

“A Health Resort for Consumptives”: Tuberculosis and Immigration to New Zealand, 1880–1914

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In his memoirs, the prominent New Zealand surgeon, A Eisdell Moore, described his parents' decision to emigrate from Britain to New Zealand in 1885:

Father, who had been a chemist in Clifton, Bristol, had had several severe haemorrhages from his lungs. A consulting physician in Harley Street had told him that his only hope of survival was to come to New Zealand. My mother often recalled that as they were embarking at Plymouth she overheard the first officer say, “There’s another to go over the side during the voyage.”¹

In this case the officer was mistaken—Moore’s father not only survived the voyage but lived almost fifty years more. Not all were so lucky. In 1901, Dr James Mason, New Zealand’s first Chief Health Officer, wrote in relation to tuberculosis cases:

Any medical man in practice in the colony could, from his case-books, collect many cases of people who when they landed had no possible chance of recovery, and the only part of New Zealand they ever saw was the inside of a ward of a general hospital.²

The death rate from pulmonary tuberculosis, “consumption” or “phthisis”, at this time was lower in New Zealand than in Britain, at 8 per 10,000 population compared to 13 per 10,000 in Britain.³ While the death rate in New Zealand as in Britain was declining, around the turn of the century there were still more deaths from phthisis in New Zealand than from any other cause.⁴ The control of the disease was a priority of the new Department of Public Health set up in 1900.⁵

This article will discuss the encouragement of “therapeutic migration” of tuberculosis sufferers from Britain to New Zealand in the late nineteenth century and the medical beliefs on which this trend was based.⁶ It will be argued that New Zealand saw itself in

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¹ A Eisdell Moore, *Operation lifetime: the memoirs of a New Zealand surgeon*, Auckland and London, Collins, 1964, p. 11.

² Annual Report, Department of Public Health, *Appendices to the Journals of the House of Representatives* (hereafter AJHR) H-31, 1901, p. 13.

³ Rates for 1896: Registrar-General, *New Zealand official year-book*, 1900, p. 140.

⁴ Ibid.

⁵ L Bryder, ‘If preventible why not prevented? The New Zealand response to tuberculosis,

1901–1940’, in L Bryder (ed.), *A healthy country: essays on the social history of medicine in New Zealand*, Wellington, Bridget Williams Books, 1992, pp. 109–16. See also D A Dow, *Safeguarding the public health: a history of the New Zealand Department of Health*, Wellington, Victoria University Press, 1995, pp. 42, 50; F S Maclean, *Challenge for health: a history of public health in New Zealand*, Wellington, R E Owen, Government Printer, 1964, p. 361.

⁶ On “therapeutic migration” see also K B Thomas and B Gandevia, ‘Dr Francis Workman, emigrant, and the history of taking the cure for consumption in the Australian colonies’, *Med. J. Austr.*, 4 July 1959, 46 (2): 1–10; J M Powell,

competition with the Australian colonies in the bid to attract British immigrants and capital, and capitalized on the supposedly therapeutic value of the climate. Doctors were in this sense useful propagandists. Secondly, the paper will examine legislation and attempts to restrict the entry of immigrants suffering from infectious diseases among which, from the late nineteenth century, it was increasingly believed that tuberculosis had a place. Around the turn of the century the two trends overlapped and were in direct opposition. The paper will conclude with the results of a case study of those who died of tuberculosis within a year of arrival in Auckland, one of the two main ports of entry to New Zealand at this time, during the period 1880–1914. This profile of those who died will be used to provide some intimation of the effectiveness or otherwise of the propaganda and the opposing restrictive legislation.

Climatology

At the Intercolonial Medical Congress of Australasia in 1896 Dr Springthorpe, a Melbourne physician who was also a university lecturer in therapeutics, regretted that no “competent authority [had yet] prepare[d] a handbook for the profession on the important question of climatology”.⁷

Theories on the role of climate in the cure of tuberculosis did, however, have an established history. One of the best known works on the subject in Britain and its Australasian colonies was probably that by Dr Samuel Dougan Bird, a British physician who had worked at the Brompton Hospital for Consumption in London. After contracting tuberculosis himself, he emigrated to Australia. In 1863 he wrote a book entitled *On Australasian climates and their influence in the prevention and arrest of pulmonary consumption*, in which he recommended emigration to Australia to fellow Britons with tuberculosis. Other writers had for some time been promulgating the advantages of the climate of the Continent of Europe, including the various mountain health resorts of Germany and Switzerland and the warmer coastal regions of southern Europe. Hermann Brehmer’s institution at Goebersdorf, Silesia, which he set up in 1859, was particularly famous. British suspicion of things foreign limited the popularity of these European resorts and Bird was probably not alone among his compatriots in his belief that:

Most places on the continent of Europe resorted to by pulmonary invalids are open to many objections on the score of mental or moral prejudicial influences. Foreign manners, houses, servants, cookery, are amusing to the traveller for pleasure, but to the invalid they soon become irksome, and form serious subjects of annoyance.⁸

British colonies had a definite advantage over European countries for British patients, according to Dr Isaac Baker Brown Junior who had previously worked as surgeon-superintendent of Her Majesty’s Emigration Service in London and dedicated his 1865

⁷ ‘Medical promotion and the consumptive immigrant to Australia’, *Geogr. Rev.*, 1973, 63: 449–76; Robin F Haines, ‘Therapeutic emigration: some Australian experiences’, *J. Austr. Stud.*, June 1992, 33: 76–90.

⁷ ‘Intercolonial Medical Congress of Australasia: tuberculosis in man and in animals’, *Br. med. J.*, 1896, i: 1153.

⁸ S Dougan Bird, *On Australasian climates and their influence in the prevention and arrest of pulmonary consumption*, London, Longman, 1863, p. 103.

guide for consumptives to the Emigration Commissioners. In the colonies, he explained, “the new arrival . . . sees English faces and hears English voices. He is not a stranger in a strange land with a feeling of isolation”.⁹

Shipping companies seized the opportunity and chartered ships to Australasia especially for “invalids” during the second half of the nineteenth century. Doctors, particularly those who wished to take the journey for the sake of their own health, sometimes advertised their willingness to act as personal physicians on such voyages.¹⁰ But what was to be their destination?

After discussing the various climatic advantages of different parts of Australasia, Dr Bird concluded, “Taking it all in all, there is perhaps no climate in the world so generally suitable to consumptive cases at all seasons of the year as Melbourne and its neighbourhood . . .”. He explained, “In no climate with which I am acquainted is there so much pleasant weather during the year as in Victoria—so many unclouded days, when it is neither too hot nor too cold . . .”.¹¹

Later in the century, in a book entitled *New South Wales as a health resort*, the author, an actuary, reached a different conclusion. He claimed to have the “direct authority of our Government Astronomer” for stating that New South Wales, which was cooler than Victoria in the summer and warmer in the winter and had a “glorious endowment of sunny days”, was the most suitable place for a health resort.¹²

Both of these assessments were disputed by New Zealand’s Registrar-General, who stated in the *New Zealand official year-book* around that time that the death rate from tuberculosis was “considerably less” in New Zealand than in any of the Australian colonies. Since he did not believe that more people went to Australia than New Zealand “in a diseased condition, or constitutionally predisposed thereto”, he considered that “the lower [death] rate [from tuberculosis] in New Zealand may be accepted as an indication of the superiority of its climate for withstanding the development of phthisical tendencies”.¹³

The Registrar-General drew on the work of Dr Arthur Thomson, a British army surgeon who had lived in New Zealand from 1847 to 1858 and had made a special study of the troops stationed there. In 1850 Thomson claimed that the experience of the troops refuted the view of some English settlers that the climate was “productive” of consumption.¹⁴ In his popular history of New Zealand (1859), he went further and asserted that deaths from consumption among soldiers were “fewer in New Zealand than in the healthiest of the other foreign stations of the British army”, which, in his view, was a result of the salubrity

⁹ Isaac Baker Brown Junior, *Australia for the consumptive invalid: the voyage, climates and prospects for residence*, London, Robert Hardwicke, 1865, p.23.

