of the ladder’.<sup>95</sup> While some veterans recalled the ‘thrill and variety’ of wartime surgery, conducted in an atmosphere ‘tinged with excitement and gunfire’, most depict wartime conditions as anything but conducive to advanced medical research and specialisation.<sup>96</sup>

As had been the case with World War One, the social and organisational changes that World War Two wrought on professional medicine had a far more profound and lasting impact than technical change. Once again, high rates of military service among New Zealand’s qualified doctors – approximately one third of all doctors registered at the time – generated numerous informal links and friendships. Wartime relationships were often long-lasting, leading to written exchanges and travel for both personal and professional reasons long after the conflict ended. Doctors invited each other to conferences, organised formal exchanges, and notified friends about the availability of jobs. Donald Matthews’

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<sup>92</sup> See Thomas Duncan MacGregor Stout, *War Surgery and Medicine* (footnote 69), and ‘The President’s Address’ (footnote 68).

<sup>93</sup> Neil Begg, *The Intervening Years: A New Zealand Account of the Period between the 1910 Visit of Halley’s Comet and its Reappearance in 1986* (Dunedin: John McIndoe, 1992), p. 76.

<sup>94</sup> Matthews, p. 84.

<sup>95</sup> Matthews, pp. 84, 93.

<sup>96</sup> Bell, p. 107.

wartime acquaintances generated opportunities for him to work as an obstetrics tutor at University College Nigeria, as a medical officer on the Royal Mail Shipping Line to South America, as a doctor on a scientific expedition to Nepal, and as a private practitioner in Calcutta.<sup>97</sup> However, the most significant opportunities, in terms of their impact on New Zealand's medical system, were those that allowed New Zealand doctors to secure jobs in British hospitals after demobilisation. Donald Matthews believed that his appointment to a relatively prestigious position in the Obstetrics and Gynaecology Department of the Royal Postgraduate Medical School Hospital at Hammersmith came about through connections made during a short period working in the hospital while on leave during World War Two.<sup>98</sup> Writing more than thirty years after the end of World War Two, the surgeon and Dean of the Auckland Medical School, Dr David Cole, stated that 'the great surgical benefit of the war was the practical experience that many young surgeons gained, and for some, the opportunity to train during and after the war in their chosen or emerging specialty'.<sup>99</sup> Such opportunities were relatively common. Of the 123 New Zealand medical obituaries that mentioned overseas military service during World War Two, forty-nine, or almost forty per cent, also referred to post-war service in a particular British hospital. This figure is also certainly a minimum, as almost half this number again (seventy) referred to working in Britain without mentioning a specific hospital by name.

The single most important institution for overseas doctors working in London during World War Two, and for some decades afterwards, was the Royal Post-Graduate Medical School that had been established at Hammersmith Hospital in 1935. After a relatively quiet first four years in operation, the outbreak of war soon led to the School becoming a focal point for overseas military doctors visiting London. Between 1939 and 1945, the School ran seventy-two 'special war courses' that together attracted 3,700 medical officers from the armed forces of the various Allied countries. These wartime activities increased the profile and the reputation of the Royal Post-Graduate Medical School abroad, effectively bestowing upon it the status of default first destination for visiting overseas

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<sup>97</sup> Matthews was an inveterate traveller, and references such as these are scattered throughout the chapters of his autobiography.

<sup>98</sup> Matthews, p. 93.

<sup>99</sup> David Cole, 'The First Half-Century of the College in New Zealand', *The Australian and New Zealand Journal of Obstetrics and Gynaecology*, volume 47, number 6 (December 1977), p. 724.

physicians for the next thirty years.<sup>100</sup> After the war, the Royal Post-Graduate Medical School and a number of specialised London hospitals were constituted as Institutes of the newly established British Post-Graduate Medical Federation. Each specialist hospital provided a lecture room, accommodation, and research laboratories, allocated beds for post-graduate teaching, and appointed a coordinating Director of post-graduate study.<sup>101</sup> Initially, a shortage of suitable medical teachers, a lack of accommodation, wartime bomb damage to several participating hospitals, and the limited post-war availability of building material meant that only four other Institutes, alongside the Royal Post-Graduate Medical School, were considered ready to provide postgraduate education of the required standard. By 1960, however, Institutes provided post-graduate training in the specialties of otolaryngology (ear, nose, and throat surgery), ophthalmology, child health, neurology, orthopaedics, dental surgery, cardiology, chest diseases, urology, obstetrics and gynaecology, basic sciences, cancer research, and dermatology. Each of these Institutes was centred on either the main relevant specialist hospital, or dispersed, as in the case of ophthalmology, among several associated hospitals. By the start of the 1960s, almost 3,700 graduate doctors were attending courses at these Institutes each year, approximately sixty per cent of whom were from outside the United Kingdom.<sup>102</sup>

The English College of Surgeons also established a post-graduate course for surgeons at London's Lincoln Inn Fields soon after the war. While the College had run post-graduate courses in basic sciences throughout World War Two, these had been limited by severe bomb damage to its buildings in 1941, and in particular, to the museum that housed much of the teaching material. Ironically, this attack later provided the College with an opportunity to update and expand its services for post-graduate doctors. The Nuffield College of Surgical Sciences opened next to the rebuilt College in 1948, along with two converted houses that provided accommodation for overseas visitors.<sup>103</sup>

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<sup>100</sup> Newman, 'A Brief History of the Postgraduate Medical School', pp. 738-740.

<sup>101</sup> Fraser, pp. 22-4.

<sup>102</sup> Fraser, pp. 36-7, 63. During the academic year 1959-60, 1,354 postgraduate doctors were enrolled from the United Kingdom, alongside 2,314 from overseas.

<sup>103</sup> Sarah Wilde, 'Practising Surgery: A History of Surgical Training in Australia, 1927-1974', PhD Thesis, University of Melbourne, 2003, p. 204.

World War Two once again generated efforts to improve Britain's medical services through greater coordination. As war approached, the anticipation of air raids and large numbers of civilian casualties prompted unprecedented levels of cooperation between the British government, the British medical profession, and medical personnel from the various Allied countries. Upon the outbreak of war, Britain's hospitals and doctors came under centralised control under the banner of the Emergency Medical Service, in order to better facilitate the provision of blood-transfusion and pathology services over large geographical areas, and to enable particular institutions to be set up as national centres for plastic surgery, orthopaedics, burns, neurosis and other critical services.<sup>104</sup>

After the war ended, medical leaders, administrators and policymakers recognised that the coordination of health services and the close cooperation of international medical personnel had been a major factor in the Allied victory, and calls emerged for the 'combined operation' to be continued through the facilitation of 'travel, personal contact, and postgraduate study.'<sup>105</sup> Discussing the rapid recent development of surgical and medical procedures, a 1948 Editorial of the *British Post-graduate Medical Journal* stated that '[t]he greatest factor in these changes of outlook is, we believe, the freedom of travel and of the interchange of ideas now possible. If the leaders of the profession of one country are able to visit other countries to lecture and to discuss problems of mutual interest, the result can only be progress, whether in discarding the old or advocating the new.'<sup>106</sup>

There is no doubt that wartime interaction was a powerful influence over the development of specialised medicine in New Zealand after 1945. The establishment of national treatment centres under the British Emergency Medical Service during the war had required doctors from the Allied forces to be organised according to their professional expertise, rather than by nationality. Several New Zealand doctors, for example, were placed among the four national centres for reconstructive surgery that had been established in and around London in anticipation of wartime casualties. New Zealand doctors such as Sir Harold

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<sup>104</sup> Rosemary Stevens has argued that the successful cooperation of the medical profession and the British Government during World War Two eased the passing of the long-resisted National Health Service Act in 1948. Stevens, *Medical Practice in Modern England*, pp. 67-8.

<sup>105</sup> L. R. Broster, 'The B.M.A. and the Commonwealth and Empire', letter to the editor, *British Medical Journal*, volume 2, number 4519 (16 August 1947), p. 269.

<sup>106</sup> 'Editorial', *British Post-graduate Medical Journal*, volume 25, number 277 (November 1948), pp. 569-70.

Gillies, his cousin, Sir Archibald McIndoe, and Henry Pickerill had already acquired, and contributed to the development of, surgical expertise during and after World War One. During World War Two, these doctors played a central role in the development of the 'second generation' of New Zealand plastic surgeons with whom they worked at Roehampton, Basingstoke, East Grinstead, and St Albans. After 1945, surgeons such as Arthur Rainsford Mowlem, Joseph Brownlee, Leslie Ray, William Manchester, and Frank Hutter drew upon both their technical knowledge and their experience of wartime medical organisation to establish specialty departments in several New Zealand centres.<sup>107</sup>

The organisation of orthopaedics was similarly galvanised by the post-war return of large numbers of young, newly qualified surgeons with experience of British professional structures and a determination to utilise their specialised skills. While orthopaedic surgery was already well-established in clinical terms in New Zealand before World War Two, it was not until 1950 that the New Zealand Orthopaedic Association was established to promote the discipline and the interests of its practitioners, with a constitution modelled closely on that of its British equivalent.<sup>108</sup>

But World War Two also influenced the development of specialties with little or no relevance to battle injuries, as had World War One a generation earlier. Perhaps the clearest example of this was obstetrics, which also developed rapidly in New Zealand during the post-war years. Dr Bob Gudex, a Hamilton obstetrician who spent four years training in Britain from 1951, remembers the effects that wartime organisation had on his discipline:

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<sup>107</sup> See M. C. Meikle, 'The Evolution of Plastic and Maxillofacial Surgery in the Twentieth Century: The Dunedin Connection', *Journal of the Royal College of Surgeons of Edinburgh and Ireland*, volume 4, number 5 (October, 2006), pp. 325-34, and J. H. Williams, 'Sir William Manchester Memorial Lecture 1999: The Influence of One Man on Plastic and Reconstructive Surgery in New Zealand', *Australian and New Zealand Journal of Surgery*, volume 70, number 4 (April 2000), pp. 308-312. Biographies of leading practitioners include Reginald Pound, *Gillies, Surgeon Extraordinary: A Biography* (London: M. Joseph, 1964), Leonard Mosley, *Faces from the Fire; the Biography of Sir Archibald McIndoe* (London: Weidenfeld and Nicolson, 1962) and Harvey Brown, *Pickerill: Pioneer in Plastic Surgery, Dental Education, and Dental Research* (Dunedin: Otago University Press, 2007). Information also comes from Dr Patrick Beehan's unpublished 2007 Murray Clark Oration. I thank Dr Beehan for providing me with a copy of this presentation.

<sup>108</sup> Colin Hooker, *Orthopaedics in New Zealand* (New Zealand Orthopaedic Association, 1996), pp. 30-1.

After the war, the [British Obstetrical] College suddenly expanded and had a huge teaching requirement and suddenly became quite strong, because it was young. Really, as I said, post-war [the College] was just getting into its stride for the first time, [becoming] hugely interested in teaching, and that's the scene [that New Zealand trainees] went into. So when we came back after our four years or whatever it was overseas, we had this sort of background, and came to places that hadn't had these services. . . . We had – I guess – an enthusiasm for trying to produce the sort of thing that we had left in Britain, which was showing up to be so successful.<sup>109</sup>

The return of enthusiastic Australasian doctors who had witnessed the potential of wartime organisation while serving in Britain was also an important impetus behind the establishment of the Cardiac Society of Australia and New Zealand in 1952.<sup>110</sup> Similarly, the gastroenterologist and historian, Dr Ben Haneman, was adamant that despite the passing of fifteen years between the end of World War Two and the establishment of the Gastroenterological Society of Australia, 'there is little doubt that the [necessary] relationships and ties of common interest were first made during war service in the medical services of the three armed forces.'<sup>111</sup>

The twentieth century's two world wars were therefore critical to the development of an international system of medical exchange. As overseas migration for the purposes of obtaining undergraduate medical education was becoming increasingly rare among New Zealand-born doctors, two massive waves of overseas military service contributed to the development of numerous specialty organisations and generated a multi-generational network of relationships that together underpinned a powerful shift towards post-graduate migration. I suggest that this in turn played an important role in the emergence of specialisation as the dominant mode of medical practice after World War Two. At some point during the middle decades of the twentieth century, the trend towards specialisation reached a kind of critical mass, whereby it became, in effect, self-perpetuating. As

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<sup>109</sup> Interview with Dr R. G. (Bob) Gudex, 17 November 2006.

<sup>110</sup> Sir Kempson Maddox, James M. Gardiner, and John B. Hickie, 'The History of the Cardiac Society of Australia and New Zealand', in *To Follow Knowledge: A History of Examinations, Continuing Education and Specialist Affiliations of the Royal Australasian College of Physicians*, ed. by Josephine Wiseman (Sydney: Royal Australasian College of Physicians, 1988), p. 22.

<sup>111</sup> Ben Haneman, 'The History of the Gastroenterological Society of Australia', in *To Follow Knowledge*, p. 51

George Weisz has noted, this came about because specialisation was not only a response to the production of knowledge, but was also largely responsible for generating knowledge, which in turn necessitated further specialisation.<sup>112</sup> Over time, medical work that had once fallen within the occupational territory of general physicians and surgeons became stand-alone specialties. This had significant ramifications for the viability of ‘generalism’ as a mode of practice. In the private sphere, the emergence of specialists left general physicians and surgeons with a narrower range of abilities to offer their patients. In the public sphere, this same process began to erode generalists’ job satisfaction and status as it became considered unsafe for them to ‘dabble’ in specialty areas, leaving them to perform only rudimentary procedures.<sup>113</sup> The perception that specialisation required more powerful minds also contributed to a growing status for specialist practitioners, both within the profession and in wider society. This in turn led to higher incomes for specialists, further undermining the attraction of generalist work.

In a period of history that has often been characterised in terms of the weakening of imperial ties and the development of ‘indigenous’ medical organisations, structures, and identities, I contend that the emergence of specialisation as the dominant mode of practice instead strengthened the ties between New Zealand and British medicine. The growing numbers of New Zealand doctors who wished to practise specialised medicine had little choice but to travel overseas for their training, and most chose to immerse themselves in British medical systems, institutions, interpersonal networks, and traditions. This had many ramifications for New Zealand doctors, and for the development of specialised medicine in New Zealand. The following chapters explore these ramifications in further detail.

However, it is first necessary to examine the final piece in the puzzle of the post-World War Two Commonwealth. The relationship between population

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<sup>112</sup> See George Weisz, ‘The Emergence of Medical Specialisation in the Nineteenth Century’, in *Bulletin of the History of Medicine*, volume 77, number 3 (2003), p. 539.

<sup>113</sup> Sir Douglas Robb, for example, recalled that his decision to focus on chest surgery was compelled by an emerging generation of specialist urologists, gynaecologists, and orthopaedic surgeons ‘capturing’ an increasing volume of techniques and procedures. Douglas Robb, *Medical Odyssey: An Autobiography* (Auckland: Collins, 1968), p. 48. Similarly, the New Zealand plastic surgeon Keith Wilson based his decision to specialise in the early 1960s on a fear that as a general surgeon his work would soon be limited to operating on varicose veins. Interview with Dr H. K. F. (Keith) Wilson, 12 February 2007.

and specialisation only speaks to the ‘supply’ side of the New Zealand medical migration equation. On the other side, a number of factors contributed to changes in Britain that ensured that medical migrants from New Zealand, and from many other Commonwealth countries, were increasingly in high demand.

### *Situations Vacant: Job Opportunities for Commonwealth Doctors*

Of all the reforms initiated by Clement Atlee’s Third Labour Government, the introduction of the National Health Service in 1948 represented perhaps the most complete socialisation of any existing service or system, by bringing almost all existing health infrastructure and personnel under the administration of central government.<sup>114</sup> For many British doctors, the introduction of this radically new system made the prospect of forging a medical career in Britain unsustainable. The profession as a whole had a long history of resisting the encroachment of all forms of external control, and in particular, to those that sought to interfere in the organisation of payments, which doctors insisted was a private matter between patient and doctor. The proposed introduction of salaried service, alongside the various other aspects of state control, were anathema to many of Britain’s doctors.<sup>115</sup>

For Britain’s hospital-based doctors, the continuing use of staffing structures that no longer reflected the contemporary professional environment further hampered the prospect of leading satisfactory careers. The main issue was that the strictly hierarchical and ‘pyramidal’ staffing structure of Britain’s hospitals powerfully curtailed promotional opportunities, at a time when hospitals served as the venue for an increasing proportion of all medical work. The development of new specialist services during the first half of the twentieth century often generated a need for increasingly sophisticated and expensive equipment for both treatment and diagnostic purposes, and for increasing numbers of highly trained support staff, including nurses, radiographers, and laboratory technicians. Such services were soon beyond the capacity of private practitioners

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<sup>114</sup> Harry Eckstein, *The English Health Service: Its Origins, Structure, and Achievements* (Cambridge, Mass., Harvard University Press, 1958), p. 1.

<sup>115</sup> Eckstein, *The English Health Service*, p. 142.

to provide, with the result that many were offered almost exclusively in the hospital setting.<sup>116</sup> As a result, the number of doctors employed in hospitals expanded significantly in the middle decades of the twentieth century.<sup>117</sup>

Yet, despite the rapid growth of the hospital-based medical workforce, the rigid staffing structures of British hospitals continued to reflect nineteenth-century conditions. For ambitious nineteenth-century doctors, a position on the senior staff of a prestigious teaching hospital had been the ultimate professional achievement. While those doctors carried out their hospital work on a voluntary basis, many received considerable incomes through student tutorial fees, and by gaining patients from among the moneyed classes who funded the charitable hospitals. Senior doctors who volunteered their time also accrued considerable social prestige.<sup>118</sup> For these reasons, doctors who had achieved consultant status had little incentive to promote junior staff who would then become, in effect, competitors. This invariably led to promotional ‘bottlenecks’ that sometimes caused doctors to remain in ostensibly ‘junior’ roles for up to thirty years before a consultant’s vacancy appeared, usually through the death of the incumbent.<sup>119</sup>

The relatively rapid development of specialisation in the two to three decades that followed World War One, and the related expansion of the role of hospitals in health-care provision, made this system untenable. Yet the publication of the influential 1948 Spens Report, which set guidelines for the remuneration of consultants and specialists working in the new National Health Service, not only retained the ‘pyramidal’ staffing structure, but strengthened it. As part of its remit, the Spens Report recommended the establishment of a ‘ladder’ of formal hospital positions that specified the amount of time that doctors could expect to spend working at each successive grade. New graduates were to spend one year working

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<sup>116</sup> David Wright, Sasha Mullally, and Mary Colleen Cordukes, “‘Worse than Being Married’: The Exodus of British Doctors from the National Health Service to Canada, c. 1955–75’, *Journal of the History of Medicine and Allied Sciences*, volume 65, number 4 (October 2010), p. 554.

<sup>117</sup> In 1950, New Zealand’s public hospitals employed 425 full-time medical staff and 457 part-time staff. By 1964, this had increased to 653 full-timers and 717 part-timers. Six years later, the total number of full-time equivalent medical staff in New Zealand’s public hospitals was 1,309. Figures come from ‘Staffing’, *Appendices to the Journal of the House of Representatives (AJHR)*, 1951, H-31, p. 28, ‘Staff Employed’, *AJHR*, 1965, H-31, p. 35, and ‘Staff in Public Hospitals’, *AJHR*, 1972, H-31, p. 63, respectively.

<sup>118</sup> Lindsay Granshaw, ‘Fame and Fortune By Means of Bricks and Mortar: The Medical Profession and Specialist Hospitals in Britain, 1800-1948’, in *The Hospital in History*, ed. by Lindsay Granshaw and Roy Porter (London: Routledge, 1989), p. 201.

<sup>119</sup> Stevens, *Medical Practice in Modern England*, p. 144, cited in Wright, Mullally, and Cordukes, p. 554.

as hospital house officers, after which they would be eligible for full registration. This would be followed by one year periods working as senior house officers and then junior registrars, before completing three years in senior registrar or ‘chief assistant’ roles. In their seventh year after graduation, doctors could expect recognition as specialists and formal consultant appointments.<sup>120</sup> However, the number of positions that were available at each level of the specialist ‘ladder’ was limited, with the result that doctors could still only progress upwards when a vacancy appeared on the rung above.

This was a serious problem given the structure of the British hospital workforce. In 1950, British hospitals employed 4,800 senior house officers, registrars and senior registrars, but only 5,600 consultants, who remained in their posts, on average, for thirty years before retiring. Even if calculations excluded junior house officers, the Spens Report ‘ladder’ could only function as designed if half of all British consultants retired every five years.<sup>121</sup> Because this did not happen, the professional bottlenecks of the nineteenth century not only persisted into the twentieth, but got worse.<sup>122</sup> Between 1956 and 1974, the number of consultants working in the National Health Service grew from about 6,500 to 11,500. However, the number of doctors working ‘junior’ hospital grades increased at twice this rate, from about 8,000 in 1956 to almost 20,000 in 1974.<sup>123</sup> Because specialty services were often difficult to provide in the private sector, and because specialist status could not be formally attained outside the hospital system, many of those ‘junior’ doctors faced a stark choice.<sup>124</sup> Recently graduated house officers who wished to remain in Britain but did not wish to spend their careers in ‘junior’ roles had little option either to emigrate or to opt out of the hospital system altogether and enter general practice.<sup>125</sup> For the thousands of

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<sup>120</sup> Wright, Mullally, and Cordukes, p. 553.

<sup>121</sup> The justification for excluding junior house officers was that many did not progress onto specialist grades, but opted for general practice after one or two years of hospital service.

<sup>122</sup> Stevens, *Medical Practice in Modern England*, p. 144.

<sup>123</sup> Mary Ann Elston, ‘Women Doctors in the British Health Services: A Sociological Study of their Careers and Opportunities’, PhD Thesis, University of Leeds, 1986, p. 367.

<sup>124</sup> Wright, Mullally, and Cordukes, p. 554.

<sup>125</sup> Wright, Mullally, and Cordukes, p. 554. The only exceptions to this were those doctors who managed to secure the keenly sought registrarships in the most prestigious hospitals, which were widely recognised as positions of significant status. Stevens, *Medical Practice in Modern England*, p. 141.

young doctors who did wish to work in hospitals, the answer lay, increasingly, in emigration.

Together, the introduction of the National Health Service and the severe curtailment of career prospects among hospital doctors led, from the 1950s, to a mass exodus of British doctors from hospital service. It has been estimated that during the 1950s and early 1960s, between four and five hundred doctors emigrated from Britain and Ireland every year.<sup>126</sup> About half of these travelled to the less-restrictive and more remunerative North American scene, where British doctors could expect to double their incomes.<sup>127</sup> A series of articles written in the 1960s by the British doctor and researcher, John Searle, suggested that more than fifteen-hundred British or Irish-qualified doctors migrated to Canada, and just over one thousand relocated to the United States between 1953 and 1962, despite the latter country's requirement that all medical immigrants sit a re-qualifying examination.<sup>128</sup> Emigration to North America alone during this period represented a loss equivalent to the total medical workforce of 'Manchester, Leeds, Liverpool, Sheffield, and Bristol combined.'<sup>129</sup> Other prominent destinations included Australia, which registered more than one thousand British or Irish-trained doctors between 1956 and 1960 alone, and South Africa, which registered just over two hundred. During the same five-year period, New Zealand attracted 184 graduates from British or Irish medical schools, 145 relocated to Southern

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<sup>126</sup> John Searle, 'The Medical Emigration Controversy', *British Medical Journal*, volume 2, number 5423 (12 December 1964), pp. 1522-4. Dr Searle had originally estimated the rate of British emigration to be about six hundred doctors per year. He later acknowledged that double-counting doctors who had registered in more than one state, and underestimating the number of doctors who later returned to Britain had distorted his estimates for migration to Australia. While his adjusted figures reduced the number of emigrants to Australia by about fifty per cent, this still represented an overall rate eight times that in evidence during the 1930s. For refutation of Searle's Australian figures, see Dr J. M. Last, 'Migration of British Doctors to Australia', *British Medical Journal*, volume 2, number 5359 (21 September 1963), pp. 744-5. For Searle's response, see Dr John Searle, 'Migration of British Doctors to Australia' *British Medical Journal*, volume 2, number 5363 (19 October 1963), pp. 994-5. The figure of five hundred published in 1964 took these academic controversies into account.

<sup>127</sup> John Lister, *Postgraduate Medical Education* (London: Nuffield Provincial Hospitals Trust, 1993), p. 14. Information on comparative pay rates comes from Judith Fortney, 'International Migration of Professionals', *Population Studies*, volume 24, number 2 (July 1970), p. 229.

<sup>128</sup> Figures come from R. H. Davison, 'Medical Emigration To North America', *British Medical Journal*, volume 1, number 5280 (17 March 1962), pp. 786-7. Other estimates suggested higher migration rates: one source suggests that more than 2,000 British doctors migrated to Canada during the 1950s. See Stanislaw Judek, *Medical Manpower in Canada* (Ottawa: Queen's Printer, 1964), pp. 38-44, cited in Wright, Mullally, and Cordukes, p. 550.

<sup>129</sup> R. H. Davison, 'Medical Emigration to North America', *British Medical Journal*, volume 1, number 5280 (17 March 1962), p. 787.

Rhodesia, and a further 119 moved to Northern Rhodesia.<sup>130</sup> While some of these registrants remained for only a short time before returning home or moving on to some other location, Searle later estimated that about sixty per cent of the British and Irish-trained doctors who registered overseas did so with a view to permanent relocation.<sup>131</sup> All told, the emigration rate of doctors from the British Isles during the 1950s was more than five times the immediate pre-World War Two rate, and equivalent to a third of the output of all of Britain's medical schools.<sup>132</sup> Later research by Searle suggested that the annual migration rate of doctors from Britain and Ireland rose to at least 550 by the mid 1960s, but even this figure might be considered low in the light of Stanislaw Judek's findings, which suggested that approximately 4,000 British-born doctors relocated to Canada alone during the 1960s.<sup>133</sup> While many of these emigrants were general practitioners, the rate of emigration among hospital-based doctors was such that the net total of British-born doctors working in British hospitals decreased by eighty between 1962 and 1965.<sup>134</sup>

This last figure does not communicate the significant regional differences that characterised medical emigration during this period. Prestigious hospitals in London and the other large British cities continued to attract and retain enough junior doctors to provide the necessary services. But in smaller regional centres, the exodus from hospital service left serious shortages in many specialty areas. Rosemary Stevens noted that several British counties had no gynaecologists during the 1950s, while other areas had serious shortages of thoracic surgeons and paediatricians.<sup>135</sup> The 1957 Willink Report on medical education exacerbated the effects of emigration by severely underestimating the number of doctors that Britain would need in the second half of the twentieth century. Medical Schools

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<sup>130</sup> Searle, 'Medical Emigration from Britain, 1930-1961', *British Medical Journal*, volume 1, number 5280 (17 March 1962), p. 785.

<sup>131</sup> Dr John Searle, 'Medical Emigration from Great Britain and Ireland', *British Medical Journal*, volume 1, number 5391 (2 May 1964), pp. 1173-8.

<sup>132</sup> Searle, 'Medical Emigration from Britain, 1930-1961', p. 785.

<sup>133</sup> Stanislaw Judek, *Medical Manpower in Canada* (Ottawa: Queen's Printer, 1964), pp. 38-44, cited in Wright, Mullally, and Cordukes, p. 550.

<sup>134</sup> John Searle, 'Medical Emigration from Great Britain and Ireland Since 1962', *British Medical Journal*, volume 2, number 5513 (3 September 1966), p. 578.

<sup>135</sup> Stevens, *Medical Practice in Modern England*, p. 62.

reduced their intakes in the light of the Report's erroneous findings, which soon resulted in even worse shortages in many British hospitals.<sup>136</sup>

The shortages that affected many British hospitals in the 1950s and 1960s represented an invaluable opportunity for overseas doctors wishing to obtain post-graduate training in Britain. Although Britain had absorbed significant numbers of refugee doctors in the twenty years since 1930, far greater numbers of migrants began to enter Britain from the Commonwealth after 1950.<sup>137</sup> By 1960, 2,890 of Britain's junior hospital doctors were overseas born, representing thirty-six per cent of the total. Just five years later, the number had risen to 4650, which represented forty-six per cent of the entire junior hospital workforce.<sup>138</sup> The rate was higher still in regional hospitals. As early as 1957, sixty per cent of registrars working in Sheffield's regional hospitals were overseas-born.<sup>139</sup>

A survey of foreign-born doctors working in the British National Health Service, conducted in 1977, found that more than half of all medical migrants into Britain came from the Indian subcontinent. Migrants from the 'white Anglophone countries' of Australia, New Zealand, South Africa, Canada, Rhodesia and the United States *together* comprised less than ten per cent. New Zealand doctors therefore represented a very small minority of Britain's overseas medical workforce. Yet they represented a significant proportion of the total *New Zealand* medical workforce. Evidence suggests that throughout the three decades that followed World War Two, approximately thirty per cent of all New Zealand-trained medical graduates were working overseas – predominantly in Britain – at any given time: a rate similar to that apparent at the height of World War Two. In March 1969, the New Zealand medical register listed 4,435 doctors, of whom only 3,400 were active within New Zealand. The balance accords closely with a 1970 'medical manpower' survey, which reported that 990 New Zealand graduates were working overseas at that time, mostly in post-graduate training

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<sup>136</sup> David J. Smith, *Overseas Doctors in the National Health Service* (London: Policy Studies Institute, 1980), p. 1.

<sup>137</sup> David Smith's 1980 survey of overseas doctors in the National Health Service found that fifty-four per cent of European doctors who were practising in England at the time had arrived before 1950. Smith, *Overseas Doctors in the National Health Service*, p. 31. As of 2012, Professor Paul Weindling's long-term research project into medical refugees has identified more than 5,449 European physicians, dentists, psychotherapists, and other health-related workers who immigrated to Britain alone between 1930 and 1947.

<sup>138</sup> Searle, 'Medical Immigration from Great Britain and Ireland since 1962' (footnote 133).

<sup>139</sup> Stevens, *Medical Practice in Modern England*, p. 149.

positions.<sup>140</sup> This represented more than a fifth of New Zealand's entire medical workforce, and more than a third of its hospital-based practitioners.<sup>141</sup>

This chapter has discussed some of the ways in which British colonisation in the nineteenth century and two world wars in the twentieth influenced professional organisations and education structures to such an extent that the latter came to form the basis of an international system of medical migration and interaction. By the early 1960s, New Zealand doctors were almost completely reliant on this Common-health system for access to specialist training and qualifications. The following chapters look at specific ways in which New Zealand doctors engaged with the Common-health system, in terms of accessing the interpersonal networks that underpinned it, the particular opportunities that were available, and the on-going ramifications for both domestic and international medical migration. They also consider the ways in which British cultural assumptions influenced the experiences and opportunities of New Zealand specialists working in Britain.

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<sup>140</sup> 'The Government's Answer', *New Zealand Medical Journal*, volume 69, number 463 (December 1970), pp. 405–6.

<sup>141</sup> 'The Public Health: Report of the Department of Health', *Appendices to the Journal of the House of Representatives* (Wellington: Government Printer, 1970) IV, H-31, pp. 1-127, quotation from p. 58.

## Chapter 4

### *'Insiders' and 'Outsiders': Accessing the Common-health System*

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Chapter 2 of this thesis outlined the origins of a number of British organisations, structures, and attitudes, while Chapter 3 considered their transformation into the basis of an international system that underpinned and shaped the careers of medical specialists throughout the British Commonwealth for a large part of the twentieth century. The present chapter focuses on the participation of New Zealand doctors in that international system during the second half of the twentieth century, and in particular, on the ways in which individual doctors 'entered' the system. I problematise the term 'entered' here because one of the central premises of this chapter is that the Common-health system was not something that existed 'out there', to be engaged with only after migration. Instead, it argues that many of the forces and factors that contributed to the form and function of the Common-health at an international level also operated at the domestic level. The need to access large populations, for example, not only compelled prospective New Zealand specialists to travel to British, and later, to North American cities for their training and qualifications, but also drove the movement of recent New Zealand medical graduates to larger population centres *within* New Zealand. Further, the chapter explains that this population-derived 'gravitational pull' was mediated through, and inflected by, similar social, familial, and professional structures and understandings throughout the system. Fundamentally, this chapter argues for a re-conceptualisation of domestic and international migration patterns as the interrelated parts of a single system.

One of the key themes of this chapter is the vital importance of informal, interpersonal relationships for young doctors trying to access the ‘worlds’ of specialised medicine, in both the professional and geographical senses. To date, historians have largely overlooked these informal networks in favour of more formal – and better documented – institutional and organisational mechanisms. While much interpersonal networking and sponsoring took place *within* institutions such as medical schools and hospitals, the vast majority was not itself institutional in nature, but manifested instead as informal recommendations, and advice relayed from senior to junior practitioners. This chapter will attempt to redress this imbalance in the literature by foregrounding personal sponsorship as the fundamental mechanism by which young New Zealand doctors accessed and negotiated the international medical network.

### *An Interpersonal Network*

Informal relationships have long been significant in shaping the trajectories of medical careers. During the first half of the nineteenth century, many British doctors trained under an apprenticeship model, which required them to pay a senior practitioner a small fee for the privilege of observing and assisting him on his rounds.<sup>1</sup> Once the student had attained an appropriate level of expertise, the senior practitioner would usually write a certificate of proficiency, often in terms that attested to the trainee’s personal character as much as to his technical efficacy or scientific knowledge.<sup>2</sup> The quality of this personal relationship was therefore critical to the new doctor’s career prospects. Similarly, the quality of the relationships that medical students formed with the senior teaching consultants at London’s prestigious teaching hospitals, such as St Bartholomew’s, Guy’s, and St Thomas’s, also determined their subsequent success in terms of gaining house officer and residents’ jobs, and later, promotion to consultant positions. This system of personal sponsorship worked both within individual hospitals and between them, as London’s most prominent physicians and surgeons often

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<sup>1</sup> The vast majority of senior medical practitioners were male during the period under discussion.

<sup>2</sup> Michael Belgrave, “‘Medical Men’ and ‘Lady Doctors’: The Making of a New Zealand Medical Profession, 1857-1941”, PhD Thesis, Victoria University of Wellington, 1985, pp. 91-2.

worked on the honorary staff of several hospitals at once. In London at least, professorial favour was the key to a prosperous medical career.<sup>3</sup>

In 1977 and 1978, a senior research fellow at Britain's Policy Studies Institute, David J. Smith, conducted an in-depth survey into the experiences of 1,981 doctors working in Britain's National Health Service, including six hundred who had qualified overseas. All participants filled out a questionnaire, and one hundred were interviewed. The research sought to understand the ways in which the cultural backgrounds of doctors influenced their career progression, training opportunities, and overall job satisfaction. The purpose of Smith's research was to determine whether 'overseas doctors tend[ed] to be exploited' in Britain's National Health Service. Smith published the survey's findings in book form in 1980.<sup>4</sup>

One section of Smith's book, *Overseas Doctors in the National Health Service*, examined the ways in which international medical migrants, including those who stayed on in permanent positions in Britain, had gathered information in preparation for their trips to Britain. Smith found that only twenty-eight per cent of all migrants had made contact with one of the six British organisations officially charged with aiding migrant doctors, while approximately sixty per cent had contacted no formal organisations at all.<sup>5</sup> From this, Smith concluded that most migrant doctors must therefore have had 'little prior knowledge of the problems they were likely to encounter in pursuing a medical career in Britain'.<sup>6</sup>

However, Smith's conclusion overlooked the central importance of informal, interpersonal networks in the facilitation of international medical migration. Indeed, Smith's own findings contained evidence that suggest that 'unofficial' sources were not only widely used, but also highly useful. A table detailing the particular sources of pre-travel information cited by the survey's

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<sup>3</sup> Robert A. Nye, 'The Legacy of Masculine Codes of Honor and the Admission of Women into the Medical Profession in the Nineteenth Century', in *Women Physicians and the Cultures of Medicine*, ed. by Ellen S. More, Elizabeth Fee, and Manon Perry (Baltimore: Johns Hopkins University Press, 2009), p. 149.

<sup>4</sup> David J. Smith, *Overseas Doctors in the National Health Service* (London: Policy Studies Institute, 1980), p. 185.

<sup>5</sup> The six institutions that Smith cited were the General Medical Council, the British Medical Association, the British Department of Health and Social Security, the Council for Post Graduate Medical Education, any one of the Royal Colleges (these were grouped together as one institution), and the various British Embassies, Consuls and High Commissions.

<sup>6</sup> Smith, p. 34.

participants confirmed that doctors preparing to move overseas were more likely to consult personal contacts – including medical colleagues, friends, and relatives – than the British General Medical Council, the British Medical Association, the British Royal Colleges, national medical associations, national embassies, and all other British and international organisations combined.<sup>7</sup> Another of Smith’s tables clearly attested to the accuracy of those informal sources. Quantifying the degree to which the pre-travel expectations of medical migrants were fulfilled in their subsequent experiences, Smith found that seventy per cent of doctors from ‘white Anglophone countries’, including New Zealand, Australia, South Africa and Canada, felt that their pre-travel expectations had been proven correct.<sup>8</sup> Read together, these findings suggest that unofficial sources were perfectly capable of providing accurate pre-travel information. Importantly, the accuracy of pre-travel expectations also implies that informal networks were influencing the career decisions of many young New Zealand doctors even before they departed the country’s shores.

### *Joining the Common-health System*

Specialised work was most viable in large population centres, where practitioners had access to the necessary volumes of economic and clinical opportunity. For New Zealand doctors working in the context of a very small national population, this invariably meant that the development of specialist medical careers had a geographical dimension, characterised by movements to increasingly large centres. Indeed, for many, becoming a specialist necessitated a series of

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<sup>7</sup> Fifty-one per cent of all overseas doctors cited informal sources, compared to forty per cent who cited official organisations. Smith, Table A.13, pp. 216. A 2010 study of the migration of British doctors into Canada found that interviewees did not use recruitment agencies or similar formalised mechanisms, but instead secured jobs by responding personally to advertisements placed in British medical publications. See David Wright, Sasha Mullally, and Mary Colleen Cordukes, “‘Worse than Being Married’: The Exodus of British Doctors from the National Health Service to Canada, c. 1955–75”, *Journal of the History of Medicine and Allied Sciences*, volume 65, number 4 (October 2010), p. 572.

<sup>8</sup> See Smith, Table IV.13, p. 49. The corresponding figures for doctors from other parts of the Commonwealth, including the Indian Subcontinent, Africa and the Middle East averaged forty-two per cent. This can be read in two ways: as an indication of sound information-gathering techniques despite limited recourse to official sources, or as an indication of relatively poor information compared to that available to doctors from Anglophone countries.

movements from rural or smaller domestic centres to one of the few New Zealand ‘metropolitan’ areas large enough to sustain specialisation, and on to the still larger population centres of Britain, and later, North America or Australia. The Common-health system therefore did not only connect nations, but reached into them, driving and enabling movement between regions, cities, towns, as well as between institutions.

As was the case in Britain, informal professional relationships played a critical role in facilitating these movements. For some New Zealand specialists, initiation into the Common-health system began with contacts made at medical school. Dr Peter Stokes, a gastroenterologist who graduated from the Otago Medical School in 1965, recalled that the School’s tutors ‘made it relatively clear’ to fifth and sixth-year students who among them could realistically expect to embark upon specialist careers.<sup>9</sup> Many of those deemed capable then received career advice and help in various forms. While this often took the form of generic written references commending the clinical and personal qualities of new graduates to prospective employers, some staff provided more personalised testimonials, along with guidance about the practitioners or institutions that graduates should approach. Dr Graham Hill, later Professor of Surgery at the Auckland Medical School, described one of his Otago surgery lecturers, Dr Alan Clarke, as a ‘lifelong mentor’ who facilitated opportunities for Dr Hill to obtain practical surgical experience, and used his personal contacts to facilitate overseas post-graduate training opportunities.<sup>10</sup> Dame Norma Restieaux, cardiologist and later Associate Professor of Medicine at the Otago Medical School, recalled being ‘mentored’ by Otago’s Professor of Medicine John Hunter in the early stages of her career. Professor Hunter provided personalised references, advised her about the institutions most relevant to her proposed specialty, and facilitated personal contact with Dr Aubrey Leatham, a prominent figure in London cardiology.<sup>11</sup> Hunter’s ability to provide such mentorship was in turn grounded in his own overseas experiences. He had worked at the National Heart Hospital in London between 1952 and 1956, where he had formed relationships with several

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<sup>9</sup> Interview with Dr Peter Stokes, 12 November 2010.

<sup>10</sup> Interview with Professor Graham Hill, 16 February 2011.

<sup>11</sup> Interview with Dame Norma Restieaux, 18 February 2011.

prominent cardiologists, including Dr Paul Wood, widely regarded as the world leader in the field at that time.<sup>12</sup>

In these and many other cases, sponsorship by medical school staff functioned to introduce particularly capable or personable students into existing international professional networks.<sup>13</sup> However, for most students and new graduates, the recommendations of medical school staff were not intended to facilitate overseas postgraduate migration immediately; indeed, it was very rare for new graduates to travel overseas directly after qualifying. Instead, Otago's staff sought to help new graduates to secure work within New Zealand, as 'house officers' in one of New Zealand's public hospitals. For many, this first hospital appointment represented the first movement, both geographically and professionally, towards becoming a specialist.

House officers, almost all of whom were new graduates, were the foot soldiers of New Zealand's public hospitals. As medicine became more sophisticated and specialised in the middle decades of the twentieth century, an appointment as a house officer became an increasingly important part of medical education, providing a bridge between undergraduate learning and active medical practice. Spending one year working in a hospital after graduation became a formal prerequisite of full registration in Britain in 1953, and New Zealand legislation quickly followed suit.<sup>14</sup> Typically, however, most graduates spent two years in these roles, either in preparation for general practice or for more senior hospital roles. House officers usually rotated through a series of hospital departments during this period, slowly taking more responsibility for patient care under the supervision of senior doctors.<sup>15</sup> The house officer years were therefore a

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<sup>12</sup> Information comes from Professor John Hunter's obituary, published in the *Otago Medical School Alumnus Association Bulletin*, number 27 (2004/2005), URL: [http://medicalalumni.otago.ac.nz/obituaries/hunter\\_john.html](http://medicalalumni.otago.ac.nz/obituaries/hunter_john.html), accessed on 9 December 2011.

<sup>13</sup> *D. W. Carmalt-Jones: A Physician in Spite of Himself*, ed. by Brian Barraclough (London: Royal Society of Medicine Press, 2009), pp. 88-9.

<sup>14</sup> See John Lister, *Postgraduate Medical Education* (London: Nuffield Provincial Hospitals Trust, 1993), p. 11, and Georgina Jones, *The Medical Council of New Zealand: A Personal and Informal Perspective of Events during My Time as Chief Executive / Secretary / Registrar from 1986 to 2000* (Unpublished manuscript, 2002), pp. 14-5.

<sup>15</sup> In 1968, all New Zealand graduates were obliged to complete one year in an *approved* house surgeon post in order to qualify for registration. This measure obliged hospital boards to provide adequate training for house officers. The first house surgeon year was divided equally between surgical and medical 'runs'. See *Report of the Advisory Committee to the Minister of Health on Resident Medical Officers* (Wellington: Department of Health, 1978), p. 15, and *The Early*

defining period in the careers of many young doctors, during which either a taste, or a disdain, for hospital work was developed. For those doctors who resolved to remain in the hospital system rather than to opt for a career in general practice, the house-officer years represented an opportunity to form preferences about the various medical specialties, to develop relationships with senior practitioners, and to save money in preparation for a period of post-graduate training overseas.

However, not every New Zealand hospital provided the same opportunities to form the kind of relationships that facilitated international medical migration. In 1949, New Zealand had 168 public hospitals, ninety-eight of which were for maternity or other special purposes. Of the seventy general public hospitals, however, only fourteen had two hundred beds or more, and only six of these had at least four hundred beds.<sup>16</sup> Further, only four of these six, situated in the traditional 'four main centres' of Auckland, Wellington, Christchurch and Dunedin, provided the full range of available specialised services.<sup>17</sup> Again, the main reason for this was population distribution. The 1951 national census showed that only fifteen New Zealand towns had populations of more than 20,000. Of these, however, ten had fewer than 33,000 people. With populations ranging from 95,000 to 329,000, Dunedin, Christchurch, Wellington, and Auckland, respectively, were in a class of their own in terms of population size and, by extension, their ability to provide specialised services.<sup>18</sup> Michael Belgrave's research showed that New Zealand doctors urbanised at a rate even faster than the general population during the twentieth century. In 1901, almost forty-seven per cent of New Zealand's general population, and sixty-five per cent of its doctors, lived in towns of 10,000 people or more. In 1941, the last year of Belgrave's analysis, approximately eighty-two per cent of New Zealand's doctors

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*Graduate Years: A Discussion Document* (Wellington: New Zealand Council for Post-graduate Education, 1980), p. 13.

<sup>16</sup> In addition, the Department of Health ran seven psychiatric institutions, while 205 hospitals were run on a private basis. 'Available Beds', *Appendix of the Journal of the House of Representatives (AJHR)*, 1950, H-31, p. 39.

<sup>17</sup> The two other New Zealand institutions of four hundred beds or more, in Hamilton and Palmerston North, were often denied the funding needed to develop additional services because of their relative proximity to two other large hospitals, in Auckland and Wellington respectively. The Health Department argued that replicating expensive services in hospitals only a few hours' drive apart was unaffordable.

<sup>18</sup> The 1951 New Zealand Census gave municipal population figures of 329,123 for Auckland, 174,221 for Christchurch, 133,414 for Wellington, and 95,500 for Dunedin. New Zealand Department of Statistics, *New Zealand Yearbook, 1951-2* (Wellington: Government Printer), p. 19.

were working in major towns or urban areas. In 1951, when New Zealand held its first post-war Census, just under sixty-seven per cent of New Zealanders lived in towns of 10,000 people or more.<sup>19</sup> Belgrave points out that the concentration of doctors in urban areas was another crucial factor in the viability of specialist practices, which could not function without sufficient numbers of general practitioners to refer patients.<sup>20</sup> This, in addition to the economic and clinical benefits of urban practice, meant that most of New Zealand's specialised medical services were concentrated in a handful of institutions. When the New Zealand Medical Council carried out the first survey of medical specialists in 1979, it found that sixty-four per cent of all New Zealand specialists worked in just four hospitals.<sup>21</sup> As a direct consequence of this, Auckland, Wellington, Christchurch and Dunedin also employed the vast majority of registrars or 'trainee' specialists. By the mid 1970s, only seven per cent of New Zealand's medical registrars worked outside of the largest six hospital board areas.<sup>22</sup>

The concentration of New Zealand's specialists in a very few institutions in the years following World War Two meant that those institutions served as important 'gateways' to international migration. Because the vast majority of New Zealand specialists obtained at least part of their specialist training overseas, the large staffs of these institutions therefore presented junior doctors with unrivalled opportunities to make acquaintance with senior colleagues who had established international connections. Although very few new graduates selected the hospitals at which they would work as house surgeons because of their potential to facilitate entry into a particular specialty field, the opportunity to meet a number of senior specialist practitioners during the course of their rotations often influenced their

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<sup>19</sup> General population figures come from Campbell Gibson, 'Urbanization in New Zealand: A Comparative Analysis', *Demography*, volume 10, number 1 (February 1973), p. 73, while practitioner rates come from Belgrave, "Medical Men" and "Lady Doctors", p. 257.

