Citation for the published version:

Henrich, E. (2019). Constructing the 'New Australian Patient': Assimilation as preventative medicine in post-war Australia. Histoire Sociale-Social History, 52(105).

Document Version: Accepted Version

Link to the final published version available at the publisher:

https://hssh.journals.yorku.ca/index.php/hssh/article/view/40989

Constructing the "New Australian Patient":
Assimilation as Preventative Medicine in Postwar Australia

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This article brings together historical questions about the nature of assimilation and the medicalization of migrants in the postwar era, with a focus on medical writings about migrant patients in Australia in the 1950s and 1960s. It argues that physicians adopted official assimilation ideologies to construct a "New Australian patient" whose beliefs and behaviours indicated a less sophisticated understanding of medicine, and who suffered particular psychosomatic illnesses and health risks linked to their migration, socioeconomic status, and linguistic isolation. By making assimilation medical, these doctors helped bridge the cultural gulf that existed between Australian doctors and their migrant patients, but they also perpetuated cultural stereotypes through which certain unassimilable groups were blamed for their own medical problems.

In 1955, Dr. G. M. Redshaw of Australia's Department of Health presented a paper at a meeting of the Australasian Association of Psychiatrists titled "Psychiatric Problems Amongst Migrants." In light of the recent celebrations marking the arrival of Australia's "Millionth Migrant," Redshaw commented on the demographic transformation that the postwar immigration program had created, whereby "one in every ten of our population has arrived from overseas since the end of the war." However, he noted that the newcomers brought with them "problems of selection and assimilation" which must be addressed so that they "may be absorbed into our community without discordant repercussions." The severity of such problems varied. Those who arrived seeking employment and a better standard of living "meet few difficulties of assimilation for they have clear ideas on their prospects before they arrive. The mental stress to them is minimal." By contrast, many of those who have escaped the "blasts of a cold war" and

been subject to "severe nervous tension … find difficulty in assimilation because they believe that their old way of life is best." Redshaw also identified a small group who have "failed in their own country" due to "their own inherent shortcomings," and are unable to "seize the opportunities offered by a new country." Fortunately, he observed, a proportion of those types returned to their homelands. [1]

Redshaw's article, published in the *Medical Journal of Australia* in 1956, is one of the earliest examples of a burgeoning medical discourse on the health of migrants in Australia during the 1950s and 1960s. In a period where the cultural, ethnic, and linguistic makeup of the doctor's waiting room, the maternity ward, and the emergency room were changing markedly, medical professionals found themselves "managing difference" in ways they were not prepared for. [2] As the major industry periodical, the *Medical Journal of Australia* (*MJA*) provided a professional space in which these challenges and frustrations could be aired. It also offered doctors who had experience or insight into the cultures and health problems of migrants an avenue to provide advice and information for their colleagues. Some researchers found postwar migrants a useful patient population through which to observe novel conditions or to compare migrants with the Australian-born, and the *MJA* published the reports of their studies. Along with articles published in other international and domestic journals, these publications solidified an official knowledge of migrant health that, at the height of Australia's assimilation era, rendered some types of migrants more different and difficult than others.

These medical writings represent an untapped source for historians interested in the connections between migration, medicine, and changing ideas about racial and cultural difference in the mid-twentieth century. The only existing analysis of the postwar

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[1] G. M. Redshaw, "Psychiatric Problems Amongst Migrants," *Medical Journal of Australia*, vol. 2 (December 8, 1956), pp. 852-853.

[2] For this concept, I am indebted to the work of Janet McCalman in *Sex and Suffering: Women's Health and a Women's Hospital: The Royal Women's Hospital, Melbourne, 1856-1996* (Carlton, AU: Melbourne University Press, 1998), esp. chap. 12, "Managing Difference."

medical literature dates from 1978, when sociologist Jean Martin published her report for the National Population Inquiry into how Australian institutions—schools, healthcare, and trade unions—had responded to the presence of non-Anglo-Saxon migrants since 1945. Martin's guiding questions concerned power, knowledge, and institutional change. She found that doctors had been the "main definers" of the health situation of migrants, that the problems identified were primarily attributed to migrants themselves rather than structural deficiencies in the Australian health care system, and that the observations of a handful of doctors from the 1950s and 1960s had become "sacred texts," influential in perpetuating ideas about the "individual characteristics of certain categories of migrants" into the 1970s.[3]

Forty years after Martin's pioneering study, and in light of the critical literature that has been produced in the interim, the topic of migrant health in the immediate postwar period warrants a reassessment. In this article, I bring together for the first time historical questions about the nature of assimilation in postwar Australia and the medicalization of migrants in the postwar era. Medicalization in this context is used to describe the process by which certain human behaviours, beliefs, or practices came to be seen as medical problems in need of professional intervention. I argue that, in the absence of prior Australian models or frameworks for dealing with cultural and ethnic diversity, medical practitioners adopted official assimilation ideologies to construct a "New Australian patient." To define and characterize this new patient type, doctors drew on an eclectic range of intellectual influences, including Freudian psychoanalysis, group psychology, and a limited number of international studies of migrant health and combined

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[3] Jean I. Martin, *The Migrant Presence: Australian Responses 1947-1977: Research Report for the National Population Inquiry* (Hornsby: George Allen & Unwin Australia, 1978), p. 163. Martin's five "sacred texts" are discussed here, two by Ignacy Listwan, two by John M. Last, and one each by Salek Minc and Eric G. Saint. Tilaka Wickramasinge's 2005 thesis includes Martin's analysis of these texts as a precursor to an in-depth assessment of government policy on migrants' mental health in a later period in the Illawara region in New South Wales. See Tilaka Wickramasinghe, "Out of Mind, Out of Sight: Government Policy on Migrants' Mental Health, Australia 1960-2000" (PhD thesis, University of Wollongong, 2005), p. 29.

these with their own personal experience and clinical impressions. Overall, these doctors presented New Australians as patients whose beliefs and behaviours indicated a less sophisticated understanding of medicine and who suffered particular psychosomatic illnesses and health risks linked to their migration, socio-economic status, and linguistic isolation. By making assimilation medical, practitioners helped bridge the cultural gulf that existed between Australian doctors and their migrant patients, but they also perpetuated cultural stereotypes through which certain unassimilable groups were blamed for their own medical problems—Redshaw's "failed" migrants with "inherent shortcomings." This article considers how physicians used and contributed to a discourse of assimilation that defined Australian social, political, and cultural reactions to migrants in the two decades after the Second World War.

New Healthy Citizens: Contexts and Literatures

> Australia wants, and will welcome, new healthy citizens who are determined to become good Australians by adoption.
>
> Arthur Calwell, Minister for Immigration, August 2, 1945.[4]

Australia's "bold experiment" in planned mass immigration in the decades following the Second World War has been well documented in the historiography.[5] It forms part of a larger narrative about changing immigration policies over the course of the twentieth century, whereby the ideal of racial purity and a "White Australia" eventually gave way to a non-racially discriminatory immigration system and an embrace of cultural and ethnic diversity. These changes were contested and reluctantly conceded in response to

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[4] 17. Cth, Parliamentary Debates (Australia), House of Representatives, August 2, 1945, https://parlinfo.aph.gov.au/parlInfo/genpdf/hansard80/hansardr80/1945-08-02/0049/hansard_frag.pdf.

[5] John Lack and Jacqueline Templeton, eds., *Bold Experiment: A Documentary History of Australian Immigration since 1945* (Melbourne: Oxford University Press, 1995). For a recent overview of the historiography, see Ruth Balint and Zora Simic, "Histories of Migrants and Refugees in Australia," *Australian Historical Studies*, vol. 49, no. 3 (2018), pp. 378-409.

international censure, homegrown activism, and changing public opinion.[6] The postwar immigration program was a turning point in this process, marking a shift from an assumption of racial homogeneity to an insistence on cultural conformity. Race (constructed through immigration selection) and culture (addressed through settlement policy) sat together uncomfortably in the mid-twentieth century, as the language of one definer of difference was superseded by the other, and government departments struggled to respond to the presence of so many white "others" in the national polity. A language of "assimilation" was adopted as a result. As the above quote from the then-Immigration Minister Arthur Calwell suggests, physical fitness and a personal commitment to the Australian nation were at the heart of the new ideology.

Postwar assimilation has in recent years been the subject of historical re-evaluation. Writing in 2015, Margaret Taft and Andrew Markus diagnosed a common conflation in the scholarly literature between government rhetoric and implementation through policy. They demonstrate that "a complex, contested understanding of assimilation was present from the outset"; that even Immigration Minister Arthur Calwell's rhetoric on the meaning of assimilation was "equivocal"; and that the "poorly conceived" and "ill-defined" policy failed to exert control over migrants' lives.[7] Yet, the ramifications of the ideology of assimilation were widespread. As Joy Damousi has argued in relation to Greek immigrants, it "set a climate that did not allow for a public expression of grief or loss of a previous experience, or emotional response to the challenges of migration by migrants themselves."[8] The denial of migrants' pasts, particularly wartime experiences, meant that those memories remained within families and failed to find expression or recognition in Australian society. Damousi distinguishes between the "crude" government expectation of almost immediate assimilation

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[6] Gwenda Tavan, *The Long, Slow Death of White Australia* (Melbourne: Scribe, 2005).
[7] Margaret Taft and Andrew Markus, "Postwar Immigration and Assimilation: A Reconceptualisation," *Australian Historical Studies*, vol. 46, no. 2 (2015), pp. 234, 237.
[8] Joy Damousi, "'We are Human Beings, and have a Past': The 'Adjustment' of Migrants and the Australian Assimilation Policies of the 1950s," *Australian Journal of Politics and History*, vol. 59, no. 4 (2013), p. 512.

and the more nuanced accounts of social scientists, which considered psychological

implications and suggested the process could only take place over generations. Generally,

though, there was an understanding that assimilation "seemed to offer an answer" for "what

to do with or how to deal with the 'other' or the unknown."[9] Historians, in Damousi's

estimation, have not given sufficient attention to the "profound gap in understanding the

complex experiences migrants brought to Australia" in the postwar period.[10] This gap is

captured in the medical literature I analyze here. If, as I argue, we cannot understand migrant

health in the Australian context without assimilation, a focus on migrant health can also help

us to better understand the articulation of assimilation ideologies in Australian society beyond

government policy. As a group that was faced with the question of how to deal with postwar

migrants on a daily basis, medical professionals made use of assimilation ideologies to create

a road map for doctor-patient interactions. As the medical journal articles analyzed here

show, these interactions challenged Australian doctors both personally and medically.

