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# **THE HILL OF HEALTH**

**Aspects of Community at Waipiata Sanatorium 1923-1961**

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A dissertation submitted in partial fulfilment of the requirements for the  
degree of Bachelor of Arts with Honours in History,  
at the University of Otago, October 2005.

### **Acknowledgements**

Thanks must firstly go to the Murray family, who brought the world of the Sanatorium to life for me. Thanks also to my supervisor Professor Barbara Brookes, and all the lecturers in the Department of History, for their enthusiasm and guidance. Most importantly, thanks to my family, in particular my mother, for her unwavering dedication to my education.

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Waipiata Sanatorium buildings, now privately owned.

Source : Susan Haugh, July 2005.



## INTRODUCTION

### **Prevention, Isolation, Rehabilitation and Cure**

#### **The Rise of the Sanatorium**

For centuries tuberculosis was a mysterious and fatal disease, known simply as 'consumption' because of the wasting effect it had upon its victims.<sup>1</sup> It was considered neither contagious nor curable, instead it was believed to be a hereditary condition or the result of poverty and 'unhealthy living'. With no understanding of the causes of the disease, no cure and no way to prevent its spread, tuberculosis killed more people than any other disease in the nineteenth century. It was not until 1882 that the German physician Robert Koch identified the tubercle bacillus, allowing him to prove that tuberculosis was an infectious disease, and given that in most cases the disease began in the respiratory tract, that the infectious bacilli were spread through the air.<sup>2</sup> This was a transformative moment in the history of tuberculosis. No longer was the disease a case of mysterious and incurable 'consumption', it now had a scientifically identifiable cause and a frighteningly simple means of transmission. Suddenly, tuberculosis was more than a private ailment, it was a cause for public concern. What had previously been a personal tragedy became a social menace. Tuberculosis sufferers, once merely pitied, came to be feared and ostracized.<sup>3</sup> But Koch's discovery also allowed for hope that this once enigmatic and deadly disease could be cured, or at the very least, something could be done to prevent its spread.

Vigorous anti-tuberculosis campaigns began throughout the world to address two needs: prevention of the spread of tuberculosis and the search for a cure. The campaigns

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<sup>1</sup> The term 'tuberculosis' in this dissertation refers to pulmonary tuberculosis, characterised by fever, weight loss, a cough and in severe cases, haemorrhage of the lungs. Other forms of tuberculosis attacked the joints, spinal column and internal organs. These forms of tuberculosis were rare and almost always fatal.

<sup>2</sup> Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis, 1876-1938* (Philadelphia: University of Pennsylvania Press, 1992), 16.

<sup>3</sup> Ibid.

included the compulsory notification of cases of tuberculosis, widespread education about the nature of the disease and its causes, and regular examinations for the family members of known cases. Despite the promise of Koch's discovery, no miracle cure was forth coming, but the new-found nature of tuberculosis allowed for new kinds of treatment, all of which could be best carried out in the highly supervised environment of the sanatorium. Sanatoria had first emerged as refuges for tuberculosis patients in the 1850s in the mountainous regions of Europe, where the clear air was considered to be of benefit to the sufferers of lung complaints. For decades sanatoria were private establishments for the few who could afford them, concerned as much with providing a comfortable environment in which to die as they were with recovery from the disease.<sup>4</sup>

As understanding of tuberculosis increased around the turn of the century, public health authorities looked to sanatoria as the best hope for containing and curing the disease. Research revealed that a large percentage of the world's population had been exposed to the tubercle bacillus, usually through inhaling the bacilli in infected droplets of saliva dispersed when a tubercular person spat or coughed. In most cases, the body's immune system was able to contain the disease and the individual never became unwell. In a small number of cases, the bacilli overcame the body's natural defences and spread throughout the lungs, and the patient developed tuberculosis.<sup>5</sup> Insufficient diet, poor ventilation, over crowding, and repeated infection through close contact with a tubercular person were believed to increase the chances of developing the disease, as were poor workplace conditions, physical and emotional stress and the polluted air and cramped conditions that came with urban living. If tuberculosis could not be cured by medical science, then it could at least be remedied by eliminating the factors that prevented the body from overcoming the disease. Sanatoria provided the solution: they were medically supervised refuges from the poor housing conditions, family cares and work responsibilities that made people susceptible to the disease. They provided consumptives with rest, a nutritious diet, fresh air and the discipline required to convert to a healthy

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<sup>4</sup> Sheila Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: BasicBooks, 1994), 195.

<sup>5</sup> Bates, 7-8.



lifestyle. Thus the body's immune system could be enhanced so the lungs might recuperate sufficiently to build fibrosis around the points of infection and wall off the bacilli, restoring the patient to health.<sup>6</sup> This required the patient to be in the early stages of the disease. Those with chronic or advanced tuberculosis, whose bodies could not be expected to recover, were considered inappropriate candidates for sanatorium treatment. Public sanatoria were not intended to care for the patients while they died, but to provide suitable conditions for recovery.

Not only did sanatoria provide hope of recovery for tuberculosis sufferers, they isolated those affected and thus removed them from the possibility of infecting others. Public health authorities, by building and administering sanatoria, were seen to be actively protecting society from the threat of the disease. Equally importantly in the eyes of the state, sanatorium treatment would educate patients to continue the 'healthy lifestyle' in their own homes and teach them how to manage the disease without posing a risk to their families and society. Occupational therapy could be used to rehabilitate patients so that they could return as quickly as possible to being productive and safe members of society.<sup>7</sup> Isolation, education, and rehabilitation were the three mainstays of sanatorium life that would provide maximum benefit to both the individual and society.

When the first sanatoria appeared in New Zealand in the late nineteenth century they were all private or charitable institutions, set up by individuals to care for those with lung conditions. It was not until 1901 that the Liberal government set up the first Department of Health and began a public anti-tuberculosis campaign. The campaign included compulsory notification of the disease and a public education programme, but its main focus was on institutional treatment, where scientific progress made overseas could be

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<sup>6</sup> F.B. Smith, *The Retreat of Tuberculosis 1850-1950* (London: Croom Helm, 1988), 97.

<sup>7</sup> Linda Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain* (Oxford: Clarendon Press, 1988), 46-69.

applied to the New Zealand situation.<sup>8</sup> In 1903 the first sanatorium, Te Waikato, was built 150 kilometres south of Auckland. It was followed in 1904 by the Otaki and Pukeora Sanatoria in the central North Island, then by Cashmere Hills Sanatorium in Christchurch and Pleasant Valley in Otago in 1910. The last to be established was Waipiata Sanatorium on the Maniototo Plains in 1923.<sup>9</sup> The few hundred beds that the sanatoria provided hardly represented a comprehensive measure given the thousands of notified tuberculosis cases each year, but they remained the main focus of treatment until chemotherapy drugs and anti-tuberculosis vaccinations became available in the 1950s.

Although tuberculosis has ceased to be the widespread threat that it was two generations ago, it has continued to capture the interest of historians around the world. Consequently the literature on tuberculosis is comprehensive, and full accounts of the medical and social aspects of this disease and of the course of the anti-tuberculosis campaigns in Britain, Canada and the United States are plentiful. As sanatorium treatment was a fundamental part of the anti-tuberculosis campaign, historians have necessarily paid attention to the role of sanatoria in combating the disease. What is lacking from these accounts is sufficient investigation of the nature and experience of life in a sanatorium. Too often it is assumed that because sanatorium treatment involved the process of institutionalisation, it was necessarily dehumanising and unpleasant, causing more harm to the patient than good.

Perhaps the most negative view of sanatorium life is that of F.B. Smith in his book on English sanatoria, *The Retreat of Tuberculosis 1850-1950*. Smith claims “sanatoria were places of hope deferred.”<sup>10</sup> He characterizes public sanatoria as understaffed and underfunded institutions, where patients were forced to work to pay for the costs of their treatment, and where the necessities of heat and nutrition were overlooked in the interests

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<sup>8</sup> Linda Bryder, “If Preventable, why not Prevented? The New Zealand Response to Tuberculosis 1901-1930,” in Linda Bryder, ed., *A Healthy Country: Essays on the Social History of Medicine in New Zealand* (Wellington: Bridget Williams Books, 1991), 111-112.

<sup>9</sup> *Ibid.*, 112-113.

<sup>10</sup> Smith, 97.

of frugality.<sup>11</sup> Patients were bored and despondent, and became obsessed with their illness. Not only was sanatorium life itself unpleasant, the experience often left patients with an inability to find work and severed ties with family members.<sup>12</sup> Smith concludes that sanatoria absorbed public and private money but their contribution to the solution of the tuberculosis problem was minimal, not only in curing patients, but also in terms of education or prevention.<sup>13</sup>

Sheila Rothman in *Living in the Shadow of Death*, portrays sanatoria in a more balanced manner, characterizing them as places where both the fear of contamination and the hope for a cure could be addressed. Isolating those affected not only protected society, it also ensured individual well being by implementing a therapeutic regimen. "The sanatorium satisfied both the drive to coerce and cure. Inside it, fear met hope."<sup>14</sup> Yet in describing sanatorium life, she loses sight of the hope that sanatoria could provide, instead describing the experience as one of incarceration, or as merely a waiting room for death.<sup>15</sup> Patients suffered from the isolation of the remote sanatoria, lack of sympathy from staff and the frustration of not knowing how long their stay would last. It is not surprising, concludes Rothman, that so many patients left sanatoria before they had been formally discharged.<sup>16</sup>

Barbara Bates and Greta Jones portray sanatorium life in a similar manner to Rothman. Both acknowledge that patients and their families often looked to the sanatorium to provide the necessary discipline for a cure, and those with no-one to care for them or no money to support themselves found relief in institutionalization.<sup>17</sup> They conclude that good food, rest and removal from the stressful conditions outside the

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<sup>11</sup> Ibid.

<sup>12</sup> Ibid., 118.

<sup>13</sup> Ibid., 130.

<sup>14</sup> Rothman, 194.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid., 244.

<sup>17</sup> Bates, 259-60 and Greta Jones, *'Captain of all these Men of Death': The History of Tuberculosis in Nineteenth and Twentieth Century Ireland* (Amsterdam: Rodopi, 2001), 176.

sanatorium might very well have assisted in the recovery of some patients.<sup>18</sup> Yet they focus on sanatorium life as lonely and stressful, emphasizing the fact that patients did not necessarily get, or stay well.<sup>19</sup> Jones in particular notes there is little evidence to support the value of the open air treatment provided by the sanatorium as opposed to simply good ventilation, claiming that some of the more rigorous open air regimes may have even hindered recovery.<sup>20</sup> Nor does she accept that segregation necessarily did anything to reduce the spread of tuberculosis. Waiting lists meant active cases remained in the community, and some patients left the sanatoria while still in an infectious state. Many people resisted institutional care, particularly amongst the poor, where tuberculosis incidence was high, and people did not want to leave their families financially destitute, or enter the relatively unpleasant public sanatoria.<sup>21</sup>

Not all historians have been so dismissive of the conditions of sanatoria, or their effectiveness. Frank Ryan, in *The Forgotten Plague*, warns that we should not underestimate the effectiveness of general measures. The isolation of the infected from other potential victims, and the improved nutrition, the opportunity for rest and medical supervision all contributed to the reduction of mortality throughout the western world.<sup>22</sup> Thomas Dormandy in *The White Death*, agrees that the basic regime of sanatorium life was beneficial to most who experienced it.<sup>23</sup> He claims it is unfair that today sanatoria seem as remote as medieval leprosaria, and few have a good word to say in their memory.<sup>24</sup> What the sanatorium ideal promised was that, while medicine could do little, the sanatorium could help to promote the body's own healing power by providing wholesome rest and graduated exercise under strict medical attention. At the very least it

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<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup> Jones, 176.

<sup>21</sup> Ibid.

<sup>22</sup> Frank Ryan, *The Forgotten Plague: How the Battle Against Tuberculosis was Won and Lost* (Boston: Little, Brown and Co., 1993), 28.

<sup>23</sup> Thomas Dormandy, *The White Death: A History of Tuberculosis* (London: Hambledon Press, 1999), 147.

<sup>24</sup> Ibid., 148-9.

could ensure that the body's healing process was not impeded. "It sounded and still sounds obvious. Most great truths do after being recognized. It was profound", Dormandy concludes.<sup>25</sup>

Ryan and Dormandy are the exceptions. Most historians of tuberculosis in North America and Britain tend to dismiss sanatoria as unpleasant and ineffective. Undoubtedly some of the sanatoria in these countries lacked the resources necessary to run an institution effectively, exploiting patients and forcing them into unpleasant living conditions for the sake of isolating them. But we must be careful to avoid characterising the New Zealand sanatorium experience on the basis of a minority of poorly equipped and unregulated sanatoria overseas. The historian who has given New Zealand's experience of tuberculosis most attention is Linda Bryder, in her chapters "If Preventable, why not Prevented?" in *A Healthy Country*,<sup>26</sup> and "Tuberculosis in New Zealand" in A.J. Proust's *History of Tuberculosis in Australia, New Zealand and Papua New Guinea*.<sup>27</sup> According to Bryder, sanatorium treatment in New Zealand was a controversial move from its outset. It was a hugely expensive burden on local and central government, both in terms of initial outlay and ongoing expenses. Patients with no symptoms of the disease were admitted, and were kept in institutions for extended periods of time.<sup>28</sup> While Bryder details the attitude of the government to sanatoria, she does not discuss the experiences of the patients and staff who were personally involved in sanatorium life. This is an area which has been little investigated.

Kim Middleton's dissertation "The Establishment of Tuberculosis Sanatoria in Otago 1899-1928" focusing on the Waipiata and Pleasant Valley Sanatoria, helps to fill this gap, although she focuses on the treatment process as a whole rather than the experience of sanatorium life. Her portrayal of these sanatoria is essentially negative, labelling

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<sup>25</sup> Ibid., 149.

<sup>26</sup> Bryder, "If Preventable, why not Prevented?," 109-127.

<sup>27</sup> Linda Bryder, "Tuberculosis in New Zealand" in A.J. Proust, ed. *Tuberculosis in Australia, New Zealand and Papua New Guinea* (Canberra: Brolga Press, 1991), 79-89.

<sup>28</sup> Bryder, "If Preventable, why not Prevented?," 117-118.

sanatorium treatment as based on a 'specious ideology', and restricted to a small proportion of sufferers. She concludes the decline of tuberculosis cannot be attributed to sanatorium care.<sup>29</sup>

As an attempt to better understand sanatorium life, some historians have likened the experience to that of life in a prison or asylum, assuming a similarity in experiences for all institutional patients. Rothman claims many patients entering sanatoria had only one concept of institutionalization, and could not help but compare themselves to criminals entering prison. Both entered the institution against their will, spent their time as social outcasts and left forever branded by their stay.<sup>30</sup> Katherine Ott has made similar comparisons. Sanatoria, she claims, as "single purpose institutions", had much in common with prisons and insane asylums, including strict rules and daily regimens.<sup>31</sup> Bates compares sanatorium life even more closely with asylum life: "The hygienic regimen of tuberculosis patients closely resembles the moral therapy promulgated in nineteenth century insane asylums. Removal of patients from their homes to a well ordered environment, supervision by physicians and by vigilant yet humane attendants, a regulation of means and activities were all methods that doctors believed would help mentally ill patients recover their sanity."<sup>32</sup>

In order to emphasise the coercive aspects of sanatorium life, historians have compared the experience to psychologist Erving Goffman's description of a 'total institution'. Bryder, in her work on British sanatoria *Below the Magic Mountain*, claims that sanatoria conformed very closely to Goffman's model of a total institution, in that they shared features with other institutions such as prisons, schools, lunatic asylums and hospitals.<sup>33</sup> Rothman is even more emphatic, claiming that "to see the sanatorium from

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<sup>29</sup> Kim Middleton, "The Establishment of Sanatoria in Otago, 1899 – 1928" (Post Grad Dip Dissertation, University of Otago, 1998), 68.

<sup>30</sup> Rothman, 229.

<sup>31</sup> Katherine Ott, *Fevered Lives: Tuberculosis in American Culture since 1870* (Cambridge, Mass.: Harvard University Press, 1996), 148.

<sup>32</sup> Bates, 144.

<sup>33</sup> Bryder, *Below the Magic Mountain*, 200.

the inside, from the perspective of the patient, is to see it in the first instance as an incarcerative institution, a suburb example of Erving Goffman's total institution."<sup>34</sup> But closer inspection of Goffman's description of the total institution reveals that it only partially applies to sanatorium life. Goffman identifies the total institution as a "place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life."<sup>35</sup> In this definition each phase of the member's daily life is conducted in the same place under the same single authority, daily activity is carried out in the company of a large number of others and all of the day's activities are tightly scheduled.<sup>36</sup> While Bryder and Rothman are right that some of these aspects can be related to sanatorium life, the analogy with Goffman's 'total institution' is misleading. It emphasizes the coercive and regimented aspects of institutions whose inmates were incarcerated against their will, and reflects a generally negative attitude towards the process of institutionalisation. The experience of sanatorium life varies from this description to a degree that requires further analysis.

Through an investigation of Waipiata Sanatorium from 1923 to 1961, I hope to show that the experiences of both staff and patients were complex and varied, and that the sanatorium experience cannot be dismissed as uniformly unpleasant and ineffective. I also hope to show that analogies with Goffman's 'total institution' are misleading, and that Waipiata Sanatorium is better represented as a unique kind of community, more often resembling a country town than a medical institution. I will argue it was in this creation of community that the real benefit of sanatorium treatment lay, because it provided an atmosphere that was accepting of tuberculosis patients at a time when they suffered from stigma and discrimination. The sanatorium system may have had unpleasant aspects and did not 'cure' all those who participated in the treatment, but at a

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<sup>34</sup> Rothman, 227.

<sup>35</sup> Erving Goffman, *Asylum: Essays on the Social Situation of Mental Patients and Other Inmates* (Chicago: Aldine Pub. Co., 1961), xiii.

<sup>36</sup> *Ibid.*, 6.

time when medical science could offer no relief, sanatorium communities provided a way of life that made living with the disease more tolerable.

The first two chapters of this work consider the various experiences of the staff and patients who made up the core of the Sanatorium community. They explore the idea that Goffman's central tenet of a total institution, that staff and patients are unequal and opposing groups whose interaction is formally proscribed, does not apply to Waipiata Sanatorium. Instead staff and patients were fluid and interchanging members of a community that was dedicated to the wellbeing of the patients and to making life with tuberculosis as tolerable as possible, balancing the need for institutional structures with an understanding of the emotional and psychological needs of both staff and patients. The third chapter looks in more detail at aspects of community at Waipiata, both within the Sanatorium itself and its place within the wider Maniototo Plains. It also compares the experiences of Sanatorium patients with those of tuberculosis sufferers who remained outside these communities.

Alison Bashford notes that documenting the interior lives of people in institutions is challenging as the historical record privileges authority and expertise.<sup>37</sup> In the absence of patients' diaries and correspondence, and of the Sanatorium's patient records, the voices of the staff and the patients have in large part been lost. In reconstructing the experiences of those in the Sanatorium community, I have relied on the minutes of the Waipiata Sanatorium Committee and the reports of the monthly inspections the Sanatorium underwent. In addition, a preventative medicine dissertation written by a young medical student, W.E. Chisholm, who spent some months at the Sanatorium in the Christmas vacation between 1948 and 1949, was of particular use. His attention to detail, and recognition of both the medical and psychological aspects of tuberculosis, helped to reveal the many faceted nature of sanatorium life. As Linda Moore points out, "reliance on 'top down' records has contributed to the neglect of the patient. The challenge is to

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<sup>37</sup> Alison Bashford and Carolyn Strange, "Isolation and Exclusion in the Modern World: an Introductory Essay" in Alison Bashford and Carolyn Strange, eds., *Isolation: Places and Practices of Exclusion* (New York: Routledge, 2003), 13.



use these records in a way that sheds light on the patient, their community and its ways of dealing with illness.”<sup>38</sup> The Committee meeting minutes in particular proved to be remarkably valuable in this respect, as every aspect of Sanatorium life, from patient deaths to staff disputes, were discussed and reported by the Sanatorium Committee, allowing the experiences and opinions of the community to be reflected through the Committee. The reminiscences of three women who experienced life at Waipiata Sanatorium and kindly agreed to share their memories in oral interviews, described for me happy experiences of living and working at the Sanatorium as both patients and staff. Their positive representation was very different from the description of sanatorium life in the historical literature and from the negative portrayal of institutionalisation in Goffman’s description. This discrepancy indicated the need for further investigation of the experiences of staff and patients at Waipiata Sanatorium, and of the community that was formed there.

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<sup>38</sup> Linda Moore, “An Adjunct to a Hospital and a Substitute for One: The Fresh Air Home 1923 – 1927” (unpublished essay, Canterbury University, 1999), 10.