<sup>20</sup> Belgrave, "Medical Men" and "Lady Doctors", p. 259.

<sup>21</sup> This figure would have almost certainly been higher in the 1950s, when other New Zealand hospitals were yet to develop specialised services. See Table 6A of *Specialist Medical Manpower in New Zealand: A Discussion Document* (Wellington: Advisory Committee on Medical Manpower, 1980), p. 17.

<sup>22</sup> The six largest boards in terms of hospital beds were Auckland, Waikato, Wellington, Palmerston North, Christchurch, and Dunedin. *Specialist Medical Manpower in New Zealand: A Discussion Document* (Wellington: Advisory Committee on Medical Manpower, 1980), pp. 25-6, and *Medical Manpower in New Zealand: Report of a Planning Workshop Held at Wairakei, 19-23 April 1976* (Wellington: Division of Hospitals, 1976), p. 75.

subsequent choice of specialty field, and represented their first introduction to international medical networks.<sup>23</sup>

Of all New Zealand hospitals, Auckland, arguably, represented the most important link to the international medical system. In terms of catchment size, the Auckland Hospital Board was in a class of its own, serving an urban population larger than those of the second and third largest Boards in New Zealand combined.<sup>24</sup> In the 1950s and 1960s, the Auckland region had four major public hospitals: Green Lane, National Women's, Middlemore and Auckland. Of these, Auckland was the largest and oldest, and (arguably) the most prestigious. In the mid 1960s, when New Zealand authorities conducted the first comprehensive surveys of specialised medical 'manpower', Auckland's main public hospital not only employed more specialists than any other hospital in the country, but also had more doctors *per bed* than any other New Zealand hospital, and also received more funding, per doctor, to pay its medical staff.<sup>25</sup> These latter conditions reflected the advanced state of Auckland's tertiary specialist services, which generally required higher staff-to-patient ratios, and were invariably more expensive to establish and maintain than secondary hospital services.<sup>26</sup>

Auckland's size and status made an appointment to its staff the ultimate professional achievement for many New Zealand medical specialists. It also made Auckland a desirable destination for graduates who were aspiring to become specialists. An analysis of New Zealand medical obituaries seems to support this contention by indicating that recruitment patterns for house surgeon appointments at Auckland hospital appear to be unique in New Zealand. Cross-referencing the location of the secondary schools that specialist doctors attended (which represents a reasonable proxy for family location) against their first hospital appointment suggests that a significant proportion of the Otago Medical School's

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<sup>23</sup> Most doctors began to gravitate towards a particular specialty area after their first hospital appointment, and their choices were often subject to change for some time after this. A very few did choose house officer posts on the basis of their potential to facilitate specialised training. Dr Peter Rothwell, for example, chose to work at Palmerston North hospital in part because of its strong chest medicine department. Personal communication.

<sup>24</sup> *Specialist Medical Manpower in New Zealand*, p. 26.

<sup>25</sup> See Table 7 in Appendix (p. 337) for details the number of hospital beds per specialist doctor in New Zealand's twenty-one largest hospitals, as they stood in 1964. Table 8 in Appendix (p. 338) summarises payments to medical staff per occupied bed, as at March 1964.

<sup>26</sup> Primary, secondary, and tertiary services refer, respectively, to general practice or 'family' medicine, to basic hospital services, and to the more highly specialised hospital sub-specialties.

graduates opted to carry out their house surgeon work in whichever one of the four main metropolitan hospitals was nearest to their home region. Of the thirty-seven obituaries of doctors who began their professional careers at Dunedin hospital, and also which include information about secondary school attendance, twenty-five (or sixty-eight per cent) referred to a secondary school in Dunedin or its surrounding districts. Of the fifty-two doctors who started their careers with a period of work at Christchurch hospital, thirty-seven (seventy-one per cent) went to school either in Christchurch or in a relatively nearby town such as Timaru, Oamaru, or Ashburton. Sixty-three obituaries cite Wellington hospital as the venue for house officer work, of which thirty-six (or fifty-seven per cent) also mentioned attendance at a local or nearby school.<sup>27</sup> These figures probably reflect the tendency, common among final year medical students, to utilise existing support networks during their hospital placements.<sup>28</sup> In preparation for the start of their professional careers, many students chose to save money by making use of family accommodation and financial support, which meant choosing a hospital relatively close to home.<sup>29</sup> This, in turn, often led to employment in those same

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<sup>27</sup> While attempting to discern the proportion of local doctors working as house officers in New Zealand's smaller hospitals is made problematic by the relatively small sample of obituaries that include all of the required information, it appears that New Zealand's 'regional' hospitals attracted a much lower proportion of local secondary-school graduates than did the main municipal institutions. The most successful smaller institution in this regard was Invercargill hospital, which had five local graduates among the seventeen house officers listed, for a rate of twenty-nine per cent, a significantly smaller proportion of locally based graduates than in the big centres as shown in the main text discussion above. Twenty-five per cent of Napier hospital's eight house officers were local secondary school graduates, as were sixteen per cent of Timaru hospital's house officers (two out of twelve), and fifteen per cent of Palmerston North hospital's house officers (two of thirteen). Waikato hospital and New Plymouth hospital each employed only one locally educated house officer out of eleven listed house officers (nine per cent).

<sup>28</sup> A second explanation was that employing 'local' students was a matter of policy at some New Zealand hospitals. My previous research into the appointment processes of Waikato hospital during the 1960s and 1970s has revealed that the selection of local candidates was an intentional strategy designed to maximise the chances of retaining doctors in the context of nation-wide shortages. It was assumed, often correctly, that young doctors with strong pre-existing local connections would be less likely to move away as their careers progressed. While Waikato hospital, like many other so-called 'second tier' institutions faced challenges that were in several ways different to those in the 'four main centres', the need to attract and retain staff was a challenge faced by almost all New Zealand hospitals, due primarily to the country's inability to offer internationally competitive pay rates in what was effectively an international market for medical professionals. See Armstrong, 'Chapter 8: Waikato Hospital's Home Grown Specialists', pp. 189-208.

<sup>29</sup> After 1972, the introduction of an Intern Training Scheme, that grouped the final year of study and the first hospital appointment together, as Trainee Intern and pre-registration Internships respectively, consolidated this link. David Cole, 'Post-graduate Medical Education: The Graduate

hospitals after graduation, due to the advantage that students already known to staff had in the appointment process.

Auckland hospital was the exception to this pattern. Database analysis shows that only forty-eight per cent of doctors who obtained their first appointment there had attended 'local' secondary schools. It seems likely that this was largely attributable to Auckland's considerable prestige relative to all other New Zealand hospitals, which made positions on its staff both highly desirable and highly contested.<sup>30</sup> For the most capable or ambitious medical graduates, the advantages of an Auckland appointment probably outweighed the benefits associated with securing a job in a municipal hospital slightly closer to home. In addition, the appointment process for house surgeons generally ensured that the most promising graduates obtained appointments at the institutions of their choice. Before 1972, house surgeons typically applied to several hospitals boards at once, and then made a choice between those applications that had been successful. This caused considerable problems for the less-desirable Boards, which often failed to fill their establishments, or could only employ those applicants who had been declined jobs elsewhere. While an independent 'matching service' was established to alleviate this problem in 1972, the process still retained as its stated aim the desire to place the best candidates in the institutions of their choice.<sup>31</sup>

These findings suggest that while the main public hospitals in New Zealand's three smaller main centres functioned as regional hubs, attracting large numbers of local graduates, Auckland hospital's status enabled it to function as a national hub, drawing applications from strong graduates from across the country, particularly in the post-house surgeon years.<sup>32</sup> As such, Auckland hospital can also be viewed as an important link to the wider international system. The range and sophistication of specialised services on offer, and the unrivalled economic opportunities that Auckland's large urban population offered to specialists with

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Phase in New Zealand', *New Zealand Medical Journal*, volume 78, number 496 (8 August 1973), p. 124.

<sup>30</sup> Twenty-five out of the database's fifty-two Auckland Hospital-based house officers had attended schools in Auckland or surrounding districts.

<sup>31</sup> See 'House Surgeon Matching Service', in *Report of the Advisory Committee to the Minister of Health on Resident Medical Officers*, p. 19 and Appendix 4, pp. 104-9.

<sup>32</sup> In 1979, almost forty per cent of all specialist registrars worked in Auckland alone. *Specialist Medical Manpower in New Zealand*, p. 26.

private practices were clearly attractive to most prospective specialists.<sup>33</sup> However, Auckland's large specialist staff also provided greater opportunities for making international contacts than any other New Zealand hospital. A number of the doctors interviewed for this thesis have inferred that junior doctors who had worked at Auckland enjoyed an advantage over their compatriots in the competition for British jobs. The Hamilton gastroenterologist, Dr Peter Stokes, for example, recalled that many of the junior doctors that he had worked with while a registrar at Auckland hospital during the mid 1960s found it relatively easy to find positions in the more prestigious British institutions:

Some of the [Auckland] consultants who had been [overseas] maintained quite strong relationships. . . . So they had the situation where they could ring up [Britain] and say, 'Bill, I've got this bloke here, what have you got available'. . . . It was just, for them, no sweat. One day they were just finishing at Auckland and the next they were at some flash neurology place in Queen's Square in London. And some of it was with accommodation all arranged and [someone] receiving them, and it was just a breeze.<sup>34</sup>

Hamilton's Waikato hospital provides a useful counter example. At the start of the twentieth century, Waikato hospital was a small 'cottage hospital' of three wards in a township of just over 1,200 people. By the early 1920s, economic development driven by agriculture had increased the town's population almost tenfold, and more importantly, increased the regional population to almost eighty-thousand.<sup>35</sup> By the late 1960s, Hamilton had surpassed Dunedin as New Zealand's fourth-largest city, and its hospital had grown into the country's second largest in terms of available beds, with a well-developed, if incomplete, range of specialised

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<sup>33</sup> As the northernmost of New Zealand's four main centres, Auckland also offered an attractive climate compared to the other three.

<sup>34</sup> Interview with Dr Peter Stokes, 12 November 2010. Dr Stokes, whose sense of alienation from the Auckland patronage 'system' is discussed later in this chapter and again in Chapter 6, remembered that 'if I [had been] in that network, I would have finished up in Auckland.'

<sup>35</sup> See John Armstrong, *Under One Roof: A History of Waikato Hospital* (Hamilton: Half Court Press, 2009), pp. 40-62.

services.<sup>36</sup> Yet many doctors and administrators from New Zealand's other large centres continued to regard Waikato hospital as a 'second tier' institution.<sup>37</sup> In part, this was because the hospital's predominantly rural catchment area was unattractive to doctors who needed a large and easily accessible population if they were to establish economically viable part-time private practices alongside their hospital commitments. In addition, Waikato had refused to employ any part-time doctors until 1950, long after most other major New Zealand hospitals had allowed their staff to operate private practices. As a result, generalists had continued to dominate the hospital longer than anywhere else. Waikato hospital was therefore widely perceived to be 'behind the times'.<sup>38</sup>

The key point is that having a large population catchment and extensive facilities were not enough to make Waikato hospital attractive to established or prospective specialists. Other factors, including the widespread perception of Hamilton as an unsophisticated rural centre, and the related failure to acknowledge the city as a main centre in its own right made recruiting, at all levels, a perpetual problem for the hospital's administrators. As a result, Waikato soon earned a reputation as a 'working hospital'. In the mid 1960s, Waikato hospital's doctors were responsible for three times more beds each than their Auckland colleagues.<sup>39</sup> Many of the institution's first specialists worked in professional isolation as the hospital struggled to employ additional staff. New specialist services were invariably established as 'one man bands', and some remained that way for decades. For some graduates, however, this was no deterrent. Doctors who wished to work as general practitioners, as obstetricians, or as anaesthetists often valued the breadth and intensity of experience that could be obtained in smaller or less well-regarded institutions.<sup>40</sup>

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<sup>36</sup> Visiting specialists from Auckland Hospital provided a number of specialist services well into the 1960s. See Armstrong, pp. 155-89. See Table 9 in Appendix (p. 338) for population of main New Zealand urban centres, 1945-1971.

<sup>37</sup> See Armstrong, pp. 120-6, 236-8.

<sup>38</sup> See Armstrong, pp. 120-6.

<sup>39</sup> In 1964, Waikato hospital's medical staff were responsible for 8 beds each, compared to 2.9 for doctors at Auckland hospital. In 1968, the rates were 7.3 and 2.5 respectively. *Hospital Statistics of New Zealand, 1964*, pp. 32-7. Waikato's grant for medical staff salaries was approximately half that of Auckland hospital, per doctor: £107 compared to £262 in 1964, \$599 to \$1,111 in 1968. *Hospital Statistics of New Zealand, 1964*, pp. 64-9.

<sup>40</sup> Cole, 'Post-graduate Medical Education: The Graduate Phase in New Zealand', p. 121.

*'Wealth and Education': Social Factors and Medical Networking*

The need to access large populations was the primary motivating force for New Zealand doctors seeking to access the Common-health system. However, a range of social factors and professional conventions influenced the degree to which doctors were able to respond to that motivating force and access the world of specialised medicine. This section considers the ways in which factors such as socio-economic status and parental profession influenced the career trajectories of New Zealand specialists in the decades following World War Two. While it acknowledges that doctors who came from relatively privileged backgrounds enjoyed an advantage in terms of entering medicine as a profession, it also questions the assumption that socio-economic privilege or 'insider' statuses were necessarily advantageous throughout every doctor's career. To this end, the chapter concludes with an examination of the idea that many New Zealand doctors were motivated by a sense of *alienation from* medicine's traditional positions of privilege.

Medical obituaries provide a unique insight into the social and personal backgrounds of New Zealand's doctors. The standard template that most medical obituaries followed after World War Two usually includes references to the occupations of the subject's parents, and to the schools that doctors attended. Many obituaries also include references that are indicative of their subsequent political positions or social class. The theoretical discussion in Chapter 1 suggested that the form of the template itself also provides useful clues about the profession's system of values. While including references to secondary schools is not necessarily unique to medical obituaries, the fact that almost seventy per cent of the 770 obituaries examined on the database include such information does suggest that doctors placed some importance on schooling. It is difficult to know, however, whether the value of those references derives primarily from the quality of education offered by the various schools, or from their function as markers of social status.

Database analysis suggests that there is some correlation between attendance at one of New Zealand's prestigious private schools and the subsequent rates of specialisation among their graduates. Overall, the 770 obituaries include 529 discreet references to 108 separate secondary schools.

However, almost sixty per cent of all references are made to just fifteen schools, mostly either large state institutions such as Otago Boy's High School, Auckland Grammar, Wellington College, and Christchurch Boys' High School, or to prestigious private schools such as King's College, Waitaki Boys' High School, Wanganui Collegiate, and Christ's College. If the fifteen most frequently cited schools are then ranked according to the proportion of their graduates who attained specialist status, it is notable that the top four places are all occupied by private schools (see Table 1 below).

*Table 1:  
Rates of Medical Specialisation in New Zealand Medical Obituaries, by Secondary  
School Attended*

School	Citations	Specialists		Went Overseas	
	(n)	(n)	(%)	(n)	(%)
<b>All Obituaries</b>	<b>770</b>	<b>307</b>	<b>40%</b>	<b>599</b>	<b>78%</b>
*John McGlashan College	9	6	67%	9	100%
*King's College	18	11	61%	12	67%
*Wanganui Collegiate	14	8	57%	12	86%
*Christ's College	34	19	56%	27	79%
Christchurch Boy's High School	24	12	50%	22	92%
Otago Boy's High School	54	26	48%	44	81%
Timaru Boy's High School	15	7	47%	14	93%
Napier Boy's High School	9	4	45%	5	56%
Nelson College	18	8	42%	15	79%
*Waitaki Boy's High	31	13	42%	24	77%
Palmerston North Boy's High	15	6	40%	11	73%
Wellington College	24	9	37%	21	88%
New Plymouth Boy's High	9	3	33%	6	67%
Auckland Grammar	40	11	27%	34	85%
Southland Boy's High	17	4	23%	14	82%

Source: Medical Obituary Database (see Chapter 1, pp. 56-60)

On average, more than sixty per cent of the students who attended the four most frequently cited private schools went on to become specialists, compared to the forty-seven per cent of those who attended the four most frequently cited state-funded schools.

At the most basic level, these figures might be viewed as evidence for the quality of private education. Over the twentieth century, the development of medical specialisation brought an associated rise in the professional status of its practitioners. No longer assumed to suffer from ‘cerebral lop-sidedness’, specialists instead came to be regarded as intellectually superior to their generalist colleagues.<sup>41</sup> Private schools often promoted their ability to maximise academic achievement and personal development, to provide tailored mentoring, and to encourage their students into esteemed professions such as law or medicine. Several interview participants have discussed the influence of private school masters in their decisions to become doctors, while others who attended public schools recalled that privately schooled classmates at the Otago Medical School seemed better prepared for the course’s scientific content.<sup>42</sup> To the degree that specialisation was an academic exercise, tuition in private schools may well have furnished students with more solid academic foundations than did public schools, which may in turn have translated into professional success in the form of higher rates of specialisation.

But attendance at private schools is often associated with other forms of social advantage. In his 1985 thesis on the formation of the New Zealand medical profession, Michael Belgrave suggested that professional success (loosely defined in terms of becoming ‘major professional figures with specialist practices’) derived more from economic than educational backgrounds.<sup>43</sup> Belgrave’s thesis included a chapter that considered the ways in which various ‘social systems’ – including the vocational backgrounds of parents – influenced the careers of New

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<sup>41</sup> Noel Parry and José Parry, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (London: Croom Helm, c1976), p. 214. Such attitudes about specialisation were neatly summarised by the President of the New Zealand Medical Association, O. R. Nicholson, in 1981, when he stated that ‘specialisation is just another word for progress’. See O. R. Nicholson, ‘Presidential Address’, *New Zealand Medical Journal*, volume 93, number 685 (10 June 1981), pp. 396-8.

<sup>42</sup> Interviews with Dr Warren Austad, 17 March 2011, Professor Graham Hill, 16 February 2011, and Professor Barbara Heslop, 16 February 2011.

<sup>43</sup> Belgrave, “‘Medical Men’ and ‘Lady Doctors’”, p. 383.

Zealand doctors.<sup>44</sup> In that chapter, Belgrave compared the relative rates of success of doctors with medical parents compared to those from ‘working class’ families, and concluded that the former group were not only more likely to attend medical school in the first place, but were also more likely to achieve professional success after graduation. Belgrave suggested that the reason for this was primarily economic. Because medicine was ‘closely linked to wealth and education’, he argued, students with medical parents had fewer economic barriers to overcome while at medical school than did those from less economically privileged groups.<sup>45</sup> He noted, for example, that students with medical parents tended to graduate at a younger age than their ‘working class’ colleagues, who often had to support themselves financially before or during their time at medical school. As a result, some doctors from less privileged backgrounds had already started families as they began their professional careers, and were therefore less willing, or less able, to embark on long and expensive courses of post-graduate study.<sup>46</sup> Belgrave concluded that the economic advantages that the children of medical parents enjoyed was the ‘most obvious’ explanation for their professional success relative to doctors from ‘working class’ backgrounds. The relationship between specialist status and private school attendance identified in the database makes sense in this context, as private schooling is typically more accessible to the economically privileged.

As far as it goes, Belgrave’s argument aligns with the obituary database findings, which align with the observation that doctors with medical parents were more likely to succeed than those from working class backgrounds.<sup>47</sup> However, his argument does *not* explain the most striking aspect of the database findings: that doctors who came from medical families had a *lower* rate of specialisation (at thirty-four per cent) than the overall database sample (forty per cent of all 770 doctors in the database specialised), and a *significantly* lower rate compared to doctors with parents from non-medical vocational backgrounds of roughly

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<sup>44</sup> Belgrave, “‘Medical Men’ and ‘Lady Doctors’”, Chapter 9, ‘The Limits of Professionalism: Professional Identity and the Social System’, pp. 355- 418.

<sup>45</sup> Belgrave, “‘Medical Men’ and ‘Lady Doctors’”, p. 383.

<sup>46</sup> Older graduates typically opted for general practice, often because they were unwilling to commit themselves to a long period of training. Gillian Durham, Clare Salmond, and Julie Eberly, *Women and Men in Medicine: The Career Experiences* (Wellington: Health Services Research and Development Unit, Department of Health for Health Workforce Development Fund, 1989), pp. 22-3.

<sup>47</sup> Belgrave, “‘Medical Men’ and ‘Lady Doctors’”, p. 383.

comparable social or economic statuses, such as science (one hundred per cent of the admittedly small sample became specialists), farming (seventy-two per cent), law (fifty-six per cent), education (fifty per cent), the clergy (forty-six per cent), or politics (forty-four per cent). Only those doctors with parents who had made their living as skilled or unskilled workers (including carpenters, shipwrights, drapers or blacksmiths, at thirty per cent), and those whose parents worked in one of several jobs that I have grouped under the label 'other white collar' (including bankers, merchants, civil servants and policemen, at seventeen per cent) specialised at lower rates. (See Table 2 next page)

*Table 2:  
Rates of Specialisation and Overseas Travel in New Zealand Medical Obituaries  
by Parental Vocation*

<i>Parent's Vocation</i>	<i>n</i>	<i>% of 199 specified vocations<sup>48</sup></i>	<i>n   % Specialised</i>		<i>n   % Travelled</i>	
All Obituaries	770	n/a	307	40%	599	78%
Vocations Cited (n)	201	100%	80	40%	166	83%
No Vocations Cited	569	n/a	227	40%	433	76%
Scientist	4	2%	<b>4</b>	<b>100%</b>	4	100%
Farmer	11	5%	<b>8</b>	<b>73%</b>	10	91%
Lawyer	9	4%	<b>5</b>	<b>56%</b>	6	67%
Education	8	4%	<b>4</b>	<b>50%</b>	8	100%
Clergy	26	13%	<b>12</b>	<b>46%</b>	22	85%
Politician	9	4%	<b>4</b>	<b>44%</b>	8	89%
Medical	94	47%	<b>32</b>	<b>34%</b>	78	83%
Skilled or Unskilled	10	5%	<b>3</b>	<b>30%</b>	6	60%
Other White Collar <sup>49</sup>	29	13%	<b>5</b>	<b>17%</b>	23	79%

Source: Medical Obituary Database (see Chapter 1, pp. 56-60)

While the small number of citations in most discreet vocational groups means that these findings are only indicative of patterns, and are not statistically reliable, those patterns are reinforced when the almost two hundred parental vocations

<sup>48</sup> This figure excludes two parental occupations that were too vague to be satisfactorily categorised: 'tea-planter' and 'associated with the New Zealand Observer'.

<sup>49</sup> The categorisation of the various jobs listed in obituaries used for Table 2 required some of the less-frequently occurring occupations to be grouped together either as 'Other White Collar' or as 'Skilled and Unskilled Workers'. These designations were made with reference to the Elley Irving Socio-Economic Index for New Zealand (see footnote 50). This required some more-or-less arbitrary choices when insufficient information was available to justify categorisations one way or another: 'engineers', for example are categorised as 'Other White Collar' rather than 'Skilled Workers' because the Elley Irving Index includes engineers in socio-economic level 2, alongside the other occupations in the 'Other White Collar' category, such as bankers, merchants, policemen and civil servants. Skilled and unskilled workers consist mainly of occupations from socio-economic levels 3, 4, and 5, and include shipwrights, printers, grocers, carpenters and surveyors.

cited in the obituaries are agglomerated into one of the five socio-economic levels specified in the Elley Irving Socio-Economic Index for New Zealand (see Table 3 next page).<sup>50</sup> Grouping vocations according to educational attainment and income – the basis of the Elley Irving scale – confirms Belgrave’s finding that doctors from lower socio-economic backgrounds tended to achieve specialist status less frequently than doctors with medical parents.<sup>51</sup> Indeed, only thirteen of the almost two hundred references to parental profession mentioned a parental vocation from socio-economic levels 3, 4, or 5, and of these, only three (or twenty-three per cent) became specialists. Importantly, grouping occupations in this way also appears to confirm that doctors with medical parents specialised at lower rates than doctors from comparable, but non-medical, socio-economic backgrounds. Overall, more than ninety per cent of all doctors whose obituaries mentioned the vocation of at least one parent came from families whose main source of income was derived from a job ranked within levels 1 or 2 of the Elley Irving Socio-Economic Index. Almost seventy per cent came from socio-economic level 1 alone. In total, forty per cent of doctors from the two highest socio-economic levels became specialists, a rate consistent with that of the whole database sample. However, if doctors with medical parents are excluded from these calculations, the rate of specialisation among all other doctors from the highest socio-economic level rises to forty-five per cent.

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<sup>50</sup> W. B. Elley and I. C. Irving, ‘A Socio-Economic Index for New Zealand based on Levels of Education and Income from the 1966 Census’, *New Zealand Journal of Education Studies*, volume 7 (1972), pp. 153-67. This Index combined educational and income data from the 1966 census in order to rank 315 discreet male occupations into five socio-economic levels. Elley and Irving argued that data on male occupations was both more readily accessible and more indicative of overall family income than female occupation data. Although its authors acknowledged that the exercise required a number of simplifications and arbitrary connotations (‘farmer’ and ‘businessman’, for example, each encompass a broad range of income levels), they argued that the resulting ‘levels’ provided a meaningful picture of occupational status in New Zealand. Although more recent models (particularly the 1997 New Zealand Socio-economic Index of Occupational Status and Well-being, created by Davis, McLeod, Ransom, Ongley) have superseded this earlier model, its basis in 1966 data make it more relevant to the period under discussion.

<sup>51</sup> It is acknowledged that a scale based on income is likely to underestimate the position of high-status but low-income occupations such as the clergy.

*Table 3:  
Parental Occupations of Doctors in Obituary Database,  
Categorised according to Socio-Economic Level*

<i>Socio-Economic Level</i>	<i>Parental Occupations Cited (Total n=196<sup>52</sup>)</i>	<i>Travelled Overseas (n) (%)</i>	<i>Specialised (n) (%)</i>
1	132	109 / 83%	51 / 39%
2	51	45 / 88%	22 / 40%
3, 4, 5 combined	13	7 / 54%	3 / 23%
Doctors only	94	78 / 83%	32 / 34%
Level 1 excluding doctors	40	34 / 85%	18 / 45%

Source: Medical Obituary Database (see Chapter 1, pp. 56-60)

Overall, these findings suggest that parental vocation influenced the careers of doctors in three broad ways. First, they show that the children of medical parents often chose to become doctors themselves. With ninety-four references, medicine was by far the most cited parental profession in the obituaries analysed, comprising almost half of all references, and more than four times the number of the second most cited parental vocation, that of the clergy. In addition, almost thirteen per cent of all the obituaries analysed made mention of surviving children who had themselves become doctors.<sup>53</sup> The second influence of parental profession is a relatively clear-cut – and unsurprising – difference between the career prospects of the children of parents from high socio-economic backgrounds compared to those from lower ones. Doctors from families of low

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<sup>52</sup> Two parental professions, namely 'tea-planter' and 'associated with the New Zealand Observer' could not be categorised using the Elley Irving Scale. The three cases where only the mothers' occupation was specified (which were included in Table 2) have been excluded here, as the Elley Irving Scale was created using data pertaining to male occupations only. The overall sample size therefore differs from that provided in Table 2.

<sup>53</sup> Of the 770 obituaries analysed, ninety-nine mentioned children who had also become doctors. This rate does not seem to alter significantly in relation to the backgrounds of the obituaries' subjects: fourteen per cent of the children of doctors whose parents were themselves doctors had medical children (i.e. third generation doctors), while fifteen per cent of the doctors without medical parents had medical children. The children of specialists and general practitioners also became doctors at comparable rates (fifteen and eleven per cent respectively).

socio-economic status were relatively rare, migrated at lower rates, and were relatively under-represented within the ranks of medical specialists. It is likely that these differences were primarily grounded, as Belgrave contends, in economic disadvantage. However, economic disadvantage is almost certainly not responsible for the third apparent outcome: the lower rate of specialisation among doctors from medical families compared to those with other high socio-economic backgrounds. The calculations used to construct the Elley Irving Index suggest that, at the time it was compiled in the 1960s, doctors had a higher socio-economic status than any other vocational group in New Zealand. The strong economic position of the children of doctors is further supported by the finding that they migrated at a rate about six per cent *above* the overall sample: around eighty-three per cent of all doctors who were themselves the sons or daughters of doctors travelled overseas for training purposes, compared to around seventy-seven per cent of all other doctors in the database.<sup>54</sup> This suggests that other factors must have been at play.<sup>55</sup>

The challenge, then, is to explain why doctors from medical families did not in fact specialise at *higher* rates than other doctors – the finding that intuition would expect. Belgrave’s discussion, for example, suggests that doctors from medical families gleaned multiple benefits from their status as professional ‘insiders’, beyond the mere financial. These included a greater ability to negotiate the medical school recruitment process, and a greater awareness of the requirements of medical work.<sup>56</sup> Other benefits include a much greater pre-knowledge of basic medical terminology than their fellow medical students, and a useful network of professional connections ‘inherited’ from parents.<sup>57</sup>

There is, however, evidence to suggest that ‘insider’ status was not necessarily and always advantageous. The case of the ‘chronic’ or ‘waster’ – the perpetually failing and long-term medical student who prioritised social life well above study – illustrates one way in which it was possible for insider status, and even high socio-economic status, to have *inhibited* some medical careers. Medical

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<sup>54</sup> The Index’s calculations, which took into account income and educational attainment, gave doctors the highest ‘z score’ of any discreet vocational group.

<sup>55</sup> The size of the samples used in these calculations make it unlikely that the relatively low rates of specialisation among doctors from medical families can be attributed to statistical distortions.

<sup>56</sup> Belgrave, “Medical Men” and “Lady Doctors”, pp. 381-3.

<sup>57</sup> Interviews with Dr James Faed, 17 February 2011, and Dr Peter Stokes, 12 November 2010.

school staff and other commentators often attributed the on-going poor performance of such students to the presence of an overly generous family stipend. One un-named interviewee cited in Belgrave's thesis, for example, recalled that he was happy to keep failing the Otago medical course as long as his father was happy to keep paying for it.<sup>58</sup> Anecdotes suggest that particularly dedicated 'wasters' could draw a medical degree out to twelve or fifteen years, and in one case, twenty.<sup>59</sup> However, such characters were, by the second half of the twentieth century, too rare to have any significant bearing on the statistical findings under discussion. While 'wasters' had been a relatively common feature of nineteenth and early twentieth-century medical schools, warranting regular mentions in the correspondence sections of medical journals, in medical biographies and in institutional histories, increasingly stringent institutional requirements later made the lifestyle much more difficult to sustain. Sir Francis Gordon Bell's 1968 autobiography claimed that the 'genus' of waster was by that time effectively extinct.<sup>60</sup>

Yet, their historical demise notwithstanding, the oft-noted existence of such students from an earlier era provides a useful conceptual background against which to examine a theme that has arisen in several interviews conducted for this thesis, and which, I suggest, played a significant role in shaping the career trajectories of many New Zealand specialists. For, if it is plausible that the availability of strong support conferred upon some 'insiders' the effective means to make a less than complete commitment to their studies, it must also be plausible to suggest that those who lacked such supports – be they financial or 'cultural' – may have felt a need to work even harder.

### *Medical 'Outsiders'*

From the time he was a small child, Dr Graham Hill, who later went on to serve as Professor of Surgery at the Auckland School of Medicine, had wanted to be a surgeon. In an interview conducted for this thesis, Dr Hill recalled that he had

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<sup>58</sup> Belgrave, "Medical Men" and "Lady Doctors", p. 381.

<sup>59</sup> 'Chronic Medical Students', *British Medical Journal*, volume 1, number 5383 (7 March 1964), p. 640.

<sup>60</sup> Sir Francis Gordon Bell, *Surgeon's Saga* (Wellington: A. H. & A. W. Reed, 1968), p. 47.

kept his ambition to himself until secondary school because he was uncertain about his academic abilities, and because an almost total lack of interactions or relationships with doctors had left him unsure about what medical study and medical work involved.<sup>61</sup> Without this background knowledge, the prospect of becoming a doctor ‘seemed an awesome thing’:

When I got to medical school, it was a wonderment for me. The privilege of being there, of opening up the anatomy books and seeing the body there, it was just wonderful. I worked terribly hard. . . . I think the people from, say, Auckland Grammar who had scholarships in physics and chemistry during the intermediate year had huge confidence in almost re-forking over the learning they had already done. Whereas to me, it was totally new.<sup>62</sup>

Several other interview participants spoke explicitly about the positive influence of similar feelings of alienation from the medical world in their subsequent medical careers. Dr John Conaglen, who transferred to the Otago University medical course during his second year of veterinary training, attributed some of his early professional success to a ‘naive’ belief that medicine was a field of knowledge that could be mastered completely if sufficient effort was applied, because, unlike veterinary science, only one kind of animal was being studied. By the time Dr Conaglen realised that attaining mastery was impossible, the successes he had achieved pursuing it had brought him to the attention of lecturers and senior hospital colleagues who later went on to play a significant role in shaping his career.<sup>63</sup> Dunedin pathologist Dr James Faed also had no family background in medicine, and remembered having difficulty with many of the medical terms that he encountered during the early stages of his medical education. However, he also found his outsider status motivating:

I never saw myself as being an insider. . . . I came in [to medical school] as a non-medical person and saw myself as perhaps slightly

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<sup>61</sup> Professor Hill did have one elderly uncle who worked as a doctor, but he lived in Edinburgh. Interview with Professor Graham Hill, 16 February 2011.

<sup>62</sup> Interview with Professor Graham Hill, 16 February 2011.

<sup>63</sup> Interview with Dr John Conaglen, 28 April 2011.

inferior to people who were already in the medical scene. But in my schooling I'd been a rural guy who bussed in fifteen miles to the high school each morning and fifteen miles back again. So I was always on the outer edge of that school as well. Medical school was in a sense a perpetuation of that process. You just get out, you work and you make some progress.'<sup>64</sup>

Hamilton gastroenterologist Dr Peter Stokes also felt that his outsider status had been helpful during the early stages of his medical career. Dr Stokes had left school at the age of fifteen with only School Certificate, New Zealand's lowest formal school qualification, and went to work on his parents' farm. After a year, he enrolled at Flock House, a live-in agricultural school in the country town of Rangitikei. Upon completing the course, he returned to work, joined the local Young Farmers Club, and in 1958 won a regional Young Farmer of the Year competition. His prize was a Northern and Auckland Farmer's Freezing Company Scholarship, which covered fees and accommodation for one year's study at Massey, New Zealand's main agricultural university. At Massey, Dr Stokes discovered an affinity for formal study, and at the completion of his sponsored year decided to continue at university, intending to enrol in a veterinary science course. However, this required him to first obtain University Entrance, a higher secondary-school qualification, which, as an early school leaver, meant enrolling in an adult education course in Auckland. Highly motivated, Stokes achieved three 'A' grades in the University Entrance examinations, which entitled him to apply for Otago's medical course instead. Dr Stokes began his medical studies in 1960, at the age of twenty-one. While this was still a relatively young age, he recalls that the six years he had already spent in the workforce by that time gave him a significant advantage at medical school. He recalls that he was less 'distracted' than other, younger students, had a stronger work ethic than most of his classmates, and also possessed a unique perspective on student politics. Dr Stokes won the Otago Medical School's chemistry prize as a first year student, and served as President of the Otago Medical Students' Association in 1963 and 1964.<sup>65</sup>

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<sup>64</sup> Interview with Dr James Faed, 17 February 2011.

<sup>65</sup> Interview with Dr Peter Stokes, 12 November 2010.

With these testimonies in mind, it seems less surprising that several of the most prominent doctors interviewed for this project came from non-medical backgrounds. Dame Norma Restieaux (cardiologist and later Associate Professor of Medicine at the Otago Medical School) had no medical relatives; Dr John Conaglen (endocrinologist and Associate Professor of Medicine at the Auckland School of Medicine), like Peter Stokes, came from a farming background, and the family of Dr Peter Rothwell (respiratory physician, ex-President of the Australasian Thoracic Society and John Sands College Medal recipient) derived its income primarily from his father's legal practice.<sup>66</sup>

Taken as a whole, I suggest that the recurring theme of 'outsiders' doing well in professional medicine represents one possible reason for the relatively low rate of specialisation among doctors with medical parents (or, read another way, for the relatively high rates of specialisation among doctors with non-medical parents) identified in the obituary database. Doctors from non-medical backgrounds, awed by the prospect of entering such a high-status profession, worked extremely hard to overcome their perceived 'inferiority', and thereby achieved successes that carried many into specialist careers or leadership roles. The logical corollary – which I make no attempt to verify here – is that doctors from medical backgrounds may not have felt the same sense of urgency. In part, this may have been because a reasonable proportion of doctors from medical backgrounds aspired only to take over their parents' general practices, and were content to achieve only the level of qualification necessary to attain that goal. Similarly, some of the mainly Australian women doctors interviewed for Rosemary Pringle's 1998 study, *Sex and Medicine: Gender, Power and Authority in the Medical Profession*, suggested that medical students from 'privileged backgrounds' tended not to aspire to the most prestigious specialties or jobs, opting instead for jobs in which they could 'achieve a comfortable mastery'.<sup>67</sup> One of Pringle's interviewees suggested that 'sensible middle-class rich chappies' realised that there was more to life than professional success, in contrast to working class doctors who felt a need to prove their worth by working hard.

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<sup>66</sup> The John Sands Medal recognises doctors who have served the Royal Australasian College of Physicians with distinction without advancing to the office of President.

<sup>67</sup> Rosemary Pringle, *Sex and Medicine: Gender, Power and Authority in the Medical Profession* (Cambridge: Cambridge University Press, 1998), p. 115.

Pringle concluded that for some socially privileged doctors, working hard ‘undercut the goal of being able to function with ease and grace.’<sup>68</sup>

Even if the comparatively low rates of specialisation among doctors with medical parents is attributable – in whole or in part – to statistical anomaly, I suggest that the preceding discussion of perceived ‘outsider’ status among Otago Medical School students and its recent graduates remains valuable to the degree that it speaks to a second apparent manifestation of this phenomenon in yet another cultural context: the experiences of young New Zealand doctors working in British hospitals. Once again, the perception of outsider status seemed to function as a motivating force at multiple levels and in multiple places within the Common-health system.

### *‘Colonials’ in Britain*

As discussed in Chapter 2, the social status of both the British medical profession as a whole, and of the individual practitioners within it, has long been influenced by the conventions and expectations of the British class system. According to classic Marxist definitions, owning the means of production and the resulting ability to live off the labour of others was a defining feature of the upper classes. While the need to perform work, either mental or manual, in order to secure an income excluded medical professionals from membership of an upper class defined on these terms, the ability to *appropriate* upper-class norms and behaviours became a key factor in the expression of professional success. Over time, such appropriation resulted in the hierarchical structures of the British medical profession coming to mimic those of broader British society. Intellectual physicians became the profession’s upper class, followed by the hands-on surgeons and the trading apothecaries.

One result of these historical developments was that the different but related concepts of ‘class’ and ‘status’ became blurred in both the literature of medical sociology and in popular usage.<sup>69</sup> Despite medicine’s universal

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<sup>68</sup> Pringle, p. 115.

<sup>69</sup> This position was first articulated by Max Weber in *Economy and Society* (Berkeley: University of California Press, 1922), pp. 302-307. For recent discussions, see Tak Wing Chan and John H.

characterisation as the model middle-class occupation (defined in terms of the means of production of the profession as a whole), the high social status of its preeminent practitioners (defined in terms of the esteem attached to medicine as a social position) often came to be described in *terms* of class. Thus, consultant physicians were not only routinely presented and perceived as the profession's equivalent of society's upper classes – the unquestioned superiors of junior hospital doctors, nurses, and the masses of working general practitioners – but as bona fide members of the upper class itself.<sup>70</sup>

While the distinction between class and status is important mainly in the field of sociology, it is worth keeping in mind when interpreting the recollections of New Zealand doctors who worked in some of Britain's most prestigious hospitals. Professor Graham Hill's observation that a far smaller proportion of New Zealand's leading surgeons came from 'upper class backgrounds' than was the case in Britain, for example, might more accurately reflect the perceived social status of surgical consultants as a group than the class backgrounds of individual practitioners.<sup>71</sup> The same might be said of Dr John Conaglen's recollection that most of the senior consultants at St Thomas's hospital were 'upper-class landed gentry'.<sup>72</sup>

Nevertheless, the frequency of such references in the accounts of interviewees suggests that perceptions of class-based 'superiority' or 'inferiority' inflected the experiences of many New Zealand doctors working in Britain. The New Zealand pathologist, Dr Barbara Heslop, who later became the first woman appointed as an Associate Professor at the Otago Medical School, worked as a pathologist in Britain during the 1950s, and remembered being surprised that prestigious British hospitals seemed to make no distinction between patients based on their class. However, 'class' distinctions among the medical staff were 'quite

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Goldthorpe, 'Is There a Status Order in Contemporary British Society?: Evidence from the Occupational Structure of Friendship', *European Sociological Review*, volume 20, number 5 (December 2004), pp. 383-401, Chan and Goldthorpe, 'Class and Status: The Conceptual Distinction and Its Empirical Relevance', *American Sociological Review*, volume 72, number 4 (August 2007), pp. 512-32.

<sup>70</sup> The clearest example of this is Vicente Navarro's *Class Struggle, The State and Medicine* (London: Martin Robertson, 1978), which repeatedly argues that the high status of the British medical profession derived from the upper class origins of its practitioners. See Navarro, pp. xv, 5-6.

<sup>71</sup> Interview with Professor Graham Hill, 16 February 2011.

<sup>72</sup> Interview with Dr John Conaglen, 28 April 2011.

apparent' to her. She recalled that some of the consultants 'behaved atrociously', demanding, for example, to be taken directly to their desired floor upon entering an elevator, regardless of who else was in the lift or its proximity to their destination.<sup>73</sup> Dr John Conaglen worked in three of London's most prestigious hospitals – St Thomas's, St Bartholomew's, and the Great Ormond Street Hospital for Children – during his time overseas, and remembered that the organisation of the medical staff in these institutions was 'extremely hierarchical'. At St Thomas's, for example:

[T]here were tiers of dining rooms. There was the general public dining room where the scientists would go and join the general public for lunch, then there was a room for the junior doctors, up to senior house officer, then there was a senior registrar dining room, and then there was a consultant dining room. Now, I could dine in all of those, bar the consultant dining room, as I pleased. But you could only go to the consultants' dining room on invitation. I got invited to that once. It was an experience. There were these people in the middle of the day drinking wine, all in suits with silver service and butlers and waiters. It was amazing. My boss said that 'some of these doctors work in the hospital, but they only come to lunch.' And he was right.<sup>74</sup>

Hierarchies based on status or perceptions of class often translated into hierarchies of power in Britain's hospitals. In a letter written home to his parents in October 1955, the Wellington ophthalmologist Dr Colin Fenton noted that the senior consultants at Moorfields, London's leading eye hospital, wielded almost complete control over the institution. He wrote that they were 'quite able to ruin the prospects of any young person they didn't like', making it 'dangerous' for junior staff to question the medical opinions of their seniors, or to complain about their own working conditions.<sup>75</sup> On his first day at the Royal Leeds Infirmary, Dr Graham Hill was informed by his new boss, the world-renowned colo-rectal

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<sup>73</sup> Interview with Professor Barbara Heslop, 16 February 2011.

<sup>74</sup> Interview with Dr John Conaglen, 28 April 2011.

<sup>75</sup> Dr Colin Fenton, unpublished personal letter, 9 October 1955.

surgeon, Dr John Goligher, that ‘we have a simple system here. If you do not agree with the style or requirements of the man above you, you leave.’<sup>76</sup>

Despite the challenges that such systems must have presented, New Zealand doctors tended to do well in British hospitals. Doctors themselves have proposed several reasons for this. One of the most commonly cited, particularly in the years immediately following World War Two, were the bonds of friendship and goodwill that had developed as a result of wartime interaction. Several prominent British doctors were known to promote the interests of Australian or New Zealand doctors for this reason. Dr Graham Hayward, a British physician based at the National Heart Hospital in London, had served with New Zealand doctors and nurses during World War Two and held them in high regard.<sup>77</sup> The British surgeon, Sir Gordon Gordon Taylor (known affectionately as G<sup>2</sup>T to many Commonwealth trainees), was literally world famous for devoting half a day each week to ‘what was effectively an informal job service’ for thousands of young Commonwealth doctors while he served as President of the Fellowship of Post-Graduate Medicine.<sup>78</sup> Gordon Taylor’s service was underpinned by a massive international network of personal contacts, many of which had originated during his service in World War One.<sup>79</sup>

Another commonly cited reason for the success of New Zealand doctors working in Britain was their supposed possession of a strong work ethic. While this characterisation was, like all ‘national traits’, not applicable to every individual, New Zealand doctors were routinely described as being reliable and self-sufficient workers who had a much less ‘relaxed’ attitude to working hours than did their British counterparts.<sup>80</sup> While British doctors and administrators also recognised Australian doctors as diligent workers, they were widely perceived to have the unfortunate trait of being willing to express discontent if conditions were

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<sup>76</sup> Professor Graham Hill, *Surgeon Scientists: Adventures in Surgical Research* (Auckland: Random House, 2006), p. 40.

<sup>77</sup> Sir David Hay, *Heart Sounds: A Life at the Forefront of Health Care* (Wellington: Steele Roberts, 2005), p. 81.

<sup>78</sup> Wilde, ‘Practising Surgery’, pp. 250-1.

<sup>79</sup> ‘Obituary: Sir Gordon Gordon Taylor’, *British Medical Journal*, volume 2, number 5203 (24 September 1960), pp. 947-8. In what was one of many obituaries published across the world, Gordon Taylor was described as ‘the chief mentor for [Indian and Pakistani] post-graduate students’ and ‘an uncrowned king’ in Australia and New Zealand.

<sup>80</sup> Interview with Dr Warren Austad, 17 March 2011. Dr Austad remembered being surprised that most British doctors began their ward rounds at 9:30am, an hour-an-a-half later than was customary in New Zealand.

not to their liking. Dr Fenton was amazed to see a junior Australian doctor showing ‘no compunction’ about refusing to work on his senior consultant’s private ward unless paid extra for it.<sup>81</sup> Dr Peter Rothwell recalled that the common wisdom in Britain was that ‘New Zealanders worked hard and didn’t gripe, that Australians worked hard and griped, and that the Brits didn’t work hard but didn’t gripe.’<sup>82</sup>

However, the strong work ethic exhibited by many antipodean doctors was less a function of their nationality *per se* than it was of their particular professional and personal situations. Most New Zealand and Australian doctors engaged in post-graduate training in Britain were young and often poorly resourced. Living in Britain was expensive and pay was generally poor. As a result, Australasian doctors tended to approach their training and studies very seriously. The New Zealand orthopaedic surgeon, Dr Wyn Beasley, who trained in Britain for three years from 1954, remembered living ‘strictly hand-to-mouth, which meant that we had to work hard, train hard, learn hard, or go under’.<sup>83</sup> This sense of urgency, articulated by many other New Zealand doctors, was reinforced by the knowledge that the pass rate of both major College examinations hovered between ten and twenty per cent. While it was rare for even the most capable doctor to pass any of the major examinations at the first attempt, doctors from New Zealand and Australia could simply not afford to make multiple casual attempts, like some doctors from Britain, and to a lesser extent, Canada, were reputed to do. At a time when almost all post-graduate specialist training took place on the job, this urgency to succeed invariably manifested as early morning starts, long hours, attention to detail, and a willingness to ask questions.<sup>84</sup>

Unsurprisingly, such an approach made doctors from Australia or New Zealand very popular with the leaders of British specialist departments, with the

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<sup>81</sup> Dr Colin Fenton, unpublished personal letter, 9 October 1955.

