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Cancer, Dread, and Hope

Institutional, Medical, Alternative, and Popular Responses to Cancer in New Zealand from the Late Nineteenth Century to 1940

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in History

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Abstract

This thesis examines cancer in New Zealand from the late nineteenth century until 1940. During this period, the rise of cancer incidence, cancer’s mysterious nature, and popular dread of cancer converged to transform cancer into a significant public health issue. As the first history of cancer in New Zealand, this thesis focuses on encapsulating the institutional, medical, alternative, and popular responses to cancer. This involves an institutional approach that centres on the role of the medical profession, New Zealand’s Department of Health, and the New Zealand Branch of the British Empire Cancer Campaign. In addition to this, significant attention is given to the role of alternative medical practitioners and popular beliefs. This shows that a pluralistic approach illuminates the relationships and interactions between these different groups and their belief systems.

Through an examination of these different responses to cancer, this thesis contributes to a growing international literature on the history of cancer, New Zealand’s public health history, and the history of alternative medicine. From an institutional perspective, the thesis finds that the introduction of radiotherapy, New Zealand’s research contributions, and the promotion of a message of hope through education shed light on the role of scientific progress and challenges to it, the prominence of the concept of hope, and institutional transformations. In addition, New Zealand is situated in respect to broad international trends and in comparison to developments in other countries.
The examination of alternative practitioners and popular beliefs demonstrates the importance of not understanding institutional responses in isolation. In particular, the thesis considers the role of metaphor and popular beliefs about cancer and the significant impact they had on institutional and alternative responses. It also questions idiopathic frameworks that position popular beliefs in relation to gullibility and ignorance. It finds that the impact that the rise of the orthodox medical profession had on the so-called decline of alternative practitioners is questionable. By examining the beliefs and impact of alternative medical practitioners outside of this model of decline, this thesis shows that there was significant continuity in the popularity, prominence, and success of alternative practitioners.
Acknowledgements

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Finally, I would like to thank my family for their support, particularly my mother, Sheree Taewa, and my fiancée, for supporting and putting up with me.
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<tr>
<td>AJHR</td>
<td>Appendices to the Journals of the House of Representatives</td>
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<td>ANZA</td>
<td>Archives New Zealand, Auckland</td>
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<tr>
<td>ANZC</td>
<td>Archives New Zealand, Christchurch</td>
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<tr>
<td>ANZD</td>
<td>Archives New Zealand, Dunedin</td>
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<tr>
<td>ANZW</td>
<td>Archives New Zealand, Wellington</td>
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<tr>
<td>ASCC</td>
<td>American Society for the Control of Cancer</td>
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<tr>
<td>BECC</td>
<td>British Empire Cancer Campaign</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
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<td>DPH</td>
<td>Department of Public Health</td>
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<tr>
<td>ICRF</td>
<td>Imperial Cancer Research Fund</td>
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<td>NCI</td>
<td>National Cancer Institute</td>
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<td>NRL</td>
<td>National Radiation Laboratory</td>
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<td>NZBECC</td>
<td>New Zealand Branch of the British Empire Cancer Campaign</td>
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<td>NZPD</td>
<td>New Zealand Parliamentary Debates</td>
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<td>NZS</td>
<td>New Zealand Statutes</td>
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Chapter One
Introduction

In 1893, New Zealand’s premier, John Ballance, suffered from a cancerous stricture of the large bowel. An Evening Post journalist, Ernest Hoben, published the story of Ballance’s illness. Hoben documented how Ballance sought out Mr Heiden, a specialist in massage and magnetism, to treat his ailment before undertaking treatment by medical professionals. After a series of consultations, surgery was undertaken as a last resort and ‘the only alternative to death’ and the ‘agony’ he was in. The surgery failed and upon Ballance’s demise, it was reported in the press that ‘the dread disease, cancer, claimed him as yet another victim’.

Ballance’s death reveals illuminating information about cancer and its treatment in the late nineteenth century. Cancer itself was considered a dread disease—dreaded because it was popularly believed to be a slow, painful, degenerating, and inevitable death. Treatment for cancer was contested territory. At this time, surgery was the main option available to the medical profession, and popular fear of ‘the knife’ encouraged many sufferers to seek out alternatives. Indeed, the Premier himself sought out magnetism as a treatment option before surgery. Both fear of cancer and of surgery were significant issues that the medical profession and public health authorities responded to. In framing this thesis there are three primary issues that are dealt with: public and professional conceptions and understandings of cancer; responses to cancer by the medical profession and public health authorities; and alternative and popular responses. The developments or lack of development in respect to cancer control are positioned within both local and international public health contexts.

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2 Bruce Herald, 28 Apr. 1893, p. 3.
This history of cancer in New Zealand begins in the late nineteenth century and continues until the end of the interwar period. This periodization is intentional. Before and after these periods there were significant changes in the intellectual understandings of cancer. In the mid-nineteenth century, understandings of diseases like cancer were different because this predated advancements in bacteriological and cellular knowledge. Definitions of cancer were not constant and could be confused with consumption, general constitutional weakness, or just lost to an unknown internal complaint. By the late nineteenth century, cancer was almost completely distinguishable from tuberculosis; it could be identified at a cellular level as malignant; and more accurate diagnosis and records meant cancer was more regularly correctly identified as a cause of death. At the other end of my chosen period — from the 1940s — responses to cancer and areas of research began to change dramatically. In particular, there was a significant focus on environmental factors, and later the role of genetics and chemotherapy represent a clear distinction from the interwar era that saw the development of radiotherapy. This thesis engages with three key areas of historical literature: the history of cancer; the history of alternative medicine; and New Zealand medical historiography. The following sections in the introduction discuss these three key areas of historiography in more detail, together with the sources of this thesis, and the thesis structure.
Historiography

In 1987 James Patterson’s *The Dread Disease* provided the first significant investigation into cancer from a historical perspective. Across the following twenty-five years, a range of historical writing revealed the methods of cancer ‘control’ in different national contexts that developed in Europe and North America. In one sense, this thesis looks sideways at this historiography to see how New Zealand developed relative to other countries. By doing this, it is possible to position developments in New Zealand, including both similarities and differences, in a broader international context. Another method of engagement with international historiography is to see how New Zealand interacted internationally. In particular, this includes international developments, trends, and influences that shaped the responses to cancer in New Zealand.

The construction of diseases is an area that has received historical attention and cancer is no exception. One of the key features of Patterson’s work is the role of the popular dread of cancer. Patterson drew on American sociologist Susan Sontag’s commentary about metaphorical associations with cancer. Sontag created a persuasive portrait of how cancer was perceived: an ‘abnormal’ and ‘lethal’ growth that worked ‘slowly’ and ‘insidiously’ to degenerate the body like a ‘demonic pregnancy’. Patterson used Sontag’s ideas surrounding disease conceptualisation and argued that popular dread of cancer was a type of illogical and ‘irrational’ ‘cancerphobia’. A Canadian historian, Barbara Clow, challenged

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5 Sontag, pp. 9-10, 16-19, 65.

6 Patterson, pp. 12-35.
the extent and appropriateness of both Patterson and Sontag’s commentaries on the construction of cancer. Clow grounded her critique on the idea that social conceptions of diseases were not entirely constructed as metaphors but were partly shaped by the ‘lived experience’ of disease. In comparing cancer with cardiovascular disorder, Clow demonstrated that the experiences of the diseases are quite different, with cardiovascular diseases being perceived as a ‘good death’. Cancer led to disfigurement and had a visual element; it was also slow and painful. The treatments for cardiovascular diseases were ‘mild’ compared to cancer. Clow argued that instead of interpreting popular reactions to cancer in terms of hysteria and cancerphobia, that, in the context of cancer experiences, popular dread of cancer was a rational and legitimate fear. David Cantor and Robert Proctor also addressed the role of the modernisation of civilization in the formation of popular understandings of cancer causation.

In addition to conceptions surrounding cancer, the role of institutional and public health responses to the cancer problem has received a significant amount of attention internationally. One of the most prominent areas of discussion in cancer historiography is the role of education as a response to cancer. A number of histories have indicated that a focus on early detection and treatment was one of the main focus areas of American cancer control, particularly after the establishment of the American Society for the Control of Cancer (ASCC) in 1913. This included large-scale public education programmes that were implemented in conjunction with physician education, political lobbying, and fundraising. Cantor argued that

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8 Clow, Negotiating Disease, p. 11.


before 2000 a ‘standard’ narrative had been established that claimed that cancer prevention developed after the Second World War. This definition of prevention focussed on environmental and external factors that excluded early detection and treatment using surgery and radiotherapy. Cantor contested that prevention was a malleable concept and that this approach needed to be revised because contemporaries viewed early detection and treatment as a form of prevention. Cantor and others argued that despite broad similarities, there were diverse approaches between nations in educational responses to cancer. In the early twentieth century, British and European responses, in terms of public education, were more cautious and paternalistic than American responses. For example, there was no public education on cancer in the Netherlands until the 1950s. In Britain, there was a reluctance to educate the public and there was a focus on educating medical professionals and using localized and low-key methods of education until the 1950s. Instead, there was a stronger research focus through major research charities, The Imperial Cancer Research Fund (ICRF) and the British Empire Cancer Campaign (BECC).
In shaping responses to cancer, key institutions dedicated to cancer played a significant role in many countries. Patterson argued that in America a ‘cancer establishment’, made up of upper-middle class groups, medical elites including surgeons and gynaecologists, journalists, and laboratory researchers and epidemiologists, was increasingly influential as a politically powerful group that influenced the direction of cancer organization. While there was extensive localized variation, a hierarchical structure developed that channelled patients into specialized centres, including local, regional and national cancer centres. In France, Patrice Pinell argued, a negotiation between research groups, elite society, hospitals, and physicians led to the institution of an anti-cancer league that oversaw the establishment of anti-cancer centres. In contrast, according to historian Charles Hayter, the interaction between competing interest groups was influential in its relatively delayed establishment of specialist cancer institutions.

One of the most prominent features of the period of this thesis is the introduction of radiotherapy as a cancer treatment. Historiography on cancer and radiotherapy focuses primarily on comparative institutional developments in the interwar period. In the United States, most scholars agree that there was a focus on a market-driven approach in relation to the treatment of cancer. This resulted in significant variations based on geography, economics, and the perceived value of radiotherapy. There was no central agency and investment was based on individual institutions’ funding and philanthropy. From the 1920s, there was a large expansion in the United States of specialized cancer clinics. From the late

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16 Patterson, *The Dread Disease*, considers the role of this cancer establishment in relation to the medical profession, institutional investment, and the development of government institutions and bureaucracy.
1930s, the establishment of the National Cancer Institute (NCI) provided greater access to radium by acting as a source of purchasing and distribution.\textsuperscript{21}

In contrast to the United States, in Britain and Canada there was a stronger involvement by the state in healthcare. In Britain, individual institutions and philanthropy were influential in purchasing radium. This resulted in a fragmentation in radiotherapy services with key centres like Manchester dominant.\textsuperscript{22} In 1929, the Radium Trust and Radium Commission were established for the centralized purchase and distribution of radium. This provided the opportunity for the government to influence and shape services.\textsuperscript{23} A similar situation was evident in Canada where there was initially a fragmentation in cancer care but state involvement in healthcare during the 1930s brought a strong degree of centralization.\textsuperscript{24}

During the period of this thesis, research institutions dedicated to cancer were established across North American, Britain and Europe. Britain was dominated by major cancer charities, the ICRF and the BECC, which focussed on research. They saw other areas, like education, as a diversion from their main aims.\textsuperscript{25} In America a number of dedicated cancer research centres were established; however, America’s

\begin{flushleft}
\textsuperscript{23} Murphy, pp. 10-14; Pickstone, pp. 176-177. \\
\textsuperscript{24} Hayter, \textit{An Element of Hope}, pp. 4, 7. \\
\textsuperscript{25} Prominent British cancer research institutions include: The Cancer Investigation Committee at Middlesex Hospital (1900), the Imperial Cancer Research Fund (1902), and the British Empire Cancer Campaign (1923); on the role of research in hospitals in Britain see Murphy, ‘A History of Radiotherapy to 1950’; on radiology in British institutions see Murphy, ‘From Friedenheim to Hospice’, pp. 221–41; on the ICRF and BECC see Austoker, \textit{A History of the Imperial Cancer Research Fund}, pp. 16-19; Austoker, ‘The Politics of Cancer Research’; and on the role of Britain’s Medical Research Council see Cantor, ‘The MRC’s Support for Experimental Radiology during the Inter-war Years’, pp. 181–204.
\end{flushleft}
major cancer charity, the ASCC, also included a strong educational focus. A stronger centralized and national approach to research developed after the establishment of the National Cancer Institute (NCI) in 1937. The NCI not only undertook its own research but also funded outside research. Across a number of major countries, including France, Sweden, the Ukraine, and the Netherlands, multilayered research programmes were established that investigated radiotherapy and considered a variety of pathological causes of cancer. In Germany, unlike other countries, there was a strong early focus on environmental prevention of cancer. Significant Canadian investment into cancer research began after the United States from the 1930s. Provincial institutions developed in the early 1930s and the educationally focussed Canadian Society for the Control of Cancer was established in 1938.

One area of cancer that has received a significant amount of historical attention is the role of gender. Ornella Moscucci argued that in Britain, due to the high proportion of cervical and breast cancer rates in women, cancer was often seen to be a women’s disease and this was reflected in anti-cancer propaganda. In America, some forms of cancer education focussed on educational messages specific to gender. There has also been a significant amount of writing on gendered cancer treatment, particularly linked to breast cancer and gynaecology, as this was an area

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26 Notable institutions involved in research include the New York State Institute for the Study of Malignant Disease (1898), cancer research laboratories at the Rockefeller Institute (1905) Roswell Park Research Institute (1907), the American Association for Cancer Research (1907), the American Society for the Control of Cancer (1913), and the National Cancer Institute (1937) in America; see Victor Triolo and Ilse Riegel, ‘The American Association for Cancer Research, 1907-1940: Historical Review’, Cancer Research, 21 (1961), p. 138; Cantor, ‘Introduction’, p. 6.


28 The Laboratoire Biologique du Radium in Paris (1906) and the French League against Cancer (1918) in France; institutions were established in the Ukraine (1908), Sweden (1910), and the Netherlands (1913); Pinell, ‘Cancer’, pp. 674-5.

29 On issues of the meaning of prevention see Cantor, ‘Introduction’, p. 3; on the German Central Committee for Cancer Investigation (1900) in Germany see Proctor, The Nazi War on Cancer.

30 Hayter, An Element of Hope, pp. 83, 163, 184; on research issues in the University of Montreal Institute du Radium see Hayter, ‘Tarnished Adornment’, pp. 343-65.

31 Moscucci, p. 368

that received a significant amount of attention by contemporaries in America and Britain.  

In 1984, Roy Porter observed that both physicians and historians have written the history of medicine as the history of orthodox medicine. James Olsen indicated that for every publication on the history of medicine by historians, there were a hundred by physicians. These medical-based histories tended to be heroic narratives that focussed on achievements by doctors, technical advances in knowledge, and new methods of treatment. Without a stronger inclusion of alternative medicine, Judith Leavitt argued, there is a ‘distorted’ picture of the realities of medical treatments. Since the late 1980s, as part of developing social history trends, the subject of alternative medicine has received considerable historical attention in response to its relative exclusion from physician-based history that focussed on the progress of scientific medicine. This resulted in a number of works that drew attention to a range of alternative sects to provide a more diverse and inclusive history.

A standard historical model of alternative medicine became established from the 1980s. This was based on a premise of decline in the early twentieth century and revival from the 1970s. Paul Starr’s influential work, *The Social Transformation of American Medicine*, traced the rise of the medical profession and its monopolization

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of healthcare. Accepting the perception of alternative medicine’s revival, John Burnham described the first half of the twentieth century as a ‘golden age’ of conventional medicine. A number of historical works have positioned alternative medicine in relation to these models. Historians, including Hans Baer and Roberta Bivins, while championing pluralism, positioned alternative medicine in the context of decline in relation to the rise of the medical profession. However, there is a growing historical literature that challenges this model of decline and revival. Instead, the extent of dominance by the medical profession is questioned and a model of continuity is adopted. Robert Johnson, Barbara Clow, and others challenged the ‘legitimacy’ of Starr’s medical model and the ‘marginality’ of alternative medicine.

While alternative medicine has increasingly become a subject of greater historical scrutiny, another significant issue is how alternative practitioners and their patients have been viewed. A number of works have presented what I identify as a skewed picture of both alternative medicine and their patients. For example, James Harvey Young and Patterson characterized the popular appeal of alternative medicines in terms of popular gullibility and the success of alternative treatment methods was attributed to unscrupulous methods. Phillippa Martyr challenged historical constructions that favour ‘orthodox’ medicine by rewriting the history of medicine from an alternative perspective: primacy was given to alternative methods and she critically scrutinized the success and legitimacy of

orthodox medicine. The lesson from Martyr is that the writing of alternative medical history needs to avoid uncritically accepting either orthodox or alternative perspectives. James Whorton also challenged these types of constructions and argued that health faddists, like other alternative practitioners, have been incorrectly characterised in historiography in terms of ‘credulity’. Whorton explained that their popularity has been ‘lazily’ explained as ‘human gullibility’ in ‘idiopathic’ terms rather than being ‘symptomatic’ of their ‘intellectual and social environment’. In addition to this, in respect to alternative medicine more generally, Clow argued that patient perspectives tend to be marginalized in many alternative medical histories and that by focussing on the actions of alternative healers themselves a ‘skewed’ history was formed. Clow called for a greater focus on patients and sufferers’ perspectives in addition to the medical profession and alternative practitioners.

Cancer is a subject that is mostly absent in New Zealand’s medical historiography. Some physician-based history has detailed the development of radiology in New Zealand. There is one book chapter on the historical origins of radiotherapy that outlined hospital purchases and staff appointments. Derek Dow’s history of the Department of Health (DOH) briefly discussed the debate surrounding cancer education from 1914-1916, the institution of educational
pamphlets, and the production of statistical commentary.\textsuperscript{49} Naturally, as a general history of the DOH, Dow’s coverage is limited to the most prominent periods and events from a DOH perspective. The relative absence of cancer in Dow’s history, and perhaps New Zealand’s medical history more generally, is an illuminating fact in itself. This silence is reflective of how cancer was viewed as a low priority by the DOH and the government more generally. In some ways, as cancer becoming more significant in the twentieth century, a number of diseases that were already prominent in the early twentieth century overshadowed it. This was, in part, due to the fact that death from cancer typically occurred in the later stages of life. Dow argued that with the exception of a brief period around 1915, tuberculosis was the focus of the Department of Public Health (DPH)/DOH in the early twentieth century.\textsuperscript{50} There are a number of other diseases that were prominent in brief periods across the twentieth century that have received historical attention: influenza in 1918, venereal disease in the 1920s, and mental illness in the late 1920s and early 1930s.\textsuperscript{51}

One characterization of cancer in New Zealand in \textit{New Zealand’s Official Yearbook} was that it was an ‘old man’s disease’.\textsuperscript{52} Both women and Maori were generally excluded from this understanding. In general, the role of gender and cancer in New Zealand was less pronounced than many other countries. The relatively small size of New Zealand meant that evidence relating to specialist medical attention and concern relating to female cancer rates was lacking. Other reasons include New Zealand’s relatively small population base and different demography that reflected a gender imbalance; the early centralization of public health and a focus on preventative approaches; and the fact that male cancer rates exceeded female

\textsuperscript{50} ibid.
\textsuperscript{52} \textit{New Zealand Official Yearbook}, Wellington: Govt Printer, 1919, p. 176
rates. It was a commonly held belief that cancer was a relatively rare disease among indigenous populations and it might be expected that a history of cancer in New Zealand would include detailed discussion of cancer and Maori. In terms of historiography and contemporary sources, commentary on cancer in relation to Maori is virtually non-existent. Raeburn Lange, writing on Maori health development in New Zealand, indicates that in respect to Maori ‘there is no record of cancer, but it may well have existed’. Lange argued that as Maori life expectancy was significantly lower than New Zealand Europeans that Maori health responses focussed on mortality from communicable diseases, particularly tuberculosis. This meant that non-communicable diseases that predominantly affected the aged, like cancer, received limited attention. In my research, I have not found enough evidence concerning cancer and race to merit detailed investigation. There are small snippets of newspaper evidence relating to faith-based treatments by Maori prophets, an obituary of a Maori chief dying from cancer, commentary on Maori incidence based on statistics of dubious quality, and medical case-study reports from Rarotonga of approximately six potential cases of cancer in Cook Island Maori.

The final significant area of New Zealand’s medical historiography is the role of the medical profession and alternative practitioners. Like much of New Zealand’s historiography generally, there is a lot of significant information in unpublished thesis work. Michael Belgrave’s writing on the medical profession and its impact on alternative medicine is significant. In a similar way to Starr’s model, Belgrave traced how New Zealand’s medical profession became politically powerful,

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56 ibid., pp. 4-5, 35, 261, 286.
educationally homogenous, and economically successful. Belgrave argued that from the late nineteenth century to 1939 the medical profession monopolized medicine through restricting professional membership, marginalizing non-professional practice, increasing its status and cultural authority, and forging strong political relationships. Belgrave also argued that in relation to this model of the rise of the medical profession that alternative therapy was ‘pushed to the outside’. They ‘continued to survive but did not flourish’ and the medical profession was not significantly challenged by alternatives until the 1980s. Using Belgrave’s model, Katherine Lucas traced the decline of homeopathy, and alternative medicine in general, in relation to the rising status of the medical profession. The problem with this approach was that the decline of alternative medicine was linked with professional exclusion and the so-called effectiveness of legislative measures. The effectiveness of measures to control alternative practitioners is questionable. The Tohunga Suppression Act 1907 and the Quackery Prevention Act of 1908 failed to limit patent medicines. Change should not automatically be associated with decline, and many alternative practitioners were never included within the medical profession. In addition to this, Jennifer Gray’s research essay explores quackery in early twentieth-century New Zealand. It places a particular focus on legislative developments and their lack of impact on alternative practitioners. Gray’s approach characterises all alternative practitioners in a negative light that is more reflective of contemporary medical opinion than historical analysis. In contrast, Elinor Harris’ thesis points to continuity in terms of alternative medicine and argues that medical advertising from 1935 continued to be prominent and widespread. This thesis revises New Zealand’s limited historiography on

59 Belgrave, p. i.
62 Dow indicates that measures to combat quackery were ineffective and it remained a ‘perennial problem’ after the Quackery Prevention Act, Safeguarding the Public Health, p. 76; Lange indicates that in reality the Tohunga Suppression Act was ‘powerless’ against influential prophets and strong belief in Mate Maori meant Tohunga remained influential, pp. 249-55.
alternative practitioners and positions alternative medicine in New Zealand in the context of recent international historiography.
Sources

This study of cancer in New Zealand draws upon a range of sources that change in emphasis as periods change. Some countries, like America and Britain, have the advantage of a richer source base from an institutional perspective and a medical research perspective. New Zealand possessed a small and relatively isolated medical community who relied on international developments and publications as sources of knowledge developments. Independent research publications on cancer by New Zealand’s scientific and medical experts are sporadic. New Zealand had its own medical and scientific journals. The *New Zealand Medical Journal* only includes a few isolated instances of cancer research, brief reports of minutes from meetings, and a period of heated public discussion from 1914-1916 about cancer and education. Likewise, *The Transactions and Proceedings of the Royal Society of New Zealand* provides a few sporadic research papers on the topic of cancer in New Zealand. In addition to this, a number of New Zealand medical professionals published their research in British medical journals. For the most part, however, New Zealand looked abroad, particularly to Britain, and to a lesser extent Australia and America, in terms of knowledge about cancer. This is perhaps best exhibited by the fact that the DPH/DOH archives possess more material from abroad — including research reports from the Imperial Cancer Research Fund or information from the American Medical Association — than from local sources. Finally, in the 1930s the Australian Cancer Conferences act as an important source and influence on cancer in New Zealand. New Zealand medical professionals participated and drew from these conferences in a significant way.

In addition to medical and scientific sources, this thesis draws on a range of official sources. *The New Zealand Official Yearbook* not only acts as a useful statistical source but also includes commentary on cancer causation as well as special dedicated statistical studies on the incidence of cancer. In addition, the DPH/DOH annual reports provide an important source to assess the relative importance of cancer to the DPH/DOH. They also provide information about investments and information on incidence and current medical theories on cancer. *The New Zealand*
Parliamentary Debates (NZPD) are also a useful source as they act as an indicator for those issues related to cancer which were important on a political level at any specified date.

The DOH archives provide one of the main repositories of sources for this study. Within these archive files are a range of different types of sources. New Zealand’s DPH/DOH collected relevant newspaper articles to keep abreast of what issues were of current interest to the public and of interest to the DPH/DOH officers. There are also handwritten notations providing commentary on the articles. Archival sources specifically relating to cancer begin from 1908 but it is not until 1912 that a significant amount of archival source material becomes available. Naturally, for this study, this leaves a hole in the sources before this period with a limited institutional source base relating to cancer in the earlier period. These files include a range of correspondence relating to cancer which involve public health officials providing advice to relevant ministers; correspondence between public health officials; and between the DPH/DOH and associations including the New Zealand Branch of the British Medical Association (NZBMA) and the New Zealand Branch of the British Empire Cancer Campaign (NZBECC). In addition to this, there are a number of archive files relating to the DPH/DOH’s investigations into alternative cancer cure claims. There is a vast amount of insightful material about alternative healers and their interrelationship with government and public health authorities. There is also a lot of material relating to the NZBECC after its establishment in 1929. This includes recordings of minutes, details on research plans, commentary on cancer conferences, details on the National Radiation Laboratory, and records of cancer consultation clinics and a range of other activities.

Another significant type of source that this thesis draws on is newspapers. The sources available in newspapers go beyond news articles and include a diverse array of information: local board meeting minutes; detailed information on local fundraising events; publicized cases of cancer treatments; obituaries of cancer sufferers; commentary on vital statistics; cultural information on the literary use of
cancer; and most importantly, a massive amount of material on popular understandings of cancer and alternative practitioners. While a number of newspapers are used in this thesis, there are three papers that have been particularly useful.

The first of these is *The New Zealand Truth (Truth)*. *Truth* was overtly controversial and did not hold back in its commentary with moderate language. *Truth*’s revelling in scandal is in fact why it is such a useful source. *Truth* hounded and attacked a range of alternative practitioners and in doing so, brought to life individuals who, and events which, may have otherwise gone unnoticed. It also acted as a negative commentator against the DPH/DOH over what *Truth* viewed as its inaction in addressing an increasing prevalence of cancer. Richard Joblin has challenged the role of *Truth* as simply a scandal rag. He contends that *Truth* was deeply alarmed by challenges to breaches of law and mores. Thus, *Truth*’s discussion of the transformation of cancer into a significant killer of New Zealanders as well as the unscrupulous actions of alternative practitioners fit into Joblin’s model of *Truth*.

Two of the other main newspapers used in this thesis are more traditional — Wellington’s main daily newspaper *The Evening Post* and Christchurch’s main daily *The Press*. *The Evening Post* had a strong focus on local Wellington issues. This comes through in terms of cancer as it provides a lot of information about fundraising, cancer and Wellington Hospital, and the local branch of the NZBECC. *The Press* on the other hand is important because, from an editorial perspective, it often chose to focus on cancer. It acted as one of the main forums for discussion about cancer and education, and was critical of the DPH about its lack of effort in combating the cancer problem.

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Framing

Modern conceptions of cancer differ greatly from how cancer was understood in the late nineteenth and early twentieth century. Modern medical understandings of cancer enumerate hundreds of different varieties. This became particularly prominent in the post-war period after a fracturing of cancer and oncological specialties. As disease definitions are culturally constructed, this thesis prioritizes the understandings of cancer by historical contemporaries, not modern ones. These understandings were often varied and sometimes contradictory. However, the majority of medical professionals and laypersons in New Zealand understood the concept of cancer in the singular: from the compilation and reporting of statistics, to publications by medical professionals, to concerns about unsightly growth in livestock, to alternative and medical responses to cancer. Yet, despite this general understanding of cancer as a singular concept, there was medical debate between competing theories on cancer’s causation and public confrontations over the legitimation of cancer. In short, the idea of cancer was contested territory and what historical contemporaries understood to be cancer could be quite different to other contemporaries and our modern assumptions. In New Zealand understandings of cancer, both popular and medical, assumed it was a generalized entity. Therefore, the primary focus of this thesis is on the conceptualization of and responses to this general understanding of cancer. The negotiation of contested disease definitions by contemporaries is a significant area that this thesis explores and is the focus of the first section. Therefore, the primary focus of this thesis is on the conceptualization of and responses to this general understanding of cancer.

The structure of this thesis and the selection of content acts to present a holistic interpretation of cancer in New Zealand from the late nineteenth century to 1940. It does not seek to provide extensive and specific narratives chronologically and it does not endeavour to include an exhaustive account of the areas that are addressed. The structure of this thesis is divided into three distinct sections: conceptions and understandings, institutional responses, and alternative responses.
Each of these areas could have been extended to encompass the entirety of this study. This has often been the trend in historiography. As discussed previously, historiographical approaches to cancer tend to be dominated by institutional accounts with a number of works on alternative medicine in an attempt to counterbalance this focus. This thesis argues that these areas should not be viewed in isolation but that they are fundamentally integrated with each other: each of these three areas shape the others. Therefore, the structure of this thesis, while divided into these three sections, intends to demonstrate the connections between these areas through a layering approach that is distinct from how the history of cancer has been typically written. It begins with conceptions and understandings of cancer, but within this section the connections with influence of medical, institutional, and alternative responses is clear. Similarly, the conceptions and understandings of cancer flow throughout the remainder of the thesis: medical, institutional, and alternative approaches respond to these understandings in different ways. The same can also be said when comparing institutional and alternative responses. The intersection between these approaches can be seen through conflicts between the medical profession and alternative practitioners and also through the relationships that both groups sought to develop with key government institutions and figures and the general public. The importance of these connections is significant and this is an area that requires further scrutiny in both institutional and alternative cancer histories.

Chapter Two and Three examine the forces that helped transform cancer into a significant social and public health problem in the late nineteenth and early twentieth centuries. They ask what factors influenced cancer’s rise to prominence. In doing this, Chapter Two considers medical and popular statistical interpretations and how cancer and its treatments were conceptualized. It also asks if the historical constructions of the idea of cancerphobia are appropriate. Chapter Three examines a range of popular and medical understandings of causation and the forces that shaped them. It considers the role and influence of scientific and popular theories and how differing perspectives on causation interacted.
Chapters Four, Five, and Six answer the question — in what ways did New Zealand respond to the cancer problem? They discuss the roles of a variety of public health institutions (including local bodies, national institutions, international institutions, and dedicated cancer institutions) and consider the position of these institutions in both a national and international context. Chapter Four considers the ways that the medical profession and public health institutions publicized and provided cancer education to the public. In particular, it asks what types of messages were conveyed, how they were represented, what actions were undertaken, and what debates informed these actions? Chapter Five examines the impact of new cancer treatment technologies in New Zealand. It considers the local reception of radiotherapy, how it was represented, and its integration into New Zealand’s public health institutions as a cancer treatment. Chapter Six focuses on the role of research in New Zealand. It asks what role cancer research played in New Zealand, how cancer research was organized, and what influences shaped New Zealand’s cancer research.