While the nature of assimilation ideology was specific to the Australian context,

the impulse to absorb ethnic or racial minorities into a national culture was common

among immigrant-receiving nations in the postwar period.[11] Social and cultural historians

have been alert to the role medical bodies played in these efforts. Franca Iacovetta has

shown how Canadian anxieties about the "moral and mental health" of "New Canadians"

shaped the regulation of migrants' lives, and points out the irony that "all this hand-

wringing reflected in part the Europeans' status as more preferred immigrants."[12] Roberta

Bivins's work on medical responses to migrants in Britain is of particular interest to this

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[9] Joy Damousi, *Memory and Migration in the Shadow of War: Australia's Greek Immigrants After World War II and the Greek Civil War* (Cambridge: Cambridge University Press, 2016), p. 52.
[10] Damousi, "'We are Human Beings,'" p. 502.
[11] For UNESCOs role in promoting cultural assimilation of post-war migrants internationally, see Damousi, *Memory and Migration*, pp. 51-52.
[12] Franca Iacovetta, "The Sexual Politics of Moral Citizenship and Containing 'Dangerous' Foreign Men in Cold War Canada, 1950s-60s," *Histoire Sociale/Social History*, vol. 33, no. 66 (2002), pp. 363-364. See also Franca Iacovetta, *Gatekeepers: Reshaping Immigrant Lives in Cold War Canada* (Toronto: Between the Lines, 2006).

study, given the close cultural and historical links between the two countries and their medical professions.[13] Bivins argues that changing attitudes to race were an important factor in the British medical state's noninterventionist approach to the health of postwar migrant communities:

> … with the concept of biological race too tainted for public use, differences in the health pictures presented by immigrants and their children were deferred to culture-and therefore long dismissed as evanescent. Implicitly, immigrant assimilation would not only be comforting, but curative; health education was itself therapeutic, even when it was not combined with more direct interventions.[14]

Assimilation thus provided the path to health, and resistance to assimilation became medicalized as a health risk—an inference that is also evident in the Australian medical literature. Bivins's study offers a model for assessing how language and the naming of migrant groups inscribe assumptions about difference and culture into medical knowledge and institutional structures—"none can be accepted as neutral or merely factual." [15] Postcolonial migration brought large numbers of non-white migrants to the metropole, creating a situation where "empire persisted" in medical practice and research.[16] If in Britain, "New Commonwealth" migrants reflected imperial legacies, in postwar Australia, the New Australian patient reflected the inheritance of White Australia. Groups were identified variously as "Mediterranean," "Southern European" or "Latin," "Eastern

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[13] The British Medical Association was the primary professional membership body in Australia until 1962, when it became the Australian Medical Association. Fallon Mody's research on British medical migrants to Australia in this period highlights the medical networks between the two countries. See Fallon Mody, "Revisiting Post-war British Medical Migration: A Case Study of Bristol Medical Graduates in Australia," *Social History of Medicine*, vol. 31, no. 3 (August 2018), pp. 485-509, https://doi.org/10.1093/shm/hkx009.

[14] Roberta Bivins, *Contagious Communities: Medicine, Migration and the NHS in Post War Britain* (Oxford: Oxford University Press, 2015), p. 372.

[15] Bivins, *Contagious Communities*, p. 8.

[16] Bivins, *Contagious Communities*, p. 8.

European," "Baltic," and "Anglo Saxon," or by their country of origin. These terms could connote ideas about inherent racial characteristics, personality and temperament, social class, and intellectual capability, all of which contributed to their perceived ability to assimilate to cultural, medical, and social norms. Differences within the broad category of "white" were therefore the yardstick against which migrants were delineated. And without a nationalized health system, as in Britain, there was no centralized response to migrant health needs. Migrants were encouraged to take out voluntary insurance with private health funds, as was the rest of the population, which was subsidized by the government.[17] In principle, self-help was deemed by the medical profession to be conducive to better health, but in practice the system protected the profession's independence and ability to charge a fee for service at the expense of those who could not afford to insure themselves. By the 1960s, it was clear that migrants were overrepresented in this group.[18]

Beyond important contextual variations, Bivins's work demonstrates that the medicalization of racialized others in postwar Britain follows a pattern of similar institutional responses to migrants and Indigenous peoples in "white men's countries" in the nineteenth and early twentieth centuries.[19] Nayan Shah's *Contagious Divides* is an example of how an immigrant group—Chinese Americans in San Francisco—became the locus for changing ideas about public health, race, and citizenship in this period. Once maligned as a "medical menace," this community was by the twentieth century appealed

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[17] For more on the complex development of Australia's medical system in this period, see James A. Gillespie, *The Price of Health: Australian Governments and Medical Politics 1910-1960* (Cambridge: Cambridge University Press, 1991).

[18] Gillespie, *The Price of Health*, p. 283.

[19] On the concept of "white men's countries," see Marilyn Lake and Henry Reynolds, *Drawing the Global Colour Line: White Men's Countries and the International Challenge of Racial Equality* (Cambridge: Cambridge University Press, 2008). There is a wealth of work on medical responses to ethnic and racial "others" in this period. For a range of examples see the following collections: Angela McCarthy and Catherine Coleborne, eds., *Migration, Ethnicity and Mental Health: International Perspectives*, 1840-2010 (New York: Routledge, 2012); Catherine Cox and Hilary Marland, eds., *Migration, Health and Ethnicity in the Modern World* (London: Palgrave Macmillan, 2013); and Marjory Harper, ed., *Migration and Mental Health: Past and Present* (London: Palgrave Macmillan, 2016).

to by health authorities as "deserving citizens."[20] And in Alan Kraut's influential *Silent Travelers*, the desire among reformers and social workers to assimilate immigrants into American culture through "care and education in health and hygiene" is a key theme. As he writes, "they hoped to achieve cultural uniformity humanely."[21] My analysis of medical writings on migrants in postwar Australia further adds to this emerging historiographical picture of health as a tool of assimilation across white, immigrant-receiving countries.

Medical Expertise and Migrant Selection

The Australian medical profession played a vital role in the selection of migrants overseas, and doctors were therefore were positioned politically as experts on migrant bodies. As Alison Bashford and Ann Howard have detailed, the policies in place in the postwar period were those established following the federation of the Australian colonies in the early twentieth century, namely the Immigration (Restriction) Act (1901) and the Quarantine Act (1908). Together they imposed health restrictions in the areas of infectious and communicable diseases, mental illness, and a range of chronic, noncommunicable diseases in order to protect the health of the Australian population and prevent new arrivals becoming a fiscal burden.[22] Together with immigration officers, medical officers were tasked with ensuring that selected applicants would be fit, healthy, and productive members of society. Redshaw's 1956 article in the *MJA* provides a snapshot of this system at work:

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[20] Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkley: University of California Press, 2001), p. 2.

[21] Alan Kraut, *Silent Travelers: Germs, Genes, and the Immigrant Menace* (Baltimore, MD: John Hopkins University Press, 1995), p. 5.

[22] Alison Bashford and Ann Howard, "Immigration and Health: Law and Regulation in Australia, 1901-1958," *Health and History*, vol. 6, no. 1 (2004), pp. 97-112.

There are at the present moment three [Australian medical officers] in England, eight in Germany, four in Holland, 10 in Italy, and three in Greece. In the United Kingdom, in addition, use is made of a selected panel of private practitioners, spread throughout the country and covering every town. In London there are examination rooms at Australia House staffed on a sessional basis by Australian graduates doing post-graduate work overseas. This composite method gives a consistent and satisfactory level of selection.[23]

By this time Australia's postwar immigration program was in full swing, accompanied by twin public relations campaigns designed to sell the Australian dream to potential migrants from Britain and Europe, and sell the idea of immigration to sceptical Australians. Key to the latter project was the presentation of healthy, white newcomers who could be easily absorbed as useful workers and future citizens.[24] For the first time in Australia's settler history, non-British "aliens" were assisted to migrate as potential citizens, and doctors were important and visible arbiters in this process. For instance, media coverage of the first large intake of assisted foreigners (dubbed "Balts" as a reference to their Baltic countries of origin), demonstrates the role ascribed to medical officers in ensuring desirable racial, aesthetic, and physiological attributes: "the fair-skinned, flaxen haired Balts are magnificent human material from displaced persons' camps in Germany, selected after medical examination by Australian doctors and checks by immigration officials."[25] Later journeys of government health officials and medical professionals to migrant camps in Europe were covered enthusiastically in the press as

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[23] Redshaw, "Psychiatric Problems Amongst Migrants," p. 853.
[24] Anna Haebich, *Spinning the Dream: Assimilation in Australia 1950-1970* (North Fremantle, AU Fremantle Press, 2008), p. 163.
[25] "Australia: Fabulous Mecca of the Migrant," *The Argus* (Melbourne), January 24, 1948.

efforts to "tighten up" health checks.[26] Commentary on the appearance, character, and

health of migrant arrivals in the press reflected public interest in the novelty of organized

mass migration, as well as deep-rooted anxieties about immigrants, disease, and

contagion.[27] As the forward troops in the defence of the national health, Australian

medical personnel overseas represented the reassuring experts on whom the Australian

people could rely.