<sup>82</sup> Interview with Dr Peter Rothwell, 28 August, 2010.

<sup>83</sup> Interview with Dr Wyn Beasley, 17 March 2011. Living conditions experienced by New Zealand medical migrants are explored in detail in Chapter 5.

<sup>84</sup> Evidence suggests that the standard of medical education provided by the Otago Medical School might also have served New Zealand doctors well internationally. During this period, the United States required all medical immigrants to sit an examination before entering the country. In 1963, the American Educational Council for Foreign Medical Graduates collated the results of the examination by medical school, and found that graduates of the Otago Medical School achieved the fourth highest average mark out of the 144 medical schools with twenty-five or more graduates attempting the examination. See ‘Performance of Medical Graduates from New Zealand’, *New Zealand Medical Journal*, volume 63, number 381 (May 1964), p. 259.

result that an Australasian contingent became a constant presence in many of Britain's specialised hospital departments. The Brompton Hospital heart surgeons, Tudor Edwards and Price Thomas, for example, were known to favour surgeons from Australia and New Zealand in their appointment process, with the result that a generation of young Australasian cardiac surgeons received their training in that prestigious London institution.<sup>85</sup> Similarly, a large number of Australasian heart physicians were mentored by Dr Paul Wood, a prominent cardiologist working at the National Heart Hospital in London.<sup>86</sup> Such 'dynasties' of Australasian trainees were enabled by a third important factor: the knowledge that most intended to return home once their training was complete. This meant that British hospital administrators could employ New Zealanders and Australians to senior registrar positions without compromising the prospects of British-trained doctors attaining consultant status.<sup>87</sup>

While interpersonal goodwill and a sense of economically driven urgency undoubtedly contributed to New Zealand doctors' success, their status as 'outsiders' also seems to have played a significant role. This manifested in two ways. The first could be described as a diffuse, but very real, sense of inferiority. This sense was neatly summarised in a phrase included in *Suggestions for Young Graduates Leaving for Study Abroad*, a guidebook published by the Dean of the Otago Medical School annually from 1958 until the mid 1970s:

England has many advantages that New Zealand can't ever offer – intellectual stimulus, art, culture, interesting people to meet, opportunity, nearness to the Continent, and being the centre of the civilised world.<sup>88</sup>

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<sup>85</sup> For examples, see Rowan Nicks, *Surgeons All: The Story of Cardiothoracic Surgery in Australia and New Zealand* (Sydney: Hale & Iremonger, 1984), pp. 68, 76, 87, 91, 105, 134, 145, 148-9, and 154. Brompton Hospital was later presented with a plaque in 'appreciation of the important role played by the hospital staff in inspiring the growth of cardiothoracic surgery in Australia and New Zealand.' Hay, p. 181.

<sup>86</sup> Dr Wood was born in Australia and worked as a resident in Christchurch during the early part of his career. See Hay, p. 84.

<sup>87</sup> Interview with Dr Warren Austad, 17 March 2011. Twenty-nine per cent of the New Zealand doctors working in British hospitals achieved senior registrar status. This rate was higher than that for any other Commonwealth country. The average rate for all immigrant doctors was twenty-one per cent. Oscar Gish, 'Overseas-Born Doctor Migration, 1962-66', *British Journal of Medical Education*, volume 5, number 2 (June 1971), pp. 103.

<sup>88</sup> *Suggestions to Young Graduates Leaving for Study Abroad* (Dunedin: New Zealand Postgraduate Medical Federation, 1968), p. 32.

If one of New Zealand's most prominent medical leaders could express such a strong sense of cultural inferiority, it is unsurprising that many New Zealand doctors felt apprehensive about their ability to work alongside Britain's medical elite. Hamilton general surgeon Dr Archie Badger travelled to Britain in 1946, and remembered being surprised that his Otago Medical School education and his experience as a house officer at Waikato Hospital had left him no less capable than most of the British surgeons he encountered. A quarter of a century later, Dr John Conaglen remembered feeling 'embarrassed' about his accent when treating upper class British patients.<sup>89</sup> Similarly, Dr Colin Hooker attributed his success in obtaining a series of highly prestigious British training posts not to his remarkable academic abilities – Dr Hooker was one of very few candidates to pass both the Primary and Final examinations of the Royal College of Surgeons at his first attempts – but to 'the humility of [his] stance' and a tendency to present himself as 'a keen student rather than any kind of expert'.<sup>90</sup> This deferential approach was well received by Britain's medical 'upper classes', and helped Dr Hooker to find work at the National Orthopaedic Hospital in London under the direct tutelage of the Faculty Dean, Jackson Burroughs, and at the Oswestry Hospital in Wales, arguably the world's leading orthopaedic unit at the time.<sup>91</sup>

All of these doctors, in different ways, were responding to their own self-perceptions of inferiority. For several of the doctors interviewed, such perceptions generated purposeful actions and states of being – such as studying extremely hard or adopting attitudes of social deference – that functioned to overcome the apparent disadvantages of their colonial origins. In many other cases, however, perceptions of outsider status originated not from the New Zealand doctors themselves, but from the perceptions of British doctors. I offer this as the second way in which 'outsider' status could serve to the advantage of New Zealand doctors: as outsiders, New Zealanders appeared largely to escape being placed within the restrictive professional, institutional and social hierarchies that so dominated British hospital medicine.

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<sup>89</sup> Interview with Dr John Conaglen, 28 April 2011.

<sup>90</sup> Interview with Dr Colin Hooker, 12 November 2010.

<sup>91</sup> Interview with Dr Colin Hooker, 12 November 2010.

British doctors, in short, ‘did not know where to put New Zealand doctors’ in those hierarchies.<sup>92</sup> This sentiment, expressed during an interview with Dr John Conaglen, was reiterated several times in both the written and spoken recollections of New Zealand doctors who had worked in Britain during the decades following World War Two. Strikingly, most of those doctors believed that their exclusion – or perhaps omission – from hierarchical British systems was both socially and professionally advantageous. Dr Conaglen, for example, remembered that:

[As a New Zealander] out on the streets, you were just another human being. When you were seeing [British people] clinically or in a social setting, you were a doctor, so you were okay. [In contrast] the Brits would actually stratify [each other according to] where they came from. I would find I was introduced to . . . other people much more easily, and was treated well, just as a New Zealander, because they didn’t have to classify me.<sup>93</sup>

In his autobiography, the New Zealand paediatrician, Dr Neil Begg, wrote that his antipodean accent had ‘put [him] outside the pattern of social stratification’ in Britain, and that his omission from local systems of social stratification made it easier for him to build personal relationships than it was even for British citizens. For Dr Begg, the on-campus accommodation given to him and his wife at the Royal Masonic hospital in London symbolised this. Situated on the second of three floors, their flat served as both ‘a cushion and a bridge’ between the hospital engineer below and the honorary secretary above.<sup>94</sup> Dr Colin Fenton expressed a similar idea in his interview when he suggested that New Zealander doctors succeeded in Britain because their position outside established class hierarchies left them free to achieve according to their individual merits.<sup>95</sup> Dr Fenton’s fellow ophthalmologist, Dr Peter Wellings, was explicit on this matter when he attributed

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<sup>92</sup> Interview with Dr John Conaglen, 28 April 2011.

<sup>93</sup> Interview with Dr John Conaglen, 28 April 2011. Not all New Zealand doctors were exempt from social judgements. Dr Martin Wallace remembered being excluded from a conversation among the applicants for a British hospital job after he said, in response to an enquiry, that he had attended Eketahuna District High School. Interview with Dr Martin Wallace, 2 October 2010.

<sup>94</sup> Neil Begg, *The Intervening Years: A New Zealand Account of the Period between the 1910 Visit of Halley's Comet and its Reappearance in 1986* (Dunedin: John McIndoe, 1992), p. 79.

<sup>95</sup> Interview with Dr Colin Fenton, 18 March 2011.

some of his own success to the fact that ‘British doctors couldn’t place New Zealanders within the class system’.<sup>96</sup>

Dr Conaglen’s recollections provide some useful insights into the particular ways in which omission from social hierarchies could translate into professional success. Two years after completing his first placement at St Thomas’s hospital in London, Dr Conaglen returned to work on a research project under the German-born endocrinologist, Professor Peter Sönksen. Soon after, Dr Conaglen was invited to use Professor Sönksen’s office while the latter attended a series of overseas conferences. Insightfully, Sönksen asked Dr Conaglen to ‘chat’ to the various members of the research team in his absence, in an effort to address a number of issues that were inhibiting the department’s operation, but which neither the junior nor senior staff were willing to discuss in front of the other. Dr Conaglen was certain that his ‘outsider’ status did indeed facilitate more candid discussions, with the result that he was able to make several ultimately successful suggestions upon his senior’s return.<sup>97</sup>

To an extent, the experiences of Dr Conaglen and other New Zealand doctors were a by-product of the rigid structures of British hospital medicine, as discussed at the end of Chapter 3. For many British doctors, securing promotion to a consultant’s post often relied on his or her willingness to conform to existing practices, rather than to question them. But such strictures did not apply in the same way to New Zealand doctors intending to return home after obtaining the necessary experience and qualifications. Dr Beasley recalled that his fellow New Zealanders were generally more willing to ‘give things a go’ than British counterparts who risked paying a high price for stepping outside departmental orthodoxy.<sup>98</sup>

In a professional field that placed such a high premium on interpersonal relationships and informal networking, the ability to serve as both professional confidant and clinical or administrative innovator must have been of immense value to New Zealand doctors, particularly in an environment that restricted the ability of local colleagues to do so to the same extent. This may partially explain the conspicuous success of some of the New Zealand doctors who chose to remain

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<sup>96</sup> Interview with Dr Peter Wellings, 17 March 2011.

<sup>97</sup> Interview with Dr John Conaglen, 28 April 2011.

<sup>98</sup> Interview with Dr Wyn Beasley, 17 March 2011.

in Britain after completing their specialist training. The contributions of Sir Harold Gillies and Sir Archibald McIndoe to plastic surgery, during World War One and World War Two respectively, are well known and have already been mentioned.<sup>99</sup> Yet in the post-World War Two years, several other New Zealand doctors attained similar levels of prominence in their specialty fields. The obituary of the New Zealand ophthalmologist, Barrie Jones, published in *The Times* in 2009, credited him with ‘changing the face and future direction of British ophthalmology.’<sup>100</sup> After leaving Dunedin for post-graduate training at Moorfields hospital in 1951, Jones was ‘fired by the chance to change the traditional practices still employed there’ and decided to remain in Britain.<sup>101</sup> In 1963, the University of London appointed him as its first Professor of Clinical Ophthalmology. From this position, and through his on-going relationship with Moorfields, Jones ‘led the way’ towards modern ophthalmology by making it compulsory for trainees to obtain experience working with the new operating microscopes, and by actively promoting sub-specialisation.<sup>102</sup> Through his advocacy, antipodean doctors and institutions became, and remained, prominent in that particular field.<sup>103</sup>

Dr Russell Fraser was another New Zealander credited with placing his specialty on a ‘modern’ footing in Britain. Born in Wellington in 1908, Fraser was an outstanding student who won all five gold medals in his final year at the Otago Medical School, and after travelling to Britain in 1935, achieved the highest mark in the primary examination for Membership of the Royal College of Surgeons. In 1957, he was appointed Professor of Endocrinology at the Royal Post-graduate Medical School at Hammersmith. Through his ‘innovative approach to research

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<sup>99</sup> See Leonard Mosely, *Faces from the Fire; the Biography of Sir Archibald McIndoe* (London: Weidenfeld and Nicolson, 1962), Emily Mayhew, *The Reconstruction of Warriors : Archibald McIndoe, The Royal Air Force, and the Guinea Pig Club* (London: Greenhill Books, 2004), Ronald Seth, *Sir Archibald McIndoe* (London: Cassell, 1962), Reginald Pound, *Gillies, Surgeon Extraordinary: A Biography* (London: M. Joseph, 1964).

<sup>100</sup> ‘Barrie Jones: Ophthalmic Specialist’, Obituary in *The Times*, published 4 September, 2009.

<sup>101</sup> ‘Barrie Jones: Ophthalmic Specialist’ (see previous note).

<sup>102</sup> The third volume of the History of Moorfields Hospital was dedicated ‘to Barrie Jones who led the way’. See P. K. Leaver, *The History of Moorfields Eye Hospital, Volume III: Forty Years On* (London: Royal Society of Medicine Press, 2004).

<sup>103</sup> Peter Watson, ‘Eulogy to Barrie Jones’, PDF available at Moorfields Eye Hospital website, URL: <http://www.moorfields.nhs.uk/Healthprofessionals/MoorfieldsAlumniAssociation/Alumninews/Obituaries>, accessed 2 February 2012. The obituary to Barrie Jones published by the Otago Alumni Association stated that ‘Otago has inordinate influence and that is partly a result of Barrie Jones.’ See ‘Dr Barrie Jones’, URL: [http://medicalalumni.otago.ac.nz/obituaries/Jones\\_Barrie.html](http://medicalalumni.otago.ac.nz/obituaries/Jones_Barrie.html). Accessed at 2 February, 2012.

problems and his ability to advise, encourage, and direct', Fraser came to be acknowledged as the 'father of endocrinology in Britain'.<sup>104</sup> As a keen employer of his fellow New Zealanders, Fraser ensured that the specialty also developed strongly in his home country. Similarly influential was the New Zealand otolaryngologist, Dr Chapple Gill-Cary, who led his specialty as the first Dean of the Institute of Laryngology and Otology at the Royal National Throat, Nose and Ear Hospital in London, a role that he filled for fifteen years from 1945. Like Jones and Fraser, Gill-Cary also encouraged New Zealand graduates to enter the specialty, playing an important role, for example, in the career of the New Zealand ear, nose, and throat surgeon, Sir Patrick Eisdell-Moore.<sup>105</sup>

Several other New Zealand doctors made important contributions to British medical administration and politics after World War Two. While Dr Harold Mason (Bill) Foreman's outstanding war service undoubtedly aided his subsequent career, his clinical and administrative abilities also contributed to his rise to the position of Superintendent at the Sully Hospital in Wales, an institution renowned for its treatment of respiratory illness, developed through a long association with local mining communities.<sup>106</sup> Dr Foreman was instrumental in getting several New Zealand doctors appointed to the staff at Sully, and used his influence to secure positions for them in other prestigious institutions.<sup>107</sup> Foreman was highly regarded by staff and administrators at London's Brompton Hospital, after impressing them during his pre-war appointment there as a house officer. He later drew upon this goodwill to secure positions for New Zealand doctors after

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<sup>104</sup> See 'Fraser, Thomas Russell Cumming' in *Munks Roll*, volume 10, published by the Royal College of Physicians, available online at URL: <http://munksroll.rcplondon.ac.uk/Biography/VolumeX>, accessed on 3 February 2012. See also the obituary of Dr Graham Frank Joplin, *New Zealand Medical Journal*, volume 120, number 1252 (13 April, 2007), URL: <http://journal.nzma.org.nz/journal/120-1252/2500/>, accessed on 12 August, 2011.

<sup>105</sup> See Dr Chapple Gill-Cary's obituary, published in the *British Medical Journal*, volume 284, number 6311 (23 January 1982), p. 278, and Patrick Eisdell Moore, *So Old, So Quick* (Auckland: David Ling, 2004), p. 236.

<sup>106</sup> Dr Foreman had been taken prisoner in Greece after declining to leave wounded soldiers in the field. Later, he had volunteered to be transferred to a camp where Russian soldiers were suffering from an outbreak of typhus. 'H. M. Foreman, Obituary', *British Medical Journal*, volume 1, number 6021 (29 May 1976), p. 1346.

<sup>107</sup> John Hiddlestone, *By Stethoscope and Statute: Autobiography, Part I, 1925-1983* (Self-Published, 1993), p. 37.

the war.<sup>108</sup> Foreman was also credited with making significant changes to training structures in his specialty field.

Sir John Stallworthy was another of ‘the distinguished group of New Zealand graduates who came to Britain before the war and stayed to leave their stamp of excellence on British medicine’.<sup>109</sup> Stallworthy served as the Nuffield Professor of Obstetrics and Gynaecology at Oxford University from 1967 to 1973, before being elected President of the Royal Society of Medicine from 1973 to 1975, and President of the British Medical Association in 1975.<sup>110</sup> Sir Arthur Porritt and Sir Douglas Robb also served Presidential terms for Britain’s leading medical association, in 1960 and 1961 respectively. Porritt was also elected President of the Royal College of Surgeons from 1960 to 1963, becoming the first person to hold the Presidencies of the Royal College of Surgeons and the British Medical Association concurrently.<sup>111</sup> In total, the 1966 *Encyclopaedia of New Zealand* lists almost thirty expatriate New Zealand medical professionals who had risen to positions of prominence in Britain, including departmental heads, clinical lecturers, academic medical researchers, and leaders in specialty organisations.<sup>112</sup> The *Encyclopaedia* acknowledged that this was only a partial list of New Zealander expatriates active at the time, while many others must have risen to prominence after its publication.

This chapter has made an argument for a Common-health medical system that worked both within and between nations, and that was built on a network of informal, interpersonal relationships. It has argued that British medical structures

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<sup>108</sup> Hay, p. 74. Dr Foreman was also cited as an important mentor by Dr Peter Rothwell, senior respiratory physician at Waikato Hospital from 1961 to 1995. R.P.G. Rothwell, *The Mauri Ora: The Ramblings of an Aging Respiratory Physician* (Hamilton: unpublished manuscript, 2007). I thank Dr Rothwell for providing me with a copy of this document.

<sup>109</sup> ‘Sir John Stallworthy, Obituary’, *British Medical Journal*, volume 307, number 6917 (4 December 1993), p. 1490.

<sup>110</sup> ‘Sir John Stallworthy, Obituary’ (see previous note).

<sup>111</sup> Derek A. Dow, ‘Robb, George Douglas – Biography’, from the *Dictionary of New Zealand Biography. Te Ara - the Encyclopedia of New Zealand*, URL: <http://www.TeAra.govt.nz/en/biographies/5r15/1>, accessed 2 February 2012. Diana Beaglehole, ‘Porritt, Arthur Espie – Biography’, from the *Dictionary of New Zealand Biography: Te Ara - the Encyclopedia of New Zealand*, updated 12-Nov-10. URL: <http://www.TeAra.govt.nz/en/biographies/5p34/1>, accessed 9 January 2013.

<sup>112</sup> See ‘Expatriates – Biographies, United Kingdom’, from *An Encyclopaedia of New Zealand*, edited by A. H. McLintock, originally published in 1966. Available online at URL: <http://www.teara.govt.nz/en/1966/expatriates-biographies/32>, accessed on 3 February 2012.

and traditions shaped the ability of New Zealand medical graduates to pursue training overseas, and, paradoxically, provided New Zealand doctors working in Britain with opportunities that were in some ways different, and even preferable, to those available to local doctors. The following chapter examines in detail the personal experiences of those New Zealand medical migrants and their families who negotiated this system successfully, and found themselves living and working in ‘the centre of the civilised world’.



## *Chapter 5*

### *The Migration Experience*

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This chapter seeks to provide a window onto the experiences of New Zealand post-graduate medical migrants travelling to, and living in Britain during the three decades that followed World War Two. It considers their professional goals and looks at the challenges that they faced in meeting them. It maps the particular institutions that they went to for their hands-on experience, looks at their working lives, and follows their difficulties preparing for professional examinations that four out of every five students failed. The chapter also examines some of the support systems that New Zealand doctors were able to access in Britain. With a few exceptions, the chapter does not emphasise change over time, but instead treats the period from the end of World War Two to the late 1960s as one in which conditions in Britain remained relatively constant for New Zealand doctors. The evolution of the Common-health system, and the emergence of training venues other than Britain, is dealt with in more detail in Chapter 7.

The personal insights used here come from the written autobiographies of New Zealand doctors, and from twenty-two recorded interviews with doctors who spent time in Britain between 1945 and the late 1970s. Of particular value, however, is a collection of more than three hundred letters, written by Dr Colin Fenton and sent back to his parents during six years in Britain, starting in late 1954. This collection provides a rare, and possibly unique record of the week-to-week activities, challenges, and joys of a New Zealand doctor, and his growing family, living and working in Britain.

## *Ship's Doctors*

At 8:30pm on Tuesday 23 November 1954, Dr Colin Fenton and his wife Aileen walked through the streets from their hotel to the waterfront in Gisborne, a small port town on the East Coast of New Zealand's North Island. They were going to look at the ship that would soon carry them to Britain:

The place looks simply beautiful. There was a perfect sunset and the ship looked lovely about a mile and a half offshore. . . . The ship was being loaded by a fleet of lighters, small craft which seem to be about the size of the Cobar, and it was quite fascinating watching the performance. She looks a super little ship and we're getting very excited wondering what our home for the next 4 or 5 weeks will really be like. [Departure is] only 8 hours away and we have all sorts of funny feelings. However having made up our minds for a long time it will be wonderful to be finally on our way with no more mucking around. It's an odd sort of feeling knowing that this time tomorrow we will be well on our way with New Zealand quite out of sight.<sup>1</sup>

The strong trade links between New Zealand and Britain provided thousands of New Zealand doctors with a regular and very cheap method of making the almost 20,000-kilometre journey to Britain. From the mid-1890s, refrigerated ships began to carry New Zealand meat and butter to the country's main market in Britain. During World War Two alone, these 'home ships' carried approximately 2 million tons of New Zealand meat, 1.3 million tons of butter and cheese, and 4 million bales of wool to Britain.<sup>2</sup> After World War Two, cargo ships also carried hundreds of New Zealand doctors to Britain. Although cargo ships were legally obliged to carry a doctor only if their total crew and passengers exceeded one hundred, the main shipping lines routinely employed doctors both to ensure crew

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<sup>1</sup> Dr Colin Fenton, unpublished letter, 23 November 1954. The 'Cobar' was a small ferry that operated between Wellington city and the settlements of Eastbourne and Days Bay during the 1950s. Dr Colin Fenton, personal communication.

<sup>2</sup> 'The Longest Lifeline - The Merchant Navy', URL: <http://www.nzhistory.net.nz/war/the-merchant-navy/the-longest-lifeline> (Ministry for Culture and Heritage), accessed 9 November 2012.

safety and ‘as a service to the medical profession’.<sup>3</sup> Writing just before the outbreak of World War Two, the Otago Medical School’s Professor of Systematic Medicine, D. W. Carmalt-Jones, claimed that ‘no New Zealand doctor ever pays for his passage either to England or back’.<sup>4</sup> This was not strictly true after 1945, when limited shipping and a growing demand for passage as ships’ doctors meant that some doctors did have to travel as paying passengers. However, the wool, meat and cheese ships continued to serve as the main means of transport for New Zealand medical migrants until the late 1960s, when commercial air travel began to take over.

Depending on the size of the ships, the passage to England usually took between four and eight weeks. For many doctors, shipboard life was a rare opportunity to carry out an intensive and uninterrupted period of study. For those who had graduated relatively recently, being in sole charge of medical services on a cargo ship also represented an opportunity to increase their ‘confidence index’ in preparation for specialised training. However, opportunities to carry out sophisticated procedures were limited by the convention that any seriously ill patients should be transferred to the nearest passenger vessel, where they could be cared for in better conditions.<sup>5</sup>

This is not to say that the trip was always boring. A number of interviewees offered some remarkable anecdotes about shipboard life. Perhaps the best of these came from the Hamilton general surgeon, Archie Badger. Leaving for Britain in 1946, Dr Badger sailed on a ship that was carrying a powerfully built Irish sailor who was being returned home to face court-martial. In the first few days of the voyage the sailor escaped from custody twice – once by tearing a metal bar to which he was handcuffed off the wall – and wreaked havoc on-board. After a third escape, the ship’s captain announced that he was going to shoot the

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<sup>3</sup> Sir David Hay, *Heart Sounds: A Life at the Forefront of Health Care* (Wellington: Steele Roberts, 2005), p. 63.

<sup>4</sup> D. W. Carmalt-Jones: *A Physician in Spite of Himself*, ed. by Brian Barraclough (London: Royal Society of Medicine Press, 2009), p. 188. This was not true for women doctors, who shipping companies rarely appointed as ship’s doctors before World War Two. The British Medical Association campaigned for changes to this policy from about 1937. Michael Belgrave, ‘“Medical Men” and “Lady Doctors”’: The Making of a New Zealand Medical Profession, 1857-1941’, PhD Thesis, Victoria University of Wellington, 1985, p. 123. However, the captain of the Fentons’ ship reassured Aileen that the crew was used to having women around as they ‘often had women doctors’. Dr Colin Fenton, unpublished letter, 26 November 1954.

<sup>5</sup> Hay, pp. 62-4.

sailor for putting the vessel and its crew in repeated danger. Dr Badger convinced the captain to spare the man, and after sedating him with surgical anaesthetic, made a fourth escape impossible by securing a length of chain to one handcuff, passing it out through one cabin porthole and back through another, before padlocking it to the second handcuff. The sailor remained in this position for the rest of the voyage.<sup>6</sup>

The conditions that doctors met on board these ships varied widely. Dr David Hay, who sailed for Britain on the MV *Norfolk* in April 1952, remembered that medical facilities were fit only for the most basic medical treatments. Dr Colin Fenton, on the other hand, remembered that the ‘dispensary’ on the MV *Port Victor* was equipped with a couch, a sink, a well-stocked cupboard of medical supplies, and a ward with four beds.<sup>7</sup> The Fentons were also delighted to discover that their cabin was ‘more like a stateroom than a cabin’, and that meals were regular, varied, and of high quality, with menu selections available for the three main meals. Shipboard entertainment included cards, table tennis, as well as deck tennis, golf, and outdoor films.<sup>8</sup> However, most cargo ships offered no such comforts, and some had no facilities for married men, let alone families. When Dr John Hiddlestone, later New Zealand’s Director-General of Health, secured a job as ship’s doctor on a Shaw Savill vessel in 1952, his wife and two young daughters were unable to accompany him, and he travelled alone instead on a Blue Star Line ship.<sup>9</sup>

Given that the four main shipping lines traditionally paid the doctors who worked their way to Britain in this way the sum of one shilling upon their arrival in Britain, it was fortunate that some doctors were met and aided by British relations.<sup>10</sup> Despite it becoming less common for New Zealanders to perceive Britain as ‘Home’ during the second half of the twentieth century, many New

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<sup>6</sup> Interview with Dr Archie Badger, 21 December 2006.

<sup>7</sup> Dr Colin Fenton, unpublished letter, 7 December 1954.

<sup>8</sup> Dr Colin Fenton, unpublished letter, 6 December 1954.

<sup>9</sup> John Hiddlestone, *By Stethoscope and Statute: Autobiography, Part I, 1925-1983* (Self-Published, 1993), p. 26.

<sup>10</sup> Some accounts suggest that the one shilling payment was a flat rate that covered the entire journey, while others remember that the shilling was a weekly payment, or even monthly. The difference is academic, however, as all accounts agree that the payments were never actually made, being absorbed as part of the ships’ ‘discharge fee’. See Donald Stafford Matthews, *Medicine My Passport* (London: George G. Harrap & Co, 1957), p. 85, Hay, p. 62, and Belgrave, “Medical Men” and “Lady Doctors”, p. 123.

Zealand families retained connections with British relatives. A number of New Zealand doctors remembered British relations standing at the docks to meet them, and then providing help with accommodation, transport, and social support. Colin and Aileen Fenton were met by Aileen's uncle, Dr Andrew Begg, when they arrived in London the day after Boxing Day, 1954. After driving them back to his home, where they stayed for the first few nights, Dr Begg then used his London contacts to help them find accommodation of their own.<sup>11</sup> The Beggs' country house at Bushey, north-east of London, subsequently became a 'home away from home (away from home)' for the Fentons.<sup>12</sup> When Dr Barbara Heslop and her husband Dr John Heslop arrived in London in the early 1950s, a sister of the secretary of the Otago Medical School's Pathology Department located a flat for them.<sup>13</sup>

Other new arrivals received aid from New Zealand friends and family who were already established and 'knew the ropes in the London scene'.<sup>14</sup> Dr David Hay arrived in England in 1952 to be met by his brother Hamish, while the Dunedin endocrinologist, Professor David Stewart, recalled that 'going back to England was [like] going back home' such were the number of friends and Otago classmates that he encountered in London.<sup>15</sup> In 1957, Peter and Gaye Rothwell were hosted by an Otago Medical School classmate for ten days while they searched for a place to stay.<sup>16</sup> Professor Graham Hill found short-term accommodation in Oxford through a New Zealand friend, and later inherited a house from a New Zealand doctor who had preceded him in a position at Leeds hospital.<sup>17</sup> During their first three days in London, the Fentons met with at least three sets of acquaintances, most of whom were friends of Dr Fenton's father, who had developed an extensive network of contacts in Britain during a long career in the New Zealand civil service.<sup>18</sup>

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<sup>11</sup> Dr Colin Fenton, unpublished letter, 27 December 1954.

<sup>12</sup> A year after arriving, Aileen Fenton wrote that she 'didn't know what we would have done without them'. Dr Colin Fenton, unpublished letter, 5 September 1955.

<sup>13</sup> Interview with Professor Barbara Heslop, 16 February 2011.

<sup>14</sup> John Adams, *John L. Adams M.D.: The Autobiography of a Physician: The Family, Life and Times of a New Zealand Consultant Physician* (Wellington: Steele Roberts, 2000), p. 100.

<sup>15</sup> Hay, p. 65, and Interview with Professor David Stewart, 2 February 2011.

<sup>16</sup> Interview with Dr Peter Rothwell, 28 August 2007.

<sup>17</sup> Interview with Professor Graham Hill, 16 February 2011.

<sup>18</sup> Dr Colin Fenton, unpublished letter, 5 September 1955.

Over time, the operation of informal support among New Zealanders meant that certain locations became ‘traditional’ bases for New Zealand doctors. The house at Number 4 in Endsleigh Gardens, opposite Euston Station in London, for example, housed generations of New Zealand doctors who were working in London hospitals.<sup>19</sup> Upon his arrival in Britain in the late 1940s, friends encouraged the Auckland otolaryngologist (later Sir) Patrick Eisdell Moore to live in London’s Earl’s Court, where numerous other New Zealanders and Australians already resided. Instead, he decided to move into a flat with a friend who was already in London doing post-graduate training himself.<sup>20</sup> When Dr Peter Rothwell travelled to Britain in mid-1957 with his wife Gaye, they were given rooms in North Ealing by a Polish landlord who thereafter made a point of renting his rooms to New Zealand doctors.<sup>21</sup>

New Zealand’s post-World War Two medical migrants also received various kinds of ‘official’ assistance. A very few secured scholarships before they left that provided varying levels of financial support. Among New Zealand doctors, the most prestigious of these was the Otago Medical School’s Travelling Scholarship, which usually went to the final-year student with the highest examination marks. When Professor David Stewart received the scholarship in 1956, it not only ‘topped up the wages’, but proved to be very useful when applying for jobs.<sup>22</sup> Indeed, the well-regarded Middlesex General Hospital in London actively pursued recipients of the Travelling Scholarship, with the result that Dr Stewart secured a one-year post there in chemical pathology after serving his two house officer years in New Zealand. Dr Stewart was further aided by the personal recommendation of Dr Jo Mercer, an Auckland pathologist who had worked at Middlesex some years before.<sup>23</sup>

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<sup>19</sup> Sir Francis Gordon Bell, *Surgeon’s Saga* (Wellington: A. H. & A. W. Reed, 1968), p. 79.

<sup>20</sup> Sir Patrick Eisdell Moore, *So Old, So Quick* (Auckland: David Ling, 2004), pp. 223, 228. Sir Patrick Eisdell Moore’s autobiography is almost completely bereft of references to dates. His arrival time is estimated from an associated reference to the illness of King George VI, who underwent surgery for an arterial blockage in his right leg in March, 1949.

<sup>21</sup> R.P.G. Rothwell, *Tihe Mauri Ora: The Ramblings of an Aging Respiratory Physician* (Hamilton: unpublished manuscript, 2007), unpaginated.

<sup>22</sup> Interview with Professor David Stewart, 2 February 2011. A list of all Travelling Scholarship recipients appears in Dorothy Page’s *Anatomy of a Medical School: A History of Medicine at the University of Otago, 1875-2000* (Dunedin: Otago University Press, 2008), p. 345.

<sup>23</sup> Interview with Professor David Stewart, 2 February 2011.

In 1947, the British Medical Association established the Empire Medical Advisory Bureau, an organisation that welcomed visiting colonial and dominion doctors to Britain, and helped them to find employment or enrol in courses that were appropriate to their needs. The Bureau linked migrants with British practitioners, organised accommodation, and helped them to negotiate Britain's highly bureaucratised post-war rationing systems.<sup>24</sup> The British Post-Graduate Federation also helped New Zealand doctors to find useful training opportunities.<sup>25</sup> William Goodenough House, established in 1930 to acknowledge the contribution of colonial forces during World War One, provided Commonwealth doctors with accommodation close to several major London hospitals, helped to organise private accommodation, assisted the spouses of trainee doctors to find employment, if desired, and facilitated social contact through sports teams.<sup>26</sup> Many Commonwealth doctors spent a short period of time living in a wing of the Royal Postgraduate Medical School at Hammersmith, although this was usually restricted to unmarried men only.<sup>27</sup>

### *The Objectives of New Zealand Migrants*

Writing in the early 1960s, the New Zealand surgeon, Dr Arthur Eisdell-Moore (father of Patrick, cited above) claimed that it was common for the young New Zealand medical graduate to believe that 'his general education and his outlook on life is deficient if he does not know something of England'.<sup>28</sup> Eisdell-Moore also suggested that most New Zealand surgeons felt it 'advisable to take a vacation every ten years or so to visit the bigger clinics of Britain or America' in order to maintain their standards.<sup>29</sup> While it is tempting to interpret such views as examples of the infamous New Zealand 'cultural cringe', which assumes that all things foreign must be better, several doctors have stressed that the value of travel

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<sup>24</sup> 'Empire Medical Advisory Bureau', *New Zealand Medical Journal*, volume 83, number 561 (14 April 1976), p. 280.

<sup>25</sup> Adams, p. 100.

<sup>26</sup> Adams, p. 99, and Interview with Professor Barbara Heslop, 16 February 2011.

<sup>27</sup> Matthews, p. 102

<sup>28</sup> Arthur Eisdell Moore, *Operation Lifetime: Memoirs of a New Zealand Surgeon* (Collins: Auckland, 1964), p. 128.

<sup>29</sup> Eisdell Moore, *Operation Lifetime*, p. 147.

derived mainly from the fact that clinical, cultural, and institutional practises were *different*, rather than necessarily *better*. In 1949, Dr Bernard Myers advocated for overseas work on the basis that working with ‘others of various views made us broader minded.’<sup>30</sup> Sixty years later, the Dunedin immunologist Dr James Faed remembered that the most valuable lessons he learned in Britain came from the need ‘to sever old links and forge new ones’, which gave him and his fellow migrants ‘resilience in their thinking and their practice.’<sup>31</sup> Dr John Conaglen also valued having to learn to ‘skin the cat in a different way’ in British hospitals during the late 1960s. However, for him, part of that value came from learning to appreciate the quality of New Zealand methods. In particular, Dr Conaglen felt that London’s specialist departments put far too much emphasis on ‘getting people through and out’, and not enough on ‘adding value’ to patient well-being. While he acknowledged that ‘people pressure’ left British doctors with little choice, he remembered that this sometimes compromised the standard of care. Giving an example, Dr Conaglen recalled that it was at the time routine for New Zealand doctors to ask male diabetics about erectile dysfunction, as studies showed that up to half were likely to have this symptom. Although treatment options were very limited, New Zealand doctors believed that it was helpful for patients to understand that this problem was often attributable to their disease, rather than to any psychological or relationship issues. In Britain, however, the absence of treatment options meant that most doctors considered asking the question to be a waste of valuable time.<sup>32</sup>

While these ‘cultural’ differences were a useful part of the overseas experience, New Zealand doctors generally travelled to Britain with two much more ‘practical’ objectives. One was to achieve technical mastery in their chosen specialty by practising – quite literally – on as many patients as they possibly could. The other was to secure formal post-graduate qualifications. Prior to the establishment of the Australasian College of Physicians in 1938, and indeed for many years after, Australian and New Zealand doctors who ‘wished to be regarded as physicians’ had to seek a post-graduate qualification, by examination,

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<sup>30</sup> Bernard Myers, *The Reminiscences of a Physician* (Wellington: A. H. & A. W. Reed, 1949) p. 27.

<sup>31</sup> Interview with Dr James Faed, 17 February 2011.

<sup>32</sup> Interview with Dr John Conaglen, 28 April 2011.

from one of the British Colleges.<sup>33</sup> Barbara Heslop recalled that by the 1960s, the basic MBChB degree qualified doctors to work ‘as a junior hospital medical officer . . . or as a general practitioner . . . but for very little else’, although it was ‘still just possible’ for older practitioners to work as hospital specialists without formal specialist qualifications.<sup>34</sup>

The qualification regimes of the various British Royal Colleges were highly confused. Even the qualifications of the two main English Colleges, the Royal College of Physicians and the Royal College of Surgeons, used different names for comparable levels of professional expertise. The Royal College of Physicians conferred a Licentiate as its most basic medical qualification, while the Royal College of Surgeons called its basic registerable qualification a Membership. For the Royal College of Physicians, Membership was an advanced post-graduate qualification that recognised higher learning and greater experience through examination. For the Royal College of Surgeons, this was called a Fellowship, and required candidates to pass a two part examination, the ‘Part One’ and the notoriously difficult ‘Final’. The English Royal College of Physicians also conferred Fellowships, but did so by peer election, rather than by examination.<sup>35</sup> In addition, the relative significance of these qualifications sometimes changed. In 1949, for example, the Royal College of Physicians announced that its Membership should no longer be viewed as a marker of specialist status, but instead showed that its bearer possessed medical knowledge of sufficient quality to *begin* training as a consultant. However, New Zealand doctors continued to regard the Membership as a suitable basic qualification for hospital practice,

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<sup>33</sup> Ronald Winton, *Why the Pomegranate: A History of the Royal Australasian College of Physicians* (Sydney, Royal Australasian College of Physicians, 1988), p. ix. The changing status of Australasian College qualifications is discussed in Chapter 7.

<sup>34</sup> Professor Barbara Heslop notes that the phenomenon of the ‘unqualified’ specialist persisted for longer in Australia, where the number of small isolated rural hospitals created a greater need for competent all-rounders. Barbara Heslop, ‘For Better or for Worse’, in *Women Doctors in New Zealand: An Historical Perspective, 1921-1986*, ed. by Margaret D. Maxwell (Auckland: IMS, 1990), p. 220.

<sup>35</sup> Rosemary Stevens, *Medical Practice in Modern England; The Impact of Specialisation and State Medicine* (London: Yale University Press, 1966), pp. 20-5. This discussion does not go into the complex system of conjoint qualifications and examinations that characterised the Irish and Scottish Colleges. For a summary of this as it stood in the 1970s, see Terence, J. Johnson and Marjorie Caygill, *Community in the Making: Aspects of Britain’s Role in the Development of Professional Development in the Commonwealth* (London: Institute of Commonwealth Studies, University of London, 1972), pp. 111-17.

probably because the higher elected Fellowship qualification continued to reflect peer esteem, which was not necessarily the same thing as clinical ability.<sup>36</sup>

Most New Zealand doctors therefore travelled to Britain in pursuit of one of the English post-graduate-level qualifications: the Fellowship of the Royal College of Surgeons of London or the Membership of the Royal College of Physicians of England. While many New Zealand doctors also sat the examinations of one of the Irish or Scottish Royal Colleges, these were generally regarded as ‘back up’ qualifications in case of failure to pass the English examinations.<sup>37</sup> Nonetheless, the value of such ‘back up’ qualifications was significant, as they allowed their bearers to practise as specialists in New Zealand. When Dr Colin Fenton passed the Fellowship examination of the Edinburgh Royal College of Surgeons in October 1957, he wrote that he was ‘still recovering from the surprise’. He also expressed relief, because obtaining this qualification meant that planning his return to New Zealand was no longer contingent upon later examination results.<sup>38</sup>

Doctors working in Britain were also able to obtain diplomas in particular specialties, usually from approved London specialist hospitals. These were the most basic post-graduate qualifications, and according to Sir Patrick Eisdell Moore, only qualified their holders to work in small country hospitals.<sup>39</sup> Like the Irish and Scottish College qualifications, however, diplomas were recognised markers of specialist credentials, and as such were useful for New Zealand doctors who aspired to work as specialists upon their return home. But in the short term, they were also useful in the search for jobs in well-regarded British units. In the highly informal post-graduate training structure of British medicine, getting a job in a good unit was the best preparation for higher examinations. A Diploma

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<sup>36</sup> See ‘Editorial: The London MRCP’, *New Zealand Medical Journal*, volume 49, number 268 (December 1949), pp. 531-2.

<sup>37</sup> See, Eisdell Moore, *So Old So Quick*, p. 221, and Adams, p. 98. Some New Zealand doctors continued to value the Edinburgh qualification in particular for sentimental reasons. Dr Neill Begg treasured his Edinburgh Membership because his father had been offered its Fellowship in 1916. Neil Begg, *The Intervening Years: A New Zealand Account of the Period between the 1910 Visit of Halley's Comet and its Reappearance in 1986* (Dunedin: John McIndoe, 1992), p. 77.

<sup>38</sup> Dr Colin Fenton, unpublished letter, 30 October 1957. Dr Fenton’s next letter still expressed pleasure: he was ‘walking on air’ and ‘thrilled right through’. Dr Colin Fenton, unpublished letters, 3 November 1957 and 15 December 1957.

<sup>39</sup> Eisdell Moore, *So Old, So Quick*, p. 221.

qualification therefore represented a valuable first step towards getting a good job and securing more prestigious Membership and Fellowship qualifications.<sup>40</sup>

Obtaining formal qualifications and getting practical experience were therefore closely linked objectives. But for New Zealand doctors, the value of these two related objectives was subtly different. There was no doubt that post-graduate qualifications were critical to career development and employment prospects. New Zealand hospitals had traditionally placed a great emphasis on British qualifications, and after the establishment of a specialist register in New Zealand in 1968, necessitated by the introduction of public subsidies for specialist care, recognised qualifications became a formal prerequisite of specialist practice.<sup>41</sup> Although the Australasian Colleges of Physicians and Surgeons had offered post-graduate examinations from 1938 and 1949 respectively, these did not gain prestige comparable to their British equivalents until well into the 1970s.<sup>42</sup> However, the testimonies of New Zealand doctors suggest that New Zealand hospital administrators placed undue emphasis on formal post-graduate qualifications, compared to actual clinical experience. Dr Donald Matthews described post-graduate qualifications in general as ‘laudable but often overrated’, particularly in the area of surgery, where candidates could, and often did, pass the required examinations without ever having carried out any of the surgical procedures upon which they were questioned.<sup>43</sup> Only weeks after passing his Royal College of Physicians Membership examination in 1953, Dr David Hay received a telegram from Christchurch hospital offering him a position as a senior resident. Hay thought that the offer demonstrated the ‘ill-placed emphasis on examination results rather than proper training in those days’, and declined due to his lack of practical experience.<sup>44</sup> After passing part one of the Royal College of

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<sup>40</sup> Dr Fenton’s letters describe this relationship between qualifications and experience well. After passing his diploma examination in July 1956, he wrote that ‘[t]he two things to do now are to get some surgical experience and to get the FRCS.’ After securing a job at Westminster hospital in London, he wrote that the position ‘should provide the necessary experience to attempt the English Fellowship’. Dr Colin Fenton, unpublished letters, 8 August 1956 and 30 October 1957.

<sup>41</sup> ‘Register of Specialists’, *New Zealand Medical Journal*, volume 71, number 455 (April 1970), p. 233.

<sup>42</sup> See J. H. Heslop, ‘The History of Basic Surgical Science Examinations in the Royal Australasian College of Surgeons’, *Australian and New Zealand Journal of Surgery*, volume 58, number 7 (July 1988), pp. 529-36

<sup>42</sup> Winton, p. ix.

<sup>43</sup> Matthews, p. 105.

<sup>44</sup> Hay, p. 78.

Surgeons' Fellowship examination in 1955, Dr Fenton wrote that he was 'rather humbled by the thought that I have my Fellowship and that there is still so much more to be learnt before I can even begin to understand this subject.'<sup>45</sup> Twenty months of intensive surgery later, Dr Fenton reflected upon 'how foolish I would have been to come home straight after I got my Fellowship. So many things which are just routine to me now, then were quite foreign, and I couldn't imagine myself ever coming to grips with them.'<sup>46</sup> If obtaining formal qualifications was important for career progression, getting hands-on practical experience was critical for gaining clinical competence and professional self-confidence.

Yet the ways in which New Zealand – and indeed British – doctors obtained practical experience were far less structured than post-graduate qualification requirements. Whereas most Colleges specified that candidates should be of a minimum age, or have spent a minimum amount of time in training before sitting their examinations, the content and location of that training was not prescribed.<sup>47</sup> New Zealand trainees formed after-hours study groups, organised access to libraries and specimen collections, and attended informal courses run in the living rooms of British experts such as Dr Maurice Pappworth, an establishment outcast who was also a brilliant teacher of postgraduate medicine.<sup>48</sup> Most importantly, they applied for jobs in good British units, and set about learning directly from leading British practitioners. As the Wellington gastroenterologist, Dr Warren Austad, remembered, 'you just had to keep your eyes and ears open and go back to the books at night.'<sup>49</sup>

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<sup>45</sup> Dr Colin Fenton, unpublished letter, 30 October 1957.

<sup>46</sup> Dr Colin Fenton, unpublished letter, 2 June 1959.

<sup>47</sup> Some 'programmes' were established in the 1960s, but these were usually organised informally between senior figures at associated hospitals. However, positions in these highly desirable programmes were usually reserved for British graduates. David Smith, *Overseas Doctors in the National Health Service* (London: Policy Studies Institute, 1980), pp. 153-4.