¹⁰ ‘Association Intelligence. Victoria Branch, Dr W.H. Cutts, “Notes of a P. & O. Voyage to England”’, *Australas. med. Gaz.*, April 1884: 154. See also, Haines, op. cit., note 6 above, pp. 77–8.

¹¹ Bird, op. cit., note 8 above, pp. 41, 62, 63, 117.

¹² W R Dovey, *New South Wales as a health resort*, New South Wales, repr. of paper read before

the Insurance Institute of New South Wales on 22nd June 1899, 1899, p.3.

¹³ Registrar-General, *New Zealand official year-book*, 1892, p. 65; 1893, pp. 86–7; 1894, pp. 100–1; 1895, pp. 110–11; 1896, pp. 120–1; 1897, p. 134; 1898, p. 143; 1899, p. 127; 1900, p. 141.

¹⁴ A S Thomson, ‘On the influence of the climate of New Zealand in the production of disease among emigrants from Great Britain’, *Edin. med. surg. J.*, 1850, 74: 87.

of the climate.¹⁵ Miles Fairburn, a historian who has written on nineteenth-century images of New Zealand, claimed that Thomson's statistics were so widely used that they stimulated a "sub-legend" about New Zealand as a "haven for the invalid and the delicate".¹⁶

Dr Thomson was by no means alone in his assessment. Dr Alfred K Newman, a physician turned politician who was a member of parliament from 1884 to 1896 and again from 1911 to 1922, claimed confidently in the *Assurance Magazine* in 1883, "Phthical invalids from Great Britain on arrival here always improve".¹⁷ However, the following year a medical guide for "consumptives and persons afflicted with lung disease", published in London, categorically dismissed New Zealand: "accounts tend to show that the climate is rather similar to that of Great Britain, and if that be so, it is certainly not a desirable residence for this class of invalids".¹⁸ Between these two extreme views were those who maintained that within New Zealand it was necessary to be "place-specific",¹⁹ that not all parts of the country were equally suitable.

Generally, the warmer north was considered more suitable than the cooler south. For example, despite his glowing tributes to Melbourne, Australia, Dr Bird had also given Auckland a fleeting mention. With its "moist, warm and rather relaxing climate", he recommended it as suitable for the "irritable, dry bronchial complications of consumption".²⁰ This view was shared by Dr Baker Brown, who included in his guide a chapter entitled 'Tasmania and its climate—New Zealand', which concluded with "a passing word" about New Zealand. Like Bird, he referred to Auckland's moist and warm climate as "good for those with bronchial irritation". He was less enthusiastic about New Zealand's other cities; of Dunedin, he wrote, "no one can recommend [it]. All the accounts I ever heard of it were rain and mud; the temperature is by no means warm."²¹ This assessment was reinforced by a report by the Provincial Surgeon of Southland three years earlier who noted the unsuitability of the climate of Invercargill, south of Dunedin, for consumptives, though he added that "to any one having the seeds of such disease undeveloped in any way, the climate might be of use in bracing the system, and ultimately prevent its ever breaking out."²² In 1908, after forty years' experience as chaplain to Dunedin gaol, hospital and asylum, John Torrance reflected that "Now that doctors in the Home Country have a fuller knowledge of New Zealand they are not so prone as they were in the earlier days of the colony to send out their consumptives—at all events, to Otago [the province in which Dunedin was based]".²³ One of the most famous guides to health resorts in Australasia in the late nineteenth century, written by Dr Ludwig Bruck, directed

¹⁵ A S Thomson, *The story of New Zealand: past and present, savage and civilized*, London, J Murray, 1859, vol. 1, pp. 45–6.

¹⁶ Miles Fairburn, *The ideal society and its enemies: the foundations of modern New Zealand society, 1850–1900*, Auckland University Press, 1989, p. 34.

¹⁷ A K Newman, 'An enquiry into the healthiness of New Zealand . . . with statistics deduced from the census returns of the Registry of Deaths of the Colony', *Assurance Mag.*, 1883, 24: 220.

¹⁸ J W Barrett, *Victoria and Tasmania as resorts for consumptives and persons afflicted with lung disease*, London, s.n., 1884, p. 2.

¹⁹ W I Spencer, *Napier (New Zealand) as a health resort for pulmonary invalids*, pamphlet, Napier, 1885, p. 3.

²⁰ Bird, op. cit., note 8 above, p. 114.

²¹ Baker Brown, op. cit., note 9 above, p. 67.

²² 'Report by Provincial Surgeon on the climate of Invercargill', 1862, *Appendix to the votes and proceedings of the Southland Provincial Council 1861–9*, Dunedin, 1875, p. 92.

²³ Rev. James Chisholm (ed.), *Memorials of John A. Torrance: agent for thirty years of the Patients' and Prisoners' Aid Society*, Dunedin, 1908, p. 88.

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phthisis sufferers specifically to Auckland and its suburbs Devonport, Onehunga and Otahuhu.²⁴

Those with consumption then were encouraged to head for the northern parts of New Zealand. Taranaki, in New Zealand's North Island, was the ideal destination, according to one local doctor. It was,

not too hot during the summer nor too relaxing so that even the most delicate can enjoy it out of doors except perhaps during the middle of the day. Our winters are not too cold . . . The climate is not too bracing, but I think it may be taken as a happy medium between all these extremes.²⁵

In Ludwig Bruck's 1888 guide, a doctor from Motueka (on the northern tip of New Zealand's South Island) included a thinly disguised advertisement when he promised, with sufficient inducement, to build a sanatorium in this "ideal" location.²⁶ Napier, in the North Island, was "one of Nature's sanatoria", explained Dr J H L Allen in 1885, who advised that arrangements were in progress to establish a sanatorium there. Though the site had not yet been fixed, he anticipated "finding Napier in the near future the favorite [*sic*] health resort of the colonies".²⁷ His publication was written in support of a pamphlet produced by Dr W I Spencer, who was not only a local doctor but also mayor of Napier from 1882 to 1885.²⁸ It is possible that some doctors were encouraging therapeutic migration to boost their own medical practices and the local economy.

The reference to Cambridge, in the central North Island, in Thomas Cook's *New Zealand as a tourist and health resort* (1909) was no coincidence. Near Cambridge was located a tuberculosis sanatorium which had been set up by the Department of Public Health in 1903, accommodating 62 patients. Under the heading 'Cambridge' in Cook's guide, it was noted, "Those suffering from pulmonary or chest disorders find great relief, and often complete cure".²⁹ In spite of this type of advertisement, the government's sanatorium was not intended for therapeutic migrants. Indeed, in his report, Dr James Mason reassured his readers that it contained few new immigrants because such a use of a public institution might have provoked resentment.³⁰ Reinforcing the entry in Cook's guide, Mason pointed out in 1914 that "the district has long been famed for its mildness and value in chest ailments", although he also went to great lengths to stress that New Zealand had "no 'open door' for sufferers from the outside world".³¹

While it is not known how successful local doctors were in boosting their own practices, they were discriminating about the type of patients they hoped to attract. It was "early" cases of tuberculosis and those with some means of support who were urged to take the opportunity of migrating. It was commonly stressed that it was "in the earlier

²⁴ Ludwig Bruck (ed. and compiler), *Guide to the health resorts of Australia, Tasmania and New Zealand*, centennial edition, Sydney, *Australasian Medical Gazette*, 1888, pp. 62–3, 67, categories 17 and 20.