The 170,000 displaced persons (DPs) from Eastern Europe resettled through an

agreement with International Refugee Organisation were the first postwar migrants to be

ascribed the label "New Australians," a rebranding that Jayne Persian argues rendered

them acceptable both racially and politically.[28] Over the next two decades, the

Commonwealth Government brokered formal and informal migration agreements with

European countries, including Britain, the Netherlands, Italy, West Germany, Yugoslavia,

Austria, Greece, Spain and Belgium.[29] Migrants from the UK and Italy were the largest

groups of overseas-born residents in this period, with Germans, Greeks, and New

Zealanders also featuring prominently.[30] By the time the last formal postwar migration

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[26] For example, see "X-Ray Expert for Europe: Doctor to Tighten Up Migrant Health Check," *The Age*, November 26, 1949, and "Health Officer to Tour Migrant Centres," *Newcastle Morning Herald and Minders Advocate*, April 13, 1951.

[27] Coverage of a small outbreak of smallpox on the *Mooltan* in 1949 is an example. See "Tourists Guard Against Smallpox: Vaccination not compulsory," *The Argus*, April 13, 1949. For the relationship between anxieties about infectious disease, race, and immigration in the Australian context, see Alison Bashford, "At the Border: Contagion, Immigration, Nation," *Australian Historical Studies*, vol. 33, no. 120 (2002), pp. 344-358.

[28] Jayne Persian, "'Chifley liked them Blond': DP immigrants for Australia," *History Australia*, vol. 12, no. 2 (August 2015), p. 101. "New Australian" was a 1920s term for British migrants, adopted by the postwar Labor government to encourage the acceptance of non-British newcomers. See Lack and Templeton, *Bold Experiment*, p. 12.

[29] James Jupp, ed., *The Australian People: An Encyclopaedia of the Nation, Its People and Their Origins* (Cambridge: Cambridge University Press, 2001), pp. 66-68.

[30] Based on aggregate census data from 1947, 1954, 1961, and 1971. See Janet Phillips, Michael Klapdor, and Joanne Simon-Davies, "Migration to Australia Since Federation: A Guide to the Statistics," Parliamentary Library of Australia, updated October 29, 2010, p. 23, accessed November 15, 2017, https://www.aph.gov.au/binaries/library/pubs/bn/sp/migrationpopulation.pdf.

agreements expired in the early 1970s, it is estimated that three million people had arrived to settle in Australia.[31]

Paranoid Reactions: Problems of Personality, Culture, or "Migration Stress"?

Articles on the health problems of postwar migrants began to appear in the major professional periodical, the *Medical Journal of Australia*, in the late 1950s, a decade after the immigration program began in earnest. There a number of possible reasons for this delay. Having passed rigorous multistage medical examinations, or "survived the sifting" in the words of one Dutch migrant, those who arrived in Australia were comparatively young (under 40) and healthy.[32] On arrival, many assisted migrants spent their initial weeks, months, or even years in government-run migrant hostels and reception centres, separated from mainstream services and society. The delay may also indicate a lack of awareness or interest in the topic of migrant health beyond the process of medical examination and selection overseas.[33]

It is perhaps not surprising that the first publications to raise the issue were written by doctors who had themselves migrated to Australia. Dr. Ignacy Listwan was a psychiatrist who, together with his wife, Wiska, escaped occupied Poland during the war. After spending two years in Hungary and a further six months in Romania in a detention camp, the couple was resettled in Australia in 1948. Listwan was already a practicing psychiatrist in his homeland, but, because his qualifications were not recognised in Australia, he had to complete a further three and a half years of study, supported by his

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[31] Department of Immigration and Border Control, 'Fact sheet – Key facts about immigration'. Online: https://www.border.gov.au/about/corporate/information/fact-sheets/02key, Accessed 14 November 2017.
[32] "Strict Check on Health of Dutch Migrant (To The Editor)," *The West Australian*, August 17, 1953, p. 9. The letter is signed by Ruth M. Kaaks-Rackham of Darkan.
[33] The earliest article on postwar migration in the *Medical Journal of Australia* was written by K. G. Watson of the International Committee for European Migration and concerned the medical screening of applicants to the Australian Rural Workers Scheme. See K. G. Watson, "Medical Aspects of Mid-Twentieth Century Migration as Gleaned from Migrant Selection in Greece with Particular Reference to Australia and the Selection of 2500 Greek-Australian Rural Workers," *Medical Journal of Australia*, vol. 2, no. 6 (August 7, 1954), pp. 203-207.

wife, who opened a successful fashion design school.[34] By the mid-1950s, Listwan was

working in the psychiatric outpatient department of Sydney Hospital. His two articles in

the *MJA* in 1956 and 1959, published following paper presentations at meetings of the

Section of Neurology and Psychiatry at the Australasian Medical Congresses in 1955 and

1958, represent the first attempts to understand mental disorders in postwar migrants in

Australia.

In "Paranoid States: Social and Cultural Aspects," Listwan presented four case

studies of patients who were all young, single, male Displaced Persons from Eastern

Europe—one Hungarian, one Czechoslovakian, and two Polish. These "typical" cases

represented a larger sample of 244 new patients examined over a three-year period, 48 of

whom were migrants, 17 of whom were "paranoidal," and 12 of whom were from Eastern

European countries. Although he recognized that this sample could not be statistically

valid, Listwan wished to address the observation that "migrants frequently develop

paranoidal states and paranoia-like reactions in cases of mental derangement."

> The question arises whether the afore-mentioned reaction-type is due to their
>
> personality, or to their cultural and social make-up, or finally to factors
>
> operating in every migration and called for convenience 'migration stresses'.
>
> The problem is important in an era of massive movement of population with
>
> transplantation to new cultures.[35]

The question of whether mental illness in migrants was due to individual characteristics or

the process of migration was repeated in many forms throughout the following decades and

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[34] Glenn Thiele, "Life Struggle of Tireless Worker," *Sydney Morning Herald*, January 26, 1986, p. 17. On the nonrecognition of qualifications of foreign doctors, see Egon Kunz, *The Intruders: Refugee Doctors in Australia* (Canberra: Australian National University Press, 1975).

[35] Ignacy A. Listwan, "Paranoid States: Social and Cultural Aspects," *Medical Journal of Australia*, vol. 1, no. 19 (May 12, 1956), p. 776.

came to characterize the majority of the literature on migrant health in postwar Australia.[36]

By posing questions about the link between mental health and migration, Listwan engaged

directly in international psychiatric and psychological discourses. The mental health and

adjustment of European migrants, and especially displaced persons, had emerged as a

concern of the psychiatric literature in Britain and the United States from the late 1940s.[37]

Psychological approaches to personality developed in the interwar period in the United

States.[38] Listwan brought the two together in his article, stating that "make-up, personality,

character [and] temperament are different in different cultures" and "pathological reaction

types" differ accordingly:

> It is well known that inhabitants of the Mediterranean basin are emotionally
>
> unstable and excitable and that therefore they have the tendency to maniac-
>
> depressive reactions, when mentally deranged. On the other hand, inhabitants
>
> of eastern European countries with their slowness, languidity and lack of
>
> temperament tend to schizophrenic reactions and particularly to the katatonic
>
> variety.[39]

While he proposed that an understanding of "well-known" culturally-determined differences

in personality could help explain the types of reactions to different environments, Listwan's

analysis did not suggest that they were significant enough to account for the reaction itself.

Instead a combination of wartime and migration experiences united the four men's cases. The

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[36] Martin's statistical analysis reveals that between 1956 and 1977, 39% of migrant problems addressed in the medical literature concerned mental health. Martin, *The Migrant Presence*, pp. 154-155.

[37] Listwan's references include work on concentration camp survivors, prisoners of war, and displaced persons published in American journals, including the *American Journal of Psychiatry* and the *Illinois Medical Journal*, as well as F. F. Kino's article "Aliens' Paranoid Reaction" in the British *Journal of Mental Science*, which is discussed later in more depth. On the psychological study of DPs, see Peter Gatrell, *The Making of the Modern Refugee* (Oxford: Oxford University Press, 2013), pp. 103-105.

[38] Graham Richards, *Putting Psychology in its Place: A Critical Historical Overview*, 2nd ed. (Hove: Psychology Press, 2002) p. 144. Listwan cites Kimball Young's 1947 textbook *Personality and Problems of Adjustment* (London: Kegan Paul, Trench, Trubner) on the psychology of personality.

[39] Listwan, "Paranoid States," p. 776.

subjects had no history of mental disorder, had spent years "under nearly unendurable stresses in concentration camps and displaced persons' camps" before being resettled, and had spent their first two years in Australia fulfilling a work contract with the government in unskilled labouring jobs, housed in camps or hostels with others from their national group.[40] Listwan observed that mental breakdowns occurred sometime after arrival, in many cases after they had left the camp and faced responsibilities, financial insecurity, change of occupation and loneliness. Psychoanalytic theories help explain the experience of the migrant in Australian society. For the four men who shared an East European homeland, "the mother country represents symbolically the patient's mother … both are nourishing and give oral pleasures…. By being uprooted the patients have lost both." The loss of a mother language (also an oral pleasure and carrying "an emotional value of high intensity") and in some cases their name, Listwan implied, had a negative effect on their personality and sense of self.[41] The analytic detour seems somewhat to contradict Listwan's conclusion: that regardless of differences in personality or temperament, in most cases paranoid reaction types in New Australians are due to social causes best summarized as "migration stresses." They "should therefore not be considered as mental disorders in their real meaning." The prognosis, Listwan declared, was good. Patients "afflicted with them should be considered as quickly recoverable potential assets to the community."[42]

In reaching this conclusion, Listwan drew on the recent work of British psychiatrist F. F. Kino, published in the *Journal of Mental Science*.[43] Kino argued that the "acute and subacute psychotic states" observed in a number of patients from Poland who had arrived in Britain in the late 1940s were a special case. Unlike most instances of psychotic states, where

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[40] Listwan, "Paranoid States," p. 777.
[41] It is not clear why names have been "lost." Listwan could be referring to the common practice of Anglicising "foreign" names to avoid mispronunciation or discrimination in Australia.
[42] Listwan, "Paranoid States," p. 777.
[43] F. F.Kino, "Aliens' Paranoid Reaction," *Journal of Mental Science*, vol. 97, no. 408 (1951), pp. 598-594. The journal was renamed the *British Journal of Psychiatry* in 1963.

a "pre-existing 'mental derangement' is triggered by a change in external conditions," these men exhibited a "readily recognisable clinical entity of purely psychological situational origin"—in other words, their symptoms were a result of their migration experience, rather than any inherent susceptibility to mental breakdown. Hardships endured during war service were acknowledged by Kino and offered as proof of the patients' "good physical and mental health" and "high grade of constitutional make-up" rather than as a contributing factor to their later breakdown. [44] A combination of situational factors, including linguistic isolation and loneliness—similar to those Listwan noted in his DP patients—explained the episodic paranoid reaction, and patients generally responded well to treatment (including hospital stays of up to six months, electroconvulsive therapy and insulin comas). Kino concluded that "the determining causal agent in these cases is rather the character of the situation than the make-up of the personality."[45] A natural process of language acquisition and adjustment to a "new life" alleviated any further difficulties, evidenced by the fact that the disorder had not been seen in Polish patients at the hospital since 1949.[46]

The process of adjustment to British norms described by Kino was for Listwan one which necessitated "social management," intervention presumably on the part of both Australian government agencies and medical professionals.[47] By making recommendations for "New Australians," rather than Displaced Persons or single, male, non-English speaking migrants, Listwan positioned his advice as relevant to all doctors encountering migrant patients. New Australians should be encouraged to learn English as soon as possible, while also being given the opportunity to continue using their mother-language. The formation of national and cultural groups, societies, and clubs, generally frowned upon by the authorities at the time as a failure to assimilate, was to be encouraged as a "substitute for the mother

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[44] Kino, "Aliens' Paranoid Reaction," p. 591.
[45] Kino, "Aliens' Paranoid Reaction," p. 593.
[46] Kino, "Aliens' Paranoid Reaction," p. 594.
[47] Listwan, "Paranoid States," p. 777.

country," along with marriage and the formation of a family unit. Finally, he recommended that New Australians be "desensitized from their paranoid reactions to authority … by guidance and re-education." Such a course of action could have both "therapeutic" and "prophylactic" value, making it applicable to the "deranged" and the "healthy" migrant alike.[48] Listwan's recommendations suggested that a private continuance of language, culture, and traditions would be beneficial for the mental health of New Australians and ultimately aid the national project of assimilation.

In "Mental Disorders in Migrants: Further Study," published in 1959, Listwan widened his scope to consider the migrant population as a whole: "There is no doubt that collective morbid emotional reactions do exist in migrant groups on arrival. Some of them are peculiar to a certain national or cultural group, others occur in all migrants."[49] The prospect of a migrant population, neurotic by definition, painted an alarming picture for a country in the midst of a mass immigration program. To make matters worse, the conflict between migrant groups and the host population produced a "neurotic attitude" in the latter in the form of prejudice, further exacerbating the "collective anxiety state." Listwan used the principles of group psychology, including in-group and out-group rivalries, to explain the psychological conflict experienced by migrants, and combined this theory with Freudian ideas to describe a set of "clinical pictures." The "collective anxiety state" in migrants could manifest as regression, paranoid projection, escapism, depressive states, inferiority complexes, or in a craving for sympathy: "there is a need for speaking about their past and being admired for what they suffered. Nothing worse could happen to them than not to be listened to or understood." Similar attitudes, Listwan noted, could be found in returned soldiers.[50] The relationship between war neuroses and the take-up of psychoanalytic language and methods

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[48] Listwan, "Paranoid States," p. 777.
[49] Ignacy A. Listwan, "Mental Disorders in Migrants: Further Study," *Medical Journal of Australia*, vol. 46, no. 17 (April 25, 1959), p. 566.
[50] Listwan, "Mental Disorders in Migrants," p. 567.

among medical professionals has been examined by Tracey Loughran, in the context of Britain and the First World War, and by Joy Damousi in the Australian case.[51] Both point to the selective and often eclectic ways in which these ideas were adapted and implemented. Listwan's approach, and that of the other doctors whose writings are addressed in this article, is consistent with these patterns. Listening to patients, and making efforts to understand their explanations for their symptoms, was in the mid-twentieth century becoming a more accepted method of medicine. By gesturing towards soldiers' experiences, Listwan was appealing for similar patience and sympathy to be extended to New Australians.

The appropriate treatment for collective neuroses was, in Listwan's view, a social one. Education was needed to provide information about each group to combat prejudice and to teach neurotic patterns of behaviour so they could be more easily recognized and understood. Listwan saw a role for psychiatrists, psychologists, and social workers in delivering these lessons, as well as for school teachers, who should "try and erase prejudices and ... encourage assimilation in both parents and children."[52] Separating both groups by accommodating migrants in camps was, Listwan argued, an impediment to the process of assimilation (in direct contrast with the Immigration Department, who maintained that migrant camps aided adjustment to the Australian way of life).[53] The symbolic acceptance of the newcomers into the host society could be facilitated by an enhanced naturalization ceremony, which "should carry as much pageantry as possible."[54] For the Australian government, naturalization rates were the best measure of

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[51] Tracey Loughran, "Shell-Shock and Psychological Medicine in First World War Britain," *Social History of Medicine*, vol. 22, no. 1 (April 2009), pp. 79-95; Joy Damousi, *Freud in the Antipodes: A Cultural History of Psychoanalysis in Australia* (Sydney: University of New South Wales Press, 2005), pp. 63-65.
[52] Listwan, "Mental Disorders in Migrants," p. 568.
[53] See, for instance, "The Incidence of Mental Illness Among Migrants," Report by a Committee of the Commonwealth Immigration Advisory Council (Canberra: Department of Immigration, 1961), p. 16. This report is addressed in more detail later.
[54] Listwan, "Mental Disorders in Migrants," p. 568.

assimilation.[55] The therapeutic power of the ceremony itself was for Listwan a way to "do away with the in-group versus the out-group antagonisms," effectively merging two groups into one.[56] Assimilation was thus positioned as the cure for neuroses inherent to the migrant condition and a balm for neurotic attitudes in the wider Australian community.

By the late 1950s, mental ill-health had emerged as a topic of special relevance for patients born outside Australia. On arrival, even mentally and physically healthy New Australians could experience emotional distress leading to mental breakdown. A muddied picture of causation had also begun to form; it included traumatic wartime experiences and the stresses of migration, with culture and personality shaping reaction types. Listwan's "quickly recoverable potential assets to the community" were, for the Commonwealth Government, potential threats to the effectiveness of the medical screening process and, therefore, to the success of the immigration program at large. According to G. M. Redshaw of the Department of Health, whose article began this discussion, ascertaining the "presence or absence of a mental disease" was "by far the most unsatisfactory facet of the [medical] examination because of the peculiar difficulties which exist."[57] Chief among these was the "language problem"—a recurring theme in medical discourses on migrant health. While Australian medical officers were "reasonably proficient" in foreign languages, and had access to "lay interpreters," Redshaw identified inadequate local psychiatric specialists in European countries as an issue. Compounding this lack of proper understanding was, on the one hand, the "standard of education" met in particular (unidentified) countries, which he noted was far below Australian standards,

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[55] Non-British migrants had to be resident in Australia for five years before they were eligible for naturalization. Demographer and government advisor W. D. Borrie wrote in 1954 that there was an assumption in Commonwealth policy that "the act of naturalization itself implies assimilation." W. D. Borrie, *Italians and Germans in Australia: A Study of Assimilation* (Melbourne: Cheshire, 1954), p. 228.

[56] Listwan, "Mental Disorders in Migrants," p. 568.

[57] Redshaw, "Psychiatric Problems Amongst Migrants," p. 853.

and, on the other, a lack of medical records as a result of the war.[58] With mental hospital

admissions showing higher ratios of DP patients than in those from the UK or the

Australian population, Redshaw mused: "the interesting problem is how far the final

mental collapse has been due to mental instability, and how far it has been precipitated,

first by the preembarkation mental stresses to which the migrant has been exposed, and

secondly by the difficulties of realizing mental peace in the new country."[59]

Concerns about the apparent predisposition of migrants to mental illness informed

departmental investigations, which culminated in a report by the Committee of the

Commonwealth Immigration Advisory Council (CIAC) on "The Incidence of Mental Illness

Among Migrants" in 1961.[60] The medical profession was not involved in the report, but an

editorial in the *MJA* in early 1963 brought the conclusions to the attention of the readership.

The editor congratulated the Department of Immigration on the results, which found that

screening procedures "generally succeed in excluding mentally ill and potentially mentally ill

applicants for immigration."[61] However, the *MJA* also cautioned that the very idea that

governments could "screen out" mental illness was a "comforting" illusion, given the

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[58] Redshaw, "Psychiatric Problems Amongst Migrants," p. 853. .