## CHAPTER ONE

### **A Society Dangerously Split? The Experiences of the Staff**

The first sanatorium at Waipiata was established in 1914 and was a private institution owned by Dr George Byres, a Scottish physician who had emigrated to New Zealand in 1909. Dr Byres' sanatorium consisted of wooden buildings and shelters situated at a height of 1600 feet above sea level on the northern slope of the Rock and Pillar foothills in the Maniototo region. The institution was small, capable of treating only 12 patients.<sup>1</sup> In 1921 it was purchased by an association of eight Hospital Boards of the lower South Island,<sup>2</sup> along with almost 1300 acres of surrounding farmland, stock and the water rights of Pigburn Creek. This followed more than ten years of debate over the establishment of a public sanatorium in the region, sparked by increased demand for sanatorium care. Waipiata was chosen for its dry, clear conditions and the quiet of its rural location. In 1923 the Waipiata Sanatorium Committee, made up of an elected delegate from each of the contributing Health Boards and a representative from the Department of Health, was formed to administer the Sanatorium. Dr Byres continued to manage the Sanatorium until 1923 when the Committee appointed Dr Arthur Kidd as Medical Superintendent and Miss E.A. Wilson as Matron. After two years of construction, a male and a female dormitory, each accommodating 20 patients, were added to Byres' existing shelters. A kitchen, dining room, nurses' home, Dr Kidd's house and Matron's quarters were also built, and tennis courts, milking sheds and private roads were installed. When the Sanatorium was officially opened in 1925, it had bed space for 55 patients.<sup>3</sup>

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<sup>1</sup> Janet Cowan, *Down the Years in the Maniototo* (Christchurch: Caxton Press, 1978), 93.

<sup>2</sup> Southland, North Otago, Maniototo, South Canterbury, Wallace, Vincent, Ashburton and Waitaki Health Boards.

<sup>3</sup> Kim Middleton, "The Establishment of Sanatoria in Otago, 1899 – 1928" (Post Grad Dip dissertation, University of Otago, 1998), 25.

By 1925 the essential physical elements of the Sanatorium were complete: the buildings, the location and the administration had been supplied. However, as Bashford points out, while sanatoria “take shape in stone and concrete, they are also built up through relations between individuals and groups.”<sup>4</sup> These relationships ‘make’ the sanatorium as much as its physical components do. As an integral part of the human element of the sanatorium, the experiences of the staff have been of interest to all those who have studied sanatorium or institutional life. In particular their relationship to the patients, to the administrative management and to each other are vital to the understanding of the sanatorium experience.

Because of the complexity of these experiences and relationships, they have been interpreted in a variety of ways. Bates and Rothman base their understanding of the role of the staff in terms of a distinct difference between the staff and patients. They argue that the experiences of the staff were characterised by a need to remain detached and removed from the patients, caring for their physical needs without becoming involved with their lives or personal experiences.<sup>5</sup> In defining the experiences of the staff by their relationship to the patients, they echo Goffman’s definition of a total institution, based on “the basic split between a large managed group and a small supervisory staff.”<sup>6</sup> In this model the ‘inmates’ live in the institution and have restricted contact with the world outside the walls, while staff operate on an eight hour day and are socially integrated into wider society. Social mobility between the two strata is highly restricted; social distance

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<sup>4</sup> Alison Bashford and Carolyn Strange, “Isolation and Exclusion in the Modern World: An Introductory Essay’ in Alison Bashford and Carolyn Strange, eds., *Isolation: Places and Practices of Exclusion* (New York: Routledge, 2003), 12.

<sup>5</sup> Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis, 1876-1938* (Philadelphia : University of Pennsylvania Press, 1992), 201 and Sheila Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American history* (New York: BasicBooks, 1994), 227.

<sup>6</sup> Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Chicago: Aldine Pub. Co.,1961), 7.

is typically great and often formally proscribed.<sup>7</sup> Goffman even goes so far as to claim that a total institution is “a society dangerously split into inmates and staff.”<sup>8</sup>

The experiences of the staff at Waipiata Sanatorium do not conform to Goffman’s definition nor were they distinguished by a need to remain emotionally distant from the Sanatorium patients. Although I have divided the first two chapters of this work into staff and patients to highlight the different roles they played in the Sanatorium community, the distinction is an artificial one. Waipiata was not an institution in which inmates and staff were in opposing and unequal positions, as staff shortages and the ethos of the Sanatorium regimen often saw patients employed as part time staff, ex-patients join the staff after discharge, and the relatives of patients take up temporary employment at the Sanatorium. The staff and patients therefore represented two fluid and overlapping sub-groups of the Sanatorium community that included a great many individuals who did not fit exclusively into either of those categories.

Historians have also defined the experiences of the staff by the nature of the work they carried out. Bates characterises sanatorium work as dangerous and unappealing, describing sanatorium labour as “hard, unpleasant work,”<sup>9</sup> while Jones claims that “medical staff had a high incidence of disease, the work was depressing and often far from city centres, making sanatorium nursing very unpopular.”<sup>10</sup> This argument cannot be easily dismissed. Sanatorium work was exhausting as staff shortages meant long hours, missed days off and holidays, and the need to undertake duties well outside formal job descriptions. Nevertheless, it was also rewarding work, characterised by the hope of bringing a cure, or at least relief, to tuberculosis sufferers. The Sanatorium Committee were acutely aware that sanatorium work was demanding, and took all possible measures to alleviate its negative aspects. They organised regular examinations to avoid infection,

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<sup>7</sup> Ibid.

<sup>8</sup> Ibid., 109.

<sup>9</sup> Bates, 201.

<sup>10</sup> Greta Jones, *‘Captain of all these Men of Death’: The History of Tuberculosis in Nineteenth and Twentieth Century Ireland* (Amsterdam: Rodopi, 2001), 169.

provided entertainment to make the isolation more bearable, and ensured that clean, efficient work environs were the norm. Therefore, the experiences of the staff were not based around their roles as authority figures in a dangerously split society, nor was the experience characterised solely by the unpleasant nature of the work. Rather the experiences of the staff were focussed around their membership of a community that was dedicated to alleviating the suffering of those who had tuberculosis. Their part in this community required dedication and hard work, but was rewarded with every effort to make the work and the conditions as pleasant as possible.

The treatment at Waipiata Sanatorium was based on the 'fresh air regime' of bed rest, nutritious diet, open air living and graduated exercise. Staff were expected to provide the discipline and support necessary for patients to complete the regime and be restored to health, and to teach them 'healthy living' that would prevent them from relapse or spreading the disease when they returned to their homes.<sup>11</sup> All patients were placed on bed rest for a minimum of one month, and patients with temperatures or pulse rates higher than normal, who were losing weight or were still contagious were limited to complete rest until the symptoms were gone. Nurses and domestic staff were therefore responsible for the complete care of these patients. They fed and washed them, sterilised clothes and linen and, because of the infectious nature of the disease, carefully disposed of sputum mugs and paper handkerchiefs. The fresh air principle of the regimen required patients to spend as much time as possible on outdoor balconies, meaning the staff spent a considerable amount of time ensuring patients were warm and dry.<sup>12</sup> When a patient had completed the compulsory bed rest and showed no symptoms of active disease, they were allowed a certain number of hours 'up', progressing from four to eight to ten hours up, before being allowed up 'all day'. When allowed up, patients washed themselves, ate communally and were responsible for their own clothes and linen. The care of ambulant patients was therefore not concerned with the complete personal care that the bed patients

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<sup>11</sup> W.E.Chisholm, "Waipiata Sanatorium, Christmas Vacation 1948-1949" (Preventative Medicine Dissertation, University of Otago, 1949), 37.

<sup>12</sup> Catherine Beagley, "Dread White Plague: Social Aspects of Tuberculosis 1900-1930" (BA Hons Dissertation, University of Otago, 1987), 46.

required, rather staff had to provide suitable entertainment and exercise to rehabilitate patients.<sup>13</sup> The 'fresh air regime' required nurses, aids and domestic staff alike to be at once hospital staff, companions, carers, cleaners and social workers.

No one person had more influence over the experiences and lives of the patients and staff than Dr Arthur Kidd. As the Medical Superintendent from 1923 until 1956, he devoted his life to the treatment of patients at the Sanatorium and to the prevention of tuberculosis in New Zealand. His 33 years of service left his personality and medical ethos irreversibly stamped on the institution. As Rothman points out, "The physician was the key component to the sanatorium. He was responsible for the control of every aspect of the patients' lives."<sup>14</sup> Kidd decided which patients would be admitted to the Sanatorium, when a patient could progress from bed rest to four, eight or ten hours up, and eventually when they were to be discharged. He decided which treatments were suitable for which patients, and as medical science developed new techniques to treat tuberculosis, which of these were to be introduced to Waipiata. Kidd did not limit himself to those duties typical of a Medical Superintendent, but took on any duty that arose, often well outside his official responsibilities. It was his willingness to turn his hand to any task that encouraged the rest of the staff to take on any and every duty that presented itself, in order to keep the institution running smoothly and the patients comfortable. In his many years at the Sanatorium Kidd tackled everything from writing pamphlets on the care and prevention of tuberculosis to fitting up the steam calorifier to the hot water cylinder in the women's shelters.<sup>15</sup>

Kidd's time at Waipiata was not without controversy. His approach to the treatment of tuberculosis and his selection process for admission to the Sanatorium were debated and criticised throughout his time as Superintendent. Kidd's right to choose the cases that were to be admitted was very important to the Sanatorium. He was the only Medical

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<sup>13</sup> Chisholm, 37.

<sup>14</sup> Rothman, 196.

<sup>15</sup> Waipiata Sanatorium Committee Meeting Minutes, 27<sup>th</sup> June 1933. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

Superintendent in the country to be accorded this right. The South Island sanatoria at Cashmere Hills and Pleasant Valley were greatly aided by tuberculosis dispensaries at Christchurch and Dunedin which detected early cases and selected those suitable for sanatorium treatment. In contrast, the sanatoria in the North Island had no choice in the type of patients they were required to admit, and there were no dispensaries to detect early cases. Instead, hospitals referred cases to the sanatorium, meaning patients were often in the advanced stages of the disease. The Medical Superintendents of these institutions repeatedly complained that patients were sent to them whose chances of a cure were remote. Many were not admitted until there was unmistakable open lesion with positive sputum. Frequently patients died within a few weeks or had to be sent home incurable.<sup>16</sup>

Kidd's ability to choose his own patients meant that he could avoid cases that were too far advanced to benefit from sanatorium treatment. However, this led to the criticism that Kidd was admitting cases that had little or no sign of the disease, and would most likely recover in their own homes. In 1928, five years after Kidd began work at the Sanatorium, the Director General of Health, Dr T. Valintine called for the admission process to be removed from Kidd's jurisdiction.<sup>17</sup> In a report to the Waipiata Sanatorium Committee, he noted that cases at Timaru and Waimate hospitals awaiting admission to the Sanatorium were quite fit to be treated at home, whilst cases who were of the nature specially suited for Sanatorium treatment were refused admission. He suggested to the Committee that Kidd could not make a proper diagnosis after only one examination, and that all patients should be examined several times at Wakari Hospital in Dunedin before a final decision was made by the Medical Superintendent of that hospital, Dr Lyth.<sup>18</sup> In a letter to Dr F.W.B. Fitchett of Dunedin, Valintine expressed his reservations about Dr

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<sup>16</sup> F.S. MacLean, *A Challenge for Health: A History of Public Health in New Zealand* (Wellington: Government Print, 1964), 367.

<sup>17</sup> Report of the meeting of the Director General of Health and the Waipiata Sanatorium Committee, 27<sup>th</sup> November 1928. [Diseases-Tuberculosis-Otago Sanatorium. 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>18</sup> *Ibid.*

Kidd. “Dr Kidd should go Home as soon as possible to receive further instruction in the treatment of TB and ...some 18 months ago I told Dr Kidd he should seize the first opportunity of so doing. I did not belabour Dr Kidd heavily, regarding him more as the victim of the instruction that he had received as Assistant Medical Officer at the Cashmere Sanatorium under Dr Blackmore.”<sup>19</sup> Valintine even went so far as to accuse Kidd of receiving “fairly large private fees” while working at the Sanatorium.<sup>20</sup>

Valintine felt so strongly about what he considered to be the waste of public money in both Waipiata and Cashmere Sanatoria that he arranged for an inquiry into the ‘use and abuse’ of these two sanatoria. The 1928 Committee of Inquiry into ‘The Treatment and Prevention of Pulmonary Tuberculosis in New Zealand’ examined Valintine’s claim that many patients at Waipiata showed no signs of the disease. They found some evidence to support these accusations. Only four of 84 patients at Waipiata Sanatorium exhibited common signs of the disease such as sputum, cough, and high temperature, and some patients seemed even to be recovering while on the waiting list for admission.<sup>21</sup> Although the report censured the Waipiata and Cashmere Sanatoria for treating cases so early that there was doubt that the patients were infected, and for keeping patients for lengthy stays in the institutions, they did not advocate the admission of advanced cases, nor did they call for the resignation of either Medical Superintendent. Instead they emphasised that the primary role of sanatorium care should be educational. Patients should be kept only long enough to teach correct living and discipline; no more than three months should be necessary.<sup>22</sup>

Kidd seems to have largely ignored the report as he continued to admit early cases for long periods of time. But it was by no means the last he heard of the matter. Because the

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<sup>19</sup> Letter from Dr T. Valintine to Dr F.W.B. Fitchett of Dunedin, 30<sup>th</sup> November 1928. [Diseases-Tuberculosis-Otago Sanatorium. 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>20</sup> Ibid.

<sup>21</sup> “Prevention and Treatment of Pulmonary Tuberculosis in New Zealand”, *AJHR*, H-31A, 18.

<sup>22</sup> Linda Bryder “If Preventable, why not Prevented? The New Zealand Response to Tuberculosis 1901-1930” in Linda Bryder, ed., *A Healthy Country: Essays on the Social History of Medicine in New Zealand* (Wellington: Bridget Williams Books, 1991), 118.



associated Health Boards who sent patients to the Sanatorium had no institution for the care of advanced cases, they pressured Kidd and the Sanatorium Committee to provide space for such cases at Waipiata. In 1930 the Southland Hospital Board offered to erect accommodation if the Committee would undertake the care and oversight of advanced patients on the same basis as was provided for the early cases.<sup>23</sup> Kidd was adamant that this would be detrimental to current patients and against the general principles of sanatorium care. He reported to the Committee that the “lower vitality” of advanced cases would require additional features such as central heating and more staff, an expense that the Sanatorium could not afford. More importantly: “The mixing of both types of patients in open air pavilions was not desirable as although advanced cases may eventually benefit from open air treatment, their presence usually had a depressing effect upon the early cases under treatment and to some extent retards the latter’s progress.”<sup>24</sup> In refusing to accept advanced patients, Kidd may be seen to be neglecting the needs of many tuberculosis sufferers in the associated districts. But in doing so he also prevented the Sanatorium from becoming the “waiting room for death” that many sanatoria in the United States and Britain became. For Kidd, the recovery of early cases took precedence over the comfort of advanced ones. The subject arose periodically throughout Kidd’s term as Superintendent, but always met with the same response.

While Kidd may have had an opponent in the form of Valentine and suffered criticism from many members of the medical fraternity, he held the loyalty and appreciation of his staff and the Sanatorium Committee. His personality dominated life at the Sanatorium, where Kidd was respected to the point of reverence, and well liked and trusted. One nurse remembers the regard in which she held Kidd: “The Superintendent had his thumb on everything...and when he came round we just grovelled.”<sup>25</sup> There was only one reported instance of friction between Kidd and his staff, when tension between Kidd and Matron Wilson became such that it impacted on the running of the Sanatorium.

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<sup>23</sup> Waipiata Sanatorium Committee Meeting Minutes, 26<sup>th</sup> November 1930. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>24</sup> Ibid.

<sup>25</sup> Oral interview with JM, a nurse at the Waipiata Sanatorium 1937-9. November 2004.

The Committee was forced to investigate the “evident lack of coordination between Kidd and the Matron with a view to bring about a better understanding between these two officers.”<sup>26</sup> The matter was quickly resolved and in general the Committee found no fault with Kidd’s treatment, and considered that the Sanatorium under his supervision was a convincing success. In 1938 the Committee noted “the 10<sup>th</sup> of May being the 15<sup>th</sup> anniversary of the taking over of the Waipiata Sanatorium by Dr Kidd it was resolved that a letter of appreciation and thanks be forwarded to Dr Kidd for the excellent results that had been achieved at the institution due to his good work over that period.”<sup>27</sup> Chisholm was also positive in his assessment of Kidd: “Kidd has made his sanatorium into a happy place and if this is due in some part to too little interference with his staff, he has indeed kept everybody, patients and staff alike, working in harmony and content towards a common goal.”<sup>28</sup> In 1952 Kidd’s contribution was officially recognised when he was awarded an OBE.<sup>29</sup>

In 1954 Kidd formally tendered his resignation, an event that was met with widespread concern. The Committee refused to accept the resignation and urged Kidd to reconsider his decision.<sup>30</sup> He requested a month to consider his position, and during that month inspectors noted the disruption his departure was causing: “I found the staff restless pending the resignation of Dr Kidd.”<sup>31</sup> He eventually deferred his retirement until 1956, when he was replaced by Dr Paterson for the last five years of the Sanatorium’s life. Kidd’s influence over the lives of both the staff and the patients cannot

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<sup>26</sup> Waipiata Sanatorium Committee Meeting Minutes, 28<sup>th</sup> February 1933. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>27</sup> Waipiata Sanatorium Committee Meeting Minutes, 25<sup>th</sup> May 1948. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>28</sup> Chisholm, 40.

<sup>29</sup> Waipiata Sanatorium Committee Meeting Minutes, 3<sup>rd</sup> January 1952. [Waipiata Sanatorium-Minutes 1936-1956. Archives New Zealand, ADBZ 16163 H1 22/1]

<sup>30</sup> Waipiata Sanatorium Committee Meeting Minutes, 28<sup>th</sup> April 1954. [Waipiata Sanatorium-Minutes 1936-1956. Archives New Zealand, ADBZ 16163 H1 22/1]

<sup>31</sup> Report of Inspection, 7<sup>th</sup> April 1954. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

be over emphasised. He decided which patients were admitted, how long they stayed, and what form their treatment took. His recommendations shaped which staff were hired and what duties they performed, and his abounding enthusiasm and dedication provided inspiration for staff faced with demanding and exhausting work. Every aspect of life at the Sanatorium was in one way or another influenced by Dr Arthur Kidd.

Next to the Medical Superintendent in terms of responsibility and influence was the position of Matron. The position was held by several women over the 38 years the sanatorium was in use, although Miss Pryor's 17 years of service as Matron represent the most committed contribution to this challenging role.<sup>32</sup> The duties of the Matron were many and varied. She hired domestic and nursing staff, supervised the kitchen and the nurses' home, and arranged the patients' diet. She organised the Tuberculosis Training Certificate course and gave a large number of lectures as part of this course. She relieved staff on their days off, and in times of extreme staff shortages, took on many duties other than those assigned to her, including the relatively menial tasks of cooking meals and washing dishes.<sup>33</sup> Her duties increased when the Medical Superintendent was away from the Sanatorium, as one report from the Director of Nursing noted "Dr Kidd is by necessity away from the institution a great deal and he relies on the Matron to maintain discipline and care of the patients in his absence."<sup>34</sup> In 1933, the appointment of a full time Secretary relieved the Matron of her administrative role, and in 1948 the employment of an assistant Matron eased her hospital duties, but pressure on the Matron seems to have been almost overwhelming at times. One inspector noted "the Matron never can manage to have a day off and has had ten days annual leave in the two years

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<sup>32</sup> Waipiata Sanatorium Committee Meeting Minutes, 2<sup>nd</sup> December 1952. [Waipiata Sanatorium-Minutes 1936-1956. Archives New Zealand, ADBZ 16163 H1 22/1]

<sup>33</sup> Report of Inspection, 31<sup>st</sup> October 1938. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>34</sup> Report of Inspection, 29<sup>th</sup> October 1938. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

she has been there. She appeared in a nervous state and is obviously working herself much too hard.”<sup>35</sup>

The Matron was at the head of a hierarchy of nurses and domestic staff. Directly beneath her were the Senior and Junior Sisters, who made up the fully registered nursing staff. Because sanatorium care required little medical knowledge, a number of nursing aids were also employed, who held Tuberculosis Training Certificates, awarded after a two year course that could be undertaken at the Sanatorium. Beneath the nurse aids came a range of domestic staff, including cooks, kitchen maids, dining room staff, laundry men, and seamstresses. Qualifications for these staff were relatively light, the only formal requirements being 18 years of age and a primary school education.<sup>36</sup>

An overriding and inescapable aspect of Sanatorium life was the constant and often severe shortage of staff from all levels of this hierarchy. At no time was the Sanatorium adequately staffed and the Committee constantly sought more nurses, aids and domestic staff. Chisholm reported after two months observation of the Sanatorium: “Nurses just do not want to go there.”<sup>37</sup> This had serious consequences. A number of beds had to be closed for extended periods of time, as there were insufficient staff to care for the full number. Given that another constant feature of Sanatorium life was a waiting list, this was a serious consideration. It also affected the experiences of those who chose to work at the Sanatorium. Staff worked long hours, often went without days off and holidays, and had to take on duties that were well outside of their official responsibilities.

