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Medical Refugees and the Modernisation of British Medicine, 1930–1960

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Summary

This paper reappraises the position of medical refugees in Britain between the 1930s and 1950s. Advocates of reforming British medicine in terms of its knowledge base and social provision emerged as strongly supportive of the medical refugees. By way of contrast, an élite in the British Medical Association attempted to exercise a controlling regime through the Home Office Advisory Committee. The effects of these divisions are gauged by reconstructing the complete spectrum of refugees as a total population. Applying this methodology of population reconstruction provides a corrective to the notion of a cohesive ‘medical establishment’ exercising rigid and discriminatory controls.

Keywords

medical refugees; aliens; Second World War; internment; public health; Jewish refugees; Polish government in exile; Czechoslovak government in exile

In 1942, the Independent Conservative Member of Parliament for Cambridge University and Secretary of the Royal Society, A. V. Hill, was exasperated by the entrenched hostility of the British Medical Association to refugee physicians. Hill argued that refugee medical practitioners could contribute to ‘our national health’ at a time of acute shortage of qualified practitioners, not only because of the war but also because of chronic under-provision in areas of social deprivation. Continental models of research-led medical teaching could raise standards of medical practice as part of a complete reform of the practice, teaching and provision of medicine.¹ While studies of medical refugees examine persecution and exclusion in their countries of origin, the receiving contexts remain rarely scrutinised. This paper offers an explanatory framework, a set of methodologies, an overview and a critique of existing interpretations.

Hill approached the medical refugee question in population terms. In a Parliamentary speech of May 1943, he coolly examined the statistics of refugees showing that refugee numbers were minute in proportion to the population, perhaps one in five hundred, and numbers of medical refugees were similarly low in relation to the overall numbers in the medical, dental

¹Royal Society (hereafter RS), Hill Papers, MDA A4.2, June 1942.

and nursing professions. Yet it was also the case that the refugees' clinical expertise and rigorously scientific training had the potential to contribute to the transformation of British medicine.² Hill looked forward to a changed system when 'medical service is available for any sick person, and health science is available to prevent every person from becoming sick'. He considered that 'if the rich consultants and practitioners are left to decide on the plan they will look back and not forward'.³ Although medically qualified, Hill entered Parliament with the intention of being a nuisance to the medical lobby.⁴ The issue of refugee doctors and dentists was contentious, as it involved far more than just filling in for wartime shortages. While medical representative bodies, the British Medical Association (BMA) and the rank and file Medical Practitioners Union (MPU) opposed the admission of 'aliens', innovative figures in medical research and clinical practice were supportive.

The prospect of scientifically-informed professionals modernising health care provision was doggedly opposed by those seeing science and the state as in sinister collusion. The BMA and MPU regarded alien practitioners as a threat, because they represented a wholesale transformation in the structures of medical power and knowledge. Lord Dawson, as President of the Royal College of Physicians, memorably commented that 'the number that could be usefully absorbed or teach us anything could be counted on the fingers of one hand'.⁵ Within the debate on medical refugees, we find two images of the medical practitioner in conflict—traditional private practice with an honorary hospital appointment, contrasting to the scientifically-trained specialist and moderniser of health service provision.

These ideological parameters need to be assessed in conjunction with cumulative refugee experiences, offering the historian a corrective to any top-down administrative view of the refugee problem. Life histories—the experience of persecution and exclusion in the country of origin, the journey (direct or via intermediate locations) to the place of final refuge, and the experiences of entry, residence and gaining professional acceptance in the UK, or onward migration or (far more rarely) eventual return—need to be considered at an individual and aggregate level, illustrating the processes of adaptation at a time of social transformation.

Taking a longer-term view, we find that the Aliens Act of 1905—originally targeted at pauper aliens, and intended to curb the influx of victims of Russian pogroms—and the Aliens Order, 1920 came by 1933 to be used as a means of selective admission to the UK, and as regulatory controls.⁶ During the 1930s, the medical refugees encountered a hardening of professional restrictions, as the British medical profession was under pressure to reform the science, funding and practice of medicine. After negotiating with the BMA concessionary quotas for Austrian and Czechoslovak medical and dental practitioners in 1938–9, the Home Office convened in early 1940 a Medical Advisory Committee. On 26 September 1941, this committee was replaced by 'the Aliens Committee', which met at the BMA; on 27 November 1942 the Medical Advisory Committee became a sub-committee of

²House of Commons (hereafter HC), *Parliamentary Debates*, vol. 389, 19 May 1943, col. 1188; Cooter 2004.

³RS, Hill Papers, MDA A 4.2.

⁴Cooter 2004, pp. 73, 99.

⁵The National Archives (hereafter TNA), HO 45/15882 Minute, 23 November 1933; Sherman 1973, p. 48.

⁶Sherman 1973, pp. 30–2.

the Central Medical War Committee.⁷ Interpreting this Committee in its various incarnations is by no means straightforward. The question arises whether taking a regulatory approach, based primarily on BMA records, is adequate to understand the situation, when the Home Office was under pressure from a range of medical lobbies. This paper draws on government administrative papers, Parliamentary records and background correspondence to gain a fuller picture of the workings of the Medical Advisory/Aliens Committee. Karola Decker bases a regulatory approach on the BMA 'Aliens Committee' records. Her view that the BMA exerted a determining influence was flatly contradicted in the House of Commons on 13 May 1941 when it was variously stated that 'the Central Medical War Committee is not a BMA Committee' and that its views were not to be confused with those of the BMA.⁸ These defensive statements indicate how its authority was contested, and suggest that the Medical Advisory/Aliens Committee represented only one agency operating within a more complex situation.

Whereas Decker follows the line that the Aliens Committee was effective as a regulatory body, analysis of its operations shows that certain categories of refugee practitioners were deemed exempt; others circumvented the tough regulatory regime, confounded the official mind by presenting it with unanticipated circumstances, or had such over-whelming support that concessions had to be granted or tacitly conceded. It is necessary to scrutinise the actuality of admission to practice and re-qualification, and the rapidly changing circumstances of wartime medical provision. These indicate why a restrictive administrative interpretation fails to explain the dynamic situation, when the refugees found extensive support from reforming medical lobbies. Britain as an Island Refuge took in proportionally more refugees than other countries; despite the restrictive schemes and regulations, numbers in medicine and medically related occupations were substantial.⁹ The characterisation of the Home Office as 'selective' and 'manipulative', cherry-picking for the rich and famous, needs to be set against the many *kleine Leute* (the ordinary people), in medicine the general practitioners, the dental surgeons, the psychotherapists, nurses, who also managed to find refuge.¹⁰

We should replace the scenario of a medical élite exercising regulatory powers with a five-stage process based on the refugee experience: admission to the UK as a place of safety; recognition of qualifications; obtaining the right to practise; obtaining a clinical post. Finally, to obtain a post commensurate with experience and qualifications, with autonomy and appropriate seniority. In contrast, Decker depicts an exclusive and exclusory 'medical establishment' without specifying its composition. Her focus is on the second and third stages, of validation of qualifications and admission to practice. The control that the London-based élite dominating the BMA sought to exercise was reminiscent of the situation in early modern England, when the College of Physicians pursued strangers (i.e. unlicensed practitioners) 'disproportionately to their presence in the population' with markedly mixed fortunes.¹¹ The rank and file MPU needs to be added to the BMA and RCP on the exclusory

⁷TNA, MH 76/330 Central Medical War Committee: Agenda and Minutes. HO 213/263 Medical Advisory Committee 19 April 1940. HO 213/259 German and Austrian refugee Doctors: Correspondence with the British Medical Association (hereafter BMA).