[59] Redshaw, "Psychiatric Problems Amongst Migrants," p. 853. Redshaw writes that "from the figures available it can be shown that the rate of mental disease is higher in the International Refugee Organization group than in the later groups of migrants. In the group from the United Kingdom the rate is approximately the same as the Australian rate of 0.6 admission to hospital per 1000 population, while in the European group the rate is appreciably lower." He does not cite the source of his figures. The first statistical study to compare admission rates by country of birth was published in the July 28, 1956 issue of the *MJA* (vol. 2, no. 4). In "The Aetiology of Schizophrenia," Melbourne psychiatrist John (J. F. J.) Cade observed a higher incidence of schizophrenia amongst non-British European males and females than among Australian-born and British-born, based on admissions to Royal Park Receiving House between 1952 and 1954 and compared with the 1947 and 1954 census data on the same national groups. These findings were confirmed in a larger, state-wide study by Cade and the Polish psychiatrist Jerzy Krupinski in 1962, and further explored by Krupinski and colleagues at the Mental Health Research Institute of Victoria. See J. F. J. Cade and J. Krupinski, "Incidence of Psychiatric Disorders in Victoria in Relation to Country of Birth," *Medical Journal of Australia*, vol. 49, no. 1 (March 17, 1962), pp. 400-404; J. Krupinski and Alan Stoller, "Incidence of Mental Disorders in Victoria Australia, According to Country of Birth," *Medical Journal of Australia*, vol. 2, no. 7 (August 14, 1965), pp. 265-269; and J. Krupinski, Frieda Schaechter and J. F. J. Cade, "Factors Influencing the Incidence of Mental Disorders in Migrants," *Medical Journal of Australia*, vol. 2, no. 7 (August 14, 1965), pp. 269-277. Frieda Schaechter's research is discussed in more depth later.

[60] "Incidence of Mental Illness Among Migrants."

[61] "The Screening of Mentally Ill Applicants for Immigration," Editorial, *Medical Journal of Australia*, vol. 50, no. 1 (March 9, 1963), pp. 361-362. Success was defined by first-admission rates to mental institutions, which in a typical Western community were estimated at 0.7 per 1000, a figure matched by migrant arrivals between 1948 and 1952.

episodic nature of "depressive or schizophrenic reactions." Even if mass screening for mental illness was possible, the editor asked, was it ethical, or even desirable? People suffering from mental illness were, he maintained, "contributing usefully, even unusually, to society." Rather than screening mental illness out, a more effective approach was "management-in-depth" after arrival.[62]

The CIAC report had for the time being shelved the problem of mental illness among migrants and, with it, broader issues of the management and treatment of migrant health issues.[63] While its authors acknowledged that for "non-British migrants … inability to communicate can foster a feeling of isolation, and could prevent a migrant from discussing his problems adequately with a doctor," they also maintained that the "comprehensive system" of migrant reception centres, employment and social services helped migrants overcome initial problems.[64] However, the limits of these arrangements were inadvertently revealed by a discussion of deportation, which could be implemented under ministerial discretion in the case of mental illness "knowingly concealed" on arrival. A provision added by the Minister acknowledged that removal to a migrant's "homeland" could also be recommended in cases "where it was clearly in [their] best interests." Where assimilation and medical attention had failed, chances for improvement could be enhanced by a change of environment and the care of family and friends.[65]

From Screening to Settlement: "difficult to handle" Patients

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[62] "Screening of Mentally Ill Applicants," p. 362.

[63] The issue was revisited within the department in a 1967 study of psychiatric admission rates of migrants, and again in a 1972 survey of premigration mental breakdown. Neither brought about change to screening procedures. See Ann-Mari Jordens, *Alien to Citizen: Settling Migrants in Australia, 1945-75* (St. Leonards, AU: Allen & Unwin, 1997), pp. 79-80.

[64] "Incidence of Mental Illness Among Migrants," p. 16.

[65] "Incidence of Mental Illness Among Migrants," p. 20. Ann-Mari Jordens' analysis of Department of Immigration records reveals 297 deportations on the grounds of medical and physical illness between 1950 and June 1962. See Jordens, *Alien to Citizen*, pp. 195-196.

In the early postwar discourse on the aetiology of mental illness in migrants, a focus on screening narrowed the field of consideration to either a prior, undetected mental illness, or one brought on after examination by the process of migration itself. Assimilation could aid in the case of the former, and the low rates of the latter could be dealt with in the same way as the main population, with deportation providing a last resort. As new waves of postwar migrants arrived from a range of national and cultural backgrounds, and with varying premigration experiences, the possibility was raised that assimilation itself might be a contributing factor to the incidence of mental stress or illness. If this was the case, it was the responsibility of medical professionals to alleviate their patients' distress and assist in the settlement process. The focus of the medical literature began to turn towards the relationship between doctor and patient and the many challenges it entailed.

Dr. Freida Schaechter was a young psychiatrist working as a Medical Officer at Royal Park Receiving House in Victoria in this period. She had migrated from the Netherlands in 1947, naturalized as an Australian citizen in 1953, and completed her medical degree at the University of Melbourne in 1956.[66] In her study of psychoses in female migrants, published in the *MJA* in September 1962, Schaechter analyzed the socioeconomic, educational, and cultural backgrounds of 63 non-British patients admitted to Royal Park with acute psychotic states, as diagnosed by a consultant psychiatrist.[67] Schaechter re-examined these patients and found 41 to be suffering from "paranoid

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[66] For Schaechter's arrival, see National Archives of Australia K269, July 14, 1947, Charon. Her naturalization is listed in the *Commonwealth of Australia Gazette*, no. 73 (November 19, 1953), p. 3112. For her degree conferral see University of Melbourne, *University of Melbourne Calendar 1957*, p. 600. Either during her studies or following her appointment at Royal Park, Schaechter became involved in the work of the Mental Health Institute of Victoria and later coauthored an article with Jerzy Krupinski and John Cade, "Factors Influencing the Incidence of Mental Disorders Among Migrants," *Medical Journal of Australia*, vol. 2, no. 7 (August 14, 1965), pp. 269-277. The Institute was housed in prefabricated army buildings within the grounds of the annex of the Royal Park Receiving House, facilitating collaboration and supervision of research. See Jerzy Krupinski, Alan Mackenzie, and Rachelle Banchevska, *The History and Achievements of the Mental Health Research Institute, 1956-1981* (Melbourne: Mental Health Research Institute, Health Commission of Victoria, 1981), p. 7.

[67] F. Schaechter, "A Study of Psychoses in Female Migrants," *Medical Journal of Australia*, vol. 49, no. 2 (September 22, 1962), pp. 458-461.

reactions" (referring back to the work of Kino and Listwan). However, seven were in no need of psychiatric treatment:

> With regard to the seven patients considered non-psychotic, their behaviour and their customary national excitability and exuberance, coupled with the examining doctors' frustration at the language barrier, gave the appearance of psychosis. One certificate read: "The patient is lying on a bed, weeping bitterly. She does not respond when addressed in English, nor in Italian". The patient was later found to be Ukrainian.[68]

This glimpse into fraught doctor-patient relationships, frustration, and misdiagnosis is only a passing observation in Schaechter's article, but it is nonetheless revealing. She attributes the patients' behaviour to "national excitability and exuberance," confirming the widespread acceptance of national "traits" also referred to by Listwan. Similar impressions of migrants responding in languages "unintelligible" to medical professionals have been found in the case notes of late nineteenth- and early twentieth-century asylums in Australia, New Zealand, and Canada.[69] As Catherine Coleborne observed in her work on Victorian colonial asylums in Australia, "the problem of miscommunication and language difference was heightened inside institutional contexts because insanity was itself often incoherent, making other forms of cultural or linguistic diversity challenging for inmates and doctors alike."[70] In the case Schaechter described, the misattribution of

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[68] Schaechter, "Psychoses in Female Migrants," p. 459.
[69] Quote from an asylum doctor in British Columbia in 1907 describing a patient who "yells in Gaelic," in Marjory Harper, "Ethnicities and Environments: Perceptions of Alienation and Mental Illness Among Scottish and Scandinavian Settlers in North America, c. 1870-c.1914," in Harper, *Migration and Mental Health*, p. 116. Angela McCarthy notes that continental Europeans were most likely to be distinguished in case books from the Auckland asylum in the period 1903-1910 for their inability to communicate in English. See McCarthy, "Ethnicity. Migration and the Lunatic Asylum in Early Twentieth-Century Auckland, New Zealand," *Social History of Medicine*, vol. 21, no. 1 (2008), pp.47-65.
[70] Catherine Coleborne, "Locating Ethnicity in the Hospitals for the Insane: Revisiting Case Books as Sites of Knowledge Production about Colonial Identities in Victoria, Australia, 1873-1910," in McCarthy and Coleborne, *Migration Ethnicity and Mental Health*, p. 83.

Italian nationality also suggests a recurring stereotype of hysterical foreign women. Southern European migrants increasingly dominated medical descriptions of the New Australian patient in the 1960s, taking over from the early focus on the stresses suffered by Eastern Europeans. Such a shift reflects, in part, the changing migrant intake, however as this example neatly demonstrates, many Australians were not well equipped to distinguish between the nationalities or languages of migrants and could easily mix up the two.[71] As New Australians, their previous identities were no longer relevant, and they were instead encountered as problematic. Differences of language and culture thus combined to create a situation in which migrants' behaviour could render them psychotic in the eyes of Australian medical professionals.