<sup>48</sup> Dr M. H. Pappworth was unpopular with the College of Physicians after writing a book entitled *Guinea Pigs: Experimentation on Man*, which criticised the research methods of several prominent Hammersmith doctors. See Hay, p. 71. Patrick Eisdell Moore recalled utilising the teaching resources of many London hospitals, and examining the holdings of various pathology museums. Eisdell Moore, *So Old So Quick*, p. 236. Soon after arriving in London with her husband, Barbara Heslop recognised that there were no such courses for pathologists. She filled this gap by teaching pathology to friends who were also studying for the FRCS examination. Interview with Professor Barbara Heslop, 16 February 2011.

<sup>49</sup> Interview with Dr Warren Austad, 17 March 2011. Dr Austad spent five years in Britain from 1960, working at the Central Middlesex and Hammersmith Hospitals, the Mayday Hospital, the Croydon Chest Clinic, and the Bristol Royal Infirmary, before spending 1965 and 1966 as a Clinical and Research Fellow at the Duke University Medical Centre in North Carolina.

### *The Distribution of New Zealand Specialists in Britain*

For New Zealand physicians in particular, the Royal Post-Graduate Medical School at Hammersmith hospital in London represented a vital point of entry into British medicine. Because it was possible to enrol in the School's three-month 'refresher' course from New Zealand, the School served as a default first destination for many New Zealand graduates.<sup>50</sup> Indeed, the School served this role for doctors from across the Commonwealth: between 1935 and 1965, it hosted 6,456 Commonwealth doctors, 3,639 'foreign' doctors (meaning from outside the Commonwealth), and 2,811 doctors from within the United Kingdom.<sup>51</sup>

The course itself was a useful introduction to the particular requirements of British medicine, and of British examinations. But of greater value to New Zealand doctors were the opportunities to meet and form relationships with the hospital's teaching consultants, many of whom had appointments in other London hospitals, and who were therefore in a position to find jobs for particularly able graduates. Dr Warren Austad remembered that getting jobs in London 'was easier from the inside than the outside' during the 1960s, particularly in emerging specialties which, like his own area of gastroenterology, had yet to develop extensive interpersonal and institutional networks.<sup>52</sup> Other doctors went to Hammersmith without any clear preference for a particular specialty, but soon formed one after working with consultants who they admired, or who were able to facilitate entry into attractive training positions. The Hamilton renal physician, Dr Martin Wallace, only entered renal medicine after securing a job in the renal unit of Hammersmith Hospital. This in turn came about because the head of the unit had previously employed a New Zealand registrar, and wanted another to replace him.<sup>53</sup> The Dunedin cardiologist, Dame Norma Restieaux, by contrast, had already chosen her specialty of choice before enrolling at Hammersmith, and was able to secure a position at the prestigious National Heart hospital in London

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<sup>50</sup> Some sources give different lengths for the Hammersmith course; Dr David Hay, for example, wrote that it was six months long. However, most sources indicate that the course was three months in duration. See Hay, p. 71.

<sup>51</sup> W. H. Morris-Jones and T. J. Jones, 'A Commonwealth of Learning: A Common Professional Culture', *The Round Table*, volume 60, number 240 (November 1970), pp. 391-2.

<sup>52</sup> Interview with Dr Warren Austad, 17 March 2011. Dr Peter Rothwell also characterised the Hammersmith course as 'a foothold for employment in London.' Rothwell, *Tihei Mauri Ora*, unpaginated.

<sup>53</sup> Interview with Dr Martin Wallace, 2 October 2010.

through contacts made during the course.<sup>54</sup> While the Royal College of Surgeons also ran a pre-examination course for surgeons at Lincoln Inn Fields in London, this seems to have played a much less significant role in the careers of New Zealand attendees.

After completing the Hammersmith course, New Zealand graduates invariably began the process of applying for jobs in other hospitals. Here, a significant difference existed between the aspirations of New Zealand migrants and those of the local graduates. For British graduates, the ultimate professional achievement was securing a house officer or registrar job in one of London's iconic teaching hospitals. Gaining employment in an institution such as Guy's, St Thomas' or St Bartholomew's provided the best possible foundation for building a career, in terms of professional esteem and a successful private practice. Writing in 1968, the New Zealand surgeon and medical statesman, Sir Douglas Robb, claimed that an appointment to the staff of a large teaching hospital was 'what every [British graduate] has worked for since he entered medical school. It promises him recognition and status and increased experience, and valued professional contacts with colleagues of all grades.'<sup>55</sup> Perhaps as a sign of their own superiority, these hospitals typically appointed their junior doctors from within the ranks of their own graduates.

However, for New Zealand graduates seeking intensive, hands-on experience, the value of such posts was limited. One reason for this was that the strong undergraduate focus of the teaching hospitals left little time for post-graduate teaching.<sup>56</sup> In addition, as general hospitals, their specialist services were invariably less well developed than those provided by London's dedicated specialist hospitals. Further, at least some of the post-graduate training posts in the major teaching hospitals were unpaid. Dr Arthur Eisdell Moore suggested that this policy was based on the assumption that the sort of doctors that London's premiere hospitals wished to employ would have the financial means to work voluntarily. Unpaid work as a junior doctor was perhaps also viewed as an appropriate service to an institution that would later facilitate significant private

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<sup>54</sup> Interview with Dame Norma Restieaux, 18 February 2011.

<sup>55</sup> Douglas Robb, *Medical Odyssey: An Autobiography* (Auckland: Collins, 1968), p. 51.

<sup>56</sup> A. Paton, 'The Place of the Regional Hospital in Postgraduate Education: The Provinces', *British Post-graduate Medical Journal*, volume 38, number 442 (August 1962), pp. 439-42.

wealth.<sup>57</sup> Regardless of the reasons, few New Zealand graduates could afford to work without pay.<sup>58</sup> When Patrick Eisdell Moore bucked convention by declining an offer made by one of his Royal College examiners to organise a junior position at a prestigious London teaching hospital, it took some time for the consultant ‘to see the sense of it from a New Zealander’s point of view.’<sup>59</sup>

For New Zealand doctors who sought to gain experience, rather than to establish a career, the ultimate goal was to get an appointment in one of Britain’s preeminent specialist institutions. The Great Ormond Street Hospital for Sick Children, the Brompton Hospital for Consumption and Diseases of the Chest, Moorfields Ophthalmic Hospital, the National Hospital for the Paralysed and Epileptic, Queen’s Square, and a number of others not only conferred considerable professional prestige, but also provided the necessary volume and range of clinical experience.<sup>60</sup> London’s unrivalled population and the related concentration of wealth meant that the vast majority of these institutions were located in that city. Indeed, an analysis of references to British hospitals in the obituary database shows that nineteen of the twenty most-cited hospitals were in London, with only the Rotunda Hospital in Dublin (in eleventh place) breaking the monopoly. Overall, more than half of all specific references to overseas hospitals made in New Zealand medical obituaries after 1939 are to institutions in London.<sup>61</sup>

Dr Colin Fenton’s letters describe in detail both the process of obtaining a job in a London specialist hospital and the advantages that came with success. When Dr Fenton arrived in Britain in the mid 1950s, London had six specialist eye hospitals, and all of the major general hospitals had departments of ophthalmology. However, he described Moorfields hospital and the associated Westminster hospital as ‘streets ahead’ of the rest, noting that ‘there is no comparison at all with the amount of eye surgery one gets at Moorfields and at

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<sup>57</sup> Eisdell Moore, *Operation Lifetime*, p. 73.

<sup>58</sup> Johnson and Caygill, *Community in the Making*, p. 36.

<sup>59</sup> Eisdell Moore, *So Old, So Quick*, pp. 249. Dr John Adams also declined a post at St Bartholomew’s hospital in London because his primary focus was to pass his examination and returning to his wife in New Zealand. Adams, p. 100.

<sup>60</sup> Sarah (Sally) Wilde, ‘Practising Surgery: A History of Surgical Training in Australia, 1927-1974’, PhD Thesis, University of Melbourne, 2003, p. 253.

<sup>61</sup> 237 out of 453 references (52.3%) were to London hospitals.

any other place.’<sup>62</sup> Dr Fenton estimated that in the eighteen months to two years that most appointments lasted, a junior surgeon on Moorfields’ staff could expect to perform as much surgery as a New Zealand private practitioner could do in ten or even twenty years.<sup>63</sup>

Positions at Moorfields, therefore, were highly sought after. But during his first six months in Britain, Dr Fenton had managed to find only a series of short-term locum (relieving) jobs for London general practitioners. In desperation, he arranged a visit with the Dean of the Institute of Ophthalmology ‘to see if the immediate future for eye specialists was really as dim as I imagined’:

It is that, and more so. To get on the staff at Moorfields, which is the eye hospital, is well-nigh impossible unless one has enough money here to hang around the place for eighteen months or so, picking up a clinic or two here and there when someone is big enough to give something out.<sup>64</sup>

The following month, however, Dr Fenton passed the Primary Fellowship examination of the English Royal College of Surgeons, which then enabled him to obtain a locum appointment at the outpatients’ clinic at Moorfields. His description of the hospital’s workload clearly illustrates the value of such positions to trainee specialists.

The outpatients clinic here is quite fantastic; each morning there are four ‘teams’ each of six doctors working flat out from 9:30am to 12:30 or 1:00, and wherever you go there is just a sea of faces. As fast as you put patients through and clear a few seats, their places are taken from

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<sup>62</sup> Mainly, this was because the work conducted at Moorfields was almost purely surgical, with the other eye hospitals taking most of the medical ophthalmology cases. Dr Colin Fenton, unpublished letter, 3 February 1957. In order to avoid the distracting overuse of square brackets in the extensive quotations that follow, I have avoided converting Dr Fenton’s contemporary descriptions into the past tense.

<sup>63</sup> Dr Colin Fenton, unpublished letter, 16 July 1955.

<sup>64</sup> Dr Colin Fenton, unpublished letter, 24 September 1955. (This letter was almost certainly misdated, however, as Dr Fenton writes of being able to do nothing until the Primary exam is passed. Dr Fenton passed his Primary examination in June 1955. Also, the address section of the air-form letter was stamped May 1955.)

this limitless reservoir and its environs. It seems to me that every morning every other person in London must come to Moorfields.<sup>65</sup>

After this position ended, Dr Fenton secured another locum position, working as a house surgeon in Moorfields' casualty clinic. In October 1955, Dr Fenton wrote that during one three-and-a-half hour session, he personally saw ninety-six patients, at an average consultation time of just over two minutes each. He observed that working in such conditions for two years made the hospital's registrars 'capable of dealing with any eye condition at all.'<sup>66</sup> While Dr Fenton's locum jobs provided him with invaluable experience, a full-time appointment remained the goal. He knew, however, that achieving this would probably require three or four more years of 'hammering away' in London. This in turn would mean that the Fentons would have to start their family away from family support, which would preclude Aileen from continuing to augment their meagre income.<sup>67</sup>

By July 1957, Colin Fenton was beginning to wonder whether a full time Moorfields job would ever appear. A colleague who had an appointment at the Western Ophthalmic Hospital had offered him a position there that paid half as much again as a house officer job at Moorfields, but which would have provided only a fraction of the surgical experience.<sup>68</sup> Dr Fenton's letters make it clear that the decision was very difficult. He had learnt that doctors who accepted jobs outside of London were rarely able to get back in, and he was concerned that this might also apply to 'lesser' hospitals within London.<sup>69</sup> But as the father of a two month old boy, economic factors were less easy to put aside. The upcoming examination for the Fellowship of the Edinburgh Royal College of Surgeons therefore assumed significant importance, as passing would enhance Dr Fenton's chances of securing his preferred position. In October 1957, Dr Fenton passed the examination, describing himself as 'walking on air' and 'thrilled right through'.<sup>70</sup> Two months later, Dr Fenton won a two year appointment to Moorfields Eye

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<sup>65</sup> Dr Colin Fenton, unpublished letter, 4 September 1955.

<sup>66</sup> Dr Colin Fenton, unpublished letter, 9 October 1955.

<sup>67</sup> Dr Colin Fenton, unpublished letter, 16 July 1955.

<sup>68</sup> Dr Colin Fenton, unpublished letter, 14 July 1957.

<sup>69</sup> Dr Colin Fenton, unpublished letter, 16 July 1955.

<sup>70</sup> Dr Colin Fenton, unpublished letter, 3 November 1957.

Hospital.<sup>71</sup> For the first six months, he worked in the casualty department, seeing seventy to eighty patients each morning. After that, Dr Fenton worked on the hospital's wards, having responsibility for about thirty cases at any one time. By the end of his appointment, Dr Fenton was relishing his work as a senior registrar.<sup>72</sup>

I've been getting quite a lot of surgery recently, most of it to do on my own, and I reckon now that I could tackle almost anything that came along – not that I am being overconfident – but a job like this with two years concentrated surgery gives one an opportunity of becoming familiar with most of the procedures and of working out one's own technique.<sup>73</sup>

As intimated earlier, Hammersmith hospital's unique status in British post-graduate training made it the most frequently cited hospital on the obituary database. Given the value of experiences such as those described in Dr Colin Fenton's letters, it is unsurprising to find specialty London hospitals filling seven of the next eight places on the list, followed as a group by London's general teaching hospitals, which comprised eight of the next nine most frequently cited institutions (see Table 4, next page). However, the temptation to mention only the most well regarded institutions in obituaries might mean that these citation rates reflect the respective institutions' prestige as much as actual attendance. This seems to be borne out by the fact that the obituary database includes very few specific references to Britain's regional hospitals, despite anecdotal and spoken evidence that these were significant venues for post-graduate training among New Zealand doctors.

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<sup>71</sup> Dr Fenton noted that the work conditions were very good for full-time staff, with morning cups of tea provided, street shoes cleaned by porters while in surgery, excellent meals, and welcome access to a shower. Dr Colin Fenton, unpublished letter, 9 October 1955.

<sup>72</sup> Dr Colin Fenton, unpublished letter, 26 October 1959.

<sup>73</sup> Dr Colin Fenton, unpublished letter, 8 November 1959. About half of the surgical procedures conducted by Dr Fenton involved him assisting his seniors, while he acted as lead surgeon for the other half, often with his seniors assisting. Dr Colin Fenton, unpublished letter, 18 January 1959.

*Table 4:*  
*Rates of Citation of Overseas Hospitals in the Obituaries of New Zealand-born Doctors*

<i>Hospital Cited</i>	<i>Number of References</i>
Hammersmith (General)	16
Great Ormond Street (Children)	16
Guy's (General)	10
Moorfields (Eyes)	9
Brompton (Respiratory)	8
Royal Marsden (Cancer)	8
Queen's Square (Neurology)	7
Royal Ear, Nose and Throat	7
Royal Orthopaedic	6
St Thomas' (General)	5
Middlesex (General)	4
Rotunda (Dublin, Maternity)	4
Charing Cross (General)	4
London Hospital (General)	4
St Mark's (Intestinal / Renal)	4
St Bartholomew's (General)	4
Central Middlesex (General)	4
Royal Sussex (General)	3
Queen Mary's (Orthopaedic)	3
National Heart (Cardio)	3
Royal Northern (General)	2

Source: Medical Obituary Database (see Chapter 1, pp. 56-60)

In part, this was a consequence of the intense competition for places in London's specialty hospitals. But it also reflected the particular needs of New Zealand post-graduate trainees. London's specialised hospitals had large staffs with clear hierarchical structures. For physicians (those in non-surgical specialties), this was not a serious problem, as it was possible to learn by

observing the work of senior practitioners.<sup>74</sup> For surgeons, however, hands-on experience was vital. Sally Wilde's research argues that the need to develop 'touch' or 'feel' was a prime motivator for Australian surgeons who struggled to gain the necessary experience in their home hospitals.<sup>75</sup> In London's specialist hospitals, the combination of staff size and staff hierarchy sometimes limited the range of experiences that could be obtained. Surgical 'lists' were typically arranged in order of difficulty, with consultants performing the hardest procedures first. As operations became more routine, responsibility would be handed over to the senior registrars, who would in turn hand the easiest 'rats and mice' procedures to their juniors at the end of the operating session.<sup>76</sup> Typically, doctors who succeeded in gaining appointments in such institutions did so at a very junior level, with some having to repeat their house officer years before securing more senior positions.<sup>77</sup> In some cases, years could pass before any significant experience with the more complex procedures could be gained. Patrick Eisdell Moore estimated that a junior surgeon working in a provincial hospital could experience as much as ten times more surgery than could be expected in a London specialist hospital in the same amount of time.<sup>78</sup> While the standard of tuition was sometimes not as high, having an opportunity to carry significant clinical responsibility in busy units in Liverpool, Manchester, Edinburgh, and other 'regional' British centres was perfect preparation for doctors aspiring to work in New Zealand's small specialised departments.<sup>79</sup>

Inevitably, inconsistencies in the standard of training available in British hospitals arose from the varying skill and enthusiasm of consultants, the size and resourcing of the institutions, the socio-economic characteristics of surrounding

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<sup>74</sup> Interview with Dr Peter Rothwell, 28 August 2007.

<sup>75</sup> Wilde also argues that Australian surgeons, trained in the empiricist British tradition, tended to be sceptical of new discoveries, and had to witness them to be convinced. Wilde, 'Practising Surgery', p. 177.

<sup>76</sup> Eisdell Moore, *So Old, So Quick*, p. 248.

<sup>77</sup> While the Medical Act of 1950 had officially designated the first year out of medical school as a training year, growing pressure on Britain's health services quickly subsumed the educational focus of junior posts. The work of house officers and junior registrars quickly returned to being heavily service oriented, with only senior registrar posts remaining training oriented. John Lister, *Postgraduate Medical Education* (London: Nuffield Provincial Hospitals Trust, 1993), p. 11.

<sup>78</sup> Eisdell Moore, *So Old, So Quick*, p. 248. John Hiddlestone's biography made similar claims, see Hiddlestone, pp. 19-20.

<sup>79</sup> See Johnson and Caygill, *Community in the Making*, pp. 37-40 for a discussion of the role of regional hospitals in the careers of medical migrants in Britain. For biographical references to the London job-finding scene, see Gordon Bell, *Surgeon's Sag*, p. 144, and Barraclough, p. 75.

areas, and the particular research emphases or treatment styles of the various units.<sup>80</sup> Dr David Hay described his British post-graduate experience as ‘hit and miss’, because there was no way of knowing what kind of training would actually be obtained in a given role until after he had started working in it.<sup>81</sup> Most New Zealand trainees therefore rotated through a number of jobs during their time in Britain, in an attempt to obtain the widest possible range of experiences within their chosen specialties.<sup>82</sup> Other doctors relocated in response to financial pressure, or because they had struggled to find a job in their desired geographical location. For some, such geographical moves also meant a change in specialty. Several interviewees recalled that their ‘choice’ of specialty was less a reflection of their preferences than it was of the appearance of an attractive job opportunity. Dr Peter Rothwell applied unsuccessfully for a house officer position under the London cardiologist, Dr Paul Wood, before securing his future direction as a respiratory physician through registrarships at London’s Brompton hospital and Sully hospital in Wales.<sup>83</sup> Dr Wyn Beasley applied for a general surgery position at St Margaret’s Hospital in Epping because he needed at least three months in a general surgery job to become eligible for the final Royal College of Surgeons examination. Although he did not get the job, he impressed his interviewers and was offered an orthopaedic registrar job instead. After negotiating a three month general surgery ‘run’ to meet his immediate examination requirements, Dr Beasley accepted the position, and practised orthopaedic surgery for the rest of his career.<sup>84</sup>

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<sup>80</sup> As an example, Dr John Conaglen remembered that the number of cases of Cushing’s Disease encountered at London’s St Bartholomew’s hospital was approximately ten times greater than those that he saw at St Thomas’. Interview with Dr John Conaglen, 28 April 2011.

<sup>81</sup> Hay, p. 61. The Hamilton anaesthetist, Professor Jamie Sleigh, described British specialist training as ‘haphazard’, but he also stressed that exposing doctors to a broad range of approaches was not necessarily a weakness, and was in some ways preferable to contemporary ‘task oriented’ training approaches. Professor Jamie Sleigh, personal communication, March 2010. The Wellington orthopaedic surgeon, Dr Wyn Beasley, concurred with this when he suggested that more formalised training programmes ran the risk of ‘cloning surgeons, rather than training them.’ Interview with Dr Wyn Beasley, 17 March 2011.

<sup>82</sup> Lister, pp. 20-4.

<sup>83</sup> Rothwell, unpaginated. A study of two cohorts of New Zealand doctors found that only a very few – four per cent of women doctors and twelve per cent of men – chose their specialties before graduation. See Gillian Durham, Clare Salmond and Julie Eberly, *Women and Men in Medicine: The Career Experiences* (Wellington: Health Services Research and Development Unit, Department of Health for Health Workforce Development Fund, 1989), p. 60.

<sup>84</sup> Interview with Dr Wyn Beasley, 17 March 2011.

*'Work Hard, Train Hard, Learn Hard, or Go Under': The Challenges of Life in Britain*

Living in 'the centre of the civilised world' had its advantages.<sup>85</sup> New Zealand doctors wrote and spoke positively about the cultural opportunities that life in Britain provided, including visiting galleries and theatres, seeing films, and for some, travelling to the Continent. But pursuing post-graduate training in post-World War Two Britain was not always an easy life. For several years after World War Two, on-going food rationing and poor quality produce provided a stark contrast with conditions in New Zealand.<sup>86</sup> Pay was poor in many British hospitals, living expenses were high, and the pressures of work and study often left little time for social activities. Multiple movements made for an unsettled existence, and, as Dr Fenton's example shows, career decisions had implications for all family members. Competition for jobs was fierce, and the extreme difficulty of post-graduate examinations required New Zealand doctors to study hard, and to grow accustomed to failure. During the early, difficult part of his stay in England, Dr Fenton wrote that 'if this trip teaches us nothing other than to appreciate what we have in New Zealand and the comparative comfort in which we live . . . that alone would make it quite worthwhile.'<sup>87</sup>

References to the British weather are a cliché, but for doctors from temperate New Zealand, the climate often presented a major challenge. Dr Frances Gordon Bell described Scotland's weather as 'probably the greatest deprivation to all of us students from down-under.'<sup>88</sup> When the Fentons arrived in England in the middle of winter, they were pleasantly surprised to find the weather less severe than expected. They were also amused to find a story about the appearance of discernible shadows at the feet of Buckingham Palace's guards on the front page of the *Times*. Subsequent experiences dimmed their humour, and by the middle of their sixth London winter, Dr Fenton admitted to 'hating this place', primarily because of the weather-imposed oppression that they

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<sup>85</sup> See Chapter 4, footnote 87.

<sup>86</sup> Eisdell Moore, *So Old, So Quick*, pp. 225, 230, 241.

<sup>87</sup> Dr Colin Fenton, unpublished letter, 24 September 1955. (This letter was almost certainly misdated, as it speaks of being able to do nothing until the Primary exam is passed. Dr Fenton passed his Primary examination in June 1955. Also, the address section of the airform letter is stamped May 1955.)

<sup>88</sup> Gordon Bell, *Surgeon's Saga*, p. 45.

experienced for four months of the year. This was even more challenging after the appearance of two energetic children.<sup>89</sup> Patrick Eisdell Moore's autobiography includes several references to the oppressive nature of British winters, and particularly to the fog that made entering the streets a serious hazard.<sup>90</sup> The biography of the Auckland heart surgeon, Sir Brian Barratt-Boyes, also mentions the London fog, not on the streets, but appearing in his upper floor bedroom on particularly cold days.<sup>91</sup> The weather was one of Dr Peter Rothwell's abiding memories of his time in Britain:

London winters go on forever. It's bleak and it's cold and you switch the lights on at 3:00pm and everything's freezing. We spent most of the time stopping up draughts under doors and in rusted metal louvers that had rusted shut, so I put paper over them. I'd come home on a cold day and find Gaye in her overcoat, boots, hat on, and all four gas jets going to warm the room up so she could peel the spuds. And the same with the bath. I could see why Brits said they had a bath once a week whether they needed it or not because it was so damn cold getting to the bathroom. And you had that [gas-fuelled] califont thing which could as easily blow up as heat the water. You know, you'd put it off. They were pretty basic flats we were in. On the other hand, the positive thing was that it was a wonderful life. The art galleries were free - and heated.<sup>92</sup>

Yet the most serious challenge for New Zealand doctors and their families living in Britain was isolation, from their New Zealand families, from British people, and often from each other. Dr Neil Begg described Londoners as 'reserved', and Dr Peter Rothwell remembered that 'a more impersonal place you could not imagine'.<sup>93</sup> The mobility of New Zealand doctors exacerbated this problem by making it difficult to establish social networks. During the first ten years of their marriage, including the six years spent in Britain, the Fentons had 'been able to plan [their] future for no more than twelve months in advance, and .

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<sup>89</sup> Dr Colin Fenton, unpublished letter, 21 February 1960.

<sup>90</sup> Eisdell Moore, *So Old, So Quick*, pp. 225, 230, 241.

<sup>91</sup> Chisholm, p. 60.

<sup>92</sup> Interview with Dr Peter Rothwell, 28 August 2007.

<sup>93</sup> Begg, p. 81, and Interview with Dr Peter Rothwell, 28 August 2007.

. . . had only the vaguest idea of [their] activities even of the immediate future.’<sup>94</sup> When the Fentons moved into a furnished London flat in November 1956, they calculated that it was their thirteenth major shift in just over three years of marriage.<sup>95</sup>

Most New Zealand medical migrants were young, and almost half of them arrived in Britain single.<sup>96</sup> For those who travelled alone, loneliness could be a serious problem. While working at the Peterborough hospital in 1953, the Hamilton obstetrician, Dr Bob Gudex, recalled hosting a dinner, along with his wife, for a young New Zealand doctor who they had recently befriended. Half way through the meal, their guest broke down in tears and told them that he could not endure the loneliness any longer.<sup>97</sup> When Dr Patrick Eisdell Moore travelled to Britain for the first time, he could not afford to take his wife and newly born son with him, and they remained with parents in New Zealand. His sense of isolation was such that he returned home before sitting the second part of his Royal College of Surgeons examination. Resolving later to return to Britain, he refused to leave his family a second time, despite the concerns of family members about the lack of support for his wife. Dr Eisdell Moore knew, however, that the second trip would probably be longer, because the notoriously difficult Final examination usually required at least two attempts, and examinations were held only twice each year. He was unwilling to endure a second long separation.<sup>98</sup> Dr Donald Matthews was unable to be with his father when he died, and also missed his funeral because it was impossible to travel from Britain to New Zealand quickly enough to attend. ‘It was the price I had to pay for having to leave my family to go overseas to do postgraduate degrees.’<sup>99</sup>

Working conditions for junior doctors in British hospitals also contributed to personal isolation. House officer and registrar positions were called ‘resident’ jobs because doctors were expected to live on site for a number of nights each

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<sup>94</sup> Dr Colin Fenton, unpublished letter, 16 March 1958.

<sup>95</sup> Dr Colin Fenton, unpublished letter, 14 November 1956.

<sup>96</sup> David Smith’s survey of overseas doctors working in Britain’s National Health Service found that almost half arrived in Britain between the ages of twenty-five and thirty, about eighty-four per cent were under forty. See Smith, p. 31, and table IV.3, pp. 33, and Gish, ‘Overseas-Born Doctor Migration, 1962-66’, p. 95.

<sup>97</sup> Interview with Dr Bob Gudex, 15 November 2006.

<sup>98</sup> Eisdell Moore, *So Old, So Quick*, p. 221-2.

<sup>99</sup> Matthews, p. 104.

week in order to provide twenty-four hour medical cover. This seemed to be particularly challenging for doctors with families. Dr Peter Rothwell recalled that:

I hardly ever saw Gaye. That month I was at Middlesex I could hardly get away from the place. I had to live in there, we didn't have a phone, and she was working at Ealing or somewhere. I had no way of talking to her . . . and we were isolated for days at a time. I couldn't even get a message across, we were stuck in two different places.<sup>100</sup>

Dr Fenton's full-time position at Moorfields was invaluable professionally, but made normal married life impossible. After an initial six-month period in the casualty department, during which time he was able to live at home, Dr Fenton transferred into a resident's role that initially required him to live in the hospital for two nights each week, and every third weekend. Over the next eighteen months, the number of nights spent on campus increased. As the father of a growing family, Dr Fenton lamented the few opportunities that his work situation allowed for family time.<sup>101</sup> On the rare occasions when he was left in sole charge of his children, he invariably commented on the pleasure of 'getting to know them'.<sup>102</sup>

Communication technologies were unable to bridge the 20,000 kilometres that separated Britain from New Zealand. The existence of Dr Fenton's collection of weekly letters is itself a testament both to the importance of family and to the challenges of staying in touch with them. During six years in Britain, the Fentons were able to organise only a single telephone call back to New Zealand. At that time, long distance international phone calls were transmitted via radio, which was rendered ineffective by bad weather anywhere along the call's route. It took several letters and a cable, over the span of two months, to successfully coordinate both the participants and the global weather system. When the connection was finally made, the 'conversation' was conducted as a series of one-way monologues, with each party speaking for a short time before the channel was switched, allowing the other person to reply.<sup>103</sup> Communication by post was much

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<sup>100</sup> Interview with Dr Peter Rothwell, 28 August 2007.

<sup>101</sup> Dr Colin Fenton, unpublished letter, 27 October 1957.

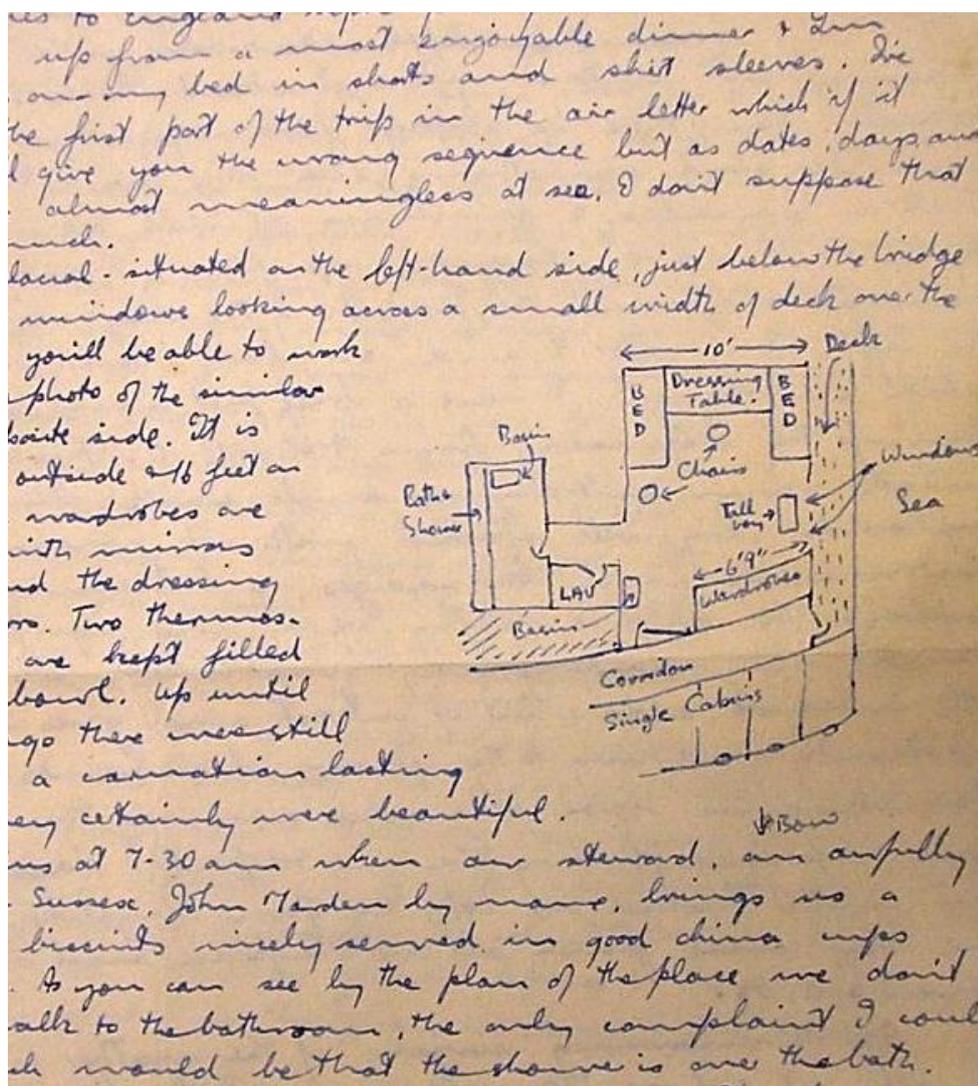
<sup>102</sup> Dr Colin Fenton, unpublished letter, 17 November 1959.

<sup>103</sup> Dr Colin Fenton, unpublished letter, 2 June 1957.



Figure 3:

Plan of Colin and Aileen Fenton's Shipboard Cabin



Source: Dr Colin Fenton, unpublished letter, 7 December 1954

Post-graduate training was therefore a very different experience for New Zealand doctors compared to their British counterparts. Sometimes, however, British doctors seemed to be ignorant of the sacrifices that New Zealand doctors had made in order to pursue British qualifications and experience. In preparation for his final examination for fellowship of the English Royal College of Surgeons, Dr Patrick Eisdell Moore attended a lecture given by a London Professor of Surgery. At the end of the lecture, the lecturer advised the candidates to remain calm during the examination process, and made some disparaging comments

about nervous, shaking, sweating candidates, the sight of whom ‘put him out’. Eisdell Moore’s response, recorded in his autobiography, was to think:

You stupid bastard! Don’t you realise what it means to so many of us who have come thousands of miles to do this, cutting ourselves off from our families, mortgaging our homes, and in my case, putting the future of my wife and children into this gamble? It may be a success or a huge mistake, but it is certainly not trivial.<sup>105</sup>

*‘Five Months of Desperate Work’: The Royal College Examinations*<sup>106</sup>

One thing that the vast majority of post-graduate trainees had in common was the ordeal of preparing for, and sitting, the Royal College examinations. But even here, the additional financial and personal pressures that New Zealand medical migrants faced may have made examination preparation more harrowing than it was for local candidates. Together, the expense of travelling to Britain and the importance of obtaining qualifications in terms of their subsequent careers meant that most New Zealand doctors literally could not afford to fail.

Throughout the post-World War Two period, the pass-rates of the major British College examinations hovered between ten and twenty per cent.<sup>107</sup> The Royal Colleges claimed that setting such difficult examinations was an important part of safeguarding clinical standards. However, some New Zealand doctors felt that the objective was more to safeguard the status and economic position of the profession’s elite. Dr Warren Austad, who passed the final English Royal College of Surgeons examination on his third attempt, insisted that the examinations were primarily a mechanism for regulating the numbers of doctors in the profession. Professor David Stewart argued that the low pass rates of both British and Australasian post-graduate medical examinations had to signify either one or a

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<sup>105</sup> Eisdell Moore, *So Old, So Quick*, pp. 244-5.

<sup>106</sup> Matthews, p. 104.

<sup>107</sup> When John Hiddlestone sat the Membership Examination for the Royal College of Physicians of Edinburgh in the early 1950s, the pass rate was sixteen per cent. Very few candidates passed at their first attempt. Hiddlestone, p. 29. Dr Fenton wrote that the pass rate for the Royal College of Surgeons examination in 1956 was also sixteen per cent. Dr Colin Fenton, unpublished letter, 30 January 1955.

combination of poor candidate selection criteria, poor training, poorly designed examinations, or the operation of a professional ‘chokepoint’.<sup>108</sup> Other New Zealand doctors wondered if the low pass rates also served a fundraising purpose. At a time when his family’s total weekly expenditure was about £10, Dr Colin Fenton had to pay £25 before sitting the final Royal College of Surgeons examination, a further £25 to join the College when he passed, and £3 for the printed diploma.<sup>109</sup> In the mid 1970s, Dr Jack Gudex declined an (elected) Fellowship from the Australasian Royal College of Physicians because of the high fee that they requested in exchange for the honour.<sup>110</sup> The English Royal College of Surgeons also extracted money through the Lincoln Inn Fields course fees, which were practically unavoidable due to the apparent impossibility of passing the examination without first attending the course.<sup>111</sup>

Most New Zealand doctors therefore took their examination preparation very seriously. Dr Colin Hooker, who was one of the very few doctors who passed both parts of his English Royal College of Surgeons examination on the first attempt, dedicated so much time to his studies that he was able to recall only one or two social occasions from his whole time in Britain.<sup>112</sup> Dr Warren Austad also devoted little time to social activities, recalling that while ‘it was a bit dramatic to say that your life depended on it, I was there to get a membership.’<sup>113</sup> As Dr Fenton waited, without much hope, for the results of his first examination attempt, he consoled himself with the thought that it was ‘impossible to have worked any harder’.<sup>114</sup> Dr Neil Begg’s recollection captures the effort that these doctors expended:

It seemed so important to me that it blocked out most other considerations. After the day’s work I began my studies, reading my medical books, rewriting my notes and filling my head with the multiplicity of facts which were necessary for my examinations. I read

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<sup>108</sup> Interview with Professor David Stewart, 2 February 2011.

<sup>109</sup> Dr Colin Fenton, unpublished letter, 15 December 1957.

<sup>110</sup> Interview with Dr Jack Gudex, 13 November 2006.

<sup>111</sup> After being notified of his first-attempt failure in early 1955, Dr Colin Fenton was told that it had been seven years since a candidate had passed without first attending the course. Dr Colin Fenton, unpublished letter, 16 February 1955.

<sup>112</sup> Interview with Dr Colin Hooker, 12 November 2010.

<sup>113</sup> Interview with Dr Warren Austad, 17 March 2011.

<sup>114</sup> Dr Colin Fenton, unpublished letter, 30 January 1955.

in the bath; I read in bed till my eyelids drooped. I got up early and read in the dawn light. I propped my books on the table at meal times and asked my long-suffering wife to hear me [sic] mnemonics and pharmaceutical doses. And so the weeks and months passed in a kind of academic haze.<sup>115</sup>

Part of the challenge for New Zealand doctors was that success in the College examinations seemed to rely to a significant extent on ‘knowing the local emphasis on things.’<sup>116</sup> After failing his primary Royal College of Surgeons examination because of a poor performance in the anatomy section – despite having previously spent a year working as an anatomy demonstrator at the Otago Medical School – Dr Patrick Eisdell Moore obtained personal tutoring from a senior British colleague who was familiar with the examination system. His suggestions included keeping an eye on topical health stories, which, he argued, would invariably come up in conversations between College Members and Fellows, and subsequently in the College’s examinations. He predicted, for example, that recent newspaper coverage of King George VI’s circulatory deficiency would result in a question on circulation of the limbs. This proved to be the case. He also advised Eisdell Moore about the specific interests and personalities of his likely examiners. A convention that forbade College members from examining students of whom they had personal knowledge made it possible to predict which examiners a given student was likely to face. Eisdell Moore was told that the surgeon who would probably examine him ‘liked colonials’, and admired in particular their tendency to use ‘direct’ communication. The examining surgeon was also engaged in research into the relative flexibility of different kinds of muscle. These predictions also proved to be correct, with a question on muscle flexibility featuring in Dr Eisdell Moore’s subsequent viva voce.<sup>117</sup> Dr Fenton wrote that a New Zealand candidate had failed his primary examination soon after arriving in Britain because he had not noticed the slightly darkened skin pigmentation of the patient he was asked to diagnose. Dr Fenton complained that through the eyes of a New Zealand doctor still bronzed by six weeks of shipboard life, and not yet accustomed to the ‘extreme pallor’ of the

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<sup>115</sup> Begg, p.79.

<sup>116</sup> Dr Colin Fenton, unpublished letter, 30 January 1955.

<sup>117</sup> Eisdell Moore, *So Old So Quick*, pp. 226-7.

London complexion, the darkened skin had appeared normal.<sup>118</sup> Dr Fenton himself commented several times that he had no idea how he had fared in various examinations, such were the idiosyncrasies of the examiners.

The format of the examinations themselves was also challenging. The final examination for Fellowship of the Royal College of Surgeons was not a single ‘test’, but comprised a series of tasks conducted over several days. When Colin Fenton sat the examination in the mid 1950s, three hundred candidates were accepted every six months to attempt the initial written examinations over three successive mornings. These were followed by a series of clinical examinations, and a session demonstrating familiarity with surgical instruments, although no actual surgery was conducted. Two weeks later, the College invited eighty of the original candidates to sit a pathology examination. Several days after that, about forty were invited to take the final oral examination. It was possible to fail even at this late stage, resulting in an overall pass rate of approximately ten per cent.<sup>119</sup> The entire process took approximately five weeks.<sup>120</sup> The Membership examination for the Royal College of Physicians was also a drawn out affair. Although the exact form of the examination changed over time, it typically involved sitting at least two four-hour written papers, a series of ‘short’ and ‘long’ clinical cases that tested diagnostic abilities and knowledge of appropriate treatments respectively, and an oral examination. Up until the 1950s at least, the English Royal College of Physicians examination also involved the translation into English of Latin, Greek, French and German passages, although this section appeared to be optional.<sup>121</sup> Even the process by which candidates were informed of their results seemed designed to induce stress. Dr Peter Rothwell remembered that the Royal College of Physicians invited all candidates to mount a staircase. Those who had failed the examination were then asked, one at a time, to walk

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<sup>118</sup> Dr Colin Fenton, unpublished letter, 24 September 1955.

<sup>119</sup> Professor David Stewart noted that the very low pass rates were in part due to a high number of insufficiently educated candidates sitting the examination, particularly from the Indian sub-continent. However, Robin Dowie cites figures that suggest that doctors from the subcontinent and the Middle East *overachieved* in College examinations, compared to ‘Anglophone’ candidates. See Robin Dowie, *Postgraduate Medical Education: The System in England and Wales* (London: King’s Fund Publishing Office, 1987), pp. 14–44.

<sup>120</sup> Dr Colin Fenton, unpublished letter, 15 March 1956. See also Patrick Eisdell Moore, *So Old, So Quick*, p. 237.

<sup>121</sup> Barraclough, p. 79. John Adams’ biography (p. 98) also mentioned the presence of French, German, and Latin sections in the English Royal College of Physicians examination.

back down, and were directed out of the building, invariably continuing to the nearest tavern. Successful candidates were taken to a room where they shared drinks and jokes with the College's examiners.<sup>122</sup>

Negotiating this long process successfully was therefore a joyful experience. In June 1955, Dr Fenton wrote to his parents about passing the Royal College of Surgeons' primary examination:

I guess by now you will have received my cable, and what a thrill it was sending it off too! At 1/4 [one shilling and fourpence] a word it is a little difficult to let oneself go and express adequately one's feelings, but I'm sure there is no need to tell you that the thrill and relief of passing are both intense. For so long I've not even dared to think I might pass, in order to be not too disappointed if I failed, and now after consciously putting from my mind the possibility that I might one day get this jolly Primary, now that I have I can scarcely believe it's true. . . . I feel now that I've more or less justified myself coming over. Boy, what a relief it's over!<sup>123</sup>

The following day, Dr Fenton did in fact convince himself that there had been a mistake, and called the College for confirmation of his pass, which he duly received.<sup>124</sup>

### *Support Systems and Networks*

New Zealand doctors training in Britain did have access to various kinds of support. Some of this was 'official', provided by professional and specialist organisations. During their time in Britain, Colin and Aileen Fenton attended several 'At Home' meetings organised by the British Medical Association. By gathering large numbers of New Zealand and other Commonwealth doctors together, these meetings sought to make migrant doctors feel 'at home', and to facilitate the formation of self-sustaining social networks. Dr Fenton's account

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<sup>122</sup> Interview with Dr Peter Rothwell, 28 August 2008.

<sup>123</sup> Dr Colin Fenton, unpublished letter, 3 June 1955.

<sup>124</sup> Dr Colin Fenton, unpublished letter, 3 June 1955.

suggests that this was effective: at the first meeting that the Fentons attended, three months after their arrival, they ‘saw a lot of people [we] hadn’t seen for years and met many others.’<sup>125</sup> They also attended social outings organised by New Zealand House, including several trips to the theatre, a reception for visiting New Zealand Prime Minister Sid Holland, and a visit to the House of Commons, during which they were delighted to witness Sir Winston Churchill enter the house and vote on a housing bill.<sup>126</sup> The Post-graduate Medical Federation, through the Institute of Ophthalmology, organised at least one Christmas dance for post-graduate doctors training in that specialty.<sup>127</sup>

For most New Zealand doctors, informal support networks played a much more significant role. Of particular note were the regular interactions that occurred between ex-classmates of the Otago Medical School. Michael Belgrave has argued that the small size of the Otago Medical School, and its status as New Zealand’s only medical school prior to the opening of the Auckland School of Medicine in 1968, meant that most members of most graduating classes knew each other, and often stayed in contact.<sup>128</sup> Because New Zealand’s aspiring specialists usually travelled overseas within four years of graduation, those friendships were often still active, or were easily rekindled in Britain. The written and spoken recollections of New Zealand doctors invariably contain references to meetings with ex-classmates while overseas.<sup>129</sup> As mentioned earlier in this chapter, a number of New Zealand doctors arrived in Britain to be welcomed by Otago classmates. These friendships continued to be important throughout their stays. After arriving in London in 1947, John Adams was ‘taken under the wing of my old schoolmate Dr Malcolm Watt which helpfully checked the inevitable feelings of strangeness and homesickness.’<sup>130</sup> Dr Barbara Heslop’s Otago friends were sufficiently numerous in London that she was able to earn a small income coaching them through the pathology section of the College examinations.<sup>131</sup> Dr Fenton wrote that at one London Christmas party he met seven members of his own Otago graduating class, and his letters regularly mention the activities of

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<sup>125</sup> Dr Colin Fenton, unpublished letter, 16 February 1955.

<sup>126</sup> Dr Colin Fenton, unpublished letters, 14 February 1955 and 16 February 1955.

<sup>127</sup> Dr Colin Fenton, unpublished letter, 23 December 1959.

<sup>128</sup> Belgrave, “Medical Men” and “Lady Doctors”, pp. 119-20.

<sup>129</sup> See footnotes 14-17 above.

<sup>130</sup> Adams, p. 99.

<sup>131</sup> Interview with Professor Barbara Heslop, 16 February, 2011.

Otago classmates who were working in Britain.<sup>132</sup> In addition to providing welcome social support, classmates could be helpful in a crisis. When the Fentons' nine month old son needed urgent medical attention, a New Zealand paediatrician friend who was working at Great Ormond Street hospital for Children was able to organise admission more quickly than was normally possible.<sup>133</sup>

The vast majority of references to spousal support in written and spoken recollections were to the wives of male doctors. Primarily, this was because the vast majority of New Zealand medical migrants were men. Analysis of the post-1939 New Zealand medical obituaries shows that seventy-eight of the New Zealand-born doctors on the database travelled overseas for some form of post-graduate training or qualification.<sup>134</sup> Of these, almost ninety-six per cent were men.<sup>135</sup> But women doctors also had a significantly lower marriage rate than men.<sup>136</sup> Of the twenty-one New Zealand-born women doctors who travelled overseas, only eleven were married. In comparison, eighty-five per cent of the 447 New Zealand-born male medical migrants were married.<sup>137</sup>

The numerical dominance of men among medical migrants should not obscure the important role that women played in facilitating those migrations. When I asked Professor David Stewart how he made the travel and accommodation arrangements for his trip to Britain, he replied, 'Dorothea'. His wife had contacted a good friend who was married to a surgeon and was already in London. This friend organised temporary accommodation, but soon after their arrival, Dorothea Stewart went to William Goodenough House and met with a contact that she had made by post before departing New Zealand. Through these efforts, the Stewarts soon gained access to a self-contained flat in Goodenough House, and were allowed to remain in it for eighteen months, the maximum time

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<sup>132</sup> Dr Colin Fenton, unpublished letter, 23 December 1956.

