Australia, South Australia, Tasmania, South Africa, and Southern Rhodesia, the Director of Medical Services of Northern Rhodesia, the Director of Recruitment of the Department of Technical Co-operation, and the Records Officer of the Commonwealth Relations Office for providing me with much of the data which have formed the basis of this paper.

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MEDICAL EMIGRATION TO NORTH AMERICA

BY

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"You'll get no promotion this side of the ocean,
So cheer up my lads, Bless 'em all."

From Popular Army Song. Circ. 1940.

The purpose of this paper is to indicate the extent of medical emigration from the U.K. to North America in recent years. Data from the archives of the Canadian and U.S. Governments have been used, because the strictness of North American immigration laws gives support to the accuracy of the figures presented. It is impossible to enter the U.S.A. without going through elaborate formalities. Each immigrant requires a visa, and his personal details are carefully classified, and filed in Washington. Although statistics concerning the occupations of immigrants have been kept for some years, a breakdown of this information for each national group has only recently been made available.

The U.S. Department of Justice began the collection of data about the immigration of foreign doctors in 1952. Since that time the Immigration and Naturalization Service has published figures showing the number of foreign physicians and surgeons admitted to the U.S.A. for permanent residence. These figures naturally

do not include those admitted for postgraduate training in American medical centres, who enter on special visas. Table I gives data concerning medical emigration from the U.K. to the U.S.A. in recent years.

During the past 9½ years 1,048 British doctors have left this country to settle in America. This figure is possibly smaller than the actual figure, as some may have entered on visitors' visa and decided to stay. The average medical migration to the U.S. during this period is therefore 110 doctors annually. There was a sudden sustained increase in this migration from 1957, and since 1958 the U.K. has provided the U.S. with more doctors than any other country with the single exception of Canada. Assuming there is one doctor to each 1,000 of the population in the U.K., we should expect about 15-20 doctors to settle in the U.S. each year if the medical migration rate was to be the same as the general rate. It will be seen from Table I that the medical migration rate has never been below 5, and in some years has reached almost 10 times the general rate during the period under review.

Emigration to Canada

Canada takes as great a care in the screening of immigrants as does the U.S., and detailed information is published in the *Canada Year Book*. The Department of Citizenship and Immigration in Ottawa has collected details of immigrant doctors since 1953. These are set out in Table II.

During the past eight years there has been an average export of 196 British doctors to Canada each year. The medical migration rate has varied a good deal, and will be seen to be lowest in those years when the emigration of the general population is highest. It seems, therefore, that the factors controlling medical emigration are different from those for the population as a whole. Over the eight years reviewed the medical emigration rate has been six times the general rate.

The Royal Commission

The Royal Commission (Pilkington) contains a good deal of misleading and inaccurate information about medical emigration. Its conclusions were stated: "... It must be borne in mind that British medical schools have always taken a pride in providing doctors for overseas countries, and that the continuance of this

TABLE I.—*Immigrant Doctors Admitted for Permanent Residence in U.S. by Specified Country of Last Permanent Residence, 1952 to June 30, 1961*

Country of Last Permanent Residence	Total	Years Ended June 30									Jan.-June, 1952
		1961	1960	1959	1958	1957	1956	1955	1954	1953	
United Kingdom ..	1,048	140	125	147	189	142	76	62	66	66	35
England ..	837	116	96	118	158	113	61	47	56	44	28
N. Ireland ..	65	9	6	14	13	9	4	4	1	3	2
Scotland ..	129	15	18	12	16	18	10	10	8	18	4
Wales ..	17	5	5	3	2	2	1	1	1	1	1
Quota immigrants from Gt. Britain ..		27,034	24,640	15,599	19,771	19,553	15,605	12,475	12,923	12,921	
Medical migration rate ..		5+	5	9+	9.5+	7.5+	5	5+	5+	5	

TABLE II.—*Migration of British Doctors to Canada by Years*

	Years Ended June 30							
	1960	1959	1958	1957	1956	1955	1954	1953
British doctors to Canada* ..	162	182	202	311	214	195	160	195
immigrants from U.K. ..	18,011	16,604	22,439	102,994	46,135	29,228	49,974	51,962
Medical migration rate† ..	7	11	8.5+	3.0	4.5	6.5+	3+	3.5+

* These figures do not include Canadians returning to Canada after graduation in the U.K. or British doctors entering Canada from the U.S.A.
† Deduced assuming one doctor to each 1,000 of population in U.K. Figures for 1961 available on March 31, 1962.

practice need have no current significance. Finally, we noted that the rate of emigration by doctors was no higher than the general rate."¹

A number of criticisms may be made. Firstly, the whole subject of medical emigration was outside the terms of reference of the Commission as set out in the Royal Warrant. Secondly, the information given was misleading, as air movements were not considered and no differentiation was made between doctors and dentists in the data provided. Thirdly, and most alarming of all, the conclusions reached were at variance with the evidence given to the Commission.