²⁵ Letter written by Dr Murray Gibbes of New Plymouth, in *Taranaki. The garden of New Zealand*, compiled by W Courtney, London, Howard & Jones, 1887, p. 44.

²⁶ Bruck, op. cit., note 24 above.

²⁷ J H L Allen, *The advantages of sanatoria in the treatment of phthisis*, pamphlet, Napier, 1885, pp. 13–14.

²⁸ Spencer, op. cit., note 19 above.

²⁹ Thomas Cook, *New Zealand as a tourist and health resort*, Auckland, Thomas Cook & Son, 5th edn, 1909, pp. 23, 69.

³⁰ Annual Report, Department of Public Health, AJHR, H-31, appendix A, 1903, p. vi.

³¹ J M Mason, 'New Zealand and the fight against tuberculosis', in T N Kelynack (ed.), *Tuberculosis year book and sanatoria annual, 1913–1914*, London, John Bale, Sons & Danielsson, 1914, vol. 1, pp. 115, 116.

stages of the disease alone [that] climate [could be] expected to promote or effect a cure".³² When Mason expressed concern about the large number of "consumptives" arriving in the colony in 1901, his objections related to the number of "advanced and penniless cases".³³

Not only doctors extolled the advantages of New Zealand's climate. Immigration promotion literature invariably followed suit. Handbooks for intending immigrants referred to the salubrity of the climate,³⁴ as did the reports of New Zealand's Department of Immigration. In 1907, for example, it was recorded that:

Owing to the limited area of Crown lands which New Zealand has to offer to its immigrants it is useless to attempt to compete with such a country as Canada, with its vast areas of fertile lands and its comparative proximity to the United Kingdom. But what New Zealand can, and does, offer is an equable climate and life generally under the most agreeable and favourable conditions.³⁵

New Zealand's Registrar-General continued to provide proof of "the superiority of New Zealand's climate for withstanding consumptive tendencies", in the *New Zealand official year-book* each year until 1908.³⁶

While nineteenth-century British physicians may have welcomed the opportunity to rid themselves of incurable cases of tuberculosis, or may even have believed in the therapeutic value of migration, by the early twentieth century attitudes in Britain were changing. The prevailing view was beginning to turn against the alleged role of climate in the cure of tuberculosis, and "open-air treatment", wherever located, was becoming popular. Dr Robert Philip (later the first Professor of Tuberculosis at Edinburgh University and knighted for his work on tuberculosis) argued in 1898 that "[Phthisis] can, I believe, be treated with approximately equal success, or want of success, in all climates".³⁷ This was almost thirty years after at least one local physician in Australia, Dr William Thomson of Melbourne, had questioned the climatic theory, but his views had little impact in Britain or Australia.³⁸ The belated agreement by British tuberculosis specialists around the turn of the century could be related to the growing acceptance of the germ theory of disease. However, this was clearly not the whole story. This was a time when tuberculosis was becoming a medical specialism in its own right in Britain.³⁹ It is possible that the new specialists were reluctant to lose their better-off patients to foreign institutions. By 1900,

³² J W Moore, *Br. med. J.*, 1896, ii: 1009.

³³ Annual Report, Department of Public Health, AJHR H-31, 1901, p. 13.

³⁴ *The immigrant's prospects in New Zealand 1s. handbook of information, resources, advantages and attractions, soil, climate, products, trade and wages*, London, F W Hetherington, 1883, p. 15: "The advantages of New Zealand as contrasted with other colonies, are:- 1. A genial and healthy climate. . . . Why New Zealand is a Good Country:- 4. Because in New Zealand, according to Governmental returns, the sickness and mortality among Britons is less by 10% than in any other British military station in the world." See also Captain Ashby, *New Zealand, the land of health, wealth and prosperity: Its present position and future prospects*, London, s.n., 1889, pp. 23-4.

³⁵ Annual Report, Department of Immigration, AJHR D-9, 1907, p. 1.

³⁶ Registrar-General, *New Zealand official year-book*, 1908, p. 283.

³⁷ R W Philip, 'Remarks on the universal applicability of the open-air treatment of pulmonary tuberculosis', *Br. med. J.*, 1898, ii: 217.

³⁸ William Thomson (LRCS Edinburgh), *On phthisis and the supposed influence of climate being an analysis of statistics of consumption in this part of Australia with remarks on the causes of the increase of that disease in Melbourne*, Melbourne, Stillwell & Knight, 1870, and Stillwell, 1879; see Powell, op. cit., note 6 above, pp. 461, 470.

³⁹ L Bryder, *Below the magic mountain: a social history of tuberculosis in twentieth century Britain*, Oxford University Press, 1988, pp. 22-45.

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there were 23 private tuberculosis institutions in Britain with almost 400 beds; and by 1907 there were almost 700 beds. This was not a large number, but they were rarely full despite extensive advertising to attract patients.⁴⁰

Specialists might have been decrying the advantages of special climates, yet, significantly, attention continued to be drawn to local climatic conditions of sanatoria in Britain. The *Tuberculosis year book* published in 1914 is revealing. The climate at Merivale Sanatorium, Essex, was described as well suited for the treatment of tuberculosis, for the atmosphere was dry and bracing with an abundance of sunshine and very little rain. At Mundesley Sanatorium, Norfolk, the air was said to be “bracing, dry and very pure with a great deal of sunshine throughout the year”. At Crossley Sanatorium, Cheshire, the climatic conditions were “specially healthy, dry and invigorating”. Fairlight Sanatorium, Hastings, had “a maximum of sunshine” and the air was “invigorating and at the same time sedative”. It was claimed that although Pandyffryn Hall was situated in Wales, it was outside the rains; mist was rare, and as a rule the climate was dry and sunny, and the air pure and invigorating.⁴¹

The King Edward VII Sanatorium at Midhurst, in Sussex, an expensive private middle-class sanatorium opened in 1906, had special meteorological equipment which showed the climate to be “mild and equable”.⁴² So too did the Eversfield Chest Hospital, St Leonards-on-Sea, where a meteorological report was included in the medical superintendent’s annual report which stated: “We are in the proud position of having no rival with regard to our amount of bright sunshine.”⁴³

Thus, during this period, even after the infectious nature of the disease had been identified in 1882, there appeared to be a certain rivalry between the various Australasian colonies—and latterly within Britain itself—relating to whose climate was the most agreeable for those suffering from tuberculosis. Sunshine and equable temperatures appeared to be the key components in the calculation. Within New Zealand the preference was for the milder climate of the north.

Legislation restricting entry of those suffering from a “loathsome or dangerous” disease

Another trend emerged simultaneously with the dispersal of this promotional and officially sanctioned propaganda. That was the attempt to restrict the entry of those suffering from infectious diseases, among which it was increasingly realized that tuberculosis had a place. When one such bill was being discussed in New Zealand’s parliament in 1898, several members spoke against it, pointing out the anomaly in “at once advertising the climate and attempting to attract immigrants, and at the same time preventing entry to those who came for the express purpose of improving their health”.⁴⁴

⁴⁰ Michael Worboys, ‘The sanatorium treatment for consumption in Britain, 1890–1914’, in J V Pickstone (ed.), *Medical innovations in historical perspective*, New York, St Martin’s Press, 1992, pp. 53–4, 59.