<sup>133</sup> Dr Colin Fenton, unpublished letter, 22 December 1957.

<sup>134</sup> Of 597 New Zealand-born doctors, 468 travelled overseas.

<sup>135</sup> Analysis of all one hundred obituaries of women doctors published after 1939 suggests that the overall migration rate among women doctors was just under fifty per cent, compared to seventy-five per cent for male doctors.

<sup>136</sup> This is discussed further in the following chapter.

<sup>137</sup> Michael Belgrave's research found that twenty per cent of all doctors who were born in New Zealand married overseas, and of those, seventy per cent married in Britain. Belgrave, "Medical Men" and "Lady Doctors", p. 281.

allowed.<sup>138</sup> Dr Peter Wellings also reflected that his wife, who had recently returned from a tour of Europe and was well acquainted with London, coordinated most of their movements and activities. She also provided the family income while Dr Wellings attended a diploma course at the Institute of Ophthalmology and the Lincoln Inn Fields basic surgical science course, in preparation for the primary Fellowship examination. Aileen Fenton also ‘paid the bills’ while her husband attended Lincoln Inn Fields, by teaching in East End schools, and later, by working as receptionist at New Zealand House.<sup>139</sup>

The wives of New Zealand doctors also provided invaluable emotional support. In February 1955, only two months after arriving in London, Dr Fenton expressed gratitude that he had his wife with him, as ‘on one’s own I could imagine that it could be hellish’.<sup>140</sup> A month later, he wrote that ‘it’s always been wonderful coming home to her at the end of the day. It means so very much more here – I suppose it is because being on one’s own in this vast place can be a little lonely.’<sup>141</sup> In June, one of Dr Fenton’s New Zealand colleagues decided that the loneliness was too ‘serious’ to be tolerated, and returned to New Zealand before obtaining any qualifications. Reflecting on his own good fortune, Dr Fenton wrote that:

unless one is fighting it all the time, the fight for survival can have a very sobering effect. Aileen and I have both remarked many times on the changes we have noticed in our friends, and how lifeless and serious they have become. . . . I’m sure with each other’s help we will be able to retain a sense of proportion and a sane outlook.<sup>142</sup>

As this passage suggests, life in Britain could be as demanding for spouses as it was for the doctors. When Dr Fenton passed his primary examination in June 1955, he acknowledged that his wife ‘has had to make a lot of sacrifices in the interest of my swot. . . . I am as thrilled for Aileen as I am for myself.’<sup>143</sup> Dr John Conaglen’s wife gave up a career in architecture when the family travelled to

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<sup>138</sup> Interview with Professor David Stewart, 2 February 2011.

<sup>139</sup> Dr Colin Fenton, unpublished letters, 13 February 1955 and 20 March 1955.

<sup>140</sup> Dr Colin Fenton, unpublished letter, 6 February 1955.

<sup>141</sup> Dr Colin Fenton, unpublished letter, 28 March 1955.

<sup>142</sup> Dr Colin Fenton, unpublished letter, 17 June 1955.

<sup>143</sup> Dr Colin Fenton, unpublished letter, 17 June 1955.

Britain in the late 1970s, and had to deal with social isolation and a lack of intellectual stimulation.<sup>144</sup> To assuage these difficulties, medical spouses formed their own support networks. The wives of doctors living at William Goodenough House contributed one afternoon each fortnight to a childcare service that ran between 2pm and 5pm every weekday afternoon. For some years during the 1950s and 1960s, the wives of New Zealand doctors who chose to work or study in Edinburgh had access to a childcare service provided by 'Laudie', the wife of a Scottish ambulance driver. 'Laudie's group' was for New Zealand children only, and gave their mothers half a day off each week for rest, recreation, or to get other work done. Spaces in Laudie's group were limited, and tended to be 'inherited' as families came and left: Dr John Hiddlestone's children filled vacancies that were created when the children of the Hamilton-based tuberculosis specialist, Dr Hugh Short, left Edinburgh, and passed their places on to another New Zealand family upon their own departure.<sup>145</sup> The Fentons regularly babysat for other New Zealand couples they met in London, and Dr Colin Hooker and his wife looked after the child of the New Zealand orthopaedic surgeon (and later Speaker of the New Zealand House of Parliament) Sir Peter Tapsell while he and his wife went to Russia on a medical scholarship.<sup>146</sup>

### *The Return Home*

David Smith's 1980 survey of overseas doctors working in Britain's National Health Service found that over ninety per cent of all adult migrants to Britain intended to leave after a period of time, mostly to their home country.<sup>147</sup> Several of the doctors interviewed for this thesis recalled that although they too had travelled to Britain with no intention of remaining, the obvious professional advantages had led them to re-evaluate this position. Despite regular assurances to his parents that he would 'never dream' of remaining in Britain, Colin Fenton admitted in one of his final letters that 'it is quite fun to speculate about what the

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<sup>144</sup> Interview with Dr John Conaglen, 28 April 2011. Helen Conaglen later returned to study.

<sup>145</sup> Hiddlestone, p. 29.

<sup>146</sup> Interview with Dr Colin Hooker, 12 November 2010, and Dr Colin Fenton, unpublished letter, 16 April 1955.

<sup>147</sup> Smith, p. 53.

future might hold if we remained here. Really it's much easier to see how things might work out here than it is to imagine what will happen at home.' He went on to discuss an informal approach that he had received from the head of Moorfields' contact lens department. The consultant asked Dr Fenton if he was committed to returning to New Zealand, before suggesting that he considered Dr Fenton a potential departmental leader. Dr Fenton noted with interest that the job came with an automatic consultant's post, and 'by the way', that the incumbent, 'has a large house south of the river, rooms in Harley Street, runs a big Armstrong Sidley [car], and spends at least a month each year holidaying in Majorca off the coast of Spain.'<sup>148</sup> Compared to possible jobs in New Zealand's rural Southland or in a West Coast mining community, a future as a London consultant must have been tempting.<sup>149</sup>

When asked about this in an interview, Dr Fenton admitted that he and his wife had seriously considered staying in Britain as opportunities began to appear, but had returned out of a desire to be close to family as they raised their two young children.<sup>150</sup> Dr Peter Rothwell also travelled to Britain with 'absolutely no intention' of staying, but after three years 'could have considered it', if he had been able to earn enough money to maintain a quality of lifestyle comparable to that available in New Zealand.<sup>151</sup> Professor Graham Hill chose to decline academic Chairs in surgery at Sydney, Glasgow, and Bristol because 'I am a family man', and his family was in New Zealand.<sup>152</sup> Dr Patrick Eisdell Moore also recalled that the decision to return to New Zealand was more difficult than he had anticipated. For him too, lifestyle factors ultimately drove the decision to return. After receiving a number of job offers in London, and an exchange opportunity in

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<sup>148</sup> Dr Colin Fenton, unpublished letter, 21 February 1960.

<sup>149</sup> Dr Fenton's father had made inquiries about possible job opportunities, and wrote that he had found openings in Invercargill, a large town in rural Southland, and somewhere on the West Coast, an area famous for both its heavy reliance on mining and its high annual rainfall. Dr Colin Fenton, unpublished letter, 21 February 1960.

<sup>150</sup> Interview with Dr Colin Fenton, 18 March 2011.

<sup>151</sup> Interview with Dr Peter Rothwell, 28 August 2008. Some participants in the survey of New Zealand doctors carried out by Gillian Durham, Clare Salmond, and Julie Eberly also acknowledged the importance of 'lifestyle' factors in their return to New Zealand. See Durham, Clare, and Eberly, p. 28.

<sup>152</sup> Interview with Professor Graham Hill, 16 February 2011.

Switzerland, the Eisdell Moores decided to return because they believed that New Zealand was a better place to raise children.<sup>153</sup>

Despite all the challenges that life in Britain presented, the richness of the learning experience and the cultural opportunities that went with it stayed with these doctors for the rest of their lives. As mentioned in the Introduction to this thesis, interviewees in an earlier research project routinely steered the conversation around to the topic of their post-graduate migration experiences. Dr Barbara Heslop admitted that after getting used to the isolation of London, she came to value its professional and social opportunities deeply, and after returning to Dunedin felt as if she was ‘gasping from afar’ from ‘the end of the world’.<sup>154</sup> The most poignant recollection came from Dr Colin Hooker, who, as an outstanding young scholar and surgeon, had received offers to work in some of the most prestigious orthopaedic hospitals in the world. Fifty years after the fact, and twenty years after retirement, Dr Hooker was in tears as he described the decision to return to New Zealand, which was finally driven by his wife’s desire to return to her sick mother:

My greatest regret, even today, is that in leaving London I left the centre of the world. London and England were the very centre of my specialty, and I came out right to the very edge. I missed that, and I still miss it. I missed that for the next thirty years. And that was one of the stimulants that led me to do so much travel because I travelled a great deal during that thirty years. . . And that was the stimulus. I was only too aware that here in New Zealand we were right on the edge of the world.<sup>155</sup>

There is no doubt that New Zealand occupied a peripheral place in the world of post-graduate medicine, both geographically, and in terms of the sophistication of its specialist training infrastructures. Yet Dr Hooker’s quote also makes it clear that this did not necessarily equate to professional isolation, but instead acted as a stimulus for international exchange. However, for some New Zealand doctors,

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<sup>153</sup> Eisdell Moore, *So Old So Quick*, p. 259.

<sup>154</sup> Interview with Professor Barbara Heslop, 16 February 2011.

<sup>155</sup> Interview with Dr Colin Hooker, 12 November 2010.

accessing the Common-health system that facilitated those exchanges was a significant challenge.



## Chapter 6

### *A System of Exclusion*

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Previous chapters have argued that the Common-health system directly facilitated the post-graduate migrations and subsequent career trajectories of the vast majority of New Zealand medical specialists active in the two to three decades that followed World War Two. Going further, this chapter interrogates these findings. It proposes that the Common-health system could also serve to exclude certain doctors from participating, or more accurately, to condition the terms and form of their inclusion and delimit their professional options.<sup>1</sup> In particular, the chapter examines the experiences of New Zealand women attempting to forge careers as medical specialists in the context of a professional system that was, in many ways, an ‘old boys’ club’.<sup>2</sup>

While women’s overall participation rates in professional medicine improved steadily throughout the late-nineteenth and twentieth centuries, even to the point of numerical parity, women doctors throughout the period faced, and continue to face, structural and attitudinal impediments that contributed to both their marginalisation from specialty medicine, and their concentration in a relatively limited range of specialties. The marginalisation of women doctors into particular specialties during the earlier part of this period has been attributed to beliefs about their inherent suitability for work with other women, children, and families, or to related beliefs about their unsuitability for work that required physical strength, endurance, or ‘scientific’ thinking. Research into gender

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<sup>1</sup> Celia Davis, ‘The Sociology of Professions and the Profession of Gender’, *Sociology*, volume 30, number 4 (November 1996), p. 663.

<sup>2</sup> I recognise that the term ‘women doctors’, used throughout this chapter, carries an implication that the normative term ‘doctor’ is therefore masculine. In the context of this chapter, however, the distinction is necessary, and to a degree also recognises the unequal challenges that the chapter describes.

marginalisation during the second half of the twentieth century invariably cites the assumed incompatibility of family life with the demands of specialty training and practise, or sexist attitudes among male practitioners as central factors.<sup>3</sup>

This chapter posits that for New Zealand women at least, the inherently international nature of specialised training after World War Two, together with the gendered nature of the interpersonal networks that underpinned the Common-health system were two important, but as yet unstudied, factors in the continuing marginalisation of women doctors in specialty medicine. Given the critical importance of overseas training to the careers of New Zealand specialists in the latter half of the twentieth century, this is a significant oversight. I suggest that examining the mutual interaction of interpersonal networks, specialist training regimes, beliefs about gender in medicine, the role of population in specialist training, and international migration patterns can provide valuable insights into both the respective rates of specialisation of men and women doctors, and the kinds of medical specialties that women doctors tended to choose.<sup>4</sup>

On the surface, the contention that the Common-health system could limit participation in speciality medicine on the basis of gender might appear to contradict the assertion, made in Chapter 4, that ‘outsider’ status appeared to assist the careers of some New Zealand doctors. This chapter begins by addressing this apparent contradiction, arguing that there were, in effect, degrees of ‘outsiderness’. While the doctors discussed in Chapter 4 felt alienated because of their non-medical backgrounds or their status as colonials, this chapter will argue that as white males they were very much insiders, conforming to the profession’s demographic traditions. For those doctors who did not fit into professional medicine’s normative ethnic and gender categories, however, the barriers to participation in medical networks were much more difficult to

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<sup>3</sup> For a summary of these factors in a New Zealand context, see J. C. Van Rooyen, *Women in Medicine: Department of Health Occasional Paper, Number 9* (Wellington: Department of Health, 1978). See also I. C. McManus and K. A. Sproston, ‘Women in Hospital Medicine in the United Kingdom: Glass Ceiling, Preference, Prejudice or Cohort Effect?’, *Journal of Epidemiology and Community Health*, volume 54, number 1 (January 2000), pp. 10-11, and other sources cited in footnote 111, below.

<sup>4</sup> The relative scarcity of New Zealand women specialists during the study period has made it difficult to obtain first-hand testimonies of women’s experiences within international medical networks. The chapter’s focus on the *absence* of a particular group from the field of specialised medicine has therefore necessitated a greater reliance on the selection and syntheses of existing research than on primary sources.

overcome. Indeed, in some branches of specialised medicine, they were almost insurmountable.

### *The Importance of Medical Mentoring*

To paraphrase Mark Granovetter, the American sociologist who wrote the standard work on job-finding among professionals, securing an appointment in a hospital after World War Two was not ‘a rational economic process’, but was ‘heavily embedded in other social processes.’<sup>5</sup> For aspiring specialists striving to access the Common-health system, gaining the sponsorship of a senior, well-connected practitioner was critical. As Granovetter’s comment implies, sponsorship was rarely based on a student’s academic or technical abilities alone, but also relied on factors such as their social backgrounds and their social competence. As discussed in Chapter 4, relationships between British medical professors and their students were often powerful determinants of the subsequent trajectories of those students’ careers. The most beneficial relationships were those that were both professional and personal in nature. Professors would often invite promising students to their homes for social occasions, and those found acceptable in this setting were more likely to be integrated into the professor’s network of professional contacts.<sup>6</sup> Staff at the Otago Medical School replicated this practise. In her autobiography, Dr Frances Preston recalled that Otago’s obstetrics lecturer, Dr Frederick Riley, invited fourth and fifth year students to his country house every year during the early 1900s.<sup>7</sup> Preston also noted that Professor D. W. Carmalt-Jones’ wife began to organise dinner parties for promising students soon after arriving in Dunedin from England in 1919, and that

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<sup>5</sup> Mark Granovetter, *Getting a Job: A Study of Contacts and Careers*, 2<sup>nd</sup> edition (Cambridge, Massachusetts: Harvard University Press, 1974), p. 39.

<sup>6</sup> See Robert A. Nye, ‘The Legacy of Masculine Codes of Honor and the Admission of Women into the Medical Profession in the Nineteenth Century’, in *Women Physicians and the Cultures of Medicine*, ed. by Ellen S. More, Elizabeth Fee, and Manon Perry (Baltimore: Johns Hopkins University Press, 2009). New Zealander Dr Agnes Bennett recalled being invited to the home of one of Edinburgh’s leading surgeons, Dr Alexis Thompson, during her time as a student there. Cecil Manson and Cecelia Manson, *Doctor Agnes Bennett* (London: Michael Joseph, 1960), p. 33.

<sup>7</sup> Frances I. Preston, *Lady Doctor, Vintage Model* (Wellington: A. H. & A. W. Reed, 1974), p. 33. See also Frederick Riley’s obituary, published online at URL: <http://www.northerncemetery.org.nz/burial/15128/bio>, accessed 17 November 2012.

‘other staff wives felt they must follow suit’.<sup>8</sup> Dr Patrick Eisdell Moore wrote that during his tenure as the Otago Medical School’s Professor of Medicine from 1940 to 1961, Sir Horace Smirk often invited his students to his home for informal lunches.<sup>9</sup>

Sponsorship was no less important to the careers of late-twentieth-century New Zealand doctors than it had been for their nineteenth century British counterparts. Some of the doctors interviewed for this thesis recalled that their mentors’ preferences had been more influential in determining the course of their early careers than had their own. Dr John Conaglen was ‘encouraged’ to select endocrinology as a specialty by two Dunedin doctors, David Stewart and Jack Kilpatrick, while still enrolled at the Otago Medical School. When Dr Conaglen graduated, they organised a job for him with colleagues at Christchurch hospital, who in turn helped facilitate a position in Professor Peter Sönksen’s unit at St Thomas’ Hospital in London. While Dr Conaglen was immensely grateful for the assistance provided by successive sponsors, he remembered not always feeling in complete control of the process.<sup>10</sup> Professor Graham Hill also claimed to have become a colo-rectal surgeon not ‘by design’, but by being ‘channelled’ into it through a series of appointments also facilitated by senior colleagues.<sup>11</sup> Senior New Zealand doctors were clearly important figures in the earliest phase of many young specialists’ careers. They not only inspired graduates to enter particular specialties, but facilitated valuable contacts with British colleagues.

However, New Zealand’s aspiring specialists also had to establish relationships with *British* mentors if they were to obtain the training that they required. British sponsors were particularly useful for their ability to facilitate the transfers between British units that characterised the training of many New Zealand specialists. The accounts of New Zealand specialists suggest that senior British consultants generally facilitated such transfers willingly, as they viewed the development of capable trainees as an important part of their jobs. During a period characterised by the emergence of new medical and surgical sub-specialties, and by the associated struggle to earn recognition and respect from their generalist colleagues, leading specialists often worked hard to foster high

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<sup>8</sup> Preston, p. 30.

<sup>9</sup> Patrick Eisdell Moore, *So Old, So Quick* (Auckland: David Ling, 2004), p. 83.

<sup>10</sup> Interview with Dr John Conaglen, 28 April 2011.

<sup>11</sup> Interview with Professor Graham Hill, 16 February 2011.

standards and a sense of common professional identity among their junior colleagues.<sup>12</sup> Given the sound reputation of New Zealand doctors, it is therefore unsurprising that British specialists were willing to help them find the jobs they needed to facilitate specialist training. It is also unsurprising that more than half of the references to professional mentors made in post-1939 New Zealand medical obituaries were to doctors based in Britain.<sup>13</sup> If formal qualifications recognised ‘academic’ or theoretical proficiency, then association with leading practitioners seemed to function as a marker of experience – a much less tangible, but no less desirable quality. Mentors, both New Zealand and British, had an almost totemic presence in the professional identities of many of the doctors that they fostered.<sup>14</sup>

*‘Not in that System’: Exclusion from Networks of Sponsorship*

However, not all young graduates enjoyed the benefits of collegial support, or at least, not to the same degree. For the Wellington-based gastroenterologist, Dr Warren Austad, the fact that his chosen specialty barely existed in New Zealand at the time of his graduation in 1957 meant that a network of supportive senior practitioners simply did not exist. None of the Otago Medical School’s staff had any special interest in gastroenterology, so none encouraged him to pursue it. Dr Austad described his attraction to the specialty as ‘purely subject generated’.

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<sup>12</sup> See, for example, Sarah Wilde, ‘Practising Surgery: A History of Surgical Training in Australia, 1927-1974’, PhD Thesis, University of Melbourne, 2003, pp. 192, 217.

<sup>13</sup> A significant proportion of the mentors mentioned by name in post-World War Two New Zealand medical obituaries were prominent figures in British medicine, rather than New Zealanders. Across the 770 obituaries analysed in the database, 127 mention at least one medical mentor by name, and twenty three others name two or more mentors. Of the 102 references to mentors whose geographical location can be established, fifty-six were to British doctors or Australasian doctors based in Britain.

<sup>14</sup> Michael Belgrave noted a similar pattern in pre-World War Two obituaries. It was not uncommon for doctors to be associated not with particular institutions, but with well-known mentors whose names functioned as bywords for excellence in their given field. Dr Malcolm Kennedy Gray’s obituary, for example, described him as ‘resident under Sir James McKenzie the founder of cardiology at St Andrews’, while Dr Hamilton Robertson was ‘assistant to the Regius Professor of Surgery, Sir William MacEwen’. Malcolm Kennedy Gray, Obituary, *New Zealand Medical Journal*, volume 87 (1978), p. 364, and Hamilton Robertson, Obituary, volume 24 (1925), p. 231, both cited in Michael Belgrave, ‘“Medical Men” and “Lady Doctors”’: The Making of a New Zealand Medical Profession, 1857-1941’, PhD Thesis, Victoria University of Wellington, 1985, p. 120.

When he decided to travel to Britain in 1961, he received no informal guidance, and had no professional contacts. It was, in his words, ‘every man for himself’.<sup>15</sup>

Dr Peter Stokes, who was also a gastroenterologist, felt similarly alienated from networks of support and sponsorship. However, his lack of professional support was not attributable to an *absence* of professional networks, as the specialty had developed rapidly during the decade that separated Dr Austad’s postgraduate migration from his own. Dr Stokes’ problem was alienation from *existing* networks. Following his graduation from the Otago Medical School in 1965, Dr Stokes became aware that his peers were being integrated into personal and professional networks much more readily than he was, despite his strong academic record and the relatively high personal profile that he had developed through his two-year Presidency of the Otago Medical Students’ Association. His recollection of working at Auckland hospital immediately before his migration to Britain in 1971 is worth quoting at length:

So, that old boys system was operating, but I wasn’t really in that system. I’m not entirely sure why, but I really wasn’t. I was completing a six-month registrarship in gastroenterology at the time. By that stage, I was fairly experienced. I had a lot to offer. I could do all the tests and procedures in gastroenterology. I had got my [Australasian] Membership, I was really quite capable. But I don’t think I even asked [my consultants] ‘what about a job’, because I didn’t feel I would be well received. So I felt I had to go and do it myself, which isn’t something I was bothered about. But some of my peer group at the time were being eased into jobs, and I was pretty envious about that. . . . I had no relationships whatever. So, when I finished [the registrarship], everybody was very pleasant to me, and I had not done badly, but I just wasn’t, seemingly, an anointed one. I had no medical support from the hospital people at all – my colleagues, my seniors, the consultants, nothing.<sup>16</sup>

To an extent, Dr Stokes’ failure to establish supportive relationships during the early stages of his career was a by-product of the considerable enmity that existed

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<sup>15</sup> Interview with Dr Warren Austad, 17 March 2011.

<sup>16</sup> Interview with Dr Peter Stokes, 12 November 2010.

at the time between three of Auckland hospital's leading gastroenterologists. This situation created tensions between other staff, and did little to foster the nurturing attitude that underpinned medical sponsorship.<sup>17</sup> But, tellingly, Dr Stokes also attributed his inability to find a sponsor among the hospital's senior staff to the fact that he 'just couldn't speak their language'.<sup>18</sup> Given his academic success, this statement clearly did not refer to the technical language of medicine. Instead, it referred to his intolerance of the 'game-playing' that characterised Auckland hospital at the time. Dr Stokes was by that time heavily involved in the New Zealand Territorial Army, and placed a very high value on teamwork and discipline. In his interview, Dr Stokes recalled that 'those who did things in conventional ways went further' in medicine, and then conceded that he had himself not always been willing to conform to the unwritten rules and expectations of his fellow professionals.<sup>19</sup> At medical school, where success had been measured primarily through formal examination, such a stance had been little hindrance. In the professional workplace, where advancement relied on a much more diffuse set of qualities, attitudes, and relationships, non-conformity appeared to be a much more significant barrier.

Yet despite their difficulties, both Dr Stokes and Dr Austad managed to access specialised medical networks after arriving in Britain. For Dr Austad, and for many other doctors intending to pursue medical (i.e. non-surgical) specialties, the first introduction to British post-graduate training was the 'refresher course' run by the Royal Post-Graduate Medical School at Hammersmith Hospital in London.<sup>20</sup> For a recent graduate with no British contacts, the Hammersmith course represented an invaluable opportunity to get 'a foot on the rung' of British medicine. There, Dr Austad met Dr Christopher Booth, a 'charismatic' Hammersmith gastroenterologist who 'encouraged [him] along that line'.<sup>21</sup> Their relationship prospered, and subsequently led to jobs in the chest department of London's Mayday Hospital, to a gastroenterology unit in Bristol, and eventually

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<sup>17</sup> Dr Peter Stokes, personal communication, 19 January 2012.

<sup>18</sup> Interview with Dr Peter Stokes, 12 November 2010.

<sup>19</sup> Dr Peter Stokes, personal communication, 19 January 2012.

<sup>20</sup> The specialty of gastroenterology has both medical and surgical aspects. Dr Austad was a medical gastroenterologist, with qualifications from the English and Australian Colleges of Physicians. See 'Warren Iver Austad', Capital & Coast District Health Board Website, URL: [http://www.ccdhb.org.nz/hhist/staff/AustadWI\\_19611980gen.html](http://www.ccdhb.org.nz/hhist/staff/AustadWI_19611980gen.html), accessed 17 November 2012.

<sup>21</sup> Interview with Dr Warren Austad, 17 March 2011.

into the unit of Dr Avery Jones, the ‘doyen’ of gastroenterology in London at the time. Dr Austad’s Bristol connections later led him to a research position at Duke University in North Carolina.<sup>22</sup>

Dr Stokes also accessed specialist training, although through a much more protracted process. After a long series of unsuccessful job applications, Dr Stokes had no option but to take up general practice locums in order to support what was by then a growing family. As his situation became increasingly ‘desperate’, Dr Stokes visited an official at the ‘Commonwealth Postgraduate Federation’ to ask for advice.<sup>23</sup> The official informed him that the registrar jobs he had been applying for were all in relatively prestigious hospitals, and were therefore almost certainly reserved for their own house officers. After a ten-minute discussion and a single phone call, the official found Dr Stokes a job in a Birmingham hospital. Upon arriving at Birmingham, Dr Stokes found that he was the unit’s third successive Auckland-trained registrar.<sup>24</sup>

Dr Stokes’ experience was, in several ways, a classic example of the Common-health system in action. His appointment was facilitated by the positive reputation of New Zealand doctors, and by the existence of an Auckland ‘dynasty’ at Birmingham. The official’s knowledge of the vacancy, and his ability to utilise interpersonal networks in order to fill it, even within the setting of a formal organisation, were also typical of the Common-health system. But in one important way, Dr Stokes’ experience was not typical. The system had functioned to his advantage quickly and efficiently despite his having almost no direct personal connection to it. Like Dr Austad, Dr Stokes had left New Zealand without any professional guidance or contacts. His decision to live in Bromhurst near London was not based on personal recommendations, but on its proximity to train and bus routes.<sup>25</sup> Clearly, this initial lack of engagement with the Common-health system contributed to Dr Stokes’ early difficulties. However, his first engagement with that system had successfully facilitated his entry into the world of specialised medicine. The ease with which Dr Stokes was integrated into the

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<sup>22</sup> Interview with Dr Warren Austad, 17 March 2011.

<sup>23</sup> Dr Stokes was unsure that this was the exact name of the organisation he visited, so it may have been one of a number of organisations set up to help Commonwealth doctors training in Britain.

<sup>24</sup> Interview with Dr Peter Stokes, 12 November 2010.

<sup>25</sup> Interview with Dr Peter Stokes, 12 November 2010.

Common-health system, despite a complete absence of pre-existing interpersonal relationships, suggests that other criteria for entry were in operation.

I suggest that a doctor's conformity to, or divergence from, the medical profession's traditional ethnic and gender demographics powerfully influenced that doctor's ability to access the Common-health system. In the context of the post-World War Two British Commonwealth, the ideal medical practitioner was indisputably white, heterosexual, and male.<sup>26</sup> Such doctors dominated the profession in numerical terms, and held a virtual monopoly on leadership positions. Until at least the 1970s, medical journals and texts used masculine personal pronouns by default. Warwick Anderson, the Australian historian of colonial science and medicine, has argued that in spite of its regular claims to universality and cultural neutrality, Western medicine is generally 'imagined as white'.<sup>27</sup> Numerous studies have illustrated the ways in which medical education and medical socialisation have served to reflect and reinforce Eurocentric and masculine norms, ideals, and knowledges.<sup>28</sup> Chapter 4 discussed the ways in which Drs Stokes, Conaglen, Faed, Hill, and Austad had, at various times in their careers, perceived themselves to be medical 'outsiders' due to their atypical social, professional, or economic backgrounds. For these doctors, and for others like them, the resulting sense of alienation was sufficiently acute to spur

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<sup>26</sup> For a useful discussion of the 'maleness' of medicine, see Patricia Gerald Bourne, and Norma Juliet Wikler, 'Commitment and the Cultural Mandate: Women in Medicine', *Social Problems*, volume 25, number 4 (April 1978), p. 430-40, and particularly the open section. Although the article examines medicine in the United States in particular, its insights are applicable to other 'Western' jurisdictions. See also Agnes Miles, *Women, Health and Medicine* (Milton Keynes: Open University Press, 1991), and Rosemary Pringle, *Sex and Medicine: Gender, Power, and Authority in the Medical Profession* (Cambridge: Cambridge University Press, 1998).

<sup>27</sup> Anderson, Warwick, 'How's the Empire: An Essay Review', *Journal of the History of Medicine and Allied Sciences*, volume 58, number 4 (October 2003), p. 464.

<sup>28</sup> A comprehensive survey of the Western cultural foundations of biomedicine can be found in *Biomedicine Examined*, ed. by Margaret Lock and Deborah R. Gordon (Dordrecht: Kluwer Academic Publishers, 1988). Many of the most influential studies of medical socialisation have been conducted in the American context. See, for example, Oswald Hall, 'The Informal Organization of the Medical Profession', *The Canadian Journal of Economics and Political Science*, volume 12, number 1 (February 1946), pp. 30-44, H. S. Becker et al., *Boys in White: Student Culture in Medical School* (Chicago: University of Chicago Press, 1961), S. Sinclair, *Making Doctors: An Institutional Apprenticeship* (Oxford: Berg, 1997), M. Konner, *Becoming a Doctor: A Journey of Initiation in Medical School* (New York: Viking, 1987), M. Shapiro, *Getting Doctored: Critical Reflections on Becoming a Physician* (Toronto: Between the Lines, 1987), J. Haas and W. Shaffir, *Becoming Doctors: The Adoption of a Cloak of Competence* (Greenwich: JAI Press, 1987). In the Australian context, see Haida Lukes, *Medical Education and Sociology of Medical Habitus: "It's Not All About the Stethoscope"!* (Dordrecht: Kluwer Academic Publishers, 2003), especially pp. 72-8.

exceptional effort, and in several cases, exceptional success. However, for women doctors and for those from ethnic minorities, atypicality was a much more difficult barrier to overcome.

### *Women in Medicine*

From the middle decades of the nineteenth century, changing social norms and specific historical events began to provide British women with opportunities to negotiate a place within the previously all-male domain of regular professional medicine.<sup>29</sup> Together, effective campaigning, legislative measures, the rise of ‘scientific’ medicine, and the resulting decline of gentlemanly conduct as the basis of professional status allowed women to demand access to medical schools on the strength of individual merit. The number of registered women doctors in Britain increased from two in 1871 to over a hundred in 1891. During World War One, the absence of up to half of all active British doctors on military service generated unprecedented opportunities for women to enter the profession, with the result that approximately one thousand were either in training or in practise by the end of that war.<sup>30</sup>

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<sup>29</sup> Detailing the evolution of women’s participation in professional medicine is outside the scope of this chapter. Useful references include E. M. Bell, *Storming the Citadel: the Rise of the Woman Doctor* (London: Constable, 1955), J. Manton, *Elizabeth Garrett Anderson* (London: Methuen, 1963), Mary Roth Walsh, *“Doctors Wanted: No Women Need Apply”*: *Sexual Barriers in the Medical Profession, 1835-1975* (New Haven: Yale University Press, 1977), M. Hutton Neve, *This Mad Folly: The History of Australia’s Pioneer Women Doctors* (Sydney: Library of Australian History, 1980), Mary Ann Elston, ‘Women Doctors in the British Health Services: A Sociological Study of their Careers and Opportunities’, PhD Thesis, University of Leeds, 1986, *Gender, Work and Medicine: Women and the Division of Medical Labour*, ed. by Elianne Riska, and Katarina Wegar (London: Sage, 1993), Mary Wilson Carpenter, *Health, Medicine, and Society in Victorian England* (California: ABC-Clio, 2010), especially pp. 165-75. For information in the New Zealand context, see Margaret D. Maxwell, *Women Doctors in New Zealand: An Historical Perspective, 1921-1986* (Auckland: IMS, 1990), Gillian Durham, Clare Salmond and Julie Eberly, *Women and Men in Medicine: The Career Experiences* (Wellington: Health Services Research and Development Unit, Department of Health for Health Workforce Development Fund, 1989), and *The Goods Train Doctors: Stories of Women Doctors in New Zealand, 1920-1993*, ed. by Jill McIlraith (Dunedin: New Zealand Medical Women’s Association, 1994).

<sup>30</sup> Elston, p. 267. Elston notes that these figures can only be approximate, due to problems identifying active or inactive practitioners and those who had emigrated, and whether to include or exclude those who claimed to be doctors without a recognised qualification. She concludes that there is ‘no simple answer to the question ‘how many women doctors have there been in Britain?’ See Elston, pp. 41-56.

To a large extent, the entry of New Zealand women into medicine later in the nineteenth century followed a path already laid by campaigners in Britain. Legislative precedents had been set, and philosophical and moral debates had already been conducted and largely won.<sup>31</sup> There was little professional objection to the granting of medical degrees to women in New Zealand, and Otago University placed no limit on the number of women enrolling in medicine.<sup>32</sup> Between 1893, when Eliza Frikart became New Zealand's first registered woman doctor, and 1919, fifty-three women registered to practise medicine in New Zealand. As in Britain, World War One led to a significant increase in the number of women practitioners.<sup>33</sup> Between 1920 and 1929, eighty more women registered as doctors in New Zealand.<sup>34</sup>

After World War One, the number of women in medicine remained relatively constant in both countries. Opportunities diminished as male doctors returned to take up their pre-war roles, and as professional organisations responded to unwanted female competition.<sup>35</sup> After World War Two, the introduction of the National Health Service in Britain brought all existing health infrastructure under the administration of central government, and made issues of medical staffing a core government concern. This weakened the profession's grip

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<sup>31</sup> Michael Belgrave has argued that accepting women practitioners allowed the New Zealand medical profession to harness 'current stereotypes of women's role in society', thereby reinforcing the politically advantageous image of 'compassionate, serving healers, more concerned with preventing suffering than amassing fortunes.' Michael Belgrave, 'A Subtle Containment: Women in New Zealand Medicine, 1893-1941', in *Women Doctors in New Zealand: An Historical Perspective, 1921-1986*, ed. by Margaret D. Maxwell (Auckland: IMS, 1990), p. 204.

<sup>32</sup> Barbara Heslop, 'Women's Suffrage Day Lecture, 1987', in *Women Doctors in New Zealand: Historical Perspectives, 1921-1986*, ed. by Margaret Maxwell (Auckland: IMS, 1990), p. 232.

<sup>33</sup> During World War One, British doctors all but stopped migrating to New Zealand. For the first time, the Otago Medical School had to provide all of New Zealand's doctors, for both civilian and military service, and more women were accepted as a result. Doris Gordon, *Back Blocks Baby Doctor* (London: Faber and Faber, 1960), pp. 69-70.

<sup>34</sup> Rex Wright-St Clair, 'Women in New Zealand Medicine before 1930', in *Women Doctors in New Zealand: Historical Perspectives, 1921-1986*, ed. by Margaret Maxwell (Auckland: IMS, 1990), p. 180.

<sup>35</sup> The more prestigious London medical schools, for example, either introduced quotas that restricted women to five per cent of entrants, or ceased enrolling women at all. Elston, pp. 9, 93. For a comprehensive study of the experiences of British women during the interbellum period, see Caroline Dyhouse, 'Women Students and the London Medical Schools, 1914-39: The Anatomy of a Masculine Culture', *Gender and History*, volume 10, number 1 (April 1998), pp. 110-32. After reaching a high of about thirteen per cent immediately after World War One, the proportion of women among New Zealand's medical graduates dropped to about ten per cent in the late 1920s as male doctors returned from overseas service. The figure remained almost unchanged for the next forty years.

on staffing policies, and arguably, eased women's entry into medicine.<sup>36</sup> Women's participation then increased rapidly during the 1960 and 1970s, lifted on the rising tide of second-wave feminism. Between 1961 and 1983, the number of women enrolling in British medical schools increased by 250 per cent, compared to a fifty per cent increase for men. By 1983, about thirty-eight per cent of Britain's medical graduates were women.<sup>37</sup> Similar changes occurred in New Zealand. In just fifteen years from 1974, the proportion of women among New Zealand's medical graduates increased from less than fifteen per cent to approximately half.<sup>38</sup>

As early as 1948, the British Medical Women's Federation had felt able to comment that they were 'relatively content' with the position of women doctors.<sup>39</sup> In the late 1980s, the achievement of numerical parity in both British and New Zealand medical schools looked like a watershed for women's participation in the medical profession. However, achieving numerical parity in medical schools was not the same thing as achieving professional equality. Gaining a basic qualification in medicine was only the first of many steps required to establish a successful career. For many women doctors, the sternest professional challenges only appeared *after* they had graduated.<sup>40</sup>

*'In the Profession but Not in the Club': Women Post-graduates*<sup>41</sup>

There is no doubt that medical school was a difficult experience for many women. For almost a century after the first women entered Britain's medical schools, students both there and in New Zealand faced discriminatory selection processes, segregated lectures, exclusion from extracurricular social events, and treatment

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<sup>36</sup> Elston, pp. 113-16, 394.

<sup>37</sup> The number of women graduates more than tripled over this period, from 445 in 1961 to more than 1,300 in 1983. The proportion of women graduates increased from less than a quarter in 1961 to well over a third in 1983. See Tables 4.2, 4.3 and 4.4 in Elston, pp. 105-7.

<sup>38</sup> *Health Manpower Resources, 1983 Data* (Wellington: Department of Health, 1983), p. 57.

<sup>39</sup> *Journal of the Medical Women's Federation*, volume 49 (1967), p. 89, cited in Elston, p. 383.

<sup>40</sup> See Jill McClraith, 'Introduction', in *The Goods Train Doctors: Stories of Women Doctors in New Zealand, 1920-1993*, ed. by Jill McClraith (Dunedin: New Zealand Medical Women's Association, 1994), pp. 4-6.

<sup>41</sup> Phrase comes from an article published in the *Journal of the Medical Women's Federation*, volume 49 (1967), p. 89, cited in Elston, p. 383.

from lecturers and fellow students that could only be described as harassment.<sup>42</sup> However, such experiences were not universal. Dr Frances Preston recalled that while some of the Otago Medical School's lecturers regarded women with disapproval or at best 'tolerance', others were very encouraging of women students.<sup>43</sup> Dr Caroline Stenhouse, an ophthalmologist who graduated from Otago in 1923, recalled that 'as students, [women] were simply accepted as part of the student body, and those of us who showed signs of exceptional brilliance . . . received just as much encouragement and help as their male counterparts.'<sup>44</sup> Professor Barbara Heslop also felt no strong sense of discrimination at the Otago Medical School during her attendance there in the early 1940s, although she recalled that 'things were said which could hurt if you let them hurt'.<sup>45</sup>

All of these women, and many others, faced far greater difficulties outside of medical school. Dr Frances Preston noted that although most women students worked very hard at medical school, and some excelled, all were aware that 'opportunities for advancement' were rare for New Zealand women after graduation. Preston struggled to obtain even a basic house-officer job, because hospital boards claimed to be unable to provide suitable accommodation for a woman doctor.<sup>46</sup> Dr Alice Bush was declined a house officer position at Auckland hospital in 1937 for the same reason, despite her quite exceptional academic credentials. Bush had passed the primary examination of the Royal College of Surgeons during her second year at medical school, and was described by Auckland hospital's superintendent as 'probably the most brilliant student we have had at the hospital' during her sixth-year placement. Bush eventually secured a position at Auckland hospital after a family friend and hospital board member arranged for her to stay in a family home nearby.<sup>47</sup> Dr Caroline Stenhouse's recollection of life after medical school could hardly have been more different in tone to her positive memories of undergraduate life at Otago. She remembered that 'after we graduated, the medical school washed its hands of us. We were

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<sup>42</sup> Examples of discrimination are discussed several times in McIlraith's *The Goods Train Doctors*. See in particular Susi Williams, 'Sober Suits and Flat Heels – And Don't Dare Be Pregnant', pp. 6-8. See also Belgrave, 'A Subtle Containment', pp. 206-7.

<sup>43</sup> Preston, p. 12.

<sup>44</sup> Maxwell, pp. 156-7.

<sup>45</sup> Interview with Dr Barbara Heslop, 16 February 2011.

<sup>46</sup> Dr Preston was unequivocal in describing this as an 'excuse'. Preston, p. 12.

<sup>47</sup> Maxwell, pp. 105-6.

thrown out into a cold, hard post-war world equipped with a medical education that was largely theoretical, since little opportunity had been given us for practical work.<sup>48</sup> Barbara Heslop did manage to secure a junior hospital position after graduating, but she also recalled feeling excluded by her male peers. On one occasion, she discovered that her colleagues had intentionally excluded her from a journal club they had established. When confronted, they claimed that their wives were uncomfortable with them associating with a woman colleague after hours.<sup>49</sup> Dr Eleanor McLaglan faced overt discrimination when a hospital superintendent admitted to rescinding her house officer appointment solely because of her gender.<sup>50</sup> Dr Doris Gordon recounted one occasion in which a woman house surgeon had lost her hospital appointment after feeling obliged to claim responsibility for a surgical error that had in fact been made by a male colleague.<sup>51</sup>

The challenges that many New Zealand women doctors faced trying to gain hospital appointments left meant that there was often little option but to take on barely viable rural general practises or to move between short-term locum positions. The New Zealand medical historian, Dr Rex Wright-St Clair, noted that New Zealand's earliest women doctors were often transient, moving regularly between jobs, regions, and sometimes countries. To survive, some contravened accepted codes of conduct, such as the stricture against advertising, and several were ostracised as a result.<sup>52</sup> Many gave up professional medicine, choosing to practice only in their own family settings, or not at all.<sup>53</sup> Dr Preston's autobiography, for example, describes a prolonged period of existing as a 'hanger-on-the-fringes', culminating in the abandonment of medicine for life as a farmer's wife.<sup>54</sup>

Even after women began to enter medicine in greater numbers from the late 1960s, professional success remained elusive. New Zealand's medical leadership, for example, was exclusively male. In 1973, the New Zealand

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<sup>48</sup> Maxwell, pp. 156-7.

<sup>49</sup> Interview with Dr Barbara Heslop, 16 February 2011.

<sup>50</sup> Eleanor McLaglan, *Stethoscope and Saddlebags* (Auckland: Collins, 1965), pp. 121-3.

<sup>51</sup> Gordon, pp. 98-100. On another occasion, Gordon recalled watching an overconfident but under-qualified junior surgeon face no repercussions after removing the wrong rib from a newborn baby. After the incident she recalled not wanting 'to see another pair of trousers for the rest of the day'. Gordon, p. 90.

<sup>52</sup> Wright-St Clair, 'Women in New Zealand Medicine before 1930', pp. 168-70.

<sup>53</sup> See Belgrave, 'A Subtle Containment', pp. 208-12.

<sup>54</sup> Preston, p. 122.

Department of Health's four divisional heads and its eighteen senior medical officers of health were all men. Every member of the New Zealand Medical Council and the Medical Research Council were men, as were all office-holders in the Medical Association of New Zealand and its various sub-committees. Men occupied all fifty-two of the Otago Medical School's professorial or associate professorial Chairs, the Presidencies of every specialist association, and all of the 'Dominion Head' positions within every British Royal College. The medical superintendent of every major New Zealand hospital was a man.<sup>55</sup> Evaluating New Zealand medical women's progress near the end of the United Nations Decade for Women, 1980-1990, Barbara Heslop found little to celebrate. The number of female teachers at the Otago Medical School had not substantially increased, and women still occupied very few top hospital positions.<sup>56</sup> A 1988 survey of 1,525 New Zealand medical graduates found that women were less likely to be partners in or sole charge of a general practice, to be in clinical leadership roles in hospitals, or to be in positions likely to influence medical or professional policy.<sup>57</sup>

Women also struggled to achieve the other widely accepted marker of success in professional medicine: specialist status. Of the one hundred obituaries of women doctors published in the *New Zealand Medical Journal* between 1939 and 2008, thirty-two described their subjects as specialists, compared to forty-one per cent of the 714 obituaries of male doctors analysed for this thesis. In 1976, women comprised about fourteen per cent of New Zealand's medical workforce, but only five per cent of its registered specialists.<sup>58</sup> Eight years later, the

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<sup>55</sup> Barbara Heslop, 'For Better or for Worse? Women Doctors at the End of the Decade', in *Women Doctors in New Zealand: Historical Perspectives, 1921-1986*, ed. by Margaret Maxwell (Auckland: IMS, 1990), p. 254. Article originally published in *New Zealand Medical Journal*, vol. 100, number 820 (25 March 1987), pp. 176-9. In 1973, Dr Barbara Heslop became the first woman appointed as an Associate Professor at the Otago Medical School.

<sup>56</sup> See Heslop, 'For Better or for Worse?', Table 1, p. 226, and Heslop, 'Women's Suffrage Day Lecture, 1987', p. 235.

<sup>57</sup> See Durham, Salmond, and Eberly, pp. 1-2. Fifty-two per cent of women and eighty per cent of men were in 'career posts' (defined as being a solo practitioner, a partner or associate in general practice, a specialist, an academic, or a manager) on the survey date. Among general practitioners, eighty-five per cent of men described themselves as being in a 'secure position', while only forty-nine per cent of women did so. Ninety-four per cent of men and fifty-nine per cent of women in this later cohort were working full-time in medicine on the survey date.