Chapters Seven, Eight, and Nine examine alternative practitioners in the late nineteenth and early twentieth century. Chapter Seven examines alternative practitioners around the turn of the twentieth century. It asks how alternative practitioners interacted with the medical profession, patients, the press, and government authorities. It considers the representation of treatment methods and alternative practitioners’ engagement with popular beliefs. Chapter Eight examines alternative practitioners in the 1910s and 1920s. It asks — what was the relationship between the alternative practitioner, key medical institutions, and the medical profession? It considers the impact of scientific knowledge in the promulgation of alternative causal theories and in the continuation of alternative practice. Chapter Nine focuses on alternative practitioners in the 1930s. It asks how and why the relationship between the medical profession, public health authorities and alternative practitioners changed? It also asks whether a model of continuity or decline is an appropriate characterization for the role of alternative medicine and what forces shaped this model.
This thesis is the first detailed historical study that gives significant historical attention to cancer in New Zealand. In this undertaking, the thesis is situated in the broader historical contexts of cancer history and the history of alternative medicine and popular beliefs. In terms of cancer history, the thesis positions New Zealand in an international context. In particular, it focuses on research, radiotherapy, and education and publicity. First, it shows New Zealand’s responses to cancer in comparison to other histories on different national contexts. Second, it finds how New Zealand fits into broader international trends relating to cancer and international influences that helped shape New Zealand cancer responses. In addition to this, it illuminates aspects of New Zealand’s distinct national context that contributed to cancer control. As well as cancer responses, it also explores the forces that shaped these responses and popular understandings of cancer. This engages with a historical debate about the nature of how popular associations were shaped, including statistical understandings, and the history of emotions (like dread and mystery). The thesis also contributes to a growing international literature that challenges the extent of the rise of the medical profession and models of decline in alternative medicine. It develops New Zealand’s history of alternative medicine more generally, which has been a subject of limited historical attention, and challenges the current historical assumption about the decline in alternative medicine. In addition to this, the popular beliefs and understandings of cancer sufferers and patients, an area that continues to remain absent in medical historiography, is given greater consideration. Moving beyond a framework of negative characterization of alternative practitioners and their patients, this thesis focuses on conveying a broad range of perspectives including those of the medical profession, alternative practitioners, the press, politicians, and patient testimonials. Most histories of cancer, like medical history generally, have tended to focus on significant medical advancements, the role of institutions, and public health responses to cancer. In addition to considering these aspects of New Zealand’s history of cancer, the role of alternative medicine and popular beliefs is given detailed attention in this thesis.

In developing this holistic approach that layers the connections between these different areas, a number of fruitful areas for further investigation are evident that were not within the scope of this thesis. As mentioned previously, the prominence
of Maori and women in respect to cancer were not significant areas of focus in institutional responses to cancer. However, further investigation into conceptions of race and gender and diseases in New Zealand could prove to be a useful path forward. An obvious area for further investigations includes extending the scope into the post-war period where alternative practitioners like Milan Brych or hereditary cancer research by Arthur Veale could be related to the key themes and arguments presented in this thesis. Alternatively, the fracturing of cancer specialities from the post-war period could also be investigated. Likewise, an extension to considering new approaches to cancer in light of genetics and chemotherapy or environmental factors are also key areas that can be investigated in the post-war period. This thesis has focussed on significant case studies to represent its arguments but there is opportunity for more in-depth study into the tens of thousands of medical adverts relating to cancer that are readily available or to explore alternative case studies. Finally, a lot of insight could also be gained from developing a comparative investigations between different diseases and cancer, particularly heart disease and tuberculosis.
Section A

The Cancer Problem
Chapter Two
The Emergence of Cancer as a Social and Public Health Issue in New Zealand, 1870s-1916

There was a dramatic transformation in the importance of cancer to New Zealand society from the 1870s to the 1910s. Across this period, there was a change in the historical context of numerous diseases, particularly infectious diseases. The causation of a wide-range of diseases was discovered. In 1881, cancer was a relatively minor player on New Zealand’s list of death-causing diseases. It was ranked seventh, behind tuberculosis, diarrhoea, heart disease, bronchitis, pneumonia, and convulsions.\(^1\) Over time, the relative statistical importance of chronic illnesses, like cancer, increased. By 1899, cancer was only behind tuberculosis and heart disease.\(^2\) By 1910, cancer had overtaken tuberculosis to become New Zealand’s second largest killer.\(^3\) Moreover, unlike tuberculosis, cancer’s incidence was increasing.

A combination of factors influenced the transformation of cancer into an important social and public health problem. The fact that cancer became a significant issue and heart disease did not indicates that increasing incidence is not enough in itself to explain how cancer became a subject of strong social concern. In the case of Britain, Ornella Moscucci, a medical historian, argued that the growing mortality from cancer stimulated social concerns but key interest groups sustained these concerns. This included the medical profession, philanthropists, politicians, feminists, health reformers, and insurers.\(^4\) Patrice Pinell, a historical sociologist, argued that in the case of France there was no ‘mechanical relationship’ between the rise in incidence and the onset of social concerns. In Pinell’s view, cancer became an important social and public health problem because of the role of influential interest groups in stimulating social concerns; these groups were

\(^1\) *Statistics of New Zealand*, Wellington: Govt. Printer, 1881, pp. 27-46.
\(^2\) ibid., 1881, pp. 27-46; 1899, pp. 38-40.
\(^3\) *The New Zealand Official Yearbook*, Wellington: Govt. Printer, 1910, p. 455.
motivated by cancer’s increasing incidence. In New Zealand, both incidence and interest groups had a role to play in the transformation of cancer into an important social and public health issue. Building on Moscucci and Pinell’s explanations, I argue that cancer became an important social and public health problem in New Zealand because of popular dread of cancer and the development of social perceptions about the increase in cancer.

Meaningful social perceptions about the increase in cancer began to take shape from the late nineteenth century. In a sense cancer was, as American cultural historian James Patterson argued, a disease that was feared in the abstract because its level of incidence was relatively low. As cancer became a more common occurrence, a higher proportion of the population began to have first-hand experience of the dreadful nature of cancer. It was not until the late 1870s that cancer first began to spark significant public interest, and more particularly, the late 1880s and 1890s that strong social concerns surrounding the incidence of cancer manifested themselves. It was around this period that the factual representation of statistics began to transform into social commentary. Pinell argued that cancer became a prominent public health problem once factual reporting of incidence was transformed into political discussion. This included changes in the reporting of statistics where different tabulations and statistical comparisons received greater scrutiny by the public, the press, and the medical profession. As Australian historian Patricia Jalland has argued, from the late nineteenth century and into the early twentieth century there was a fundamental transformation in mortality. This saw old age replace childhood as the most likely time of death.

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7 Pinell, pp. xi-xvi.
Popular dread of cancer was also a significant factor that shaped the transformation of cancer into an important social and public health problem. Canadian historian Barbara Clow compared popular attitudes and metaphors between cancer and heart disease in North America. Clow argued that in many cases, death from heart disease ‘epitomized’ a ‘good death’ that came swiftly and painlessly. It was also conceived as a more natural form of death, like a mechanical type of failure. In comparison, cancer was slower, more painful, and caused deformity and loss of control of bodily functions. In popular imagination, cancer was not just believed to be a horrible disease or an awful way to die, but the most horrible disease or way to die imaginable. In response to the question, ‘why cancer and not heart disease?’ I propose that popular dread of cancer was an essential factor in the onset of social concerns. In conceiving this popular dread, two central themes emerge: that cancer caused suffering, and it inspired a strong sense of hopelessness. The theme of suffering primarily relates to cancer itself; while the theme of hopelessness relates to the inefficacy of surgical intervention and assumptions about the failure of the medical profession to combat cancer. I also argue that the shaping of this dread was not created by metaphorical constructions of irrational cancerphobia. Rather, metaphorical associations with cancer were also shaped by what Clow described as the ‘lived experience’ of cancer.

Cancer Incidence.

The March of cancer ... continues to increase in these islands ... and still science is baffled.12

Geoffrey Rice, writing on public health in New Zealand in the late nineteenth century, argued that it is important to consider the context of statistics before analyzing them.13 This section discusses cancer incidence and examines the contexts that influenced them. In particular, it considers the types of statistical comparisons that were made. This is significant because it reveals the fact that statistics were used for political purposes. Incidence statistics also acted as forms of evidence in a debate about the significance of the increase in cancer incidence.

In the late nineteenth century and into the early twentieth century, cancer challenged the contemporary perception that this period was an era of progress that led to the restriction of many deadly diseases. Cancer was an impediment to the authority of scientific medicine and by association, the medical profession. Lay commentary was often hostile to the progress of science in respect to cancer. As the opening quote demonstrates, the continued increase of cancer ‘baffled’ scientific medicine. This section traces the transformation of the increase of cancer from a statistical fact into a prominent social concern. Popular dread was intimately linked with this transformation.

The focus of statistical attention on cancer in New Zealand was on both cancer’s numerical increase and its rate of increase. Cancer statistics were officially recorded for the first time in 1872. That year, there were fifty-five deaths at a rate of 2.01 per

10,000 people; in 1899, there were 468 deaths, at a rate of 6.24 per 10,000 people;\textsuperscript{14} and in 1911, this had reached 809 deaths at a rate of 7.97 per 10,000 people.\textsuperscript{15}

From 1872 to 1899, the number of cancer deaths increased by eight times, and the rate of cancer deaths had more than tripled. By 1910, once cancer statistically overtook tuberculosis, the growth of cancer deaths was in excess of thirteen times the 1872 numbers, and by 1911, the rate of cancer was nearly four times that of 1872.\textsuperscript{16} Cancer continuously grew both numerically and also progressively.

While this statistical rise may seem to be significant, and alarmist press reporting regularly drew on such trends, its importance is a fallacy. Demographic shifts in an ageing population meant that the majority of this increase was more apparent than real. In contrast to Thomas McKeown’s argument that economic growth, rising living standards, and better nutrition were the primary sources of improved health, contemporaries believed success in combating infectious diseases helped increase


\textsuperscript{15} ibid.

\textsuperscript{16} ibid., 1893-1913.
population longevity. More people lived long enough to reach an age that was more susceptible to cancer. In addition, more accurate recording of deaths and a clearer differentiation between disease types meant that deaths that had previously been miscategorised were correctly diagnos ed as cancer.

The publication of cancer statistics changed from being a simplistic statement or table outlining regional and national vital statistics to reports that included social commentary on these statistics. In addition, the types of statistical comparisons that were made changed. Rather than just narrating changes in vital statistics, particular emphasis was placed on comparing cancer in New Zealand in a range of different ways. This mirrors what Pinell has described in the case of France where the tabulation of statistics transferred into forms of political discussion. One consequence of this was that cancer was compared to other countries, particularly Australia and Britain.

From the late nineteenth century onwards, it had become a part of national identity myth making that New Zealand was a healthy country. Negative comparisons over the incidence of cancer led to concerns about the state of New Zealand’s health. The first evidence of strong concern regarding cancer incidence in New Zealand was an 1882 article by Dr Alfred Newman, a politician and ethnologist. In his article, he asserted that New Zealand was ‘the healthiest’ place ‘on the face of the globe’. Newman indicated that the incidence of tuberculosis in New Zealand was lower than the Australian colonies and most parts of the world. However, to Newman, cancer was a significant thorn in the side of New Zealand’s

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18 Pinell, pp. xi-xvi.
identity as a healthy country. Newman claimed that ‘[o]ur healthiness in other respects makes the comparison look unfavourable so far as cancer is concerned.’

Public perceptions in respect to cancer in the 1880s were that New Zealand was worse than some Australian colonies, while death rates from tuberculosis were favourable. In fact, New Zealand’s cancer death rates were worse than all the Australian colonies, with the exception of Victoria. New Zealand’s cancer rate in 1898 was 6.4 per 10,000 people, whereas Victoria was 6.7 per 10,000 people. Other Australian colonies were significantly below New Zealand’s cancer death rate. For example, the cancer death rate of Western Australia was 2.5 per 10,000 people and 3.9 per 10,000 people for Queensland. By 1909, the comparison reversed and New Zealand fared better. The lowest rate of the Australian colonies was Tasmania, with 8.2 per 10,000 (compared to New Zealand’s 7.3 deaths per 10,000 people).

The most common statistical comparison was made with Britain. Cancer rates in England continuously outstripped New Zealand in the 1890s and 1900s. However, the rate of increase across the same period was greater in New Zealand than England. In 1897, one newspaper article expressed concern over New Zealand’s statistical comparison with England: ‘The returns for the last four years show that the percentage of mortality from [cancer] has nearly doubled, while in England the increase is not fifty per cent.’ In 1909, England and Wales had a cancer death rate of 9.5 per 10,000. In comparison, New Zealand only had 7.3 deaths per 10,000 people. Statistically, New Zealand’s incidence was less than Britain but it was increasing at a faster rate.

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21 Marlborough Express, 30 Dec., 1898, p.4.
22 North Otago Times, 30 Dec., 1886, p. 2.
26 Grey River Argus, 29 Mar., 1897, p. 4.
The issue of its greater rate of increase than Britain gained the attention of New Zealand medical practitioners. Dr Patrick Hislop, a Geraldine practitioner educated in Edinburgh, and Dr Percival Clennell Fenwick, a London-educated Christchurch surgeon with a strong interest in radiotherapy, published an article in the *British Medical Journal* in 1909 that investigated the potential causes of cancer. They stated that ‘[a]lthough New Zealand has the lowest death-rate for the world, there is a persistent increase in the percentage of deaths from cancer’. The article compared the high rate of change: in 1881, New Zealand’s cancer rate was 2.69 per 10,000 people compared to England’s 5.20 per 10,000 people; by 1906, New Zealand rose to 6.96 per 10,000 people compared to England’s 9.17 per 10,000 people. From this comparison, the rate of cancer in New Zealand increased significantly more than England. From 1881-1909 the level of cancer incidence increased by over 80 per cent for England and Wales and by over 170 per cent for New Zealand.\textsuperscript{28} Fenwick followed up this analysis in 1912 with an article in *The New Zealand Medical Journal* (NZMJ) that also charted the increase in cancer in New Zealand.\textsuperscript{29} These unfavourable comparisons increasingly received the attention of both newspapers and medical practitioners.

In 1916, William Herbert, the President of the New Zealand Branch of the British Medical Association (NZBMA), drew attention to comparative cancer rates in an article in the *New Zealand Medical Journal*. The comparative rates that were discussed are summarized in the following table:

\textsuperscript{28} This is just a statistical outline and no explanation for the difference in the rate of increase is given: P.W. Hislop and P. Clennell Fenwick, ‘Cancer in New Zealand’, *British Medical Journal*, 2, 2547, 1909, p. 1222.

## International Cancer Rates per 10,000 People

<table>
<thead>
<tr>
<th>Country</th>
<th>1894</th>
<th>1913</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
<td>6.07</td>
<td>8.01</td>
</tr>
<tr>
<td>Australia</td>
<td>4.95</td>
<td>7.5</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>6.87</td>
<td>10.43</td>
</tr>
<tr>
<td>France</td>
<td>9.6</td>
<td>8.0</td>
</tr>
<tr>
<td>Norway</td>
<td>7.1</td>
<td>10.5</td>
</tr>
<tr>
<td>German Empire</td>
<td>6.6</td>
<td>8.1</td>
</tr>
</tbody>
</table>


In 1913, New Zealand’s rate was comparable to France, while Germany was slightly greater than Australia, but was significantly less than the United Kingdom and Norway. The rate of increase in this comparison indicated that the greatest increase occurred in the UK (in contrast to the above statistics from 1881–1909). This demonstrates how the selection of statistical periods can be used to emphasize different results and illustrates how confused messages and interpretations about incidence can occur. The subject of cancer and its comparative incidence was an issue that increasingly received attention from medical practitioners in the 1910s in New Zealand as elsewhere.

Another statistical comparison that was important was the incidence of cancer in New Zealand relative to other diseases in other countries. By the end of the nineteenth century, cancer moved from being the seventh most common medical cause of death in New Zealand to the third. In 1881, cancer was behind tuberculosis, diarrhoea, heart disease, bronchitis, pneumonia, and convulsions, but

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30 Herbert, ‘Some Facts Regarding Cancer’, pp. 95-100.
by 1899, it was only behind tuberculosis and heart disease.\textsuperscript{31} From the 1890s, the comparison was expressed graphically. The most prominent of these comparisons was between cancer and tuberculosis. Newman’s 1882 article discussed New Zealand’s comparative healthiness in relation to cancer and tuberculosis.\textsuperscript{32} The following graph expresses the visual representations of the comparison between cancer and tuberculosis that were made every year in New Zealand’s official statistics in the 1900s.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{tuberculosis_cancer_deaths.png}
\caption{Tuberculosis and Cancer Death Rates per 10,000 People, 1899-1910}
\end{figure}

Tuberculosis was still proportionately more important as a cause of death than cancer until 1910. However, throughout the period, cancer was continually closing the gap on tuberculosis. The tuberculosis death rate was consistent across the 1890s making up over ten per cent of all deaths. Across the first decade of the twentieth century, though, inroads began to be made in incidence and the rate of tuberculosis declined.\textsuperscript{33} In contrast, the rate of cancer across the same period rose by over thirty

\begin{thebibliography}{9}
\bibitem{31} Statistics of New Zealand, 1881, pp. 27-46; 1899, pp. 38-40.
\bibitem{32} Newman, p. 510.
\end{thebibliography}
per cent. During this period, infectious diseases were generally static or on the decline, while the rate of cancer was increasing. In 1898, one newspaper article reported what was, by then, a common observation: ‘It is clear that the deaths from cancer are increasing, whilst those from typhoid, smallpox, and tuberculosis are decreasing’.34

The comparative rate of disease was also an area that Herbert gave significant attention to in his 1916 article. In relation to statistics on the incidence of heart disease, Herbert was dismissive: ‘I need hardly remind you to attach little importance to them, as you are all familiar with the fallacies connected with this convenient and unscientific way of filling in the cause of death in obscure cases’.35 In this comparison, Herbert paid particular attention to the fact that cancer rates in New Zealand were outstripping tuberculosis: ‘In almost all countries there is a rapid increase in the number of deaths due to malignant disease, but in no country can I find a record equal to that of New Zealand, where, for the last five consecutive years, the number of deaths from cancer has exceeded that due all forms of tuberculosis’.36 In comparing tuberculosis rates between countries, New Zealand stands out as possessing a significantly lower rate. This, in turn, means that the timing of cancer overtaking tuberculosis incidence occurs earlier in Australasia than in Britain, Canada, and a number of European countries.

34 Marlborough Express, 30 Dec., 1898, p. 4.
36 ibid.
International Tuberculosis Rates per 10,000 people

<table>
<thead>
<tr>
<th>Country</th>
<th>1894</th>
<th>1913</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
<td>8.48</td>
<td>6.12</td>
</tr>
<tr>
<td>Australia</td>
<td>10.57</td>
<td>6.77</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>15.02</td>
<td>10.7</td>
</tr>
<tr>
<td>France</td>
<td>25.8</td>
<td>12.8</td>
</tr>
<tr>
<td>Norway</td>
<td>18</td>
<td>17.4</td>
</tr>
<tr>
<td>German Empire</td>
<td>23.9</td>
<td>12.9</td>
</tr>
</tbody>
</table>


The statistics from this table indicate a general decline in tuberculosis rates. What they also demonstrate is the fact that New Zealand and Australia’s rates were significantly lower than those of other countries. Of importance, though, is the comparative difference between the tuberculosis and cancer rates.
International Tuberculosis Rates less Cancer Rates per 10,000 People.\textsuperscript{37}

<table>
<thead>
<tr>
<th>Country</th>
<th>1894</th>
<th>1913</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
<td>2.41</td>
<td>-1.89</td>
</tr>
<tr>
<td>Australia</td>
<td>5.62</td>
<td>-0.73</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>8.15</td>
<td>0.27</td>
</tr>
<tr>
<td>France</td>
<td>16.2</td>
<td>4.8</td>
</tr>
<tr>
<td>Norway</td>
<td>10.9</td>
<td>6.9</td>
</tr>
<tr>
<td>German Empire</td>
<td>17.3</td>
<td>4.8</td>
</tr>
</tbody>
</table>


This table indicates that New Zealand’s cancer rates were proportionally higher than its tuberculosis rates at an earlier stage than most other countries except Australia. While New Zealand’s cancer rates were similar to other countries, its tuberculosis rates were significantly lower. By 1913, the difference in incidence rates between cancer and tuberculosis meant that cancer had overtaken tuberculosis to become New Zealand’s second largest cause of death.

As cancer’s relative incidence became increasingly significant, there was an increase in social commentary in newspapers on cancer’s increase. For example, one 1895 report claimed that ‘the dreaded disease cancer is spreading with alarming rapidity. Scores of people are cut off every year by this terrible disease’.\textsuperscript{38} Of particular interest here is the connection between dread and cancer’s corresponding rise. One report in 1900 even claimed that cancer was almost as common as fever.\textsuperscript{39} Concerns relating to the increase of cancer were not limited to newspapers but also received attention from scientific sources. Edward Tregear, a

\textsuperscript{37}This table shows the difference between cancer and tuberculosis rates per 10,000 people. A positive figure indicates the amount that tuberculosis exceeded cancer. A negative figure shows the amount that cancer exceeded tuberculosis.

\textsuperscript{38}Grey River Argus, 17 Oct., 1895, p. 2.

\textsuperscript{39}Observer, 27 Oct., 1900 p. 4.
prominent civil servant and anthropologist, commented on cancer in his inaugural presidential address to the New Zealand Institute in 1898. Tregear claimed that cancer was ‘continually widening’ its ‘field of advance’.40

In the 1890s, concerns over the growing incidence of cancer received political attention. In 1895, G.W. Russell, Liberal member for Riccarton and later Minister of Public Health (1912, 1915-1918), brought the incidence of cancer to parliament’s attention:

> I should like to mention, on the other hand, a disease which is largely on the increase; I refer to cancer. You will find that in 1885 there were 177 deaths from cancer, and in 1894 408, which is a tremendous increase.41

Russell called for a Royal Commission to investigate cancer and the reasons behind its increase of ‘gigantic proportions’.42 Richard Seddon, the Liberal Premier, stated in 1898 that the increase of cancer ‘was a matter of great concern to the Government’. Seddon added, ‘the steps now being taken in regard to tuberculosis would prove largely helpful’.43 This statement by Seddon indicates a complex set of understandings in respect to cancer and its cause, details of which are discussed in the following chapter. It also assumed that cancer could be contained through public health measures. Efforts in response to cancer by the medical profession and Department of Public Health (DPH) will be discussed in Section B.

Dr Walter Fell entered public discussion over the incidence of cancer in his presidential address to the NZBMA in 1898. Fell was an Oxford trained medical officer at Wellington Hospital and President of the New Zealand Branch of the British Medical Association from 1898-9. The NZMJ ceased publication from 1896 until 1900 but detailed versions of Fell’s address were reproduced in the press. There was a lot of attention given to the issue of Fell’s address in a range of

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41 *New Zealand Parliamentary Debates (NZPD)*, 89, 1895, p. 372.
42 ibid.
newspapers across the country. Fell did little to actually play down fears over the increase. It was reported that ‘Unlike English statisticians’, Fell ‘believed the increase to be real’. Fell proclaimed that cancer had made a ‘continuous and astonishing increase’, killing more than one New Zealander per day. Fell embraced popular assumptions about the increase of cancer and at the same time tried to uphold the authority of the medical profession. He used his address as a platform to promote the success of the medical profession in combating some forms of cancer. He claimed that ‘despite popular beliefs to the contrary, many cases are cured’ and that it was successful surgery that prevented the increase being even more ‘pronounced’. He pointed to a number of successful areas for surgery. In particular, he focused on breast cancer where he claimed that there was only a ‘slight increase’ because of the success of surgery in reducing mortality.44

Despite Fell’s reassurance of medical progress, the reaction of the press to Fell’s address indicates that the issue of cancer caused strong public anxiety. The figures Fell quoted were reported to be ‘disquieting’.45 One newspaper reported that Fell’s address attracted a ‘great deal of interest in the colony’ as it was believed that cancer ‘shared with consumption [tuberculosis] in the fears of the people’.46 It was reported in another article that there were ‘few more gruesome subjects’ than that of the ‘modern scourge’ cancer.47 One article even explicitly stated that ‘no disease’, ‘not even the twin scourge tuberculosis’, caused more ‘terror in people’ than cancer.48 As a result of Fell’s address and the anxiety surrounding cancer, one report called for some type of action to be taken: ‘the knowledge that cancer is increasing in the colony must be a matter for very serious consideration not only by medical professionals, but by our legislators and the public generally.’49

In the 1900s, the cancer problem had well and truly attracted the attention of newspapers, politicians and a number of experts. Some of them tried to play down

45 New Zealand Tablet, 22 Apr., 1898, p. 28
46 Evening Post, 16 Mar., 1898, p. 2.
47 Hawera and Normanby Star, 17 Mar., 1898, p. 2.
49 ibid.
the significance of the rising incidence, but inevitably, a failure to explain cancer causation, meant reasons for the increase were ‘simply not known’. Experts entered into public debate to try to counteract perceived exaggerations but also to try to exercise medical authority and control over knowledge. The opinion of the New Zealand Yearbook was that ‘the increase was not believed to be an actual fact, ... [but] the result of more careful certification of the causes of death and of improved diagnosis’. In 1901, it was reported in the press that Dr Jarvis, a member of the Hawkes Bay Hospital Board, dismissed conclusions that cancer was increasing. He claimed that the ‘progress of medical science’ enabled cancer to be treated in its initial stages and that early diagnosis meant cancer was also caught more often in its earliest stages.

In addition to medical authorities, scientific authorities also weighed into the debate about the increase in cancer. In 1901, H.W. Seager, a professor of mathematics at Auckland, entered into the incidence debate with a publication on the use of statistics. Seager noted that much ‘alarm’ had been ‘excited’ by cancer in the newspapers and specifically aimed to try and counteract the alarmist use of statistics in newspapers. Seager complained about the common presentation of cancer statistics in the colony: ‘statistics of cancer, as commonly presented, make it appear that the relentless disease is increasing its ravages at a rate that is somewhat horrifying.’ Seager’s article attempted to debunk this statistical myth. He indicated that the rate over the last twenty years had only increased two and a half times. He focused on indicating that cancer affected older members of the population and that, as cancer traditionally ravaged the aged, much of the increase could be accounted for by changing demographics: ‘Much of the apparent increase in cancer’, ‘as properly represented by statistics’ can be ‘explained away’ by changing populations. The whole increase was not accounted for but Seager indicated that some of the reasons medical professionals had put forward could be plausible
explanations. In particular, Seager suggested that improved diagnosis and stating the causes of death more carefully could be reasons for this.\textsuperscript{53}

In addition to medical and scientific authorities, New Zealand’s Insurance Institute also commented on the increase in cancer. It concluded in its investigative report that cancer was only ‘apparently’ on the increase and their views of ‘life risk’ assessment were not modified.\textsuperscript{54} Thus, in response to alarmist reporting of cancer statistics, a number of sources played down exaggerated interpretations.

Despite some authorities playing down cancer incidence, a strong current of opinion remained that was critical of the inaction of scientific medicine. Irrespective of any debate about changes in incidence, the number of cancer deaths in proportion to other deaths was increasing. Individuals knew more people dying of cancer, either personally, or through friends, or second hand accounts. For example, one article from an unnamed author with a Bachelor of Science in 1893, indicated why many people believed cancer was increasing. The author claimed that ‘each person seems to hear his own experience of far more cases than old people had any knowledge of in their early days’.\textsuperscript{55} The obituary of Joseph Kilgour referred to cancer as ‘that most common of colonial illnesses’.\textsuperscript{56} Based on these experiences, assumptions surrounding the increase of cancer were seen to be a ‘very natural thing’ given the more personal experiences with cancer sufferers.\textsuperscript{57} In addition to this, there were strong regional concerns when disproportionate statistics appeared.

Regional statistics reported in newspapers raised fears over localities and disproportionate cancer rates were seen to be a blot on a region’s reputation. In

\begin{footnotes}
\item[54] J.H. Richardson, \textit{The Assessment of life risks where there is a predisposition to phthisis or cancer: being a paper read before the members of the Insurance Institute of New Zealand}, Wellington: New Zealand Times co., 1899, p. 17.
\item[56] \textit{New Zealand Tablet.}, 9 Sep.,1898 p. 6.
\item[57] ibid.
\end{footnotes}
1894, at the Southland Borough Council meeting, a presentation was made of the local hospital’s increasing cancer statistics. The response of the council was to recommend imposing sanitary measures to prevent ‘Southland’s fair name being blotted with the taint of that dread disease’. When Dr Harry de Latour, a London trained practitioner and the medical superintendent of Oamaru hospital, drew attention to the fact that the ‘Dunedin medical men’ believed that the Tapanui district had the highest reported cancer rate in the country, it was believed to be ‘bad news for what has generally been considered a healthy place’. These regional concerns were not only grounded on statistical information but at this time were seen as a genuine issue of public health by the public and the press.

While scientific and medical authorities sought to allay fears, the press was often highly critical of the medical profession. One 1893 report claimed that ‘the doctors wholly slur over their failures, and they claim in the most exaggerated terms to have diminished disease — almost to have extirpated it; yet, cancer is now frequent, where until late years it was a most rare malady’. In 1895, it was reported that cancer was a ‘disease which all the discoveries of medical science have as yet failed to cope’. Another report in 1900 claimed that the current generation was leaving an ‘awful heritage of woe’ to their children in their failure to adequately address cancer. ‘Helplessness’ to ‘check the advance’ of cancer was the image portrayed of scientific medicine, it was ‘still groping in the dark’.

There were regular critiques of scientific medicine in newspapers in reaction to the growing incidence of cancer. Regular commentary was inspired not only by the yearly publishing of the annual vital statistics, but also monthly records of regions and monthly hospital records. The constant publicity given to cancer statistics regularly reminded contemporaries of the increase of cancer in New Zealand. To those well versed in the statistical arguments, the dismissal of concerns about cancer’s increasing incidence was logical. However, medical commentary playing down the increase of cancer was simply viewed as being self-serving.

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58 Otago Witness, 19 Apr., 1894, p. 21.
59 Bay of Plenty Times, 11 May., 1898, p. 2.
60 Otago Witness, 20 Apr., 1893, p. 8.
63 Tuapeka Times, 6 Nov., 1901, p. 2.
In the early twentieth century, responsibility for an official response to cancer fell to New Zealand’s DPH. Since its establishment in 1901, there was no formal response to the cancer problem in the 1900s. The DPH had a strong focus on other issues, particularly disease prevention, especially relating to tuberculosis. By 1905, the official line on cancer statistics fell under the scope of the DPH and its Chief Health Officer, Dr James Mason, a medical practitioner also trained in public health and law. The *Evening Post* reported that Mason proclaimed that the increase in cancer was a ‘most alarming matter’.

In 1912, Mason’s successor to Chief Health Officer since 1909, Thomas Valintine, and Inspector-General of Hospitals since 1907, also commented on cancer incidence in the DPH’s annual report. Valintine noted that the increase in cancer used to be attributed to better diagnosis, but stated that ‘no longer can this solace be allowed’. It is around this period, from 1908-1914, that the first organised responses to the cancer problem would begin to take form. One of the first calls for action from the medical profession came in 1912 when Fenwick published his article in *NZMJ*. Fenwick hoped that a special committee could be established to investigate cancer.

In the 1910s, there were also regular calls for action to encourage investment in radiotherapy. In addition to this, Herbert’s 1916 commentary was also part of a push for action by the medical profession and the DPH that led to educational efforts to combat cancer. Concerns about cancer also led to the development of further statistical research to investigate and respond to the cancer problem.

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64 See Bryder, ‘“If Preventable, Why not Prevented”’, pp. 109-117.
65 *Evening Post*, 23 Sep., 1905, p. 5.
The Dread Cancer

‘Seddonism is a growing cancer that is poisoning our public life’, wrote one commentator disgruntled with the direction of the Liberal Government in 1899 and its Premier, Richard Seddon. The likening of politics to disease through allegory was a powerful form of imagery that was generally used to create a less than favourable impression. The use of cancer in this metaphor was not an image created in a vacuum. It alludes to the insidious and deadly nature of cancer. Western perceptions and impressions of cancer had been negotiated through a long period of historical development dating back to ancient Greece.

Much can be derived about the perceptions of cancer from the way it was used through language in a range of mediums. Sontag produces a persuasive portrait of the beliefs and metaphors associated with cancer. According to Sontag, cancer was conceived in the nineteenth and twentieth century as an ‘abnormal’ and ‘lethal’ growth that worked ‘slowly’ and ‘insidiously’ to degenerate the body like a ‘demonic pregnancy’. Building on Sontag’s metaphors, Patterson conceptualized cancer in the twentieth century as ‘The Dread Disease.’ He argued that cancer ‘evoked popular fears that transcend its deadliness’; that the public use of the word ‘cancer’ was uncommon; and that most people felt ‘squeamish about public discussion’. In short, cancer was fundamentally private and people tried to keep that ‘unmentionable affliction’ out of the newspapers. When cancer did present itself in the public arena, Patterson dismissed it by pointing to newspaper sensationalism ‘revelling in the macabre’ through ‘ghoulish prose’. He conceives such reaction as a kind of irrational ‘cancerphobia’. Patterson’s use of the term

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68 Evening Post, 28 Nov., 1899, p. 4.
70 Sontag, pp. 16-19.
71 Patterson, pp. vii, 4.
72 ibid., pp. 30, 69, 151.
73 ibid., p. 3.
74 ibid., p. vii.
cancerphobia is derived from medical perspectives that intended to dismiss legitimate concerns about the nature of cancer and its treatment.

Clow has challenged Patterson and Sontag’s arguments that the dread of cancer transcended its deadliness. Clow argued that the metaphors were partly ‘a product of the lived experience of disease’ and that they act as an expression of the experiences of sufferers and the impressions from family and friends. Clow also persuasively argued that in the popular mindset, the difference between sickness and health was pain. The lived experience of cancer, evident in source material, indicates that cancer was strongly linked to excruciating pain. In addition, popular associations with surgery, the primary method of cancer treatment used by the medical profession, were also strongly related to pain. The lived experience of cancer significantly shaped popular dread of cancer.

In addition to this, dread was an essential factor in the onset of strong social concern relating to cancer in the late nineteenth and early twentieth century. Cancer and dread were words synonymous with each other. Cancer was often referred to as ‘the dread cancer’, or ‘the dread disease’. Fear of cancer outstripped all other diseases in popular imaginations, even its twin scourge tuberculosis. The basis for this dread, though, was derived from impressions from cancer experiences in addition to metaphorical constructions. Eric Sinclair was a South Island settler since 1857 and was at different stages a farmer and a builder. The following description of Sinclair’s death in his obituary is a story told by others:

It was not long til the hard lumps began to ulcerate, and for weeks the deadly work went on, the cancer eating out the strong life, and slowly but surely undermining the iron constitution, til at last nothing but a well-built frame was left. Throughout all the weary weeks of increasing suffering he never murmured, and although at last he could not take food, but only sip water, still for five weeks the strong life within bid defiance to death…. But for him death had no terrors …

75 Clow, ‘Who’s Afraid of Susan Sontag?’, p. 308.
76 Clow, Negotiating Disease, p. 8.
for he had fixed his hope on high and longed for the time when he would be free from pain and suffering.77

Highly descriptive obituaries of the suffering that cancer caused were a common feature in the late nineteenth and early twentieth century. Popular fears were largely based on perspectives of those watching friends or family die a slow and painful death. Obituaries, from around the 1880s, increasingly focused on deathbed scenes. Pat Jalland, in her histories of death, has described cancer as the ‘archetype’ of a bad death: one of prolonged suffering and illness that included details of physical suffering and pain. Jalland argued that narratives on deaths from cancer were notably bleaker than most other forms of obituary.78 Sinclair’s obituary describes a prolonged and agonizing suffering that includes literal starvation over a long period. Only death, not successful medical intervention, could provide a release from suffering.

As will be seen in Section B, a strong focus of action by the medical profession and the DPH was to try to inspire hope that cancer could be cured. This focus was in reaction to the strong negative impression of a cancer prognosis in the popular mindset that this section discusses. The source material for popular impressions is difficult to find. However, there are four main areas that popular perceptions of cancer can be derived from. The first is commentary by the medical profession complaining about popular perceptions; the second is patient testimonials of their experiences of cancer and its treatment; the third is news reports that include snippets of evidence about popular perceptions; and the fourth is from reports of sufferers dying from cancer (including obituaries, coroners’ reports or reports of suicide). The general impression of cancer from sources where sufferers died is negative and source bias plays a significant role. The focus of this section is on the fourth type of source, but alternative evidence via testimonials, news reports, medical perspectives, or exceptional circumstances are also considered to corroborate the evidence from this source base. Of importance is the fact that details about certain types of experiences are missing, particularly the unsightly

78 Jalland, Death in the Victorian Family, pp. 6, 62; Jalland, Australian Ways of Death, p. 103.
visual element of cancer, and the off-putting smell. One example of this was a cancer patient named Stoneham who caused one Dunedin hospital medical practitioner to ‘retch’ after leaving the ward.79

From analysing the available sources, it is evident that the two main popular perspectives from this source base were that cancer was perceived as a painful disease that caused excruciating suffering and that cancer and its treatments inspired a sense of hopelessness. Linking with a general trend of detailed reporting of death from the 1880s, the source base in this section begins in the late 1870s and extends to the 1900s. While the representation of cancer as a dread disease was not new, a transition took place across the late nineteenth and early twentieth century that meant experiences of cancer were becoming increasingly common.

Dread of cancer was derived from the experience of cancer as a slow and painful death, and in some cases death was considered a more pleasant alternative. The basis for hopelessness was grounded in the perception of the failure of scientific medicine to combat cancer, and the painful and prolonged nature of surgical intervention. Jalland argued that in terms of cancer, doctors were often considered to be no use, except for the provision of palliative care via opiates.80 This section builds on current literature by further considering the two main themes of suffering and hopelessness.

The most common description of cancer in obituaries was that it was a ‘dreadful’ and ‘terrible’ disease.81 Yet, cancer was perceived as the worst type of disease that could be inflicted on a person. In 1900 the obituary for W. Crowther, a former mayor of Auckland and Liberal and independent member for Auckland City, told

79 For commentary on the visual nature of cancer see Clow, Negotiating Disease, p. 15; Report of the Dunedin Hospital Inquiry Commission, AJHR, H-01 (1891), p. 17.
80 Jalland, Death in the Victorian Family, pp. 80-93; Jalland, Australian Ways of Death, p. 98.
how his initial diagnosis was merely for ‘a touch of influenza’, but as time wore on it was revealed that ‘his malady [cancer] was far more serious’. Likewise a sense of great relief was reported after T.M. Wilford, Liberal member for Hutt, Wellington, had travelled to London to see a cancer specialist who informed him that he had but a throat affection. ‘[H]e was so overcome when the specialist told him he was not suffering from cancer that he could not even write his name on the doctor’s cheque’. Tuberculosis was also conceived as a death sentence but even this did not inspire the degree of terror that cancer did. Dr Walter Fell, president of the New Zealand Branch of the British Medical Association (NZBMA) in 1898, claimed in his presidential address for the NZBMA that year that there was ‘no disease that causes more terror to people than [cancer] — not even the twin scourge of consumption’. It is important to consider the reasons behind this extreme dread of cancer.

The 1881 obituary for Edward Bence exemplifies the associations in people’s minds between cancer and suffering. Bence was a well-known resident of Gore who was prominently involved in horse racing. He had been in ‘continuous agony’ after being ‘long held’ ‘in cancer’s torturing grasp’. So great was the perceived torture that it was stated that ‘his death was a relief from a life of pain’. What is pertinent in his obituary is the fact that it was not confirmed that Bence had cancer. The obituary assumed from the painful description that it was cancer: ‘we presume from the description of the torture endured that it was cancer’. Dread of cancer was shaped by perceptions of pain and suffering, and from Bence three descriptive aspects are observable: that the pain from cancer was understood to be of the most excruciating kind; that this pain was not short but lasted over a long time; and that death was viewed as a kinder option, as a release from torture. The fact that this case was not confirmed as cancer, but was the assumption because of the painful descriptions, is even more telling.

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83 New Zealand Tablet, 4 Jun., 1903, p. 10; Observer, 6 Jun., 1903, p. 7.
84 Poverty Bay Herald, 24 Mar., 1898, p. 2.
Descriptions of suffering in painful agony from cancer were frequent in obituaries. There was a readiness in obituary writing to dwell on pain, suffering and death and this reflects a general trend in describing deathbed scenes, of which cancer’s painful descriptions were often the most horrific.\textsuperscript{86} Cancer was ‘a most painful’ ‘malady’, \textsuperscript{87} which meant sufferers ‘endured incessant agony’ and ‘all hours of torture’, which was ‘nigh insupportable’.\textsuperscript{88} Many descriptions were vague but included mention of suffering: in 1888 David Taylor, an upholsterer, was ‘suffering severely’ and in 1900, W.H. Newman was described as having a ‘very painful illness’.\textsuperscript{89}

Many diseases caused discomfort, pain, and suffering, but the impression from cancer obituaries are that few, if any diseases, presented a worse fate than cancer. Mary Ann Poulton’s obituary in 1879 stated that cancer was ‘one of the most painful illnesses which it is possible to conceive’.\textsuperscript{90} Mrs R. Hicks in 1890 ‘suffered more than one would think human nature could endure’.\textsuperscript{91} Other descriptions were more specific and went into significant detail. For example, it was ‘death from literal starvation’ for Mr Stedman, the registrar of Canterbury College, who had cancer of the face. Stedman gradually declined over four weeks, as he was ‘kept alive by liquid nutriment only, for he could not, owing to cancer, having entirely deprived him of all power of mastication, partake of solids’.\textsuperscript{92} While these examples demonstrate the horrid nature of cancer, not every description was consistent with this. William Coley, a Hutt resident, in 1878 died of gradual starvation, but it was reported that ‘happily, he did not suffer from much of the actual pain’. Even with an exception like this, stereotypical conceptions are evident

\textsuperscript{86} Jalland, \textit{Death in the Victorian Family}, p. 6.  
\textsuperscript{87} Mr Taylor, \textit{Tuapeka Times}, 23 Sep., 1891, p. 2.  
\textsuperscript{90} \textit{Evening Post}, 2 Jun., 1879, p. 2.  
\textsuperscript{91} \textit{Taranaki Herald}, 9 Jan., 1890, p. 2.  
\textsuperscript{92} Mr Stedman, \textit{Tuapeka Times}, 25 Mar., 1891, p. 6.
with the appended note in Coley’s obituary, ‘which usually accompanies this dreadful disease’.93

The experience of cancer did not just depict an impression of severe suffering, but it was often a severe suffering over a long length of time. In 1901, Arthur Morrison, member for Caversham, died from cancer of the tongue. Tongue cancer or cancers of the buccal cavity were one of the most common areas of cancer in men during this period, with tobacco as its most likely cause.94 A news report commented on Morrison’s correspondence to a friend. The friend claimed how horrible it was that another friend had been ‘suddenly struck down’. Morrison, from his own personal experience, wrote, ‘not a bit of it…. To die like that is easy, but to die by inches is terrible’.95 Inches it was for some through gradual starvation from their inability to swallow food.96 Other accounts stated a specific time, ranging from several months in the case of Evelyn Ellen Cannons in 1898, to 12 years for Mrs Hastie in 1886.97

Emotive power was given to the descriptions of cancer through linking suffering and time. For example, in 1879, Mr Harrison, a journalist and a Grey River council member, experienced ‘long enduring agony’ from malignant cancer of the jaw.98 In 1882, Philip Leddy, a member of the Ancient Order of Foresters, had been ‘suffering for a considerable time’ from cancer in the stomach before committing suicide.99 In 1891, George Tabor’s cancer in the stomach was a ‘long and painful illness’.100 Other examples simply emphasized the length of the illness vaguely: ‘for some time

93 Evening Post, 2 Nov., 1878, p. 2.
95 Hawera & Normanby Star, 19 Oct., 1901, p. 2; Observer, 9 Nov., 1901, p. 4.
98 Grey River Argus, 11 Jun., 1879, p. 2; Taranaki Herald, 16 Jun., 1879, p. 2
99 Evening Post, 19 Aug., 1882, p. 3.
100 Evening Post, 29 Jul., 1891, p. 2; See also Mr Henson, Wanganui Herald, 21 Jul., 1897, p. 2; Joseph Evison, Evening Post 23 Feb., 1903, p. 5; Samuel Morgan, Otago Witness, 18 Nov., 1903, p. 31.
past’, or, a ‘lengthy, ‘long’, or ‘prolonged’ illness. One report on a legal proceeding includes evidence on the burden of a lengthy cancer death. An unnamed brother, whose sister was dying of cancer, had refused to provide charitable aid on the basis that ‘she’s been dying a long time’. As the obituary for Miss Agnes Beaven in 1895 put it, it ‘was the dreaded cancer of slow growth’ that was feared the most. Dread of cancer was based on the belief, as derived from evidence of the lived cancer experience, that it could cause immense suffering over a prolonged period.

In some instances within cancer death narratives, there is a trope that indicates a progression from a painful state to a near-death state. David Taylor, discussed previously, had years of ‘indifferent health’ due to cancer in the throat, but progressed in the last few weeks ‘to a dying state’. Tom Kenrick ‘gradually sank’ with his stomach cancer ‘until he wasted to a shadow’, before death in 1888. The internal cancer of Charles Lewis, a New Plymouth hotel proprietor, in 1899 left him ‘lingering between life and death’ in his last six weeks. To one undertaker’s surprise when he came for the Maori chief Haimona Hiroti, he found the chief still alive. He had collapsed and ‘been mistaken for dead’; this was in 1898. In its final stages, cancer could be conceived as a living death as sufferers deteriorated into a near death state.

Such was the perceived extent of long suffering that numerous reports saw death as a release, while others with cancer took matters into their own hands. Death was often conceived as being merciful or positive. The obituary of Mr Harrison wrote that ‘death must have proved a merciful relief to his long enduring agony’ from cancer in the jaw in 1879. The obituary writer for Mrs T.M. Longargan believed

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that she ‘must have felt thankful for the mercy of God when the end came, and the spirit was set free from its abode of pain’. In some instances, death was seen as a better alternative to a life of suffering from cancer. In the case of Arthur Perry, a solicitor, who was suffering from cancer in the mouth, in 1898 he was ‘relieved by the kind hand of death’. It also seemed that the consensus in this case was that the death was a good thing: ‘The general feeling was that in his case the death was not one to be grieved over.’

Others sought release by suicide through a variety of methods. The publication of coroner’s reports on suicides, particularly of cancer sufferers, was a common feature in the press. For example, William Kelly, who had cancer in the brain, killed himself in 1891 after drinking alcohol; Charles Thomas Barnard, who had cancer of the face, committed suicide by jumping off a bridge in 1892; George Clayton poisoned himself with a solution of match heads in 1898; John Miller in 1904 hung himself; Charles Charman shot himself after being ‘hopelessly afflicted’; and Thomas Hagan in 1909 drowned himself in a bath by strapping his legs down. Through these impressions, it is evident that from a popular perspective the lived experience of cancer was an extremely painful and prolonged illness. At times, it was seen as being worse than death. In addition to this, cancer was not just a private suffering but was publicly expressed. Perceptions about cancer were shaped by impressions about the experience of cancer. Obituaries and other evidence that relays the experiences of cancer sufferers indicate a set of assumptions about the nature of cancer. Central to the these assumptions was the belief in the prolonged and excruciatingly painful suffering that cancer inevitably caused.

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109 *New Zealand Tablet*, 28 Apr., 1893, p. 15.
The obituary of Alexander Sutherland, a farmer in New Zealand since 1840, was almost prophetic in its expectations of the course of cancer in 1877: ‘and almost from the first it was known that he must succumb to it .... And so it came about that after great suffering Mr Sutherland died Yesterday’.\(^{112}\) Accompanying suffering in the obituary was a sense of inevitability and hopelessness. The basis of this was not because of the trappings of metaphors around cancer, but was based on the lived experience of cancer that included the limited success of medical interventions and in many instances no expectation of medical intervention. The following discussion will examine the fatalistic language used in the death records, the reasons behind this, and the reactions of some of the sufferers.

Reports of suicide reveal hopelessness as a significant motivation. Suicide was conceptualized as a terrible death; however, by the end of the nineteenth century a transformation occurred: an increasing amount of emphasis was placed on the suffering of the body.\(^{113}\) In terms of cancer, this meant an increasing acceptance of early departure from life because of the potential for prolonged and agonizing suffering. Philip Leddy, who had cancer of the stomach in 1882, committed suicide immediately after he was told by his doctor that he had less than a week to live.\(^{114}\) George Egan, suffering from tongue cancer, committed suicide after the ‘disease made its appearance again’ after an operation in 1891.\(^{115}\) In 1899, John Sutton, who had stomach cancer, killed himself with a gun after being informed by doctors that he had ‘no hope of recovery’.\(^{116}\) Others like Ivie Silver Gibson committed suicide before engaging with the perils of surgery. He killed himself, telling his friends that he would be drowned before being admitted to hospital in 1894.\(^{117}\) These examples introduce the themes of hopeless diagnosis, disease recurrence, failed medical intervention, and no expectation of medical intervention. Jalland argued that in terms of cancer, doctors in the nineteenth century were often not expected to provide curative intervention but were limited to palliative care that focussed on

\(^{112}\) *Evening Post*, 22 Oct., 1877, p. 2.

\(^{113}\) Jalland, *Death in the Victorian Family*, p. 59.

\(^{114}\) *Evening Post*, 19 Aug., 1882, p. 3.

\(^{115}\) *North Otago Times*, 29 Dec., 1891, p.2; *Otago Witness*, 31 Dec., 1891, p. 19.


\(^{117}\) *Grey River Argus*, 20 Jul., 1894, p. 2.
relieving pain. Negative associations with hospitals and low expectations of medical intervention (or even no expectation) reveal the significance of the idea of hopelessness in relation to cancer.

The theme of hopeless diagnosis indicates that hopelessness is derived from a lack of ability of the medical profession to even attempt to cure some instances of cancer. In 1886, Wilmot Powell was adjudged to have had ‘no hope of recovery’ due to the ‘alarming rapidity’ in which the cancer progressed. New Zealand’s newspapers followed the cancer suffering of Frederick Edward Maning, a prominent colonial figure, a New Zealand Native Court Judge, and early New Zealand historian, with some interest. In February 1883, Maning went to London for medical advice, but was given ‘no hope’ and was advised ‘to put his affairs in order’. It was reported that he was ‘given up by doctors’ and that an operation was ‘too long deferred to admit any hope of successful results, and that, if attempted, it would probably end in his succumbing at once’. Maning died in July and it was reported that he had been left in a ‘dying state’ ‘from that most terrible of all diseases’ and ‘lingered on’ ‘for many months’.

Evidence from patient testimonials also indicates that abandonment by the medical profession of cancer cases was a common experience. Margaret McAliece, testifying in the manslaughter trial on the treatment her husband, William, received, narrated that after several operations the medical profession ‘refused to attend him any further’. The obituary of Hugh Stafford, a man interested in ‘turf matters’ and sports, who died from cancer of the tongue in 1880, was an exception because his doctor ‘did not lose confidence’ and ‘hopes were felt that the sufferer would ultimately recover’. Of significance is that this was considered exceptional

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118 Jalland, Australian Ways of Death, pp. 80-93
119 Wanganui Herald, 9 Mar., 1886, p. 2; see also Mr Harrison, Taranaki Herald, 16 Jun., 1879, p. 2; Mr Stedman, Tuapeka Times, 25 Mar., 1891, p. 6.
120 Taranakai Herald, 26 Feb., 1883, p. 2.
121 ibid., 5 Mar., 1883, p.2; West Coast Times, 27 Feb., 1883, p. 2.
122 Timaru Herald, 28 Jul., 1883, p. 2.
because cancer was ‘generally looked upon as hopeless’. Given the nature of obituaries as a source, the dominance of the theme of hopelessness is not surprising, but it was also an indication of the limits of the medical profession to combat advanced forms of cancer.

Another theme is the failure of medical intervention, where despite surgery the patient was not cured of cancer. Two common associations with surgery as a treatment for cancer was the fact that it often led to post-operative deaths and could not prevent the recurrence of cancer. In 1881, Walter Keen, a hardware store owner, had an operation for cancer of the tongue that resulted in his death a fortnight after the operation. In 1883 Alexander Ross, who also had cancer of the tongue, was surgically operated upon for the partial removal of the tongue. Unfortunately, after the operation the cancer ‘again commenced to grow’. It was reported that the cancer was ‘not thoroughly extirpated’ during the operation. A common theme in patient testimonial evidence is the repeated failure of operations. Margaret Douglas, who suffered from an unspecified type of cancer, received three operations over six years to no avail from the medical profession. Ruth Gerr claimed that she had consulted several doctors over eight years and had undertaken over forty operations to try to cure her cancer. A regular theme is the recurrence of cancer after operations. For example, an obituary for John Mackay, a sheep inspector, in 1883 claimed that ‘the disease showed itself again and assumed a more dangerous form’ leading to his death. For John A. Caygill, a Christchurch solicitor, in 1899 ‘the fell disease appeared again’ after the operation. A reaction of hopelessness was influenced by the belief in the inability of medical intervention to successfully cure in the majority of cases.

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124 Taranaki Herald, 7 Dec., 1880, p. 2.
125 ibid, 29 Dec., 1881, p. 2.
126 Tuapeka Times, 7 Apr., 1883, p. 3.
127 Hullett, p. 13.
128 Details of the specific type of cancer that Ruth Gerr had are unspecified, ibid., pp. 12-3.
129 John Mackay, Tuapeka Times, 9 Feb., 1884, p. 2; John A Caygill, Otago Witness, 23 Feb., 1899, p. 27; see also Mrs Lewis, Evening Post, 2 Apr., 1887, p. 2.
In addition to a lack of surgical success, perceptions of surgery were also strongly related to pain. Duncan Buchanan was ‘subjected to painful operations in hospital’ in 1899 for face cancer, but despite this ‘had to return home with the cheerless intelligence that there was no cure for cancer’. The obituary of J. Wilkie, a conservative journalist, noted that he ‘submitted to operation after operation’ from 1897-9; and W. Shore in 1882, who had cancer in the jaw, underwent ‘several painful operations’ without any success. Thomas Hullett, a Christchurch grocer, had suffered from two painful operations and decided it was better to die than undertake a radical third operation.

In addition to pain, surgery was also risky, and often resulted in death. The inquest report of James Brownlee in 1884 indicated that he died under chloroform for his operation on cancer, and the inquest into the death of John Fuller in 1886 indicated that he underwent an operation but ‘he never properly recovered’ from its effects. Failure to leave the surgeon’s table was a common theme throughout the period, with numerous inquests and reports citing the failure of surgical interventions to prevent cancer. Perceptions about surgery, shaped by patient experience, inspired some individuals to abandon surgery altogether. In the testimonial of Thomas Kenshaw, he decided against any surgical intervention after being told that the surgeon would ‘cut the cancer out, scrape the bone and burn it with nitric acid’. The inquest into the death of Agnes Graham highlighted the common result of any inquest: ‘no blame on doctors’ and that they ‘took every precaution’. Thus, it seemed in respect to cancer surgery, it was often the case that ‘medical aid proved to no avail’ and there was often no expectation of medical intervention in the late nineteenth and early twentieth centuries.

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130 Otago Witness, 13 Apr., 1899, p. 29.
132 Hullett, p. 2.
133 Wanganui Herald, 31 Dec., 1884, p. 2.
134 Evening Post, 17 Dec., 1886, p. 2; see also Joseph Lobb, Evening Post, 12 Jun., 1900, p. 5.
136 Hullett, p. 19.
137 Evening Post, 27 Oct., 1902, p. 5.
138 Evening Post, 10 May., 1894 p. 2; Tuapeka Times, 23 Sep., 1891, p. 2
Conclusion

In 1913, an article was published on the front page of *N.Z. Truth* that epitomized the merging of dread, mystery and incidence. The headline was entitled, ‘The Cancer Curse. Gigantic Growth of the Dread Disease. New Zealand Beats the World’. It was in many ways a ‘scandal rag’ but as Richard Joblin has shown, *Truth* was also deeply alarmed about breaches of law and mores.\(^{139}\) In *Truth’s* opinion, cancer had changed from being thought to be an insignificant disease, to the ‘most effective corpse-maker in New Zealand’.\(^{140}\) It had become, in *Truth’s* view, the ‘black plague’. *Truth* reported that over the previous decade cancer had become ‘the most menacing disease on record’. In *Truth’s* opinion New Zealand would become a ‘cancerous colonisation’. *Truth* in effect linked the increase of cancer, the failure of scientific medicine to combat cancer and the dreadful nature of cancer.\(^{141}\)

In New Zealand, the development of cancer into an important social and public health problem occurred because of a convergence of two key factors. First, cancer received greater prominence than rival chronic diseases because of popular dread of cancer and its treatments. Secondly, the strong sense of anxiety surrounding the dreadful nature of cancer gave the statistical increase in cancer social and cultural meaning. Consequently, the increase in cancer transformed from a statistical observation into a significant issue that gained the attention of the medical profession, scientific experts, politicians, the press, and the public imagination. *Truth* stated that ‘intelligent countries’ had already taken action, and that the ‘procrastinations of the past will become the most insidious and potent factor in the death rate and the downfall of the race’.\(^{142}\) The formal responses by government institutions and the medical profession to calls for action are the subject of Section B. There were three main areas of response: conveying a message of hope through education, investing in radium, and instituting medical research. In addition to


\(^{140}\) *Truth*, 30 Nov., 1912, p. 4.

\(^{141}\) ibid., 27 Sep., 1913, p. 1.

\(^{142}\) *Truth*, 27 Sep., 1913, p. 1.
incidence, *Truth* drew on both the mysterious nature of cancer, the subject of the following chapter, and cannibalistic metaphorical descriptions of cancer to help convey its point. ‘Not a glint of light’ was thrown on the cause of cancer which was ‘shrouded with obscurity’ claimed *Truth*. Cancer was not only ‘gnawing’ ‘ravenously’, but was ‘unhindered’ and even ‘augmented’ by ‘ignorance’ and ‘apathy’ of medical professionals and parliamentarians. The mysterious nature of cancer built on popular dread and the increase in cancer incidence.
Chapter Three

‘Mysterious’ Cancer and a ‘Storm of Discordant Replies’: Medical and Popular Understandings of Cancer Causation, 1880-1915.

Put, for example, the questions: Is cancer a germ disease? Is it an inherited disease? Is it infectious? And the result will be a storm of discordant replies.¹

The period from 1880 to 1915 was one when numerous microbes were discovered and methods of prevention and public health were introduced to help contain the spread of infectious disease.² In 1925, one local newspaper report looking back on the previous fifty years described the period as a ‘golden age of medicine’, that included greater knowledge of disease pathology and infection; a strong emphasis on developments in preventative medicine; and overall a better life expectancy.³ Recent works have challenged the accuracy of such a characterization. For example, Thomas McKeown convincingly argued that economic growth, rising living standards, and better nutrition were the primary sources of improved health as opposed to developments in medical treatment and prevention.⁴

In many ways, cancer defied the perceived success in understanding and controlling infectious diseases. There was no medical certainty over cancer causation and a multitude of medical and popular theories were hypothesized about. New Zealand primarily imported scientific information about cancer causation. What is evident is that public opinion over cancer causation included a diverse array of different theories that were often contradictory. This inconsistency created a climate of confusion made cancer, as sociologist Susan Sontag described

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¹ Evening Post, 21 Dec., 1904, p. 4.
³ Evening Post, 11 Sep., 1925, p. 3.
⁴ Thomas McKeown, The Role of Medicine: Dream, Mirage or Nemesis?: London: Nuffield Provincial Hospitals Trust, 1976; on historical questioning of the golden age of medicine see Brandt and Gardner, pp. 21-37.
it, a ‘mysterious’ disease.\(^5\) Cancer was transformed from being an unknown disease among many, to a mysterious disease that defied the knowledge and perceived progress of scientific medicine.\(^6\)

From the 1890s, as discussed in Chapter Two and Three, an increase in cancer incidence, in conjunction with the dreadful nature of cancer, provoked fears among the general public. The most obvious question to pose, in response to this perceived increase and in light of new understandings of the major infectious diseases, was what was the cause of cancer? It was hoped that understanding the cause of cancer would then help explain the reasons for its increase. The focus of this search began with searching for cancer’s aetiology in order to explain its epidemiology. In 1895, Liberal MP Russell called for a Royal Commission to find out the ‘causes of this frightful increase’. ‘There must be some cause’, Russell pleaded, and he believed that it was ‘very desirable for some light to be thrown upon this matter’.\(^7\) By 1912, the DPH’s annual report conceded that any explanation for the increase in cancer was simply ‘not known’.\(^8\) The response to this question has been aptly characterized by one contemporary newspaper article as a ‘storm of discordant replies’.\(^9\) Medical authorities, the world over, could not agree on what caused cancer, and the reality was they did not know. Some, particularly in Britain, supported the cellular theory, while others, particularly in France and Germany, believed the origin of cancer to be bacteriological. Joan Austoker, a medical historian, argued there was no definite medical understanding of cancer in Britain in the late nineteenth century.\(^10\) Similarly, James Patterson, writing on the American experience in the early twentieth century, pointed out that cancer ‘mystified’ late nineteenth and early twentieth-century commentators.\(^11\)

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\(^7\) *New Zealand Parliamentary Debates* (NZPD), Wellington: Govt Printer, 89, (1895), p. 372.
One of the consequences of this mystery was that it created a vacuum in knowledge that allowed the proliferation of popular cancer theories. A multitude of different theories were hypothesized about why cancer was on the increase. This included diet, civilization, and morality. Differing medical and popular theories competed as explanations for cancer’s causation. This chapter examines both the medical and popular understandings of cancer causation and the interaction between different perspectives. It begins by discussing the dominant medical theories on cancer causation: heredity, bacteriology, and cellular theory. It argues that medical interpretations of cancer transformed from a divergence of opinions towards a more uniform view. Following this, popular theories and their relationship with the medical profession and medical theories are considered. This shows that popular theories were often linked to ideas about civilization and morality. It also demonstrates the fact that they were often derived from scientific ideas and were supported by some medical professionals. Finally, this chapter looks at the interaction of these different theoretical viewpoints through a case study on the new public interest in cancerous cattle. I argue that popular theories warrant more significant historical attention because neither popular nor medical theories should be viewed in isolation.
Scientific and Medical Theories

New Zealand was primarily an importer of scientific and medical knowledge and was greatly impacted upon by British influences. Felicity Barnes has argued that London, the great British metropolis, acted as New Zealand’s ‘cultural capital’.12 This section examines New Zealand reception of and interaction with scientific and medical theories relating to cancer causation. Drawing on material that was disseminated in New Zealand’s press, it is evident that there was a variety of different expert opinions from abroad espousing the merits of scientific theories of causation — bacteriology, cells, and heredity. Close ties with a Britain meant New Zealand’s medical profession gave priority to the cellular origin of cancer. These responses were incongruous with what might be considered orthodox medical opinion. The result of this was often a clash between expert and popular perspectives.

Close ties to Britain can be explained through the largely British-based education of New Zealand’s medical profession. In addition, the lack of local specialised cancer hospitals and experts meant that New Zealand’s medical profession looked to Britain as a guide through this international climate of confusion. Barnes has indicated, in New Zealand, that local news was aided by the telegraph, which brought homogenization and immediacy to the news, and the perspectives that were presented tended to favour those from London.13 This same general trend is also evident in respect to cancer. What is evident is that a wide range of different theories were received from abroad, but only one, the cellular theory, received the strong backing of New Zealand’s medical profession during the late nineteenth and early twentieth century.