⁴¹ Kelynack, op. cit., note 31 above, pp. 203, 216, 263, 288.

⁴² *King Edward VII Sanatorium, Midhurst, annual report 1908–9*, Midhurst, King Edward VII Sanatorium, 1909, p. 71.

⁴³ *The Eversfield Chest Hospital, St Leonards-on-*

Sea, annual report 1904, St Leonards-on-Sea, The Eversfield Chest Hospital, 1905, p. 18.

⁴⁴ *Parliamentary debates, House of Representatives of New Zealand*, 19 October 1898, Immigration Restriction Bill (No. 2), P J O’Regan (Buller), p. 160; M J S Mackenzie (Dunedin City), p. 163; W H Herries (Bay of Plenty), p. 167; *Parliamentary debates, Legislative Council of New Zealand*, 13 July 1899, W T Jennings (Auckland), p. 529.

When problems associated with therapeutic migration had been discussed at the first Intercolonial Medical Congress, held in Adelaide, South Australia, in 1887, it was not infectiousness that was the focus but heredity. One commentator had pointed out that Australians were “ever ready to give . . . a kindly welcome to those who are seekers after renewed health in a strange country”. However, he also regretted that more attempts were not made to prevent marriages “with those who will hand down the hereditary form of this dire disease [tuberculosis]”.⁴⁵

Similarly, when a proposed amendment to New Zealand’s Public Health Act, prohibiting entry to tuberculosis sufferers, was discussed at a meeting of the New Zealand branch of the British Medical Association in 1897, Dr Francis McKenzie argued in support of the amendment, “Those suffering from tuberculosis have so often the power of increasing rapidly, and the progeny have a tendency to develop the disease more readily than an ordinary person.” The bill, he claimed, did not result from a fear of spreading infection but rather from a desire to “exclude people who are more likely to contract it”.⁴⁶

Dr McKenzie was the son of a member of parliament, and was probably aware that the dominant political view was inclining towards immigration restriction. Among his medical colleagues, however, his was a lone voice. Dr James Mason introduced the discussion of the proposed amendment at the 1897 meeting. He noted diagnostic problems involved in determining who should be excluded, but above all he considered it a “most inhuman enactment”, pointing out that he himself “and several other [doctors] around this table” would have been “shsuspected persons”[sic] under such legislation.⁴⁷ Dr W J Mackie, who also addressed the meeting, confessed that “though I might not myself have been excluded under a bill of the kind, still there would have been some doubt in the matter”.⁴⁸ (Dr Mackie, who qualified in Ireland and Brussels, had arrived in New Zealand ten years previously. He was to live to the age of 83!) Dr McKenzie, on the other hand, was locally born, and he prefaced his remarks with: “Most of the gentlemen who have spoken previously on the subject of this bill appear to have been biassed, as coming to some extent under the ban of the bill in being undesirable immigrants”.⁴⁹ Indeed, it was not uncommon for doctors with tuberculosis themselves to emigrate.⁵⁰ In his list of doctors in New Zealand prior to 1930, R Wright-St Clair identified no less than 57 such immigrant doctors (a further 16 local-born doctors died of tuberculosis—their decision to return to New Zealand may also have been influenced by their medical condition).⁵¹ Other immigrant doctors may also have been influenced in their decision to immigrate by “weak lungs”, as indicated at the 1897 meeting.

The overwhelming view of the 1897 medical meeting was that so many people would be affected by such legislation that it would have the effect of “isolat[ing] this colony from

⁴⁵ H Eustace Astles, ‘Some remarks upon the South Australian climates and their influence upon phthisis’, *Intercolonial Medical Congress of Australasia, Transactions, First Session, Adelaide, South Australia, August-September 1887*, Adelaide, 1888, p. 60.

⁴⁶ ‘Discussion on “Public Health Acts Amendment” of New Zealand’, *Australas. med. Gaz.*, 20 September 1897: 466.

⁴⁷ *Ibid.*, p. 465.

⁴⁸ *Ibid.*, p. 466.

⁴⁹ *Ibid.*

⁵⁰ David Richards, ‘Queensland’s medical men, 1824–69’, in John Pearn (ed.), *Health, history and society*, Brisbane, Amphion Press, 1992, p. 202.

⁵¹ R E Wright-St Clair, ‘Medical practitioners in New Zealand 1840–1930’, unpublished manuscript, 1989. See also R E Wright-St Clair, ‘Causes of death in colonial doctors’, *N. Z. med. J.*, 1978, **88**: 49–51.

other parts of the world”. Seemingly oblivious to similar problems being discussed elsewhere, Dr Colquhoun, editor of the *New Zealand Medical Journal* and lecturer in the practice of medicine at Otago University, argued that “A more absurd and ridiculous bill—one more likely to make us the laughing-stock of the whole world—was never brought before the Parliament of New Zealand.” This was a time when New Zealand was very conscious of its international status as a “social laboratory”—a tribute to the progressive legislation of the Liberal Government—and such an argument would therefore have carried weight. Dr Colquhoun thought that stamping out the disease depended much more on “an improved state of living, improvement of drainage, sanitation of houses, and other things we all recognise”.⁵² These were indeed to be on the agenda of the new Department of Public Health, which devoted considerable attention to the problem of tuberculosis, including the introduction of compulsory notification of the disease in 1901 (in contrast to England and Wales where compulsory notification was not introduced until 1913, and to Scotland which adopted this measure in 1914). Colquhoun could rest assured that New Zealand’s international reputation was safe; the Act establishing the Department in 1900 was described in the *British Medical Journal* as “placing New Zealand in the van as regards conservation of public health”.⁵³

While the 1897 Public Health Amendment Bill was dropped, a clause restricting entry of “persons suffering from a contagious disease which is loathsome or dangerous” was slipped into the Immigration Restriction Bill the following year, and enacted in 1899.⁵⁴ Most of the parliamentary debates surrounding this Bill focused on the question of Asian immigration. The Bill followed a series of Acts attempting to restrict Asian immigration, and directly replaced the Asiatic Restriction Act of 1896 which had been disallowed by the British Crown (which still controlled New Zealand’s external affairs). The “yellow peril”, a fear of the influx of Asians, was very real to the Liberal Government of the 1890s and 1900s. Discussion did not focus on any suggestion that the Asians were bringing in “contagious” diseases; rather opposition was based on the desire to preserve the predominantly Anglo-Saxon stock and lifestyle generally. The clause relating to “contagious” diseases was tagged on and attracted little discussion in parliament. Four years later, in 1903, tuberculosis was gazetted as “a contagious disease which is dangerous within the meaning of the Immigration Restriction Act”.⁵⁵ This was the same year in which the United States included pulmonary tuberculosis among the “dangerous contagious diseases” to be excluded by medical inspectors of immigrants.⁵⁶

Administration of the Act was another matter. Dr Mason, like other doctors, was still sympathetic. In 1901 he discussed the matter of “people suffering from consumption who . . . land in the colony in search after health”. In his opinion, “viewed from the point of international equity, it seems to me that it would be as unfair as it would be unchristian to deny any fellow creatures the privilege of sharing the beneficent effect of our climate”. His principal concern, as noted above, lay with “advanced and penniless cases” who

⁵² ‘Discussion on “Public Health Acts Amendment” of New Zealand’, op. cit., note 46 above, p. 465.

⁵³ *Br. med. J.*, cited in Annual Report, Department of Public Health, AJHR H-31, 1901, p. 1. On the origins of the Department of Public Health, see Dow, op. cit., note 5 above, pp. 42–66.

⁵⁴ *Statutes of New Zealand*, 1899, vol. 33, p. 116 (Clause 3).

⁵⁵ *N. Z. Gaz.*, 2 July 1903: 1523.

⁵⁶ Alan M Kraut, *Silent Travelers: germs, genes and the “immigrant menace”*, New York, BasicBooks, 1994, p. 273.

would become a drain on New Zealand's welfare services. His other concern was the "indiscriminate way that the sick and the hale are mixed up on board ship". He gave the example of one ship, in which three of the ten saloon passengers were suffering from "phthisis in advanced form":

Cabined with one of these sufferers, who was constantly expectorating large quantities of the tubercle bacilli, was a gentleman who was travelling because of a bad family history and a slight sore throat. Had he of his own free will wished to select an experiment whereby his power of resistance to tuberculosis could be determined, I can honestly say he could not have chosen a better set of conditions.⁵⁷

Four years later Mason noted that:

The ordinary cubic space allowed by shippers to passengers is rarely half as much as one would receive in an ordinary gaol, and when one has to share this with a man exhaling the mephitic aromas of a consumptive undergoing a cure, not forgetting the danger which comes from a careless disposal of the sputum, there is reason for his wondering whether a 'sea voyage' has all the health-bringing influences which he imagined and was told it would have.⁵⁸

This could indeed account for some of the deaths among the newly arrived immigrants.⁵⁹ Despite his concerns, Mason still believed that "To exclude all persons suffering from tuberculosis in any shape or form would be as unfair as it would be difficult to enforce." He explained that following the 1903 regulations, the Port Health Officer only inspected those who were obviously ill on arrival and asked about their financial circumstances. If they were found to be unable to work and therefore likely within a year or so to become chargeable to the state, the shipping company was asked to enter into a £100 bond for five years or to ship them back to the port of dispatch. All shipping companies had been notified to that effect.⁶⁰

In 1904 Dr Thomas Valentine, who was later to succeed Mason as Chief Health Officer, also:

protest[ed] emphatically against the practice of some physicians at Home of sending out unfortunates, who without means, or friends to go to, are indiscriminately packed off to this colony, only to be sent back if the shipping company importing them fails to sign the necessary bond; or who, if successful in passing the Customs authorities, drift into our hospitals and swell our rates.⁶¹

Among health administrators, despite the description of tuberculosis as a "dangerous contagious" disease, the issue of infectiousness was secondary to concern about State dependency and pressure on New Zealand's health services.

All assisted passengers coming to New Zealand in the nineteenth century were, in theory at least, subject to a medical examination before departure from their home country. However, inspections of those heading for New Zealand were in all probability as

⁵⁷ Annual Report, Department of Public Health, AJHR H-31, 1901, p. 13.

⁵⁸ *Ibid.*, 1905, p. xxix.

⁵⁹ See statistics on Auckland below; see also Helen R Woolcock, *Rights of passage: emigration to Australia in the nineteenth century*, London, Tavistock, 1986, p. 297.

⁶⁰ The working of the legislation was explained in the Annual Report, Department of Public Health, AJHR H-31, 1905, p. xxix-xxx.

⁶¹ Annual Report, Department of Public Health, Report by Wellington District Health Officer, AJHR H-31, 1904, p. 22.

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haphazard and cursory as those heading for the USA and Australia.⁶² By the early twentieth century regulations in New Zealand as elsewhere were tighter and appear to have been more rigorously enforced. In 1906 New Zealand's High Commissioner in London boasted that he insisted on "the emigrants being of good physique, and healthy in body and mind".⁶³ The Immigration Department claimed some success in this. Its 1909 report included an extract from a report by a Dr W Spooner who inspected the passengers on the *S.S. Morayshire* which sailed from Liverpool in 1908 and "found them all in good health and of good physical stamina". He took the opportunity to add that:

from the experience I have had in examining passengers for the Board of Trade, I have found that the emigrants embarking for Australia and New Zealand are much superior in physique and stamina to those proceeding either to the United States or Canada, which points to the conclusion that the coming race of New-Zealanders [*sic*] and Australians bid fair to be the pick of the British Empire.⁶⁴

Those who made their own arrangements with the shipping companies escaped such close medical inspection.⁶⁵ The "examiner of the Board of Trade" was charged with excluding those with infectious diseases among prospective immigrants. However, paying passengers probably slipped through the net more easily than assisted passengers.⁶⁶ Certainly there is evidence of a reluctance, as conveyed by the Minister of Health, to subject middle class "ladies" to the indignities of a medical examination.⁶⁷ In relation to tuberculosis, as late as 1910, despite diagnostic advances over the previous decade and despite the prohibited entry of tuberculosis cases from 1903, it was admitted by New Zealand's Department of Immigration that it was in reality very easy to conceal tuberculosis from the examiner.⁶⁸ It was equally possible to escape detection at the port of arrival, as noted by Mason in 1914.⁶⁹

Despite a decade of claims that health examinations were being tightened, in 1911 Wellington's District Health Officer described "some of the pitiable cases" he had been obliged to deal with:

For instance, three persons arrived by one ship, and one died within a fortnight, another within three days, and a third went back to England. It was stated in these cases that the persons had never been told in England about the non-admission of such cases to New Zealand. The Health Officers here had the painful duty in turning such cases back, because such patients often came here with the object of trying to improve their health.⁷⁰

⁶² See Kraut, *op. cit.*, note 56 above, p. 51; Woolcock, *op. cit.*, note 59 above, p. 295.

⁶³ Annual Report, Department of Immigration, AJHR D-9, 1906, p. 2.

⁶⁴ *Ibid.*, 1909, p. 1.

⁶⁵ For the nineteenth century see E M Elder, 'The public health of Dunedin 1848–1860', *Public health thesis*, Otago 1935, p. 100.

⁶⁶ See also Kraut, *op. cit.*, note 56 above, p. 51.

⁶⁷ See Dow, *op. cit.*, note 5 above, p. 51; on similar concerns in Canada see G Bilson, 'Dr Frederick Montizambert (1843–1929): Canada's first Director General of Public Health', *Med. Hist.*, 1985, 29: 386–400, on p. 391.

⁶⁸ Annual Report, Department of Immigration, AJHR D-9, 1910, p. 1. On diagnostic problems, see L Bryder, "Not always one and the same thing": The registration of tuberculosis deaths in Britain, 1900–1950', *Soc. Hist. Med.*, 1996, 9(2): 253–65.

⁶⁹ J M Mason, 'New Zealand and the fight against tuberculosis', in Kelynack, *op. cit.*, note 31 above, p. 114.

⁷⁰ Annual Report, Department of Public Health, Minutes of proceedings of conference of delegates of Hospital and Charitable Aid Boards, Wellington, AJHR H-31, 1911, p. 180.

The following year, in 1912, a further attempt was made to tighten regulations when it was decided that the New Zealand government should appoint its own “medical men” to inspect emigrants at the point of departure. However, this decision was not supported by New Zealand’s medical community. In 1912 the Department of Public Health convened a conference on tuberculosis, where the restriction on immigration was the only subject about which the delegates at the conference were not unanimous. Some were in favour of admitting early cases of tuberculosis, arguing that, as British subjects, such people should not be “denied the advantages that were available to their more-robust fellow-countrymen”.⁷¹ At least one of the delegates at the conference was himself later to die of tuberculosis—Sydney Champtaloup, Professor of Bacteriology and Public Health at the University of Otago from 1911, died of tuberculosis in 1921, aged 41. As had been made clear during the 1897 discussions, he was far from being the only doctor who arrived in the colony with “weak lungs”.