While the figures provided were obviously inaccurate, trends were nevertheless apparent. For example, during the period under review (1951-7) the Commission was informed that 1,522 Indian and Pakistani doctors entered the U.K. while 930 left.² Those who remained were clearly providing semi-permanent staffing within the N.H.S. This theory has received powerful support from the Platt Committee³ and more recently from the Sheffield Regional Hospital Board, who have revealed 58% of their junior hospital posts held by overseas doctors.⁴

There was considerable immigration of South African doctors to the U.K. in the early and mid 1950s. The African continent as a whole, however, seems to have been poorly served, for there was a net annual export of only 10 doctors from the U.K. Interpretation of the African figures should be made in the light of the following remarks extracted from the Commission's Report (paragraph 141): "... The number of doctors leaving Great Britain by sea each year is collected, but many of these are men of overseas origin returning to their home countries after qualifying as doctors here. On arrival they are counted as undifferentiated students, but on departure as doctors, a fact which can give a false impression of the balance of migration."

Emigration from the U.K. was mainly to Canada, U.S.A., and Australasia. I have criticized the Canadian figures elsewhere.⁵ So far as America is concerned, our own Board of Trade found a net export of 208 British doctors during the years 1953-6, inclusive, whereas the U.S. Department of Justice issued 270 permanent visas to British doctors during this period. The position with regard to Australasia is also confused, largely because the Commission failed to differentiate between doctors and dentists. Many Australian dentists migrated to the U.K. at the inception of the N.H.S. to enjoy a bonanza era of British dentistry. It would be imprudent to predict any trend from these figures, although other sources suggest that medical migration to the Antipodes is similar to that to North America. For example, Martin has claimed that the medical migration of British doctors to Western Australia from 1955 to 1960 was 13 times the general rate.⁶

Conclusion

Taking the North American continent as a whole, we find that on an average we have exported 311 doctors annually during the years 1953-60, inclusive—the output of three medical schools. Although the figures for 1961 are not yet complete, our medical manpower loss over a nine-year period is equivalent to the total G.P. and specialist services of the cities of Manchester, Leeds, Liverpool, Sheffield, and Bristol combined. Leaving numbers aside, there can be no denying that many highly skilled doctors settled in the U.S. during the 1950s. The cause is not difficult to find. Not only has

the N.H.S. provided outrageous terms and conditions of service, it has completely failed to inspire respect among the younger members of the profession, who see through its Fabian humbug.

The size of the medical migration rates is matched only by the complacency of our leaders. The proposed expansion of our medical schools⁷ is claimed to be the answer to our present shortage of doctors. Yet if it were not for the excessive medical emigration no shortage would exist.⁸ We are about to watch the manpower losses of nationalized medicine written off in the same fashion as the financial deficits of our nationalized industries—by asking for more.

Nor can any pride be taken in the fact that our hospital service relies on medical labour from the under-developed countries. According to the Board of Trade, there is a net annual import of 90 doctors from India and Pakistan. Now that this supply shows signs of dwindling Lord Taylor has suggested that the advent of the Common Market will permit us to import Italian doctors to run our Health Service.⁹ Clearly 14 years of socialism have made us completely shameless, for no one can believe these policies to be in the national interest.

Recommendations

1. Our Health Service should be reformed along the lines proposed by D. N. Lees in his Hobart paper, "Health through Choice."¹⁰

2. Our *Medical Register* should be reorganized along the lines suggested by me last year.⁵ This would enable the Government to obtain reliable statistical data.

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ARE SPECIAL HOSPITALS DOOMED?

BY

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What is the place of special hospitals in the ideal system we are trying to build? Or is there no place for them at all? No sensible person would suggest the immediate scrapping of reasonably up-to-date efficient hospitals conveniently situated for service to the public. But before we can even start building such a hospital system we must have some idea of the edifice we want eventually to create, though the blueprint that we have in mind may require repeated revision.

The quality of the work carried out in any hospital, general or special, must inevitably depend to a very large extent on the capacity and diligence of its medical and nursing staff. Specialists may be divided roughly into three main classes. (1) Some doctors specialize in the diagnosis or treatment of special types of disease: