**Professional Migration, Occupational Challenge, and Mental Health: Medical Practitioners in New Zealand, 1850s-1890s[[1]](#footnote-1)**

**Abstract:** Australasian colonies were promoted as ‘lands of opportunity’ for British medical practitioners of the Victorian period, but once there doctors often found that any problems they faced had travelled with them. Furthermore, the act of migration could add to personal difficulty. This article builds on existing work about the challenges confronting doctors in England, and on the potential of asylum records to address the consequences of migration, to consider the experiences of men who chose to move round the globe. It concerns practitioners’ turbulent careers in New Zealand, with an emphasis on their poor mental health and suicide. Official and personal sources are used to evaluate the impact of professional drivers, and the consequences for medical men. It concludes that migration did not mitigate professional stresses and instead induced or exacerbated personal crisis. The visibility of alcohol-related distress is particularly marked in contrast to evidence for practitioners in England.

**Keywords:** mental health, migration, New Zealand, medical, professions

During the nineteenth century, the Australasian colonies were promoted as ‘lands of opportunity’ for British medical practitioners.[[2]](#footnote-2) Yet as historians of migration argue, mobility could be perilous for people’s mental health, doctors included. Colonial medical lives were potentially disrupted, and also difficult, perhaps especially in the context of a medical professionalism emerging globally, where distances between geographical sites, and conflicting cultures of health, problematised the physical and ideological landscapes.[[3]](#footnote-3) Ironically, it was the very mobility of medical practitioners that offered independence, adventure and possibility; for example, where professional men including doctors were enticed by the lure of the goldfields, which also encouraged isolation, loneliness, and in some instances, mental breakdown. This article examines the experience of mental anguish for professional men in medicine, arguing that its complexity owes much to the combination of motives for migration (including pre-existing conditions), the manner in which acts of mobility took place, and the ongoing experience of professional strain in the wider environment of the colonies.[[4]](#footnote-4)

An agenda for studying the blended professional and personal difficulties in medical careers has been set out by Tomkins for the English context, seen in men’s struggles for solvency, probity, and sanity.[[5]](#footnote-5) Her work found that the increasingly-stringent criteria for defining medical professionalism provided ample opportunity for men to ‘fall short’. Medical practitioners who fell bankrupt, behaved in inappropriate ways, or suffered severe distress might be either vilified by the wider profession or adopted as the occasions for displays of professional unity. This article transposes a similar agenda of discovery to New Zealand – did men evidently suffer comparable distresses? - for a period when the vast majority of practitioners in the country were qualified in Britain: the country’s Medical Register of 1891 describes 96 per cent of the 442 medical men in New Zealand as being qualified wholly or partly in British training centres.[[6]](#footnote-6) It asks how far, and in what ways, the hopes of doctors migrating to New Zealand were challenged or frustrated in a fashion that demonstrably undermined their mental health. What were the discernible features of their struggles? Did the difficulties perceived in New Zealand align with or diverge from those experienced in England? These questions are pertinent to a historiography which is moving away from assumptions of professionalisation as an uncomplicated rise in standards and fortunes.[[7]](#footnote-7) An attempt to answer them contributes to the literature comparing and contrasting New Zealand with England.

At the same time, the article draws on existing published research about the colonial asylum, which has variously opened up the potential of asylum records in the Australasian world to speak to both the phenomenon of migration and aspects of the asylum experience.[[8]](#footnote-8) Migration and mental health are closely intertwined, as different historians attest. Marjory Harper’s volume, *Migration and Mental Health: Past and Present*, reminds us of the deeply dislocating experience of mobility for many historical actors, and signals the value of the many studies of colonial insanity that privilege the stories of migration and identity.[[9]](#footnote-9) This article builds on these works: it concerns mobile practitioners’ turbulent careers in New Zealand, working through the forms these took, with a focus on a well-documented group of extant cases. The voice of professional discomfort or distress is usually heard only at one remove, mediated by superintendents of hospitals and official observers such as coroners, but can also occasionally be found expressed by the men directly. Profession is used as the key criterion for defining the cohort rather than ethnicity, although ethnic background can be seen to play a part in practitioners’ experiences (as will be seen below).[[10]](#footnote-10)

The analysis here foregrounds the cases of twenty-four people: thirteen were admitted to one of New Zealand’s asylums and eleven committed suicide while in the country.[[11]](#footnote-11) They have been identified by reference to their entries in asylum case books (consulted from such books’ earliest survival until 1899) and from newspaper reports of inquests on suicidal practitioners. Separating medical asylum patients from their non-medical peers relied on the notation of occupations on admission to the hospital using labels such as surgeon or medical practitioner. Successful medical suicides were located via a structured search of the digital collection of newspapers in New Zealand, PapersPast, specifically by manual checking of every ‘hit’ up to 1899 which featured the keyword suicide AND an occupational keyword such as physician or surgeon in the article title. This methodology cannot find all medical suicides: cultural sensitivities in Victorian England, for example, inhibited the specification of suicide as a cause of death.[[12]](#footnote-12) Newspapers in New Zealand were less liable to be constrained by some varieties of sensitivity than their counterparts in Britain, as is discussed below, but even so the cases of suicide considered here are the minimum that occurred.

All of the resulting twenty-four cases for particular focus were male. Women’s entry into medicine as qualified practitioners coincided with the period under study, and women could be highly mobile as work by Elston (among others) proves.[[13]](#footnote-13) Even so, no women were revealed by these means as professional migrants facing mental-health challenges. Very few if any women travelled to New Zealand in search of professional medical careers; the Register of January 1891 reveals none. Furthermore the first woman to graduate from the Otago Medical School qualified in 1896, just three years before the end of this study. Therefore, while women were making significant advances in medicine in Britain and elsewhere, and despite the migration of medical women to other locations (most notably India), they had no appreciable presence in New Zealand before 1900.

In addition to asylum and newspaper evidence, this article also draws on a rich collection of personal papers such as letters and diaries, and official reports to the *Appendices to the Journal of the House of Representatives* (AJHR, New Zealand). These provide additional texture to migration stories, whether before or without entailing the authors’ asylum admission or suicide. It also relies on the encyclopaedic work of Rex Wright-St Clair, who made a painstaking catalogue of New Zealand’s early practitioners.[[14]](#footnote-14) Wright-St Clair was both thorough in his collection of biographical detail, and unafraid of listing the frailties or misfortunes of pioneer doctors. He was broadly more attentive, though, to success than to failure (however construed): this research therefore makes a selective use of his data to identify patterns in cohorts rather than in the entire medical population.

In line with Tomkins’s monograph, this article acknowledges both medical masculinity and the emerging international medical marketplace as two prominent motivators for medical-professional migration. Reading masculinity is at the heart of this article’s methodological approach. British middle-class masculinity struggled to accommodate psychological difficulty, and colonial settings were not necessarily any easier to inhabit: Australian men traumatised by their service in the Boer War, for example, tended to be treated for physical ailments or questioned on moral grounds.[[15]](#footnote-15) Therefore, while the twenty four men considered here are not statistically significant, close attention to their movements, difficulties and behaviours allows an analysis of the way that migration, medical ambition for market participation, and masculinity combined to force men beyond their endurance.