In the late nineteenth century, some doctors continued to believe that one of the primary causes of cancer was heredity. In 1885 Herbert Snow, a surgeon at London’s cancer hospital, wrote in the *British Medical Journal* that almost the ‘whole’ of the medical profession would answer in the ‘affirmative’ if asked if cancer was hereditary. Snow wrote to try to dispel this belief and argued that such assumptions were derived ‘merely from popular tradition’.14 In 1893, *The New Zealand Official Yearbook* included commentary on hereditary cancer. The author of this commentary was Dr Robert Macdonald, a Scottish doctor in practice in New Zealand since 1882. The Yearbook claimed that the ‘general’ opinion of ‘medical experts’ was that the development of ‘growths’ was due to a ‘constitutional and inheritable tendency’. The Yearbook claimed that this meant that the ‘constitutional defect’ that caused cancer would ‘spread wider amongst the population’, instead of the ‘weeding-out’ that diseases like tuberculosis caused.15 In the 1890s, heredity was a common topic in discussion about the cause of cancer. One newspaper article claimed that cancer had the ‘greatest tendency to run in families’.16 The local press in New Zealand, drawing on international cable news, referred to famous figures from abroad, like the German Kaiser Wilhelm II, who had his cancer linked to a hereditary disposition, as evidence of the hereditary theory of cancer.17

Around the turn of the twentieth century, the relative importance of beliefs in heredity as an attributed cause of cancer waned. David Cantor suggested that in Britain, educational campaigns played down the role of heredity as a cause in order to send out a clear message that cancer could be cured if it was diagnosed early.18 It is clear that strong messages against the hereditary theory of cancer were espoused

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15 *New Zealand Official Yearbook*, Wellington: Govt Printer, 1893, p. 87; despite this, the question of heredity was also a prominent issue in debates about the etiology of tuberculosis in Britain, Michael Worboys, *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865–1900*, Cambridge: Cambridge University Press, 2000, pp. 193–233.
16 Otago Witness, 5 May., 1892, p. 45.
17 Hawera and Normanby Star, 27 May., 1901, p. 4.
publicly. Already in 1895, the London surgeon Herbert Snow claimed that the position of heredity changed. Snow wrote that ‘no one would now regard heredity... as a primary excitant of cancer’. In 1902, this was reflected in Macdonald’s commentary in the *New Zealand Official Yearbook* which excluded heredity as a potential cause of cancer for the first time. However, due to the earlier prominence of the theory, the silence on heredity was confusing to the public. In 1902, one health columnist pleaded for the ‘great doctors’ to ‘assure the world that [cancer] is not a hereditary disease’. The message that heredity was not an important cause of cancer filtered through to the press in the 1900s. Some reports ridiculed the idea of heredity as a primary cause of cancer. For example, in 1907 the *Christchurch Star* reproduced an article written by a London medical practitioner, Dr Hugh Riddle, who claimed that heredity was simply a ‘popular belief’ that had been present since the ‘Dark Ages’.

The views of a number of eminent British medical authorities on the subject of cancer causation and the role of heredity were reported in New Zealand newspapers in the early twentieth century. Not all British medical professionals were as unequivocal as Snow but many aimed to play down the relative importance of heredity. Dr E.F. Bashford, Director of the Imperial Cancer Research Fund, indicated in 1911 that while a hereditary predisposition for some cancers could be found in mice, the existence of this in humans was a ‘coincidence of considerable rarity’. The role of heredity was not a direct causal correlation but indicated a ‘susceptibility of the individual’, in the words quoted in the press of Sir H.T. Button, President of the British Royal College of Surgeons. Such commentary played down the relative importance of hereditary theories and was part of a transformation in the importance of cancer’s causal theories. Heredity transformed from an important causal explanation for cancer in the 1880s to a relatively minor one by the early twentieth century.

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20 *New Zealand Official Yearbook*, 1902, p. 294.
21 *Otago Witness*, 10 Sep., 1902, p. 64.
22 *Christchurch Star*, 9 Nov., 1907, p. 2.
24 *Grey River Argus*, 27 Sep., 1911, p. 3.
The second of the mainstream medical theories surrounding cancer in the late nineteenth century was bacteriology. Across the 1890s it was reported in the press that the ‘conviction’ was ‘gaining ground’ that cancer was a ‘microbial disease’ and was compared to tuberculosis. The relatively strong focus on the infectious nature of cancer can be explained in terms of historical context. The late nineteenth and early twentieth century was a time where definite pathological understandings of a large number of infectious diseases were being discovered. In addition, while cancer itself began as a disease that was local in nature, the fact that more advanced forms of cancer became metastatic meant that a strong area of medical investigation was focused on the potentially parasitic nature of cancer. Cable news reports that were disseminated into New Zealand’s press from France focussed on the contagiousness of cancer through a parasitic explanation. In 1893, it was claimed that the cancer microbe was a ‘living parasite’. The parasitic theory had its defenders in British medical journals who believed no theory should be automatically ruled out. In Australia, it was reported in 1896 that the retiring president of the Victoria branch of the BMA, Dr O’Sullivan, claimed that ‘cancer was caused by some specific microorganism’. However, the key point against infectious theories was the fact that hospitals and families had always been in regular contact with cancer sufferers. For example, in the British Medical Journal in 1903, W. Roger Williams pointed to the fact that after the experience of working eight years in cancer wards he believed there were strong grounds for believing that cancer was not infectious.

Despite this, regular reports came to New Zealand around the turn of the twentieth century about the potential discovery of a cancer microbe. The origin of most of these cable reports was France. In 1899, Dr Bras, a ‘well known

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26 Tuapeka Times, 10 May., p. 2.
28 There is no entry of Dr O’Sullivan in the Australian Dictionary of Biography; Otago Witness, 31 Dec., 1896, p. 19.
bacteriologist’ in Paris, claimed to have cultivated the cancer microbe. Such reporting continued into the early twentieth century. The most prominent figure in cable reporting that reached New Zealand’s press was Dr E.L. Doyen. Doyen was a prominent and independently wealthy surgeon who had become ostracized from the French medical profession after turning down a position at the Pasteur Institute that required him to give up surgery. Doyen used his own personal fortune to fund over twenty clinics in Paris, his own private medical and ballistic research, and was a vocal critic of the French Academy of Medicine. In 1902, he claimed to have found the microbe of cancer. In 1904-5, Doyen believed he had discovered a serum to cure cancer and sought to get it recognised and investigated. Doyen established his own specialist cancer hospitals, including one of forty beds in London. Doyen’s claims were pronounced a failure in 1905 after a Parisian Surgical Congress rejected his cancer cure. Such setbacks did not stop Doyen repeatedly trying to get his claims recognised and in 1906 he presented at the Fifteenth International Medical Congress. In 1908 it was still being reported in New Zealand that Doyen had discovered the ‘germ’ of cancer. Doyen’s alleged cancer cure even received attention from Joseph Ward, the Minister of Public Health, in 1905. Ward publicly stated that Doyen had gained ‘political attention in New Zealand’ and that his alleged cure had ‘raised hopes’.

Doyen was involved in a conflict of medical theories — between the bacteriological and cellular theories of cancer. In 1892, a report in the Otago Witness stated that ‘a serious conflict of opinion’ had occurred. At issue was ‘whether cancer can be regarded as a disease produced and spread by bacteria or not’. While not significant in itself, this report is an example of the confused state of medical

30 *Evening Post*, 14 Apr., 1899, p. 4.
32 ibid., 1 Mar., 1902, p. 5.
34 *Grey River Argus*, 15 Jul., 1905, p. 3.
35 ‘The Fifteenth International Medical Congress,’ *British Medical Journal*, 1.2366 (1906), pp. 1051-1053.
knowledge over contagion as a cause of cancer. The report stated that some medical experiments failed to infect animals with human cancer, that some claimed success in similar experiments, and that the issue of contagion ‘remains to be settled’.38 This uncertainty, particularly in the 1890s, is part of a general trend in British research into cancer pathology that originally focussed on bacteriology and this was increasingly supplanted by cellular research.39 This is reflected through New Zealand medical commentary. In 1893, Macdonald wrote in The New Zealand Official Yearbook that there were two competing theories in respect to the cause of cancer: ‘that cancer can be inoculated, and is contagious’; and that it is ‘due to the exigencies of cell life.’40 In Macdonald’s opinion, the ‘contest now lies between the bacillus and the cell, and it remains to be seen who shall win the day’.41

The conflicting opinions over the central cause of cancer were played out in medical journals and the press. In 1914, Doyen’s views continued to be published in international newspapers like the New York Times. Doyen attacked treatment with radium because its efficacy was based on cellular theories, and he labelled radium as a ‘fraud’.42 Local New Zealand reporting often drew on British sources that were hostile to belief in the infectious nature of cancer from the 1890s. In 1894, it was reported in the New Zealand press that Dr Barwell, a consulting surgeon at Charing Cross Hospital, London, was particularly specific that ‘cancer is not, as many believed, due to a specific microbe, and is not in any respect infectious or contagious’.43 A decade later, supporters of cellular theory proclaimed via the press that, ‘It is safe to say that cancer is not infectious.’44 This wide exposure in the press indicates the interest the New Zealand public took in the debates. Another article reported that Sir Henry Morris, a London surgeon, who wrote a paper for the Royal College of Surgeons, wanted to ‘clear the ground of encumbering conjectures and hypotheses’, and stated that ‘any such agency as bacterium... must now be definitely excluded’.45 The repeated announcements by medical professionals

39 Austoker, pp. 16-19.
40 New Zealand Official Year Book, 1893, p. 103.
41 ibid.
43 Wanganui Herald, 14 Nov., 1894, p. 3.
45 Wanganui Herald., 29 Jan., 1904, p. 5.
claiming that cancer was not infectious that were regularly reported in the press could also be symptomatic of a strong current of public opinion that continued to believe cancer was contagious.

From around the turn of the century the medical profession started taking issue with newspapers advocating bacteriological explanations of cancer causation. One Otago Witness correspondent was openly criticized for implying, not explicitly stating, that cancer may have been spread from unclean hospital bedding. An Otago medical practitioner, Dr John Hyde, responded by criticising the report and stated that ‘it is impossible’ for cancer to be communicated through bedding. The reporter hit back by pointing to Hyde’s clear defensive posturing, which the reported considered to be premature.

In New Zealand, scientific authorities weighed into the infectious debate to counteract popular beliefs about the cause of cancer. The idea that cancer was a communicable disease became an important political issue for New Zealand around the turn of the century when meat as a cause of cancer was hypothesized, which will be further discussed below. The government’s veterinarian, John Gilruth, who was also a bacteriologist, regularly used the press to try and play down fears and alarm about the potential spread of cancer through diseased meat. One article in the Transactions of the New Zealand Institute assured its readers that vegetarians were as likely to get cancer and that there was no cause for believing in the infectious nature of cancer through diseased meat. Despite such pronouncements from the 1890s, in 1910 medical professionals continued to refute the connection in the press. A front-page article in the Ashburton Guardian indicates the dissemination of information from British authorities on cancer. A message from the Imperial Cancer Research Fund (ICRF) categorically denied the infectious nature of cancer: ‘No “cancer” germ has been discovered’ it pronounced, and ‘It is

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46 Otago Witness, 9 Feb., 1899, p. 34.
47 ibid.
not thought that there is one’. Repeated reaction to bacteriological theories indicates that these theories continued to remain prominent.

The position presented by British and New Zealand medical professionals in the early twentieth century was that neither heredity nor bacteriology were considered to be the central cause of cancer. Instead, the cellular theory of cancer was posited as the most likely cause. From 1902, Macdonald’s opinion in the New Zealand Official Yearbook had changed from discussing competing perspectives about cancer’s causation to a sole focus on the cellular theory of causation. The competing perspective posited against bacteriology was that the cause of cancer was local in origin, was cellular, and was stimulated by some form of chronic irritation. The basis of the cellular theory was that the cells became excited from a particular cause. Most commonly, this was what might be termed the ‘chronic irritation’ theory. It was correlative to some extent, in the sense that it was asserted that cancer ‘frequently occurs on a part of the body which has been subject to an accident or to constant irritation’. For example, one doctor warned that you should not let the sharp edge of your tooth irritate your tongue. Other theories that can be linked to the effects of civilization include overstimulation of cells due to over nourishment (excess consumption of food). Once stimulated the cancer cells would ‘continually multiply’ like reproductive cells.

An investigative article in the British Medical Journal by New Zealand medical practitioners in 1909 is indicative of the multiple causal considerations as well as the position of New Zealand’s medical profession in supporting cellular and chronic irritation theory. In their article, P.W. Hislop and P. Clennell Fenwick investigated the potential causes of cancer. Thirty-one cases of cancer were investigated in an unnamed West Coast region. A number of causal explanations

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50 New Zealand Official Yearbook, 1902, p. 294.
51 Evening Post, 30 Sep., 1897, p. 4.
53 Otago Witness, 3 Jun., 1903 p. 64.
54 Evening Post, 3 Sep., 1904, p. 2.
were considered. These included an examination of occupation and searching for hereditary links between patients. Neither of these explanations was considered satisfactory. The issue of the existence of ‘cancer houses’ was considered but only six of the thirty-one patients were found to have lived in the same residence and this theory was dismissed.

Two main connections were made. The first involved a link between native bush and a creek water supply. It was noted that the majority of cases occurred along the line of the river or the creek and a number of instances were close to native bush. It was hypothesized that there may have been some connection between the bush, the streams, and cancer. This indicates an interest in potential environmental causes, but despite this the main explanatory model for the cases of cancer used in the article was an examination of cellular theory and its links to forms of chronic irritation. In a number of cases, a clear history of injury could be traced to account for the development of cancer: examples included having a horse fall on top of the patient; being kicked by a sheep; irritation caused by holding nails between lips while working; and piles in conjunction with constant bicycling and riding. Aside from these specific cases, the habits of the sufferers were looked into. The findings included the drinking of alcohol and smoking as potential cancer causing irritants. It was, however, the ‘excessive’ drinking of tea that a large proportion of the sample cancer sufferers were linked to. The article concluded in favour of the chronic irritation theory because it was believed that many of the cases could be traced to a definite injury or irritation.\textsuperscript{56} 

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\textsuperscript{56} ibid.
Popular Theories

The failure of scientific medicine to reach a consensus, to establish unequivocal proof of the cause of cancer, or to have consistent reporting of causal hypotheses in the press, meant that a vast array of popular theories about the cause of cancer were in circulation. In Britain, medical debate over cancer causation meant that ‘no full satisfactory explanation’ about the cause of cancer was clearly articulated to the public, as the Lancet declared in 1911.57 J. Bland, a surgeon at Middlesex Hospital, blatantly admitted in 1907 that ‘we are still hopelessly ignorant of the cause of cancerous diseases’.58 In a New Zealand article in the Evening Post in 1908 conveyed to the public the self-described position of scientific medicine’s knowledge on cancer causation. The Post claimed that the battle against cancer was a ‘fight in the dark’ where ‘in spite of ... the searchlights of science’, cancer ‘still walks in darkness’.59 In 1904, Dr Andrew Wilson, a London health columnist, whose work was disseminated into the New Zealand press, complained about popular conjecture about the causation of cancer. He complained that ‘year by year an old idea is revived that the eating of tomatoes causes cancer’. In Wilson’s view, these interpretations were merely ‘fanciful theories’.60 In the absence of medical consensus, public conjecture about the causes of cancer was rife.

Popular cancer theories were a mixture of scientific theories, assumptions, and invention. Understandings of medical ideas were appropriated and applied to experiences and observations. Popular connections were often based on the fact that cancer was increasing and this was linked with the increase habits, particularly habits associated with ‘civilisation’. Popular associations, while not in tune with orthodox medical opinion, often had medical sources or backing.

59 Evening Post, 29 Dec., 1908, p. 6.
60 Otago Witness, 9 Mar., 1904, p. 64.
Historians of cancer have briefly addressed the role of civilization as a cause for cancer.\(^6\) Robert Proctor, writing on cancer in the United States from the nineteenth century, has discussed the definition of civilization. He argued that civilization was a ‘diverse cluster of ideas’ with varied meanings. Often civilization was linked to environmental ideas and habits of modern Western civilization. In particular, this was tied to the idea of excess in relation to consumption and habits that are symptomatic of modern Western civilization. Central to this idea was that cancer was rarer in ‘uncivilized’ peoples than Europeans and aspects of civilization were part of a search for an explanation for the cause of cancer.\(^6\) David Cantor has argued that the American Society for the Control of Cancer (ASCC) viewed ideas about diet and civilization as a form of quackery and tried to play down the importance of this association.\(^6\) James Gregory has argued that vegetarianism was seen to be the answer to cancer because of the underlying associations with rising meat consumption.\(^6\)

Public perceptions can also be understood in relation to the popularity of certain alternative medical treatments. An example of this was the Mattei remedies that were an international phenomenon from the late 1890s. Count Cesare Mattei was an Italian aristocrat who developed a system of electro-homeopathy and won favour with Pope Pius IX as a lay practitioner. This system was a blend of natural remedies and chemical treatment of diseases in the tradition of Paracelsus. In short, the treatment involved a combination of fermented vegetables with a variety of added ingredients. Its popularity in Britain and its colonies rose massively once it gained the support of Lady Walburga Paget, the wife of Sir Augustus Berkeley Paget, the British ambassador in Vienna in 1890. Over the following decade, there were over a hundred publications on the subject and the British medical profession


\(^{63}\) Cantor, pp. 111-19.

had made a formal inquiry into the Mattei cure. New Zealand newspapers had dozens of reports on the validity of the cure from both its defenders and detractors, and hundreds of advertisements promoted the purchase of the remedy. The basis of its claim was to counteract the development of the perceived artificial nature of modern civilisation. A front-page article in the Tuapeka Times in 1893 outlined how these ideas interlink. The article suggested that ‘all meat, fish, and fowl’ be abstained from entirely, and that ‘everybody that leads an artificial life would probably be better for this cure’. It also proposed that this, combined with a return to nature, particularly the pure air from the ocean or from hills, and some of the Mattei patent medicine, would restore purity to the blood. This type of approach can be positioned in relation to broader themes relating to nature cures and the role of fresh air in relation to health and tuberculosis. In particular, James Whorton has argued that the correct habits of life through a return to nature were believed to provide resistance to disease. Medical responses to these cures were regular features in medical journals. Information on the Mattei cures can be found in articles in the Lancet with such titles as ‘the vulgarisation of medical science’ and ‘cancer “cures”’. These lament the attention given to the cures and were damning of the false illusions given when these cures received support from qualified medical practitioners. The issue of the Mattei cure became prominent in debate surrounding the Quackery Prevention Bill of 1907. Dr Thomas Cahill, a Wellington surgeon and New Zealand Branch President (1907-08) of the British Medical Association, giving evidence to the Quackery Prevention Bill Committee, specifically referred to the Mattei treatment as an example of a treatment that was worthless and caused unnecessary delay. These concerns about the effect of alternative treatments will be further explored in Section C.