⁸HC, *Parliamentary Debates*, vol. 371, 13 May 1941, cols 1158–78.

⁹Sherman 1973; London 1999.

¹⁰Cf. Decker 2003, pp. 851–2.

side, along with certain heavy-handed and at times anti-German or anti-Semitic physicians and administrators, the security services with an inveterate suspicion of aliens and 'extremists', and an anti-alien public lobby.¹² The medical refugees gained support from advocates of scientific medicine, leading specialists in certain clinical disciplines, pragmatic hospital administrators, reformers of medical service provision and—not to be underestimated—humanitarian supporters of the persecuted.

The Home Office vacillated between pressure to dismiss and intern, and pressure to retain refugees coming from many hospitals and from professional leaders aware of their scientific potential. Even among those pressing for regulation, we find distinct groups who had conflicting interests. Any form of insurance provision was anathema to the idea of the free practitioner in a paternalist relationship to his patients: the MPU was less resistant here than the BMA. By way of contrast, A. V. Hill liaised with a group of scientific progressives linked to the Medical Research Council (MRC), the Royal Society and innovators in epidemiology, cardiology, pharmacology and psychiatry. The modernisers saw how a system of state medical insurance could extend the benefits of medicine, while ensuring research was adequately funded. The medical refugees were less targets of a homogeneous and discriminatory establishment, but caught in the divide on issues of the organisation, training, research, clinical outlook and public provision of health care. The situation was dynamic and rapidly changing, as dismissal and exclusion in 1939–40 was followed in 1941–4 by concessions, and the recognition of the shortage of practitioners in a society at war.

Free Movement of Medical Labour to Corporate Exclusivity

Whereas until the 1880s, free transnational movement prevailed among students and the medically qualified, by the time of the First World War and its aftermath, regulations conceded only limited reciprocity in foreign medical qualifications. The number of foreign degrees accepted for registration by the General Medical Council (GMC) diminished after 1886, when German university degrees lost their validity in Britain. For British medical students, a European degree offered additional clinical or scientific training, rather than an alternative to a British qualification. Some refugees held a British medical degree, similarly gained long ago for supplementary clinical training. Emil Schwarz, the dismissed Head of the Second Clinic in Vienna, had a degree from Charing Cross Hospital, obtained in 1905; Carl Prausnitz, Chair of Hygiene at Breslau until 1933, had passed the London Conjoint degree MRCS LRCP in 1907, while Demonstrator at the Royal Institute of Public Health.

The more welfare benefits were extended in the nascent welfare state, the greater were the incentives to exclude 'aliens'. Welfare entitlement became a primary reason for excluding migrants and refugees, although in 1933 Jewish community representatives undertook that no Jewish refugee would become a public charge.¹³ The issue of an 'overfull' profession was a secondary issue, which could be resolved after the primary issue of guarantors, or conversely offer of an appointment could secure admission to the UK. Set against this

¹¹Pelling with White 2003, p. 336.

¹²Honigsbaum 1979.

¹³Sherman 1973, pp. 30–3.

situation was that improving the funding of medical care within any welfare system created the need for well-trained medical and dental personnel. Medical refugees in the 1930s and 1940s were caught in this structural contradiction. The situation explains the vacillations of official policy, and cautions against an over-literal interpretation of how regulations were enforced.

The GMC continued to accept Italian qualifications until 11 October 1940 and from Japan until 6 February 1942 on the basis of reciprocity.¹⁴ Italian degrees provided an entry to British medicine not only for persecuted Italians, but also for Austrians, Germans and East Europeans. The pulmonary specialist (and medical historian) Robert Heller, after taking a Vienna MD in 1933, presciently obtained an MD degree in Rome in 1934. His Italian degree meant that he could move without apparent difficulty to the UK after the Nazi annexation of Austria. At least 176 Italian degree-holders arrived in the UK. Additionally, the GMC had discretionary powers to recognise an individual applicant's overseas qualifications, although it registered mainly German dental degrees.¹⁵

In 1920s Britain, a socially-stratified, conservative professional faction opposed socialisation, scientisation and gender equality, placing income and status over such problems as rising rates of maternal mortality and other infections, and ill health from social deprivation.¹⁶ Having mobilised against women in the 1920s, the conservative wing in the profession used the same mechanisms of exclusion against refugees in the 1930s. The BMA and MPU pressed for a tightening of the Aliens Act, and opposed professional re-qualification after six months clinical study. What was intended in 1905 as a measure against the unskilled and illiterate was turned against the scientifically well-trained continental medical refugees. But rather than any comprehensive exclusion, the civil servants effectively devolved admission to the UK. Each refugee required a guarantor, who undertook that they would not become a burden on public funds. The historian of medicine, Charles Singer, was among those acting as guarantor to as many as possible.¹⁷ While far from an open-door, the situation permitted numbers admitted to the UK to increase, and it made sense that the refugees should become self-supporting.

The Problem of Requalification

The Home Office Advisory Committee in 1940 suggested that aliens be employed 'in a semi-medical capacity such as first-aid assistants in A.R.P. [Air Raid Protection] work'. But the Ministry of Labour favoured clinical appointments in hospitals.¹⁸ The policy of the Advisory Committee was to prevent refugees engaging in 'unauthorised private practice', particularly in Central London.¹⁹ Once a mechanism was established to recognise foreign degrees in early 1941, the situation was that suitably qualified refugees should work as assistants in private practices, or in hospitals supervised by a British physician or surgeon. Hospital administrators varied as to how they reported the dismissal of aliens in 1940. Some

¹⁴*Medical Register* 1942, p. xxi.

¹⁵Zamet 2007.

¹⁶Palmer 1986; Hill 1942.

¹⁷Wellcome Library, PP/CJS/A.52/52, Box 6. Correspondence with Central Office for Refugees.

¹⁸RS, Hill Papers, MDA A4.2, C. G. Anderson to A. V. Hill, 27 November 1940.

¹⁹TNA, MH 76/330, Central Medical War Committee.

complied energetically, some wished to moderate regulations to ensure their former employees should not be left destitute, and others prevaricated, protecting their employees. Increasingly, they made the case that they were short of medical personnel, so that official orders were moderated, extended and relaxed. After 1941 we find, in addition to practice in accordance with the progressively relaxed regulations, refugees also practising in their own right, whether privately or in senior clinical positions.