The generally sympathetic attitude of the medical profession, for whatever reason, towards immigrants with tuberculosis was not shared by Dr James Mason, whose views had hardened over the years. After retiring as Chief Health Officer in 1909, he acted briefly as consulting medical officer in London for intending immigrants, though his own poor health led him to return to New Zealand as the climate in Britain was “too hard to bear”.⁷² In 1914 he was invited to contribute an article to the first volume of the British-based *Tuberculosis year book and sanatoria annual*. He stated unequivocally: “New Zealand does not invite persons suffering from tuberculosis, in any form, to come to the Dominion. Therefore, in no sense of the word can this Southern Britain be regarded as a health resort for the consumptive”.⁷³

Tuberculosis deaths in Auckland, a local study⁷⁴

How successful was the promotional literature and how effective the restrictive legislation? A local study of those who died from tuberculosis in Auckland during the period 1880–1914 gives some indications. Auckland, accommodating approximately 100,000 people in 1900 (out of a total population for New Zealand of just over 800,000), was, alongside Wellington, the major port of entry of immigrants to New Zealand. It also appeared to be a favoured destination among those who promoted therapeutic migration to the country.

A notable feature of the 3,500 or so deaths from tuberculosis in Auckland in the period 1880–1914 was indeed the number of recent immigrants. Over 500 had lived in the colony for under five years; and 167 for less than one year. Another 282 were immigrants for whom the length of time in the colony was unknown. Most of these, like other immigrants,

⁷¹ Annual Report, Department of Public Health, ‘Administrative control and treatment of tuberculosis (report of conference, 1912)’, AJHR H-31, 1913, p. 4.

⁷² D A Dow, ‘James Malcolm Mason (1864–1924)’, *Dictionary of New Zealand biography*, vol. 3 (in press).

⁷³ Mason, op. cit., note 69 above, pp. 114–15 (italics in original).

⁷⁴ Using the death certificates of those whose cause of death was stated to be tuberculosis in Auckland, 1880–1920, I created a database of c. 4,000 names and their personal details. Information given on the death certificates included age at the time of death, sex, place of death, place of residence, marital status, number of children, place of birth, place of marriage, and length of residence in New Zealand.

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came from Britain. Did those immigrants contract tuberculosis in New Zealand, or on the voyage coming out, or did they leave their homeland already suffering from the disease?

While these questions cannot be answered, a study of those who died from tuberculosis within one year of arrival in the colony during this period does reveal a very distinctive pattern which differentiates them from other immigrants as well as from the general pattern of tuberculosis deaths, in Britain and elsewhere. Conforming to general immigration trends, men predominated among the tuberculosis deaths. However, the gender imbalance was more accentuated among tuberculosis deaths than among immigrants in general. While the ratio of male to female arrivals around that time was 4.5 to 3 (among adults),⁷⁵ the ratio among those who died from the disease was almost 4 to 1. The male deaths peaked at ages 20–29 (see Figure 1), which does not reflect the usual age distribution of tuberculosis deaths. In England and Wales, for example, the highest male tuberculosis death rate occurred in the age group 45–55 (see Figure 2).⁷⁶ For New Zealand as a whole the tuberculosis death rates for males peaked at ages 20–40 (apart from 60–65), but were almost as high in the age group 40–60 (see Figure 3).

Most of the male immigrants in the sample were single, while most of the women were married. Indeed, only four single women appeared among the deaths in the period 1880–1899, and one of these had her brother with her (he was the informant to the Death

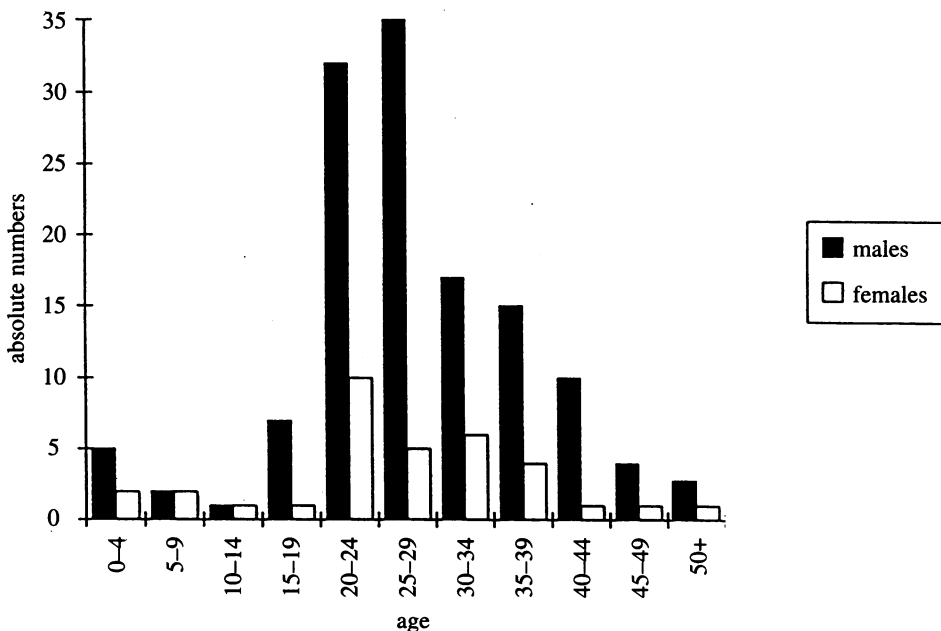


Figure 1: Immigrants by age and sex who died within a year of arrival in New Zealand, 1880–1914.

⁷⁵ Report on Immigration, 'Arrivals from United Kingdom, May—September 1894', AJHR, D-4, 1894, pp. 1–3.

⁷⁶ Bryder, *op. cit.*, note 39 above, Table 7, p. 122.

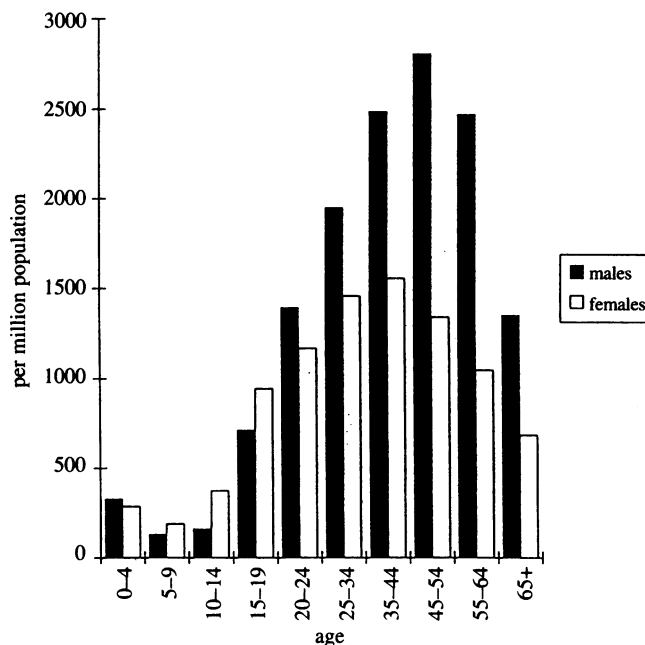


Figure 2: Phthisis mortality per million living, England and Wales, 1905-9. Source: Registrar General, *Annual report, England and Wales*, 1911, p. lvii.