<sup>58</sup> The New Zealand Specialist Register included 1,112 doctors in 1976, fifty-six of whom were women. Heslop, 'For Better or for Worse?', Table 1, p. 226. The scarcity of women specialists before the mid-1970s, and the lack of any formal specialist registration system before 1969 means that no data is available on women specialist's situation before this.

proportion of women in the medical workforce increased to almost twenty per cent, but the number of women specialists remained disproportionately low, at just under ten per cent.<sup>59</sup> These low figures translated into an even greater paucity of women in the upper ranks of specialised medicine. In 1971, about a quarter of New Zealand's medical specialists were recognised as senior practitioners by virtue of their placement on the 'additional steps' salary grade. All of these were men.<sup>60</sup> By 1976, just three of the fifty-six registered women specialists (five per cent) were on the additional steps, compared to 325 (or over thirty per cent) of the 1,056 male specialists. In 1984, women made up just over ten per cent of New Zealand's medical specialists, but less than one per cent of its recognised senior specialists.<sup>61</sup>

### *'Women's Specialties'*

In addition to their overall underrepresentation in specialised medicine and their relative absence from the upper ranks of specialised medicine, women also appeared to be restricted in terms of the particular specialty areas in which they practised.<sup>62</sup> The attitudes, discourses, and structures that characterised professional medicine seemed to generate not only a 'glass ceiling' that curtailed vertical movement into senior clinical or leadership roles, but 'glass walls' that limited horizontal movement into particular specialties.<sup>63</sup>

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<sup>59</sup> Heslop, 'For Better or for Worse?', Table 1, p. 226, and Department of Health, *Health Manpower Resources, 1983 Data* (Wellington: Department of Health, 1984), p. 7.

<sup>60</sup> From 1968, New Zealand doctors with recognised qualifications could formally register as specialists, and were assigned a salary grade based on their qualifications and experience. Doctors with advanced professional experience or expertise could be placed on 'additional steps', which allowed them to be remunerated at a level beyond that stipulated by the normal specialist grades.

<sup>61</sup> Heslop, 'For Better or for Worse?', Table 1, p. 226. In 1984, there were 1,572 male specialists (of whom 436 or twenty-seven per cent were on the additional steps) and 169 women specialists and just fifteen senior specialists (8.9 per cent).

<sup>62</sup> The question of whether this apparent marginalisation was 'forced' on women, or the result of their own agency is discussed later in this chapter.

<sup>63</sup> The sociologist David Cotter defines a 'glass ceiling' as a gender or racial inequality that cannot be explained by other job-relevant characteristics of the employee. He also argues that the glass ceiling effect is generally more apparent in the top end of professions. David Cotter, Joan Hermsen, Seth Ovadia, and Reece Vanneman, 'The Glass Ceiling Effect', *Social Forces*, volume 80, number 2 (December 2001), pp. 655-81.

While women have for centuries filled a wide range of health care roles, various social beliefs and conditions resulted in a significant proportion of them caring for other women and for children.<sup>64</sup> As part of the effort to facilitate women's entry into professional medicine in the mid-nineteenth century, some campaigners had argued that the 'feminine virtues' of compassion and nurturing would make women ideal providers of medical care for women and children, and as such, would make a valuable addition to a profession often perceived as frightening or even hostile to women.<sup>65</sup> However, this strategy only reinforced the belief that women doctors should practise only within circumscribed areas. Well into the twentieth century, fields such as obstetrics, child health, and 'family medicine' (general practice) continued to absorb a significant proportion of women doctors.<sup>66</sup>

During the first half of the twentieth century, a handful of other specialties also emerged as important areas for women doctors. These included psychiatry, geriatrics, anaesthetics, radiology, and public health.<sup>67</sup> Commentators continued to assume that women's capacity for compassion and nurturing lay behind their apparent gravitation towards specialties such as psychiatry and geriatrics.<sup>68</sup> However, it is also clear that the relatively low status of such work made it unattractive to many male doctors, thereby providing women with greater opportunities than was the case in more prestigious specialties.<sup>69</sup> Jobs in

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<sup>64</sup> For references to early women practitioners, see Barbara Ehrenreich and Deirdre English, *Witches, Midwives and Nurses: A History Of Women Healers*, second edition (New York: Feminist Press, 2010), Hilary Bourdillon, *Women as Healers: A History Of Women And Medicine* (Cambridge: Cambridge University Press, 1988), and Johanna Geyer-Kordesh, 'Women and Medicine', in *Companion Encyclopedia of the History of Medicine*, ed. by W.F. Bynum and Roy Porter (London: Routledge, 1997), pp. 888-914.

<sup>65</sup> Some campaigners suggested, for example, that more women doctors would allow women patients to avoid the indignity of examination by a male doctor if they so wished. Elston, pp. 134-45.

<sup>66</sup> Belgrave, 'A Subtle Containment', pp. 210-11.

<sup>67</sup> Many of the women profiled in Patricia Sargison's *Notable Women in New Zealand Health: Te Hauora ki Aotearoa: Ōna Wāhine Rongonui* (Auckland: Longman Paul, 1993) worked in these traditional areas.

<sup>68</sup> Historical accounts of women's entry into professional medicine are full of references to such attitudes. See Catriona Blake, *The Charge of the Parasols: Women's Entry into Medicine* (London: The Women's Press, 1990), and other works cited in footnote 28 above.

<sup>69</sup> The prevalence of multi-faceted and persistent illness among the elderly and the mentally ill often made for frustrating and unrewarding work, while the need for long-term and often institutionally based care regimes, combined with the high proportion of economically marginalised patients within their particular demographics made private psychiatric or geriatric practice almost impossible. The obituary of the Auckland psychiatrist, Donald Henry Ashdown Blackley commended him for retaining his 'understanding and sympathy' while dealing with 'the

government medical services were also available to women largely by default. ‘State medicine’, as it was sometimes derisively called, was held in low esteem by a profession that had long treasured its autonomy and resisted the involvement of third parties in the doctor / patient relationship. ‘Salaried doctors’ were therefore derided as lacking the initiative, character, or physical endurance needed to stand up to the rigors of private practice.<sup>70</sup> In New Zealand, such characterisations, along with the relatively limited economic opportunities that public medicine brought, ensured that more women practitioners worked in government services, such as the School Medical Service or in the Family Planning Association, than in most areas of private medicine.<sup>71</sup> A workforce survey conducted by the Medical Council of New Zealand in 1967, for example, found that more than sixty per cent of the Department of Health’s field medical officers were women.<sup>72</sup>

Specialties that were practised primarily in the hospital setting, such as anaesthetics, pathology, and radiology, were also often unattractive to ambitious male practitioners. With the rapid development of specialisation after World War Two, and the related emergence of the hospital as the venue for the most complex medical interventions, diagnostic technology became increasingly important, and more sophisticated. It also became more expensive, to the extent that services such as radiology became difficult to practise outside of the state-funded hospitals. In New Zealand, and in Britain after 1948, the ‘publicly funded’ status of all major hospitals meant that full-time hospital employment came to be viewed as but a short step away from government service proper.<sup>73</sup> As suggested in a 1955 article on ‘the future of anaesthetics in New Zealand’, that specialty was also

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tedium of dealing with people with vague and difficult problems’. See ‘Obituary: Donald Henry Ashdown Blackly’, *New Zealand Medical Journal*, volume 63 (May 1964), pp. 319-21.

<sup>70</sup> Belgrave, “‘Medical Men’ and ‘Lady Doctors’”, p. 204.

<sup>71</sup> A number of the biographies and autobiographies of New Zealand medical women describe the process whereby low status jobs in psychiatric institutions or in state services were sometimes the only remaining option for paid medical work after failing to become established in private or hospital practices. See, for example, Fay Hercock, *Alice: The Making of a Woman Doctor, 1914-1974* (Auckland: Auckland University Press, 1999), p. 97, Manson and Manson, p. 40, Maxwell, p. 119, McLaglan, pp. 122-24, Preston, pp. 122, Sargison, pp. 25, 27, 30.

<sup>72</sup> Thirty-one of New Zealand’s forty-nine Medical Officers were women. This does not include doctors employed by the Department of Health to work in one of the country’s state-run mental institutions. Of these, three out of twenty (fifteen per cent) were women. *Employment of Medical Practitioners in New Zealand, 1967*, pp. 20-1. Most of the New Zealand women doctors profiled in Jill McIlraith’s *The Goods Train Doctors* spent at least a portion of their careers in the School Medical Service or in the Family Planning Association.

<sup>73</sup> Belgrave, ‘A Subtle Containment’, pp. 210-11.

relatively low in the hierarchy of specialties. In making the case that the specialty needed to attract high-quality practitioners in order to develop, Dr G. V. Anson commented that anaesthetics could no longer be viewed as ‘the refuge of the weak, the lazy, or the inept, nor should it be the retiring hobby of the aged.’<sup>74</sup>

Characterisations such as these sat in stark contrast to those usually applied to the more prestigious specialties. Surgery provides a useful illustrative example. During the eighteenth century, surgeons had approached, and sometimes surpassed physicians in terms of their ability to generate lasting relief from illness and injury. While this elevated the surgeon’s social status, the absence of effective anaesthetics meant that the willingness to ‘cut like an executioner’ remained an important vocational attribute.<sup>75</sup> Physical strength was an advantage in this, as was the ability to make rational decisions in the presence of acute human suffering. Because such qualities were traditionally associated with men, surgery came to be cast as the ultimate masculine specialty.<sup>76</sup> Even after the introduction of effective anaesthetics in the late 1870s, the manual nature of surgery perpetuated the perception that it was a job for men. In 1948, the prominent English surgeon, Sir William Heneage Ogilvie, described surgery as a natural career choice for any ‘young man who has the normal combative instincts of the healthy male’. He went on to say that surgery would appeal to ‘the craftsman who likes using his hands’, and to ‘the footballer, mountaineer, [and] the yachtsman’. Ogilvie characterised surgeons as men who were ‘doers rather than thinkers . . . courageous, independent, self-sufficient, and distrustful of tradition . . . pioneer[s] by instinct, able to make quick decisions and to act on them.’ The physician, by contrast, was typically ‘the prizewinner, the editor of the hospital journal, the debater, the naturalist’.<sup>77</sup>

The contrast between Ogilvie’s representation of the ideal surgeon and the supposedly sensitive, nurturing, and compassionate attributes of women doctors

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<sup>74</sup> G. F. V. Anson, ‘Thoughts on the Future of Anaesthesia in New Zealand’, *New Zealand Medical Journal*, volume 56, number 313 (June 1957), p. 157.

<sup>75</sup> Richard Shylock, *Medicine and Society in America, 1660-1860* (Icatha, N.Y.: Cornell University Press, 1960), p. 125.

<sup>76</sup> Pringle, p. 70.

<sup>77</sup> Sir William Heneage Ogilvie, *Surgery, Orthodox and Heterodox* (Oxford: Blackwell Scientific, 1948), pp. 3, 36-8, 66, cited in Christopher Lawrence, ‘Medical Minds, Surgical Bodies, Corporeality and the Doctors’, in *Science Incarnate: Historical Embodiments of Natural Knowledge*, ed. by Christopher Lawrence and Steven Shapin (Chicago: University of Chicago Press, 1998), p. 156.

could not be clearer. However, this alone does not explain the particular ways in which such ideas and perceptions influenced the career decisions of women doctors. There is no doubt that overt discrimination and discouragement is part of the answer. Studies of medical schools and workplaces have shown that demeaning jokes, insults and disrespectful communications sometimes served to discourage women from pursuing specialties that men considered their own.<sup>78</sup> Some male doctors refused to engage women students or colleagues in conversation or in informal learning experiences.<sup>79</sup> Overall, however, those studies suggest that overt discrimination was relatively rare in the medical profession.<sup>80</sup>

In 1984, the medical sociologist Judith Lorber surveyed the literature on women's participation in medicine and found that most work foregrounded women's agency as the main determining factor in their career trajectories.<sup>81</sup> This conclusion was grounded in feminist scholarship of the 1970s, which initially sought to examine women's oppression within masculine social structures, but which later evolved to foreground women's actions and strategies in resisting those structures.<sup>82</sup> Such work played a central role in transforming women from the mute subjects of historical writing to active participants and producers. However, the conviction that women's lives were shaped primarily by their own actions has also been used to assert that women must also be 'responsible for their own lack of progress' in professional medicine.<sup>83</sup> A typical manifestation of this idea appeared in a 1973 *New Zealand Medical Journal* Editorial, which argued that the lack of women in leadership positions in New Zealand was probably due

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<sup>78</sup> For a summary of findings relevant to the period under discussion, see Patricia Gerald Bourne, and Norma Juliet Wikler, 'Commitment and the Cultural Mandate: Women in Medicine', *Social Problems*, volume 25, number 4 (April 1978), pp. 430-440. For a discussion in the New Zealand context, see Van Rooyen, pp. 10-12.

<sup>79</sup> Patricia Gerald Bourne and Norma Juliet Wikler, 'Commitment and the Cultural Mandate: Women in Medicine', *Social Problems*, volume 25, number 4 (April 1978), pp. 430-1.

<sup>80</sup> See, for example, Morag C. Timbury and Maria A. Ratzer, 'Glasgow Medical Women 1951-4: Their Contribution and Attitude to Medical Work', *British Medical Journal*, volume 2, number 5653 (10 May 1969), pp. 372-4, and Barbara Heslop, et al., 'Women in Medicine in New Zealand', *New Zealand Medical Journal*, volume 77, number 491 (April 1973), pp. 219-29.

<sup>81</sup> Judith Lorber, *Women Physicians: Careers, Status, Power* (New York: Tavistock, 1984).

<sup>82</sup> Joanne Bailey, 'Is the Rise of Gender History "Hiding" Women from History Once Again?', *History in Focus*, Volume 8 (Gender) (Spring 2005), unpaginated, URL: <http://www.history.ac.uk/ihr/Focus/Gender/articles.html>, accessed 13 March 2012.

<sup>83</sup> Walsh, *Doctors Wanted: No Women Need Apply*, pp. xvii-xviii. To clarify, this quote does not summarise Walsh's position, but is used in her introductory survey of the historiography of women in medicine.

to women's tendency to be 'deflected into a different destiny, that of children', rather than to any 'intrinsic bar to the top', the existence of which was explicitly denied.<sup>84</sup> Three years later, and in a similar vein, the New Zealand Medical Council wrote that women's underrepresentation in specialised medicine was due to the fact that:

[m]ost women in medicine have in the past adopted a passive approach towards their professional careers. About half of those who marry, marry doctors, and in most instances the husband's career comes first. Many opt out completely for long periods in favour of family responsibilities, and have difficulty in finding the confidence to return to even relatively undemanding medical work. Few fulfil their early academic potential, few hold top professional or administrative posts, and few play an active role in professional colleges and specialist societies.<sup>85</sup>

This passage, and many others like it, paints a bleak picture of the ability, determination, and initiative of medical women. It also paints a misleading picture, to the extent that it overlooks the influence of external factors and structures in shaping – and usually limiting – the choices that were available to women doctors.<sup>86</sup> If gender was not generally asserted as a reason for curtailing women's participation in specialised medicine, it frequently operated as one. The structure of post-graduate training and qualification was perhaps the main mechanism constraining women's participation in specialised medicine. Female doctors might not be declined an appointment because of their gender, but they could easily be excluded because of a lack of qualifications, which itself was often a consequence of gendered educational structures, and particularly, to the almost exclusively full-time nature of specialty training within the Commonwealth prior to the 1970s.

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<sup>84</sup> 'Editorial: Women in Medicine', *New Zealand Medical Journal*, volume 77, number 491 (April 1973), pp. 258-9.

<sup>85</sup> *Medical Manpower in New Zealand: Report of a Planning Workshop Held at Wairakei, 19-23 April, 1976* (Wellington: New Zealand Medical Council, 1976), p. 34. The Medical Council also argued that 'medical women have greater difficulty than men in making up their minds about career objectives.' P. 79.

<sup>86</sup> Elston, p. 41.

The emergence of specialisation as an important mode of medical practise in the 1920s and 1930s, and its rise to pre-eminence after the 1950s brought changes that, according to several New Zealand women doctors, made it more difficult for women to become specialists than ever before.<sup>87</sup> Whereas earlier general physicians and surgeons had required no formal training or qualifications in order to pursue their 'special interests', the specialist organisations that emerged after World War One began to specify post-graduate qualifications as basic prerequisites for specialised practise. After World War Two, most of those organisations required prospective members to undergo minimum training periods in approved units. In addition, almost all made full-time training compulsory, usually on the grounds that part-time trainees were unable to follow patients from admission to discharge, which was considered an important part of learning to develop and evaluate treatment plans.<sup>88</sup> In Britain, the introduction of the 'Spens ladder' in 1948 also served to formalise specialist training. Doctors were required to progress through a set series of posts for at least eight years before attaining consultant status, during which time they were expected to be available for long periods of night duty, to study intensively for postgraduate examinations, and to participate in exchanges with other institutions.<sup>89</sup>

While these requirements did not exclude women *per se*, neither did they make any allowance for circumstances that were, in reality, unique to women. For women doctors who wanted to have children, for example, the formalisation of specialist training represented a significant barrier. As post-graduate training was usually undertaken by doctors during their late twenties and early thirties, the near-universal requirement for full-time training all but excluded women doctors who aimed to have children around the same age. The few studies to have considered the marginalisation of New Zealand women in professional medicine during the second half of the twentieth century invariably cite maternal status as a central factor. In 1971, for example, Professor Barbara Heslop surveyed 313 of the Otago Medical School's 374 surviving women graduates, and concluded that motherhood was the single most significant determinant of the trajectory of their careers. Among those respondents who had had children, approximately forty per

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<sup>87</sup> Almost every entry in McIlraith's *The Goods Train Doctors* provides an example of post-graduate discrimination.

<sup>88</sup> Heslop, 'Women's Suffrage Day Lecture, 1987', pp. 232-3.

<sup>89</sup> Elston, p. 362-5.

cent had worked less than half the time available to them since their graduation. In contrast, just three per cent of women who had married but had not had children had worked less than half-time, while none of the unmarried and childless women graduates had worked less than half of their available time.<sup>90</sup> Database analysis of New Zealand medical obituaries also suggests some correlation between the rate of specialisation and parental status, at least for women doctors. While parental status had no bearing on rates of specialisation for male doctors, analysis shows that twenty-eight per cent of women doctors with children specialised, compared to thirty-nine per cent of those without children.

In her study of the careers of American medical women, Judith Lorber notes that although the decision to start families was clearly an example of women's agency, those decisions were made in the context of professional structures that were known to be generally not amenable to women with family commitments.<sup>91</sup> Barbara Heslop reached a similar conclusion when she noted that many of the respondents to her 1971 survey of Otago's women graduates suggested that their medical careers had been shaped less by motherhood *per se* than by professional responses to motherhood, at the individual, institutional, and professional levels.<sup>92</sup> Their responses suggested that women doctors with children were hampered by hospital administrators and senior general practitioners who were sometimes reluctant to employ women who might create 'problems' by becoming pregnant, and by the lack of support structures within hospitals.<sup>93</sup> In many cases, those professional responses derived from the traditional perception of medicine as a calling, rather than a vocation.<sup>94</sup> The professional expectation that doctors should always be on call clearly conflicted with the social expectation that women should give priority to their families, with the result that women faced a relatively clear choice between having children and establishing a specialist career.<sup>95</sup> Given this choice, many women chose part-time practice. One of the earliest comprehensive surveys of the New Zealand medical workforce, conducted by the Medical Council of New Zealand in 1968, found that twenty-nine per cent

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<sup>90</sup> Heslop, 'Women in Medicine in New Zealand', Table X, p. 264.

<sup>91</sup> Lorber, pp. 2-3.

<sup>92</sup> Durham, Salmond, and Eberly, p. 1.

<sup>93</sup> Durham, Salmond, and Eberly, p. 33.

<sup>94</sup> Pringle, p. 10-13, and Durham, Salmond, and Eberly, p. 137.

<sup>95</sup> Bourne and Wikler, p. 435.

of all women doctors working in New Zealand were employed on a part-time basis, compared to just three per cent of the men.<sup>96</sup> Given the structure of specialist training, this effectively precluded women with from pursuing careers in most medical specialties.

The exceptions to this were those specialties that were conducive to rostering in advance. Anaesthetists, pathologists, radiologists, psychiatrists, and geriatricians, along with those doctors working in the public service, could generally plan their work commitments much more easily than doctors working in areas with a higher quantum of on-call, night, or emergency work.<sup>97</sup> This was a critical factor in the emergence of these specialties as the 'natural' home for women doctors in the twentieth century. The 1988 survey of New Zealand medical women cited earlier found that thirty-seven per cent of women specialists had selected their particular areas because of their conduciveness to sessional organisation, compared to just seven per cent of male specialists.<sup>98</sup>

The result of all these factors was that by the mid 1960s, when economic pressures and planning needs led to the first serious attempts to map the structure of the New Zealand specialist workforce, women were clearly overrepresented in some medical specialties and underrepresented in others. Table 5 on the next page quantifies the proportion of women active within each of the main medical specialties in New Zealand, as reported in medical workforce surveys conducted in 1967, 1975 and 1983:

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<sup>96</sup> Of 396 women respondents, 145 worked part-time, compared to seventy-seven of the 3,083 male doctors. *Employment of Medical Practitioners in New Zealand, 1967*, p. 11.

<sup>97</sup> Belgrave, "Medical Men" and "Lady Doctors", p. 398. See also Durham, Salmond, and Eberly, pp. 3-4.

<sup>98</sup> Durham, Salmond, and Eberly, pp. 3-4.

*Table 5:  
Rates of Participation in Medical Specialties in New Zealand by Gender, 1967,  
1975 and 1983 (Ranked according to the combined participation rates across the three  
data sets)*

<i>Specialty</i>	<i>Total Practitioners / Percentage who were Women</i>		
	1967 Data	1975 Data	1983 Data
Paediatric Medicine	20 / 20%	57 / 25%	70 / 30%
Anaesthetics	73 / 29%	144 / 28%	182 / 16%
Psychiatry	68 / 16%	142 / 17%	145 / 24%
Obstetrics & Gynaecology	56 / 11%	113 / 18%	139 / 10%
Pathology	56 / 7%	114 / 13%	129 / 16%
General Practice	1,141 / 6%	1,500 / 10%	1,968 / 14%
Radiology	68 / 4% <sup>99</sup>	97 / 8%	115 / 10%
Ophthalmology	43 / 12%	65 / 5%	67 / 4%
Dermatology	Not collected	24 / 0%	31 / 13%
Internal medicine	171 / 5%	215 / 4%	315 / 5%
Otolaryngology	37 / 1%	48 / 2%	48 / 2%
Other Surgery	197 / 1.5% <sup>100</sup>	287 / 0%	342 / 0%

Source: See footnote <sup>101</sup> below.

<sup>99</sup> Radiology figures for 1967 included radiotherapists and are therefore not directly comparable to later figures.

<sup>100</sup> Surgery figures for 1967 combine general surgery, orthopaedic surgery and urology.

<sup>101</sup> Data comes from *The Employment of Medical Practitioners in New Zealand: A Report on the 1967 Questionnaire Survey of the Medical Council of New Zealand* (Wellington: Medical Council of New Zealand, 1968), pp. 20-1, *Medical Manpower in New Zealand: Report of a Planning Workshop Held at Wairakei, 19-23 April 1976* (Wellington: Division of Hospitals, 1976), pp. 40, 49-67, and 'Health Manpower Resources, 1983 Data' (Wellington: Department of Health, 1983), tables 19.7 – 20.2 (pp. 60-77.) Analysis of the obituaries of New Zealand medical women published after World War Two also show women working in a limited range of medical specialties. Of the thirty-four women's obituaries that mention any specialty area, three quarters (or twenty-five) worked in one or a combination of the classic women's specialties of anaesthetics, paediatrics, obstetrics / gynaecology, psychiatry, radiology, or pathology. Radiography – whose practitioners do not require a medical degree – has been left out of this table despite being listed as a medical specialty in the 1983 figures. At that time, ninety-five per cent of radiographers were women.

### *The Common-Health, Migration, and Specialisation*

Most research into the participation of New Zealand women in specialised medicine in the twentieth century accepts that the prevalence of full-time training programmes and the challenge that this presented to women with families were the most significant factors in both the participation and distribution of women in specialised medicine. However, medical migration and the networks that sustain them have never been considered as factors in the careers of New Zealand women specialists active during the latter half of the twentieth century. A 1978 New Zealand Department of Health report into the factors that shaped women's participation in medicine, for example, discussed in detail the restrictive effects of full-time training regimes without once acknowledging that, for much of the previous thirty years, most of that training had been delivered in British hospitals.<sup>102</sup> Given the critical importance of overseas training to the careers of New Zealand specialists during this period, this is a significant oversight. My research suggests not only a relationship between the overall migration rates of men and women doctors and their relative rates of specialisation, but a correlation between migration patterns and the particular medical specialties that women doctors worked in after World War Two.

Overall, migration rates were lower among women doctors than they were among their male colleagues. My analysis of post-war New Zealand medical obituaries suggests that just over three-quarters of New Zealand-born male doctors, and just over ninety per cent of male specialists spent some time training overseas. In comparison, just over fifty per cent of women doctors' obituaries included references to medical migration, while less than three-quarters of women specialists migrated. While there is no doubt that this difference reflected the preferences and aspirations of women doctors, it is again necessary to consider those preferences in the context of the professional conventions, structures, and expectations within which they were formed. For aspiring specialists, one of the

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<sup>102</sup> J. C. Van Rooyen, *Women in Medicine: Department of Health Occasional Paper, Number 9* (Wellington: Department of Health, 1978). Rosemary Pringle's study of medical women in Britain and Australia after World War Two also makes practically no mention of post-graduate migration for training purposes, despite its international frame of reference. Her characterisation of Britain and Australia as a 'continuous system' perhaps goes too far, to the extent that it ignores the differences that drove movements between them.

key structures was the network of interpersonal relationships that, I have argued, underpinned the post-graduate migrations and careers of New Zealand specialists in the three decades that followed World War Two.

One of the consequences of systems of mentorship such as the one which characterised the Common-health system after World War Two is that they tend to replicate and preserve the ethnic, gender, and class makeup of the groups in which they operate.<sup>103</sup> The American sociologist, Judith Lorber, has argued that within the male-dominated medical profession, this replication is often motivated by a desire to foster a culture of shared beliefs, values, vernacular language, jokes, and ultimately, behaviours, which together form the basis of workplace trust and collegiality.<sup>104</sup> The American historian, Robert Nye, also argues that mentor relationships, and the ‘culture’ that they reproduced in professional medicine, were strongly masculine in terms of their discourses and understandings. In nineteenth century Britain, Nye argues, medical sponsorship often began as ‘benevolent paternalism [but] shaded, as the student grew towards professional competence, into a shared “gentlemanly” code of conduct.’<sup>105</sup> The tendency of mentors to select mentees similar to themselves contributed to the perpetuation of associated professional patterns. The extreme scarcity of women surgeons, for example, meant that very few women mentors were available to encourage later generations into that area of work.

The particular avenues through which junior doctors formed congenial relationships with their seniors also reflected masculine norms and behaviours. Knowledge and ability in sport is one example. Caroline Dyhouse notes that between the two world wars, senior consultants in some of London’s major teaching hospitals resisted the entry of women students out of fear that they would

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<sup>103</sup> Some sociologists have ascribed this to the workings of ‘status expectation’, or the belief – conscious or subconscious – that the members of ‘higher status’ groups such as white, non-working-class males are assumed to be inherently appropriate for leadership roles, while the members of ‘lower status’ groups ‘carry the burden of proof.’ Lorber, pp. 4-5.

<sup>104</sup> Lorber, pp. 4-7, and Lukes, p. 74. In 1992 an inquiry into discriminatory appointment practices at the King George V Hospital in Sydney found that the senior specialists were effectively ‘cloning’ themselves by appointing only candidates from the same schools, who had trained in the same overseas hospitals, and who played the same sports. The report stated that ‘a much more diverse set of backgrounds and experiences would be present if appointments had been based on personal merit. Pringle, p. 64.

<sup>105</sup> Nye, p. 149.

compromise their institutions' sporting traditions.<sup>106</sup> Michael Belgrave argued that for New Zealand doctors, sporting prowess was 'as much a mark of personal distinction as social service, and [was] often regarded as a complement to professional acclaim'.<sup>107</sup> To paraphrase Bourdieu, sporting 'capital' was therefore readily translatable into the medical field, and helped those doctors who possessed it to form valuable professional relationships. The sociologist, Haida Lukes, found evidence for this among junior Australian doctors, several of whom suggested that being able to display a knowledge of sports such as cricket and rugby was an important attribute when 'catering' to senior doctors.<sup>108</sup> Rosemary Pringle's study of British and Australian women doctors found that some struggled to form friendly relationships with senior consultants because they lacked sufficient interest in sport to engage in such conversations, while those who did have knowledge still tended to be excluded.<sup>109</sup>

Similar issues seemed to arise around alcohol consumption. The New Zealand pathologist, Dr Barbara Heslop, remembered that although women attendees at medical conferences and society meetings were officially invited to dinners and other social occasions during the 1960s, they were often 'taken aside' and informally asked to refrain from attending. Heslop speculated that this was due to a heavy drinking culture among male New Zealand doctors, and to their desire to socialise in this way without the 'stifling' presence of women colleagues.<sup>110</sup> Some of Rosemary Pringle's interviewees also remembered that male consultants were generally unwilling to invite women juniors out for a social drink.<sup>111</sup> Although this probably reflected current social mores as much as professional discrimination, the effect was the same: women doctors found it

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<sup>106</sup> Dyhouse, pp. 113, 125-7.

<sup>107</sup> Belgrave, "'Medical Men" and "Lady Doctors"', p. 385. Belgrave's comment is borne out by the post-World War Two obituaries of New Zealand doctors, almost half of which refer to the sporting interests and achievements of their subjects. Of the 714 obituaries of male doctors, 319 (forty-five per cent) made some reference to a sporting interest.

<sup>108</sup> Luke, pp. 74-80.

<sup>109</sup> Pringle, p. 87.

<sup>110</sup> Barbara Heslop, 'Postgraduate Training: The Eternal Tug of War for Women and How It Has Got Tougher', in Jill McIlraith, *Goods Train Doctors: Stories of Women Doctors in New Zealand, 1920-1993* (Dunedin: New Zealand Medical Women's Association, 1994), p. 11.

<sup>111</sup> Pringle, p. 87.

much harder to establish the friendly relationships that were critical to entering and negotiating the Common-health system.<sup>112</sup>

### *'Demographic' and 'Organ' Specialties*

The masculine nature of informal medical networking almost certainly contributed to the lower rates of migration among medical women, and by extension, to a slightly lower overall rate of specialisation among women doctors (about thirty per cent) compared to men (about forty per cent). Women doctors who were excluded from social interactions, and who struggled to form friendly relationships with senior doctors were clearly at a disadvantage when it came to obtaining contacts in British hospitals, and by extension, specialised training. However, I suggest the particular distribution of women doctors among the various specialties might also be attributable to post-graduate migration systems, and in particular, to the differing *relevance* of post-graduate migration to the various medical and surgical specialties.

In previous chapters, I have argued that the need for specialists to have access to large populations was a driving force behind many of New Zealand's post-World War Two post-graduate migrations. However, this did not apply to all medical specialties equally. The importance of 'hands on' experience in the training process differed from specialty to specialty, which meant that the need to access large populations, and therefore to migrate, also differed. I suggest that it is useful in this regard to categorise medical specialties into two broad categories,

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<sup>112</sup> Indeed, Pringle's study suggests that medical mentoring was so closely enmeshed in masculine codes and understandings that many women professed to not knowing how the system worked. Paradoxically, this also meant that women tended to assign greater importance to networking than men, for whom much of the system's conventions were 'natural', and therefore taken for granted. Pringle, p. 117. British sources which illustrate the importance of relationships with senior colleagues in building a career include Isobel Allen, *Doctors and Their Careers* (London: Policy Studies Institute, 1988), M. L. Johnson and M. A. Elston, 'Medical Careers: An End of Grant Report Prepared for the Social Science Research Council', 1980, and Rosemary Hutt, Richard Parsons, and David Pearson, *The Determinants of Doctors' Career Decisions* (Brighton: Institute of Manpower Studies, 1979).

which for the purposes of this discussion I will call ‘demographic’ and ‘organ’ specialties.<sup>113</sup>

Demographic specialties are those that deal with conditions associated with particular demographic groups, such as children (paediatrics), pregnant women (obstetrics), and the elderly (geriatric medicine), or with medical techniques that are broadly applicable across a range of conditions, such as anaesthetics and the diagnostic specialties of radiology and pathology.<sup>114</sup> The broad range of conditions that general practitioners deal with also places them within this category. Organ specialties, on the other hand, are those which deal with particular conditions and illnesses in particular parts of the body, or which involve the provision of specific medical or surgical techniques. On the basis of this definition, organ specialties include ophthalmology (eyes), otolaryngology (ear, nose and throat), and the vast majority of surgical specialties, including urology, orthopaedics, gynaecology, and reconstructive surgery. Clearly, this demarcation cannot be exact, as some of the organ specialties (gynaecology, urology) involve a high quantum of work with patients at particular life stages. While a case could also be made for placing psychiatry in either category, it will be categorised here as a demographic specialty because of the wide range of conditions that came under the psychiatric banner during much of the period in question.

The crucial difference between these two broad categories of medical specialty is that population size, and therefore migration, was less important for trainees in demographic specialties than it was for doctors aspiring to one of the organ specialties. Because young, pregnant, and elderly people make up a significant proportion of any healthy population, even a relatively sparsely populated country like New Zealand was able to provide sufficient ‘clinical material’ to facilitate the necessary experience. Similarly, the broad applicability

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<sup>113</sup> The phrase ‘organ’ specialties derives from an article by the Dean of the Auckland Medical School, Professor David Cole, in which he used the term ‘organ societies’ to describe medical organisations in the areas I am discussing here. The term is not ideal, as it is used here to cover specialties, such as reconstructive surgery, that do not in fact deal with a particular organ. However, alternative terms that were considered are no more exact: ‘technical’ specialties, for example, is unsatisfactory because of its associations with technologically advanced specialties such as radiology and pathology, which do not fit the criteria under discussion. D. S. Cole, ‘A Single Medical College for New Zealand’, *New Zealand Medical Journal*, volume 72, number 461 (September 1970), p. 191.

<sup>114</sup> Elston uses the term ‘service specialties’ to describe anaesthetics, radiology, pathology, on the grounds that their practitioners tend to operate under instruction from other doctors. See Elston, p. 50.

of anaesthetics, radiology and pathology allowed training in these areas to occur in any reasonably sophisticated hospital. In contrast, having access to a large population was imperative in the training of specialists in areas such as ophthalmology and otolaryngology, where obtaining and maintaining the necessary technical skills, particularly with respect to rarer conditions and procedures, was almost impossible in the context of small populations. As discussed in Chapter 5, acquiring technical skill through repetition was particularly important in surgical disciplines, where manual dexterity and ‘feel’ could only be achieved – quite literally – through ‘hands-on’ practise.<sup>115</sup> For surgeons in small population centres, obtaining the necessary ‘feel’ was difficult to acquire without migrating.<sup>116</sup>

It is therefore no surprise to find that the database analysis of New Zealand medical obituaries reveals a higher rate of post-graduate migration among ‘organ’ specialists than among those doctors who worked in ‘demographic’ specialties. Column 1 of Table 6 (next page) enumerates the proportion of specialists in each field whose obituaries contained references to overseas post-graduate migration. However, it is particularly interesting to note that there is a clear inverse relationship between the migration rates associated with each specialty and the corresponding gender participation rates, as highlighted in Table 5. In other words, the specialties with the highest proportion of women practitioners tended to be those with the lowest rates of migration. Invariably, these were the demographic specialties. Column 2 of Table 6 gives the average participation rates of women practitioners in the various specialties between 1967 and 1983:

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<sup>115</sup> In 1894, the Australian surgeon Dr J. Greig Smith summarised the manual nature of surgery when he stated that ‘by many devices and practisings [the surgeon] may and ought to improve [his hands’] capacity, but their final and most perfect training is in the actual work.’ J. Greig Smith, ‘Address In Surgery: The Art Of The Surgeon’, *British Medical Journal*, volume 2, number 1753 (4 August 1894), p. 251.

<sup>116</sup> As one of Sally Wilde’s Australian surgeons stated, ‘England was where you got the cutting’. Interview conducted by Sally Wilde in Melbourne, 12 November 2001, cited in Wilde, ‘The English Patient in Post-colonial Perspective’, p. 118.

Table 6: Rates of Migration and Gender Participation by Specialty

<i>Specialty</i> <i>*Denotes organ specialty</i>	<i>Column 1</i> <i>Rates of Post-graduate Migration in New Zealand Medical Obituaries, 1939-2008</i>	<i>Column 2</i> <i>Average Percentage of Women Practitioners, 1967, 1975, and 1983 Combined<sup>117</sup></i>
Paediatric Medicine	86%	25%
Anaesthetics	76%	24%
Psychiatry	71%	19%
Obstetrics & Gynaecology	95%	16%
Pathology	79%	12%
General Practice	68%	10%
Radiology	85%	7%
*Ophthalmology	100%	7%
*Dermatology	100%	6.5%
*Internal medicine	84%	5%
*Otolaryngology	100%	1.6%
*Surgery	94% <sup>118</sup>	.5%

Source: Medical Obituary Database and Workforce Data, footnote 100 above.

The two most obvious anomalies in the overall pattern are obstetrics / gynaecology and internal medicine. In contrast to the overall trend, obstetrics / gynaecology (O&G) had a high associated migration rate and a relatively high proportion of women practitioners, while internal medicine had relatively low migration rates and few women practitioners. In the case of O&G, this anomaly is almost certainly due to the failure of the manpower surveys that provide these figures to differentiate between ‘pure’ obstetricians, many of whom were women,

<sup>117</sup> The three data sets are combined here in order to provide data across a time span as similar as possible to that covered in the analysed medical obituaries.

<sup>118</sup> This figure combines the migration rates for general surgeons, orthopaedic surgeons and urologists, as does the corresponding category in the gender participation rates.

and obstetrician / gynaecologists, whose work contained a greater surgical load, and whose practitioners were more often men.<sup>119</sup> All of the twenty-three doctors described as obstetrician / gynaecologists or ‘pure’ gynaecologists in their obituaries were men. In comparison, four out of the eleven ‘pure’ obstetricians were women. When calculations are adjusted to acknowledge this difference, the respective migration rates correlate much more closely with the trends observable in Column 1: eighty per cent of the doctors who specialised in obstetrics alone travelled overseas, compared to ninety-six per cent of those whose work included a gynaecological element. The other slightly anomalous finding, in internal medicine, is probably explained by the fact that by the early 1980s, between fourteen and eighteen per cent of New Zealand specialist geriatricians – who were included in the ‘internal medicine’ category in manpower surveys – were women.<sup>120</sup> If this speciality is treated separately, the rate of migration among the database’s remaining physicians rises to almost ninety per cent.

With these clarifications in mind, I suggest that the figures in Table 6 demonstrate a clear relationship between the three variables under consideration: the distinction between demographic and organ specialties, overseas migration rates, and women’s participation rates. I also suggest that particular features of the Common-health system, already outlined in this chapter, provide plausible explanations of the relationships between those variables. First, I have suggested that the difficulties that women faced in entering informal professional networks may have limited their ability to facilitate overseas migrations, and therefore to specialise. Second, as discussed above, I contend that the differing importance of large population centres in specialised training contributed to different migration rates among the practitioners of demographic and organ specialties. Finally, I suggest that the relationship between the remaining pair of variables can be derived logically from these first two arguments. Women tended to gravitate towards the demographic specialties because they were, in general, less able to access the interpersonal networks that facilitated the migrations that were a critical part of entering one of the organ specialties.

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<sup>119</sup> Elston, p. 55. Rosemary Pringle asserts that modern gynaecology has, as a specialty, been ‘extraordinarily hostile to the presence of women’. Pringle, p. 44.

<sup>120</sup> *New Zealand Medical Manpower Statistics, 1983* (Wellington: Department of Health, 1984), p. 78.

It is important to note that I do not propose that the interaction of these variables provides a complete explanatory framework for the specialty choices of all women doctors. Similar patterns of distribution among the specialties could be found among British women doctors, for example, who of course had no need to migrate. These shared patterns can largely be attributed to other factors common to both jurisdictions, such as medical economics. Regardless of where they were practiced, demographic specialties tended to be less prestigious and less remunerative than the organ specialties. Surgical specialties in particular were often more profitable than non-surgical ones because private patients were more willing to pay for tangible and observable ‘procedures’ than for courses of medicine that were often slow to produce results. As a result, training positions in less lucrative demographic specialties tended to be less competitive, and therefore more accessible to women.<sup>121</sup> The decision to enter demographic specialties was also probably influenced by marital and maternal status. Database analysis in this area is limited by the fact that only eight of the one hundred obituaries of women doctors published in the *New Zealand Medical Journal* after 1939 identified their subjects as practitioners of organ specialties.<sup>122</sup> Of those eight, however, only two were married, and none had children.

The contention that the careers of women doctors in New Zealand and Britain could be limited by the same factors is, in many ways, the point of this chapter, and of the thesis as a whole. The Common-health system did not only facilitate the movement of doctors between New Zealand and Britain, but also transmitted attitudes, discriminatory practices, and restrictive professional conventions. Because certain British institutions functioned as the hubs for their respective specialties both domestically and for the Commonwealth as a whole, it is plausible to view the difficulties that New Zealand women faced getting access to the jobs that they needed to obtain specialist experience as long-distance versions of the very same challenges that British women faced. All of these women needed access to the same British institutions if they were to become

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<sup>121</sup> D. W. Carmalt-Jones: *A Physician in Spite of Himself*, ed. by Brian Barraclough (London: Royal Society of Medicine Press, 2009), p. 132. For discussions of medical economics, see Glenn Gritzer and Arnold Arluke, *The Making of Rehabilitation: A Political Economy of Medical Specialization* (Berkeley, University of California Press, 1985), Eliot Freidson, ‘Client Control and Medical Practice’, *American Journal of Sociology*, volume 65, number 4 (January 1960), pp. 374-82. See also, Pringle, p. 76.

<sup>122</sup> This is if gynaecology is considered an organ specialty.

specialists, but all struggled to access and negotiate the interpersonal networks that enabled that access. Together, these shared challenges ensured women in Britain and in New Zealand ended up making similar career decisions. Despite their position on opposite sides of the planet, the New Zealand and British medical establishments were in many ways parts of a single system. Understanding the experiences of New Zealand women doctors and the career choices that they made must take into account the international nature of New Zealand professional medicine.

I am aware that the preceding discussion is limited by the absence of first-hand accounts of women doctors who experienced some of the challenges that it describes. This is a direct result of the fact that my awareness of the potential of the Common-health system to function as a system of exclusion emerged relatively late in this research project. Prior to this, the research sought only to understand the ways in which the various networks facilitated medical specialists' careers. Although I did seek to understand the influence of gender in these networks, my focus on the facilitative nature of those networks led me to interview women specialists who, by definition, had negotiated these challenges successfully, and who therefore tended to downplay the restrictive aspects of international medical networks in the two to three decades that followed World War Two. Because of this, this chapter cannot include any informed comment, for example, about the ways in which lower marriage rates among women doctors might have contributed to more intense experience of loneliness among women migrants than among the male doctors interviewed for Chapter 5. Given the prominence of narratives of loneliness in the accounts of male doctors, and their recognition of the role of spouses in mitigating such feelings, this seems likely, but cannot be confirmed through the available sources. It is also conceivable that, given the financial and emotional support that the wives of male doctors provided in Britain, that the lower marriage rates among women doctors might have contributed, in some small way, to the lower migration rates observed in the obituary database. In the context of a chapter that discusses the marginalisation of women, the absence of women's voices on such issues is regrettable, and will be rectified in future research.

## *Ethnicity and the Common-health*

This chapter has also left the issue of ethnicity in the Common-health system to one side. Initially, I had hoped to conduct research into the participation of Māori in the Common-health system, but I was unable to locate any Māori medical specialists to interview. Further, the various professional surveys, academic studies, and government reports on the New Zealand medical workforce that underpin much of this chapter's discussion on women doctors together make almost no mention of Māori doctors. Primarily, this was because Māori doctors made up only a tiny fraction of New Zealand's medical workforce. During its first twenty-five years in operation, the Otago Medical School graduated 130 doctors, of whom eleven were women and only two were Māori.<sup>123</sup> The 1926 New Zealand Census suggests that only three Māori were working as doctors that year, with one other studying medicine. The occupational questions included in the 1936 Census did not include a category that allows medical practitioners to be clearly identified, but the 1945 census again shows only four male Māori practitioners.<sup>124</sup> Although specific occupational categories changed regularly thereafter, figures suggest that there were three Māori doctors in 1951, eleven in 1956, thirteen in 1961, and seventeen in 1966. Paradoxically, the marginalisation of Māori in New Zealand medicine was so thorough that their situation was not considered a subject worthy of consideration in the literature on the medical workforce until the mid 1990s.

Evidence suggests that – just like their women colleagues – very few of these Māori doctors went on to work in the hospital setting. Michael Belgrave's research into the New Zealand medical profession before World War Two shows that many of those few Māori who did qualify in medicine ended up working either in general practice or in government services. Two of the most prominent Māori doctors, Maui Pomare and Te Rangihiroa (Sir Peter Buck), both spent time

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<sup>123</sup> Daniel Colquhoun, 'The History of the Medical School', *New Zealand Medical Journal*, vol. 8 (15 July 1910), p. 1.

<sup>124</sup> *New Zealand Population Census, 1945, Volume 3: Māori Census* (Wellington: Government Printer, 1945), p. 40. Michael Belgrave's research suggests that it is difficult to state definitively the number of doctors at work in New Zealand during the pre-World War Two period. Figures for 1941, for example, vary from 1,109 doctors identified in the national census to 1,416 doctors listed on the New Zealand Medical Register. Belgrave, "Medical Men" and "Lady Doctors", p. 242, footnote 2.

in the public service, and both devoted considerable portions of their careers to non-medical enterprise, in the New Zealand House of Representatives and, in Te Rangihiroa's case, also in academia. Dr Tutere Wi Repa spent most of his professional life in rural practice on New Zealand's East Coast, after having an appointment to Gisbourne Hospital rescinded.<sup>125</sup> Again, it was not until I became aware of the exclusionary potential of the Common-health system that I began to envisage a research approach that might have shed light on the reasons for this form of marginalisation. Specifically, interviewing doctors who had *not* succeeded in accessing Common-health networks, and who had entered other fields of medical work, such as general practise or government health services, could have generated further valuable insights into the particular ways in which the Common-health system excluded outsiders. This remains a potentially rich avenue for future study, the repercussions of which will be considered in the Conclusion to this thesis.

In lieu of the absence of sources on Māori participation in Common-health systems, I did conduct some preliminary research into the experiences of 'non-Anglophone' doctors seeking specialised training in British hospitals. By far the most valuable source of such information relevant to this study's time period was David J. Smith's 1980 study of *Overseas Doctors in the National Health Service*, already discussed in Chapter 4. Smith's study included both quantitative data and the results of qualitative surveys and interviews with doctors from the Indian subcontinent, Africa, the Caribbean and the Middle East who were working in Britain in 1977 and 1978. Overall, Smith's study suggests that the experiences of these doctors accessing and negotiating international systems were similar to those of women doctors. While Smith did find evidence to suggest that some British doctors exhibited discriminatory practices, he also noted that doctors from the 'new' Commonwealth often failed to understand the informal systems by which training appointments were obtained.<sup>126</sup>

For example, many respondents expressed a reluctance to approach the consultants who ran the units to which they had applied for jobs before their formal interviews, out of fear that this might be viewed as impertinent or even improper. Yet this was standard practise among British graduates, who recognised

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<sup>125</sup> Belgrave, "Medical Men" and "Lady Doctors", pp. 408-9.