Decker argues that the Home Office worked with its Advisory Committee to exercise 'complete control' and that this was 'more or less watertight until the end of 1946'.²⁰ The term 'Aliens Committee' reflected the stigmatising mentality of the BMA elite, even though the Committee remained advisory. According to Decker, an inner group of BMA office-holders dictated Home Office policy between the time the quota of Czechs was drawn up in 1939, and 26 September 1941 when the Home Office Medical Advisory Committee was replaced by 'the Aliens Committee' to advise on employment questions of refugee physicians.²¹ In using BMA rather than Home Office records, Decker overlooks other lobbying groups shaping Home Office policy, and that the Aliens Committee was advisory rather than exercising devolved authority.

Any interpretation of how the BMA manipulated the Home Office policies to keep refugees in temporary and marginal posts overlooks several significant groups among the refugees. There were: those with British nationality granted prior to 1941, who were not subject to any restrictions; those who opened independent central London practices before or during the war; scientifically-oriented clinicians who moved between pure laboratory research and research-led clinical practice, often with support from British colleagues; refugees opting for military service (thereby making a nonsense of military rationales for excluding 'aliens'); dental surgeons with dual medical and dental qualifications; refugees with Italian MDs, attained between 1930 and 1938, and recognised by the GMC; those granted concessions which allowed refugees to treat other refugees, as those in the medical retinue of Sigmund Freud, or permitted to treat Freud; or for the clinic at the Austrian Centre in Bayswater; and refugee physicians recruited into British military units.²² Psychoanalysts without medical degrees—not least Anna Freud—were beyond the Advisory Committee's reach. When the Committee tried to control psychoanalysts holding medical degrees, it had only partial success. At a disadvantage, but also outside the control of the Committee, were refugee medical students, and refugee nurses who held medical qualifications. There was medical lobbying from those seeking that refugees should be offered concessions in terms of being allowed to take private patients. The Advisory Committee recognised how 'exceptional cases' of refugees in private practice meant that it had breached its own strictures on granting temporary refuge.

These modifications suggest that restrictive professional controls could be circumvented. Evacuation and dispersal meant a shift of population away from London to the provinces, so the provincialisation policy was less grievous than it might at first appear. Academic centres

²⁰Decker 2003, pp. 853–4.

²¹Decker 2003, pp. 862–4.

²²Archiv für die Geschichte der Soziologie in Österreich, Graz, Friedrich Hertz Papers (hereafter FHP). Edith Hertz to GMC, 24 January 1940. BMA to Kolmer, 14 November 1939. Home Office Aliens Department to Kolmer, 4 August 1939.

like Manchester offered refugees strong supportive networks. The internment crisis in May 1940 and restrictions on employment and movement meant a severe blow to many refugees. Yet we need also to understand that working as an assistant could lead to a partnership, and refugees could rise to senior positions in specialist hospitals. Military service with the Royal Army Medical Corps (RAMC) offered status as an officer, again on a par with British colleagues. These arrangements offered opportunities for socialisation and integration into 'the British medical establishment'. Although not intended as such by the BMA, its system allowed for greater dynamism benefiting the refugees.

Decker has accepted literally official estimates of alien practitioners. Again, a population-based approach provides a corrective. The official numbers were markedly below actual numbers in the UK, suggesting that officials may have downplayed numbers of medical refugees to mollify the opposing groups. John Zamet suspected this to have been the case in dental surgery.²³ The same is likely to be true for general medicine. A relational database of medical refugees confirms that numbers in the UK were in fact rather higher than official and publicly debated figures. The actuality of how the medical emigration played out in terms of aggregated life histories reveals a dynamic and developing situation with set-backs in 1940 followed by rapid relaxation. The exceptions to the regulations add up to a significant proportion. First, a few refugees had British nationality, such as the paediatrician Friedrich Hüttenbach, who was born in Penang. Some had a British parent or were born in the UK or a British colony. Second, at least 12 medical refugees were naturalised by 1939, so removing them from controls on aliens, such as the psychiatrist Erich Wittkower, the dismissed professor of hygiene Carl Prausnitz (who had a British mother), and the muscle physiologist, Paul Rothschild. A third category held British medical degrees. Fourth, some refugees married a British citizen. Fanny Stang (born Knesbach) was naturalised by marriage in 1939, and then requalified.²⁴ These individuals were free of formal restrictions.

The Home Office accepted that refugees with guarantors and other UK support should become self-supporting by acquiring the requisite qualifications. While re-qualifications show that BMA-instigated pressure reduced degrees granted in Scotland from 1935, Decker overlooks the fact that numbers substantially increased in England from 1939.²⁵ Many examined in Scotland completed the requisite clinical study at an English or Welsh medical school or at Queen's Belfast, but as the war progressed more were examined in England.

Regulating Settlement

Britain offered a place of safety, particularly after the 'incorporation' (Anschluss) of Austria by Germany in March 1938. We find different intentions among the medical refugees. There were those who always intended to travel on to the USA (such as the industrial health expert Ludwig Teleky), and who were assisted from the UK in obtaining a US visa through the more amenable London embassy. Others decided to move on from Britain. Reasons included disappointment at the UK's capacity to offer a suitable professional opportunity; the possibility of an imminent Nazi invasion of Britain; internment; relatives elsewhere; or,

²³Zamet 2006 and 2007.

²⁴Stang 1997.

²⁵Decker 2003, p. 852.

despite a quota place or the necessary UK recognition for their degrees, they looked forward to better professional opportunities elsewhere.

Other refugees opted to endure the perils of bombing, the deprivations of rationing, and the risks of an invasion, and—despite aliens' registration, tribunals, internment and travel restrictions—they were keen to contribute to the war effort and the defeat of Hitler. They could do so either from 1941 directly in a strategically significant role (as in the army or treating military casualties), or indirectly by working in a 'reserved occupation' as dental surgery, when they could treat such groups as merchant sailors from Allied countries. For others (not least Czechoslovak and Polish students for whom special schemes were arranged in Oxford and Edinburgh), their presence in Britain was felt at the time as temporary because of their intention to return home on liberation.

While Decker suggests that 'the British Isles were only a transitional stage for the majority of refugees', this interpretation reflects the BMA's expectations rather than the historical reality.²⁶ Hill recognised that the German and Austrian refugees would never return in any numbers. Overall, Decker follows the BMA line by stating that only about 2,000 medical refugees were in the UK at any time, and that most migrated onwards.²⁷ Of the known destinations of 474 of 594 Austrian doctors, 362 remained in Britain, 94 re-migrated and only 18 returned to Austria.

Some eminent, elderly individuals did open private practices in London, such as the ophthalmic specialist Oskar Fehr or paediatrician Edmund Nobel, indicating that when there were influential backers, the Advisory Committee tended to give way.²⁸ Other elderly individuals such as Freud (born in 1856) or his former Vienna colleague, the paediatrician Julius Zappert (born in 1861), were not seeking employment, while their eminence and status were duly recognised. I have identified 23 physicians born between 1856 and 1870. For the two Vienna historians of medicine, Max Neuburger and Isidor Fischer, support for academic activities was a priority, and Neuburger certainly secured support and recognition at the Wellcome Museum, while Fischer was in a more precarious situation.²⁹ Zollschan, a disabled radiologist, energetically campaigned against Nazi race theory.³⁰ This was his preference, and marked the culmination of a 30-year engagement with the racial question. Figures like Zollschan, Neuburger or a younger generation of scientists such as Blaschko in pharmacological research, were not marginalised in the UK, but found motivation, purpose and recognition outside clinical medicine. At the same time, emigration was accompanied by stress and trauma. Felix Plaut, Walter Zweig and the analyst Wilhelm Stekel tragically committed suicide, and some refugees like Alice Balint died tragically young, as stress arising from persecution and forced migration took its toll.³¹

²⁶*Ibid.*

²⁷*Ibid.*

²⁸BMA Archives, Home Office Medical Advisory Committee 1939–49 B/12/1/1, letter from Central Medical War Committee, 16 June 1943.

²⁹Weindling in Eckart (ed.) 1999.

³⁰Weindling in Cantor and Swetlitz (eds) 2006 and Weindling in Turda and Weindling (eds) 2006.

³¹Weindling in Marschalek and Wiedl (eds) 2001.

Decker refers to the majority of Germans and Austrians as 'Jews'.³² This accords with Nazi racial categories, although this requires some qualification. First, there were the political refugees. An example is the medical student and communist activist, Eva Kolmer, or the radical sexual reformer Max Hodann (who after a sojourn in Britain found refuge in Sweden). There were gentile spouses of Jews, such as Paul Glees, a talented physiologist. There were those of mixed parentage, for example Eva Glees, or Lore Fry (previously Schulte-Frohlinde). There were those whom the Germans regarded as Jews, but whose ancestors two or three generations previously had converted to Protestantism (for example, Erich Wellisch, supported by the Quakers), or were committed Roman Catholics (such as the endocrinologist Cornelius Medvei). Jewish identity was itself variable. Some were genuinely religious, such as Ernst Adler (formerly physician to the Vienna Jewish Kultusgemeinde), whereas other 'Jews' were secular in outlook, for example Siegmund Foulkes. The Polish School of Medicine at Edinburgh, overwhelmingly Polish nationalist and Catholic in ethos, nonetheless contained a few students and teachers with a Jewish background, some German-speaking.³³

Women were excluded in British medicine to a greater extent than in interwar Austria and Germany. We see a variation between nearly one quarter of the Austrian cohort being women—who were predominately Jewish—and about one ninth of the Poles, who were predominately Catholic. Austrian women, arriving in a short window between the Anschluss and the declaration of war, benefited from the concession to give permits for domestic service and nursing.

Refugees could gain entry to the UK with a Domestic Service permit issued by the Home Office. Domestic staff was an area of officially acknowledged shortage. First, one needed to find an employer. *The Times* contained numerous—and desperate—advertisements. Women benefited from this area of employment more than men, and we should note that the number of women among the German and Austrian medical refugees was high. Examples of former domestics include Rosa Aaronson, Alice Blau, Mancie Desser-Diamant (soon a GP in Stoke-on-Trent), the psychiatrist Stefanie Felsenburg, and the Austrian (male) medical student Jan Loewit. Nursing, although an occupation with an acknowledged shortage of recruits, was somewhat harder to enter. German nursing qualifications were not recognised by the General Nursing Council. We find cases of a refugee admitted under a domestic permit who then registered for nurse training, such as Annie Altshul (later the UK's first professor of Nursing). The Ministry of Labour allowed a tenth of 1,600 applications in 1938. The professional nursing organisations remained intransigent against the foreigners in terms of qualifications, but qualification in the UK was a possibility. With 147,000 nurses and midwives in Britain in 1946, the refugees represented just a small proportion of the labour force.³⁴

All those wishing to register their medical degrees had to apply to the Central Medical War Committee. The temporarily registered could not at first open a practice in their own right,

³²Decker 2003, p. 852.

³³Lewis 2000.

³⁴Webster 1988, p. 122.

although they could work in hospitals and clinics. But these strictures on practice were rapidly relaxed. The initial channelling of refugees to hospitals favoured specialists, given that in the UK specialists were, on the whole, hospital or clinic-based. We find a discrepancy between the BMA seeing the future of British medicine as dominated by élite physicians in private practice, and the progressives' vision of specialist hospital appointments and laboratories. The BMA supported a policy against private practice by those on the Temporary Register. Decker gives the impression that this policy was watertight.³⁵ Set against the provincialisation policy, we find refugees opening independent practices in London. The *Medical Register* provides an analysis by street and postal district in London, so indicating the social geography of dispersal in the complex metropolitan setting. For the year 1944, we find nine refugee doctors among the élite with consulting rooms in Harley Street, and proportionally more in neighbouring streets, such as seven in Devonshire Place and thirteen in Wimpole Street. What also needs to be taken into account was that London in the Blitz had its dangers, and that many happily settled in the provinces. For example, Ernst Adler's biochemist wife, Regina Kapeller-Adler, held a university lectureship at Edinburgh (obtained for having devised a pregnancy test), and this was where Dr Adler opened an independent practice in 1943.

Quotas and Qualifications

Decker presents the non-Scottish medical schools as antagonistic to refugee physicians seeking the necessary clinical courses for re-qualification. This antagonism can be modified by evidence from medical school archives, suggesting a need to distinguish between the examination boards and the medical schools, which were hospitable to the refugee students. A case in point is the Welsh National School of Medicine. Its generous admissions policy is obscured by most students having then taken the Scottish Conjoint examinations, as requiring a shorter course of study. Decker suggests that the concessionary group had to study for at least two years.³⁶ This official statement was not adhered to in all cases.

The formal opening of the Welsh National School of Medicine in 1933 coincided with Hitler's takeover in Germany. The Jewish Refugees Committee in London explained to the Welsh School in May 1933 the difficulties of placing refugee physicians, so that they might take a recognised UK qualification.³⁷ In October 1933, six Germans holding medical qualifications were admitted as students, and in January 1934 the overall number of 'German medical men' admitted to study in Cardiff was fixed at twelve.³⁸ In January 1934, the Senate heard how the Jewish refugee students were so satisfactory that 'the School would be well advised to admit a further number of such students'.³⁹ In November 1934, it was recorded how 'the four German students who had completed the Final Examinations of the Edinburgh Conjoint Board, viz. Dr Last, Dr Gruenbaum, Dr Abeles and Dr Levy, had personally communicated their very grateful thanks for allowing them to pursue their studies

³⁵Decker 2003, p. 854.

³⁶Decker 2003, p. 857.

³⁷Welsh National School of Medicine (hereafter WNSM), Senate 7 July 1933 with attached letter from Jewish Refugees Committee 28 May 1933. Weindling in Michael and Webster (eds) 2006.

³⁸WNSM, Council Minutes, 20 June 1933, 20 July 1933, 17 October 1933, 30 January 1934.

³⁹WNSM Senate, 7 February 1934.

here'.⁴⁰ Other German students were Siegfried Cohn, Ilta Wolpert (technically stateless), Peter Salzberg and Ernst Sklarz (admitted in October 1936). The *Annual Report* of 1934–5 stated that seven German students had obtained a registrable qualification and that 'they proved very satisfactory students in every respect'.⁴¹

When it came to the emergency of the Austrian Anschluss and the Nazi takeover of Czechoslovakia, the Welsh National School showed itself to be generous in terms of admissions. While most medical schools agreed to take two students from the Austrian and Czech quotas, the Welsh National School took seven Austrians and fifteen Czechs. The Welsh School explained to Edith Hertz that it was instituting a course specifically for refugees. When the Austrian, Marcell Gang, was allowed to re-qualify in Cardiff, this was on the understanding that he would proceed to Newfoundland, where there was a British government scheme to encourage doctors and dental surgeons to settle. This requirement was never enforced. His application to be included on one of the five vacant positions on the quota, which had arisen as a result of emigration, was rejected by the Medical Advisory Committee, and yet he was still granted permission to practise in the UK.⁴² Women also received a sympathetic response. Edith Hertz was not one of the selected quota doctors, but she was still 'allowed to sit for the final of the Conjoint examination under the special conditions granted to the selected Austrian doctors'.⁴³ While the quota remained, its privileges were extended to others.

The Welsh School was by no means unique, and it is premature categorically to prejudge the situation before every UK medical school archive is scrutinised. The situation in Northern Ireland at first sight appeared restrictive, as at first admission was restricted to students from Northern Ireland during the war. But then Queen's University, Belfast, instituted bursaries for six refugee students between 1940 and 1944—four being medical—and the first holders in 1940–1 were Czech, Polish, Czech-British and stateless.⁴⁴ At Leicester and Manchester Universities, the Vice-Chancellors set a sympathetic and accommodating tone with regard to refugee physicians and medical students.⁴⁵ The BMA-endorsed quotas were exceeded and circumvented.

When it came to opening a practice, the quota categories were losing significance after 1941. Decker suggests that there were approximately 80 German medical students by 1943, a sizeable number, and that they were subject to discriminatory restrictions on qualification.⁴⁶ The courageous option of military service meant immunity from restrictions. Wilfred Harding, born in Berlin in 1914, contributed to public health in the British zone of occupation.⁴⁷ There is no evidence of any distinction between the refugees and UK nationals in the military medical services. It would also be wrong to assume that, on qualification, the refugees could not practise.

⁴⁰WNSM Senate, 7 November 1934. Student record cards of Friedrich Moritz Abeles, Max Gruenbaum, Julius Levy, Samuel Siegfried Last.

⁴¹WNSM Annual Report 1934–5, p. 5.

⁴²BMA Archives, Home Office Medical Advisory Committee 1939–49 B/12/1/1, f. 118, 125.

⁴³FHP, Samson Wright to Edith Hertz, 21 March 1940. Examining Board to Edith Hertz, 27 March 1940.

⁴⁴Queen's University Belfast Archives, Qub/e/1/3, f. 82, 24 July 1940.

⁴⁵University of Manchester Archives, 1930s Refugees files. Harris and Oppenheimer 2000, pp. xi–xii.

⁴⁶Decker 2003, p. 854.

⁴⁷Oxford Brookes Video Collection, Wilfred Harding interview.

In July 1938, the Germans reduced all Jewish physicians to *Krankenbehändler*, abolishing their state registration as physician (Arzt) and instead restricting treatment by Jewish physicians to Jews. The German authorities proceeded to strip Jews of their nationality, and selectively to annul MD degrees. The UK authorities were recognising degrees just when the Germans were vindictively abolishing them. Given that even after the war, degrees were not restored by right by the Austrian and German universities, Decker's view of a decade of unremitting discrimination seems misplaced. Importantly, Decker considers the Austrian and Czechoslovak concessionary schemes, adding to what is known about their operation.⁴⁸ But while she considers the 50 Austrian doctors, she omits the scheme for 40 Austrian dental surgeons who all held an MD qualification. Similarly, Czechoslovak, Polish and Italian dental surgeons all held medical qualifications. They had the opportunity to cross back to general medicine, which a few did, as Josef Glatter (MD Vienna 1917), or Olga Muller (MD Vienna 1922) to accident and emergency medicine. Secondly, Decker overlooks the role of the GMC, and its powers to recognise degrees comparable to those in the UK, a situation which Zamet has explored.

Decker explains that the onset of war meant that only 19 Czechs were able to make use of the privileged quota as a route to re-qualification.⁴⁹ What Decker does not explain is that the Czechs benefited from their status as 'friendly aliens' and many gained UK qualifications and were able to practise in hospitals and privately. So far from just 19 quota physicians, we find 240 Czech physicians in the UK in September 1939 appearing on the Kapp List, and 52 students granted degrees in Oxford. Overall, approximately 472 Czechoslovakian doctors in Britain found employment during the war, as they fell into the category of 'friendly aliens'. The 'Aliens Committee' dealt sympathetically with Czech applications. In March 1942, Dr Hynek Rotenstein, one of the quota of 50 Czechoslovaks, was granted permission to practise in Harley Street in London's West End.⁵⁰ The Committee recognised that, by March 1942, approximately 200 Czech physicians found appointments, as had 300 German and Austrian doctors. The balance of the Czech physicians were on active military service. Military medical service with a fighter squadron (as in the case of Arnost Kraus) cannot be seen in terms of restriction and exclusion. Moreover, Decker fails to mention the extent of autonomous medical organisation achieved by the Czechs and Poles. The Czech Refugee Trust Fund oversaw a comprehensive system of medical care with its own hospitals. B. Silbiger, one of the 50 'official' Czechs in charge of medical research at the Czechoslovak Research Institute, was also at the St Bartholomew's Hospital Ear, Nose and Throat department. We find rapid integration rather than discrimination.⁵¹

The Aliens Committee encountered significant conflict as regards psychotherapists, and the insistence that any continental psychotherapist had to work under the control of a GP. Decker overlooks the clash of interest groups evident in the proceedings of the committee.⁵² The Tavistock Institute was a major supporter of refugee analysts. Lay analysts could practice—something which was advantageous for the non-medical Anna Freud. There were

⁴⁸Decker 2003, pp. 856–9.

⁴⁹Decker 2003, p. 858–9.

⁵⁰BMA Archives, Home Office Medical Advisory Committee 1939–49 B/12/1/1 March 1942, 17 February 1943.

⁵¹Cf. Decker 2003, p. 866.

⁵²Decker 2003, pp. 867–8.

at least 32 lay refugee psychotherapists. The point at issue was whether those holding medical qualifications could have these overlooked. For some, like Michael Balint, it meant being relegated to a provincial city (in his case Manchester), but it gave him a realistic sense of the problems of general practice. Decker confuses analysts and medically-qualified psychiatrists; her account overlooks a substantial group of psychiatrists, many associated with the Maudsley Hospital, as well as a stellar group of non-medical psychoanalysts, notably Anna Freud.⁵³ The BMA was using the disputed status of aliens to extend its opposition to lay psychotherapy in general. The BMA insisted that any continental psychotherapist had to work under the control of a GP. The clash of interest groups in the proceedings of the committee was evident, when the Tavistock Institute was outraged at what it rightly saw was a massive attack on the status of psychotherapy.⁵⁴

Foreign degrees were recognised in the UK by stages from 1940. This was a major step towards inclusion. The Foreign List of the Medical Register already contained German and Austrian refugees with permission from the GMC to practise; from 1941 it noted that 'practitioners to whose names in the Foreign List an asterisk (*) is prefixed are temporarily registered in pursuance of the Medical Register (Temporary Registration) Order, 1940, made under Defence Regulation 32B'.⁵⁵ This list rapidly grew until 1948.⁵⁶ The *Medical Register* from 1942 similarly listed 'Practitioners temporarily registered in Great Britain' on an annual basis until 1949 when the separate 'Temporary List' ceased to appear, and former refugees appeared under the general listing.⁵⁷

The great breakthrough had come with the Medical Registration (Temporary Registration Order) of 1 January 1941. This extended the GMC's registration powers for inclusion in the Foreign List of the *Medical Register*. It covered not only service in the armed forces but also employment in 'certain hospitals, institutions, or services'.⁵⁸ This was a far-sighted gesture, one meriting recognition as a landmark in the internationalising of professional qualifications. It allowed so-called 'friendly alien doctors' the opportunity to practise in Britain. Just at the point in time when the German universities were withdrawing the degrees of refugees, their continental qualifications gained validity as the basis for practice.

The effect of this order was to allow refugees to practise on the basis of their original qualifications. The Order was ambivalent in that the BMA clearly saw it as a limited emergency concession, while others, like Hill, saw it (rightly as events turned out), as signifying eventual permanency. The procedures could at times be bureaucratic, but the acute shortage of practitioners, reinforced by hospital administrators clamouring to fill vacancies, exerted pressure on the Home Office to grant the necessary authorisations. Qualifications were recognised without any further qualifying test. It allowed those hospitals and local authorities so wishing, to offer employment. It meant that in effect the top-down control mechanisms of 'the medical establishment' were broken. The Aliens Acts still

⁵³Cf. Decker 2003, pp. 867–8.

⁵⁴BMA Archives, Home Office Medical Advisory Committee 1939–49 B/12/1/1, 31 October 1940.

⁵⁵*The Medical Directory* (J. and A. Churchill, 1941), pp. 1922–33.

⁵⁶Decker 2003, p. 865.

⁵⁷*Medical Register* (General Medical Council, 1942), pp. 2318–30. *Medical Register* (General Medical Council, 1949), pp. 1208–22.

⁵⁸*Supplement to the British Medical Journal*, 25 January 1941, 1, p. 9.

applied, giving Czech and Polish displaced practitioners an advantage, and the regulatory structures were open to exercise in an exclusive or permissive manner. But—and here there was a far reaching liberalisation—the practice was permissive, and increasingly so as the war went on. The most restrictive period covered the acute emergency for the months between the Dunkirk invasion scare, and the end of 1940—only a period of several months. The ensuing seven years, until the introduction of the National Health Service (NHS), were marked by progressive liberalisation, so that eventually the emergency recognition of foreign degrees in 1941 became the basis for full equivalence.

Wide-ranging opportunities opened up, as the 1941 concession covered ‘any sanatorium, convalescent home, or public assistance institution’, as well as ‘any clinic, dispensary, hospital centre, or patient department’. Psychiatrists benefited as the Order related to any institution under the Mental Treatment Act of 1930, as well as all institutions covered by the Mental Deficiency Act. Although the scheme was far slower to be implemented than its advocates would have liked, by 1943 the situation was positive in terms of registrations and vacancies filled.

Academic Hybrids

Modernisers, associated with MRC, and with university and research laboratories, saw that the scientifically-trained continental refugees were an opportunity to confront obstructive elements. Britain gained around 47 biochemists with such illustrious figures as Hans Krebs, Max Perutz and Albert Neuberger; over 20 innovative pharmacologists as Hans (‘Hugh’) Blaschko and Edith Bülbring at Oxford; and stellar groups of psychiatrists and psychoanalysts. Many (as Krebs who in Freiburg worked in a clinical laboratory) held medical qualifications; although they did not seek clinical employment, they saw their work as clinically relevant. Bülbring gave up a career in paediatrics when, from 1933, she worked in pharmacology with J. H. Burn at the Pharmaceutical Society of Great Britain.

Here it is rewarding to examine the role of the Society for the Protection of Science and Learning (SPSL). The view that this energetic refugee assistance organisation was narrowly geared to scientists, and was not interested in clinicians is open to question.⁵⁹ Here again we find a dynamic situation. The SPSL initially was perplexed by clinicians with substantial numbers of research publications. Even so, outstanding clinical innovators (such as the neurologist Ludwig Guttmann) did have support. After the Anschluss of Austria, it meant SPSL policies broadened to support the ‘scientifically-oriented clinicians’. For these represented the type of moderniser (as Herbert Herxheimer or Paul Rothschild) that Hill wished to transplant to the UK. We find a contrast between the Academic Assistance Council (from 1936, the Society for the Protection of Science and Learning) favouring the bringing of refugees to the UK, and the hostility of British professional medical organisations. Thanks to such medical reformers as Hill, Britain took sizeable numbers of biochemists, physiologists and geneticists. It saw, rightly, that once they had a place of safety in the UK, then they would either find an academic or clinical niche, or they would be able to negotiate the more time-consuming American formalities.

⁵⁹Cf. Decker 2003, pp. 859–60.

The SPSL had long been faced with the problem of scientists who had clinically-based positions, and clinicians with an immensity of scientific publications. For some stellar scientists like the biochemist Hans Krebs, arrival in Britain fulfilled the aspirations of a research-based career; Krebs in Germany had a position in a hospital laboratory. Guttmann found laboratory research too limited, until offered an outstanding clinical opportunity as Director of the Spinal Injuries Unit at Stoke Mandeville in 1944. The Austrian brain chemist Efraim Racker worked in the brain research laboratory in Cardiff, but internment prompted his move to the USA where he did well. Similarly, the dermatologist Emil Meirowsky, when released from internment, had his application to open a practice turned down by the BMA in 1942. He consequently did not stay in the UK. Mayer-Gross in psychiatry and Guttmann in neurology offer examples of noteworthy success. The situation was certainly not one of an open door, and there were periods of crisis, but these need to be offset by dynamism and breakthroughs that were achieved. What Meirowsky's case indicates is, rather than blanket exclusion, dermatology was not an accommodating specialty, in contrast to psychiatry and pharmacology.⁶⁰ The situation requires analysis on the basis of distinct specialisms.

The idea of keeping refugees as clinical assistants became something more dynamic. The London County Council (LCC) and the neighbouring Middlesex County Council employed former refugees to staff new specialist public hospitals. The LCC was developing a system of specialist hospitals like the Maudsley (where Willy Mayer-Gross, Erwin Stengel and Felix Post were), and high quality general hospitals like the Hammersmith Hospital, where Paul Rothschild held a clinical post. The LCC favoured the employment of well-qualified German specialists and nurses. The Central Middlesex Hospital was a modern, dynamic institution employing such people as Walter Pagel, the TB pathologist, who continued part-time as a medical historian. This type of hospital suited the refugees who were used to the dynamic municipal hospitals such as Moabit in Berlin or Lainz in Vienna. What was emerging was something new—the full-time specialist consultant, as opposed to the honorary position held by the conservative élite in the BMA. Thus, the demeaning and temporary could in fact be a dynamic career opportunity, in a system which came to fruition under the National Health Service (NHS). There were those who sought out innovative alternatives. The paediatrician Anni Noll worked for the Peckham experiment, and Karl Koenig and his medical disciples opted for the Scottish Highlands where they founded the first Camphill village settlement for disabled children. Here, the Aliens Committee's strictures were irrelevant.

The SPSL had a strong medical lobby, including the indefatigable Hill, its Treasurer was the medical statistician Major Greenwood, and Samson Wright of the Middlesex Hospital was much involved. Charles Singer worked tirelessly behind the scenes. Importantly, restrictions were relaxed to support medically-qualified refugees in this crucial year of crisis. By the time of the Nazi annexation of Austria, the severity of the Nazi persecution was clear. The SPSL became more inclusive, stressing the scientific distinction of clinicians, recognising that the need was to bring people out. The Home Office also veered towards a more open-door policy, contemplating the admission of something like 1,000 Austrian physicians and

⁶⁰Weindling in Scholtz and Heidel (eds) 2004.

dental surgeons, given the emergency. While the numbers in concessionary schemes were limited by pressure from the BMA and British Dental Association to 50 Austrian doctors and 40 dental surgeons, far higher numbers came to the UK. The quota doctors had one great advantage—the Home Office viewed them as likely to be permanently in medical practice in Britain. They were referred to as the ‘fifty doctors, who are to be allowed to practise in this country’.⁶¹ Yet, given that 501 Austrian physicians (and 67 dental surgeons) came to the UK, and 473 Czechoslovak doctors and 16 dental surgeons, the quotas represent only one element of a broader picture. A total of 53 Czechoslovak students obtained MD degrees at Oxford between 1942 and 1945. Similarly, 211 Poles qualified at Edinburgh between 1941 and 1949. Decker suggests that the British never recognised the Czech and Polish schemes for practice in the UK.⁶² This is contradicted by the *Medical Register* and Directory, and official records, showing that in view of the unforeseen political situation, the degrees were converted under section 5 of the Polish Resettlement Act 1947.⁶³

Conclusion

Fortunately, the active support of engaged individuals, organisations and certain medical schools counter-acted the BMA/MPU hostility, and influenced the Home Office to admit far higher numbers of refugee doctors to Britain. Yvonne Kapp, working for the Central Refugees Fund of Woburn House, gives details of 1,626 doctors and dental surgeons.⁶⁴ She has estimated there were approximately 2,000 medical refugees in 1941. The Central Office for Refugees estimated there were c.1,400 refugee doctors without a British qualification in 1941. Hill, at the House of Commons in May 1943, spoke of 800 Jewish refugee doctors to mollify the critical lobby of professional monopolists and anti-Semites.⁶⁵ These are all underestimates.

While Decker alleges that ‘the British medical establishment’ succeeded in preventing immigration during the crisis period between November 1938 and the outbreak of war, I would suggest instead that the evidence is of a divided establishment, indicative of different trajectories for clinical medicine. Overall, to date, 5,219 refugee physicians, dental surgeons, nurses, psychotherapists and others involved in health care, research or studies have been identified in the Medical Refugees project, which covers the UK and the handful in the Republic of Ireland. The project covers 1930 to the immediate post-war aftermath when some survivors of concentration camps (as the Auschwitz prisoner-doctors Alina Brewda and the notorious Wladislaw Dering) and military doctors from locations such as Palestine (as Fred Barber) and Italy (particularly Polish military physicians) were admitted. Not everyone wished to settle: the Norwegians and French were intent on return, while others saw the UK as primarily a place of safety while arranging onward migration.

⁶¹Wellisch Family Papers, New York, Home Office to German Jewish Aid Committee, 17 November 1938. Co-ordinating Committee for Refugees to E. Wellisch, 15 August 1938.

⁶²Decker 2003, p. 855.

⁶³Edinburgh University Archives, Special Collections. Box 22 Faculty of Medicine, Polish School of Medicine 1939–71. *Medical Register*, Foreign List 1948 p. 2220, adding ‘section 5 of the Polish Resettlement Act 1947’.

⁶⁴Oxford Brookes Medical Refugees Collection, copy of Kapp List.

⁶⁵HC, *Parliamentary Debates*, vol. 389, 19 May 1943, col. 1182.

Opportunities steadily improved during the war. In June 1942 the LCC agreed a quota of 78 posts for medical refugees.⁶⁶ The Emergency Medical Service agreed to increase positions for ‘alien practitioners’, whose assistance was recognised as valuable and justified by experience.⁶⁷ In the wartime situation, quotas were elastic. Moreover, Britain’s underdeveloped sickness insurance system meant that municipal clinics were a niche for alien specialists. In Britain, specialist posts were generally hospital-based, so that the clinical posts represented a genuine opportunity. Some, like Mayer-Gross, were at the level of consultant. Later, under the NHS specialist appointments, others were hospital or clinic appointments. Here we have not discrimination, as suggested by Decker, but adaptation to an alternative structure of medical care in the UK.

By the time a case was considered by the ‘Aliens Committee’, it was not an issue of denying whether an alien could practise, but where they could. Decker confuses stage two (validation of qualifications) and stage three (control on location). The BMA lobbied for a policy of dispersal, subordination and temporary employment. It protested that there could be no controls on aliens after they were naturalised.⁶⁸ Such sentiments betray a wholesale opposition to aliens. Fifteen young refugee physicians pleaded with the BMA that they were ‘anglicised in thought and mode of living’, but they still lost their positions. Yet this was on 20 December 1940, and by then the new regulations on alien practitioners were prepared.⁶⁹ The tensions rapidly diminished. The Home Office recognised that once the war ceased, aliens with British qualifications could remain in the UK, and then the authority lapsed to restrict independent practice.⁷⁰

The inauguration of the NHS, with its modernised system of specialist health care, meant the former refugees found permanency of employment and professional opportunities. We see that certain specialisms were more open to working with refugees. The vision of the modernisers—that there was a real need to improve the scientific basis of all aspects of health-care delivery—has been vindicated. Here the dynamic is less formal control by the BMA, but differentiated attitudes within professional specialisms. Ironically, the NHS has suffered from labour shortages throughout its existence. The élite professional organisations have consistently underestimated training requirements, so causing reliance on overseas professionals. Instead of viewing the successive waves of refugee practitioners as a positive opportunity, they have consistently encountered bureaucratic and professional barriers. The BMA opposition to the inauguration of the NHS exposed its protectionism. The situation became regularised by re-registration with the GMC.⁷¹ Decker overlooks a further crucial factor: between 1946 and 1948, naturalisation was granted on a massive scale. Once naturalised, the Home Office controls on aliens ceased to apply. The Aliens Committee indeed made a last-ditch attempt to sustain the Temporary List and encourage re-migration. Yet, here there was an irony that naturalisation was also in the hands of the Home Office, again evidence of an official doublethink which pursued apparently contradictory policies,

⁶⁶RS, MDA 7 Hill Papers, June 1942, letter Ernest Brown to A. V. Hill, Hill reply 7 July 1942.