The constant shortage of staff was predominantly caused by the isolation of the Sanatorium. The Director of Nursing noted in 1940: “It is a great problem to keep staff in so isolated a spot. The expense incurred to get away from the place, even to Waipiata

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<sup>35</sup> Report of Inspection, 7<sup>th</sup> February 1955. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>36</sup> Report of Inspection, 6<sup>th</sup> November, 1941. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>37</sup> Chisholm, 16.

township costs 5/-. Then to go to Dunedin takes two days of their leave, besides being expensive for them.”<sup>38</sup> With hospital staff in demand throughout New Zealand, many chose to forgo the problems of Waipiata’s isolation and find employment elsewhere. The Committee was well aware that life in such an isolated spot was uninviting, especially to the young, single women who made up the bulk of Sanatorium staff. They took every measure to make Sanatorium life comfortable and pleasant in spite of the isolation. The nurses’ home was a brick building capable of accommodating 33 nurses in single bedrooms with “sitting rooms and balconies [that] are pleasant and comfortable”, and communal cooking and bathroom facilities. The bedrooms were “wallpapered and built for comfort rather than the Spartan cleanliness of some nurses’ homes with their highly polished walls and ceilings,” and the facilities were “reminiscent of the usual Suburban family home.”<sup>39</sup> Domestic staff lived in the top story of the Diet Pavilion, while the porters and male orderlies had their own accommodation in a Porters’ Lodge on site, all built to combine comfort with ease of cleanliness that was so important at the Sanatorium.<sup>40</sup>

Entertainment was vital in alleviating the more unpleasant aspects of sanatorium life for staff. A bus to Waipiata township was provided free of charge once a week to allow the nurses to attend dances and movies, in a deliberate and somewhat desperate attempt by the Division of Hospitals to overcome the isolation that deterred so many nurses from employment at the Sanatorium.<sup>41</sup> The Committee also invested a considerable amount of money in providing entertainment on site. Tennis courts had been installed in the original construction period between 1923 and 1925, croquet was added in 1938, and by 1941 basketball and golf were available and “a small but growing library catered for reading tastes.”<sup>42</sup> The dam behind the Sanatorium provided swimming in the summer,

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<sup>38</sup> Report of Inspection, 12<sup>th</sup> September 1940. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>39</sup> Chisholm, 16.

<sup>40</sup> Author unknown, “Waipiata Sanatorium”, *Kai tiaki* 18, no. 3 ( July 1925), 141-142.

<sup>41</sup> Report of Inspection, 3<sup>rd</sup> March, 1958. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>42</sup> Chisholm, 16.

and ice skating in the winter. The Sanatorium supported both a tennis and a netball club, and the male staff, in particular those who worked on the farm, played rugby.<sup>43</sup> Nurse JM remembers her time off and social life with great excitement. “Oh we had a wonderful time! We had concerts and we had parties and they were looked forward to by everyone... we had lots of lovely sports, in the winter time we had a big pond out the back of the Nurses’ Home, only about two feet deep, but it used to ice over with such thick ice that we’d come off duty at 11 o’clock at night, and go out and skate for an hour before we went to bed.”<sup>44</sup>

Exposure to infection was an aspect of tuberculosis care often considered amongst the most dangerous and unpleasant aspects of sanatorium work. Concern over tuberculosis in nurses was nationwide during this period. The strain of long hours, physically and emotionally exhausting work and, at a period in New Zealand’s history when nurses were in short supply everywhere, overtime, overdue holidays and general overwork, meant that nurses were often run down, leaving them in even greater risk of succumbing to the disease.

An investigation by the Department of Health in 1932 found that nurses had a higher incidence of tuberculosis than women of the same age groups. At this stage there was no regular system of checking nurses, nor any enforceable standards to protect nurses from exposure to infection.<sup>45</sup> Concern was such that in 1935 a further investigation was undertaken into the extent, causes and possible solution to the problem. The investigation found that very few hospitals and sanatoria were taking sufficient precautions to ensure that nurses did not catch tuberculosis. As a result the Health Department initiated new requirements for nurses in tuberculosis annexes and sanatoria, including annual x-rays,

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<sup>43</sup> Oral interview with RM, resident at Waipiata Sanatorium 1929-1961. November 2004. See also Waipiata Sanatorium Committee Meeting Minutes, 24<sup>th</sup> September 1946. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>44</sup> Oral interview with JM.

<sup>45</sup> Maclean, 377.

chest examinations, Mantoux tests<sup>46</sup> and monthly weight records.<sup>47</sup> In 1937, of 1757 nurses in New Zealand, 43, or 2.4 percent had tuberculosis.<sup>48</sup> The new measures helped to lower morbidity to 47 out of 5,299 nurses in 1943 or 0.8 percent, but the government remained concerned about possible exposure to the disease, and an increase in the number of known cases in tuberculosis in nurses notified between 1946 and 1948 sparked a new investigation.<sup>49</sup> It was not until the introduction of the BCG vaccination in 1949 that fears over nurses' health were allayed. The vaccination provided greatly increased immunity and nurses had first priority for the relatively expensive series of injections. In 1955, only 20 out of 7,043 nurses had tuberculosis, or a mere 0.3 percent.<sup>50</sup> By this stage the advent of chemotherapy drugs had reduced the incidence of tuberculosis, and hope of recovery was greatly increased.

Despite the high rates of infection and great concern throughout the nation in the 1930s and 1940s, the risk of infection for staff at Waipiata Sanatorium was relatively low. Even before the Health Department required it, all staff were given regular chest examinations, x-rays and Mantoux tests. Staff were weighed weekly, and any change meant a chest examination and close supervision. Nurse JM remembers: "They took great care of us, we were examined every week for the slightest sign or check just to see that we were fit and well."<sup>51</sup> As an extra precaution, staff were encouraged to live the fresh air life style. All accommodation was built with sleeping verandas and large windows. Staff ate the same diet as patients, rich in dairy and meat, and took extra care with sterilisation

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<sup>46</sup> Mantoux tests were skin tests that indicated the presence of the tubercle bacillus. A positive reaction did not necessarily mean that the patient had tuberculosis, only that the body had been exposed to the bacillus.

<sup>47</sup> E.R. Bridges, "Tuberculosis in New Zealand Nurses", *New Zealand Nursing Journal* 42, no. 6 (October 1949), 168.

<sup>48</sup> R.S.R. Francis, "Tuberculosis in Nurses", *New Zealand Nursing Journal* 34, no. 2 (February 1941), 40.

<sup>49</sup> Waipiata Sanatorium Committee Meeting Minutes, 25<sup>th</sup> May 1948. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>50</sup> Maclean, 379.

<sup>51</sup> Oral interview with JM.

and cleanliness.<sup>52</sup> In some hospitals and sanatoria, nurses wore gowns, masks and gloves when attending to infectious cases. Waipiata had no such procedure, an absence that caused concern for many inspectors. Kidd was firm in his resolution against these measures: they produced complacency amongst nurses, causing them to neglect vital sterilisation procedures and lose vigilance against the spread of infection. It was better that the nurses took all possible care to protect themselves from infection than that gowns and masks should give nurses a sense of false security. "Masks are a panacea that cause slackening of precautions", Kidd asserted.<sup>53</sup>

Kidd's measures proved more than adequate, as there was almost no infection of staff at Waipiata. The high number of patients who were very early cases and therefore not contagious must also account for the low rate of infection of staff. In the history of the Sanatorium, only one member of staff developed tuberculosis, but the nurse in question had been a patient in Cashmere Sanatorium and her illness is better characterised as a relapse rather than a case of infection.<sup>54</sup> In general staff suffered very little sickness of any kind, a fact that Medical Inspectors regularly noted with surprise and approval.<sup>55</sup>

The Depression meant hardships for everyone from Kidd to the domestic staff. In 1931, the Committee cut all wages by ten percent for those who earned more than 100 pounds a year, and five percent for those who earned less. The staff voluntarily accepted that usual pay increments would also be suspended.<sup>56</sup> Although the voluntary element of this change suggests a degree of cooperation and understanding, it was a time of increased tension amongst staff. In 1933, five nurses complained to Kidd that the Matron

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<sup>52</sup> Report by Dr Arthur Kidd to the Director of Nursing re the employment of ex-patients on the Sanatorium staff. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>53</sup> Chisholm, 41.

<sup>54</sup> Reports of Inspections 1936-1961. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>55</sup> Ibid.

<sup>56</sup> Waipiata Sanatorium Committee Meeting Minutes, 28<sup>th</sup> April 1931. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]



had hired a nurse at 90 pounds rising to 100 after six months. The nurses had willingly given up their increments and they were displeased with the inequality of the situation. Kidd had not been consulted about the employment of the new nurse and considered the nurses had a legitimate grievance. The Committee agreed. The new nurse was to have her increments suspended until such time as they were reinstated for all staff members. The decision was controversial. Committee member Mr Fenton felt that, as the new nurse was a fully registered general nurse, not an aid with a Tuberculosis Certificate, she was a rare and valuable addition to the Sanatorium staff, and therefore deserved the offered increment.<sup>57</sup> In any case, all staff increments were reinstated the very next month, although the initial pay cut of five or ten percent was not restored until 1936.<sup>58</sup>

The Second World War caused further disruption to the Sanatorium. The ever present problem of staff shortages intensified as the war meant that nurses were in demand in all hospitals in New Zealand, and the number of tuberculosis patients increased as servicemen returned with the disease. In 1942 the Sanatorium needed 26 nursing aids, but had only 15. Similarly they needed 16 domestic staff, but were seven short of that number.<sup>59</sup> Inspectors concluded that “The problem of staffing at the present time is so acute that unless some relief is given those at present engaged will break down owing to over work.”<sup>60</sup> The government was not unsympathetic to the Sanatorium’s plight. The Man-Power Officer sent four nurses, and early in 1943 the government established a Civil Nursing Reserve “with a view to supplementing the staff of hospitals during periods of staffing difficulty.”<sup>61</sup> The Health Department collaborated with the Education Department and introduced a course of instruction and lectures on nursing to the

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<sup>57</sup> Waipiata Sanatorium Committee Meeting Minutes, 28<sup>th</sup> March 1933. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>58</sup> Waipiata Sanatorium Committee Meeting Minutes, 25<sup>th</sup> February 1936. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>59</sup> Report of Inspection, 6<sup>th</sup> November 1941. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>60</sup> Ibid.

<sup>61</sup> Waipiata Sanatorium Committee Meeting Minutes, 3<sup>rd</sup> January 1943. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

curriculum of girls in secondary schools for the purpose of stimulating interest in nursing as a career.<sup>62</sup> When the war ended, the Director General of Health advised that “a considerable number of Sisters will be released from the New Zealand Army Nursing Service” and would be directed towards sanatorium work.<sup>63</sup> None of these measures alleviated the situation. In October 1945 the Committee applied to the Department of Health for assistance “otherwise consideration would have to be given to the closing of part of the institution.”<sup>64</sup> By 1946 this had indeed happened.<sup>65</sup> Twenty-five beds were closed, a figure that grew to 30 in 1948, with only 118 out of 148 beds occupied.<sup>66</sup>

The Committee and Kidd implemented two policies to augment the staff. The first measure was introduced to alleviate war time shortages but it continued long after the war had ended. The Committee gave priority to those patients who could bring a relative to work at the Sanatorium for the length of their stay.<sup>67</sup> This solution was so successful that in 1949 patients’ relatives made up between 20 and 30 percent of the staff.<sup>68</sup> The other measure was the employment of current and ex-patients. When patients reached eight hours up, they were employed for four hours a day as a domestic aid or a hospital orderly for a minimum of three months. They were known as “half timers” and were still officially patients, continuing to live by the fresh air regime. Half timers and patients’ relatives were given a “general grounding” in hospital care, and “put on to nothing more

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<sup>62</sup> Waipiata Sanatorium Committee Meeting Minutes, 4<sup>th</sup> January 1945. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>63</sup> Waipiata Sanatorium Committee Meeting Minutes, 25<sup>th</sup> September 1945. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>64</sup> Waipiata Sanatorium Committee Meeting Minutes, 31<sup>st</sup> October 1945. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>65</sup> Waipiata Sanatorium Committee Meeting Minutes, 25<sup>th</sup> June 1946. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>66</sup> Ibid. Waipiata Sanatorium was not alone in this predicament. Pleasant Valley Sanatorium near Dunedin could only take 32 patients although it had provision for 54 because they had only four staff members out of a necessary 12.

<sup>67</sup> Waipiata Sanatorium Committee Meeting Minutes, 30<sup>th</sup> July 1946. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>68</sup> Chisholm, 32.

than routine.”<sup>69</sup> Those who became interested were encouraged to study towards the Tuberculosis Certificate, with a view to joining the staff permanently when their treatment was complete. This involved a two year course of lectures and practical instruction given by the Matron, the Medical Superintendent and his assistant. One patient remembers discussing her plans for the future with Kidd shortly before discharge. At his suggestion she stayed on at Waipiata and undertook the two year tuberculosis training course, which she completed successfully.<sup>70</sup>

The use of patient labour was at times controversial. Manual labour as a form of exercise had turned some sanatoria in the United States and Britain into nothing less than workhouses, where patients were forced to construct sanatorium buildings and work on the farms. Although this was always excused as part of the rehabilitation process, it was almost certainly doing the patients harm.<sup>71</sup> The conditions of these sanatoria were well publicised, and the New Zealand medical profession was anxious to avoid the same kind of scandal here. One of the first experiments into using physical labour as part of the rehabilitation process quickly proved to be inappropriate. In 1908 the Medical Superintendent of Te Waikato Sanatorium put patients to work in a tree planting camp, which he considered appropriate as it involved fresh air and exercise and helped to provide employment for consumptives who were often discriminated against. However, it was unpleasant and isolated work that proved to be degrading as prisoners were also allotted this task.<sup>72</sup> It was not long before the experiment was abandoned. Similarly, in the early years of the Waipiata Sanatorium there was some suggestion that patients might be assigned work on the farm as part of the rehabilitation process.<sup>73</sup> As the controversy heightened over patients being used as free labour to the detriment of their health, this plan was quickly abandoned.

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<sup>69</sup> Ibid.

<sup>70</sup> Oral interview with ‘EH’ quoted in Middleton, 35.

<sup>71</sup> Rothman, 207.

<sup>72</sup> Bryder, “If Preventable, why not Prevented?,” 113.

<sup>73</sup> Waipiata Sanatorium Committee, *Waipiata Sanatorium: A Brief History of a Successful Institution* (Invercargill: Southland Times Print, 1929), 14.

Increased knowledge of the exploitation of sanatorium patients as manual labourers in New Zealand and throughout the world sparked discussion over the merit of patients undertaking any form of sanatorium work. The Director of Nursing accused the Waipiata Sanatorium of poor judgement over their employment of patients and ex-patients: “Ex-patients had to work off their maintenance after being taken on as staff at the Sanatorium, thus leading to an unsatisfactory type being employed.”<sup>74</sup> Despite being definitively wrong (ex-patients did not pay off their maintenance), it challenged Kidd’s principles of sanatorium care. His response was swift and emphatic. “Many of the best nurses are ex-patients, and our poorest nurses have not been ex-patients. The ex-patient knows the tuberculosis subject and the effect of the disease on them, and is more considerate and helpful, thereby helping in restoring them to health. If we do not employ ex-patients, who will? It gives them a chance to consolidate their condition. The nurses’ home and porters’ lodge were built on the fresh air principle for this reason.”<sup>75</sup> Medical inspectors agreed, concluding “it entails careful watching of their health and changes of duty, but for a year after their recovery it would be helpful to themselves and to the institution.”<sup>76</sup> Above all, no-one could disregard the reality that the contribution of patients was absolutely vital for the survival of the institution. As Chisholm summed it up “were it not for the presence on the staff of ex-patients, half timers, male orderlies and patients’ relatives, [the Sanatorium] would probably have to close down.”<sup>77</sup>

Bryder warns against seeing the patients’ habit of staying on at the Sanatorium as a sign of their dedication to the institution. She argues “the number of patients on the staff

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<sup>74</sup> The Director of Nursing quoted in a letter from the Secretary of Waipiata Sanatorium Committee to the Director General of Health, 31<sup>st</sup> January 1933. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>75</sup> Report by Dr Arthur Kidd to the Director of Nursing re the employment of ex-patients on the Sanatorium staff. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>76</sup> Report of Inspection, 12<sup>th</sup> September 1940. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>77</sup> Chisholm, 32.

was not a measure of their commitment to the institution so much as a desire to gain confidence in working ability before leaving the sanatorium, or sometimes the inability to find employment elsewhere.”<sup>78</sup> This is a valid point. Although some patients may have stayed at Waipiata Sanatorium out of a feeling of affection, we cannot necessarily interpret the choice as a dedication to the institution. As Bryder suggests, the choice may also represent practical considerations that made patients willing to join a community that allowed them gain work experience, surrounded by people who understood the complexities of the disease, and free from the stigma and discrimination they might otherwise have suffered. It was not necessarily a sentimental affection that kept them there, but an understanding that this community offered them the best chance of coping with the disease.

Goffman’s assertion that the patients and staff of total institutions were split into distinct and opposing groups is contradicted at Waipiata Sanatorium by the presence of so many patients and ex-patients on the Sanatorium staff. Rather than a “society dangerously split,” patients and staff shared duties, social activities and common goals. Staff did not return to the ‘outside world’, but rather to accommodation on site, or to their beds in the shelters. Interaction was not formally proscribed and there was no social distance between staff and patients, as the two overlapped and interchanged.

The presence of so many patients on the staff also undermines the assertion that staff treated the patients with cold detachment. Bates claims that staff were expected not only to treat patients but also to control them and to establish the discipline that was so essential to healing.<sup>79</sup> Rothman agrees, stating that by the 1920s and 1930s life at sanatoria had become more regulated and actively encouraged distance between staff and patients.<sup>80</sup> Staff in some sanatoria may have kept the formal distance that Goffman considers to be fundamental to the nature of institutional life, but no such detachment

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<sup>78</sup> Linda Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain* (Oxford: Clarendon Press, 1988), 214.

<sup>79</sup> Bates, 201.

<sup>80</sup> Rothman, 227.

existed at Waipiata. This reflects the large proportion of half timers, ex-patients and patients' relatives on the staff whose understanding of the experiences of the patients naturally created an empathy and understanding for the situation. One tubercular nurse reported: "What has the disease taught me? It has taught me the importance of knowledge and sympathy in the nurse who cares for patients suffering with tuberculosis. Life as a patient in a sanatorium is not half so bad as I had imagined. In many ways it teaches a nurse to look at things from a patient's point of view."<sup>81</sup>

The understanding between the patients and staff also reflects the New Zealand medical profession's belief that tuberculosis nursing was not merely a matter of treating the chest, but coping with a wide range of social and psychological problems: "Today we realise it is not enough to treat the lesion only but rather to treat the whole patient...the sister, then, must get to know each patient as an individual. Her understanding of her patients and helping them to adjust to their illness is of great benefit."<sup>82</sup> The Committee expected, and were pleased with, a friendly relationship between the staff and the patients: "mention was made of the evidently happy relationship that existed between patients and staff. Thanks to the Medical Superintendent and Matron for the care and attention shown to all the patients in the institution."<sup>83</sup> The Committee themselves were praised for their attention to the wellbeing of the patients. The 1928 government investigation into sanatoria reported "the personal interest of the Committee in the welfare of patients was striking."<sup>84</sup>

Work at the Sanatorium was undoubtedly hard, as the sheer number of vacant positions doubled the workload of the remaining staff. The frequent references to overwork and the possibility of breakdown by the nurses suggest demands on the staff's

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<sup>81</sup> Natali Allen and Eve Brister, "Nurses with Tuberculosis: A Preliminary Study," *Women's Studies Journal* 5, no.2 (December 1989), 50.

<sup>82</sup> T. Burton, "The Sister of a Chest Block as a Social Worker," *New Zealand Nursing Journal* 44, no. 1 (February 1951), 12.

<sup>83</sup> Waipiata Sanatorium Committee Meeting Minutes, 26<sup>th</sup> January 1938. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>84</sup> "Prevention and Treatment of Pulmonary Tuberculosis in New Zealand", *AJHR*, H-31A, 25.

time that bordered on the unhealthy. Yet nurse JM remembers: “I had a lovely time. I enjoyed every bit of it, even getting up at five o’clock in the morning and ploughing through knee deep snow to get on duty. Everybody did it, and you just accepted it was part of life.”<sup>85</sup> The Committee, quite aware that the work was exhausting, depressing and potentially dangerous, alleviated the unpleasant aspects of working in a sanatorium as much as possible. They took all measures to prevent infection, and provide entertainment options and comfortable living conditions. We cannot therefore, characterise the experiences of the staff as uniformly unpleasant. Nor can we define staff as opposite and contradictory to the patients. Waipiata Sanatorium was not a “society split dangerously,” but a community in which staff were dedicated to alleviating the suffering of tuberculosis patients and providing them with hope for recovery.

A medical inspector in 1940 best summed up the state of staff at Waipiata: “The standard of nursing care is excellent. The atmosphere and general environment of the patients good. Good cooperation of the staff. A loyal and mutual understanding exists on the part of the administrative officers.”<sup>86</sup> Despite the constant shortage of staff, the prevailing atmosphere was one of dedication to quality, understanding and cooperation and a team effort towards a common goal. This goal was to alleviate the suffering of the patients who, faced with a debilitating and potentially fatal disease, had joined the Sanatorium community in the hope of finding a way to cope with their situation. The patients, inseparable in many ways from the staff, nevertheless had their own distinct experiences of sanatorium life, characterised by the same compromise between unpleasant but necessary aspects of sanatorium care and the balance between cure and contentment.

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<sup>85</sup> Oral interview with JM.