Specifically *medical* migration has attracted new attention in recent years. The emerging meta-narrative of mobility among medical personnel over historical periods and across places allows medical historians to reconceive of the story of medicine itself: the way that patterns of migration also provide insights into medical education, the spread of ideas about disease, treatments, practices and medical systems.[[16]](#footnote-16) Histories of medical migration in the nineteenth century narrate the patterns for men who trained in the medical cultures of Scotland and England then dispersed to the edges of empire.[[17]](#footnote-17) John Armstrong’s study of New Zealand medical personnel, and the development of the systems of education and training that was established in the colony of New Zealand by the early twentieth century, argues that ‘British medical structures and patterns’ persisted and were reflected in early New Zealand.[[18]](#footnote-18)

Doctors were distinctive as a cohort of migrants: they also shared some traits of mobility with other professional and educated men and women, as Alan Lester and David Lambert show.[[19]](#footnote-19) In the widest sense, ‘ideas, practices and identities developed trans-imperially as they moved from one imperial site to another’ with professionals who emigrated.[[20]](#footnote-20) Moreover the direction and influence of ideas could disrupt expectations about expertise, because it was not only doctors from Britain, but also from other places, who were highly mobile.[[21]](#footnote-21)

This article engages with Lambert and Lester’s framing of ‘writing colonial lives’ by thinking about a distinctive set of cases among male doctors and their encounters with mental illness; this is an important subject in the context of imperial networks of professional and of knowledge-making about careers, as well as reminding us about the fragility of the imperial subject and personal identities.[[22]](#footnote-22) Diana Dyason’s seminal work on the medical professional in colonial Victoria, Australia, argued that doctors in the colonies considered themselves part of the ‘British medical profession’, but that they experienced different challenges from their counterparts in the British Isles.[[23]](#footnote-23) Building on Dyason’s work, this article also provides an opportunity for thinking about the challenges presented by ‘atomisation’ of colonial societies, with evidence that the loneliness of distance, fragmented communications and only fledgling communities of care and association could impact on mental wellbeing in early New Zealand.[[24]](#footnote-24) The hospitalisation of some professional men in the nineteenth century also points to the propensity for their dislocation as single men who travelled as imperial agents, often without family or personal networks. The study of professional men in the asylums is still under developed, but it shows that the public institutions in New Zealand, like Australia, were home to all classes of patient, with very pronounced patterns of single men confined in the institution in the colonial world, which was already distinctive for its lack of familial bonds.[[25]](#footnote-25)

To this end, this article will consider the historiographical background to writing New Zealand’s medical lives, and the new factors which we believe should be taken into account in evaluating migrant practitioner experiences. We go on to survey the multiple difficulties facing practitioners who travelled to New Zealand, with a focus on financial pressure and personal despondency, before making an in-depth analysis of the twenty-four men admitted to asylums or judged to have committed suicide.

Twenty-four constitutes a tiny minority of the medical practitioners who migrated to New Zealand before 1900. Yet close reading of their cases allows us to consider the wider implications of medicine, migration and masculinity, because their experiences of distress were merely the most visible among their occupational cohort. Collectively they indicate the personal and professional challenges undergone, and the measures adopted to alleviate suffering, to support a more variegated understanding of colonial medical professionalisation.

**Professional Medical Migration to New Zealand**

The doctors who migrated to New Zealand in the nineteenth century were once presented as social heroes in early historiography, with many finding medical practice ‘entirely satisfying’.[[26]](#footnote-26) They were viewed as male pioneers with formidable abilities and a civilising mission, who may have occasionally faltered, and may have shed their medical work along the way, but who brought both education and social justice to the new nation. They may have held strong views, and have been divisive, but their commitment to the greater good was not questioned.[[27]](#footnote-27) The vast majority of practitioners in this period were of necessity people who experienced global movement, as even those born in New Zealand may have travelled for their education: the first graduates of the University of New Zealand’s medical school at Otago were listed as registered practitioners in the *New Zealand Gazette* from 1887 onwards, but for a long time remained a tiny minority compared to men born and educated elsewhere. Of the 442 men listed in the *Gazette* of 1891 whose residential address was given as New Zealand, just nine had been trained locally and only ten more received all of their listed training beyond England, Scotland or Ireland.[[28]](#footnote-28)

Medical men were notable in the early political life of the colonies, perhaps as one commentator concluded because many chose not to enter formal practice, because they found time for political hobbies, or because as educated men in a nascent community they fell into roles as leaders.[[29]](#footnote-29) It is certainly possible to find men who took up political representation (such as Andrew Sinclair, colonial secretary of New Zealand 1844-65) or journalism (John Greenwood, some-time editor of the *Nelson Examiner*).[[30]](#footnote-30) By careful selection of subjects by the authors of medical lives, this heroism was extended to the protection or championing of the Māori people. The life of Arthur Guyon Purchas, admittedly written up for the *New Zealand Medical Journal* (NZMJ) by his grandson E. H. Roche, is a case in point. Purchas was probably a polymath since he seems to have added architecture, engineering, surgical instrument design and musical prowess to his life accomplishments, and was described by New Zealand’s Archbishop Averill as ‘the most gifted man that ever came to New Zealand’.[[31]](#footnote-31) But he also learned the Māori language, became interested in the social welfare of Māori people, and seems to have acted as a sort of negotiator between the combatants in the Māori wars. Therefore, at the time Roche was writing in 1954, Purchas could be co-opted into a more inclusive (if still patronising) vision of colonial history.

Participation in their wider adopted communities was characteristic of medical migrants elsewhere. Medicine played a ‘central role’ in public life in colonial Victoria, for example. Doctors were plentiful, with almost 2,500 medical practitioners emigrating to Victoria between 1838 and 1901.[[32]](#footnote-32) They were licensed by many British institutions, with the majority from Scotland, and some from Ireland and Canada. The University of Melbourne was also graduating its own doctors, so the sense of an over-supply of physicians became stronger, with contemporaries observing that many found it hard to earn a living in the crowded marketplace of practitioners.[[33]](#footnote-33) Yet doctors were also central to the project of building the new colonial governance, and were busy forging professional bodies, maintaining professional and learned practice, and becoming involved in the local political world as elected representatives.

The very positive narratives about medical involvement in the early nationhood of New Zealand, confirmed by those for the Australian colonies, are entirely in keeping with the place of medical biography and ‘great men’ in the historiography of medical history in Britain, Europe, America and elsewhere.[[34]](#footnote-34) Recent biographical interventions are more sceptical and measured.[[35]](#footnote-35) Not only emigrant doctors faced challenges. Men in England and Wales who aspired to practitioner status in the period up to the second Medical Registration Act of 1886 also fell prey to poor mental health, asylum admission, or suicide.[[36]](#footnote-36) For these men, professional and financial concerns dominated their thinking, and palpable occupational risks can be identified: for instance, medical men were compelled to make their living as self-employed entrepreneurs at the same time that professional standards were deprecating or forbidding open competition for patients. This gave rise to a pervasive but risky form of covert competition, including private attempts to constrain the practice of a rival, occasionally even resulting in anonymous letter-writing.[[37]](#footnote-37)

Furthermore the professionalising process was influenced by conflicted masculinity, because the core features of manliness *per se* were given an additional set of requirements by a medical vocation. Solvency, household authority, and the cast of a gentleman, which were base-line requirements for middle-class men in mid-century England, were augmented for practitioners with education and intellectual power. The right internal state was to be ambitious for medical science, and fulfilled by one’s career, but at the same time disinterested in material or worldly reward. In the later century muscular Christianity offered an ideal for men beyond the home and in arduous physical endeavour, but at the same time the doctor was required to be increasingly attentive to the domestic as the scene of their patient consultations, and to be (ideally) emotionally involved with patients, but stoical about their sufferings or deaths. This was an irreconcilable set of requirements for many men who struggled to balance their public probity and manly presence with their private worries about income and social marginality.[[38]](#footnote-38)

Men who travelled half way around the world to be able to pursue their medical work carried additional expectations and burdens. New Zealand was briefly held up in the British medical press as ‘the most suitable home for the Anglo-Saxon that has yet been colonised by his race’ replete with professional opportunity for those with emigration in mind.[[39]](#footnote-39) The naivety around any hope this may have inspired of a simpler variety of medical masculinity was soon satirised for a specifically medical audience: ‘people imagine that they are going to lead a life of adventure, that they will wear red flannel shirts, wideawake hats, big boots with the trousers stuck in them, and perhaps, a revolver in their belt’, whereas the occasional correspondent to *The Lancet* was keen to point out that lifestyles were very much like those at home, but that the police were ‘far stricter than in London’.[[40]](#footnote-40)

Migrating practitioners will have interpreted ‘opportunity’ in a variety of ways, professional and personal, albeit we do not always know what they were in individual cases. The British medical press implied that the appeal of New Zealand lay in access to sufficient paying patients to enable a decent standard of living. It was axiomatic that the profession was ‘overstocked’ in England, prompting travel overseas to both settler colonies and elsewhere.[[41]](#footnote-41) The men who migrated were not specialists but were seeking independence-with-prosperity in general practice, or indeed in landowning, of a kind that they feared was out of their reach in Britain.[[42]](#footnote-42) They trained in London, Edinburgh, Glasgow or Dublin. Medical opportunities in New Zealand were regionalised by rates of urbanisation, by climate, and by geographical serendipity. The four urban areas of Auckland, Christchurch, Dunedin and Wellington developed significantly over the period covered by this article, but even by the late 1890s they were small relative to cities elsewhere in Australasia like Sydney or Melbourne: choices for emigration to New Zealand ‘were largely a matter of working out how many practitioners the local economy could support and staking out an area’.[[43]](#footnote-43) Non-medical motivations can also be inferred from, for example, men responding to news of the New Zealand goldrush.[[44]](#footnote-44)

For those in notable difficulty ‘at home’, New Zealand offered the scope for personal reinvention. Doctors Sinclair, Greenwood and Purchas considered above have stories that can be told simply as success transferred from Britain to New Zealand: others had problematic or even criminal careers that were rehabilitated or overhauled by emigration. Alfred Ginders, for instance, had an uncertain start in medical practice but achieved surprising success in the North Island. He had been apprenticed to a dry-salter in Staffordshire but a preliminary trip to New Zealand in the early 1860s was decisive. He returned to England, became medically qualified and, after a stint practising in south Yorkshire, returned to New Zealand where he eventually secured the post of Superintendent to the Rotorua Sanatorium.[[45]](#footnote-45) He was only the second holder of this high-profile post, and is referenced as a prominent figure in local histories of the district.[[46]](#footnote-46) The disparity between Charles Grimes’s career before and after emigration is even more stark, since he went from being a patient in Broadmoor hospital for the criminally insane to a successful career; he qualified in medicine before being convicted of trying to shoot a policeman, and his discharge from the asylum was conditional upon his being sent to live with his brother in New Zealand.[[47]](#footnote-47)

It is important to emphasise, though, that these rejuvenated or relaunched careers were not enjoyed by all who made the attempt, and for every vaunted success story there is at least one parallel tale of thwarted hopes, disappointing incomes and/or an unwelcome departure from medicine. Men who travelled to escape professional overcrowding in the British medical market found that *de facto* competition was either reiterated in New Zealand or replaced by a different sort of penalty in the forms of professional or personal isolation. Medical men in common with others might have to live at a distance from their neighbours in basic conditions and suffer exposure to extremes of weather or ‘monotonous’ scenery. William Draper died aged just 24 having been swept from his horse while crossing the Ashburton river in 1853.[[48]](#footnote-48) Furthermore, the dispersal of the lay population and the perception of distance from doctors might have made recent immigrants rely on their own resources rather than attempt a formal medical consultation except in the most prolonged or extreme circumstances. In the 1840s, one historian has concluded, ‘doctors must have made much of their income from sources other than medicine’ and financial difficulties or worries certainly persisted in succeeding decades.[[49]](#footnote-49) Alexander Fox settled at Thames in 1869 to take advantage of the population growth consequent on gold-mining, but his career was threaded with financial concern. His wife Ellen reported in her letters home to England that their medical income was highly variable, ranging from £2 to £11 per week between November 1869 and February 1870, depending on the demand for his attendance and the types of treatment he offered. The amount received in ready money (rather than debts owed) could be disappointingly small, comprising mere shillings. Fox also struggled with professional rivalry. His own assistant Mr Irving who had travelled out to New Zealand with him asked to borrow money and, when Fox declined, insisted on being released from Fox’s practice. Irving then demanded a testimonial, the money that was owing in wages, and threatened Fox with legal redress (presumably for financial gain). A few years later Fox had to put up with a nearby relation and fellow doctor Martin Payne attempting to poach his patients which, as his wife Ellen reported, ‘might be annoying if it were successful but as it is not we can afford to smile’.[[50]](#footnote-50)

Fox continued to practise until his early death in 1876, but others were driven away from medicine altogether. Alfred Barker had hoped to make a good living in the South Island and settled at Christchurch in 1851, but his medical career there lasted less than a decade. The arrival of other doctors, and the intransigence of some patients over paying their bills, undercut his motivation. A fall from his horse and a slow recovery dented his spirits further: he wrote to his brother in 1858 ‘I feels as if I had reached a turning point in my life – I find my strength is not what it was and my rivals are gradually eating away my practice’.[[51]](#footnote-51) Four months later he was predicting ‘I fully expect to give up practice … I am but poorly & very down in the mouth having lost all at once my best patients who have gone off in a leap to a new Doctor’.[[52]](#footnote-52)

Private disappointment of expectations as revealed in personal letters was possibly pervasive (if only accessible in occasional cases). Public displays of dissatisfaction or reproach were both more visible and potentially highly damaging. Registrants to the British General Medical Council were formally bound not to advertise for patients, or to behave in such a way as to betray conflict between peers or professional rivalry. In Britain this meant that medical conflict became a matter for anxious self-examination which, combined with the strict prohibition on advertising, created a set of pressures that gave rise to covertly competitive behaviour. Distance alone meant that there were fewer immediate constraints on medical men in New Zealand, and advertising in the press was ubiquitous (to the eventual disgust of British colleagues).[[53]](#footnote-53) There was also the option of making accusations anonymously or satirically, as in the fictional Sopemdown hospital, featuring the venal house steward and dispenser ‘Scupperson’.[[54]](#footnote-54) The social norms of middle-class Britain were seemingly loosened in this instance by emigration to Australasia or, in the words of one nineteenth-century commentator, conduct might fall either within or beyond ‘the bounds of even colonial license’.[[55]](#footnote-55) In this respect medical behaviour is at odds with the idea that, generally, New Zealanders’ respectability was sought under the imagined scrutiny of home.[[56]](#footnote-56)

Competition between practitioners was more open in a number of ways, in part because there was an important difference between the press in Britain and in New Zealand over the kind of coverage that doctors could expect. The British newspapers were certainly capable of printing stories damaging to medical reputations, but the preference was for shaping accounts to ameliorate the opprobrium or blame accruing to practitioners except in the most egregious of cases.[[57]](#footnote-57) The New Zealand press was of much more recent foundation and enjoyed, at least at the outset, an idealistic and egalitarian expression.[[58]](#footnote-58) This meant that spats between medical men were more likely to be given column inches, and to have been reported more frankly, than in Britain, even if the press did become somewhat more conservative by the end of the century. In 1884, for example, a clash between Dr Francis McBean Stewart and surgeon Courtney Nedwill at Christchurch Hospital over the death of a male surgical patient went beyond the confines of the hospital board to be aired acrimoniously in the local and national press.[[59]](#footnote-59)

A loss of countenance in public could precipitate a crisis of solvency as, like their English counterparts, doctors in New Zealand might have been forced to file for bankruptcy. The risk of ultimate financial failure is difficult to ascertain, but individual bankruptcy petitions survive in the national archives, to shed some light on selected medical men’s financial difficulties. Lawford David Evans, for example, qualified as physician in Edinburgh in 1871 and had registered in New Zealand in November 1881. He filed a bankruptcy petition on August 1886, having tried to practise for five years in Auckland. His notional income did not exceed £400 a year, but achieving this sum relied on patients paying their debts. He experienced particular difficulties in collecting the money owed to him in the two years before his petition, and borrowed £140 against his furniture to try to pay his own creditors, but without balancing his finances. At the time of filing for bankruptcy Evans had liabilities of £183 9s 3d and assets of only £37, against book debts owed to him of £430. This means that he was probably a better doctor than a businessman, as his extension of credit to others was too generous.[[60]](#footnote-60)

The personal and occupational challenges faced by medical practitioners in New Zealand were, therefore, quite similar to those confronted by their peers in England as illustrated by Tomkins, with some local inflections. Somewhat greater freedom to engage in disputes with colleagues was matched by greater publicity for professional failings. The consequences for men’s health, however, pulled even further away from those of British counterparts.

**Occupational health: physical and mental tolls**

Migrants to New Zealand, as Angela McCarthy demonstrates, brought with them an array of weaknesses and experiences of mental and physical illness, and doctors were no exception. Voyages could be prescribed as good for mental health; evidence of this tends to show that the shipboard experiences might also exacerbate illness and create new terrors among travellers.[[61]](#footnote-61)

This article opened with the suggestion that medical men who were emigrants to the Australasian colonies were sometimes themselves afflicted by mental illness. Indeed, doctors were alone in their task even diagnosing mental illness as professionals, with a lexicon of diagnoses, treatments, and rudimentary processes for care and ongoing support for families in dynamic development.[[62]](#footnote-62) Practitioners could become depressed with or without suffering specific private or public griefs. Samuel Hodgkinson attributed his own ‘great depression of spirits & mind’ to somatic causes, namely dyspepsia and over-exertion, for which he at length sought relief by a trip to England.[[63]](#footnote-63) Among other men, too, the first official intimations of mental health problems might be signified by treatment of physical health, at one of New Zealand’s early general hospitals. Admission of qualified medical practitioners to hospitals as patients was in strict contrast to the experience of doctors in England. Charity hospitals in England, for example, were founded from the first half of the eighteenth century and were intended to cater for a carefully delineated subset of the economically disadvantaged: one of the rules held in common by English infirmaries was that patients should not have been able to pay for their own care. This, combined with the lack of occupational data for patients, strongly suggests that medical men were not admitted.

However, the situation in New Zealand was quite different, with medical men demonstrably admitted to hospitals for the sick. The Auckland Provincial Hospital, for example, opened in 1859 and saw nineteen practitioners in its first fifteen years of operation, seven of them on multiple occasions.[[64]](#footnote-64) Maladies that were chiefly physical included diagnoses of erysipelas, dyspepsia, dysentery, and pleurisy, but the most common single cause of admission was *delirium tremens*. Seven men were treated for their alcoholism, most of them recommended by fellow practitioners (although Richard Jackson was admitted on the recommendation of the police, suggesting that alcohol consumption had led to a public order offence). Jackson, aged 28, had three short spells in the hospital between December 1862 and August 1863, although after the first admission this was technically for physical complaints such as ‘ulcers on the leg’. Other doctors who had problems with alcohol consumption were all aged between thirty and forty, and most spent up to one week in hospital before either discharge or death. Two men died in the Auckland hospital, one only nine hours after admission. The other, Shadwell Keane, suffered repeated attacks of *delirium tremens* which were blamed for his developing jaundice.

Alcoholism as a discrete problem for physical medicine (rather than as a symptom of poor mental health or a factor in ‘insanity’) was well recognised by the medical profession as a problem for the new colony. Alcoholic addiction was being pathologised by western medicine at the same time that New Zealand was becoming increasingly populated with emigrants from the west, so it is unsurprising that the phenomenon was given sustained attention in British medical publications.[[65]](#footnote-65) In 1874 an article in the *BMJ* lamented that drunkenness had attracted legislation in Canada and notable action elsewhere but not yet in the ‘mother country’.[[66]](#footnote-66) Medical commentators were not accustomed, though, to considering the phenomenon among their occupational peers. There were warning signs for the attentive reader of the medical press: ‘One hardly ever hears of a doctor up-country without the addition “He’s very clever, but its’s a pity he drinks so”’.[[67]](#footnote-67) Brave or self-abasing individuals might confess on their own account; colonial masculinity was perceptibly threatened by ‘weakness’ in the form of addiction. Doctors moralised about such weak subjects in their communities in print.[[68]](#footnote-68) Yet full recognition of alcoholism within the nineteenth-century profession is only now becoming apparent. Forty practitioners who died in New Zealand before 1899 have been listed by Wright-St Clair as being known alcoholics, or for whom alcoholism, cirrhosis of the liver or *delirium tremens* was a cause of death, and these were likely to have been only the most egregious or visible cases.[[69]](#footnote-69)

The short-term physical attention to ‘drying out’ apparently offered by institutions like the Auckland hospital was not the whole story for struggling practitioners. For most of the second half of the nineteenth century, there were six public asylums in New Zealand. A single private establishment was added in 1882 (see Table 1). Admissions registers and case books from the first four out of these seven asylums listed in the table (ie Auckland, Christchurch, Seacliff and Hokitika) have been scrutinised to find patients with medical backgrounds.

[insert Table 1 here]

Thirteen qualified medical men have been identified who were admitted to one of these asylums as patients.[[70]](#footnote-70) The probability is that the thirteen represented three quarters of the medical men undergoing this experience across all seven institutions, given that the four asylums studied here – Auckland, Christchurch, Seacliff, and Hokitika - offered 75 per cent of places at this time.[[71]](#footnote-71) Therefore, if we extrapolate from these findings approximately seventeen men, or the equivalent of four per cent of the total number of practitioners thought to be present in the country in 1890, were patients in asylums. This calculation suggests the rate at which medical men were sent to asylums in New Zealand. The rate was ostensibly much higher than that for England and Wales in 1881, when 0.4 per cent of practitioners were asylum inmates at the time of the census. Admittedly the English figure provides a reasonably reliable snapshot in contrast to the New Zealand figure, which works with less reliable data, lacking formal census returns, and takes asylum admissions over time rather than on a single date. Even so, given the rapid growth in practitioner numbers over the second half of the nineteenth century, the proportion seems unlikely to have been lower than the English and Welsh percentage overall.[[72]](#footnote-72)

These are small numbers, but comparison with the experiences of counterparts in England reveals important differences which point up other reasons why practitioners were more prominently represented among New Zealand’s asylum admissions. Ten, or over 75 per cent, were in their thirties and forties. It took time to both qualify and transfer to New Zealand, so the absence of men in their twenties is understandable. This age profile is rather younger than that for medical men in English asylums, though, who might have been admitted in their twenties (typically as medical students) but were rather more likely to have been fifty or over at the time of asylum entry. In addition, unlike doctors in England, these practitioners underwent different types of stay. In England men had an approximately equal likelihood of entering an asylum shortly before death, or of having a mid-length stay of up to two years, or enduring asylum life for years/decades. In New Zealand two men died in asylums but not very rapidly after admission, while a further seven men had stays of less than one year (on average less than five months). Just one man remained in an asylum for more than three years. William Wells was admitted to Auckland in 1853 aged 48 and remained there for over 36 years before being discharged ‘not improved’. Medical men admitted to asylums in New Zealand were more akin to their fellow patients than to their English peers. Ethnicity had a part to play in this, as five of the thirteen men were certainly or probably of Irish birth.[[73]](#footnote-73) Therefore, in common with asylum populations in general in New Zealand at this time, men of Irish origin were prominent and even over-represented. Practitioners may have lacked the low occupational status of Irish men who were caught up in either the criminal justice or the asylum systems, but they had other features in common which will be mentioned again below.[[74]](#footnote-74)

The most important reason why practitioners were found in the asylum case notes lies in a difference between admissions policies in England and New Zealand: the former did not take cases of alcoholism or *delirium tremens* unless aggravated by other factors indicating insanity, whereas the latter routinely admitted ‘habitual drunkards’.[[75]](#footnote-75) Alcohol — which for Lindsay was the commonest cause of insanity in the colonies — played a significant part in these medical men’s stories.[[76]](#footnote-76) The admissions to hospital identify over-consumption as the cause of insanity in seven cases, and alcohol is implicated in a further three cases, but we might be more inclined to read it as a symptom.[[77]](#footnote-77) William Wells, mentioned above, was one of those for whom the physical challenge of ship-board emigration proved too much. He was ‘a surgeon by profession and came out to this colony in medical charge of an immigrant ship’, much like Alfred Barker and Alfred Ginders did in their turn. Unlike them though he ‘became demented on the voyage through excessive drinking and was committed to the lunatic asylum on his arrival’.

In this respect, too, doctors were behaving like other patients who were not medically trained, because intemperance was regarded as a leading cause of insanity among men in New Zealand’s asylums, both in respect of the published annual returns to the House of Representatives and in the data extracted from Dunedin and Seacliff asylums by Angela McCarthy for 1860-1910.[[78]](#footnote-78)

A stay in hospital might have permitted a drinker to recover from *delirium tremens*, as was the case for Bernard Doyle. He was admitted to Christchurch asylum with ‘tremors so bad that he cannot keep quiet in bed’ but two and a half months later he was ‘greatly improved so very much ashamed of himself’. Other men’s poor mental health was of longer standing and less amenable to repair. Whether this arose from the lack of fresh intellectual stimulus in colonial life, from physical injury, or from more deep-seated causes that themselves provided the impulse to migrate, is unclear.[[79]](#footnote-79) A combination of factors was blamed for Michael O’Connor who first became ‘unsettled’ as the doctor on a whaling trip to Greenland. He transferred to Melbourne and ‘gave way’ to drink while working in Benalla, in Victoria. A fall from his horse while drunk appeared to have induced epileptic fits thereafter: ‘gradually he became worse & unfit for practice. The he began to work about the goldfields.’ At some point in his search for gold O’Connor travelled to New Zealand where he spent 594 days in the Dunedin asylum 1880-82. It is not recorded whether his mental state had improved by the time of release.

Drink was also identified as a consequence of financial trouble, the latter being the original cause of anxiety. John Lake tried to make his living on the South Island, but Otago, Cromwell, and Arrowtown in turn failed to supply him with a successful practice. He fell bankrupt, became depressed, and got into the habit of drinking half a bottle of whiskey a day. Lake was admitted to Dunedin asylum and remained there for nearly a year before his death in June 1878.

The significance of family in these cases is difficult to detect. No kin are evident for the thirteen men as offering a support structure. They feature in contemporary case notes only as alleged indicators of hereditary insanity or as the victims of the men’s unbalanced state. Lake’s asylum admissions records, for example, noted that, his mother was a lunatic and two of his siblings were subject to trances. Like the Irish men who were placed in prisons or asylums, the doctor-patients were relatively young, and apparently unmarried. Therefore, even if the asylums were permeable, as Coleborne has suggested, their flexibility was not available to these doctors as part of a recovery or rehabilitation strategy.[[80]](#footnote-80)

Whatever the causes or indicators of poor mental health, these took time to develop. Men had been living in New Zealand for an average of a little under twelve years before being admitted as asylum patients, and if a handful of outliers are excluded (that is men admitted immediately or less than two years after arrival) this average rises to a little under fifteen years. It seems that for medical men, migration did not rapidly induce the kind of difficulty that led to hospitalisation. In this respect they were akin to their non-medical fellows: ‘the majority of patients were admitted having spent considerable time in their new environment’.[[81]](#footnote-81)

Poor mental health among medical professionals might be signalled by asylum admission, but equally it can be inferred for those doctors known to have committed suicide.[[82]](#footnote-82) New Zealand’s digitised newspapers can be searched for medical suicides, and were located for use here wherever the word suicide occurred in an article title alongside a suitable occupational label (such as surgeon, physician, or doctor).[[83]](#footnote-83) This methodology chiefly gives rise to a number of instances where practitioners killed themselves in Britain or elsewhere, but provides a modest clump of evidence for suicide by men in New Zealand. The group can be augmented by reference to deaths by suicide in Rex Wright-St Clair’s *Medical Practitioners in New Zealand, 1840-1930*.[[84]](#footnote-84)

Eleven cases of medical suicide span the years 1859 to 1896, and this must be taken as a confirmed minimum of men whose deaths were at one stage viewed as suicidal. Other cases or verdicts might have been manipulated by families, coroners or others to conceal additional examples under the guise of accidental death.[[85]](#footnote-85) The demise of John Bligh illustrates this tendency at work, since on 19 September 1877 he was said to have committed suicide by taking prussic acid (the contemporary term for hydrocyanic acid in aqueous solution), whereas the inquest of the following day took evidence from Dr Leonard Boor who complicated this judgement. Boor ‘failed to detect indications of the presence of sufficient poison to cause death. He found a very small quantity of prussic acid, but knew that deceased had been taking it as medicine…[his] opinion was that a man in his state of mind might have raised the poison to his lips, and the mere idea of committing suicide would cause such a shock to the system as to cause death’ [sic]. By these means, Boor ensured that the verdict was not formally suicide, but rather ‘paralysis of the heart caused by a shock to the system’.[[86]](#footnote-86)

Any reasons for these drastic actions generally emerged in reports of the subsequent inquests, and the victims display some similarities with their counterparts in asylums. Alcoholism was explicitly implicated in six of the deaths. James Campbell wrote out his own informal certificate, to explain his self-poisoning by chloroform ‘Cause of death – broken heart, caused by inability to resist the damned glass’ (and the jury read this as blaming alcohol rather than addiction to the fatal drug). Charles Galbraith and William Hayne were noted for heavy drinking, and the only reason that Robert Storey was not suffering directly from *delirium tremens* was because he was under medical care at the time of his death. Edmund Marshall seemed to have been drinking the last time anyone saw him alive, albeit his body was not found for over a year.[[87]](#footnote-87)

Family concerns and personal illness were more prominent for suicide victims than for asylum patients, in that fears for a spouse or a child were retrospectively acknowledged as influential for two practitioners’ self-destruction. John Innes managed his own diagnoses of epilepsy and Bright’s disease, and he drank during his declining health, but the event which accounts for the timing of his suicide was his invalid wife’s admission to hospital. He self-administered strychnine and resisted attempts to make him vomit, asking the attending doctor to ‘Make it easy for me’. Robert Storey’s alcoholic depression was augmented by fears for his child, who he dreamed had died. Ethnicity among suicides was also at odds with the evidence for asylum patients, as it was not decisively implicated; the practitioners known to have killed themselves exhibited no clear patterns in their countries of birth.

There is no concrete evidence that doctors before 1900 were impelled by the same overriding motive identified for their successors of all occupations after 1900 — ‘the powerful ideology of paid work’ – but the possibility has to be acknowledged, particularly given the cases featuring such details.[[88]](#footnote-88) Reports of Moritz Mark’s death juxtaposed his relatively recent marriage with ‘unpleasantness’ at the Christchurch hospital resulting in his resignation; his own note blamed ‘pecuniary embarrassment’, and it is not too difficult to see why professional conflict, loss of income, and a dependent wife, might drive a medical man to sudden despair.[[89]](#footnote-89) The combined threat of a failure to maintain one’s household, and friction with occupational peers, comprised a perfect storm of challenge to masculinity.

The fullest and most poignant account among the New Zealand medical men relates to the earliest of the suicides, Henry Fleetwood. A recent arrival in New Zealand, Fleetwood of Christchurch entered partnership with George Gregson, a surgeon of Lyttleton, and the pair advertised their business throughout August 1859.[[90]](#footnote-90) But this partnership plan was abandoned by early September, and Fleetwood came under accusations of fraud.[[91]](#footnote-91) His circumstances were compounded by his very recent marriage (just five days before his death) and by an unfortunate tendency of those around him to assume that he was joking. He had apparently threatened suicide before, in front of his wife, who ‘believed him to be in jest’, and after confessing to swallowing eight grains of strychnine on 7 September the people in the same room did not initially believe his claims to have done so. Fleetwood’s case presents a marked contrast with his peers in England because his death was judged ‘*Felo de se’*. Only three men out of 285 reports of suicide in England were found to have killed themselves feloniously, but Fleetwood’s jury, ‘one of the most respectable which we have ever seen gathered for such a purpose’, were not prepared to equivocate with the ‘temporary insanity’ agreed for most suicides (of doctors or others) in England.[[92]](#footnote-92) In this way Fleetwood was treated more candidly (or more harshly) in New Zealand.