⁶⁷RS, Hill Papers MDA 7 Ministry of Health 10 February 1942, Circular 2569.

⁶⁸BMA Archives, Home Office Medical Advisory Committee, 15 December 1942.

⁶⁹BMA Archives, Home Office Medical Advisory Committee 1939–49 B/12/1/1, 20 December 1940.

⁷⁰BMA Archives, Home Office Medical Advisory Committee 1939–49 B/12/1/1, 17 April 1945.

⁷¹Decker 2003, pp. 872–3.

but one working in favour of the refugees. The post-war situation again meant moderate concessions to medical refugees.⁷² The NHS ensured that registration would become permanent.

The argument has been made here that understanding the situation pertaining to medical refugees requires analysis of the numbers of refugees in the UK and how they arrived and fared in Britain, rather than taking a literal and restrictive approach to the regulations. In taking a 'total population' approach in a situation which was changing rapidly due to the general political context and professional micro-politics, Decker's analysis has relied on a fictive and never defined category, that of 'the medical establishment'. Her claim that 'the British medical establishment was at no time proactive in helping their refugee colleagues' is at best only very partially valid.⁷³ Evidence emerges for a *divided* establishment with scientific modernisers pitted against more conservative traditionalists, in a process of structural transformation in which the refugees became caught up. They also expressed their opinions as to the restructuring of medicine in Britain and Europe, as indicated by the wartime Health Charter movement.⁷⁴

The regulations and procedures were undergoing constant modification and adaptation. What is necessary is to examine life histories and build up a composite picture, in a highly differentiated situation. Specialisms could be more or less hospitable—dermatology appears resistant, whereas psychiatry was proactively hospitable. Whatever the controls, the system was subject to constant modification, exceptions and those who came through alternative routes. One needs to assess any overly rigid administrative approach to these problems by first considering a range of exempt categories—the medically-qualified dental surgeons, the Italian degree-holders, those who were naturalised, and categories beyond medical control such as psychoanalysts. Second, we need to take account of the actuality of medical careers, and here there were certain hospitable specialisms such as psychiatry and pharmacology, and more welcoming medical institutions. Professional restrictiveness has to be offset by a multiplicity of organisations—scientific, Jewish, Quaker, Anglican, socialist, etc.—all moderating regulatory provisions.

Naturalisation for most in 1946 and 1947, and the launch of the NHS in 1948 with its opportunities for clinical specialists as well as in general practice, provided a basis for the full integration of refugees among the 27,000 doctors entering the NHS. Decker's jaundiced conclusion that only those 'who were still alive and young enough' were to benefit from the professional opportunities under the NHS is a misinterpretation.⁷⁵ Figures in active retirement, like Neuburger and Zollschan, took much pride in a country where they found not only a place of safety (despite Nazi bombing) but also recognition and support. They lectured on the radio and published extensively. Refugees enjoyed relief from vicious forms of persecution, and while Britain had its anti-Semites and hostile currents evoked by the internment, the 'island refuge' offered relative safety and security. Here a contrast can be drawn with Nazi Germany, which abolished individual refugees' degrees, just when the UK

⁷²United Nations Archives New York, UNA S-048 box 43 file 1 Doctors for Re-settlement, 17 May 1947.

⁷³Decker 2003, p. 872.

⁷⁴*Year Book of the Inter-Allied Health Charter Movement* 1945.

⁷⁵Decker 2003, p. 873.

granted recognition. Decker's interpretation denies the significant wartime medical contributions made by refugees, who were rightly proud of their service, whether it was as auxiliary fire-service personnel, as officers in the RAMC or in ensuring the medical and dental fitness of allied troops or auxiliaries such as the Merchant Navy. The refugee physicians looked after civilians at a time of upheaval, including a range of fellow refugees, while supporting the medical services of a country at war. After providing a place of safety for more medical refugees proportionally than any other country, and recognising foreign degrees on a large scale from 1941, the former refugees could register with the NHS as long as they were under the statutory retirement age. That most did so with an optimistic enthusiasm indicates British medical provision was in the throes of a major restructuring which defied the traditionalists and conservatives among the 'medical establishment'. A. V. Hill's strategic vision was ultimately to be vindicated.

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Table 1

Medical requalifications in the UK, 1930–49

Year	Number of degrees	England and Wales ^a	Scottish Conjoint	Scottish universities	Polish School of Medicine, Edinburgh
1930	2	2	—	—	
1931	1	—	1	—	
1932	2	—	2	—	
1933	2	—	1	1	
1934	71	9	61	1	
1935	75	4	71	—	
1936	30	3	25	2	
1937	44	8	33	3	
1938	33	8	24	1	
1939	43	14	26	3	
1940	40	15	23	2	
1941	54	41	13	—	
1942	42	39	3	—	
1943	37	26	7	3	1
1944	33	19	9	3	2
1945	22	16	5	—	1
1946	21	19	—	—	2
1947	36	28	3	5	
1948	33	29	1	3	
1949	27	20	2	3	2
Totals	648	300	310	30	8

Source: Weindling, Medical Refugee Database, Oxford Brookes University, UK.

^a Degrees from Wales were obtained in 1940, 1941 and 1942, while other Cardiff clinical students took Scottish degrees.

Table 2

Czechoslovak and Polish degrees awarded, 1941–9

Year	MD Cz (Oxford)	Polish School of Medicine Edinburgh
1941	—	5
1942	19	15
1943	24	34
1944	3	16
1945	6	21
1946	—	33
1947	—	34
1948	—	29
1949	—	19
Totals	52	206

Source: Weindling, Medical Refugee Database, Oxford Brookes University, UK.

Table 3
Settlement and onward migration and return of Austrian medical refugees, 1930–60

Remained in UK, Migrated onward to, or Returned to Austria	Settled in UK	To USA	To Australia	To Canada	To Israel	To India, Kenya, New Zealand, Singapore	Returned to Austria	GDR	Place of final settlement not known	Total
Medical	295	55	4	9	3	5	16	1	114	502
Dental Surgeons	58	5	1	1			2			67
Scientists in medically related disciplines	9	9	1	2					6	26
Totals	362	69	6	12	3	5	18	1	120	595

Source: Weindling, Medical Refugee Database, Oxford Brookes University, UK.

Table 4

Medical refugees in the UK, 1933–50

Nationality	Male	Female	Total
German	836	275	1111
Polish	933	146	1079
Austrian	474	164	638
Czechoslovak	401	93	494
Nationality uncertain	948	481	1429
All Nationalities (including others unidentified)	4002	1204	5206

Source: Weindling, Medical Refugee Database, Oxford Brookes University, UK.