<sup>86</sup> Waipiata Sanatorium Committee Meeting Minutes, 31<sup>st</sup> October 1940. [Waipiata Sanatorium-Minutes 1936-1956. Archives New Zealand, ADBZ 16163 H1 22/1]

## CHAPTER TWO

### **Cure and Comfort: A Delicate Balance The Experiences of the Patients**

“What a patient with tuberculosis has in his head is more important than what he has in his chest.”<sup>1</sup>

William Osler, a revered Canadian physician of the nineteenth century, expressed in this statement a belief that became popular amongst those who campaigned against tuberculosis in the twentieth century: “wiser in his day than most, he recognised the great part that the personality, the emotions and the mind play in effecting cure.”<sup>2</sup> Because sanatorium treatment was based around restoring the body’s natural healing powers, it was a long, slow process that required discipline, isolation and considerable patience. It was not enough, therefore, to attend to the tubercular patient’s physical condition at the expense of his or her mental and emotional well being. Accounts of the experiences of patients often focus on the neglect of these aspects as the primary reason for the unpleasant and even harmful nature of sanatorium life. Smith claims that “the patients were bored, easily tired, despondent, strictly non-responsible for themselves, felt ‘TB’ – ‘totally bitched.’”<sup>3</sup> Jones notes that open air treatment in bad weather was not popular, many left the sanatorium early because they could not stand the strict and often unpleasant routine, and the ‘rest cure’ made patients restless and uninterested. The enclosed life of the sanatorium gave rise to a sense of isolation and a feeling of difference from ‘normal’ people. Arching over this, she concludes, was the presence of death.<sup>4</sup> Rothman’s portrayal is perhaps the most grim: “for many sanatorium life represented

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<sup>1</sup> Sir William Osler quoted in E.R. Bridges, “Tuberculosis in New Zealand Nurses,” *The New Zealand Nursing Journal* 42, no. 6 (October 1949), 170.

<sup>2</sup> Ibid.

<sup>3</sup> F.B. Smith, *The Retreat of Tuberculosis 1850-1950* (London: Croom Helm, 1988), 117.

<sup>4</sup> Greta Jones, *‘Captain of all these Men of Death’: The History of Tuberculosis in Nineteenth and Twentieth Century Ireland* (Amsterdam: Rodopi, 2001), 171.



incarceration, or, at worst, a waiting room for death... the experience was humiliating and denigrating, as patients had to give up personal identity and become an inmate.”<sup>5</sup>

The idea of imprisonment and loss of identity is also at the heart of Goffman’s interpretation of patients’ experiences in total institutions. The experience of the inmate, according to Goffman, was characterised by ‘mortification processes’, the means by which inmates were stripped of their individual identities and became members of the institution, and ‘reorganising influences’, the ways in which inmates resisted the institutional process.<sup>6</sup> The experience was therefore one of the struggle for individual freedoms in an institutionalised atmosphere characterised by the unbending structure of routine and strict rules. As an institution, Waipiata Sanatorium necessarily had rules that limited some of the patients’ individual freedoms and these were often resisted or blatantly disregarded by patients. Yet this disregard for the rules seldom represented an attack on the institution or its staff, rather it allowed a release from the frustration and boredom of sanatorium life. Moreover, staff often deliberately overlooked or even aided patients who were breaking rules as they had to tread the fine line between maintaining the order and discipline so necessary to the sanatorium cure, and making an undesirable situation as bearable as possible.

The experiences of the patients at Waipiata were not characterised by the loss of personal identity, boredom, frustration and neglect of patients’ personal well being in the quest for physical recovery. Rather, they were based around the balance that the staff achieved between maintaining the discipline required to fulfil the fresh air regime and alleviating the more unpleasant aspects of sanatorium life. Instead of being an institution in which patients, through ‘mortification’ were stripped of their individuality in order that they may meet the requirements of the institution, Waipiata was a community that

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<sup>5</sup> Sheila Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: BasicBooks, 1994), 227.

<sup>6</sup> Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Chicago: Aldine Pub. Co., 1961), 12-74.

focussed around the needs of the patients; instead of moulding the individual to suit the institution, the community was shaped to suit the individual.

The journey to becoming a patient at the Waipiata Sanatorium began with an examination by Dr Kidd, who visited each contributing district's clinic once every three months to select patients he considered to be suitable for sanatorium care. Kidd and the Sanatorium Committee were absolutely rigid in their dedication to admitting only those who lived within the contributing districts. Letters from patients outside the districts requesting admission were relatively common, but uniformly rejected. Even Dr Valentine, the Director General of Health, could not persuade the Committee to admit a patient from Blenheim.<sup>7</sup> Residency did not guarantee admission: many who lived within the districts did not qualify for sanatorium treatment. A large number of those Kidd examined he declared to have no sign of the disease. Others, although clearly suffering from pulmonary tuberculosis, were considered unsuitable for sanatorium care because they had tuberculosis of the spine or joints or non-tubercular ailments such as diabetes. Those whom Kidd suspected were in the very early stages of the disease were kept under supervision, to be examined again if any further symptoms developed.<sup>8</sup> Only those patients who were classified "early cases suitable for sanatorium care" were placed on the waiting list, and would be contacted when a bed became available.<sup>9</sup> Because the waiting list was often as many as 30 patients, the wait for a bed often extended from weeks into months.

Patients were admitted according to a strict hierarchy of priority. First priority was given to nurses who had caught tuberculosis in the district hospitals. Tuberculosis nurses were in short supply and their quick recovery was of importance to both hospitals and sanatoria alike. High priority was also given to returned servicemen from the First and

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<sup>7</sup> Waipiata Sanatorium Committee Meeting Minutes, 25<sup>th</sup> March 1930. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>8</sup> Waipiata Sanatorium Committee Meeting Minutes, 26<sup>th</sup> April 1939. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>9</sup> Ibid.

Second World Wars, and to those patients who could bring a relative to work as a nurse aid or domestic for the time of their stay. Finally, those who were “poorly adjusted psychologically and living in an unsatisfactory environment” were given priority over others who were considered less of a risk to themselves and society.<sup>10</sup> Regardless of priority, following notification of an available bed, patients had just seven days to arrive at the Sanatorium before the bed was assigned to the next patient on the waiting list,<sup>11</sup> a reasonably short time given that it took two days to get to Waipiata by train from the furthest away centres of Invercargill in the south or Ashburton to the north.

The first weeks at the Sanatorium were widely acknowledged to be the most difficult. Patients were apprehensive in the unfamiliar surroundings, concerned about their jobs, families, and financial situation, and were faced with the prospect of a month of complete bed rest.<sup>12</sup> “The first few days at the sanatorium often seem tedious, almost tiresome. So much time is spent in absolute rest, the sudden turn from the strenuous life seems to bewilder the patient”, noted one long serving nurse.<sup>13</sup> A sometimes unnerving aspect of arrival at the Sanatorium was the presentation of a rule book, “some pamphlets if he [sic] is of sufficient intelligence and instruction on how to look after himself and control his coughing.”<sup>14</sup> Patients had to be dispelled of any misconceptions about sanatorium life and tuberculosis. Chisholm was outraged by “popular literature of a certain type” for misleading portrayals of the sanatorium experience. Betty MacDonald’s account of her time in an American sanatorium caused particular outrage in Chisholm. “Its effect on the lay public is only to be deplored. The removal of these ideas and their substitution by a sane outlook are amongst the first things to be done.”<sup>15</sup> Such a routine was in many ways exactly the kind of mortification process to which Goffman refers, as patients were

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<sup>10</sup> W.E. Chisholm, “Waipiata Sanatorium, Christmas Vacation, 1948-1949” (Preventative Medicine Dissertation, University of Otago, 1949), 38.

<sup>11</sup> Waipiata Sanatorium Committee Meeting Minutes, 27<sup>th</sup> April 1933. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>12</sup> Chisholm, 35.

<sup>13</sup> Author unknown, “Life in a sanatorium,” *Kai tiaki* 11, no. 2 (April 1928), 93-94.

<sup>14</sup> Chisholm, 35.

<sup>15</sup> *Ibid.*

conditioned to cope with the discipline and routine that were necessary, if unpleasant, aspects of the fresh air regime. The experience at Waipiata Sanatorium however, differs from Goffman's description of 'mortification processes' in that staff were aware that the transition to life in an institution was difficult for most patients, and took care to make the change as easy as possible. As Chisholm put it "it is at this time that good handling can make such a difference."<sup>16</sup>

The patients at the Sanatorium were remarkably homogenous: young, white and tubercular. The most significant exception to this was the presence of a small but significant number of Maori patients. Although an almost complete lack of records makes the history of tuberculosis amongst Maori frustratingly vague, it is certain that the disease had a devastating effect on the Maori population. When consistent records began in the 1930s they showed that infection rates amongst Maori were ten times the Pakeha rate.<sup>17</sup> Kidd reported in 1944: "there are some 96,000 Maori in the North Island and five percent of whom are tubercular. That is some 4,800 and the problem of accommodation and treatment seems insurmountable."<sup>18</sup> Despite the obvious need for assistance amongst the Maori population, anti-tuberculosis campaigns were primarily targeted at the Pakeha population and while there was no legal barrier to Maori entering sanatoria, many were excluded by the fact that they did not participate in the public health care system.<sup>19</sup> Maori were also believed to be fatalist and apathetic, and criticised for their reluctance to seek medical attention or to be admitted to hospitals or sanatoria. As Bryder rightly points out, this was probably a reflection of misunderstood cultural differences, and an attempt to

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<sup>16</sup> Ibid.

<sup>17</sup> Athol Wells, "Tuberculosis in New Zealand Maoris," in A.J. Proust, ed. *Tuberculosis in Australia, New Zealand and Papua New Guinea* (Canberra: Brolga Press, 1991), 100.

<sup>18</sup> Report of Dr Arthur Kidd to the National Tuberculosis Conference, 1944. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>19</sup> Derek Dow, *Maori Health and Government Policy 1840-1940* (Wellington: Victoria University Press, 1999), 209-212.

shift the blame away from the inadequate resources and socio-economic circumstances faced by Maori that were more easily ignored than remedied.<sup>20</sup>

Nevertheless, the Sanatorium's records indicate that about ten percent of patients at Waipiata were Maori.<sup>21</sup> Given the relatively small population of Maori in the South Island, this represents a relatively high number of Maori living at the Sanatorium. In Pukeora and Otaki Sanatoria in the central North Island, where Maori populations were much larger, roughly half of the patients were Maori. Although these Maori were the few who participated in publicly run anti-tuberculosis measures, they were still characterised as lacking the will to fight the disease, and the discipline to participate in the sanatorium regime. Wright, a medical student visiting the Otaki Sanatorium in 1948 noted: "The Maoris provide most of the cases of failure to stick to the regulations. Also, there have been some cases amongst the Maoris where money given to the patient to enable her to travel to Otaki was used for other purposes. Some have shown evidence of having broken the alcohol abstinence regulations."<sup>22</sup> SC, in remembering Maori patients at Waipiata Sanatorium, expresses the commonly held belief that Maori lacked the will to fight the disease: "The Maoris, if they got it they would sort of give up the ghost and they didn't fight it and they succumbed much more easily."<sup>23</sup>

In the first ten years of the Sanatorium's life the Committee's commitment to admitting only those cases with a high chance of recovery meant the patients were overwhelmingly young. In 1927, of 80 patients, 64 were between the ages of 10 and 30.

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<sup>20</sup> Linda Bryder "If Preventable, why not Prevented? The New Zealand Response to Tuberculosis 1901-1930," in Linda Bryder, ed., *A Healthy Country: Essays on the Social History of Medicine in New Zealand* (Wellington: Bridget Williams Books, 1991), 125.

<sup>21</sup> Waipiata Sanatorium Committee Secretary's Report Re Bed State, 1961. [Waipiata Sanatorium-Reports of inspections 1936-196. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>22</sup> J.E.W. Eton, "Otaki Sanatorium: A Short Survey" (Preventative Medicine Dissertation, University of Otago, 1952), 11.

<sup>23</sup> Oral interview with SC, a patient at Waipiata Sanatorium 1941-42. November 2005.

Only one patient was over the age of 40.<sup>24</sup> Older patients began to be admitted as the introduction of surgical techniques made more people eligible for sanatorium care. By 1949, 40 percent of the patients were between 30 and 40, and three were older than 50. Just nine were less than 20.<sup>25</sup> By the end of the 1950s, the number of people over 50 rose considerably, as the use of chemotherapy drugs meant that there were significantly fewer patients requiring treatment, and a better chance that elderly patients could be effectively treated. In 1958, with just 43 patients remaining in the Sanatorium, five were over 60 and three were over 70.<sup>26</sup>

Children were admitted throughout the entire period, some as young as four years old, often in relatively high numbers. This inevitably raised the question of education. Kidd's response was clear: the children's first priority was to get well.<sup>27</sup> Any child who was not contagious could take correspondence schooling, but Kidd forbade it for those still on bed rest. This often had serious consequences for the children involved. One teenager was admitted to the Sanatorium having completed one year of high school studying Latin and French. After a year she returned to school but was forced to repeat the year in the less demanding home science regime. Bored and underachieving, she left school. "I never forgave them", she recalls, especially when considering the career options she had missed.<sup>28</sup> The problem of education was one not easily overcome at Waipiata: there were not enough children to warrant a full time teacher, and problems of sterilizing work to be sent to the correspondence school prevented any active cases from schooling.

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<sup>24</sup> Waipiata Sanatorium Committee Secretary's Report Re Bed State, 1927. [Waipiata Sanatorium-Patients 1927-1953. Archives New Zealand, ADBZ 16163 H1 22/11]

<sup>25</sup> Waipiata Sanatorium Committee Secretary's Report Re Bed State, 1949. [Waipiata Sanatorium-Patients 1927-1953. Archives New Zealand, ADBZ 16163 H1 22/11]

<sup>26</sup> This was not simply a case of patients aging in the institution. Although long stays in the Sanatorium were relatively common, they seldom exceeded five years in duration, and cannot account for the significantly increased average age of patients between 1923 and 1961. Waipiata Sanatorium Committee Secretary's Report Re Bed State, 1958. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>27</sup> Chisholm, 36.

<sup>28</sup> Author unknown, "At the San: the Human Cost," *Historical Journal* 20 (2000), 40.

Interruption to education was just one of a raft of concerns that arose throughout New Zealand over children's care in sanatoria. Their removal from family life into predominantly adult communities was of great concern, particularly when recovery was slow and the patients spent the greater part of their childhood in a sanatorium. In response the government built fresh air homes, or 'preventoriums' for 'high risk' children: those who had tubercular family members, or who suffered from malnutrition and poor living conditions. The fresh air homes followed the sanatorium regimen and were intended to boost the children's general health so as to prevent them from succumbing to the disease.<sup>29</sup> The government also opened a children's home for tuberculosis sufferers at Gonville in the North Island, which allowed the children to have the benefits of sanatorium treatment in a community that was suited to their needs.<sup>30</sup>

For all patients at Waipiata, the Sanatorium buildings were home for the months or years of their stay. The buildings were designed in accordance with the principle of fresh air, but with the knowledge that they must also be a comfortable living space for patients. The facilities changed considerably over time, from the modest shelters that provided beds for 55 patients in 1925, to the two brick pavilions that grew to house 152 patients at the height of the Sanatorium in the 1940s. The pavilions consisted of wards with partitioned rooms each accommodating four patients, and were fronted with a veranda. A sitting room for ambulant patients and an examination room were located in the middle of each pavilion. The windows of all rooms were always left open, regardless of weather or temperature, a factor which was a considerable challenge in the difficult climate of Waipiata. Summers were hot and windy, often reaching temperatures well above 30 degrees Celsius. Winters were extremely cold, with fog, frost, and snow.<sup>31</sup> When snow came in the open windows and settled on the patients' beds, patients used umbrellas as an

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<sup>29</sup> Linda Moore, "An Adjunct to a Hospital and a Substitute for One: The Fresh Air Home 1923-1927" (unpublished essay, Canterbury University, 1999), 5.

<sup>30</sup> Eton, 7.

<sup>31</sup> Weather Reports 1929-1939. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

attempt to stop it, and nurses replaced hot water bottles throughout the night as they froze.<sup>32</sup> It was not only the patients who suffered from the cold. One nurse remembers Kidd slipping on a newly mopped and frozen ward floor, resulting in a painful blow to the head and a new rule for the nurses: floors were not to be mopped until after Kidd had finished his rounds.<sup>33</sup>

When a patient reached eight hours up, they were transferred to a shelter, which allowed them to escape the hospital-like atmosphere of the wards and to enjoy the relative privacy and freedom of a single room. Chisholm described the shelters as having “the air of a health camp” and none of the sterilised nature of the wards. Because no infectious cases were allowed in the shelters, ambulant patients could have the comfort of furniture, rugs and personal items that were banned on the wards to stop the spread of infection.<sup>34</sup>

The Diet Pavilion was situated directly between the two dormitory pavilions and it too was built on the open air principle. It contained three dining rooms, one each for the patients, nurses and domestic staff. Three of the Diet’s four walls had open windows, an irresistible attraction to local birds which were a significant menace during meal times. The Diet did more than provide a place to eat: it was an important part of the interaction of the patients, a place to socialise away from the relative solitude of the shelters. The pavilions, shelters, and the Diet represented the boundaries of the patients’ world. Every effort was made to ensure they were as pleasant as possible. “The general impression obtained is one of airiness, cleanliness and the greatest comfort and privacy obtainable under the circumstances” reported Chisholm.<sup>35</sup> But high standards required constant maintenance, and at times facilities became run down and in need of restoration. One inspector criticised: “The women’s day room is very comfortless. The seagrass furniture

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<sup>32</sup> Catherine Beagley, “Dread White Plague: Social Aspects of Tuberculosis in Otago 1900-1930” (BA Hons Dissertation, University of Otago, 1987), 46.

<sup>33</sup> Oral interview with JM, a nurse at Waipiata Sanatorium, 1937-1939. November 2004.

<sup>34</sup> Chisholm, 14.

<sup>35</sup> *Ibid.*, 11.



is now very worn and dilapidated. The room is in need of more comfortable chairs and lounges and wants brightening up very much indeed.”<sup>36</sup> The inspectors were outraged that Dr Byres’ shelters, constructed in 1914, were still in use until the last of them was demolished in 1948, by which stage they were considered negligently out of date and insufficient.<sup>37</sup> Nevertheless, Chisholm’s conclusion is positive: “For the patient, the Sanatorium is home. Small, unimportant things will come to worry him. Will he be satisfied with his surroundings? The answer is yes: as satisfied as he could be anywhere under institutional care.”<sup>38</sup>

Kidd, the Sanatorium Committee, and the Director General of Health frequently discussed the need for occupational therapy. Both the government and the general public feared that years of inactivity would create useless and idle citizens. The Director first suggested that the Committee employ an occupational therapist in 1938, but because of “the lack of accommodation at present and the isolation of the Sanatorium from business centres, the Committee considered it would not be convenient.”<sup>39</sup> The Director asked them to reconsider this decision in 1941, when he sent the names of two suitable candidates, recently graduated and looking for work. The Committee was still concerned about the lack of accommodation, but felt that when the extensions to the nurses’ home were complete they would be able to accommodate an occupational therapist. They went so far as to select their preferred candidate, but for reasons unknown, she was never employed,<sup>40</sup> and the Committee rejected any further recommendations on the matter. Instead the Sanatorium relied on the provision of hobbycrafts to combat the forces of idleness. This was enough to satisfy the inspectors: “There was no organized occupation

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<sup>36</sup> Report of Inspection, 12<sup>th</sup> September 1940. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>37</sup> Chisholm, 11.

<sup>38</sup> *Ibid.*, 19.

<sup>39</sup> Waipiata Sanatorium Committee Meeting Minutes, 28<sup>th</sup> July 1938. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>40</sup> Waipiata Sanatorium Committee Meeting Minutes, 1<sup>st</sup> October 1941. [South Otago Hospital Board – Waipiata Committee 1942-1949. DAHI D336/5a]

but all seemed to work at some hobby when well enough: gardening, glove making, knitting, tapestry, toy making, and all seemed quite contented.”<sup>41</sup>

The question of occupational therapy was fraught in many sanatoria. The Department of Health considered it essential for the rehabilitation of patients, but many physicians did not agree. One medical student disputed the notion that such activities were of real benefit to patients' rehabilitation. Occupational therapy, he claimed, was in fact “diversional therapy”, used for the enjoyment of convalescent patients, but with very little relevance to patients hoping to return to the workforce. Kidd shared similar views. In a report to the national tuberculosis conference in 1944 he stated “one very debatable question is the rehabilitation and general education of the sanatorium patient. A few of us are of the opinion that we are in danger of forgetting that the sanatorium is for the cure of the patient and that it is better for the patient to regain his health before attempting to teach him a new trade or profession.”<sup>42</sup> His attitude toward rehabilitation is a possible explanation for the lack of an occupational therapist at Waipiata.

Because one of the symptoms of tuberculosis was rapid and severe weight loss (hence the popular term “consumption”), the diet provided at Waipiata Sanatorium was intended to be fattening, and was high in meat and dairy products, most of which came from the Sanatorium farm.<sup>43</sup> The diet is recalled by many with distaste. Patients particularly disliked the endless supply of rice, sago and tapioca puddings and the “ghastly cocoa” that was a compulsory daily requirement.<sup>44</sup> The Sanatorium even came under attack for over-feeding their patients. The Director General of Health complained to the Committee that “a number of patients at the Sanatorium were carrying too much flesh for their own

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<sup>41</sup> Report of Inspection, 22<sup>nd</sup> October 1948. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>42</sup> Report from Dr Arthur Kidd to the National Tuberculosis Conference, 1944. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>43</sup> Chisholm, 25-28.

<sup>44</sup> Oral interview with SC.

good.”<sup>45</sup> The Committee denied the claim and felt that Kidd’s aim of discharging patients half a stone heavier than their normal weight protected patients from emaciation in the case of a relapse.<sup>46</sup> Chisholm was positive about the food: “Meals served at the Sanatorium are good. They are simple and of high quality. No caloric or other dietary requirements are worked out but a balanced fare provided, and the Matron and Sisters watch to see that everyone is eating sufficient.”<sup>47</sup> In many cases, especially during the Depression, the Sanatorium provided far more, both in quality and quantity, than patients could have provided for themselves at home.

The Sanatorium treatment necessitated a high degree of discipline and regulation. Every aspect of the patients’ lives was governed by the rules and the daily routine. All patients were woken at five-thirty to take their temperatures; washing took place from seven to eight o’clock, when breakfast was served. Kidd made his rounds at ten and rest hours were between eleven and noon, and four and five in the afternoon, during which time all patients had to be lying down; no talking, reading or listening to radios was permitted. The day ended with lights out at nine o’clock.<sup>48</sup> Activity at other times depended on how many hours ‘up’ a patient was allowed. When the Sanatorium first opened, patients were given graduated exercise in the form of walking, but as the staff shortage became acute, patients were employed as nursing or domestic aids as part of the rehabilitation process. The strict daily routine and regulated progression from bed rest to graduated exercise are aspects of sanatorium life that fit very closely to Goffman’s definition of institutional life. His description of a “formally administered round of life”, in which each phase of daily activity is proscribed and uniform, and all of the day activities are routinely scheduled,<sup>49</sup> bears considerable resemblance to the discipline and

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<sup>45</sup> Dr T. Valintine quoted in a letter from the Secretary of the Waipiata Sanatorium Committee to Dr T. Valinitine, 18<sup>th</sup> March 1927. [Diseases-Tuberculosis-Otago Sanatorium. 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>46</sup> Letter from the Secretary of the Waipiata Sanatorium Committee to Dr T. Valinitine, 18<sup>th</sup> March 1927. [Diseases-Tuberculosis-Otago Sanatorium, 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>47</sup> Chisholm, 28.

<sup>48</sup> Ibid., 36.

<sup>49</sup> Goffman, xiii.

daily routine required for sanatorium treatment. While many of Goffman's tenets are misleading when considering Sanatorium life, it is in this respect that his description can be applied to the situation at Waipiata.

The regimen and discipline were often hard to enforce. Despite repeated claims that discipline was a fundamental part of the treatment and that without it hope of a cure was greatly diminished, bored and frustrated patients often broke the rules. Chisholm noted that "the placid of temperament make the best patients and others must be watched for fretting."<sup>50</sup> SC remembers breaking one of the most strict rules: the observance of rest time. "Rest times, when we weren't supposed to read, I must admit I did."<sup>51</sup> She was not alone. Chisholm noted that "the regime of complete rest is abused, especially with such short staffing."<sup>52</sup> SC also remembers "We used to go for walks. We weren't supposed to do that either, but a few of us, we'd pack some sandwiches, kid round the house maids to give us something to eat and go out to get sort of away from it."<sup>53</sup> This provided a valuable release from the monotony of the Sanatorium life, although it was directly in breach of two rules: no eating outside of meal times, and no unauthorised exercise.<sup>54</sup>

Staff often allowed such relatively harmless rule breaking in order to alleviate the more dangerous aspects of frustration with the treatment. One nurse remembers: "Some of the men used to get very impatient and sick of the life that they were leading there, which wasn't very good for them and they were not fit enough for work and they used to break things. They would send a locker flying along the ward and crash against the wall, anything like that to vent their temper."<sup>55</sup> SC also recalls those who did not cope with the experience: "It was a pretty lonely, cut off life. You had to be cut out for it...there were some people who went strange."<sup>56</sup> Sometimes staff themselves broke the rules, ignoring

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<sup>50</sup> Chisholm, 36.

<sup>51</sup> Oral interview with SC.

<sup>52</sup> Chisholm, 36.

<sup>53</sup> Oral interview with SC.

<sup>54</sup> Chisholm, 52.

<sup>55</sup> Oral interview with JM.

<sup>56</sup> Oral interview with SC.

the regime for the sake of compassion. One nurse remembers that she and the other nurses would take the youngest patient, a boy of four, into the nurses' sitting room, and read him a story in front of the fire. She knew this was "strictly against orders but did it just the same."<sup>57</sup> Rules about smoking, which was never banned outright but restricted to half an hour after meals, were relaxed in the 1940s because of the high number of returned servicemen in the Sanatorium.<sup>58</sup>

The Committee was well aware that Sanatorium life and the fresh air regime could create boredom, restlessness and a tendency to break the rules. They made every effort to alleviate these factors by providing suitable entertainment for patients. For those on complete bed rest, the only diversion was the view of the Maniototo Plains and the Rock and Pillar Ranges. Some patients said the beauty of the view was the only thing that kept them going, although, perhaps more honestly, one woman said that if she had to look at those hills again she would scream.<sup>59</sup> Once patients gained time 'up' and access to the sitting room, activities extended greatly. They could play cards, write letters, and read. They met new people, could move about, visit the canteen and dine in the Diet.<sup>60</sup> A library was provided for ambulant patients, but SC remembers the selection as poor, and the Matron often brought the Committee's attention to the need to augment the library.<sup>61</sup> The Committee proposed a wireless radio system in 1932, but Kidd refused to allow a radio to be installed until they had sufficient money for headsets for the bed patients, claiming the loudspeaker system would simply disturb those patients whose first priority was rest. It was not until 1948, 16 years after it was first suggested, that a radio loudspeaker and headsets for bed patients were finally installed.<sup>62</sup>

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<sup>57</sup> Oral interview with JM.

<sup>58</sup> Chisholm, 35-36.

<sup>59</sup> *Ibid.*, 8.

<sup>60</sup> *Ibid.*, 37.

<sup>61</sup> Waipiata Sanatorium Committee Meeting Minutes, 25<sup>th</sup> January 1933. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>62</sup> Waipiata Sanatorium Committee Meeting Minutes, 28<sup>th</sup> January 1948. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

Further activities were provided for those with eight or more hours up. Two pianos, one for the patients and one for the staff, were provided by donations from the Committee members and the Associated Health Boards.<sup>63</sup> One generous member also purchased a billiards table for those up for ten hours.<sup>64</sup> In 1930, the Committee installed a croquet pitch and set for use by ambulant patients,<sup>65</sup> and a bowling green soon followed.<sup>66</sup> In 1947 the Committee purchased a film projector,<sup>67</sup> and films were brought up to the Sanatorium from the nearby Waipiata township and played in the Diet Pavilion.<sup>68</sup> Visiting concert parties and bands came up on Sundays.<sup>69</sup> The use of the Diet for these activities was sufficient, but it was not ideal. The Committee made repeated requests to the Health Department for permission to build a social hall for the entertainment of both the staff and patients. The Department was resolute: a social hall was an unnecessary extravagance. In 1947 the Joint Council of St John and the Red Cross of Wellington offered to contribute to the construction of a social hall, because “of the scarcity of any building suitable to be used as a recreation centre.”<sup>70</sup> The Committee received the offer with thanks, but without the support of the Department no such facility was possible.

A Patients' Social Committee was responsible for organising activities and caring for leisure equipment, and had at its disposal a Social Activities Fund. The main event for the Social Committee was an annual concert, to which members of the Sanatorium

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<sup>63</sup> Waipiata Sanatorium Committee Meeting Minutes, 27<sup>th</sup> January 1925. [Waipiata Sanatorium-Committee. 1924-1957. Archives New Zealand, ADBZ 16163 H1 22/4]

<sup>64</sup> Ibid.

<sup>65</sup> Waipiata Sanatorium Committee Meeting Minutes, 24<sup>th</sup> September 1930. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>66</sup> Waipiata Sanatorium Committee Meeting Minutes, 31<sup>st</sup> August 1937. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>67</sup> Waipiata Sanatorium Committee Meeting Minutes, 25<sup>th</sup> March 1947. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>68</sup> Oral interview with SC.

<sup>69</sup> Chisholm, 38.

<sup>70</sup> Waipiata Sanatorium Committee Meeting Minutes, 29<sup>th</sup> October 1947. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

Committee, staff, patients' relatives and residents of Waipiata township were invited.<sup>71</sup> One patient remembers: "We put on a concert. It was quite a good concert too, I remember. Every year the patients who were up used to put it on. They'd have it in the Diet, they'd erect a stage and people would come from all around, from Waipiata, people who weren't patients would come to it, and then we'd put it on both dormitories so that the sick patients could see it."<sup>72</sup> The Social Committee also organised an annual magazine, *The Tatler*, with contributions from both staff and patients. The writing, collection and collating of the magazine provided as much diversion as reading and discussing it did. The Social Committee was responsible for organising farewell celebrations for long serving staff members, and Christmas presents, decorations and activities were an annual part of sanatorium life organised by the Social Committee.

Goffman identifies concerts, magazines, parties, and Christmas celebrations as 'institutional ceremonies', meant to bring staff and patients together and facilitate understanding between two separate and opposing groups.<sup>73</sup> Staff only participated because they were required to, and patients because they were less restricted at these functions than at other times.<sup>74</sup> He concludes that this was often a futile effort; any understanding between the two groups was soon eroded as the daily institutional routine re-established the distinctions between the groups.<sup>75</sup> The presence of such 'ceremonies' at the Sanatorium would seem to be evidence that Goffman's description of the total institution is applicable to Waipiata. Certainly these activities reflect the reality of institutional life in that they were easily organised, involved large numbers of people and provided relatively inexpensive and well controlled entertainment and excitement. But the nature of these activities, and their purposes, do not conform to Goffman's divided and hostile depiction of institutional life. Both staff and patients participated in these

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<sup>71</sup> Waipiata Sanatorium Committee Meeting Minutes, 27<sup>th</sup> June 1933. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>72</sup> Oral interview with SC.

<sup>73</sup> Goffman, 94.

<sup>74</sup> *Ibid.*, 110.

<sup>75</sup> *Ibid.*, 112.

'ceremonies' at Waipiata Sanatorium, but as no rigid divide existed between the two groups, the purpose of the activities was not one of reconciliation. Instead, the function of social activities at Waipiata was to break the monotony of Sanatorium life for both patients and staff. Staff were not compelled to participate in the activities and the patients gained no significant 'freedoms' at these events. Organised by and for patients and staff, they were, as Bryder puts it, "making sanatorium life more endurable."<sup>76</sup>

The most ordinary activities provided the most entertainment. Talking was popular, although discouraged for those on complete rest. For the sake of peace and the comfort of the patients, nurses took care to put people together who would complement each other. While infectious cases were always kept separate "they endeavoured to have people of like interests together."<sup>77</sup> This was especially appreciated by the women patients who "tended to gossip more than anything."<sup>78</sup> Compatibility of bed neighbours was of great concern in most sanatoria: "In a general hospital this may not be of importance but in a sanatorium, when a man's companions for the most part consist of his bed neighbours, it has very real importance. Care must be taken to ensure the compatibility of bed neighbours and shack companions. Age, intelligence, interests, habits, and stage of disease should all be taken into account. Wherever necessary, changes should be made so that incompatibles living together are not found."<sup>79</sup>

Two things did more than anything else to revive the patients' spirits: home leave and visitors. However, they were often hard to facilitate. The isolation of the area and lack of affordable boarding accommodation had a considerable impact on visitor numbers, to the point where it caused tension between patients, staff and residents of Waipiata township. The issue first arose in 1934 when the Committee officially forbade employees with

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<sup>76</sup> Linda Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain* (Oxford: Clarendon Press, 1988), 212.

<sup>77</sup> Chisholm, 36.

<sup>78</sup> *Ibid.*, 37.

<sup>79</sup> D.G.R. Wright, "Pukeora Sanatorium: A Public Health Survey" (Preventative Medicine Dissertation, University of Otago, 1948), 98.



private houses from keeping paying boarders, after complaints from hoteliers and boarding house owners in Waipiata township: “staff were taking in paying guests which [the Chairman] considered was hardly fair to those who had their living to make at this occupation, the employees having advantages in the way of cheap housing and supply of provisions which gave them an advantage over regular boarding house keepers.”<sup>80</sup> The patients, who relied on boarding accommodation on site for their visitors, petitioned the Chairman to reverse this decision. Although the Chairman sympathised with the patients, he officially refused to change this rule. Instead, he turned a blind eye to its continued occurrence, thus having been seen to address the hoteliers’ complaints but without causing any inconvenience to the patients.<sup>81</sup> The issue was raised again in 1945 when the owner of the Waipiata Hotel complained about two of the Committee’s employees taking boarders. The Chairman decided that the Committee’s resolution passed in 1934 prohibiting the keeping of boarders by Sanatorium employees would, from that date, be enforced.<sup>82</sup> Whether he kept his word this time is unknown.

Even with the illicit accommodation, the costs and length of the journey meant that visitors were the exception rather than the rule.<sup>83</sup> One 17 year old patient’s mother visited her only once during her 14 month stay at the Sanatorium: “it was during the war and we were right up in the back blocks and it was hard to get petrol to travel. You were allowed visitors though, although there weren’t actually, when I come to think of it, they weren’t very common.”<sup>84</sup> As with all aspects of Sanatorium life, there were rules about visitors. Officially, no visiting was allowed during rest hours, all visitors had to leave at 8pm sharp and permission from the Matron was required to visit anyone on bed rest.<sup>85</sup> But the staff were well aware of the difficulties that visiting in such a remote area posed, and of

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<sup>80</sup> Waipiata Sanatorium Committee Meeting Minutes, 30<sup>th</sup> November 1934. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>81</sup> Ibid.

<sup>82</sup> Waipiata Sanatorium Committee Meeting Minutes, 31<sup>st</sup> October 1945 [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>83</sup> Beagley, 46.

<sup>84</sup> Oral interview with SC.

<sup>85</sup> Chisholm, 53.

the importance of visitors to the mindset of the patients. Like so many “strict rules” at the Sanatorium, visiting rules were often relaxed or ignored.<sup>86</sup>

Leave provided the only other possibility for patients to see their families. Two weeks of leave were granted to all patients at Christmas time, provided they were not contagious and could be trusted to maintain the discipline of the regimen when returned to their ‘normal’ lives. The Sanatorium Committee sometimes went to great lengths to secure leave for those they felt were responsible enough to benefit from it. In 1930, the Secretary requested railway passes for a group of 25 patients who “would be of no danger to the public and would not be in any way impaired but rather benefited by the change home for a few days” but were in “very poor circumstances with practically no means” and could not afford the railway fare home.<sup>87</sup> Leave at any time other than Christmas had to be requested from the Matron, who sought permission from Kidd on the patient’s behalf. There was a general fear that patients would forget the discipline they had learned at the Sanatorium: “Patients under treatment sometimes when granted holiday leave foolishly undid the value of their previous treatment.”<sup>88</sup> As a result, leave was always a serious consideration, and Kidd granted it only when it would not be to the detriment of the cure.

There is one area of patient need that seems to have been overlooked at the Sanatorium. Unlike sanatoria elsewhere in the world and in New Zealand, Waipiata provided no formal religious or spiritual care. Pukeora Sanatorium, for example, had a chapel which was shared between visiting Anglican, Methodist, Presbyterian and “Maori” ministers, so that ambulant patients could attend a church service of their choice. In addition, ministers visited twice a week to attend to the religious needs of bed

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<sup>86</sup> Ibid., 38.

<sup>87</sup> Waipiata Sanatorium Committee Meeting Minutes, 1930. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

<sup>88</sup> Waipiata Sanatorium Committee Meeting Minutes, 30<sup>th</sup> May 1933. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

patients.<sup>89</sup> Although the Waipiata Sanatorium Committee had a Chapel Fund, it never requested funding or permission from the Department of Health to build one. It was not until the institution was taken over by the Department of Justice and converted into a borstal that a chapel was built on site.<sup>90</sup> It is possible that ministers from Waipiata township visited the Sanatorium, and that the Diet Pavilion was used for religious services, but neither the Sanatorium Committee, Health Department inspectors, nor Chisholm mentioned the provision of religious care or the need for it.

Although a 'medical facility', there was almost no medication given at the Sanatorium before the end of World War Two. The one notable exception to this was the use of tuberculin treatment.<sup>91</sup> It had been popular in the 1890s, but had been dismissed as useless by the 1920s.<sup>92</sup> Its use at the Waipiata Sanatorium in the 1940s is therefore astonishing. Kidd received some criticism for his continued use of the treatment, not only because of its ineffectiveness, but also because it extended a patient's stay, a serious consideration given the huge public cost of sanatorium care, and the constant waiting lists that were a feature of Sanatorium life.<sup>93</sup> One patient recalls receiving the tuberculin treatment at the astoundingly late date of 1942. When she was admitted, she was started on a course of injections which was to last for nine months, and, she believed, would immunise her for thirty years. "They would start you with a very mild dose and then you would build up to one cc which we always used to joke stood for 'one cured consumptive'." In her case, the controversy over extended stay was very relevant. While

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<sup>89</sup> Wright, 115.

<sup>90</sup> Kim Dungey, "Facelife in Waipiata," *Otago Daily Times* (January 26<sup>th</sup> 2003), 17.

<sup>91</sup> Tuberculin treatment was invented in the nineteenth century by Dr Robert Koch, who had first identified the tubercle bacillus that allowed him to classify tuberculosis as an infectious disease. Koch developed a vaccine of dead tubercle bacilli, to be given as a series of injections in order to create a resistance to the disease. It initially seemed to have promising results in animals, but tests on humans very soon proved it to be entirely without benefit. Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis 1876 – 1939* (Philadelphia: University of Pennsylvania Press, 1992), 37-8.

<sup>92</sup> Bryder, "If Preventable, why not Prevented?," 118.

<sup>93</sup> Kim Middleton, "The Establishment of Sanatoria in Otago, 1890 – 1928" (Post Grad Dip Dissertation, University of Otago, 1998), 36.

on the treatment she caught a cold, and had to cease the treatment until her temperature had returned to normal. This interruption meant she had to start the treatment again, skipping every second dose until she reached her previous dosage. Thus a nine month stay became a 14 month stay.<sup>94</sup>

This length of stay was longer than average, but by no means unusual. Chisholm gives the average length of stay for a patient at Waipiata in 1948 as 152.7 days, or around five months.<sup>95</sup> This statistic belies the reality that many patients stayed for more than a year, and some stayed more than five. In 1932, out of 110 patients at the Sanatorium, 25 had been at the Sanatorium for more than one year, and eight for more than two years.<sup>96</sup> By 1950 these figures had risen considerably. Out of 83 patients, 29 had been in the Sanatorium for more than one year, 12 for between two and five years, and six patients had been there for more than five years, including one man, who had been in the Sanatorium for eight years.<sup>97</sup> The 1938 Social Security Act may have affected the length of stay. The Act gave a benefit to anyone over the age of 16 who had lived in New Zealand for more than one year, and who, through injury or illness, suffered loss of income. This allowed breadwinners to continue to support their families while in the Sanatorium, and therefore allowed them to stay longer without the worry of destitution. The extended length of stay also reflects Kidd's convictions about Sanatorium care. He vigorously resisted allowing discharge before treatment was complete. When the Wallace Hospital Board requested the discharge of three of its patients as they could no longer afford to pay for their care, Kidd and the Committee refused on the grounds that it made neither economic sense nor was it ethically sound to discharge patients before their treatment was finished.<sup>98</sup> To Kidd early release meant nothing but relapse. An extended

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<sup>94</sup> Oral interview with SC.

<sup>95</sup> Chisholm, 31.

<sup>96</sup> Report of the Medical Superintendent to the Waipiata Sanatorium Committee Meeting Minutes, 27<sup>th</sup> April 1933. [Waipiata Sanatorium-Patients 1927-1953. Archives New Zealand, ADBZ 16163 H1 22/11]

<sup>97</sup> Report of the Medical Superintendent to the Waipiata Sanatorium Committee Meeting Minutes, 31<sup>st</sup> March 1950. [Waipiata Sanatorium-Patients 1927-1953. Archives New Zealand, ADBZ 16163 H1 22/11]

<sup>98</sup> Waipiata Sanatorium Committee Meeting Minutes, 30<sup>th</sup> June 1931. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

sanatorium stay that guaranteed permanent recovery was preferable to a short stay followed by recurrent ill health.<sup>99</sup>

The development of surgical techniques between the 1920s and the 1940s allowed some patients to reduce the length of their stay. The most common of these techniques was the artificial pneumothorax (APT). During this procedure, a needle was inserted between the ribs, pushing air into the pleural cavity, causing the lung to collapse. This allowed the lung to 'rest', and gave the body's natural healing processes a chance to contain the disease. While one lung was resting, the patient could continue to live a normal if slightly restricted life. Several other techniques involved collapsing the lung, including phrenic crush, in which the nerve that controlled the diaphragm was paralysed, and thoracoplasty, the removal of one or more ribs to facilitate collapse. More extensive surgeries removed the affected portion of the lung, or, in severe cases, an entire lung. Collapse therapy was not without dangers nor was it always successful, and like the sanatorium regime, its medical worth has come under scrutiny following the advent of chemotherapy drugs. Even at the time, the risks involved were widely recognised: "The management of an APT is not easy. The mere routine of giving refills carries a measurable risk of lung puncture, even in experienced hands, and is often far too lightly undertaken by those not experienced."<sup>100</sup> When to terminate the procedure was an equally difficult decision, given that it could not be restarted. As one whimsical doctor put it, "Like a love affair, [APT] is easy to start, difficult to bring to a satisfactory conclusion."<sup>101</sup> More invasive surgeries posed even greater risks: the removal of ribs or portions of the lung could result in infection and death.

Given the risks, it is not surprising that Kidd took a cautious approach to collapse therapy. He was reluctant to perform APT, and he was vehemently opposed to the more invasive surgeries: "In my mind it is an admission of failure that we have to subject a

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<sup>99</sup> Chisholm, 39.

<sup>100</sup> Brian Thompson, "Collapse Therapy in Pulmonary Tuberculosis: A Contemporary View," *New Zealand Medical Journal* 47, no. 262 (December 1948), 581.

<sup>101</sup> *Ibid*, 582.

patient to such a mutilating operation as the removal of all the ribs of one side.”<sup>102</sup> Only artificial pneumothorax was carried out at the Sanatorium.<sup>103</sup> Any patient Kidd considered suitable for other surgical techniques was granted leave to go to Ranfurly or Dunedin hospital for the procedure, and was readmitted after they had recovered from the surgery. Chisholm was slightly critical of Kidd’s reluctance to recommend patients for surgery. “Surgery is postponed if possible” he complained, and “operations are undertaken only if unavoidable.”<sup>104</sup> Again, this criticism is directed at the length of stay of patients at the Sanatorium, as surgical treatment allowed patients up sooner and discharged sooner. According to Chisholm, patients were up much earlier in Wakari Hospital in Dunedin and Cashmere Hills Sanatorium in Christchurch. “If anything Waipiata tends to be too conservative”, Chisholm concluded.<sup>105</sup>

It was not until the 1950s that new chemotherapy drugs were widely available in New Zealand, and even then their importance was not always recognised. While the government watched the drug trials overseas with interest, they chose to continue their prevention based anti-tuberculosis campaign until the benefit of the drugs was proven. The first drug to be released, streptomycin, was used only infrequently, and the government recommended that if a patient was seen to be recovering under the sanatorium regime, they should not be given the drug. Streptomycin was to be a last resort only.<sup>106</sup> The initial lukewarm response seems a little surprising given that the chemotherapy drugs eventually reduced numbers of tuberculosis sufferers to almost none. However, streptomycin had severe side effects in some patients, including vomiting, blindness and painful skin conditions. As the *British Medical Journal* reported in 1946: “there seems to be a very real risk that even if the infection is controlled, the patient will

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<sup>102</sup> Report from Dr Arthur Kidd to the National Tuberculosis Conference, 1944. [South Otago Hospital Board – Waipiata Committee 1942-1949. DAHI D336/5a]

<sup>103</sup> Chisholm, 38.

<sup>104</sup> *Ibid.*, 39.

<sup>105</sup> *Ibid.*

<sup>106</sup> April McDonald, “A Chemotherapy Revolution? Tuberculosis in New Zealand 1940-1960” (BA Hons Dissertation, University of Otago, 2000), 26.

usually be left mutually deficient, deaf, blind or otherwise a hopeless invalid.”<sup>107</sup> The limited use of chemotherapy was also related to its restrictively high cost. Streptomycin cost five times as much as penicillin, and required large doses over long periods. Therefore, before it was of proven value, it was used only sparingly. Moreover this was not the first time a ‘miracle cure’ had promised the end of tuberculosis forever, and for some time it seemed the natural resistance of the tubercle bacillus would render streptomycin useless.<sup>108</sup> It was not until the development of the new drugs Para-aminosalicylic acid (PAS) and Isoniazid and their use in conjunction with one another that it became apparent that chemotherapy was effective.<sup>109</sup> Its use at the Waipiata Sanatorium in the 1950s saw the average length of stay drop considerably, and numbers in the Sanatorium plummet.

The last procedure for a patient at the Sanatorium was discharge. At this time Kidd detailed to patients the nature of their condition, and gave instructions on how they must alter their home lives to deal with their condition and what precautions they should take to avoid relapse. Because of the frequency of recurrence of tuberculosis, patients were discharged ‘disease arrested’ rather than cured. A patient was declared ‘arrested’ if they had negative sputum over a long period, an x-ray showed that fibrosis had formed around the infected area of the lung, they had no cough, their weight was increasing or stable at a good level and their blood showed no inconsistencies.<sup>110</sup> For a minimum of five years after patients had been discharged they had to report for examination at their district tuberculosis clinic. If they showed no signs of the disease throughout that period they were considered cured, and their names deleted from the national tuberculosis register. If not, visits had to continue until five consecutive years without signs of the disease had

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<sup>107</sup> Ibid., 28.

<sup>108</sup> Ibid., 29.

<sup>109</sup> Ibid., 32.

<sup>110</sup> Chisholm, 40.

passed.<sup>111</sup> Around four percent of those discharged 'arrested' went on to relapse and about one percent died within five years of leaving the Sanatorium.<sup>112</sup>

More than 80 percent of patients were discharged 'disease arrested' from Waipiata Sanatorium. Others were discharged 'disease quiescent,' which meant that while they did not meet all of the requirements to be pronounced 'arrested', they were considered to be in sufficient health to allow them to return to their normal lives. Others were discharged 'improved' or 'unchanged.' Unchanged was merely a euphemism for those for whom sanatorium life had been of no benefit, and very often these patients were simply being sent home to die. Finally there were those who were discharged deceased. Because of the Committee's commitment to admitting only early cases, very few patients died at the Sanatorium. Of over 5000 patients treated between 1923 and 1961, only 61 are recorded as having died at the Sanatorium.<sup>113</sup> Rothman's claim that sanatoria were little more than waiting rooms for death can therefore be denied in the case of Waipiata. Although the possibility of death must have been apparent to all tuberculosis patients, the Waipiata Sanatorium offered hope of recovery far more than it created fear of death.

The range of experiences of Sanatorium patients varied according to the severity of the case, the length of stay, the disposition of the patient and the family responsibilities they had left behind. For some patients, the discipline of complete rest was frustrating and removal from family and friends was unbearable. Beagley quotes an oral interview that recalls an instance of suicide at the Sanatorium,<sup>114</sup> and Maud McLay remembers that one man, after 17 years in the Sanatorium, committed suicide to free his wife from

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<sup>111</sup> Frank Maclean, *A Challenge for Health: A History of Public Health in New Zealand* (Wellington: Government Print, 1964), 374.

<sup>112</sup> Reports of the Medical Superintendent to the Waipiata Sanatorium Committee, 1930-1961. [Waipiata Sanatorium-Reports of inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>113</sup> Deaths at the Sanatorium were reported monthly in the Medical Superintendent's Report to the Committee. The last reported death was in the Waipiata Sanatorium Committee Meeting Minutes, 30<sup>th</sup> August 1955. [Waipiata Sanatorium-Minutes 1936-1956. Archives New Zealand, ADBZ 16163 H1 22/1]

<sup>114</sup> Beagley, 45.



having to visit from South Canterbury.<sup>115</sup> Whether these two anecdotes are the same event, or if they represent two separate instances, they reflect the horrific nature of the disease that could leave sufferers invalided for decades, unable to live a 'normal' life.

Not all who experienced Sanatorium life paint such a negative picture. As Linda Moore concludes, "despite the nature of the disease, other evidence suggests that the actual experience of sanatorium life was not so bad."<sup>116</sup> Certainly the Sanatorium Committee believed the patients to be perfectly contented: "it would be hard to find a happier looking lot of men and women than those at Waipiata. A band of happy holiday makers is the impression they create and after all there are many worse places than Central Otago to spend a holiday".<sup>117</sup> While this is a biased view written to promote the Sanatorium to the medical profession and general public, there are others who supported the idea that Sanatorium life was not as uniformly unpleasant as it is often portrayed. Some look back on their sanatorium days as an opportunity to broaden their horizons and have experiences that would have otherwise been denied them. "The days always seemed to be full, and I certainly don't have any recollections of deep unhappiness or loneliness," remembered one woman.<sup>118</sup> SC learnt how to interact with other people, and how to cope with unpleasant situations. It was at the Sanatorium that she gained independence and confidence that she applied to her life when she returned, 'disease arrested', to Invercargill: "I always said it was my finishing school. I learnt more there, I think, than I learnt anywhere else."<sup>119</sup> The Sanatorium inspectors were uniformly positive. "All were

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<sup>115</sup> Maud McLay, "Orangapai Sanatorium" in Jim Sullivan, ed., *As I Remember: Stories from 'Sounds Historical'* (Auckland: Tandem Press, 1999), 80.

<sup>116</sup> Moore, 23.

<sup>117</sup> Waipiata Sanatorium Committee, *Waipiata Sanatorium: A Brief History of a Successful Institution* (Southland Times Print, 1929), 13.

<sup>118</sup> Author unknown, "At the San: the Human Cost," *Historical Journal* 23 (2000), 40-41.

<sup>119</sup> Oral interview with SC.

comfortable and contented and in good spirits” noted one inspector.<sup>120</sup> “All were happy and interested in their work” reported another.<sup>121</sup>

Patients’ experiences cannot therefore, be dismissed as uniformly unpleasant. While aspects of the fresh air regime were undeniably frustrating, the Waipiata Sanatorium was a community for those whose lives had been disrupted by tuberculosis. It provided rest, nutrition and freedom from responsibility as well as the hope for a cure in an atmosphere that was free from the stigma from which many patients suffered in their home towns. It provided contact with other patients who understood their situation and staff who worked hard to provide the best possible chance for recovery, with as much attention to the comfort and needs of the patients as the regimen would allow.

While many of Goffman’s characteristics of patients’ experiences in total institutions may seem to be present at Waipiata Sanatorium, a closer inspection of their nature reveals that the comparison is misleading. What appear to be ‘mortification processes’, ‘reorganising influences’ and ‘ceremonial institutions’ were altered at Waipiata Sanatorium by the unity of the staff and patients who were cooperative members of the same community. The staff overlooked Sanatorium rules, provided entertainment and made every effort to promote recovery without removing individual identities or dehumanising patients. Patients were treated with an understanding that healing the body should not come at the expense of making life unbearable. Waipiata Sanatorium shows a different experience of institutional life to that of Goffman’s coercive and regimented total institution: it was a community delicately balanced between the discipline needed for the cure and the comforts required to make Sanatorium life as pleasant as possible.

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<sup>120</sup> Report of Inspection, 6<sup>th</sup> November 1941. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>121</sup> Report of Inspection, 24<sup>th</sup> August 1943. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

## CHAPTER THREE

### **Orangapai, the Hill of Health**

#### **A Community of Sufferers and Sufferers in the Community**

“The total institution is a social hybrid, part residential community, part formal organisation; therein lies its interest.”<sup>1</sup>

Goffman’s comparison between the residential community and the formal organisation is of particular relevance to an institution such as Waipiata Sanatorium, in which patients lived for months if not years in the hope that the regimen would return them to health. Goffman, however, characterises the relationship between residential community and formal organisation as creating “forcing houses for changing persons; each is a natural experiment on what can be done to the self.”<sup>2</sup> Goffman asserts that the balance between the community and organisational aspects of total institutions is an exercise in the manipulation of inmates through the control of all aspects of their lives. Waipiata Sanatorium cannot be characterised in this way, as the level of interaction and empathy between patients and staff, and the genuine understanding of the need for sympathetic and responsible treatment prevented the Sanatorium from becoming the kind of ‘forcing house’ Goffman describes. Yet the notion that the institution was a social hybrid, combining aspects of community with institutional care is valid. Waipiata Sanatorium, as a medical facility for the care and treatment of tuberculosis sufferers, was a community that was necessarily part residential township, and part formal institution. The medical staff and the patients made up the core of this community, as they filled the roles of carers and cared for, in an atmosphere that was dedicated to the recovery of the body without neglect of the spirit. Yet the medical staff and the patients were not the only members of the Sanatorium community, and the medical facilities were by no means the only buildings on site. The plethora of goods, services and trades people that grew up

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<sup>1</sup> Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Chicago, Aldine Pub. Co., 1962), 12.

<sup>2</sup> Ibid.

around the Sanatorium extended it from merely a medical institution into a township that was deeply embedded in the wider Maniototo Plains community.

The supposed benefits of isolation and rural surroundings in the treatment of tuberculosis meant that many New Zealand sanatoria were built in remote areas, restrictively far away from the goods and services required to administer them. Unlike institutions built in or near towns and cities, a great many facilities and services had to be provided on site. Waipiata Sanatorium employed, outside of the medical, nursing and domestic staff, an engineer, carpenter, gardener, typist, secretary, butcher, farm manager, three laundrymen, an irrigator, two cowmen, a teamster and seven farm hands. With the exception of the farm hands who lived in shared accommodation, each employee was provided with a private home on site.<sup>3</sup> The Committee had a deliberate policy of employing married men wherever possible,<sup>4</sup> and their wives and children came with them to live at the Sanatorium. The medical superintendent and his assistant also had their own homes and families on site. Therefore, far from being merely an institution with medical staff and patients, the Waipiata Sanatorium site became home for a number of tradesmen and their families. Perhaps no one sums up this situation as succinctly as RM: “We finished up with a sort of community, more or less, of people and houses.”<sup>5</sup>

The story of RM and her husband best exemplifies both the fluid and interchanging nature of the Sanatorium population and the range of employment opportunities within the community. When her husband suffered a relapse of tubercular pleurisy, RM moved with him to the Waipiata Sanatorium to work as a nurse. As part of his rehabilitation, her husband was employed as the engineer’s assistant and when he was discharged he was offered the opportunity to take over the recently vacated engineer’s position. Promised their own home and tempted to stay for the benefit of Mr M’s health, the couple accepted

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<sup>3</sup> Reports of Inspections, 1960. [Waipiata Sanatorium-Reports of Inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>4</sup> Waipiata Sanatorium Committee Meeting Minutes, 12<sup>th</sup> November 1942. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>5</sup> Oral interview with RM, wife of the Waipiata Sanatorium engineer, 1929-1961. January 2005.

the position and lived on site for more than 30 years. RM was therefore a relative's nurse and the engineer's wife, and her husband was at varying times a patient, staff-patient and permanent staff, as the couple changed roles but remained within the Sanatorium community.<sup>6</sup> Goffman's description of "two different social and cultural worlds, jogging alongside each other with points of official contact but little mutual penetration"<sup>7</sup> does not therefore apply to the Waipiata Sanatorium.

It is clear that those who lived there conceived of the Sanatorium as a distinctive community. Although I have referred to the institution by its official Health Department name of Waipiata Sanatorium, for those who lived and worked there, the community was known only as Orangapai. Translated literally Orangapai means "good health" but was interpreted by those who lived there as "the hill of health"<sup>8</sup> or even, by those who saw potential in the name for promoting the Sanatorium, as "the restoration of perfect health."<sup>9</sup> The alternate name of Orangapai was undoubtedly adopted partly to avoid confusion with the nearby settlement of Waipiata township, but also in order to better describe the entire community, including those whose contact with the Sanatorium itself was minimal. It also allowed for the community to distance itself from the negative connotations associated with the public's fear of tuberculosis and sanatorium life. SC remembers that "'Waipiata' was a dirty word. That's why we always called it Orangapai."<sup>10</sup>

Those who experienced life at the Sanatorium describe their experiences in terms that reflect both the community atmosphere of Orangapai and the more restrictive aspects of institutional life. SC remembers her time at the Sanatorium as though "we were living in a small town." She made friends with both patients and staff through concerts, sports

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<sup>6</sup> Ibid.

<sup>7</sup> Goffman, 9.

<sup>8</sup> Oral interview with SC, Waipiata Sanatorium patient 1941-42. November 2005.

<sup>9</sup> Waipiata Sanatorium Committee, *Waipiata Sanatorium: A Brief History of a Successful Institution* (Southland Times Print, 1929), 9.

<sup>10</sup> Oral interview with SC.

clubs and social activities that brought all community members together. At the same time it is clear that she was well aware that institutional life had firm restrictions, routines, and rules. “We lived by the bells,” she concludes.<sup>11</sup> Similarly, RM remembers Orangapai as “just like a normal little village of its own, more or less.”<sup>12</sup> For her life at the Sanatorium mixed imperceptibly with life in a rural community. Her husband ran and maintained the power generators, while she was a wife and mother, who found friendship in the wives and families of the other staff and patients. Yet when staff shortages became extreme, she worked as a nurse, joining the routine of institutional life for weeks or months, until the shortage could be relieved. Having spent more than 30 years at Orangapai, RM remembers fondly: “I had a very good life there. Very good, yes, thoroughly enjoyed every bit of it and all the people, we were a great community and a very happy community, we all looked after each other. There was no such thing as quarrelling, we didn’t have anything like that, we just didn’t have any.”<sup>13</sup> The passage of time has removed from her memories the considerable challenges and hardships of living in this isolated area during both the Depression and the Second World War, but it is clear that RM’s understanding of life at Orangapai was one of community rather than of an institutional life.

Visitors to the Sanatorium were struck by its community atmosphere. A visiting nurse reported “On arriving at the Sanatorium, one is surprised to find such a complete little township...so secluded and still so well provided with all that is necessary to make life go along with an easy swing.”<sup>14</sup> Even Chisholm, who spent only two months at Orangapai, noted: “the community spirit has become so strong in an isolated unit such as Waipiata...everybody knows everybody else and what they are doing. It has a small village atmosphere.”<sup>15</sup> Chisholm was conscious that a community based around a medical

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<sup>11</sup> Ibid.

<sup>12</sup> Oral interview with RM.

<sup>13</sup> Ibid.

<sup>14</sup> Author unknown, “Life in a Sanatorium”, *Kai tiaki* 11, no. 2 (April 1928), 93-94.

<sup>15</sup> W.E. Chisholm, “Waipiata Sanatorium, Christmas Vacation, 1948-1949” (Preventative Medicine Dissertation, University of Otago, 1949), 33.

institution, particularly a tuberculosis sanatorium, would have some unusual aspects:

“Another interesting thing is the hygiene-consciousness of the whole population. Being in contact with a medical institution it grows on them and it is amusing sometimes to see the conflict between life-long custom and rural tendencies on one hand and newer teaching on the other.”<sup>16</sup>

Orangapai soon became a functioning part of the wider community of the Maniototo region, finding its place in the local system of small towns that characterised the Plains: “Many friendships are made with the people on the plain and “the Sanny” is by now well fitted into the social life of the county.”<sup>17</sup> The closest relationship was formed with Waipiata township, 15 kilometres to the north of Orangapai. Members of the township came to the Sanatorium for the annual concerts and sports competitions, and marriages between staff and residents of Waipiata were not unusual. JM left her position as a senior nurse at the Sanatorium when she married the local Presbyterian minister, moving away from the Sanatorium but not the community when she relocated to the Waipiata manse.<sup>18</sup>

The relationship between Waipiata township and Orangapai was also an economic one. The township provided a taxi service to the Sanatorium, hotels and boarding houses for visitors, and dances, concerts and films for the entertainment of the staff. Any threat to the township’s right to supply these services met with great discontent amongst the town’s residents. When the town’s hoteliers discovered that the Sanatorium’s employees with private houses had been taking paying boarders, they sent petitions to the Committee to prevent the practice from continuing. The establishment of a post office and general store at the Sanatorium, although run by a Waipiata township resident, irritated the existing store owner, and those who felt that their community would suffer from the loss of business.<sup>19</sup> The complainants accused the Committee of allowing the storeman to run

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<sup>16</sup> Ibid, 34.

<sup>17</sup> Ibid, 33.

<sup>18</sup> Interview with JM, nurse at Waipiata Sanatorium, 1937-39. November 2004.

<sup>19</sup> Waipiata Sanatorium Committee Meeting Minutes, 23<sup>rd</sup> March 1935. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. Archives New Zealand, DAHI D336/4e]

his business at the Sanatorium without paying rent, and with the use of the Sanatorium truck to transport his goods from the railway. The Committee were quick to correct this misunderstanding (in fact, the storeman did pay rent and was responsible for transporting his goods) and, stating that “the keeping of goods such as [the storeman] had been doing for some years past was a great convenience to the patients and staff of the institution, many of whom were confined to bed”, refused to close the store and post office down.<sup>20</sup> Such tensions are representative of the delicate symbiotic relationship that existed between Orangapai and Waipiata township, in which each was reliant on the other for survival.

Although Orangapai interacted most closely with Waipiata township, its influence was felt throughout the Maniototo region. Ranfurly, in particular, was affected by the presence of the Sanatorium community on the Plains. Kidd sent patients whom he felt would benefit from surgery to Ranfurly hospital for the treatment and any specialist goods that Waipiata township could not provide were sent from Ranfurly.<sup>21</sup> Just as the relationship between Waipiata township and Orangapai was based on a delicate economic balance, Orangapai’s relationship with Ranfurly was easily strained. Kidd’s work at the Ranfurly hospital as a private anaesthetist caused outrage in other doctors in the area who felt that, as Kidd already had full time employment, he had no right to take further work; a feeling of resentment that intensified during the economic hardship of the Depression.<sup>22</sup>

The spirit of cooperation between Orangapai and the Plains’ community was most strongly displayed in times of emergency. When the railway disaster at Hyde in 1943 killed 21 people and wounded many others, Kidd and the nursing staff assisted at both the accident site and later at Ranfurly hospital. They gave their assistance freely as members

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<sup>20</sup> Waipiata Sanatorium Committee Meeting Minutes, 6<sup>th</sup> April 1937. [Waipiata Sanatorium-Minutes 1936-1956. Archives New Zealand, ADBZ 16163 HI 22/1]

<sup>21</sup> Chisholm, 39.