Finally, whatever their stated motives, the most marked difference between the experiences of men admitted to asylums in New Zealand and men committing suicide there lay in the time it took for a crisis to be reached. Men who killed themselves spent an average of less than seven years in the colony, and if a single outlier (of a suicide after 34 years) is excluded, this average falls to under five years. The manifestation of distress was acute in the months and years immediately after a decisive migration event, but suffering became chronic as time passed. Therefore, we can can use this evidence from New Zealand to offer a tentative reframing of a conclusion by Littlewood and Lipsedge, made in relation to migration to twentieth-century Britain: difficulties *might* be felt severely in the initial period after migration and spur an active response, but a fuller appreciation of the shortcomings of an adopted country entails a gradual erosion of mental resource.[[93]](#footnote-93)

**Concluding reflections on the Career Turbulence of Migrant Practitioners**

Just as medical theory and practice was inflected by both prior training and appreciation of life on the ground, so too were career challenges altered or intensified by migration. The lot of the unsuccessful migrant practitioner was more acute in the colonies than it was in England, having been exacerbated by the act or acts of movement. The visible dimension of professional difficulty was the recourse to alcoholism recognised by contemporaries, but with the benefit of hindsight this phenomenon can be unpacked more decisively. The New World offered hospital or asylum admissions to men in obvious difficulty because other support structures were lacking and perhaps because public drunkenness was tackled with a relative lack of social inhibition; practitioners were customarily handled more warily in the Old World.

In contrast with Tomkins’s work on England, there are far fewer men to study in New Zealand, but the yield of using similar techniques in other geographical contexts is clear. Medical masculinity remains a useful concept to interpret behaviour and outcomes for individuals, albeit apparently revealing a narrower channel of options for men who experienced severe distress in New Zealand. At the same time Coleborne’s work on the view of migration from the perspective of the asylum patient reminds us of the very real impact of individuals and families separated and scattered around the colonies in the context of imperial mobility, with nineteenth-century asylum superintendents aware of the dangers of this isolation and dislocation as elements in the institutional populations.[[94]](#footnote-94)

Doctors were clearly integral to the formation of colonial nations, but the experience of migration to or between colonies had a concomitant impact on professional medical careers. The Pacific colonies offered new opportunity to selected individuals, but also familiar forms of challenge to many others. Overcrowding in the ‘home’ market was replicated very quickly in settler colonies while adding fresh obstacles to professional and personal satisfaction.[[95]](#footnote-95)

[Insert appendix here]

[ 11403 including notes, table and appendix]

1. We are grateful to the three anonymous peer reviewers who read this article in advance of publication by the *Journal for the Social History of Medicine* for their searching and supportive comments. [↑](#footnote-ref-1)
2. J. Belich, *Making Peoples:* *A History of the New Zealanders: from Polynesian settlement to the end of the nineteenth century* (Honolulu: University of Hawaii Press, 1996) See Chapter 12 for crusading promotion of emigration to ‘paradise’; ‘Medical practice in the colonies’, *British Medical Journal* 5 September 1885, 456-7. [↑](#footnote-ref-2)
3. For examples of colonial cultures of health and illness in New Zealand and Australia, see Catharine Coleborne and Ondine Godtschalk, ‘Colonial families and cultures of health: Glimpses of illness and domestic medicine in private records in New Zealand and Australia, 1850-1910’, *Journal of Family History,* 2013*, 38*, 403–221. [↑](#footnote-ref-3)
4. For the purposes of this article, a migrant practitioner was one not born in New Zealand. [↑](#footnote-ref-4)
5. A. Tomkins, *Medical Misadventure in an Age of Professionalisation, 1780-1890* (Manchester: Manchester University Press, 2017). [↑](#footnote-ref-5)
6. The New Zealand Medical Register was printed regularly in the *New Zealand Gazette* following the passage of the Medical Practitioners Act of 1867, the first appearing in 1868; R. E. Wright-St Clair, *Medical Practitioners in New Zealand, 1840 to 1930* (Hamilton, NZ: R. E. Wright-St Clair, 2003), 424.. [↑](#footnote-ref-6)
7. For illustration of the changing field, see first P.J. Corfield, *Power and the Professions in Britain 1700-1850* (London: Routledge, 1995) followed by K. Price, *Medical Negligence in Victorian Britain. The crisis of care under the English Poor Law, c.1834-1900* (London: Bloomsbury, 2015). [↑](#footnote-ref-7)
8. C. Coleborne, *Madness in the Family: Insanity and institutions in the Australasian Colonial World, 1860–1914* (Basingstoke, Hampshire: Palgrave, 2010), 44–54; A. McCarthy and C. Coleborne, eds, *Migration, Ethnicity and Mental Health: International perspectives* (New York: Routledge, 2012); C. Coleborne, *Insanity, Identity and Empire: Immigrants and institutional confinement in Australia and New Zealand, 1873–1910* (Manchester: Manchester University Press, 2015). [↑](#footnote-ref-8)
9. M. Harper, ed. *Migration and Mental Health: Past and Present*, (London: Palgrave Macmillan, 2016) 4-9; see also A. McCarthy, *Migration, Ethnicity and Madness: New Zealand, 1860-1910*, (Liverpool: Liverpool University Press, 2015). [↑](#footnote-ref-9)
10. M. Lipsedge and R. Littlewood, Aliens and Alienists: ethnic minorities and psychiatry (London: Routledge, 1997) chapter four. [↑](#footnote-ref-10)
11. See appendix for full details of each person, including place/year of birth/qualification where known. [↑](#footnote-ref-11)
12. R. Woods, ‘Physician, Heal Thyself: the Health and Mortality of Victorian Doctors’, *Social History of Medicine* 9:1 (1996), pp. 1-30, on pp. 17-20. [↑](#footnote-ref-12)
13. M. A. C. Elston, ‘Women doctors in the British health services: a sociological study of their careers and opportunities’ (unpublished PhD thesis, Leeds University, 1986),153-155, 198. [↑](#footnote-ref-13)
14. WrightSt Clair, *Medical Practitioners* . See also R. E. Wright St-Clair, ‘New Zealand Medical Biography in Mass’, *Journal of Medical Biography*, 2005*,* 13, 170–73. On biographical sketches, see also D. Lambert and A. Lester, eds, *Colonial Lives across the British Empire: Imperial Careering in the Long Nineteenth Century* (New York: Cambridge University Press, 2006), 20-21. [↑](#footnote-ref-14)
15. J. Oppenheim, “*Shattered Nerves”: Doctors, Patients, and Depression in Victorian England* (Oxford: Oxford University Press, 1991); E. Karageorgos, ‘Mental illness, Masculinity, and the Australian soldier: military psychiatry from South Africa to the First World Ward’, *Health and History*, 2018, 20(2), 10-29. [↑](#footnote-ref-15)
16. L. Monnais and D. Wright, eds, *Doctors Beyond Borders: The Transnational Migration of Physicians in the Twentieth Century*, (Toronto, Buffalo and London: University of Toronto Press, 2016), 5-7, 10-13. [↑](#footnote-ref-16)
17. M. A. Crowther and M. W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007); D. Dyason, ‘The medical professional in colonial Victoria, 1834–1901’, in R. MacLeod and M. Lewis, eds, *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London and New York: Routledge, 1988),194–216. [↑](#footnote-ref-17)
18. J. Armstrong, ‘The Common-Health and Beyond: New Zealand Trainee Specialists in International Medical Networks, 1945 – 1975’ (unpublished PhD thesis, University of Waikato, New Zealand, 2013), 96. [↑](#footnote-ref-18)
19. Lambert and Lester, *Colonial Lives*. [↑](#footnote-ref-19)
20. Ibid., 2. Other studies of mobility and empire include T. Ballantyne and A. Burton, eds, *Moving Subjects: Gender, Mobility and Intimacy in the Age of Global Empire*, (Urbana and Chicago: University of Illinois Press, 2009). [↑](#footnote-ref-20)
21. See for instance work by N. Rhook and W. Jackson, ‘The Balms of White Grief: Indian Doctors, Vulnerability and Pride in Victoria 1890 -1912’, *Itinerario*, 2018, 42, 33–49. [↑](#footnote-ref-21)
22. Lambert and Lester, *Colonial Lives*, 16-17. [↑](#footnote-ref-22)
23. Dyason, ‘The medical profession’, 194–5. [↑](#footnote-ref-23)
24. See M. Fairburn, *The Ideal Society and Its Enemies: The Foundation of Modern New Zealand Society 1850 – 1900 (*Auckland University Press, Auckland, 1989). For evidence of the colonial world of isolation and loneliness, see also Coleborne, *Madness in the Family*, 43-64. [↑](#footnote-ref-24)
25. Coleborne, *Insanity, Identity and Empire*, 97-100, 121-23; Coleborne, *Madness in the Family*, 44-9, 52-4. [↑](#footnote-ref-25)
26. A. Porritt, ‘The History of Medicine in New Zealand’, *Medical History,* 1967, *11*, 334. [↑](#footnote-ref-26)
27. For equivalents in Victoria, see T. S. Pensabene, *The rise of the medical practitioner in Victoria* Australian National University Medical Monograph 2 (Canberra: Australian National University Press, 1980), 111. [↑](#footnote-ref-27)
28. *New Zealand Gazette*, (1891), 40-52. Unfortunately it is not possible to calculate how many of these specific 442 men were born in New Zealand. None of the twenty four men among our case studies was known or is suspected to have been born in the country. [↑](#footnote-ref-28)
29. R. E. Wright-St Clair, ‘Medical Men in early New Zealand Politics’, *New Zealand Medical Journal* 1955, *54*, 551-555. This was in marked contrast to medical men in England who tended not to enter politics, on either the local or national stages. The *Oxford Dictionary of National Biography* identifies only four such men in the period, drawn from a much larger population, who were active in England namely John Burrows (1813-76), William Collins (1859-1946), John Fife (1795-1871), and Balthazar Foster (1840-1913). [↑](#footnote-ref-29)
30. Ibid., where the broader significance of medical politicians is perhaps overstated. Of the 37 members elected to the first House of Representatives, four were medical men, so just less than 10 per cent. [↑](#footnote-ref-30)
31. E. H. Roche, ‘Arthur Guyon Purchas: a New Zealand pioneer’, *New Zealand Medical Journal*, 1954, *53*, 209. [↑](#footnote-ref-31)
32. Dyason, ‘The medical profession’, 195. [↑](#footnote-ref-32)
33. Pensabene *The rise of the medical practitioner*, 64-5, 75-8. [↑](#footnote-ref-33)
34. J. C. Burnham, ‘How the Idea of Profession changed the Writing of Medical History’ *Medical History*. Supplement, 1998, 42 and *passim*. [↑](#footnote-ref-34)
35. For example, E. Knewstubb, ‘Medical Migration and the Treatment of Insanity in New Zealand: The doctors of Ashburn Hall, Dunedin, 1882–1910’, in McCarthy and Coleborne, eds, *Migration, Ethnicity and Mental Health*, 107–122. [↑](#footnote-ref-35)
36. Tomkins, *Medical Misadventure* . [↑](#footnote-ref-36)
37. Ibid., 132. [↑](#footnote-ref-37)
38. Tomkins, *Medical Misadventure*. Chapter one gives a fuller exploration of these themes. [↑](#footnote-ref-38)
39. T.G. Hake, ‘The Climates of the World’, *British Medical Journal* 8 April 1853, 299; Belich, *Making Peoples*, 320, 323. [↑](#footnote-ref-39)
40. ‘New Zealand’, *The Lancet*, 29 August 1874, 328. [↑](#footnote-ref-40)
41. I. Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford: Clarendon Press, 1986), 214-223; D. M. Haynes, *Fit to Practise: Empire, Race, Gender, and the Making of British Medicine, 1850-1980* (Rochester, NY: University of Rochester Press, 2017), 19. [↑](#footnote-ref-41)
42. Crowther and Dupree, *Medical Lives*, 272. [↑](#footnote-ref-42)
43. Ibid. [↑](#footnote-ref-43)
44. Porritt, ‘Medicine in New Zealand’, 337-8. [↑](#footnote-ref-44)
45. A. Tomkins, ‘Fragility and resilience in a middle-class family: Jeremiah Ginders (1777-1845) and his kin’, *Staffordshire Studies*, 2001, *13*, 105. [↑](#footnote-ref-45)
46. D. M. Stafford, *The Founding Years in Rotorua, A History of Events to 1900* (Rotorua District Council – Ray Richards Publishers: Rotorua, 1986), 166, 169, 175, 212, 300-1, 314. [↑](#footnote-ref-46)
47. Tomkins, *Medical Misadventure*, 213. For purposeful shipment of the insane to New Zealand see McCarthy, *Migration, Ethnicity and Madness*, Chapter two. [↑](#footnote-ref-47)
48. Wright-St Clair, *Medical Practitioners* , 120. [↑](#footnote-ref-48)
49. M. Belgrave, ‘Medicine and the Rise of the Health Professions in New Zealand, 1860-1939’ in L. Bryder, ed., *A Healthy Country. Essays on the Social History of Medicine in New Zealand* (Wellington, NZ: Bridget Williams Books, 1991), 10. [↑](#footnote-ref-49)
50. Letters of Ellen Fox 1867–1887 [transcribed], NZMS 1036, Sir George Grey Special Collections, Auckland City Library, 51. [↑](#footnote-ref-50)
51. Correspondence of Alfred Barker, letter of 19 April 1858. Canterbury Museum Archive 92/62. [↑](#footnote-ref-51)
52. Correspondence of Alfred Barker, letter of 10 August 1858. Canterbury Museum Archive 92/62. For his later career as a photographer, see J.B. Turner, ‘Barker, Alfred Charles’ *Dictionary of New Zealand Biography*, https://teara.govt.nz/en/biographies/1b4/barker-alfred-charles , viewed 9 March 2020. [↑](#footnote-ref-52)
53. 53 ‘Medical ethics at the Antipodes’, *British Medical Journal* 15 February 1879, 258.