For those patients who were suffering from psychoses, Schaechter found the "outside pressure for assimilation" played an important part in their breakdown. More than half had a high degree of "social isolation and backwardness," coming from backgrounds of "ignorance, superstition, belief in witchcraft, poverty and primitive conditions" as well as "geographical isolation," with the rest being made up of middle-class or "bourgeois circumstances."[72] The new environment had become "overwhelming," leading to a retreat into their own national culture as a "defence" against feelings of "inferiority."[73] Schaechter's psychoanalytic understanding of the situation culminated in the conclusion that these migrants had suffered a "disturbance of their deeper sense of identity."[74] Treatment was both pharmaceutical and psychological, with the antipsychotic drug chlorpromazine having an "excellent effect … trebled when it is offered by a nurse one can trust, who can speak one's language and who can give explanations and

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[71] Ann-Mari Jordens notes that post-war Australia was a monolingual society, a status quo that had been "reinforced by censorship regulations during both world wars, which produced fear and suspicion of those using foreign languages in Australia." Jordens, *Alien to Citizen*, p. 97.
[72] Schaechter, "Psychoses in Female Migrants," p. 459.
[73] Schaechter, "Psychoses in Female Migrants," p. 461.
[74] Schaechter, "Psychoses in Female Migrants," p. 461.

reassurances."[75] Together they also cured the "noisy and aggressive" behaviour of the patients, transforming them from being "the most difficult to handle" to "relatively easy."[76]

Schaechter's paper located the stress of assimilation as a situational factor in the mental breakdown of her patients and suggested that those most susceptible to this risk were the least able to adapt due to their ignorance, backward beliefs, and lower socioeconomic status. Her key message, as reported in a women's column in the *Dutch-Australian Weekly*, was that "assimilation should not be forced."[77] Where efforts may have failed, hope lay with future generations, who, as Schaechter observed "speak English fluently and regard this country as their 'homeland'"—whether Schaechter saw herself among this group is a matter of speculation.[78] These migrant women were not deemed "quickly recoverable," like Listwan's single, male Eastern Europeans. Instead, the assets they could provide to the Australian community were located in their reproductive abilities and in the future assimilation of their children. In this otherwise critical account of the psychological dangers of assimilation, becoming "indistinguishable from the indigenous population" remained an unquestioned goal, and Schaetchter recommended that "opportunities for assimilation" should continue to be offered.[79] In the meantime, patience and understanding would make the treatment of the New Australian patient an easier task for the medical profession.

Understanding the Problems of the Migrant: Doctors' Impressions and Advice

A series of articles published in the *MJA* in the 1960s addressed the general health of migrants through a socio-anthropological lens. They were written by general practitioners

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[75] Schaechter, "Psychoses in Female Migrants," p. 461.
[76] Schaechter, "Psychoses in Female Migrants," p. 460-461.
[77] "Vrouwen Varia," *Dutch Australian Weekly*, October 26, 1962, p. 4.
[78] Schaechter, "Psychoses in Female Migrants," p. 461.
[79] Schaechter, "Psychoses in Female Migrants," p. 461.

or doctors working in public hospitals, most with migrant backgrounds themselves, and at different stages of their careers. Unlike the formal studies in this period, which examined the incidence of tuberculosis, illness in pregnancy, and thalassemia and sickle-cell anaemia in migrant populations, these articles were more wide-ranging. They presented case studies and discussions about the health conditions seen in migrant or "New Australian" patients based on clinical experience. They also shared common aims: to educate the reader about the major health problems of migrants, to explain migrants' beliefs and behaviours, and to provide advice as to how to deal with them.

John Murray Last graduated medicine at the University of Adelaide in 1949 and worked in hospital settings, including residencies in London, before joining a busy group practice in the Adelaide suburb of Mile End in the mid-1950s.[80] It was a formative experience that would spark an interest in epidemiology that shaped his future career. Looking back on that time in 2010, Last recalled:

> I became interested in the different ways in which people reacted to illness, which seemed to relate to cultural background. The practice served a mixed population of "old" and New Australians, the latter being displaced persons from Eastern and Northern Europe, and voluntary immigrants from Southern Europe. It was striking that some seriously ill people carried on working, whereas others who were not very ill required long periods of sick leave. Fundamental questions about perceptions of health and sickness began to interest me. I began to keep records that enabled me to count and classify my patients—primitive descriptive epidemiology.[81]

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[80] John Murray Last, "Quality of General Practice: Epidemiological Studies, 1961-67," (MD thesis, University of Adelaide, 1968), p. i.

[81] Julian Little, "A Conversation with John Last," *Epidemiology*, vol. 21, no. 5 (September 2010), p. 749.

Those records would become the basis for his first publications, two articles published in the *MJA* in 1960 and 1961. In the first, "The Health of Immigrants: Some Observations from General Practice," Last presented eleven clinical impressions identifying "patterns of behaviour" which he hoped would generate further study.[82] His discussion was framed by the concept of assimilation, and he quoted a definition from the Australian demographer W. D. Borrie in 1954: "Assimilation is a psychological, socio-economic and cultural process, resulting in the progressive attenuation of differences between the behaviour of immigrants and nationals within the social life of a given country." With this in mind, Last asked, "can a person be uprooted from the homeland and set down in a new country—new climate, social customs and economic conditions, to say nothing of a new language—without some deleterious physical or psychological consequence?" If, "during the process of assimilation, immigrants may suffer the same diseases of their fellow men," were they also "particularly prone to some diseases because they are immigrants?"[83] In Last's thinking about cultural difference and reactions to illness then, assimilation presented a way to understand the problems encountered by immigrants. British migrants, coming from a culturally and linguistically similar background, did not easily fit within this framework. Although they constituted a higher proportion of the migrant population in Adelaide than in other Australian cities, and are used as an Anglo-Saxon comparator group in a number of formal studies, they are not included in Last's writings.[84]

What impression of the New Australian patient could be gleaned from Last's articles? Of the eleven case studies presented in 1960, most were young, aged in their twenties and thirties, and working hard to establish themselves in the new country. Four were from Germany, two from "Holland," two from Italy, and the rest from Austria,

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[82] J.M. Last, "The Health of Immigrants: Some Observations from General Practice," *Medical Journal of Australia*, vol. 47, no. 1 (30 January 1960), p. 159, 160.
[83] Last, "Health of Immigrants," p. 159.
[84] I. H. Burnley, "British Immigration and Settlement in Australian Cities, 1947-1971," *The International Migration Review*, vol. 12, no. 3 (Autumn 1978), p. 352.

Yugoslavia, and Hungary. The health conditions addressed included those brought to the country by migrants, such as intestinal parasites and injuries on the road or at work caused by "unfamiliarity with local speech and customs"—these were environmental, potentially harmful, but easily monitored and controlled, and, in Last's telling, even humorous.[85] For instance, "there is a story, probably apocryphal, about the Italian who attended with two black eyes and the story that he had merely called *abbastanza* (enough) to his Australian workmate, who was helping him load a truck. Apparently he had been misinterpreted."[86] But the bulk of the article was concerned with three issues—tuberculosis, "difficulties relating to childbirth," and mental ill-health—all of which could prevent the New Australian from contributing to the Australian nation.[87] The first two issues are captured in the case of a young Austrian woman:

> Case IV – A female patient, aged 25 years, from the Austrian Tyrol, arrived in Australia in 1953. She had lived in a small village near Innsbruck and had never had a day's illness in her life before she left to come to Australia. From the time of her arrival she worked without a break in a small factory making leather goods. Her husband was a shift-worker, mostly on night-shift. Both worked overtime and did odd jobs, she, for example, taking evening work as a waitress in one of the "continental" restaurants in Adelaide. They had paid for a block of land and lived in an asbestos hut, containing good quality furniture they had bought. They had no children, but she had a miscarriage, perhaps self-induced, about two years after their arrival in Australia. She was seen in April, 1958, when she complained of a cough with mucoid sputum present for several months. The result of clinical examination was unremarkable, but X-ray films showed tuberculosis infiltration in

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[85] Last, "Health of Immigrants," p. 162.
[86] Last, "Health of Immigrants," p. 159.
[87] Last, "Health of Immigrants," p. 166.

the right hilar region and her sputum contained tubercule bacilli. After ten months

of medical treatment her disease was rendered quiescent.[88]

The striking contrast between the patient's premigration health and postmigration illness,

brought on by overwork and a change of environment, also comes through in Last's other

examples. The reversal of a progressive migration journey from danger to safety, or

illness to health, challenged widely held notions of Australia as an abundant, healthful

place, superior to the environments migrants left behind.[89] Last's description of the "good

furniture" the couple had been able to purchase whilst working multiple jobs and saving

to build their own homes suggests a keenness to assert their good character and

willingness to assimilate. The detail with which the home environment and life history is

evoked gives the impression of a level of intimacy and multiple home visits. Last's

overriding concern was that his migrant patients' determination to work hard may have

negative consequences for their health. The case of the young Austrian woman

demonstrated "a not-uncommon pattern of behaviour among the hard-working, thrifty and

in some ways far sighted young migrants from countries like Germany and Holland."

A different "pattern of behaviour" was illustrated by the case of an Italian woman,

who at age 34 presented with problems conceiving, having recently arrived in Australia to

join her fiancé, who came out years earlier. While Last recognized the "praiseworthy aim"

of providing a good home for the family before sending for them, he also regretted the

loss of children who might have become young Australians. Other migrants, who had

"planned better" or were "more fortunate … have been able to contribute children as well

as labour in return for their passage to Australia." While "sad," the blame for these

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[88] Last, "Health of Immigrants," pp. 159-160.
[89] Janis Wilton and Richard Bosworth, *Old Worlds and a New Australia: The Post-war Migrant Experience* (Ringwood.: Penguin Australia, 1984), pp. 104-105.

problems was ultimately attributed to the decisions of the individual migrant.[90] These impressions were relayed with a concern that, while sympathetic, also verged on paternalistic.