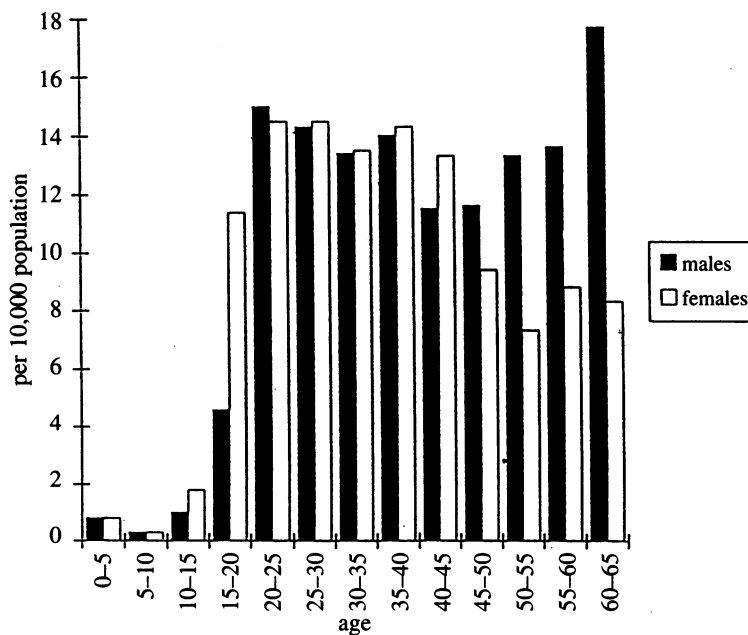


Figure 3: Deaths from phthisis per 10,000 population, New Zealand, 1894-98. Source: M A Segar, 'On the recent statistics of insanity, cancer, and phthisis in New Zealand', *Transactions and Proceedings of the New Zealand Institute*, 1901, 34: 122.

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Registrar). The male predominance appears not to have been unique. Sheila Rothman's work on America indicates a gender difference in the response to tuberculosis. While American men were encouraged to seek health (which usually meant, "Go West young man"), women were much more likely to stay at home.⁷⁷ This trend was also noted in relation to New South Wales in 1899: "Probably young women frequently shrink from undertaking alone a long voyage and residence in a new and distant land. Perhaps also, amid the stern realities of life, male lives being the better producers, are taken more care of,"⁷⁸ claimed the actuary, W R Dovey, in 1899.

There was another important way in which the immigrant tuberculosis victims differed from the general run of immigrants and from the perceived patterns of tuberculosis deaths in Britain at the time; that was in their socio-economic status. The great influx of immigrants to New Zealand in the mid-nineteenth century and in the 1870s had been "solidly working-class".⁷⁹ Among the tuberculosis deaths there was no such clustering (see Figure 5). Tuberculosis in Britain in the nineteenth century was commonly perceived as a disease of the slums, "causally linked . . . with poverty and overcrowding".⁸⁰ Well into the twentieth century, the Registrar General for England and Wales produced statistics to show tuberculosis deaths inversely related to socio-economic status (see Figure 4). The deaths from tuberculosis in Auckland in general, in the period 1900–20, did not replicate such a neat pattern (see Figure 6). The graph charting tuberculosis immigrant deaths was even more skewed; the immigrant tuberculosis deaths differed from both the British and the overall Auckland patterns in the number who came from socio-economic group 1. Table 1 gives examples of the occupations of some of the tuberculosis victims as well as the occupations of their fathers (which was sometimes a more accurate indication of social status). Not only were these the people who could afford to send consumptive relatives away, but if, as seems likely, tuberculosis was being increasingly stigmatized as a disease of the slums, or the "unbeautiful poor",⁸¹ in Britain around the turn of the century, the attractiveness of disposing to the colonies favoured sons of the middle classes who had had the misfortune of catching tuberculosis, becomes more explicable.

This presence of young, single, well-to-do males among the tuberculosis deaths of recent arrivals, suggests more than coincidence. Rather, it is probable that these young men were indeed the failures in the current curative practice of "therapeutic migration". The legislation and regulations of the early twentieth century had little impact on them, directed as it was to the non-British and to those without financial resources.

⁷⁷ Sheila M Rothman, *Living in the shadow of death: tuberculosis and the social experience of illness in American history*, New York, BasicBooks, 1994. On American migration, see also Michael E Teller, *The tuberculosis movement: a public health campaign in the progressive era*, New York, Greenwood Press, 1988, pp. 11–12, 79.

⁷⁸ Dovey, op. cit., note 12 above, p. 15.

⁷⁹ Rollo Arnold, *The farthest promised land: English villagers, New Zealand immigrants of the*

1870s, Wellington, Victoria University Press, 1981, pp. 350, 353.

⁸⁰ Anne Hardy, *The epidemic streets: infectious disease and the rise of preventive medicine 1856–1900*, Oxford, Clarendon Press, 1993, p. 227.

⁸¹ H de Carle Woodcock, *The doctor and the people*, London, Methuen, 1912, pp. 184, 202–3, cited in Bryder, op. cit., note 39 above, p. 20.

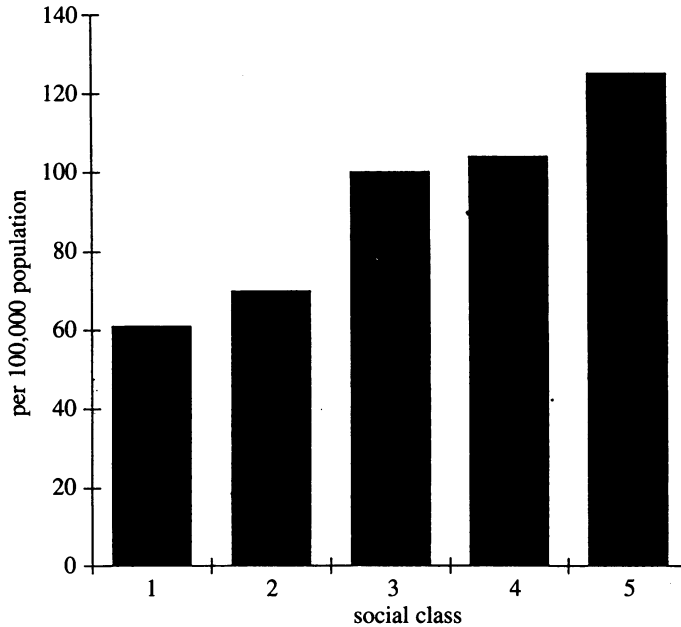


Figure 4: Standardized death-rates per 100,000 population from pulmonary TB among occupied males (aged 20 to 65) by social class in England and Wales, 1930–32.

Source: Registrar-General, *Decennial supplement, England and Wales, 1931, 1935*, p. 31.

Conclusions

After the infectious nature of tuberculosis was established in the late-nineteenth century, legislation was introduced to restrict the entry to New Zealand of those suffering from tuberculosis, declared a “dangerous contagious” disease in 1903. In reality, the attempts to restrict entry by British tuberculosis sufferers were minimal, both before and after the new regulations. Emigration to a British colony seems to have been considered their birthright. British people with tuberculosis were still considered more desirable immigrants than Asians, however healthy. The restrictions on British entry certainly appeared to have little medical support as late as 1912. Only those without adequate financial means were to be denied access. Even then, it is not clear how many were excluded. Dr Mason’s denial of New Zealand as a “health resort for the consumptive” came at the end of almost half a century during which such a belief had not only been condoned in New Zealand but had been actively encouraged.