<sup>126</sup> Smith, pp. 123-6.

the importance of informal relationships in the job-seeking process. Others were not aware that positions in the most prestigious institutions were often decided in advance, and as a result continued to apply for such positions despite repeated failures.<sup>127</sup> Smith cites remarkable statistics about the comparative success rates for Anglophone (meaning white, non-British) doctors and their non-Anglophone colleagues. On average, Anglophone doctors had to apply between two and three times before securing a position in a British hospital. By contrast, non-Anglophone doctors had to apply, on average, between sixteen and seventeen times before getting a job.<sup>128</sup> It is therefore not surprising to find that doctors from new Commonwealth countries often ended up working in the same low prestige specialties as women. Both David Smith and the British Postgraduate Medical Federation researcher, Robin Dowie, found that overseas graduates frustrated by repeated failures often applied for jobs in ‘unpopular’ specialties such as psychiatry, obstetrics / gynaecology, anaesthetics and geriatrics.<sup>129</sup>

These similarities make it tempting to conclude that the employment patterns of women and non-white doctors were shaped by similar attitudes, mechanisms and factors. However, other evidence suggests that such conclusions would be premature. David Smith’s study, for example, found that while doctors from New Zealand, Australia, and other Anglophone countries secured jobs much more easily than their non-Anglophone peers, they also found jobs more easily than British-born and trained graduates.<sup>130</sup> Anecdotal accounts suggest that the crucial factor in favour of white Commonwealth doctors was that relatively few of them applied for British jobs with the intention of gaining permanent appointments.<sup>131</sup> Hospital authorities could therefore employ them to fill much-needed service shortfalls without undermining the ability of local doctors to reach consultant status: the pinnacle of Britain’s pyramidal hospital promotional

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<sup>127</sup> Smith, pp. 164-5

<sup>128</sup> Six per cent of non-Anglophone had to apply *ninety-nine times* or more, while only five per cent of Anglophone doctors had to apply more than seven times. Smith, pp. 143-4.

<sup>129</sup> Dowie, pp. 116-7. Smith noted that psychiatry and geriatrics were not easier areas for overseas doctors to work in, as they often required the soundest knowledge of idiomatic English, and also dealt with patients who perhaps less tolerant than average of ‘foreign doctors’. Smith, pp. 11-13.

<sup>130</sup> British doctors applied an average of 3.1 times before securing a job, compared to 2.6 times for Anglophone doctors. Seventy-nine per cent of Anglophone doctors secured jobs after three applications or fewer, compared to seventy-two per cent of British doctors. Smith, pp. pp. 143-4.

<sup>131</sup> Interview with Dr Peter Rothwell, 8 August 2007.

structure. By comparison, a higher proportion of non-Anglophone doctors were believed to be pursuing permanent careers in Britain, and were therefore perceived as a threat to the career progression of British graduates. Further research, conducted with an awareness of the relevance of the international connections and processes discussed in this chapter, may help to generate a more nuanced understanding of the experiences of overseas doctors working in Britain and elsewhere, both in the past and in the present.

By the early 1960s, the presence of large numbers of non-white overseas doctors in Britain was becoming a political issue, leading to the introduction of immigration laws that were operationally, if not explicitly, racist.<sup>132</sup> While these altered Common-health migration patterns for doctors from India, Pakistan, the Middle East, the Caribbean, and Africa, their emphasis on race meant that they had only a limited influence on the movements of New Zealand doctors. Nonetheless, migration patterns among New Zealand doctors shifted significantly during the late 1960s and early 1970s. The final chapter in this thesis examines those changing patterns, and considers some of the factors that contributed to the reconfiguration of the New Zealand 'branch' of the Common-health system.

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<sup>132</sup> Ian R. G. Spencer, *British Immigration Policy Since 1939: the Making of Multi-racial Britain* (New York: Routledge, 1997), pp. 22-3.



## Chapter 7

### *The 'Fragmenting' of the Common-Health, 1965-1975*

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Previous chapters have examined the origins and development of the Common-health system, and its operation during the two to three decades that followed World War Two. During this period, specialised medicine became well established, and its practitioners accrued significant social and professional status. As a result, growing numbers of doctors chose specialty medicine as a career, which, for New Zealand doctors at least, necessitated migration. The strong cultural and economic links that existed between New Zealand and Britain contributed to a pattern whereby the vast majority of New Zealand's aspiring medical specialists travelled to Britain to live, work, practise, and obtain post-graduate qualifications during the 1950s and 1960s.

In 1968, the *New Zealand Medical Journal* published an editorial that read as a eulogy to this established post-graduate pattern:

By tradition when the New Zealand doctor thought that he had done enough house surgeon jobs he drifted over to Britain to undertake post-graduate study in medicine. There was a delightful informality about it; he attended what course he fancied, often obtained higher diplomas, and had little difficulty in finding congenial employment in hospital or in general practice. A fortunate few were sponsored by their seniors and worked at prestigious institutions. Our doctors acquired a high reputation and were universally liked. Britain was a second home and formality was minimal. All this has changed and Great Britain has been compelled by her domestic situation to restrict entry of members of the Commonwealth, and without regard for colour or creed. . . . The Commonwealth Immigration Acts of 1962 and 1968 have made it

impossible for New Zealanders to enter Britain without considerable formality, and we are no different to other Commonwealth citizens.<sup>1</sup>

In reality, however, New Zealand doctors were very different to other Commonwealth citizens, for two important reasons. The first of these reasons was that highly skilled migrants such as doctors were exempted from the restrictions imposed by Immigration Acts. Although the 1962 Act required immigrants to obtain work vouchers before entering Britain, the desirability of medical qualifications meant that this was little more than a formality for medical migrants.<sup>2</sup> It was not until 1985 that regulations began to restrict the immigration of doctors into Britain. Even then, rules stipulating that all doctors from outside the European Economic Community had to have work permits, and that employing bodies had to demonstrate that no locally qualified people were available did not apply to doctors entering Britain for post-graduate training purposes. The only restriction that applied to New Zealand doctors was that the duration of their visits to Britain for post-graduate training should not exceed four years.<sup>3</sup>

The second main reason that British immigration policies had minimal influence over the movements of New Zealand doctors was that, contrary to claims in the editorial cited above, they did in fact differentiate between Commonwealth citizens on the basis of race.<sup>4</sup> While continuing exemptions for doctors meant that the 1968 Act's requirement that immigrants seeking 'settled' or on-going residency status must have at least one British parent or grandparent did not influence New Zealand post-graduate medical migrants unduly,

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<sup>1</sup> 'Study in Britain', *New Zealand Medical Journal*, volume 68, number 436 (September 1968), pp. 179-80.

<sup>2</sup> Oscar Gish, 'British Immigration, 1955-1968', *International Migration Review*, volume 3, number 1 (Autumn 1968), p. 19. Indeed, Gish suggests in passing that Australian doctors, and therefore presumably New Zealand ones, were exempt even from requiring work vouchers, although this has proved difficult to verify. Gish, 'British Immigration, 1955-1968', p. 33.

<sup>3</sup> Robin Dowie, *Postgraduate Medical Education: The System in England and Wales* (London: King's Fund Publishing Office, 1987), pp. 89-90.

<sup>4</sup> Immigration historian Ian Spencer notes that British immigration policy differentiated between Commonwealth citizens on the basis of race even before the introduction of the 1962 Act. While all British subjects had theoretically enjoyed the right of free entry into the United Kingdom irrespective of colour or country of origin, the processes of immigration often placed informal barriers before applicants from Africa, South Asia, or the Caribbean. Spencer contrasts Britain's welcoming 'public face' against its 'private calculation to exclude'. Ian R. G. Spencer, *British Immigration Policy since 1939: the Making of Multi-racial Britain* (New York: Routledge, 1997), pp. 152-3.

subsequent measures that were applied to all doctors left New Zealanders largely unaffected. The introduction of English language proficiency tests in 1979, with pass rates of between twenty-five and thirty per cent, for example, immediately restricted the immigration rates of doctors from the ‘new Commonwealth’ – South Asia, Africa, and the West Indies – but were little obstacle for doctors from New Zealand.<sup>5</sup>

Immigration legislation therefore had little impact on the post-graduate migrations of New Zealand doctors. However, Common-health patterns did undergo significant changes during the 1960s and 1970s, driven mainly by the same factors that had contributed to the establishment of those patterns in the first place. Britain’s *ad hoc* training systems, for example, both underpinned large scale specialist migration to Britain, and contributed to its decline by failing to keep pace with the increasingly sophisticated needs of trainee specialists. Similarly, while the rise of specialisation in medicine had made Britain a hub for specialised training within the Commonwealth after World War Two, its continuing development from the 1960s led to the establishment of increasingly sophisticated services and organisations elsewhere in the Common-health, with the result that post-graduate training ceased to be centred almost solely on Britain and became increasingly multi-centred in character. For New Zealand doctors, a growing proportion of specialised post-graduate training came to be carried out in the United States, in Australia, and eventually, in New Zealand.

This chapter contends that the 1960s and early 1970s was a period of reconfiguration for the Common-health system. It discusses the ways in which the process of specialisation impacted migration patterns, and altered the relative prestige of British and Australasian College qualifications. It also examines the ways in which Commonwealth doctors and professional spokespeople perceived, and often resisted, the reconfiguration of the Common-health system during this period. An examination of British and New Zealand medical journals from the period shows that medical spokespeople constructed and deployed discourses that drew upon notions of internationality, common values, and Christianity in an attempt to justify and preserve a system of international connections that they

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<sup>5</sup> John Lister, *Postgraduate Medical Education* (London: Nuffield Provincial Hospitals Trust, 1993), pp. 66-7. See also Dowie, pp. 90-1.

thought was under threat, but which continued to be valued as the basis of medical practice, and the profession itself.

*'Rather Out Of Step with the Rest of the English Speaking World'*<sup>6</sup>

As discussed in earlier chapters, Britain's position at the centre of Commonwealth post-graduate training was in part attributable to the underdeveloped state of its post-graduate training programmes. The lack of formal training structures enabled large numbers of Commonwealth doctors to access British hospitals and to learn specialist medicine first hand. However, the numerical opportunities provided by an *ad hoc* system did not compensate for its operational weaknesses. Despite the emergence of numerous specialist societies after World War One, and the acceleration of specialisation after World War Two, British specialist training continued to be delivered almost exclusively on an informal basis, with little centralised planning or control. The maintenance of medical standards through accreditation, credentialing, and the devolving of qualifications was not deemed a task for clinical teachers, but was instead controlled by Britain's Royal Colleges and their notoriously difficult examinations. The 'get what you can, where you can' nature of British specialty training created significant inconsistencies in training standards and content. In addition, the traditional hostility towards specialised medicine in Britain, and particularly in England, meant that the Royal College examinations charged with maintaining medical standards were slow to make any provision for the particular needs of specialists. It was not until 1943 that the examination of the English Royal College of Surgeons included a section designed to test specialist knowledge. This was in ophthalmology, which had by that time been established as a hospital-based specialty in London for almost a hundred years.<sup>7</sup> An otolaryngology section followed in 1947, approximately seventy years after the establishment of London's Royal National Throat, Nose

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<sup>6</sup> David Cole, 'Post-graduate Medical Education: The Graduate Phase in New Zealand', *New Zealand Medical Journal*, volume 78, number 496 (8 August 1973), p. 122.

<sup>7</sup> Specialist ophthalmologists served on the staff of London's St Mary's hospital from at least 1851. See Rosemary Stevens, *Medical Practice in Modern England: The Impact of Specialisation and State Medicine* (London: Yale University Press, 1966), pp. 26-9.

and Ear Hospital.<sup>8</sup> The College of Surgeons introduced other specialties only slowly thereafter, with the result that well into the 1960s, surgeons trained in urology, for example, could be asked to demonstrate knowledge of orthopaedics during a College examination. Because of this, the examinations of Britain's Royal Colleges were by that time generally viewed as 'entry' examinations that recognised a candidate's suitability to *begin* specialist training, rather than recognising its completion.

In 1961, a Nuffield Provincial Hospitals Trust Conference held in Oxford recommended the formalisation of several aspects of British post-graduate medical training. The reorganisation of Britain's health system under the National Health Service had contributed to the modernisation of many provincial hospitals, and a general improvement in the standard of care they provided. Recognising this as an opportunity to improve post-graduate training, the Trust recommended that all positions between Senior House Officer and Senior Registrar should be formally designated as training posts, and called for the establishment of Regional Postgraduate Committees to co-ordinate training. It also recommended that provincial hospitals should develop dedicated teaching facilities and appoint official tutors to monitor the delivery of training.<sup>9</sup> While this was a positive step in theory, observers noted that the recommended £100 yearly honorarium for clinical tutors suggested that appointees were not expected to dedicate much time or effort to the role.<sup>10</sup> Nonetheless, by 1968, British provincial hospitals had employed 311 clinical tutors to oversee post-graduate training.<sup>11</sup> During the same period, the English Royal College of Surgeons began to appoint regional 'advisors' on clinical training, with the Royal College of Physicians following suit in 1969.<sup>12</sup> In 1966, several British surgical Colleges formed Specialist Advisory Committees in nine different surgical specialties, to ensure that registrars were receiving training appropriate for both their own needs and for the needs of the NHS as a whole. The following year, British Royal Colleges, universities, and medical schools, together with the Ministry of Health, establish a joint Central

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<sup>8</sup> Stevens, p. 112.

<sup>9</sup> Lister, pp. 20-4.

<sup>10</sup> 'Editorial: Postgraduate Education in Regional Hospitals', *British Post-graduate Medical Journal*, volume 40, number 468 (October 1964), p. 569.

<sup>11</sup> Lister, pp. 20-4.

<sup>12</sup> The Royal College of Physicians appointed its first formal tutors in 1987. Lister, p. 24.

Committee on Postgraduate Medical Education for the same purposes.<sup>13</sup> Specialised training in Britain was finally being subject to central organisation. The tardiness of these developments however was noticed in other parts the Common-health. In 1973, for example, the Dean of the Auckland Medical School, Professor David Cole, wrote an article in the *New Zealand Medical Journal* claiming that British post-graduate training was by now ‘rather out of step with the rest of the English speaking world’.<sup>14</sup>

Importantly, similar developments were occurring, but at a faster pace, in the Australasian medical and surgical Colleges. For decades, these Colleges had exerted little influence over post-graduate training within their own jurisdictions, and even less over international post-graduate migration patterns. In the 1960s, the Australasian Colleges began to implement changes that would radically, and rapidly, alter the form and function of the Common-health system.

### *The Rise of the Australasian Colleges*

The founders of both the Royal Australasian College of Physicians and the Royal Australasian College of Surgeons were motivated by a desire to gain autonomy from their British counterparts, in the form of more direct control over their professional affairs and the creation of clinical standards ‘appropriate to the local scene’.<sup>15</sup> Yet the new antipodean bodies continued to associate themselves with their illustrious British forebears. When the Australasian College of Surgeons held its first annual meeting in Sydney in 1928, local press condemned it as a ‘farcical attempt to corner [the] sawbones market’, and wrote that its members were motivated primarily by a desire to discuss ‘appendix snooping, snaring the tonsil, dissection of the pay-roll, and other subjects dear to the top-notch sawbones’.<sup>16</sup> By 1931, however, the College had obtained a Royal Charter and had adopted a

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<sup>13</sup> ‘Central Committee on Postgraduate Medical Education’, *British Medical Journal*, volume 2, number 5555 (24 June 1967), p. 833.

<sup>14</sup> Cole, ‘Post-graduate Medical Education’, p. 122 (see footnote 6 above).

<sup>15</sup> Robert G. Evans, ‘A Quest for Identity, Authority and Status: The Development of Paediatrics in Australia’, *Health and History*, volume 10, number 2 (2008), pp. 54-5.

<sup>16</sup> The first quote from the *Sunday Times* (Canberra), 22 April 1928, while the second comes from the *Daily Guardian* (no date) March 1929, both cited in Sarah (Sally) Wilde, ‘Practising Surgery: A History of Surgical Training in Australia, 1927-1974’, PhD Thesis, University of Melbourne, 2003, p. 31.

number of symbolic rituals designed to create associations with traditional British values.<sup>17</sup> When Australian newspapers reported that representatives of the British College of Surgeons were visiting to present the Australasian College with a ceremonial Mace that year, their tone could hardly have been more different from that of the *Sunday Times* just a few years before.. The *Melbourne Herald* referred to the British guests as ‘a distinguished group of men’, who, as ‘members of a profession which avoids self-advertisement . . . will slip as quietly as possible into the city’s stream’.<sup>18</sup> When the Royal Australasian College of Physicians was established in 1938, it also acquired – in addition to its Royal Charter – a venerable Sydney mansion as its headquarters, a heraldic shield, a Latin motto, and presidential robes.<sup>19</sup>

Despite their appropriation of British devices, neither Australasian College had sufficient prestige to replace membership of the British Colleges as the recognised marker of the senior practitioner.<sup>20</sup> The Membership qualification of the Royal Australasian College of Physicians ‘was hardly known beyond Australasia’ at the end of World War Two.<sup>21</sup> When Dr Wyn Beasley travelled to Britain in 1954, only ‘a small minority of specialists did the local [surgical] fellowship or membership before departing’.<sup>22</sup> While the New Zealand physician and administrator, Dr John Hiddlestone, sat and passed the examination for membership of the Royal Australasian College of Physicians in the mid 1950s, he only did so in order to generate connections that would help to overcome the sense of isolation that came with provincial practise.<sup>23</sup>

Both Australasian Colleges attempted to increase both their status and their membership, but these two factors proved to be practically mutually exclusive. Encouraging local doctors to become members by making their

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<sup>17</sup> Wilde, ‘Practising Surgery’, pp. 32-7.

<sup>18</sup> *Melbourne Herald*, 16 February 1932, cited in Wilde, ‘Practising Surgery’, 2003, p. 32.

<sup>19</sup> Ronald Winton, ‘Vocational Medical Colleges in Australia and New Zealand: A Latter Day Phenomenon’, in *New Perspectives on the History of Medicine: First National Conference of the Australian Society of the History of Medicine, 1989*, ed. by H. Attwood, R. Gillespie and M. Lewis (Melbourne: University of Melbourne, 1990), pp. 282-6.

<sup>20</sup> Ronald Winton, *Why the Pomegranate: A History of the Royal Australasian College of Physicians* (Sydney, Royal Australasian College of Physicians, 1988), p. 4.

<sup>21</sup> John Adams, *John L. Adams M.D.: The Autobiography of a Physician: The Family, Life and Times of a New Zealand Consultant Physician* (Wellington: Steele Roberts, 2000), p. 98.

<sup>22</sup> Interview with Dr Wyn Beasley, 17 March 2011.

<sup>23</sup> John Hiddlestone, *By Stethoscope and Statute: Autobiography, Part I, 1925-1983* (Self-Published, 1993), p. 48.

examinations easier than the British equivalents eroded the credibility of their qualifications, while attempts to improve their credibility by making examinations harder only encouraged Australasian doctors to seek the easier but more prestigious British qualifications. During the 1940s and 1950s, both the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians adjusted the difficulty of their examinations and their pre-examination training requirements several times, ending up with conditions that were broadly similar to those of the British Colleges.<sup>24</sup> Despite these changes, the continuing prestige differential still left Australasian doctors with little to gain from seeking membership of their local Colleges.

From the early 1960s, The Australasian Colleges of Physicians and Surgeons began to differentiate themselves from the British Colleges by providing formal, organised post-graduate training.<sup>25</sup> In 1962, the Royal Australasian College of Surgeons initiated formal tutoring in the surgical sciences through evening lectures designed to aid candidates preparing to sit the College's Primary examination. Initially, this was very similar to the pre-examination surgical science course that the British Royal College of Surgeons had held at Lincoln Inn Fields since World War Two. The acquisition of 'practical' surgical training continued to be the responsibility of the trainee, and most Australasian doctors continued to travel to Britain for this aspect of their training.<sup>26</sup> Over the next decade, however, the Australasian Surgical College provided increasingly comprehensive training programmes. Sally Wilde has noted that this development was initiated by local specialised medical and surgical societies, in an attempt to promote the interests of their members and the standing of their respective disciplines.<sup>27</sup> By the 1970s, the training programmes provided by the Royal

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<sup>24</sup> Wilde, 'Practising Surgery', pp. 80-3, and Warwick J. Benson, 'The History of the College Examination', in *To Follow Knowledge, A History of Examinations, Continuing Education and Specialist Affiliations of the Royal Australasian College of Physicians*, ed. by Josephine Wiseman (Sydney: Royal Australasian College of Physicians, 1988), pp. 1-10.

<sup>25</sup> By this time, other Australasian Colleges had been established. These are discussed later in the chapter.

<sup>26</sup> Wilde, 'Practising Surgery', p. 196.

<sup>27</sup> Wilde notes that the initial shift towards providing a training function was initiated by the Australian Orthopaedics Association, followed soon after by neurosurgeons and plastic surgeons. Wilde, 'Practising Surgery', pp. 267-8. The Royal Australasian College of Physicians had also catered to the needs of specialists by including specialised questions in their examination from an early period. From 1938, candidates were able to have the clinical part of their examination

Australasian College of Surgeons were of sufficient value to make obtaining a local Membership a viable alternative to the expensive and inconvenient British post-graduate path.<sup>28</sup> Similarly, the Royal College of Physicians established a Centre for Continuing Education in 1972, and then established Accreditation and Credentials Boards in both Australia and New Zealand to assess the suitability of hospitals for providing training in preparation for the introduction of a two-part examination, which occurred in 1975.<sup>29</sup> At that point, it became compulsory for candidates to complete two years in an approved hospital before sitting the examination, followed by at least three years in an approved training post and a final examination.<sup>30</sup> By providing post-graduate training in these ways, the Australasian Colleges successfully cast their examinations as ‘exit’ qualifications that denoted full specialist status.<sup>31</sup> The change was gradual, however, and during the 1960s most trainee specialists from Australia and New Zealand continued to require access to larger population centres than either country could provide, and therefore continued to travel to Britain to obtain practical experience.

Crucially, obtaining an Australasian qualification that was becoming more widely recognised before departure proved to be a considerable advantage to these migrants. The Hamilton renal physician, Dr Martin Wallace, attained Membership of the Australasian College of Physicians before departing for Britain in 1965. The College’s pre-examination training requirements meant that Dr Wallace was older and more experienced than many of the medical graduates against whom he was competing for jobs in Britain.<sup>32</sup> The Hamilton gastroenterologist, Dr Peter

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orientated towards their intended specialty, although provision for a specialised written component did not appear until 1964. Benson, p. 1.

<sup>28</sup> Wilde, ‘Practising Surgery’, p. 196. The Australasian Urological Society specified that members had to be ‘graduates of British Universities or Colleges’, and from 1950, to hold ‘a surgical degree obtained by a two-part examination of a British University or College.’ In 1975, The Society made the Diploma (Part One) or Fellowship (Part Two) of the Royal Australasian College of Surgeons, or an equivalent qualification with similar training requirements, its basic prerequisite for membership, Sarah (Sally) Wilde, *Joined Across the Water: A History of the Urological Society of Australasia* (Melbourne: Hyland House, 1999), p. 81.

<sup>29</sup> James R. Lawrence, ‘The History of the Continuing Education Centre’, in *To Follow Knowledge: A History of Examinations, Continuing Education and Specialist Affiliations of the Royal Australasian College of Physicians*, ed. by Josephine Wiseman (Sydney: Royal Australasian College of Physicians, 1988), p. 11-12, and Benson, p. 5.

<sup>30</sup> Benson, p. 5.

<sup>31</sup> Sarah (Sally) Wilde, ‘The English Patient in Post-colonial Perspective, or Practising Surgery on the Poms’, *Social History of Medicine*, volume 18, number 1 (April 2005), pp. 107-21. See also Lister, p. 25.

<sup>32</sup> Interview with Dr Martin Wallace, 2 October 2010.

Stokes, recalled being advised to sit the Australasian Surgical Fellowship before going to Britain in 1971 because ‘the place was awash’ with medical graduates, many from the Indian subcontinent, seeking training positions without any qualifications.<sup>33</sup>

The emergence of Australasian College membership as viable post-graduate qualifications in their own right had other ramifications for Australasian post-graduate migration patterns. In 1962, an article in the *British Post-graduate Medical Journal* predicted that

[Australasian] postgraduates will increasingly tend to travel having already attained a postgraduate qualification, and many of them will also already have gained some years’ experience in investigational work and teaching. Their primary object will be to gain special practical and research experience which they cannot get in Australia, rather than to pass a postgraduate examination.<sup>34</sup>

By the time the Otago immunologist, Dr James Faed, travelled to Britain in 1979, he felt that attempting the British College examinations would be little more than an exercise in ‘jumping through hoops’, with no professional advantage over the Australasian qualifications that he had attained before departure.<sup>35</sup> By that time, most New Zealand hospital boards preferred Australasian qualifications over European or North American ones, although they continued to prefer candidates who had obtained some overseas work experience.<sup>36</sup>

This process of ‘localisation’ was repeated and reinforced as the number of Australasian practitioners in various sub-specialties increased, and eventually, reached a critical mass sufficient to justify the establishment of local societies. Radiologists and anaesthetists established Australasian organisations in 1952, followed by pathologists in 1956, psychiatrists in 1963, and dermatologists in 1967. During the 1960s and 1970s, the *New Zealand Medical Journal* regularly notified its readers about the formation of national specialist organisations, such

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<sup>33</sup> Interview with Dr Peter Stokes, 12 November 2010.

<sup>34</sup> W. W. S. Johnston and R. R. H. Lovell, ‘Postgraduate Medical Education in Australia’, *British Post-graduate Medical Journal*, volume 38, number 440 (June 1962), p. 327.

<sup>35</sup> Interview with Dr James Faed, 17 February 2011.

<sup>36</sup> *Report of the Advisory Committee to the Minister of Health on Resident Medical Officers* (Wellington: Department of Health, 1978), p. 43.

as the New Zealand Obstetrics and Gynaecology Society, the New Zealand Society for Oncology, the New Zealand Society for the Study of Diabetes, the New Zealand Rheumatism Association, and many others. All of these organisations sought to promote their specialties by accrediting training venues, providing courses, running conferences, and by stipulating the level and type of experience required to warrant specialist status.

The development of regional or national training structures did not mean the end of international migration for post-graduate training purposes. The vast majority of New Zealand specialist organisations were too small to provide the range of views and approaches that would allow their disciplines to develop, and New Zealand's small domestic population still required its specialists to travel in order to obtain the necessary volume of practical experience.<sup>37</sup> However, the specific pattern of post-graduate migration was changing. By the early 1970s, because Australasian doctors no longer needed to devote large amounts of their overseas time to examination preparation, most travelled primarily for the purposes of obtaining practical experience. At the same time, the kind of experience that New Zealand specialists sought also changed. As the Australasian specialist workforce grew, as Australasian hospitals developed specialised departments, and as specialised training programmes were refined, it became increasingly viable for New Zealand doctors to obtain a proportion of their preliminary specialised training within Australasia. Because of these changes, migrations beyond Australia or New Zealand became less frequent, shorter in duration, and more closely targeted at particular aspects of advanced specialised training. Importantly, the waning importance of British post-graduate qualifications, and the relatively sophisticated nature of much British specialised medicine encouraged New Zealand doctors to look to centres outside of Britain for those experiences. By the early 1970s, Professor David Cole was not alone in

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<sup>37</sup> In 1970, only six of New Zealand's twenty-eight clinical organisations had more than one hundred members, while ten had fewer than fifty members. This does not include 'political' medical organisations such as the New Zealand Medical Association or the New Zealand Medical Women's Association. David Cole, 'A Single Medical College for New Zealand', *New Zealand Medical Journal*, volume 72, number 460 (September 1970), p. 191.

contrasting the British situation, unfavourably, with the more highly organised system in operation in the United States.<sup>38</sup>

### *The Drift to North America*

When Dr Peter Rothwell left New Zealand for post-graduate training in 1957, Britain was ‘the only realistic choice’, mainly because all of his senior colleagues had only British connections. During his subsequent three decades of practice as a specialist thoracic physician, Dr Rothwell made four trips to the United States and Canada for formal study leave or specialist courses and conferences, but returned to Britain just twice.<sup>39</sup> In part, this was because by the late 1960s, the New Zealand Thoracic Society had several members who had both experience and contacts in United States, and who were therefore able to make recommendations about useful destinations for further training. After being educated and trained in a British system, Dr Rothwell was attracted to the United States by ‘the new names and new faces’, and also by the fact that American doctors were by then ‘leading the way’ in several aspects of thoracic medicine.<sup>40</sup>

In 1905, and again in 1914, Britain and New Zealand had implemented reciprocity agreements that all but excluded doctors with qualifications obtained outside of those two countries from registering in New Zealand.<sup>41</sup> As Michael Belgrave has noted, these provisions did not completely isolate New Zealand from United States and European medicine. During and after World War One in particular, ‘quite large numbers’ of New Zealand surgeons met American doctors, and later travelled to the United States to visit them in their home institutions.<sup>42</sup> Francis Gordon Bell wrote that New Zealand surgeons were ‘drawn to the great

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<sup>38</sup> See, for example, ‘Editorial: Postgraduate Education in Regional Hospitals’, *British Post-graduate Medical Journal*, volume 40, number 468 (October 1964), p. 569.

<sup>39</sup> Peter Rothwell, *Tihe Mauri Ora: The Ramblings of an Aging Respiratory Physician* (Hamilton: unpublished manuscript, 2007), unpaginated.

<sup>40</sup> Interview with Dr Peter Rothwell, 28 August 2007.

<sup>41</sup> Michael Belgrave, ‘“Medical Men” and “Lady Doctors”’: The Making of a New Zealand Medical Profession, 1857-1941’, PhD Thesis, Victoria University of Wellington, 1985, pp. 90-106.

<sup>42</sup> Belgrave, ‘“Medical Men” and “Lady Doctors”’, pp. 282-4.

figures dominating surgery and the warm welcome and excellent opportunities for post-graduate work in the United States of America.’<sup>43</sup>

World War Two generated more enduring links between New Zealand and American medicine. In the wake of the Japanese attack on Pearl Harbour in 1942 and the start of the Pacific War, the United States Navy built a military hospital in Remuera, a suburb of Auckland, and an Army hospital in nearby Cornwall Park. The United States established other medical teams in Wellington and in several Australian centres. The Auckland surgeon, Sir Douglas Robb, was ‘vastly impressed with the gadgetry and the new plastic and metallic materials’ that American doctors brought with them, as well as their ‘modern’ methods:

The first onslaught was a Johns Hopkins Hospital team from Baltimore, complete with shining faces and spanking new uniforms. . . . Who will forget the impact of those first meetings, having them to our homes, and to our hospitals? We had had a few leading men from U.S.A. in the years between the Wars, such as Will Mayo from Rochester and Evarts Graham from St. Louis, but this invasion was both massive and continuing and was reinforced many times before the war was over. . . . Hitherto our dependence on British Medicine had been very great. From this time onwards we embraced American methods and influences more fully.’<sup>44</sup>

While Robb’s claim that ‘New Zealand has never experienced such a massive “cultural invasion” since the great Polynesian migration nearly a thousand years ago’ somewhat overlooks the influence of his own European forebears, it clearly communicates the impact that United States medicine had on New Zealand doctors.<sup>45</sup>

As was the case with New Zealand doctors visiting Britain, many of the visiting American doctors formed friendships with their New Zealand colleagues. Some later facilitated opportunities for New Zealand doctors to visit American hospitals, or returned to New Zealand for social or professional visits after the

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<sup>43</sup> Francis Gordon Bell, ‘Forty Years On: Something on South Sea Surgery and Surgeons’, *Australian and New Zealand Journal of Surgery*, volume 39, number 1 (August 1969), p. 1.

<sup>44</sup> Sir Douglas Robb, *Medical Odyssey: An Autobiography* (Auckland: Collins, 1968), pp. 70-1.

<sup>45</sup> Robb, *Medical Odyssey*, p. 71.

War. Yet despite these new interpersonal networks, Britain remained the primary destination for New Zealand post-graduate trainees until at least the late 1960s. Of the 447 New Zealand-born doctors whose obituaries mention post-graduate migration, 243 made references to training in the United Kingdom, while only twenty-eight mention the United States. There were several reasons for this. New Zealand doctors who were considering America as a training option could not rely upon the supportive familial connections that many had in Britain, and the United States also lacked the professional networks and historical associations that arose from New Zealand's historical reliance on Britain for undergraduate education. Importantly, gaining entry into the formal specialised training programmes used in the United States was highly competitive, particularly for New Zealand graduates whose undergraduate degrees were not automatically recognised by United States medical authorities. In addition, the cheap and regular shipping links that transported so many New Zealand doctors to and from Britain were not available for those wishing to travel to the United States.

Although very few New Zealand doctors were able to obtain all of their post-graduate training in the United States during the late 1940s and 1950s, growing numbers began to return home to New Zealand via the United States in order to 'round off' their British training.<sup>46</sup> After their immersion in British medicine, New Zealand doctors often found the contrast with United States medicine striking. The New Zealand ENT surgeon, Sir Patrick Eisdell Moore, noted the advanced state of American specialisation compared to the British situation. During a visit to the United States in 1960, Eisdell Moore worked with Dr Howard House, a Los Angeles based ENT surgeon who had developed such expertise in a single procedure, the stapedectomy, that he attracted referrals from all over the country and was able to devote himself to it exclusively.<sup>47</sup> New Zealand doctors also noticed a different overall 'attitude' towards specialised medicine. An Editorial published in the *British Postgraduate Medical Journal* in October 1964 outlined some of the manifestations of this attitude:

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<sup>46</sup> Sally Wilde notes, for example, that several of Australasia's first urologists had trained in Britain, but opted to travel home through Rochester and the famed Mayo Clinic in order to take advantage of the significant opportunities for surgical experience, and to be exposed to American research and 'progressive' attitudes. Wilde, *Joined Across the Waters*, pp. 14, 23, 29, 30, 33, 37.

<sup>47</sup> Patrick Eisdell Moore, *So Old, So Quick*, p. 297. Stapedectomy is a procedure for restoring hearing loss caused by fused or damaged inner-ear bones.

[t]he intellectual ferment in even the smaller American hospitals always astonishes English visitors. The regular conferences, the excellent libraries, the frequent discussions and the fraternal attitude, with an absence of pontification and a willingness to listen to criticisms and contributions from junior staff, all combine to produce a stimulating atmosphere conducive to the development of that frame of mind which regards Medicine as a 'Life-Long Study'.<sup>48</sup>

Several New Zealand doctors recalled that exposure to 'the American attitude' changed their own attitudes towards the process of specialisation. During a visit to the United States in 1948, Douglas Robb noted with approval that American surgeons viewed their work as a 'developing business open for contribution from anyone with ideas and the energy to work them out.' This was very different to the British attitude, which viewed surgery as 'something to be achieved and practised' rather than developed.<sup>49</sup> Dr Warren Austad worked in North Carolina after carrying out gastroenterology training in Britain in the late 1960s, and remembered the sense of purpose that American doctors brought to their work. As well as being better resourced than their British colleagues, they were generally much harder working, 'didn't laugh much', and tended to 'over-investigate and over-treat'.<sup>50</sup> In 1962, a British commentator critiqued British post-graduate training by noting that the staff of most large American hospitals worked full-time, and started work at least an hour earlier than was usual in Britain. Because of this, they had more time available to devote to formal teaching and clinical discussion than British consultants, who often divided their time between several hospital appointments, and their own private practices.<sup>51</sup>

New Zealand doctors who had been to the United States often returned to New Zealand keen to implement some aspects of the American system. In the mid 1950s, Dr Peter Rothwell worked as a house surgeon under the Wellington physician Dr Vern Cable, who had just returned to New Zealand from a six-month

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<sup>48</sup> 'Editorial: Postgraduate Education in Regional Hospitals', *British Postgraduate Medical Journal*, volume 40, number 468 (October 1964), p. 569.

<sup>49</sup> Robb, *Medical Odyssey*, p. 100.

<sup>50</sup> Interview with Dr Warren Austad, 17 March 2011.

<sup>51</sup> A. Paton, 'The Place of the Regional Hospital in Postgraduate Education: The Provinces', *British Post-graduate Medical Journal*, volume 38, number 442 (August 1962), pp. 439-42.

Fulbright Lectureship at Harvard University. Dr Rothwell recalled that ‘when he came back, you could see that it had fired him up a bit.’<sup>52</sup> Dr Cable introduced ‘Grand Rounds’ at Wellington hospital. These were formal gatherings at which doctors would present unusual or illustrative cases to be discussed openly and in detail by all members of the medical staff. This system, popularised by the *New England Journal of Medicine*, was very different to Wellington’s British-style ward rounds, during which senior doctors would tour their wards with their juniors in tow, discussing their cases in an atmosphere that did not usually encourage constructive criticism. Compared to those members of Wellington’s staff who had undergone ‘orthodox’ training in pre-war Britain, Dr Rothwell thought Dr Cable to be a ‘live-wire’, ‘a different kettle of fish’, and ‘an unusual bird’.<sup>53</sup>

By the start of the 1970s, various factors were combining to make Kiwi doctors with American experience a much more common species. The rise of Australasian qualifications freed New Zealand doctors from the need to seek membership of British Colleges, and the development of specialised medical training opportunities in Australasia allowed post-graduate migrations to become shorter and more focussed. Further, the introduction of commercial air services between New Zealand and the United States in 1968 made travel easier and more affordable, thereby making the United States feasible as a destination in its own right, rather than as a stopover on the way home from Britain.

These changes did not occur uniformly across all medical specialties, and some developed connections with United States colleagues and institutions earlier than others. Primarily, this was due to the continuing importance of informal relationships in the creation and maintenance of professional medical networks. Once established, a friendship between colleagues often led to interactions between their associates, sometimes producing long-lasting bilateral links between certain institutions. In some specialties, the formation of relationships with American doctors at an early stage of that specialty’s development led to continuing associations, and a concomitant diminishing of British influence. One of the earliest and strongest relationships between New Zealand and American

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<sup>52</sup> Interview with Dr Peter Rothwell, 28 August 2007.

<sup>53</sup> Dr Rothwell remembered that doctors such as Vern Cable were sometimes given an additional unofficial post-nominal title after their official FRCS or MRCPs: ‘BTA’ meant ‘Been to America’. Interview with Dr Peter Rothwell, 28 August 2007.

specialists occurred in the field of cardiac surgery. The New Zealand cardiothoracic surgeon, Dr Rowan Nicks, wrote that his field had developed strongly in the United States because its dramatic nature appealed to the ‘adventurous’ and ‘vigorous’ nature of the American spirit.<sup>54</sup> Indeed, the first significant interactions between New Zealand and American cardiac surgeons stemmed from the latter’s development of a bold surgical technique to correct ventricular septal defects in so-called ‘blue-babies’.<sup>55</sup> In 1947, thoracic surgeons at Auckland’s Green Lane hospital, Douglas Rob and Rowan Nicks, read reports about a ground-breaking operation that had been performed at Baltimore’s Johns Hopkins University. Soon after, members of the public started fundraising to send a new-born baby with a ventricular defect to the United States for treatment. Green Lane’s surgical team realised that bringing the procedure to New Zealand would be more cost-effective in the long-term. To this end, Sir Douglas Robb travelled to Baltimore for six months in 1948, and began performing the operation soon after his return.<sup>56</sup>

Drs Nicks and Robb then worked to develop their new cardiothoracic surgical department along the lines of units they had visited at Massachusetts General, Johns Hopkins, and the Mayo Clinic in Rochester, Minnesota.<sup>57</sup> In particular, they were keen to develop the more open and less-hierarchical staff relations that were characteristic of those institutions.<sup>58</sup> In his autobiography, Dr Nicks wrote at length about the willingness of American consultants to provide graduates with one-on-one tuition and to facilitate opportunities to obtain further training in other units.<sup>59</sup> Green Lane later appointed Dr Brian Barratt-Boyes, who would go on to become a world leader in the surgical repair of cardiac defects in children. Barratt-Boyes had been offered a training position at the Mayo clinic

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<sup>54</sup> For examples, see Rowan Nicks, *Surgeons All: The Story of Cardiothoracic Surgery in Australia and New Zealand* (Sydney: Hale & Iremonger, 1984), pp. 135, 148, 175.

<sup>55</sup> The term ‘blue baby’ refers to a number of heart defects, each of which limits blood circulation in new-born babies, resulting in blue skin colouration.

<sup>56</sup> Chisholm, p. 31.

<sup>57</sup> Rowan Nicks, *Surgeons All: The Story of Cardiothoracic Surgery in Australia and New Zealand* (Sydney: Hale & Iremonger, 1984), p. 160.

<sup>58</sup> This pattern of generational development was an explicit philosophy of the founders of the Johns Hopkins Hospital in Baltimore, who retained their ablest trainees in the hope that they would then take up the mantle of professional mentor and personal guide. The Mayo Clinic in Rochester, Minnesota also played a significant role in the international dissemination of medical ideas and personnel by offering a postgraduate fellowship which provided an opportunity for doctors from around the world to train with leaders in their chosen specialty. Nicks, pp. 78-9.

<sup>59</sup> Nicks, p. 152.

under the world-leading heart surgeons Walton Lillehei and John Kirklin on the personal recommendation of senior Auckland surgeon Dr Davis Mitchell, who had himself received training at Mayo.<sup>60</sup> Informal recommendations were no less important in the United States than they were in New Zealand or Britain, particularly as neither the Otago degree nor the Australasian College Memberships or Fellowships ‘carried much weight’ in the United States. The Dunedin cardiologist, Dame Norma Restieaux, obtained a research fellowship at the Boston Children’s Hospital in the mid 1960s after her Otago mentor, Dr John Hunter, visited the hospital and mentioned her name. Coming to the United States after three years of training in Britain, Dame Norma immediately noticed a greater sense of purpose and more egalitarian relations between the institution’s paediatric cardiologists. She also observed that there were more women and international doctors than she had seen in Britain, mainly, she was told, due to the conscription of many male doctors to military service in the Vietnam War. Although Britain had given her ‘a marvellous basis’ in cardiology, Dame Norma reflected that the adoption of ‘American attitudes’ to progressing her field was the most important single lesson of her overseas migration. Inspired by the atmosphere in Boston, Dame Norma maintained her American contacts, more than her British ones, after her return to New Zealand.

### *The Development of Post-graduate Training in New Zealand*

American doctors played a prominent role in the establishment of post-graduate training in New Zealand. In 1911, Professor Sydney Champtaloup of the Otago Medical School ran New Zealand’s first course in post-graduate medicine. The three day course attracted only eight doctors, and his plan to repeat these every two years was interrupted by World War One, and ended by his early death in 1921.<sup>61</sup> Auckland doctors established a Clinical Society in 1921 to support continuing education, but this group mainly served to keep general practitioners up-to-date with recent clinical developments, rather than to provide any kind of

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<sup>60</sup> Donna Chisholm, *From the Heart: A Biography of Sir Brian Barratt-Boyes* (Auckland: Reed Methuen, 1987), p. 45, and Nicks, p. 132.

<sup>61</sup> Rex Wright-St Clair, *An Exercise in Self Help* (Hamilton: Waikato Post-graduate Medical Society, c. 1994), pp. 15-17.

specialised training.<sup>62</sup> Prior to World War Two, New Zealand had no national post-graduate infrastructure to co-ordinate such regional initiatives. In 1937, an Editorial in the *New Zealand Medical Journal* complained that ‘the absence of any facilities for post-graduate study in this country is becoming an increasing reproach to the profession.’ It claimed that New Zealand had no formal structures to support doctors preparing for post-graduate examinations, or to provide the on-going post-graduate education that doctors needed to remain up-to-date during their careers. While the Editorial acknowledged that post-graduate migration was necessary in the New Zealand context, it suggested that the tradition of overseas post-graduate training had become so firmly entrenched that the possibility of conducting any post-graduate training in New Zealand ‘had been lost sight of.’ This had in turn inhibited efforts to establish medical research in New Zealand, limited opportunities for professional fellowship, and stifled the development of medical services.<sup>63</sup>

In Easter 1943, American doctors at Auckland’s two military hospitals organised a three-day course in post-graduate medicine to be held at Auckland hospital. They anticipated only about twenty-five attendees, because many New Zealand doctors were ‘at a low ebb with overwork’ during the war and were not expected to be in a position to take three days off work to attend. In the event, two hundred doctors turned up, and according to Sir Douglas Robb, ‘[p]ost-graduate interest has never flagged in New Zealand since that time.’<sup>64</sup> Within months, Auckland doctors had established an Auckland Post-graduate Medical Committee, as had those in the Waikato region 150 kilometres to the south. In 1949, a New Zealand Post-graduate Medical Federation was set up to coordinate the activities of eight regional Post-graduate Committees, based at the Otago Medical School, at Auckland University, and at the main public hospitals in Hamilton, Napier, Palmerston North, Wellington, Christchurch, and Invercargill. The Federation organised regular courses in basic medical sciences to help doctors prepare for post-graduate examinations, held a two-week long course each year on various medical and surgical topics, and ran regular weekend courses to help general

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<sup>62</sup> Wright-St Clair, *An Exercise in Self Help*, p. 21.

<sup>63</sup> ‘Editorial: Post-graduate Education in New Zealand’, *New Zealand Medical Journal*, volume 36, number 193 (June 1937), pp. 157-8.

<sup>64</sup> Robb, *Medical Odyssey*, pp. 72, 82.

practitioners to keep abreast of new developments and to maintain their competency.<sup>65</sup>

One of the most important functions of New Zealand's new post-graduate committees was the organisation of visits to the country by prominent overseas practitioners. Douglas Robb wrote that during the 1960s, the Auckland Post-Graduate Committee hosted 'an increasing stream of visitors from Australia, the United Kingdom, and the North American Continent, and a variety of other countries including India, South Africa and Scandinavia.'<sup>66</sup> Dr Peter Rothwell recalled that even New Zealand's smaller provincial post-graduate societies succeeded in attracting world-leading international doctors:

So, we had that reverse migration after the war, where quite small places did quite big things. Invercargill were notable for that, Hawkes Bay were notable for that. Strong [post-graduate] societies. I think both of them were backed, as [Waikato] was, by the local savings bank. It was a good example of where local money went. It did a lot for them. They often had visitors that raised eyebrows from other people. Those visitors came, and more and more got into not just passing through, but actually working with you for a while . . . and in the course of that they would run a course which attracted [doctors from throughout New Zealand].<sup>67</sup>

As Dr Rothwell inferred, New Zealand's geographical remoteness meant that many of these visitors remained in the country for some time, and toured through several centres, working and teaching as they went. These visits therefore represented invaluable opportunities for New Zealand doctors to form professional relationships with overseas colleagues.

While relationships with doctors from Britain and the United States continued to be of value to New Zealand specialists, by the late 1970s Australia was undoubtedly the key 'partner' for New Zealand medical specialists. Australasian qualifications were the preferred markers of specialist skill and

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<sup>65</sup> 'Medical Profession', from *An Encyclopaedia of New Zealand*, ed. by A. H. McLintock, originally published in 1966. Te Ara - the Encyclopaedia of New Zealand, URL: <http://www.TeAra.govt.nz/en/1966/medical-services/6>, accessed at 4 December 2012.