The treatment of neurosis and psychosis, while not specific to the migrant population, was made more difficult, in Last's estimation, by the "absence of a close rapport, which occurs when interviews have to be conducted with an interpreter or in school-book German or Italian."[91] Referring back to the work of Listwan, Last suggested that in the case of "impaired mental health in immigrants," much could be achieved through "kindness and sympathetic understanding." Last wrote, "An interest in the background of the immigrants and discussion of the ways in which the old life may have differed from the new, together with discussion of the problems of establishment in the new land, have been found on many occasions to be all that is needed in the way of psychotherapy."[92] Patience, interest, and the learning of a few words in the migrant's language would go a long way in aiding the treatment of New Australians' mental health problems. As for the prejudice in the host population, Last agreed with Listwan's suggestion that education was the key, and that "where the doctor is an important figure in the community … [he] may be one individual who can help to break down this undesirable reaction by precept and example."[93] The New Australian patient here closely resembled Listwan's "quickly recoverable asset to the community," industrious, assimilable, and full of potential—potential that could be realized with the help of medical expertise.

In his second, more discursive article, "Culture, Society and the Migrant," Last directly addressed "members of the medical profession" as people involved in the

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[90] Last, "Health of Immigrants," p. 160.
[91] Last, "Health of Immigrants," p. 160.
[92] Last, "Health of Immigrants," p. 162.
[93] Last, "Health of Immigrants," p. 162.

assimilation of migrants.[94] The process, "essential to the future development of the country," could be "greatly assisted" if all involved had some understanding of the problems migrants encountered between their initial decision to migrate and successful absorption into the Australian community. In setting out these problems, Last provided anecdotal examples and broad observations that, without the caveats of his earlier piece, seemed authoritative. Considering the relevance of varied cultural backgrounds to medical practice was, he wrote, "only now beginning to be realized by a few *avant-garde* health workers and psychiatrists," thus positioning himself at the cutting edge of the movement.[95] Southern European migrants, or "the Latin races," appeared repeatedly as examples of the "very wide cultural gulf" which separated "some alien immigrants from the Australian citizen."[96] For the young Italian bride, "subservient" by upbringing and culture, social and linguistic isolation could account for the "widely-held clinical impression that these girls have difficult, stress-affected pregnancies."[97] Families with children who maintained the "undesirable custom" of both parents working also posed a "risk of neglect," which justified, in his view, "a tactical intervention in the internal affairs of the family" on the part of the general practitioner, although what form this intervention could take was not explained. Single male migrants composed "another section of the population whose fertility is impaired by migration." Poor living conditions combined with social isolation could result in psychological problems echoing those identified by Listwan, and in one case, "a lonely refugee migrant committed suicide after a medical interview in which he was tactlessly questioned and attempts at psychotherapy had failed." But most problematic were the lifestyles of single Southern European men, which could lead to a potential hotbed of disease and disorder:

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[94] J.M. Last, "Culture, Society and the Migrant," *Medical Journal of Australia*, vol. 48, no. 1 (March 18, 1961), p. 420.
[95] Last, "Culture, Society and the Migrant," p. 421.
[96] Last, "Culture, Society and the Migrant," p. 421.
[97] Last, "Culture, Society and the Migrant," p. 422.

Large numbers of single men, usually of Southern European origin, sometimes live under extremely congested conditions in slum areas, sometimes six or eight sleeping in a room meant for two or three. Bathroom and laundry facilities, kitchens and meals are often primitive and makeshift, and the most elementary principles of hygiene may not be observed. Gastro-enteric infections are likely to be endemic under these circumstances, respiratory infections including tuberculosis could have a high morbidity, and venereal disease is common among men of this social class. The psychological consequences of this kind of congested and uncongenial living conditions are often hard to assess because of language barriers; but a morbid preoccupation with minor ailments out of keeping with mental good health, and "malingering", which implies some psychological upset, are common.[98]

Last's colourful description is reminiscent of the moral judgement and public health concerns of social reformers of an earlier era, where "uncongenial" living conditions reflected the character and mental states of the inhabitants. It also demonstrates contemporary anxieties about ethnic enclave formation and a sex imbalance potentially producing a group of dangerous, foreign men without family ties.[99] Last attempted to instil "an appreciation of the migrant's social, cultural, vocational and domestic situations" in his readers, so "the process of assimilation may be facilitated, and this is surely good preventative medicine." In doing so he unwittingly propagated a stereotype of Southern European migrants as inherently neurotic and difficult, legitimized by the language of epidemiology and health risk.

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[98] Last, "Culture, Society and the Migrant," p. 422.
[99] See Zora Simic, "Bachelors of Misery and Proxy Brides," *History Australia*, vol. 11, no. 1 (April 2014), pp. 149-174; Susanna Iuliano, "Donne e buoi dai paesi tuoi (choose women and oxen from your home village): Italian Proxy Marriages in Post-war Australia," *Australian Journal of Social Issues*, vol. 34, no. 4 (November 1999), p. 327.

Dr. Salek Minc's 1963 article, "Of New Australian Patients, their Medical Lore and Major Anxieties," aspired to similar aims, but due to his personal and clinical experience Minc was able to pursue more nuanced explanations for migrants' health complaints.[100] Minc was born into a Jewish family in Siedlce, Russia in 1908, and grew up there until growing anti-Semitism and the Communist Revolution forced them to leave for Poland. He finished secondary school in Warsaw and moved to Italy in 1922, graduating from the University of Rome as Doctor of Medicine in 1930. His Italian citizenship, gained in 1932, was stripped by the fascist government in 1938, and Minc then spent time in England before working as a ship's surgeon on the journey to Australia, arriving in April 1940. In his *MJA* article, Minc submitted "impressions, recollections and thoughts gathered during 22 years of medical practice in Western Australia," modestly stating that he had "assimilated the language and some of the social culture" of Russia, Poland, and Italy in previous years. He in fact spoke eight languages and had practised as a doctor in Italy and England. In Perth, Minc held positions at the Royal Perth and Fremantle Hospitals and ran his own medical practice as a specialist physician and cardiologist.[101] This background placed him in the position of a cultural envoy or translator, a role he assumed easily in writing about the "medical lore" of New Australian patients and comparing their beliefs and behaviours to those usually found in "Anglo-Saxon countries." The Italian patient received the most attention from Minc, who noted they were "less prone to assimilation and to the learning of a new language" than Eastern European migrants, who had been uprooted before, forced to learn new languages, or

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[100] S. Minc, "Of New Australian Patients, their Medical Lore and Major Anxieties," *Medical Journal of Australia*, vol. 1, no. 19 (May 11, 1963), pp. 681-687.

[101] See *Australian Dictionary of Biography*, s.v. "Minc, Salomon (Salek) (1906-1983)," by Robin Taylor, accessed December 2, 2017, http://adb.anu.edu.au/biography/minc-salomon-salek-14973/text26162; "Alex Cohen remembers Salek Minc," Lawrence Wilson Art Gallery website, University of Western Australia, accessed December 2, 2017, http://www.lwgallery.uwa.edu.au/publicprogram/slms/cohen-remembers-minc; and "Who is Salek Minc?," Lawrence Wilson Art Gallery website, University of Western Australia, accessed December 2, 2017, http://www.lwgallery.uwa.edu.au/publicprogram/slms/salekminc-biography.

were already bilingual. For Italians, Minc wrote, "language is as much part of their person as their temperament and the colour of their hair."[102]

Minc provided his readers with a comprehensive education in the Italian concept of illness, from ideas about the origins of disease (including "the air of this country" and "blood out of order") to their treatment (for instance, *riscaldo*, or "heating up" would be treated by *rinfrescante*, or "cooling") and the relationship between doctor and patient. In gendered language common at the time, Minc pointed out that the patient enjoyed a higher status in the Eastern European or Southern European family than he did in Anglo-Saxon families, and expected to discuss with his doctor, on an "equal footing," the nature of his illness and its treatment.[103] Similar information was provided to American health professionals by Phyllis H. Williams in the 1938 handbook, *South Italian folkways in Europe and America*.[104] For Australian practitioners a quarter of a century later, Minc's explanations were indispensable—a letter to the editor praised his "masterly analysis."[105] However, culturally determined behaviours could not be considered separately, in Minc's view, from "the socio-economic 'status' of the New Australian." Citing the work of Listwan, Last, and others, he wrote that assimilation was generally accepted to be "stress-provoking." When combined with problems arising from the lack of a supporting group and restricted employment opportunities, which forced migrants to work in unskilled jobs where they were completely reliant on their physical health, Minc argued that a particular form of stress developed: "it is quite specific to the New Australian immigrant (or people in a similar situation).… It is brought about mostly by a combination of cultural and environmental influences, and therefore is not a 'personality trait' as such." A lack of adequate medical insurance and social

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[102] Minc, "Of New Australian Patients," p. 681.
[103] Minc, "Of New Australian Patients," p. 682.
[104] Phyllis H. Williams, *South Italian Folkways in Europe and America: A Handbook for Social Workers, Visiting Nurses, School Teachers, and Physicians* (New Haven, CT: Yale University Press, 1938). For discussion, see Alan Kraut, *Silent Travellers*, esp. chap. 5, pp. 78-104.
[105] Colin Greaves, "Correspondence: Of New Australian Patients, their Medical Lore and Major Anxieties," *Medical Journal of Australia*, vol. 1, no. 24 (June 15, 1963), p. 910.

security benefits compounded any injury or illness and added to mental stress. He named this condition "physical self-concern."