A legacy for New Zealand of the medical beliefs of the late nineteenth century may have been the arrival of many professional or well-to-do people who were not featured in the death registers of 1880–1920, because they survived to live for many years (as a large percentage of those who contracted tuberculosis probably did, particularly if they arrived in the “early” stages of the disease). With a prognosis as unreliable as that for tuberculosis, even “advanced” cases could go into remission and survive for a long time. Eisdell

Table 1: Sample of men born in the British Isles who died within 12 months of arrival in New Zealand, 1880–1914.

No.	year of death	sex	age	place of birth	time in NZ	occupation	father's occupation
20	1880	m	21	Norfolk, England	3 months	schoolmaster	n/a
32	1880	m	40	Ireland	few months	clergyman, RC	n/a
254	1883	m	33	Belfast, Ireland	7 months	tramway manager	merchant
352	1884	m	42	Woolwich, England	3 months	sergeant Royal Engineers	n/a
354	1884	m	26	London, England	2 months	broker	receiver, Inland Revenue
398	1884	m	36	Surrey, England	2 months	gentleman	n/a
406	1884	m	22	Devonshire, England	5 months	Imperial civil engineer	clergyman, CE
469	1885	m	22	Scotland	3 months	school teacher	n/a
537	1885	m	26	London, England	9 months	minister of religion, Baptist	n/a
621	1886	m	23	Cheshire, England	2 months	B.A.	clergyman, CE
629	1886	m	24	Loughborough, England	8 months	manufacturer of hosiery	bank manager
695	1887	m	23	Belfast, Ireland	7 weeks	commercial traveller	doctor of medicine
758	1887	m	23	Leeds, England	3 months	chemist	chemist
767	1887	m	39	London, England	10 months	solicitor	gentleman
778	1887	m	27	England	12 months	bombardier, RA	n/a
790	1888	m	27	Aberdale, South Wales	3 weeks	draper	coalmine manager
796	1888	m	31	Tyrone, Ireland	7 months	clerk	clergyman
840	1888	m	29	Scotland	6 months	gentleman	merchant
901	1889	m	29	Leeds, England	5 months	clerk in holy orders	clerk in holy orders
1068	1891	m	20	Exeter, England	12 months	gentleman	clerk in holy orders
1080	1891	m	21	Nottingham, England	14 days	accountant	n/a
1188	1892	m	19	Manchester, England	10 months	clerk	accountant
1390	1893	m	29	London, England	5 months	journalist	gentleman
1762	1897	m	25	Sussex, England	2 months	gentleman	gentleman
1976	1899	m	22	London, England	6 months	gentleman	solicitor
476	1905	m	22	Lancashire, England	10 months	solicitor	mining engineer
763	1908	m	27	Ireland	4 months	clergyman, RC	n/a
1229	1912	m	27	Cardiff, Wales	3 months	marine engineer	n/a

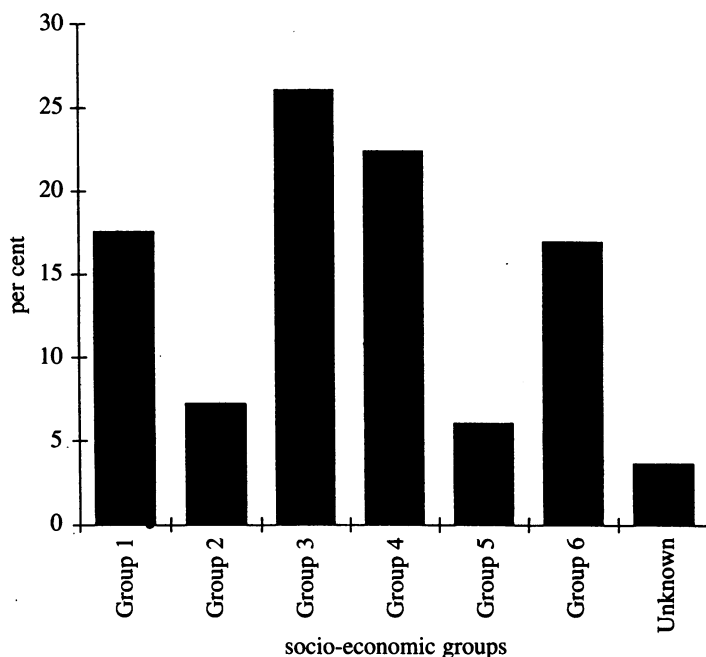


Figure 5: Socio-economic status of those who died of TB in Auckland within a year of arrival in New Zealand, 1880–1914.

Group 1 = Higher professional, administrative, and independent means

Group 2 = Lower professional, technical and executive work

Group 3 = Clerical, highly skilled, small business

Group 4 = Skilled work

Group 5 = Semi-skilled repetitive work

Group 6 = Unskilled repetitive work

Moore's father, the chemist, was by no means unique. The mid-nineteenth-century colonizer, Edward Gibbon Wakefield, claimed that the majority of British immigrants came from the "anxious" classes. This description was repeated by New Zealand's eminent historian, Sir Keith Sinclair, in his standard *History of New Zealand*, and has become an orthodoxy.⁸² A study of "therapeutic emigration" suggests that at least some migrants were indeed "anxious" though not in the economic sense meant by Wakefield and Sinclair, but rather anxious about their health.

⁸² Keith Sinclair, *A history of New Zealand*, Auckland, Penguin, rev. edn, 1988, p. 101.

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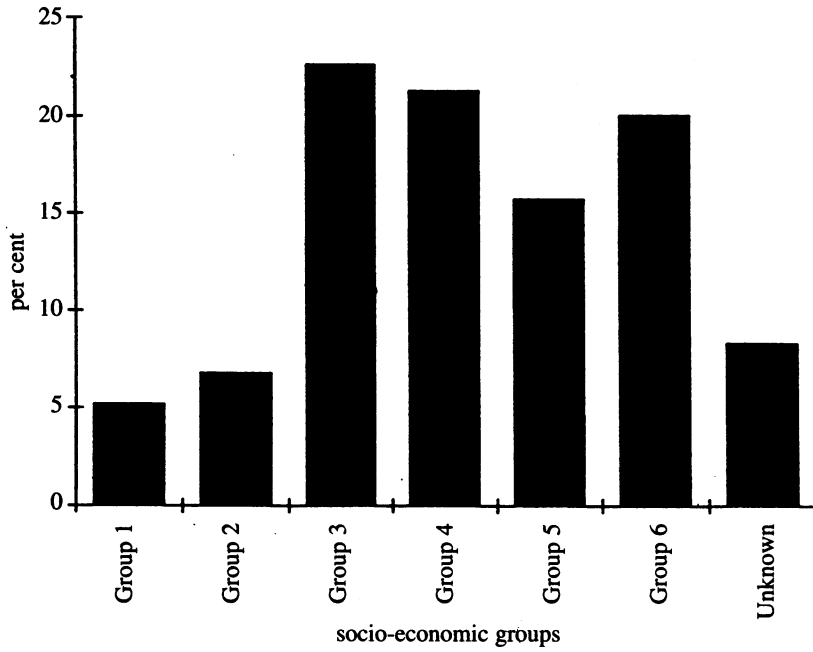


Figure 6: Socio-economic status of those who died of TB in Auckland, 1900–20.