<sup>22</sup> Waipiata Sanatorium Committee Meeting Minutes, 14<sup>th</sup> June 1933. [South Otago Hospital Board – Waipiata Committee Minutes 1929-1939, Archives New Zealand, DAHI D336/4e]



of the community, and received the thanks of all those involved.<sup>23</sup> A patient at the time remembered: “On the day of the train disaster at Hyde all staff were called to the scene and some patients and staff were actually on the train. One heroine was a nursing Sister who was going on leave. She was the first to give aid and worked until everyone was transported away. Back at the Sanatorium a skeleton staff carried on while everyone who was able helped those who were bed patients.”<sup>24</sup> Maniototo residents also helped the Sanatorium in times of need. In 1946, the men’s dormitory at the Sanatorium caught on fire. As auxiliary and medical staff fought to evacuate the patients and put out the fire, help came from both Waipiata and further a field. Thanks to the “good work of staff and neighbours in evacuating all the patients and subduing the fire” no-one was hurt.<sup>25</sup>

The creation of a community around the Sanatorium, and its incorporation into the wider community was not unique to Waipiata Sanatorium. Cashmere Hills and Pleasant Valley Sanatoria were close enough to Christchurch and Dunedin respectively to integrate into those already existing communities. Otaki and Pukeora Sanatoria in the North Island, however, were in relatively isolated locations, and like Orangapai, developed not only their own institution-based communities, but also formed close relationships with their neighbouring small towns. Otaki Sanatorium was situated four miles from Otaki township in the Manawatu. Its isolated location caused staff shortages and many of the staff members were ex-patients, removing staff-patient barriers and creating a unity of community similar to that at Orangapai.<sup>26</sup> The Otaki township soon became intricately involved with the Sanatorium community: The Women’s Institute and the Women’s Division of Federated Farmers took patients on outings, picnics and afternoon teas, and the theatre proprietor set up a film projection system at the

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<sup>23</sup> Waipiata Sanatorium Committee Meeting Minutes, 12<sup>th</sup> November 1942. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>24</sup> Maud McLay, “Orangapai Sanatorium” in Jim Sullivan, ed., *As I Remember: Stories from ‘Sounds Historical’* (Auckland: Tandem Press, 1999), 80.

<sup>25</sup> Waipiata Sanatorium Committee Meeting Minutes, 3<sup>rd</sup> February 1946. [South Otago Hospital Board – Waipiata Committee 1942-1949. Archives New Zealand, DAHI D336/5a]

<sup>26</sup> J. Eton, “Otaki Sanatorium: A Short Survey” (Preventative Medicine Dissertation, University of Otago, 1952), 17.

Sanatorium.<sup>27</sup> Otaki sanatorium was far enough from both Wellington and Palmerston North to require the kind of auxiliary staff and facilities that extended the Sanatorium from an institution to a community. "It was a world of its own" concluded an Otaki patient.<sup>28</sup>

Pukeora Sanatorium, situated near Waipukerau in the Urewera region, also developed these characteristics. D.R.G. Wright, a medical student who visited Pukeora Sanatorium in 1948, noted that "today Pukeroa is almost a self contained community."<sup>29</sup> The Sanatorium supported six private houses, a cinema, canteen and post office, blurring the distinction between medical institution and country town.<sup>30</sup> The towns of Otaki and Waipukerau benefited from providing the sanatoria with goods and services just as Waipiata township did, and Napier and Palmerston North provided the extra medical services that Ranfurly did for Waipiata Sanatorium. The similarities between the communities at Waipiata, Otaki and Pukeora Sanatoria are remarkable. The one significant exception was the segregation of gender between the two North Island Sanatoria: Otaki provided treatment only for female patients, and Pukeora only for males, creating an unnatural gender balance in these communities. The gender segregation "simplified the administration and discipline but placed the patients in a more unnatural community than need be."<sup>31</sup>

Sanatorium communities existed not only in New Zealand but in a variety of forms world wide. One of the earliest and most well known of these was the Adirondack Sanatorium near Lake Saranac in Connecticut in the United States of America. Adirondack was set up in 1885 by Edward Trudeau to test the principles of the newly propagated fresh air regime. By 1900 it had grown into a "little village for tuberculosis

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<sup>27</sup> Margaret Long, "The Otaki Sanatorium," *Historical Journal* 20 (1997), 67.

<sup>28</sup> *Ibid.*, 68.

<sup>29</sup> D.G.R. Wright, "Pukeora Sanatorium: A Public Health Survey' (Preventative Medicine Dissertation, University of Otago, 1948), 2.

<sup>30</sup> *Ibid.*, 30.

<sup>31</sup> Eton, 13.

sufferers.”<sup>32</sup> Lake Saranac soon became what Rothman calls a “one industry town” in supplying the needs of Sanatorium patients and staff: “The construction of sanatoria had a huge impact on the communities that surrounded them. Some resented the presence of so many consumptives in their midst, but many gained from it – either through jobs in the sanatorium itself or in supplying it with goods.”<sup>33</sup> The growth Lake Saranac enjoyed as a result of the Sanatorium is apparent in its population explosion: from 400 people in 1880 to 6000 in 1920.<sup>34</sup> Both in New Zealand and world wide, the isolation, country settings and discipline that were the basis of sanatorium treatment formed hybrid communities that were part institution, part small country town.

Sanatorium communities often became such integral parts of their wider communities that their closure met with significant resistance from patients, staff and neighbouring towns. The cure for tuberculosis in the form of chemotherapy drugs arrived with an astonishing rapidity that neither the medical profession nor the government had anticipated. In 1951 the government had called for extra bed space in sanatoria, and was considering construction of a new sanatorium.<sup>35</sup> By 1953 an end to tuberculosis was seen as inevitable, and funds were being diverted to “other ills which cannot be so readily controlled.”<sup>36</sup>

The advent of drug therapy meant treatment moved away from long stays in hospitals and sanatoria to a short stay in an institution for initial drug treatment followed by home care with check ups at clinics. Selman Waksman, the man credited with developing the drugs, believed that “one of the most significant developments resulting from the introduction of specific drug therapy and reduction in necessity for hospital treatment has

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<sup>32</sup> Sheila Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: BasicBooks, 1994), 203.

<sup>33</sup> *Ibid.*, 217.

<sup>34</sup> *Ibid.*, 218.

<sup>35</sup> F.S. MacLean, *Challenge for health: A History of Public Health in New Zealand* (Wellington: Government Print, 1964), 374.

<sup>36</sup> C.A. Taylor, Director, Division of Tuberculosis, quoted in Maclean, 376.

been the closing of numerous sanatoria and conversion of many to other uses.<sup>37</sup>

Waksman estimated that hospital stays were reduced by 50 percent, and that by 1955, 93 percent of patients spent less than a year in hospitals or sanatoria.<sup>38</sup> By 1960, Pukeora and Pleasant Valley Sanatoria had already been closed.<sup>39</sup> Waipiata Sanatorium was using no more than 50 of its beds, and the Health Department began to call for its closure. The suggestion met with widespread opposition. Medical professionals who had specialised in sanatorium care clung to their careers; members of the community who had spent decades at Orangapai refused to leave their homes, friends and jobs; and patients were in the uneasy position of not knowing what care they would receive outside of sanatorium treatment.

The Health Department did little to allay the fears of the community. Their first act of antagonism was to inspect the Sanatorium without notifying the Committee or the Medical Superintendent of their intentions.<sup>40</sup> Portraying their visit as a routine inspection, Dr Land and Dr Dempster<sup>41</sup> visited Orangapai with the goal of deciding the Sanatorium's fate. Their report recommended that the Sanatorium be closed, the patients from the Southland District be sent to Kew Convalescent Home in Invercargill and all other patients be sent to their local hospitals.<sup>42</sup> The Sanatorium community's response was swift and angry. The Committee claimed that the climate at Invercargill was unsuitable, there was not enough room at Kew, and that neither the Southland Board nor Southland residents wanted the return of tuberculosis patients to the district. More importantly for the patients, Waipiata Sanatorium had previously sent patients to Kew when they were

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<sup>37</sup> Selman Waksman, *The Conquest of Tuberculosis* (London: Hale, 1965), 190.

<sup>38</sup> Ibid.

<sup>39</sup> April McDonald, "A Chemotherapy Revolution? Tuberculosis in New Zealand 1940-1960" (BA Hons Dissertation, University of Otago, 2000), 36.

<sup>40</sup> Report of the Waipiata Sanatorium Committee to the Hospital Advisory Board, 11<sup>th</sup> August 1960. [Waipiata Sanatorium-Reports of inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16.]

<sup>41</sup> Assistant Director, Division of Hospitals and Director, Division of Tuberculosis and Welfare Services respectively.

<sup>42</sup> Land and Dempster Report, 20 July 1960. [Waipiata Sanatorium-Reports of inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

dying, and, according to the Southland Board representative Dr Grantham, “it still had that reputation.”<sup>43</sup> “The Department cares more about cost than the welfare of patients,” Kidd accused.<sup>44</sup> But the Department remained unmoved. Land and Dempster accepted neither climate nor isolation as important aspects of tuberculosis treatment, and they believed that Kew did indeed have enough facilities to cope with tuberculosis sufferers. “The welfare of the patient came first but the economic considerations could not be lost sight of”, they concluded.<sup>45</sup>

The debate was such that the Minister of Health, Dr Mason, made his own report on the situation. Mason was acutely aware of the impact the proposed closure was having on the Sanatorium community: “Patients were anxious as to where else they might be sent, and staff were concerned about their jobs. Many had begun to seek positions elsewhere, some had already left.”<sup>46</sup> What had been, ten years ago, a community of 120 patients, and 100 staff and their families, had diminished to less than 30 patients, and the same amount of staff. Mason’s recommendation was to close the Sanatorium and relocate patients to their local hospitals. Nevertheless, Mason was concerned about the effect the closure would have on the wider community. In particular he was concerned about the future of the farm which remained a “good, profitable farm.”<sup>47</sup> It only survived through irrigation from the Sanatorium water race that would be removed or abandoned should the Sanatorium close down. The problem of the farm served to highlight the economic consequences for the Maniototo region if they were to effectively remove an entire town

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<sup>43</sup> Notes on the Deputation from the Southland Hospital Board to the Minister of Health at Parliament buildings, 11<sup>th</sup> August 1960. [Waipiata Sanatorium-Reports of inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>44</sup> Report on Land and Dempster’s visit to Waipiata Sanatorium, 25 February 1960. [Waipiata Sanatorium-Reports of inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>45</sup> Ibid.

<sup>46</sup> Report from the Minister of Health, T. Mason, in the minutes of the 14<sup>th</sup> meeting of the Hospitals Advisory Council, 25<sup>th</sup> August 1960. [Waipiata Sanatorium-Reports of inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

<sup>47</sup> Report from Dr Grantham to the Minister of Health at Parliament buildings, 11<sup>th</sup> August 1960. [Waipiata Sanatorium-Reports of inspections 1936-1961. Archives New Zealand, ADBZ 16163 H1 22/16]

from the economic system. “Quite a lot of economy could be affected there” protested Dr Grantham.<sup>48</sup> Hoteliers, store keepers, merchants, transport and entertainment providers and the medical community would all be affected adversely by the desertion of Orangapai.

Despite protests from the Orangapai community, the government decided that the Sanatorium buildings could be put to better use. Patients were relocated to their district hospitals, and nursing and medical staff lost their jobs. Yet the government found a solution which allowed the community to survive, and provided a use for the buildings in which it had invested a considerable amount of money. The buildings were transferred from the Department of Health to the Department of Justice and the Sanatorium became a Borstal. Auxiliary staff, such as the butcher, carpenter, engineer, gardener and their families continued to be employed and the water race was maintained to allow the farm to continue to operate. The Maniototo region’s economy was supported as businesses supplied the same goods and services as they had for the Sanatorium. The transfer of the Sanatorium buildings to use as a Borstal left the Orangapai community altered but viable. RM was one for whom the closure of the Sanatorium did not mean departure from the Orangapai community. She remembers the changeover: “once [the Health Boards] had treatment that they were able to use in their hospitals, [the Sanatorium] wasn’t needed. So that’s why it was all transferred from one Department to the other.” She stayed on with her husband, who became the engineer at the Borstal, until he turned 60 and was forced to retire.<sup>49</sup>

Only a very small number of tuberculosis sufferers ever experienced life at the Waipiata Sanatorium, or in any of New Zealand’s six sanatoria. New Zealand, considered to have the most extensive system of care for tuberculosis patients in the world, never had

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<sup>48</sup> Ibid.

<sup>49</sup> Oral interview with RM.

more than 500 sanatorium beds for up to 10,000 cases a year.<sup>50</sup> For most, belonging to a Sanatorium community was never a possibility. The experiences of those who were cared for in their own homes and local communities provide an important point of contrast to the Sanatorium community experience. In order to better understand the community at Waipiata Sanatorium, the experiences of those who lived outside the community must also be understood: we must compare a community of sufferers with the individual sufferers in the wider community. Goffman does not make this comparison. While he carefully examines the institutional experience, he does not consider the experiences of those who were cared for in the wider community. Goffman, and those who have looked to his description of total institutions in order to better understand sanatorium life, base much of their criticism of institutional life on the fact that it removed patients from their families and communities and prevented them from living a 'normal' life. However, investigation of the experiences of those who remained in their own communities reveals that living a 'normal' life was not always possible, and that care at home had as many unpleasant aspects as did institutional care.

Smith has said that "the majority of poor tuberculosis sufferers lived and died at home. They would have been mostly warmer for it, and thereby had their lives prolonged."<sup>51</sup> This oversimplifies and misrepresents both the experiences of those who were treated in the sanatorium regime, and of those who were cared for in their own homes. Those who did not qualify for sanatorium treatment or refused to be admitted had a wide range of experiences. The quality of their experiences depended to a large degree on their financial and family situations. Many patients who could afford to, chose to avoid the stigma and isolation of sanatorium life. They rented houses in Central Otago, an area that had the dry, clear air and rural atmosphere considered beneficial to the treatment of tuberculosis, and with the supervision of a private physician undertook the open air

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<sup>50</sup> Linda Bryder, "If Preventable, why not Prevented? New Zealand's Response to Tuberculosis 1901-1930," in Linda Bryder, ed., *A Healthy country: Essays on the Social History of Medicine in New Zealand* (Wellington: Bridget Williams Books, 1991), 115.

<sup>51</sup> F.B. Smith, *The Retreat of Tuberculosis, 1850-1950* (London : Croom Helm, 1988), 130.

regime of rest, nutrition and graded exercise in company of their family and loved ones.<sup>52</sup> The health authorities were well aware of this trend, and encouraged it as a means of safe recovery from the disease without cost to the state: “Otago Central is, in the South, the happy hunting ground for this kind of patient.”<sup>53</sup>

Those who could not afford to recreate the sanatorium experience in private were reliant on the good will of their family members, and were increasingly subject to interference from the state. In 1901 tuberculosis was declared a notifiable disease in New Zealand, in the hope that this would provide valuable data on the prevalence of the disease, and help to control its spread.<sup>54</sup> But the social consequences of this measure had not been considered.<sup>55</sup> Notification legally allowed the patient to be monitored by Health Department officials, a process that included regular compulsory home inspections, referral of any children exposed to infection to the local medical officer, and testing of ‘contacts’ for signs of tuberculosis. There were no advantages for the patients and the notification process merely exposed them to the stigma that surrounded the disease in the early twentieth century.<sup>56</sup> Tuberculosis sufferers fiercely resisted the notification process, as did their physicians, who felt that the process was a breach in patient confidentiality.<sup>57</sup> By 1904 health authorities concluded that “notification in the strictest sense has proved a failure.”<sup>58</sup> Instead of abandoning or rethinking the notification process, in 1912 a resolution was passed for a more rigorous enforcement of notification.<sup>59</sup> The government made only one change to the notification procedure in an effort to make the inspection process more acceptable. Originally the inspections were undertaken by male health officials. The option of choosing a District Nurse was added, as it was felt a nurse was

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<sup>52</sup> Oral interview with SC.

<sup>53</sup> “Prevention and Treatment of Pulmonary Tuberculosis in New Zealand”, *AJHR*, H-31A, 22.

<sup>54</sup> Maclean, 361.

<sup>55</sup> Bryder, 111.

<sup>56</sup> *Ibid.*

<sup>57</sup> *Ibid.*

<sup>58</sup> *Ibid.*, 112.

<sup>59</sup> *Ibid.*



less invasive in private homes.<sup>60</sup> The government implemented this change after the 1928 Investigation into Pulmonary Tuberculosis recommended that “the dread of inspection is the only reasonable ground for declining to notify. Inspection would in every case be less objectionable and always more helpful if it were done by a nurse.”<sup>61</sup>

Reports from the Health Department representative in Dunedin are a valuable insight into the experiences of notified patients under home care and provide an important point of comparison with those who were treated in sanatoria. A comment by the health official at the beginning of his report is indicative of the general attitudes of those visited. “Adults are usually loath to seek medical examination, often for reasons of money. Most work, so it is hard to get in touch with them. Most assert they are perfectly fit. Patients move frequently without notifying the Department, so frequent visits are needed to keep track of people, and to disinfect their homes when they move. When visiting cases any good results seem hopeless, yet others again receive one very kindly and seem genuinely grateful for the help given by the Health Department.”<sup>62</sup>

The reports show a great variety in the quality of treatment and experiences of people under home care. A lucky few received ample care and all the benefits of the open air regime without the inconveniences of sanatorium life. One 22 year old male had been in a private hospital before returning to “excellent conditions at home.” His story had a happy ending: “He is very well now, and has returned to business.”<sup>63</sup> Another report notes one nine year old girl as cared for under “the best possible conditions” and “recovery is almost certain.”<sup>64</sup> The discipline and routine of any sort of institutional life seemed to be beneficial in facilitating the regime outside of a sanatorium. When two nuns from the

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<sup>60</sup> “Prevention and Treatment of Pulmonary Tuberculosis in New Zealand”, *AJHR*, H-31A, 9.

<sup>61</sup> *Ibid*, 22.

<sup>62</sup> Health Department Report on tubercular work in Dunedin, 1924-1926. [Diseases-Tuberculosis-Otago Sanatorium, 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>63</sup> Case report 16<sup>th</sup> October 1925. [Diseases-Tuberculosis-Otago Sanatorium, 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>64</sup> Case Report 28<sup>th</sup> May 1926. [Diseases-Tuberculosis-Otago Sanatorium, 1927-1929. Archives New Zealand, H1 131/3/123]

Kaikorai convent contracted tuberculosis, a shelter was constructed for them on the premises of the convent, and they were nursed on site by the other nuns. "These conditions are excellent. All care is taken," the health inspector noted.<sup>65</sup>

These reports are the exceptions. Most patients were reported as living in mediocre or undesirable conditions. When notified in 1924, one 29 year old returned serviceman was living on a pension, unable to work, in a single room apartment in the city centre with his wife and six children. Under the advice of the health inspector, he moved his family to a two room crib in the suburb of Tomahawk. The change did nothing to improve his condition: he died within two years of notification.<sup>66</sup> In a similarly unfortunate position was a nine year old boy whose home conditions were reported as very poor: "on the street, no windows open, poor furnishing" and without constant supervision as "the mother goes out to work as well as keeping house."<sup>67</sup> Reports of "poor conditions," "irresponsibility" and whole families with the disease are common amongst the health inspector's reports: most patients simply lacked the understanding, means or will to improve their conditions.<sup>68</sup> Of 87 notified tuberculosis cases in Dunedin between 1924 and 1926, 41 died while under notification.<sup>69</sup> Many others moved without notice or forwarding address, to avoid the inspections.

It is also apparent from the reports that the invasion of privacy involved in the inspection process often extended far beyond those aspects that directly related to the treatment and control of tuberculosis. Inspectors passed moral judgements on patients and

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<sup>65</sup> Case report 8<sup>th</sup> June 1925 and 20<sup>th</sup> April 1925. [Diseases-Tuberculosis-Dunedin, 1925-1926. Archives New Zealand, H1 131/3/112]

<sup>66</sup> Case report 4<sup>th</sup> August 1924. [Diseases-Tuberculosis-Otago Sanatorium, 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>67</sup> Case report 23<sup>rd</sup> September 1925. [Diseases-Tuberculosis-Otago Sanatorium, 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>68</sup> Health Department Report on tubercular work in Dunedin, 1924-1926. [Diseases-Tuberculosis-Otago Sanatorium, 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>69</sup> Case reports 1925-1926 [Diseases-Tuberculosis-Otago Sanatorium, 1927-1929. Archives New Zealand, H1 131/3/123]

their families, particularly when venereal disease was discovered. One returned serviceman, with a wife and six month old child, was described as “an impossible family to deal with, the mentality of both parents being poor.” Although the man himself improved “the baby took ill and died a few weeks later from tubercular meningitis. Soon after his wife became mental and at present the patient is living with a married cousin. A later visit found that the wife was attending the VD clinic.”<sup>70</sup> In a similar situation, one man’s treatment for tuberculosis was suspended when he was found to be suffering from syphilis, and his wife and children were reported to the local venereal disease clinic.<sup>71</sup> Venereal disease, it seems, was a sign of mental incapacity and inability to follow the regime necessary for recovering from tuberculosis.