With the cause of mental stress located in the situation, rather than in the cultural difference, prior experience or individual weakness of the migrant, Minc argued that "it is up to the doctor to relieve some of the immigrant's anxiety by becoming part of the supporting group not easily found in the new country."[106] Building *rapport* with the patient, listening to their complaints, and providing "rational reassurance" were in his opinion often the best treatment for psychosomatic conditions. Writing as a sympathetic confidant, he acknowledged that the foreign patient presented difficulties beyond language that could cause the doctor to react with disturbance and resentment, but urged his colleagues, in medical terms, to show tolerance: "we may condemn the symptom; do not let us condemn the patient because he is affected by it." The doctor might be "tempted to educate [the New Australian patient] into British and Australian medical ways," but this would have to be a "gradual and long-term process."[107] Like Schaechter then, Minc trod a fine line between associating assimilation with mental stress, and retaining its progressive, nation-building rationale as a desirable process in which medical professionals could play a leading role. This approach allowed him to provide information and advice without criticizing or undermining the status of the Australian medical profession.

Frustration, Difference, and the Limits of Assimilation

The ambiguity surrounding assimilation in medical discourse meant it could be understood as both a contributing cause and cure-all for migrant ill-health, and the assumption that it was a necessary and desirable process enabled medical writers to raise difficulties and frustrations

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[106] Minc, "Of New Australian Patients," p. 687.
[107] Minc, "Of New Australian Patients," p. 686.

without questioning their own skills or those of the medical profession at large. The inability or unwillingness of the migrant to assimilate was instead the problem. These assumptions persisted in the medical literature into late 1960s, even as assimilation was superseded by the less hard-line concept of "integration" in government circles.[108] A case in point is an article published in the *MJA* in 1966, in which Dr. Giuseppe Pasquarelli discussed his impressions, "gained during some 30 years of general medical practice in three Australian states," of the "general medical and associated problems of the Italian migrant family."[109] As his name suggests, Pasquarelli had an Italian background. Born in Conzano in northern Italy in 1908, he had grown up in the Italian-Australian community of Ingham, Queensland, where his father worked as a canecutter. He went on to graduate in medicine at the University of Melbourne in 1935 and worked as a general practitioner in Victoria, Queensland, and South Australia. Despite these personal insights, or perhaps as a result of them, Pasquarelli framed his impressions in purely professional terms, as "problems which have to be dealt with by perhaps the majority of general medical practitioners."[110]

Pasquarelli's concerns and observations about the choices and behaviours of his Italian patients echoed descriptions of the Southern European or New Australian patient of earlier commentators, albeit with greater exasperation and condescension. Phrases like "I have tried in desperation," "they just will not believe," and "often it is quite useless to argue" paint a picture of backward patients resistant to education or medical enlightenment. Parents and older children were in his estimation the most problematic patients, unlike young children, who "are easily assimilated into our way of life" and "soon become little Aussies in

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[108] The Department of Immigration replaced the Assimilation Section with an "Integration Department" in 1964. For more on this shift, see Brian Murphy, *The Other Australia: Experiences of Migration* (Cambridge: Cambridge University Press, 1993), pp. 162-169; and Jordens, *Alien to Citizen*, pp. 152-154.
[109] G. Pasquarelli, "The General Medical and Associated Problems of the Italian Migrant Family," *Medical Journal of Australia*, vol. 1, no. 2 (January 8, 1966), pp. 65-70.
[110] Pasquarelli, "Italian Migrant Family," p. 65.

thought, speech and clothing."[111] His most critical observations related to diet and lifestyle. The parental decision to work hard, often seven days a week, accounted for "exhaustion neuroses" and child neglect.[112] For the male Italian patient, homemade wine, large quantities of black coffee, and heavy smoking were to blame for frequently occurring stomach pains.[113] Headaches, which took "first place in the symptomatology of the Italian mother," could be attributed to general fatigue and a lack of ventilation—evidence of a failure to adjust to Australian climatic conditions.[114] Underpinning all this intransigence was the "Latin temperament." Pasquarelli warned his colleagues that "these people are very emotional and will often exhibit marked nervous reactions to things which do not affect us in the same way."[115] The inherent difference explained their "impatience" in the face of pain, and a tendency to "make a fuss" when it was not relieved quickly: "I believe this impatience is a national trait and can be traced generally to the Latin temperament in direct contrast to the Anglo-Saxon 'stiff upper lip'."[116] Temperament also accounted for the frequency of "nervous instability" as a major complaint, exacerbated by the "devastating custom of long-term mourning." In these cases, Pasquarelli recommended that most patients "respond better to talking than to antidepressant or 'anti-anxiety' drugs," where the regular dosage produces more frequent and severe side effects than in "people of other nationalities."[117] In Pasquarelli's account, a combination of temperament, a lack of education, an apparent comparative lack of physical and mental robustness and a resistance to change made the Italian a particularly problematic patient for Australian practitioners.

While Pasquarelli's article suggested a clash of cultures and misunderstanding between Australian doctors and migrant patients, expressed through a failure to assimilate,

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[111] Pasquarelli, "Italian Migrant Family," p. 65.
[112] Pasquarelli, "Italian Migrant Family," p. 66.
[113] Pasquarelli, "Italian Migrant Family," p. 67.
[114] Pasquarelli, "Italian Migrant Family," p. 68.
[115] Pasquarelli, "Italian Migrant Family," p. 68.
[116] Pasquarelli, "Italian Migrant Family," p. 67.
[117] Pasquarelli, "Italian Migrant Family," p. 68.

others pointed to a growing recognition of the limits of assimilation as a useful medical concept. A 1969 article published in the *MJA* by Sydney psychologist J. Kraus questioned earlier impressions of a link between "cultural and language differences" and rates of mental ill health.[118] In his statistical analysis of admissions to psychiatric units in NSW in nine immigrant groups, Kraus found higher rates among those from Britain and New Zealand, whereas those from Italy, Greece, and Malta had comparatively low admissions. Furthermore, migrants whose national groups were represented as a greater proportion of the population showed lower admissions, suggesting that "social support" provided by their "native socio-cultural *milieu*" was positive for mental health.[119] An earlier comparison of illness in pregnancy suggested similar factors at play. The study by New Zealand psychologist L. B. Brown was "planned to identify differences between migrants and non-migrants that could be attributable to their difficulties in assimilation," however, it found that women from Italy and Greece showed less anxiety about their pregnancies than women in other groups, including the Australian-born.[120] Its publication in the *British Journal of Preventative and Social Medicine* seems to have gone unnoticed by the Australian medical profession. And in his comparative study of mortality between the Australian-born and different migrant groups, British-born physician Eric Saint noted that language was the main barrier to establishing "smooth and harmonious doctor-patient rapport." Rather than advocating change on the part of the migrant, he wrote, "for ignorance of European languages

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[118] J. Kraus, "Some Social Factors and the Rates of Psychiatric Hospital Admissions of Immigrants in New South Wales," *Medical Journal of Australia*, vol. 2, no. 1 (July 5, 1969), pp. 17-19. Kraus's criticisms of the earlier work in this area were contested in a letter to the editor. See A. Stoller and J. Krupinski, "Correspondence: Mental health of Immigrants," *Medical Journal of Australia*, vol. 2, no. 7 (August 16, 1969), p. 356. Krupinski and Stoller maintained that a lack of assimilation, especially in Southern European women, remained an "important factor" in the incidence of mental illness.

[119] Kraus, "Some Social Factors," p. 17.

[120] L. B. Brown, "Illness in Pregnancy Among Migrants and Non-migrants: An Exploratory Study in Australia," *British Journal of Preventative and Social Medicine*, vol. 17, no. 4 (1963), pp. 202-208.

and a lack of interest in non-Anglo-Saxon culture we ourselves must accept some responsibility."[121]

Conclusion: The "Invisible Border"

Writing on historical and contemporary immigrant attitudes to the American physician for an audience of medical practitioners in 1990, Alan Kraut introduced the idea of the "invisible border," where "differences of language and culture can lead to misunderstanding and frustration, impeding a physician's ability to gain cooperation with prescribed therapy."[122] Australian medical practitioners encountered this invisible border with increasing frequency in the 1950s and 1960s. An analysis of the burgeoning medical discourse on migrant patients in the period demonstrates both the difficulties that arose and the lack of conceptual tools or experience at hand to understand and address them. Faced with this cultural gulf, medical practitioners (many from migrant backgrounds themselves) adopted assimilation ideologies to construct a "New Australian patient" who—with the help of Australian medical professionals—could become a productive member of society. This imagined patient was typically from Eastern or Southern Europe, less educated than their fellow Australians, and more likely to be suspicious of modern medicine. They were more vulnerable to mental breakdown as a result of either one or a combination of premigration experiences, the stresses brought on by migration and assimilation (including socioeconomic disadvantage and linguistic isolation), and inherent personality or character traits. Assimilatory aims could encourage greater empathy for the migrant patient by presenting interpersonal problems between doctor and patient as symptomatic of a broader, necessary process of cultural and

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[121] Eric G. Saint, "The Medical Problems of Migrants," *Medical Journal of Australia*, vol. 1, no. 10 (9 March 1963), p. 338; Lenore Layman, "Saint, Eric Galton (1918-1989)," *Australian Dictionary of Biography*, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/saint-eric-galton-15614/text26817, first published in hardcopy 2012, accessed online 24 November 2017.

[122] Alan M. Kraut, "Healers and strangers. Immigrant attitudes toward the physician in America: a relationship in historical perspective," *Journal of the American Medical Association*, vol. 263, no.13 (1990), p. 1807.

socioeconomic adjustment, one which involved the doctor as a protagonist in an important national project. However, a focus on the particularity of migrant patients and the apparent cultural and personal barriers to their assimilation also contributed to the formation of stereotypes and prejudices. This is particularly true in the case of those deemed least medically assimilable—"Mediterranean," "Southern European," or Italian patients.