<sup>66</sup> Robb, *Medical Odyssey*, p. 149.

<sup>67</sup> Interview with Dr Peter Rothwell, 28 August 2007.

knowledge in New Zealand hospitals, and the emergence of additional local Colleges enabled more New Zealand specialists to obtain local qualifications. The Royal Australasian Colleges of Surgeons and Physicians had been joined by the Royal Australian and New Zealand College of Radiologists in 1949, a Faculty of Anaesthetists within the RACS in 1952, and a College of Pathologists of Australia 1956. Between 1964 and 1978, six other Australasian Colleges were formed by psychiatrists (1964), dental surgeons (1965), dermatologists (1967), ophthalmologists (1969), general practitioners (1973), and obstetrician / gynaecologists (1978).<sup>68</sup> These Colleges both resulted from and contributed to the development of Australasian specialist medicine, and enabled more specialist training to be conducted within Australasia. Although New Zealand's small population continued to make overseas experience a necessary part of the training process, these developments, together with Australia's close geographic proximity and a national population four-and-a-half times larger than New Zealand's, allowed New Zealand graduates to begin their specialist careers without moving to 'the other end of the world'.<sup>69</sup>

### *Expressions of Unity in a Century of Fragmentation*

Between the end of World War Two and the middle of the 1970s, the migration patterns of New Zealand post-graduate doctors had changed significantly. By the end of this period, Britain was no longer the solitary, or even primary destination for New Zealand doctors pursuing post-graduate training, experience, or qualifications. The strongly bilateral relationship between New Zealand graduates and British medical structures that once characterised the Common-health system had given way to a multi-lateral system in which the United States and Australia were increasingly prominent. While the influence of British medicine was still significant, both the interpersonal relationships and the institutional networks that

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<sup>68</sup> Dates of establishment come from the various College websites. Several Australasian Colleges received their Royal Charter shortly after their establishment, including the Australasian College of Ophthalmologists (est. 1969, Royal Charter 1977), Psychiatrists (est. 1964, Royal Charter 1978). Others also changed their geographic remit over time: the College of Pathologists of Australia formed in 1956, gained Royal Charter in 1970, and became Australasian in focus in 1980.

<sup>69</sup> Interview with Dr Colin Hooker, 12 November 2010.

underpinned the Common-health system were substantially reconfigured. The monopoly on medical standards once held by the main British Royal Colleges of medicine and surgery was eroded as specialised Colleges emerged in Britain, and elsewhere in the Commonwealth. While specialised Colleges were effective in promoting the standards and interests of their respective disciplines, some medical leaders warned that specialisation and sub-specialisation threatened to undermine both inter-practitioner cooperation and the profession's political efficacy. The process of decolonisation that occurred after World War Two further contributed to the perceived fragmenting of the Common-health. Decolonisation involved not only the formation of sovereign national governments to replace colonial administrations, but the establishment of 'indigenous' professional bodies to replace the overseas branches of British organisations. In all of these ways, Britain lost its position at the centre of interpersonal and institutional Common-health systems.

However, as the New Zealand historian, Tony Ballantyne, has argued, Britain's difficult post-war position 'did not necessarily destroy a commitment to the project of empire'. Business leaders and politicians continued to value imperial connections as 'an important instrument for shoring up both national power and global influence.'<sup>70</sup> I suggest that this also applied to a medical profession that valued international connections as sources of clinical innovation and professional opportunity, as well as political and cultural strength. In response to real and perceived social, political, and professional fragmentation during the decades that followed World War Two, doctors and their representatives employed a range of strategies that sought to promote or preserve the international connections that characterised the established Common-health system.

One such unifying strategy was the construction of discourses that married the goal of preserving professional unity to that of preserving the Commonwealth as a political entity. During the late 1950s and early 1960s, when the fragmentary pressures of specialisation and decolonisation were at their strongest, a number of medical journal articles and editorials were published that characterised international connections, and particularly Commonwealth connections, as the basis of the profession's collective strength while simultaneously casting the

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<sup>70</sup> Tony Ballantyne, 'The Changing Shape of the Modern British Empire and its Historiography', *The Historical Journal*, volume 53, number 2 (2010), pp. 447-8.

medical profession as a powerful force in the creation and maintenance of peaceful and constructive international relations. The Common-health of medicine and the Commonwealth of Nations were mutually reinforcing.

A useful illustrative example of this approach can be found in an address given by Sir George Pickering, the President of the British Medical Association, at the second meeting in 1964 of the Commonwealth Medical Association (formed in 1962). The published account of his opening remarks are worth quoting at length:

[Sir George stated that] this meeting gave practical expression to a great ideal. A future generation might record that the concept of the Commonwealth of Nations was one of the most noble attempts to solve a great problem for all time. The problem was, of course, how peoples of different race and creed could live harmoniously together, retaining their liberty and yet working with one another towards a more enlightened and humane society. . . . The history of all great movements, many of them of course religious, had shown the power of faith, and Sir George said he would like to declare his faith in that great idea. 'We who are met here today for this Conference have another faith and another allegiance. In entering our profession we declared our dedication to another and a more limited goal, namely, the alleviation of human suffering. There is no conflict between these two great ideals – that of the Commonwealth and that of Medicine. Indeed, far from being incompatible they are two facets of the same great hope – the betterment of the human race and human society.'<sup>71</sup>

Such sentiments were not only produced by British medical leaders, but also featured in the writings of New Zealand doctors during this period. In 1960, Sir Arthur Porritt became the first New Zealand-born doctor elected to the Presidency of the British Medical Association. During his first year in office, Porritt wrote a piece in which he argued that professional medicine served as 'a great link between nations', ranking alongside 'the arts, science, and sport as

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<sup>71</sup> 'Commonwealth Medical Association', *British Medical Journal*, volume 1, number 5397 (13 June 1964), p. 1564.

universal common bonds of interest, understanding, and friendship.’<sup>72</sup> Of particular importance was medicine’s exemplification of British principles, which enabled Britain to maintain Commonwealth ‘leadership without either military or political power’. Porritt characterised these shared Commonwealth and Common-health principles as a mutual ‘burgeoning of evolutionary changes, an incredibly rapid opening up of new spheres of knowledge, [and] an increasingly productive co-operation’, which led to ‘an ever-deepening sense of responsibility to the population as a whole as well as to its individual parts, for its communal wellbeing.’<sup>73</sup> For Porritt, the link between medicine and the Commonwealth was clear: ‘a life without health is less than a life, a nation without health is at best second-best, an empire without health is on the way out.’<sup>74</sup>

Sir Arthur Porritt’s successor as President of the British Medical Association was another New Zealander, Sir Douglas Robb. Robb also highlighted the mutually supportive nature of international professional relationships and Commonwealth relations, emphasising in particular the value of post-graduate specialist training as a model for international connections. In his 1960 Presidential address, Robb cited Britain’s hosting of large numbers of overseas doctors as an example of the ways in which medical services could be organised ‘on a Commonwealth basis’.<sup>75</sup> Two years later, the British physician and clinical researcher, Professor Sir George Pickering, argued that improved post-graduate medical training structures would be ‘a most important potential contribution of the British people to preserving and developing the way of life and the code of morals and ethics which is the real unifying force in the British Commonwealth of Nations.’<sup>76</sup>

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<sup>72</sup> Sir Arthur Porritt, ‘Commonwealth and Common Health’, *British Medical Journal*, volume 1, number 5190 (25 June 1960), p. 1908.

<sup>73</sup> Porritt, ‘Commonwealth and Common Health’, p. 1909. I discovered Porritt’s use of the phrase ‘Common-health’ after I began using it to describe post-World War Two international medical networks. It was pleasing to discover that this prominent New Zealand medical statesman used the phrase in a similar way.

<sup>74</sup> Sir Arthur Porritt, ‘Mars and Aesculapius’, *British Medical Journal*, volume 2, number 4694 (23 December 1950), p. 1438. Sir Douglas Robb also spoke of medicine as a bearer of noble British traditions, such as its ‘great and laudable tradition of interest in underdeveloped lands and of [providing] service to them.’ Sir Douglas Robb, ‘Medicine and Health on a Commonwealth Basis’, *British Medical Journal*, volume 1, number 5223 (11 February 1961), pp. 375-379.

<sup>75</sup> Robb, ‘Medicine and Health on a Commonwealth Basis’, pp. 375-379.

<sup>76</sup> Professor Sir George Pickering, ‘Medical Education in the United Kingdom and North America’, *British Post-graduate Medical Journal*, volume 38, number 435 (January 1962), p. 2.

The historian of national narratives, Stefan Berger, argues that ‘notions of national missions were vitally important to the construction of national historical narratives’.<sup>77</sup> I suggest that the idea of mission was also important in the discourses of Commonwealth medical professionals during the twentieth century, and in particular, in the discourses of those seeking to preserve Common-health connections during the 1960s and 1970s. Numerous articles characterised the institutional links, interpersonal relationships, and individual migrations that constituted the Common-health as the key mechanism for promoting not only physical or mental health and institutional and professional attainments, but also moral standards and harmonious international relationships. In 1961, Dr Kenneth R. Hill published an article in the *British Medical Journal* encouraging British doctors to devote a period of time to working in a developing country, arguing that international practice ‘embodies the development of a culture which, dearly wrung from the past centuries, may afford a signpost for a new world.’<sup>78</sup> At the end of the decade, the Australian surgeon and past President of the British Medical Association, Sir Clarence Rieger, asked his fellow practitioners to have ‘faith in our calling . . . its international character, and the part that we can play in the concept of our Commonwealth as a potent stimulus toward individual understanding and accord.’<sup>79</sup> In 1961, the Dean of the Otago Medical School, Dr Edward Sayers, used the notion of ‘faith’ and mission more explicitly when he wrote that ‘there is probably no profession in the world, even including the Church, which is doing more for peace and understanding between nations. This is one of the fundamental glories of our profession.’<sup>80</sup>

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<sup>77</sup> Stefan Berger, ‘Introduction’, in *Writing the Nation: A Global Perspective*, ed. By Stephan Berger (Basingstoke: Palgrave Macmillan, 2007), pp. 23-4.

<sup>78</sup> Kenneth R. Hill, ‘Medical Service Within the Commonwealth and other Countries Overseas’, *British Medical Journal*, volume 1, number 5219 (14 January 1961), pp. 117-20.

<sup>79</sup> Sir Clarence Rieger, ‘The Concept of Commonwealth and Medicine’ ‘Study in Britain’, *New Zealand Medical Journal*, volume 69, number 441 (February 1969), pp. 102-5. The cited examples are but a selection of many other similar examples published during the 1960s. For examples from just one other journal, see ‘Editorial’, *British Post-graduate Medical Journal*, volume 35, number 408 (October 1959), p. 437, ‘Editorial’, *British Post-graduate Medical Journal*, volume 37, number 425 (March 1961), p. 125, ‘Editorial’, *British Post-graduate Medical Journal*, volume 37, number 424 (February 1961), p. 75, ‘Editorial’, *British Post-graduate Medical Journal*, volume 37, number 432 (October 1961), p. 569, Kenneth R. Hill, ‘Postgraduate Medical Education Overseas’, *British Post-graduate Medical Journal*, volume 38, number 438 (April 1962), pp. 191-2.

<sup>80</sup> E. G. Sayers, ‘A Heritage to Preserve’, *British Medical Journal*, volume 1, number 5232 (15 April 1961), pp. 1057-61. Not all calls for greater international involvement expressed such grand visions, or cited such admirable motivations. An Editorial published in the *British Post-graduate Medical Journal* in 1961 responded to suggestions that Britain should restrict medical

Indeed, articles promoting the value of Christianity for individual practitioners and for the profession as a whole were notably common in the *New Zealand Medical Journal* during the 1960s, and into the 1970s. While not all of these were written by doctors, all emphasised the importance of personal qualities such as compassion, gentleness, wisdom, and selflessness for medical practitioners. According to the Wellington obstetrician-gynaecologist, Dr James Edmett Giesen, such qualities would allow patients to have ‘implicit faith in [the] honesty and integrity’ in their doctors, enabling them to ‘look on him as a guide, philosopher, and friend’.<sup>81</sup> The Auckland cardiologist, Dr Edward Roche, argued that Christian faith would also protect practitioners from ‘developing certain calloused surfaces’ in the face of overwork and difficult patients.<sup>82</sup> Some articles even implied providential origins for medical work. In 1964, Rev. Father Weaver wrote a lead article for the *New Zealand Medical Journal* in which he claimed that the ideal doctor worked ‘in close association with the Author of life’ and as such was ‘the instrument of the great healer, God, and in very many cases he is His only instrument.’<sup>83</sup> In 1975, an article in the *British Medical Journal* summarised many of the claims about the role of spiritual purpose in the pursuit of a medical career:

Behind much disease, as behind world unrest, are fear, self-indulgence, jealousy, and resentment. These are problems for which Medicine might provide a radical solution. . . . Our immediate task is to teach men that health is not the mere absence of disease but includes a moral

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immigration by reminding ‘those who work in a very circumscribed area of London’ that hospital services elsewhere in the country would ‘break down’ if immigration ceased. The editorial also argued that closing Britain to overseas graduates would, over time, diminish interactions between senior figures, and would increase the likelihood of doctors from non-Commonwealth countries taking up influential posts in overseas medical schools and hospitals. ‘The Communist countries’, it suggested, ‘might be very willing to take advantage of any deficiencies on our part. See ‘Editorial’, *British Post-graduate Medical Journal*, volume 37, number 424 (February 1961), p. 75.

<sup>81</sup> J. Edmett Giesen, ‘The Christian Way of Life’, *New Zealand Medical Journal*, volume 60, number 354 (February 1962), p. 64.

<sup>82</sup> Edward Roche, ‘Doctors and Clergy’, *New Zealand Medical Journal*, volume 60, number 352 (December 1961), p. 547.

<sup>83</sup> Rev. Father Weaver, ‘The Vocation of a Doctor’, *New Zealand Medical Journal*, volume 63, number 384 (August 1964), pp. 515-7. The frequency with which articles with religious themes appeared in the *New Zealand Medical Journal* deserves further research. Examples beyond those cited elsewhere in this chapter include ‘M. Kronfeld: An Address’, *New Zealand Medical Journal*, volume 53, number 298 (December 1954), pp. 557-60 and W. J. Pryor, ‘Ethics and the Profession’, *New Zealand Medical Journal*, volume 89, number 636 (23 May 1979), pp. 409-11.

and spiritual foundation for life and the replacing of conflict and apathy with a purpose that claims the whole personality in the service of our fellows. . . . Our profession can give a lead to such a programme which is in accord with the highest ideals of our tradition.<sup>84</sup>

The motivations behind such statements were complex and varied, and clearly, often reflected deeply held personal beliefs. However, they also served a useful purpose in discourses that strived to militate against the perceived fragmentation of professional medicine. As the examples above suggest, the intersection of internationalist perspectives and Christian ethics allowed medical leaders to claim a common set of professional values that transcended national differences, and which could therefore survive the political and professional fragmentation of decolonisation. Spiritual purposes and individual morality were also cited as useful correctives to the increasingly scientific, and decreasingly humanistic, nature of professional medicine.<sup>85</sup> Professor John Rendle Short's 1963 *New Zealand Medical Journal* article, 'The Whole Man', argued that a Christian outlook enabled doctors to practise medicine 'as an art and not merely as a science' by reminding them that their patients were intellectual and spiritual beings, and not just bodies.<sup>86</sup> In the same year, the New Zealand-born physician, Professor John Caughey, argued that the increasingly scientific nature of medicine risked overlooking the humanistic and moral aspects of medical practice, which in turn risked undermining medicine's 'place of honour among men'.<sup>87</sup> In 1964, Sir Douglas Robb lamented the medical practitioner's loss of 'psychological dominance' over his 'helpers' – physiologists, anatomists, laboratory technicians and pathologists – and the resulting victory of science over the 'art' of medicine. While acknowledging the value of scientific medicine, Robb insisted that doctors

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<sup>84</sup> 'Medicine and the Present Emergency: A Manifesto on "Moral Rearmament"', *British Medical Journal*, volume 2, number 4100 (5 August 1975), p. 296.

<sup>85</sup> The Otago Medical School's Professor of Medicine, John Caughey, cited a specific historical context in 1963, when he wrote that 'recent happenings in Westminster, which have held Britain up to ignominy' reinforced the idea that personal morality was an important consideration for those aspiring to public leadership. This clearly referred to the 'Profumo affair', in which Britain's State Secretary for War was caught having an affair with the mistress of a Soviet spy. J. E. Caughey, 'Medicine in a Changing World', *New Zealand Medical Journal*, volume 62, number 372 (August 1963), p. 356.

<sup>86</sup> John Rendle Short, 'The Whole Man', *New Zealand Medical Journal*, volume 62, number 370 (June 1963), pp. 277-8

<sup>87</sup> Caughey, p. 277 (see footnote 85 above).

needed to ‘recapture our great humane inspiration and function.’<sup>88</sup> The 1975 *British Medical Journal* article cited above also insisted that it was only through the adoption of ‘spiritual values’ that ‘the resources of [medical] science [can] be liberated and a new world built in which men can attain to their inherited capacity for physical, moral, and spiritual development.’<sup>89</sup>

I suggest, then, that the use of internationalist, moral, humanist, and Christian themes in medical discourse during the 1960s and early 1970s can be interpreted as aspects of an overall ‘mission’ that sought to preserve the cohesion of a Common-health system that leading doctors viewed as coming under threat by the forces of decolonisation and specialisation. This mission was not only discursive in nature, however, but included more formal attempts to preserve international connections. The British Medical Association, for example, developed a ‘talent for compromise’ during the period of decolonisation that enabled it to retain links with the new ‘indigenous’ medical associations. Between 1945 and 1967, twenty-one former British colonies, including Australia in 1962 and New Zealand in 1967, established local associations to replace existing regional or national branches of the British Medical Association.<sup>90</sup> By 1972, however, all of these new national associations had entered into semi-official ‘affiliations’ with the British Medical Association.<sup>91</sup> While these relationships allowed the BMA to retain some influence over medical policy overseas, the two sociologists of Commonwealth professionalism, Terence Johnson and Marjorie Caygill, suggested that these changes in fact represented a considerable loss in the BMA’s power. Affiliation carried few obligations for either party beyond the ‘reciprocal recognition of certain broad standards . . . and a common cultural background’, and was motivated primarily by the desire of Commonwealth doctors to retain access to post-graduate training in Britain, and to the various services and facilities that the BMA provided for visiting doctors. For the BMA,

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<sup>88</sup> Sir Douglas Robb, ‘Science, Humanism and Medicine’, *New Zealand Medical Journal*, volume 62, number 382 (June 1964), pp. 355-8.

<sup>89</sup> ‘Medicine and the Present Emergency’, p. 296 (see footnote 84 above).

<sup>90</sup> Derek Dow, ‘Commonwealth Links of Common Health’, *New Zealand Doctor* (10 November 1999), p. 40.

<sup>91</sup> Terence J. Johnson and Marjorie Caygill, ‘The British Medical Association and its Overseas Branches: A Short History’, *Journal of Imperial and Commonwealth History*, volume 1, number 3 (May 1973), p. 315.

the main benefit was that its members continued to be eligible to work almost anywhere in the Commonwealth.<sup>92</sup>

The formation of the Commonwealth Medical Association in 1962, hailed at the time as an ‘outward manifestation of the strong links that bound together our [Commonwealth] peoples in the search for an enlightened, peaceful, and free society’ also met with limited success.<sup>93</sup> As bilateral links between Britain and the newly independent nations weakened, a number of multi-lateral, Commonwealth-wide organisations were established.<sup>94</sup> Emerging out of the British Medical Association Overseas Conferences, first held in 1921, and the meetings of the British Commonwealth Medical Council that started in 1948, the Commonwealth Medical Association sought to promote ‘the closest possible links’ between the Commonwealth’s various national medical associations in order to promote medical and allied sciences, professional interests, and member interaction throughout the Commonwealth.<sup>95</sup> However, just over twenty years after its establishment, only seven of the forty-nine potential member nations remained active within the Commonwealth Medical Association, with only the United Kingdom and India remaining of the larger countries. The other five active members were Fiji, Cyprus, Trinidad and Tobago, Singapore, and Jamaica.<sup>96</sup>

Teasing out the many factors that contributed to the relatively rapid decline of the Commonwealth Medical Association, and of other formal Commonwealth relationships, is beyond the scope of this thesis. In the New Zealand context, Rex Wright St-Clair’s history of the New Zealand Medical Association suggests that the decision to discontinue the New Zealand Association’s status as a branch of the British parent body in 1967 was simply a

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<sup>92</sup> Johnson and Caygill, ‘The British Medical Association and its Overseas Branches’, p. 324.

<sup>93</sup> ‘Commonwealth Medical Association: Second Meeting of Council: London 8-11 June’, *British Medical Journal*, volume 1, number 5397 (13 June 1964), p. 1564.

<sup>94</sup> Examples included the formation of a Commonwealth Scholarships and Fellowship Plan in 1959, a Commonwealth Society for the Deaf in 1959, a Commonwealth Education Liaison Committee and Unit in 1960, a Commonwealth Pharmaceutical Association in 1970, a Commonwealth Nursing Federation in 1971, and at least eight other Commonwealth Associations for professions such as law, accountancy, and engineering. See W. H. Morris-Jones and T. J. Jones, ‘A Commonwealth of Learning: A Common Professional Culture’, *The Round Table*, volume 60, number 240, November 1970, p. 393, and Johnson and Caygill, *Community in the Making*, p. 247-9.

<sup>95</sup> ‘Editorial: The Commonwealth Medical Association’, *New Zealand Medical Journal*, volume 62, number 365 (January 1963), pp. 1-2.

<sup>96</sup> ‘Reviving the Commonwealth Medical Association’, *British Medical Journal*, volume 293, number 6556 (8 November 1986), p. 1190.

reflection of the development of an influential national medical journal, of independent specialist training structures, of the growing irrelevance of British medical politics, and, finally, of an unwillingness to pay the British association almost £12,000 in annual subscription fees.<sup>97</sup> In short, the founding of a stand-alone New Zealand Medical Association reflected the achievement of national professional independence.

To frame this event in terms of the decreasing relevance of British medicine, however, is to tell only part of the story. The narrative of growing national independence finds no place for many of the developments that have been outlined in this chapter, such as the increasing importance of Australasian connections over the same period, and the emergence of American hospitals as important venues for advanced specialised experience. In particular, it ignores the ever-present need for New Zealand specialists to work in population centres larger than those available in New Zealand. In 1979, the New Zealand Department of Health commissioned a report on New Zealand's future medical 'manpower' needs. The report noted that one of the ways in which New Zealand lost doctors was through post-graduate trainees deciding to remain overseas after their training was complete. To ameliorate this, the report's authors recommended that consideration be given to setting up a dedicated post-graduate medical school in New Zealand, similar to the one that had operated at the Hammersmith Hospital in London since the 1930s. Soon after, however, five professors and senior lecturers from the Otago Medical School and the Wellington Clinical School published a rebuttal in the *New Zealand Medical Journal*, arguing that no New Zealand centre was large enough to provide the volume of cases that such a school would require, and that the 'justification for highly specialised post-graduate centres exists only in larger countries with major urban populations'. They also argued that it would be preferable if the benefits that post-graduate teaching generated – such as increased research interest, visits from leading international practitioners, improved health care for patients in teaching hospitals, and improved overall enthusiasm among associated staff – were evenly distributed around New

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<sup>97</sup> Rex Wright St-Clair, *A History of the New Zealand Medical Association: The First 100 Years* (Wellington: Butterworths, 1987), pp. 186-7.

Zealand.<sup>98</sup> Around the same time, the New Zealand Council for Post-graduate Medical Education wrote that ‘post-graduate overseas study is essential for the wellbeing of New Zealand medicine’.<sup>99</sup> New Zealand medicine did not sever its international connections during the late 1960s and 1970s, but transformed and redirected them.

Yet the narrative that this chapter has pursued has, to a large extent, also been centred on developments at the national level. The description of a broad shift from a powerfully British-centred post-graduate tradition to one that came to embrace American, Australian, and domestic New Zealand venues – enabled by on-going international connections – is necessitated by the immense complexity of these changes at the organisational and institutional levels. As specialised medical and surgical societies came to replace the larger Royal Colleges as the arbiters of medical standards, the designers of training requirements, and the provision of higher qualifications, it becomes increasingly difficult to acknowledge wide ranging objectives, trajectories, influences, and approaches of all these bodies. At the same time, the multitudinous and dynamic nature of institutional loyalties and interpersonal relationships meant that some Commonwealth connections persisted and prospered while others withered.

In summarising these complex changes in broad brush strokes, this chapter provides a valuable alternative to the obfuscating picture of a developing national distinctiveness. Yet the fine details are important. As is the case for the practitioners whose careers this thesis has examined, so it is for historians to focus on the details – to sub-specialise – if a fuller understanding of the immense

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<sup>98</sup> R. H. Johnson, et al, ‘The Educational Implications of Manpower Planning’, *New Zealand Medical Journal*, volume 91, number 657 (9 April, 1980), pp. 258-62.

<sup>99</sup> ‘Post-graduate Medical Education’, *New Zealand Medical Journal*, volume 91, number 670 (22 October, 1980), p. 315. The New Zealand Council for post-graduate Medical Education started as an informal body in 1973 under the initiative of the New Zealand Post-graduate Medical Federation and the New Zealand Medical Association. Its role was to ‘promote a more organised and effective range of educational activity than had existed previously’. The Council was run on a voluntary basis for its first six years, during which time it made significant progress in promoting specialist training in psychiatry, which had been almost non-existent previously. It also initiated a ‘family medicine’ training programme, which also proved successful. However, the Council’s work was limited by a lack of access to adequate funding, which it sought to alleviate by becoming a statutory body in 1979. This was achieved, but successive governments were reluctant to provide adequate funding. The Council therefore struggled to achieve its goals, and was disestablished in 1987. ‘Demise of the New Zealand Council for Post-graduate Medical Education’, *New Zealand Medical Journal*, volume 100, number 821 (8 April, 1987), pp. 207-9.

complexity of human society is to be attained. At the same time, however, sub-specialists must keep an eye on the whole, and maintain an awareness of the interaction between that whole and the parts on which they are focussed. It is my hope that for historians of post-World War Two medical migration in the Commonwealth context, the Common-health medical system functions as a lens that enables both the broad view and a closer look.

## Conclusion

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In the Preface to this thesis, I noted that this research project began with two main objectives. The first of these was to explore the utility of an analytical and conceptual framework that foregrounded international factors and connections in the careers of New Zealand medical specialists after World War Two. This objective arose out of the work of the New Zealand historian, Peter Gibbons, and in particular, his insistence that works of history that ‘consider national identity to be a natural, even organic growth rather than an ideological construction’ risk contributing to social marginalisation in New Zealand by depicting imported social structures, institutions, and values as normative.<sup>1</sup> The second objective was to ensure that the international frame that I proposed to use to meet the first did not lose sight of the personalities and experiences of the individual doctors who, in many ways, comprised those international connections.

To these ends, this thesis has developed and used the model of a ‘Common-health system’ to represent a complex and dynamic system of organisational links, interpersonal relationships, professional conventions, and cultural understandings, all of which were shaped by, and manifested in, people and conditions in places near and far. By analysing a broad range of historical sources with both quantitative and qualitative techniques, this research has generated rich insights into the motivations, experiences, and patterns of New Zealand post-graduate medical migration. It has shown that these motivations and patterns were discernible in both the domestic and international spheres: the Common-health system worked both between and within ostensibly national jurisdictions, joining and penetrating them. Common-health connections were thus critically important to the careers of the vast majority of New Zealand medical specialists active during the post-World War Two period. For many doctors, the influence was positive, providing opportunities to travel overseas, to

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<sup>1</sup> Peter Gibbons, ‘Cultural Colonization and National Identity’, *New Zealand Journal of History*, volume 36, number 1 (April 2002), p. 14.

experience new – if familiar – cultures, to work with world-class practitioners, and to obtain expertise and qualifications upon which their subsequent careers were built. For others, particular attributes of the Common-health system made these benefits much harder to obtain.

Necessarily, this thesis has examined the interaction of a small selection of people, institutions, policies, and contexts. While I have argued that the concept of a Common-health system seeks to acknowledge the mutual interaction of localities throughout the Commonwealth and beyond, the present study has focussed primarily on the connections between New Zealand and British doctors and institutions, and to a lesser extent, between New Zealand specialists and their colleagues in Australia and the United States. One of the consequences of looking in detail at a specific part of a large system is that many of the relationships and mechanisms that characterised that part may not have manifested in the same way elsewhere. Common-health connections were complicated by an enormous number of variables – individual, professional, structural, and cultural – that manifested *in* various locations, and also by the different manifestation of those variables *between* places. I have argued throughout this thesis, for example, that New Zealand’s small population size was perhaps the single most important factor contributing to the large scale migration of New Zealand medical graduates for specialist training during the two to three decades that followed World War Two. Yet this factor was probably less influential for doctors in other Commonwealth jurisdictions. Post-graduate migration rates among Australian doctors were almost certainly lower than New Zealand rates, probably because of the greater training opportunities afforded by a national population that was between four and five times larger than New Zealand’s throughout the study period.<sup>2</sup> The need to access large populations would have been even less relevant for the many thousands of

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<sup>2</sup> Professor David Stewart noted this difference in his interview, conducted 2 February 2011. Although no published sources enumerate this difference, Oscar Gish’s detailed 1971 study of medical migration into Britain noted that while Australia was by far the largest single contributor of overseas graduates among the developed countries (12 per cent of the total, exceeded only by the 59 per cent who came from the Indian Subcontinent), New Zealand’s proportional contribution was ‘as great or even greater’. Oscar Gish, ‘Overseas-Born Doctor Migration, 1962-66’, *British Journal of Medical Education*, volume 5, number 2 (June 1971), p. 99. In the late 1920s, leading British surgeon, Dr Victor Bonney, noted that post-graduate migration was usual among doctors ‘in both countries, but in New Zealand in particular’. Victor Bonney, ‘Australia and New Zealand, and Our Duty Thereto’, *British Medical Journal*, volume 3, number 3524 (21 July 1928), p. 122.

doctors from the Indian Subcontinent who travelled to Britain for post-graduate training after World War Two. Here, the greater economic and technological opportunities that arose as a consequence of Britain's higher per capita wealth may have been a more powerful attraction than population size *per se*.

Yet, if the specific manifestations of the many varieties of Common-health connection discussed in this thesis differed from place to place, I suggest that there is still significant analytical value in considering the instrumentality of those connections in the context of other localities. It seems clear, for example, that the importance of informal relationships in the career development of medical specialists was not unique to the 'Australasian Branch' of the Common-health system.<sup>3</sup> The exact form and function of interpersonal networks certainly varied from place to place, under the influence of factors such as differing patterns of wartime interaction between military doctors, language barriers, or deeply seated cultural beliefs about the relative abilities of doctors from various parts of the world. But there is little doubt that those largely undocumented, and hitherto unstudied, informal relationships were a critical aspect of professional life, regardless of their particular form. While attitudes to women doctors also probably varied from place to place, the discussion in Chapter 6 about the relationship between gender, migration, and specialty choice suggests that studies of both medical migration and women's participation in medicine would benefit from paying greater attention to the interaction of these factors in various localities. Ideas about class and status, and their role in shaping the ability of certain men and women to enter, and prosper within, the world of professional medicine also played out differently in various Commonwealth localities. I suspect that comparative studies of the qualities and conventions of informal medical relationships in different localities would generate a more nuanced understanding of global medical migration and employment patterns, and about wider cultural encounters and exchanges in the twentieth century.

By foregrounding interpersonal networks, this thesis has generated alternative narratives about the development of medicine in the twentieth century. In Chapter 3, for example, I suggested that the networks of interpersonal

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<sup>3</sup> The obituaries of Sir Gordon Gordon Taylor, cited in Chapter 4 (p. 164, footnote 79), clearly indicate the wide geographical scope of informal medical networking in the post-World War Two Commonwealth.

relationships that emerged from World War Two not only worked to facilitate the development of individual careers, but also played a critical role in the subsequent development of specialised medicine in the second half of the twentieth century. At another level, this insight suggests an alternative reading of the *meaning* of medical specialisation. Both Chapter 2 and Chapter 7 noted that from the middle of the nineteenth century until at least the 1960s, and in some cases beyond, medical leaders typically described specialisation as a mode of practice that threatened to ‘fragment’ the medical profession, both clinically and organisationally. From an institutional perspective, the shift towards increasingly focussed areas of practice did indeed appear to threaten professional cohesion. Prior to World War Two, the vast majority of hospital doctors were generalists who could relate to each other’s work, and were therefore able to provide each other with the necessary day-to-day guidance and support. After the war, the rapid development of specialisation made it increasingly difficult for hospital-based doctors to understand or aid the work of colleagues working in different specialties. To paraphrase one of the doctors interviewed for this thesis, specialisation made it increasingly difficult to ‘talk to the bloke in the next office’ about the specifics of day-to-day patient management across specialties.<sup>4</sup>

However, from an international perspective, it is clear that this same process was also responsible for the *creation* of professional links. Specialisation did not diminish the need for peer support, and in order to generate it, specialists and sub-specialists often had little choice but to look to practitioners doing similar work in other institutions, regions, or even countries. Specialists organised meetings and conferences, initiated international research programmes, established international journals, and formed societies that often spanned several national jurisdictions. At the level of individual institutions, then, specialisation was often a fragmenting, isolating force. From an international perspective, however, specialisation functioned as a connecting force that generated friendships and institutional relationships between distant localities, and which placed international conditions at the heart of medical policy. To a large extent, the process of specialisation *made* modern medicine international.

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<sup>4</sup> Interview with Peter Rothwell, 8 August, 2007.

This alternative interpretation of the outcome of specialisation raises important questions about the narrative of nation-building that this thesis set out to interrogate. In Chapter 4, I suggested that the rapid development of formal and informal connections between Commonwealth doctors during the 1950s and 1960s unsettles the standard characterisation of that period as one of imperial retraction and growing political and cultural autonomy within Commonwealth nations. It might be argued that the subsequent development of Australasian and even New Zealand training systems and organisations, as outlined in Chapter 7, weakens this conclusion, to the degree that it returns the story to the standard narrative that marries national maturity to the development of national distinctiveness and autonomy. However, Chapter 7 also noted that the development of ‘local’ training structures very much relied on international connections, including what Dr Peter Rothwell usefully described as ‘reverse migration’, or the continuation of international, interpersonal links through visits to New Zealand, in addition to migrations from New Zealand. In 1964, the President of the New Zealand Branch of the British Medical Association, Dr J. O. Mercer, presented an interpretation of national ‘maturity’ that is as relevant to perceptions of the development of wider society in New Zealand today as it was to the development of the medical profession half a century ago:

This transformation, this reversal of flow . . . is a sign of professional maturity and increasing international status. For us nothing but good can come of the comradeship of doctors of every nationality who have similar ideals and who think and work together – the gold of endeavour without the alloy of conflict.<sup>5</sup>

Mercer’s characterisation of ‘maturity’ as a movement *towards* international engagement is surely a more accurate reflection of the realities, challenges, and opportunities of globalising society than the standard national narrative, which depicts ‘progress’ in terms of a march towards independence, distinctiveness, and insularity.

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<sup>5</sup> Dr J. O. Mercer, ‘Presidential Address’, *New Zealand Medical Journal*, volume 64, number 391 (March 1965), pp. 131-4.

Together, these insights into the mechanisms, structures, and meanings of Common-health connections represent an important and necessary addition to the conceptual frameworks that historians use to understand and write about medical history, and as such, provide a useful basis for the continuing re-evaluation of the history of New Zealand's medical services. This thesis has laid the foundation for that re-evaluation by demonstrating the inadequacy of nation-centred narratives, by developing an alternative narrative and interpretive framework based on what we might call an 'inter-local' connectedness, and by using that alternative framework to begin the process of mapping the ways in which New Zealand doctors participated in international exchange. It has shown that the influence of 'British medicine' was not confined to New Zealand's distant 'colonial' past, but continued to play a central part in the training of New Zealand's specialised medical workforce well beyond the end of World War Two. In 1968, Dr Martin Wallace was appointed as the first full-time renal physician at Waikato hospital in Hamilton. In an interview conducted for this thesis, Dr Wallace reflected on the challenges of applying his largely British-based medical training in a New Zealand context:

[Māori cultural factors] had not been addressed at medical school, they had certainly not been addressed at Wellington, and Māori cultural things were not really being addressed in London either. So when I got involved in a field where Māoris are unduly represented, as they are, in chronic kidney failure, it meant that I had to learn things about that. One of the interesting things was to try to understand why Māori people under my care, who got the same care as everybody else, did so much less well. They did poorly. Their survival was just not the same as it was for non-Māori. I started to explore some of those ideas. I came across patients who said, 'well, whatever you do Dr Wallace I am not going to get better because I have been makutued.'<sup>6</sup> You know, it was 1968, and I had no idea about Māori views like that in the Māori community, and I had to learn, and it came as quite a surprise. . . . That

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<sup>6</sup> 'Makutu' is a Māori term that translates to 'curse'.

was quite a factor coming here, and I wasn't prepared for that, certainly not in London.<sup>7</sup>

It is vital that New Zealand historians working in the twenty-first century consider the ways in which the connections that this thesis has mapped continued to transmit extra-local norms and values into these islands during the twentieth century, and the influence that those norms and values had on the delivery of medical services in New Zealand. At the time of Dr Wallace's appointment, Britain was beginning to lose its status as the primary destination for New Zealand's prospective specialists. Yet, British norms and structures continued to form the basis of New Zealand's health services. The provision of medical services in private rooms and in hospitals, the objectives and methods of professional organisations, medical policies and legislation, and medico-political discourses were all conditioned by international, and particularly British, flows and factors. At a deeper level, New Zealand medicine also reflected imported cultural beliefs, such as those pertaining to the relative value of physiological versus social, emotional, and spiritual factors in human health, or the atomistic belief that parts – of bodies, families, or communities – are prior to, and more important than, wholes.<sup>8</sup> Such ideological norms informed structures, practices, and policies, not only in the field of specialised medicine, but in the health system as a whole. It is hoped that this thesis both encourages and assists historians to consider and communicate the ways in which international exchanges have shaped health service delivery in New Zealand. It is then for policy makers to decide if those services are appropriate for contemporary New Zealand society.

If the Common-health concept has value for medical historians, it is important to consider the ways in which the theories and approaches that it encapsulates might be rendered applicable to fields other than professional medicine, or to research contexts outside the Commonwealth. Earlier in this

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<sup>7</sup> Interview with Dr Martin Wallace, 2 October 2010. Soon after beginning his appointment at Waikato hospital, Dr Wallace initiated a Māori language programme that, despite being entirely voluntary, was attended by a large proportion of the hospital's medical staff. Several of the doctors who attended that course recalled that having some knowledge of Māori language and protocol made a significant difference to their medical efficacy.

<sup>8</sup> *Biomedicine Examined*, ed. By Margaret M. Lock, and Deborah R. Gordon (Dordrecht: Kluwer Academic Publishers, 1988), p. 20. See also Arthur Kleinman, 'What is Specific to Western Medicine', in *Companion Encyclopedia of the History of Medicine*, ed. by W.F. Bynum and Roy Porter (London: Routledge, 1997), pp. 15-23.

Conclusion, I used a term which comes close to capturing the close and complex inter-relationship of people and their contexts across geographical distance that has characterised this thesis, and which, at the end of this research project, I now recognise is the essence of the Common-health concept. That term is ‘inter-local’. Like ‘international’ or ‘transnational’, this term suggests exchange across distances, but by focussing on localities, rather than nations, has a tangibility that is better suited to acknowledging the specificities of the people, institutions, and communities that participated in those exchanges. For me, the term ‘international’ has always conjured the cartographer’s view, with the result that phrases such as ‘an international system of informal relationships’ seem oxymoronic to the extent that they evoke both intimacy and distance, but do not satisfactorily integrate those views. Inter-local, by contrast, suggests a view from a much lower altitude, or even from ground level, and as such is better suited to examining the activities of people in their places, and the effects of those activities in other localities.

The idea of inter-local exchange owes much to the concepts and approaches of Pierre Bourdieu, and in particular to his insistence that society is best understood as the interaction of individuals and the social fields within which they live, play, and work. However, the inter-local approach proposed here differs from Bourdieu’s approach in one important way: it is explicit in recognising that social fields are not necessarily coterminous with the borders of nation states. Although Bourdieu’s model does not preclude this possibility, his sociological background tended to produce studies that focused on practices and behaviours within particular communities, or in particular national settings.<sup>9</sup> To the extent that the inter-local approach is conceived as a corrective to historical nationalism, it makes the opposite assumption and assumes that human societies are inherently and simultaneously local and global. As Chapter 7 demonstrates, the inter-local approach is not necessarily limited to the examination of bilateral connections, but can, and ideally should, also recognise the complex and interconnected – perhaps ‘multi-local’ – nature of human societies.

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<sup>9</sup> Peggy Levitt and Nina Glick Schiller, ‘Conceptualizing Simultaneity: A Transnational Social Field Perspective on Society’, *International Migration Review*, volume 38, number 145 (Fall 2004), pp. 595-629. Quotation from p. 9 of online version, URL: [http://policydialogue.org/files/events/Levitt\\_Glick\\_Schiller\\_Conceptualizing\\_Simultaneity.pdf](http://policydialogue.org/files/events/Levitt_Glick_Schiller_Conceptualizing_Simultaneity.pdf), accessed 13 January 2013.

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In February 2008, the British Government introduced immigration laws that excluded all doctors from outside the European Union from post-graduate training posts within the National Health Service.<sup>10</sup> The change was prompted by recent increases in the number of medical graduates that Britain produced, and by the need to provide them with post-graduate training positions in an economic climate that was unlikely to generate new jobs. Because European Union rules precluded Britain from excluding European doctors, Britain sought to preserve vacancies by banning all other ‘international’ doctors, including New Zealanders. Similar developments in Australia are likely to see that country cease to be a viable venue for post-graduate training for New Zealand doctors in the next five to ten years.<sup>11</sup> Opportunities in the United States are also becoming increasingly limited, with significant international competition for places and strict entry requirements, including an external medical examination that must be passed prior to entry.

Yet the self-perpetuating cycle whereby specialised activity generates new knowledge, which in turn requires further sub-specialisation, is likely to mean that external experience and training remains a necessary part of the careers of New Zealand medical specialists, whose opportunities for domestic training continue to be limited by a small domestic population.<sup>12</sup> If a New Zealand historian working fifty years from now revisits the topic of this thesis, it is possible that he or she will extend the present narrative by examining the ways in which New Zealand post-graduate training patterns followed economic trends and became aligned with centres in South East Asia, and particularly China. That future study is also likely to contain a chapter on virtual travel, whereby trainees receive instruction or witness procedures via the internet or other dedicated electronic links. Remote

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<sup>10</sup> ‘Restricting Entry of Overseas Medical Graduates Is the “Right Way to Go”’, *British Medical Journal*, volume 336, number 7641 (23 February 2008), pp. 410-11.

<sup>11</sup> Personal communication with Professor Ross Lawrenson, Head of the Waikato Clinical School, an academic division of the University of Auckland’s Faculty of Medical and Health Sciences. I am indebted to Professor Lawrenson for a conversation that provided valuable insights into the challenges that New Zealand’s trainee specialists face in the present, and are likely to face in the near future.

<sup>12</sup> At the time of writing, New Zealand national population is approximately 4.4 million. Statistics New Zealand Website: URL: [http://www.stats.govt.nz/tools\\_and\\_services/tools/population\\_clock.aspx](http://www.stats.govt.nz/tools_and_services/tools/population_clock.aspx), accessed 9 January, 2013.

instruction is already well-established in many New Zealand training centres, and will certainly develop further as technology improves.

However, one of the main overarching themes in the recollections and written accounts of New Zealand doctors who travelled overseas for post-graduate training in the decades following World War Two was that the educations they received during the course of their travels were not purely clinical or technical. They also involved lessons in self-reliance, in resourcefulness, and in the ways in which cultural, social, and economic contexts influenced the practice of medicine. Such lessons remain as valuable today as they did in 1950, and it would be a significant loss for New Zealand doctors if the opportunity to learn such lessons was lost.

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This bibliography lists the sources consulted in the preparation of this thesis under the following headings:

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1. Unpublished Documents
2. Recorded Interviews
3. Obituaries
4. Books
5. Journal Articles
6. Government Reports and Documents\*

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## *Appendix*

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*Table 7:*  
*(From Chapter 4, p. 143, footnote 25)*

*Number of Hospital Beds per Specialist Doctor in New Zealand's Twenty-One Largest Hospitals, as at March 1964*

<b>Hospital</b>	<b>Specialists</b>	<b>Beds</b>	<b>Beds per Doctor</b>
Auckland	164	523	3.2
Dunedin	80	347	4.3
Christchurch	101	450	4.5
Wellington	139	833	6
Whanganui	29	212	7.3
Palmerston North	58	428	7.4
Invercargill	36	280	7.8
New Plymouth	29	241	8.3
Waikato	78	686	8.8
Timaru	23	204	8.9
Rotorua	24	243	10
Napier	27	285	10.6
Whangarei	25	271	10.8
Gisbourne	23	250	10.9
Nelson	23	255	11.1

Source: Table 11, 'Institutional Staffs (Treatment)', in *Hospital Statistics of New Zealand, 1964* (Wellington: Division of Hospitals, 1964), pp. 32-37.

*Table 8:*  
(From Chapter 4, p. 143, footnote 25)

*Payments to New Zealand hospital medical staff per occupied bed, as at March  
1964*

<b>Institution</b>	<b>Number of Occupied Beds</b>	<b>Payments per Occupied Bed</b>
Auckland	469	£262
Green Lane	354	£231
Wellington	687	£184
Christchurch	376	£182
Dunedin	302	£164
Middlemore	305	£144
Palmerston North	348	£112
Waikato	631	£107

Source: *Hospital Statistics of New Zealand, 1964: Supplement to the Annual Report Compiled by the Division of Hospital* (Wellington: Department of Health, 1964), pp. 32-7.

*Table 9:*  
(From Chapter 4, p. 147, footnote 36)

*Population of Main New Zealand Urban Centres, 1945-1971 (1,000s)*

	<i>1945</i>	<i>1951</i>	<i>1956</i>	<i>1961</i>	<i>1966</i>	<i>1971*</i>
<i>Auckland</i>	287	329	381	448	548	698
<i>Wellington</i>	132	133	138	150	167	324
<i>Christchurch</i>	151	174	193	220	247	302
<i>Dunedin</i>	88	95	99	105	108	117
<i>Hamilton</i>	27	33	40	51	63	136

Source: Summaries of Census data as reproduced in New Zealand Yearbooks of 1950, 1955, 1960, 1965, 1970, 1975. 1971 figures were calculated on the basis of new statistical areas. Although they are not directly comparable to early figures, they still provide a useful measure of relative inter-urban sizes.