Physicians and members of the public began to call for those who could not be trusted to care for themselves at home to be forced into institutional confinement. They pressured the government to set up prison-like institutions for the morally deficient who were unable to be educated and would be a danger for sanatorium patients should they be admitted.<sup>72</sup> As early as 1928 the delegate from the Otago Hospital Board at the Health Board conference said: “I understand consumption is a compulsorily notifiable disease but of what value is this if persons in the infective stage are not compelled to apply for and receive treatment, but permitted to roam around spreading infection not only to their own immediate families but to others who are compelled to make use of public premises frequented by undiagnosed or unrecognised patients.”<sup>73</sup> Expressing similar concerns, the Committee of the Investigation into Pulmonary Tuberculosis recommended that the state have the right to remove children “from homes where the patient is in an infective condition.”<sup>74</sup>

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<sup>70</sup> Case report, 25<sup>th</sup> February 1926 [Diseases-Tuberculosis-Otago Sanatorium, 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>71</sup> Case report 6<sup>th</sup> June 1925 [Diseases-Tuberculosis-Otago Sanatorium, 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>72</sup> Bryder, 119-120.

<sup>73</sup> Report by the Otago Hospital Board to the Health Boards Conference, 1928. [Diseases-Tuberculosis-Otago Sanatorium. 1927-1929. Archives New Zealand, H1 131/3/123]

<sup>74</sup> “Prevention and Treatment of Pulmonary Tuberculosis in New Zealand”, *AJHR*, H-31A,24.

In many respects suggestions of coercion were a response to developments overseas. The United States passed a law allowing the compulsory institutionalisation of consumptives who continued to jeopardise the safety of the public. Although the numbers confined against their will were few, having tuberculosis had become grounds for loss of liberty.<sup>75</sup> This step was initially resisted by the New Zealand Labour government. Prime Minister Peter Fraser responded to the suggestion to forcibly remove patients to reformatory institutions by labelling it as unkind to these “unfortunate people.” “It is possible to be too scared about tuberculosis”, he asserted.<sup>76</sup> However, by 1948 pressure was such that a new Tuberculosis Act included a controversial ‘leper clause’ which allowed for the forced isolation of ‘incapable’ and ‘irresponsible’ infectious cases of tuberculosis.<sup>77</sup>

In contrast to the increasingly hostile actions of the state, concerned members of the public formed voluntary tuberculosis associations in towns and cities around New Zealand. The first of these was formed in 1945 and by 1966 there were 14 affiliated tuberculosis associations in the National Federation of New Zealand.<sup>78</sup> The associations aimed to provide assistance for tuberculosis sufferers in the form of food, clothing and companionship as well as financial assistance for those who required it.<sup>79</sup> “Members of the tuberculosis associations see their role as that of a backing up agent to the normal health measures taken in the field. They know they are not the vanguard of the fight against TB. But they certainly are the sympathetic heart of the programme that aims to eradicate the disease.”<sup>80</sup> The tuberculosis associations essentially undertook the role of the sanatorium outside of institutional care. They aimed to educate the public, care for tuberculosis patients, and assist in the rehabilitation of recovered patients into suitable

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<sup>75</sup> Rothman, 193.

<sup>76</sup> Peter Fraser quoted in Bryder, 119.

<sup>77</sup> McDonald, 19.

<sup>78</sup> T. Morgan, “Don’t Underestimate Koch’s Bacillus”, *The New Zealand Nursing Journal* 59, no. 1 (January 1966), 8.

<sup>79</sup> McDonald, 20.

<sup>80</sup> Morgan, 8.

occupations.<sup>81</sup> While this undoubtedly aided some tuberculosis sufferers in the community, it could do little to prevent the poor, cramped, unsuitable conditions in which so many patients lived, and nothing to prevent the humiliation, stigma and discrimination that came with the notification process and the classification of consumptives as a social menace.

Life in a community of sufferers such as the Sanatorium may have had unpleasant aspects, but the experiences of those who suffered alone in the wider community could be equally undesirable. For those who could afford it, the regime of rest and nutrition could be undertaken in private, free from many of the negative aspects of the sanatorium experience. But for those who did not have such an option, life outside the sanatorium had unpleasant aspects of its own: notification and inspection were humiliating, invasive and clearly despised aspects of tuberculosis. Many sufferers lived in crowded, impoverished homes, unable to give up family or work responsibilities. They were at constant risk of infecting loved ones and of protracted ill health, and faced the possibility of death. If patients in their own homes had the benefit of autonomy and the comfort of family and friends, they lacked the community atmosphere of the sanatorium that provided a medically supervised haven free from the stigma and discrimination evident in society.

It is these aspects of community that raised sanatoria from 'forcing houses' in which patients were removed from society in order to protect the public from their menace, into places constructed for the benefit of individuals whose illness prevented them from continuing with their everyday lives. Chisholm highlighted the necessity of this community aspect in the treatment of patients at Orangapai: "[the Sanatorium] has a benign country-village atmosphere, so different from the urban severity of our large hospitals...the unity of spirit of such a community helps in the production of that attitude of mind, without which any treatment is of little value," he asserted.<sup>82</sup> Kim Middleton, in

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<sup>81</sup> Author unknown, "Pulmonary Tuberculosis Case Study," *The New Zealand Nursing Journal* 54, no. 2 (June, 1964), 47.

<sup>82</sup> Chisholm, 8.

her study of both Waipiata and Pleasant Valley Sanatoria came to similar conclusions: “Within the sanatorium, communities were created which contributed as much to its curative properties as the structured lifestyle they were required to adhere to.”<sup>83</sup>

The Waipiata Sanatorium, or Orangapai, was therefore a hybrid community that necessarily incorporated aspects of institutional life, but which was also a small rural town, fully integrated into the society and economy of the wider community. While the nature of sanatorium treatment sometimes caused frustration, loneliness and inconvenience to patients, it provided medical attention, removed daily responsibilities and pressures, and freed patients from the stigma and discrimination so often apparent elsewhere. Those who were treated outside the sanatorium community avoided the isolation institutional care entailed, but suffered the indignity of health inspections, and often lived and died in uncomfortable and undesirable conditions at the risk of the family members who cared for them. The creation of a unique community was a common and integral part of the sanatorium experience that elevated it from a solely institutional facility to a fascinating residential and organisational hybrid.

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<sup>83</sup> Kim Middleton, “The Establishment of Sanatoria in Otago, 1899 – 1928” (Post Grad Dip Dissertation, University of Otago, 1998), 65.

## CONCLUSION

### **Revisiting Institutional Life**

As little as two generations ago, tuberculosis was a common and feared disease, unpredictable and often fatal. For more than fifty years, sanatoria were an important source of hope for patients suffering from this debilitating disease and as such they remained an accepted part of the treatment of tuberculosis until chemotherapy drugs rendered them obsolete. Today, sanatoria have been consigned to history, and tuberculosis is a disease that receives little attention. Yet since the 1980s the number of tuberculosis sufferers has steadily risen. The AIDS virus, which attacks the body's immune system and leaves the patient unable to resist the tubercle bacillus, has led to an increase in the number of deaths from tuberculosis each year. In addition, a number of multi-drug resistant strains have emerged, making it increasingly difficult to treat tuberculosis effectively with chemotherapy.<sup>1</sup> Every year New Zealand reports three to four hundred new cases of tuberculosis.<sup>2</sup> If no new drug therapies emerge, the ethos of the sanatorium, in which patients were isolated to prevent them spreading the disease and rested to allow the body the opportunity to recover, may return as a viable option.

History has been unkind to the sanatorium experience. It is remembered as an inhumane, ineffective treatment, the barbaric forerunner to the 'chemotherapy revolution' that 'cured' tuberculosis. At least some of this negative portrayal can be attributed to what were necessarily unpleasant aspects of the regimen, in which isolation, frustration and uncertainty were inevitable. The understanding of sanatoria as coercive and dehumanising institutions has also been intensified by the high profile of those sanatoria that were understaffed and poorly equipped, where patients were maltreated and

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<sup>1</sup> For a comprehensive account of the affect of AIDS on tuberculosis and of multi-drug resistant strains, see Frank Ryan, *The Forgotten Plague: How the Battle for Tuberculosis was Won and Lost* (Toronto: Little, Brown and Co., 1993), 389-417.

<sup>2</sup> Dr Jason Eberhart-Phillips, senior lecturer of preventive and social medicine, University of Otago, quoted in "Facelift in Waipiata," *Otago Daily Times* (January 26<sup>th</sup>, 2001), 17.

exploited. The experiences of these sanatoria have coloured how we remember all sanatoria.

The negative portrayal of sanatorium life cannot be fully explained by the presence of some unpleasant experiences. We must also understand the context in which these criticisms were made. From the 1960s there was increasing dissatisfaction with the institutional process, as the medical profession and members of the public became aware of the poor conditions of some mental asylums, sanatoria and prisons. Goffman, writing at that time, outlined what he considered to be the fundamental aspects of all total institutions. He focussed on the coercive and regulated aspects of life in which inmates were dehumanised, restricted by a monotonous routine, and rigidly segregated from staff and the outside world. His description reflects a time when 'institutions' and 'community' were considered to be distinct, even opposing, forms of care. He wrote in the context of a debate that proposed, for humanitarian and pragmatic reasons, a move away from institutionalisation to 'care in the community', that would relieve the government of the huge economic burden of providing institutional care, and allow patients in these establishments the human right of living a 'normal' life.<sup>3</sup>

Historians of the sanatorium experience, such as Rothman, Bates, and Bryder, have followed in this tradition of emphasising the negative, coercive aspects of institutional life. They assume that care of patients in their own homes and communities was more humane, because it lacked the isolation, regulation and discipline of institutional care. Goffman's analysis, and that of those who have followed in this tradition, no longer seems appropriate. The notion of 'community care', for both tuberculosis sufferers, as well as the mentally ill, was based on the assumption that members of the community, in particular the family and friends of patients, were capable and willing to care for people with unusual and demanding needs. In fact, members of the community often feared those considered 'abnormal' or 'dangerous' and families lacked the financial and

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<sup>3</sup> For full information about the trend away from institutional care to care in the community, see Jeff Kavanagh, "Cherry Farm 1952-1992: the Social and Economic Forces behind the Evolution of Mental Health Care in Otago" (Post Grad Dip Dissertation, University of Otago, 1996), 43-61.



emotional support that is required to care for someone who is mentally or physically unwell. Some patients' relatives were unwilling to accept the massive commitment that caring for an invalid requires and other patients simply had no relatives on which to rely. All too often patients were abandoned to lives of poverty, at risk to themselves and potentially to others. As the case reports of inspections of tuberculosis sufferers in Dunedin homes revealed, patients frequently lived in poor conditions, unsupervised and subject to ostracism from those who feared them, and interference from the government. Care in the community was not necessarily more 'humanitarian' than institutional care.

Revisiting the experience of institutional life without the assumption that institutions were necessarily inhumane and misguided, allows emphasis to be placed on the positive aspects of sanatorium care. By challenging the idea that 'institution' and 'community' are dichotomous, we can see that many of the beneficial aspects of care in the community were evident in institutions such as Waipiata Sanatorium. The Sanatorium created a community that was a haven for those who could no longer live their normal lives without fear of worsening their condition or spreading the disease. It was a community with many layers, that blended the necessities of institutional life with the atmosphere of a small country town. Its core was made up of Sanatorium staff and patients, whose lives intertwined and overlapped, and who negotiated the challenges of institutional life in such an isolated spot. Surrounding this core was a group of auxiliary staff who transformed the institution from a purely medical facility into a home for a number of tradesmen and their families. This 'Sanatorium town' was situated in the wider community of the Maniototo Plains, in which social and economic bonds lessened the isolation of the Sanatorium by integrating it into Plains' life.

The Waipiata Sanatorium provided everything that medical care could offer at the time: nutritious food, fresh and clean air, discipline and a lack of distractions, constant medical supervision and graduated exercise. With this necessarily came isolation, boredom and frustration, but this was well recognised by the Sanatorium staff, the Committee and the wider community, who did everything they could to alleviate these factors. While the negative aspects of sanatorium life cannot and should not be denied,

nor should its benefits be forgotten. The sanatorium's importance lay not in its ability to cure the disease, but in creating a community and an atmosphere in which to cope with having tuberculosis, and in which at least the hope, if not the guarantee, of recovery could be fostered. The Waipiata Sanatorium community provided relief, comfort and hope for tuberculosis sufferers: it is for this that it should be remembered.

BIBLIOGRAPHY

**PRIMARY SOURCES**

**Unpublished**

Archives

Archives New Zealand, Wellington:

Nursing Services-Training Schools-Waipiata Sanatorium 1948-1949. ADBZ 16163 H1/2135 1/14/96.

Waipiata Sanatorium-Patients 1927-1953. ADBZ 16163 H1 22/11.

Waipiata Sanatorium-Reports of Inspections 1936-1961. ADBZ 16163 H1 22/16.

Waipiata Sanatorium-Minutes 1936-1956. ADBZ 16163 H1 22/1.

Waipiata Sanatorium-Staff 1959-1962. ADBZ 16163 H1 22/3.

Waipiata Sanatorium-Committee. 1924-1957. ADBZ 16163 H1 22/4.

Waipiata Sanatorium-Farm 1922-1956. ADBZ 16163 H1 22/5

Diseases-Tuberculosis-Otago Sanatorium. 1927-1929. H1 131/3/123

Diseases-Tuberculosis-Dunedin. 1925-1926. H1 131/3/112

Archives New Zealand, Dunedin:

South Otago Hospital Board – Waipiata Committee 1942-1949. DAHI D336/5a.

South Otago Hospital Board – Waipiata Committee Minutes 1929-1939. DAHI D336/4e

#### Preventative Medicine Dissertations

Chisholm, WE. “Waipiata Sanatorium, Christmas Vacation, 1948-49.” Preventative Medicine Dissertation. University of Otago, 1949.

Eton, J. “Otaki Sanatorium: A Short Survey.” Preventative Medicine Dissertation. University of Otago, 1952.

Wright, D.G.R. “Pukeora Sanatorium: A Public Health Survey.” Preventative Medicine Dissertation. University of Otago, 1948.

#### Oral Interviews

RM, wife of the Waipiata Sanatorium engineer 1929-1961. Interviewed January 2005.

JM, nurse at Waipiata Sanatorium 1937-1939. Interviewed November 2004.

SC, patient at Waipiata Sanatorium 1941-1942. Interviewed November 2004.

#### **Published**

#### Articles

Author unknown. “Life in a Sanatorium.” *Kai tiaki* 11, no. 2 (April 1928): 93-94.

Author unknown. "Pulmonary Tuberculosis Case Study." *The New Zealand Nursing Journal* 54, no. 2 (June 1964): 16-18.

Author unknown. "Waipiata Sanatorium." *Kai tiaki* 18, no.3. (July 1925): 141-142.

Bridges, E.R. "Tuberculosis in New Zealand Nurses." *The New Zealand Nursing Journal* 42, no. 6 (October 1949): 168-170.

Burton, T. "The Sister of a Chest Block as a Social Worker." *The New Zealand Nursing Journal* 44, no. 1 (February 1951): 12-15.

Francis, R.S.R. "Tuberculosis in Nurses." *The New Zealand Nursing Journal* 34, no. 2 (February 1941): 41-46.

Morgan, T. "Don't Underestimate Koch's Bacillus." *The New Zealand Nursing Journal* 59, no. 1 (January 1966): 8.

Taylor, C.A. "The Control of Tuberculosis in New Zealand." *The New Zealand Medical Journal* 46, no. 251 (February 1947): 17-23.

Thompson, Brian. "Collapse Therapy in Pulmonary Tuberculosis: A Contemporary View." *The New Zealand Medical Journal* 47, no. 262 (December 1948): 581-585.

Whelan, R. "Care of a Patient Suffering from Pulmonary Tuberculosis." *The New Zealand Nursing Journal* 53, no. 9 (September 1960): 26-27.

#### Pamphlets

Waipiata Sanatorium Committee. *Waipiata Sanatorium: A Brief History of a Successful Institution*. Southland Times Print, 1929.

Bennett, F.O. *Cashmere Sanatorium (now Coronation Hospital), 1906-1964.*

Christchurch: Caxton Press. 1964.

Appendices to the Journal of the House of Representatives

“Prevention and Treatment of Pulmonary Tuberculosis in New Zealand,” H-31A, 1-27.

**SECONDARY SOURCES:**

Allen, Natali and Eve Brister. “Nurses with Tuberculosis: A Preliminary Study.”

*Women’s Studies Journal* 5, no. 2 (December 1989): 38-60.

Angus, John. *The History of the Otago Hospital Board and its Predecessors.* Dunedin:

John McIndoe Ltd, 1984.

Author unknown. “At the San: the Human Cost.” *Historical Journal* 20 (2000): 40-41.

Bashford, Alison. “Cultures of Confinement: Tuberculosis, Isolation and the Sanatorium”

in Alison Bashford and Carolyn Strange, eds. *Isolation: Places and Practices of Exclusion.* New York: Routledge, 2003, 1-19.

Bashford, Alison and Carolyn Strange. “Isolation and Exclusion in the Modern World:

An Introductory Essay’ in Alison Bashford and Carolyn Strange, eds. *Isolation: Places and Practices of Exclusion.* New York: Routledge, 2003, 133-148.

Bates, Barbara. *Bargaining for Life: A Social History of Tuberculosis 1876 – 1939.*

Philadelphia: University of Pennsylvania Press, 1992.

Beagley, Catherine. “Dread White Plague: Social Aspects of Tuberculosis in Otago 1900

– 1930.” BA Hons Dissertation. University of Otago, 1987.

Bryder, Linda. *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth-Century Britain*. Oxford: Clarendon Press, 1988.

\_\_\_\_\_. "If Preventable, Why Not Prevented? The New Zealand Response to Tuberculosis 1901 to 1940" in Linda Bryder, ed. *A Health Country: Essays on the Social History of Medicine in New Zealand*. Wellington: Bridget Williams Books, 1991, 107-127.

\_\_\_\_\_. "Tuberculosis in New Zealand" in A.J. Proust ed. *The History of Tuberculosis in Australia, New Zealand and Papua New Guinea*. Canberra: Brolga Press, 1991, 79-89.

Cowan, Janet. *Down the Years in the Maniototo*. Christchurch: Caxton Press, 1978.

Daniel, Thomas. *Captain of Death: The Story of Tuberculosis*. Rochester, NY: University of Rochester Press, 1997.

Dormandy, Thomas. *The White Death: A History of Tuberculosis*. London: Hambledon Press, 1999.

Dow, Derek. *Maori Health and Government Policy 1840-1940*. Wellington: Victoria University Press, 1999.

\_\_\_\_\_. *Safeguarding the Public Health: A History of the New Zealand Department of Health*. Wellington: Government Print, 1964.

Dubos, Rene and Jean. *The White Plague: Tuberculosis, Man and Society*. London : Gollancz, 1952.

Goffman, Erving. *Asylums: Essays on the Social Situation of Mental Patients and Other*

- Inmates*. Chicago, Aldine Pub. Co., 1962.
- Jones, Greta. '*Captain of All these Men of Death*': *the History of Tuberculosis in Nineteenth and Twentieth Century Ireland*. Amsterdam: Rodopi, 2001.
- Keers, R.Y. *Pulmonary Tuberculosis: A Journey down the Centuries*. London: Bailliere Tindall, 1978.
- Long, Margaret. "The Otaki Sanatorium." *Historical Journal* 20 (1997): 58-69.
- Macdonald, April. "The Chemotherapy Revolution? Tuberculosis in new Zealand 1940-1960." BA Hons Dissertation. University of Otago, 2000.
- Maclay, Maud. "Orangapai Sanatorium" in Jim Sullivan, ed. *As I Remember: Stories from 'Sounds Historical.'* Auckland: Tandem Press, 1999, 55-57.
- Maclean, Frank. *A Challenge for Health: A History of Public Health in New Zealand*. Wellington: Government Print, 1964.
- Middleton, Kim. "The Establishment of Tuberculosis Sanatoria in Otago 1899 – 1928." Post Grad Dip Dissertation. University of Otago, 1998.
- Moore, Linda. "An Adjunct to a Hospital and a Substitute for One: The Fresh Air Home 1923-1927." Unpublished essay. Canterbury University, 1999.
- Ott, Katherine. *Fevered Lives: Tuberculosis in American Culture since 1870*. Cambridge, Mass.: Harvard University Press, 1996.
- Proust, A.J. *The History of Tuberculosis in Australia, New Zealand and Papua New Guinea*. Canberra: Brolga Press, 1991.



Rothman, Sheila. *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History*. New York : BasicBooks, 1994.

Ryan, Frank. *The Forgotten Plague: How the Battle Against Tuberculosis was Won and Lost*. Boston: Little, Brown and Co., 1993.

Southland Hospital Board, *History of the Southland Hospital and Board, 1861-1968*. Invercargill: Southland Hospital Board, 1968.

Smith, F.B. *The Retreat of Tuberculosis 1850 – 1950*. London : Croom Helm, 1988.

Teller, Michael. *The Tuberculosis Movement: A Public Health Campaign in the Progressive Era*. New York: Greenwood Press, 1988.

Waksman, Selman. *The Conquest of Tuberculosis*. London: Hale, 1965.

Wells, Athol. "Tuberculosis in New Zealand Maoris" in A.J. Proust ed. *The History of Tuberculosis in Australia, New Zealand and Papua New Guinea*. Canberra: Brolga Press, 1991, 97-102.