    54 Placebo Aspen M.D., *Experiences of a Medical Man in New Zealand, or Our Hospital at Sopemdown* (Melbourne: George Robertson, 1883). [↑](#footnote-ref-53)
54. [↑](#footnote-ref-54)
55. 55 W. Lauder Lindsay, ‘Insanity in British emigrants of the middle and upper ranks’, *Edinburgh Medical Journal,* 1869, 15*,* 216. [↑](#footnote-ref-55)
56. 56 Men might also claim qualifications they did not possess; see Lisa Rosner, *The Anatomy Murders* (Philadelphia: University of Pennsylvania Press, 2010), 265 for Wellington practitioner Frederick John Knox claiming an MD he did not hold. [↑](#footnote-ref-56)
57. 57 Tomkins, *Medical Misadventure*, 161 and *passim*. [↑](#footnote-ref-57)
58. 58 J.R. Tye, ‘New Zealand’ in J. Don Vann and R. T. VanArsdel, eds, *Periodicals of Queen Victoria’s Empire: An Exploration* (London: Mansell, 1996), 209. [↑](#footnote-ref-58)
59. ‘Hospital and Charitable Aid Board’, *Lyttleton Times*, 1 January 1885, 6, and subsequent editions in the same month. [↑](#footnote-ref-59)
60. 60 Bankruptcy file of Lawford Evans, surgeon, Archives New Zealand, Auckland Office BBAE A197 5638 Box 2. Evans had experienced a troubled personal life and career in Wales before emigration; ’Elopement’, *The Morning Post*, 28 November 1879, 3. [↑](#footnote-ref-60)
61. McCarthy, *Madness, Ethnicity and Migration,* 96-7. [↑](#footnote-ref-61)
62. See Coleborne, *Madness in the Family,* 76-84 on lay and expert knowledge; J. Damousi, *Freud in the Antipodes: A Cultural History of Psychoanalysis in Australia* (Sydney: UNSW Press, 2005), 12–13. [↑](#footnote-ref-62)
63. Autobiography of Samuel Hodgkinson [handwritten copy by daughter Gertrude f. 176], ARC-0457, Hocken Collection, University of Otago Library, New Zealand. [↑](#footnote-ref-63)
64. Auckland Provincial Hospital admissions and discharge registers 1859–69 and 1870–85. NANZ Auckland ZAAP 15287/1/a and ZAAP 15287/2/a. Admissions sought to end 1874. The nineteen medical men gave rise to thirty one separate admissions. The increased likelihood of practitioner admissions was probably also influenced by the exacerbated gender imbalance between English infirmaries and New Zealand hospitals. Infirmaries tended to admit 55 per cent men and 45 per cent women, whereas in the Auckland hospital men outnumbered women by more than five to one. See ZAAP A475 15291 box 1a, 1865–79, where in 1868 the hospital treated 412 men to just 52 women. [↑](#footnote-ref-64)
65. The term ‘dipsomania’ was coined in the 1840s. [↑](#footnote-ref-65)
66. W. C. Garman, ‘On habitual drunkenness’, *British Medical Journal,* 1874, *2*, 101-104. [↑](#footnote-ref-66)
67. ‘New Zealand’, *The Lancet* 29 August 1874, 328. [↑](#footnote-ref-67)
68. Doctor John Singleton’s accounts of life in Melbourne during the mid-nineteenth century gold rush era in Victoria include ‘dangerous experiences’ and often challenging moral situations where illness was compounded by extreme poverty, destitution and alcoholism; see J. Singleton, *A Narrative of Incidents in the Eventful Life of a Physician* (Melbourne: M. L. Hutchinson, 1891). [↑](#footnote-ref-68)
69. Wright-St.Clair, *Medical Practitioners*, throughout for forty deaths indexed under these causes. [↑](#footnote-ref-69)
70. Auckland lunatic asylum admissions 1853, 1869-85 for J.H. Horne, Angus Ross, John Rutherford Ryley, and William Wells. Archives New Zealand Auckland Office YCAA A441 1017 box 1; Auckland lunatic asylum case book 1853-71. YCAA A441 1048 box 1; Sunnyside asylum admissions registers 1872-81, 1881-4, 1884-90, 1890-1912 for Robert Knott, Bernard Doyle, Henry Spratt, Henry Williams, Jonathan Malone, David Frankish, and Robert Wilson. Christchurch Office CAUY CH 388/3212/2-5; Sunnyside asylum case books 1872 onwards. CAUY CH388/12251/15-17; Seacliff asylum admissions register 1863-93 for John Lake and Michael O’Connor. Dunedin Office DAHI D264/20105/94; Seacliff asylum medical case book 1877-85. D264/19956/39; statutory admissions papers for John Lake. D226/19850/6; statutory admissions papers for Michael O’Connor. D226/19850/10. All subsequent references to these men are drawn from these sources unless otherwise stated. Hokitika asylum admitted no medical patients before 1911. See Hokitika lunatic asylum register of patients 1872-1912. Archives New Zealand Christchurch Office CAHW CH22/25/73. The records of the Karori, Mount View, Porirua hospitals for the Wellington area are not held by Archives New Zealand, but are retained by the Medical Records Section of Capital & Coast Health, which makes securing access to general admissions records (rather than a specific patient case file) highly problematic. Records of the Nelson asylum do not feature patient records of a type used in this article for the period before 1900. See Archives New Zealand’s research guide to resources for mental health, <https://archives.govt.nz/search-the-archive/researching/research-guides/health/mental-health> last modified 19 June 2019 and viewed 25 September 2019. Access to the records of Ashburn House require special permission for each inquiry, and requests by the authors to view them were not answered, but the institution did accept medical men as patients in this period; see Wright-St Clair, *Medical Practitioners*, pages 104 and 335 for John Cunninghame and William Satchell. [↑](#footnote-ref-70)
71. Appendices to the Journals of the House of Representatives 1889 session ‘Lunatic Asylums of the Colony’ giving the total inmates of all seven extant asylums as 1681 and the residents in the four asylums surveyed here as 1324. [↑](#footnote-ref-71)
72. A. Tomkins, ‘Mad Doctors?: the significance of medical practitioners admitted as patients to the first English county asylums up to 1890’, *History of Psychiatry*, 2012, *23*, 4. [↑](#footnote-ref-72)
73. Four were Irish and a fifth man, Bernard Doyle, was either Scottish or Irish. [↑](#footnote-ref-73)
74. C J. Van der Krogt, ‘Irish Catholicism, Criminality and Mental Illness in New Zealand from the 1870s to the 1930s’, *New Zealand Journal of History*, 2016, *50*, 94. For high rates of asylum admission in Ireland among young single men in the late nineteenth and early twentieth centuries, see E. Malcolm, ‘Mental health and migration: the case of the Irish 1850s-1990s’ in McCarthy and Coleborne, *Migration, Ethnicity, and Mental Health,* 15-38. [↑](#footnote-ref-74)
75. ‘Habitual Drunkards in New Zealand’, *British Medical Journal* 8 January 1881, 58. [↑](#footnote-ref-75)
76. W. L. Lindsay*, ‘*Insanity in British Emigrants of the middle and upper ranks’, *Edinburgh Medical and Surgical Journal 1869-70*,1870, *XV*, 214-228. [↑](#footnote-ref-76)
77. And Lindsay thought it could be too, ibid., 220. [↑](#footnote-ref-77)
78. McCarthy *Migration, Ethnicity and Madness*, 116, 118. [↑](#footnote-ref-78)
79. See Lindsay, ‘Insanity in British Emigrants’, 221 on shepherds and surveyors for lack of intellectual stimulus. [↑](#footnote-ref-79)
80. Coleborne, *Madness in the Family.* [↑](#footnote-ref-80)
81. McCarthy, *Migration, Ethnicity and Madness*, 114. [↑](#footnote-ref-81)
82. Wright-St.Clair, *Medical Practitioners*, 333. [↑](#footnote-ref-82)
83. Papers Past, National Library of New Zealand, [www.paperspast.natlib.govt.nz](http://www.paperspast.natlib.govt.nz) 9 November 2017. [↑](#footnote-ref-83)
84. Wright-St Clair, *Medical Practitioners,* throughout. One of the medical asylum patients, John Ryley, subsequently killed himself in Australia. [↑](#footnote-ref-84)
85. The eleven cases are those of Harry Fleetwood 1859, Charles Galbraith 1863, Robert Storey 1865, George Martindale 1868, William Hayne 1874, John Bligh 1877, Moritz Mark 1879, Thomas O’Donoghue 1886, James Campbell 1888, Edmund Marshall 1896 and John Innes 1896. See for example the death of Charles Huxtable from self-dosing with chloroform on 7 February 1886 and widely reported in New Zealand’s newspapers including *New Zealand Herald,* February 8, 1886, 5. The phenomenon of ‘courtesy verdicts’ persisted into the twentieth century, see John C. Weaver, *Sorrows of a Century: Interpreting Suicide in New Zealand 1900–2000* (Montreal: McGill-Queens University Press, 2014), 16. [↑](#footnote-ref-85)
86. ‘Inquest on Dr Bligh – Singular Verdict’, *West Coast Times,* September 21, 1877, 2. [↑](#footnote-ref-86)
87. ‘Inquest’, *Wanganui Chronicle* July 30, 1897, 2. [↑](#footnote-ref-87)
88. Weaver, *Sorrows of a Century*, 28. [↑](#footnote-ref-88)
89. ‘Suicide of a Physician at Christchurch’, *New Zealand Mail*, 17 May 1879, 22. [↑](#footnote-ref-89)
90. ‘New Advertisements’, *Lyttleton Times,* August 13, 1859, 5 and subsequently to 24 August. Fleetwood had landed on the South Island only a fortnight earlier, see *Lyttleton Times,* July 27, 1859, 4. [↑](#footnote-ref-90)
91. *Lyttleton Times,* September 3, 1859, 5 and September 10, 1859, 4. [↑](#footnote-ref-91)
92. Tomkins, *Medical Misadventure*, 246. [↑](#footnote-ref-92)
93. Littlewood and Lipsedge, *Aliens and Alienists*, 96. [↑](#footnote-ref-93)
94. Coleborne, *Madness in the Family*, 51-2; Coleborne, *Insanity, Identity and Empire,* 75-7. [↑](#footnote-ref-94)
95. Knewstubb, ‘Medical Migration’, 18. [↑](#footnote-ref-95)