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66 Tuapeka Times, 4 Nov., p. 1.
69 Report of the Quackery Prevention Bill Committee together with Minutes of Evidence, AJHR, I-14, 1907, pp. 44-45.
Diet was a common target for commentators in New Zealand seeking to explain the increase of cancer in conjunction with changes in modern habits. Cantor argued that there were ‘confused messages’ in Britain, in respect to diet, and particularly meat. This was partly a result of disagreement within the medical profession and also a result of education campaigns dismissing diet as a possible cause in order to get their key message across — for the public to seek medical advice early.70 From the late nineteenth century, for many New Zealanders, meat became an item eaten on a daily basis. As New Zealand historian James Belich has indicated, an informal myth of settlement was that New Zealand was a working man’s paradise, and in this paradise ‘large quantities of prime roast meat’, normally reserved for genteel folk in Britain, were commonly available.71 In New Zealand’s press, the link between cancer and meat was the most prominent popular explanation for the increase of cancer, as will be further discussed in the following section.

Items of diet were a regular feature in speculation about cancer’s cause. Different foods became associated as causes of diseases in popular imaginations: pork produced scrofula, bananas caused influenza, and oatmeal caused appendicitis.72 Tomatoes were believed to have some type of special connection with cancer. The origins of this idea are uncertain but in his history of cancer Proctor suggested one explanation was that the inside of a tomato resembles a fungus growth that is associated with cancer.73 It was reported from London, that newspapers had been ‘inundated with letters’ on tomatoes as a cause of cancer, and regular reports of authoritative pronouncements were made to try to quell this popular superstition. Dr Alexander Marsden, member of the medical committee of the London Cancer Hospital, felt the need to proclaim that ‘tomatoes neither predispose to nor excite cancer formation.... On the contrary, are a very wholesome article of diet.’74 Diet, perhaps more than anything else, was a change linked with the perceived progress of civilisation and therefore cancer.

70 Cantor, pp. 111-14.
72 Progress, 1 Jan., 1908, p. 86. Progress is a New Zealand periodical established in 1905 that focussed on industrial and engineering innovation developments until an ownership change in 1910 saw it take an architectural focus.
73 Proctor, p. 32.
74 North Otago Times, 25 Mar., 1893, p. 3.
Ideas about civilisation were given scientific authority from individual medical practitioners. While these opinions were not the dominant belief of the medical profession as a collective, the support of a theory by small groups of medical professionals helped give fringe theories strong scientific weight in the press. It was often after a medical authority had commented on a theory that it became a newsworthy event. Australian doctor G. Cooke Adams denounced corsets as the cause of breast cancer, and clay pipes as the cause of lip cancer. He held the view that ‘diseases due to immorality’ were the origin of many forms of cancer. Other reports, for example one written by a British doctor, attributed it to alcohol and indulgence in food. Often hypotheses relating to causes were contradictory in nature.

Scientific authority was frequently appealed to support moral causes in relation to cancer. Those in favour of prohibition, like Auckland’s Dr Robert Bakewell, a prominent practitioner well known for the publicity he courted for his medical practice, associated alcohol as a contributory cause of the increase in cancer. Bakewell suggested that the ‘extension of total abstinence from all intoxicating liquors ... may have a very potent influence on the present increase of cancer in New Zealand’. In contrast, it was reported that a ‘French Physician’ claimed that those who gave way to drink and lived a dissolute life were rarely attacked by cancer. Anecdotal evidence was used and this was based on high cancer rates in high beer consuming countries, such as Bavaria. In addition to moral causes, the increase of cancer was used to support other causes and was linked into broader social movements, like anti-vaccination. J.M. Cowan, a New Zealand journalist, used the increase of cancer to link with his distaste for vaccinations: ‘The increase in

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75 Hawera and Normanby Star, 16 Apr., 1904, p. 4.
77 Rex Earl Wright-St Clair, Medical Practitioners in New Zealand, 1840-1930, Hamilton: R.E. Wright-St Clair, 2003, p. 43.
78 Otago Witness, 7 Apr., 1898, p. 53.
80 Taranaki Herald, 11 Aug., 1903, p. 4.
cancer cases was connected with the old demand for vaccination — that they had forced filth into the people's veins, and now they were reaping the harvest of cancer, probably as a result of that folly. Perspectives like this link cancer with anti-vaccination movements.

A regular feature of the late nineteenth and early twentieth century was scientific authorities attempting to counteract fringe medical opinions. Public announcements from the ICRF were disseminated in New Zealand’s press. One attempt to dispel links with civilization was a pronouncement that cancer was also present in cats, dogs, cattle, and fish: 'Pipe smoking, corset wearing, vaccination, and the eating of frozen mutton have each in turn been blamed as the cause of cancer, but fish do none of these things'. The ICRF focussed on critiquing the notion that cancer was communicable, but it also was quite particular about how it was not ‘a penalty for eating flesh, or fish, or tomatoes’, or a disease of civilisation, inherited, or caused by buildings. Others were more damning, with one London surgeon attacking some ‘worthless statements’ – which cancer was caused by beer or tomatoes – as having ‘no proof or probability’. The need for such scientific authorities to come out and publicly discredit various popular theories is a testament to their widespread prevalence.

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82 Tuapeka Times, 23 Sep., 1903 p. 4.
86 Evening Post, 3 Sep., 1904, p. 2.
Cancerous Cattle

‘Cancer is increasing every year, and bad tucker is the cause’.87

Popular perspectives and understandings about the nature of disease and healing have received limited attention and are often relegated to the margins of medical histories. British historian Roger Cooter has alluded to the fact that popular attitudes towards healing are underutilized by historians.88 However, there is one source that can throw light on popular views and that is the popular press. This section argues that through an examination of lay perspectives on cancer causation through the use of the press that moves beyond a framework of ignorance and gullibility, a more balanced and insightful account of lay beliefs and their interactions with theories of causality becomes possible. This case study of cancer and meat examines popular understandings and prejudices in relation to cancer and meat and the role of political and scientific encounters that aimed to counteract and critique these lay beliefs.

The popular beliefs in this case study can be situated in the historiography on diet. New Zealand’s concern about the relationship between meat and disease is comparable to developments in America and Britain. In America, there was a strong current of popular opinion in the late nineteenth and early twentieth centuries that it was better to avoid all forms of protein. In particular, concerns about bad meat led to a strong focus on attempts to regulate slaughterhouses.89 Keir Waddington, writing on tuberculosis and meat in Britain, has established that the relationship between diseased meat and health became an issue of national importance in the late nineteenth century. This was as part of a wider discussion

87 Fair Play, 1 Jun., 1894, p. 4.
about food quality and safety, and poverty and health. This section builds on historiography relating to diet and health.

In New Zealand, cancer was popularly believed to be a scourge of modern civilization that was regularly attributed to diet, and particularly diseased meat. Popular beliefs about meat drew on scientific ideas and scientific authorities as well as popular stereotypes that helped give them legitimacy. In addition, the role of popular beliefs was significant at a political level and influenced political commentary and actions. In order to counteract popular beliefs, medical and scientific authorities categorically denied and critiqued the relationship between cancer and diseased meat.

Diseased cancerous cattle in New Zealand developed into a significant issue in the late 1880s and early 1890s. New Zealand’s Premier, Richard Seddon, embraced such perspectives. He noted that the increase of cancer ‘was a matter of great concern to the Government’. He added, ‘the steps now being taken in regard to tuberculosis would prove largely helpful’. What Seddon was referring to was the latest proposals to improve sanitation in abattoirs and more rigorous stock inspection. The Premier, Seddon’s perception indicates the complex set of understandings in respect to cancer and its cause discussed in the previous section. It also indicates that government opinion in combating cancer was understood more in terms of popular authority than medical authority. The underlying assumption in Seddon’s commentary was that cancer was a communicable disease. One newspaper report in 1889 commented on the need for closer attention to the condition of cattle stock and the sale of diseased meat. It claimed that ‘Unsightly lumps as large as a man’s hand’ passed through into the national food supply. The problem at this stage was defined in terms of stock inspection: inspectors lacked the power to condemn an animal for cancer. Another article in the same year pointed out that such occurrences were not rogue events: ‘Anyone who is familiar

with the saleyards of this coast is well aware that cancerous cattle are openly sold without ... hindrance.'

In 1890, the government took action in response to these concerns and cancer was added to the disease list in the 1890 Cattle Act. A desire for more stringent measures to prevent meat or milk from diseased animals being used for food and it aimed to provide the necessary authority for the inspection of cattle and their destruction. Concern over cancerous diseased meat was part of a concern about disease in milk and meat generally. While this was primarily focussed on tuberculosis, it also involved cancer. There was a desire to ensure that ‘full information’ regarding both tuberculosis and cancer in stock be widely circulated. Previously, the Diseased Cattle Act of 1861 empowered the governor to appoint inspectors to inspect arriving ships’ stock and impose quarantine. In 1871, this role had been expanded through the creation of local cattle boards, made up of two members, who could appoint district inspectors to oversee the standards for cattle to be slaughtered. The 1890 act added cancer to a list of specific diseases that could be quarantined or ordered for destruction. The costs of such orders were to be borne by the owners. One result of this legislation was that inspectors began to order the destruction of cattle alleged to have cancer. For example, in 1891 and 1893 it was recorded in the Department of Agriculture’s reports that in Auckland a number of cases had been identified and destroyed. The timing of the development of concerns about cancer and cattle is linked with the growing concerns about the increase of cancer in the late nineteenth century. In a climate of confusion, where there was no definitive understanding of the cause of cancer, the issue of diseased meat and health merged with public anxiety about cancer. One central problem is what could be defined as cancer?

94 New Zealand Statutes (NZS), Wellington: Govt. Printer, no. 18., 1890, p. 47.
95 Extract from the General Report of the Joint Committee on Live-Stock and Rabbits, 1890, Together with Minutes of Evidence and Appendix Relative to Disease amongst Stock, AJHR, I-01, 1891, pp. 1-3.
96 Report of the Joint Committee on Live-Stock and Rabbits, AJHR, I-01, 1890, p. 3.
97 NZS, no. 23, 1861.
98 ibid., no. 35 (1871); boards were expanded to 3-5 members in 1881, NZS no. 4, 1881.
99 NZS, no. 18, 1890.
It is likely that the overwhelming majority of those cattle identified as cancerous were not actually suffering from malignant cancer. The Cattle Act of 1890 included a very broad definition of cancer: ‘cancer proper, and external manifestations of all those diseases, which in the opinion of the inspector, render the flesh or milk of any animal unfit for human consumption’. The more likely conclusion is that many of the instances were the result of actinomycosis, or lumpy jaw, a bacterial disease that produces protruding lumps on the heads and jaws of cattle. Some contemporary opinions also made this observation: ‘To the eye of the casual observer it seems to resemble closely the dread cancer’. What is important is the fact that many members of the general public believed cancer were associated with the consumption of products from diseased cattle. What this demonstrates is lay engagement with disease definitions and open public discussions on the nature of medical matters. Disease definitions are not stable concepts and should not be isolated to medical perspectives alone. From a political, social, and cultural perspective, this lay belief in cancerous cattle is significant.

There were clear attempts by scientific authorities to distinguish between ‘proper’ medical views and lay understandings. Through these criticisms it is possible to extract information relating to popular beliefs as is the case in the following 1896 example: ‘The lay mind associated with cancer a nasty-looking tumour, but the disease known as cancer in cattle was not the disease known as cancer in human beings’. This commentary is indicative of the fact that lay understandings of cancer were based on their visual perceptions about tumours. This understanding of cancer even led to a compromise in definitions. One ‘duly qualified’ veterinary surgeon distinguished cancer from ‘true cancer’ in a reply to a writer’s query about a horse. This approach attempted to distinguish medical definitions from lay ones. In 1902, one commentator attempted to explain what was perceived to be lay confusion: ‘To the public they are usually all classed as “cancer”, but the class which we are to consider are not true cancers they are called
“sarcomas”. In 1899, Charles Reakes, a government veterinarian, noted that ‘In New Zealand the term “cancer” appears to be applied indiscriminately to any growth, even if it be only a simple wart, whose surface presents an abraded or ulcerating appearance.’ There were clear attempts by scientific authorities to distinguish between different definitions of cancer. The continual need to discredit or clarify popular understandings about cancer, is indicative of their widespread nature.

While scientific authorities tried to treat popular beliefs in a dismissive way, there is also evidence that popular beliefs appropriated scientific and medical ideas. The result of this was the creation of various types of hybrid understandings of cancer where scientific and lay ideas merged. For example, the spread of cancer by meat was understood in terms of bacteriological theories: ‘The truth is the affected part is a hatchery, and the countless millions of bacilli bred there daily and hourly mingle with the blood... every ounce of flesh derived from a cancerous animal is loaded up with cancerous bacilli’. In addition to bacteriological links, there were some understandings related to cellular theory. For example, one article commented on branding as a form of chronic irritation on cattle: ‘Many bullocks are so badly injured through the heavy brands that sores of a cancerous nature frequently follow upon injury, which must, more or less, afflict the whole carcass, and be a source of danger to the health of people who consume the meat.’ What is evident is a type of understanding that merges the scientific theories of bacteriology and cells with popular understandings about the impact of consuming meat.

While medical authorities debated the merits of cellular, viral, or bacteriological theories, for many contemporaries there was little doubt that the cause of cancer was linked with diseased meat. The correlation was simple: the belief in cancer’s rapid increase merged with ideas about the increased consumption of meat. This

105 Hawera and Normanby Star, 11 Jan., 1902, p. 4.
106 ibid., 13 Jan., 1899, p. 2.
was based on myths about New Zealand being a ‘labourer’s paradise’, where meat, among other resources was in natural abundance, and its consumption was significantly higher than Britain. This correlation was aptly captured by one article in the *Tuapeka Times*: ‘The increase of cancer throughout the colony draws attention to the mischief of people eating diseased meat. The hospital returns show an increase of this terrible disease, and there can only be one cause for it, and that is the use of diseased meat as food.’

Blame and finger pointing predictably ensued with those at the supply end receiving the most attention. Greedy farmers and sly butchers were the predominant targets. Popular presumptions implied guilt in one report which stated that cancer was ‘almost unknown among butchers’, because ‘they do not eat any meat except that which they know to be entirely free from such disease germs’. It was reported that there was a popular ‘Scotch’ book in circulation that advised owners of cancerous stock to ‘dispose of the animal to the butcher at the first favourable opportunity’. Another commentator found it ‘disquieting’ that some inspectors working with the butchers ‘held that if the head were removed the rest of the body was good for food’. The problem of diseased food supply was seen as an immoral danger to public health and it is in this sense that concerns over cancer can be considered in relation to prevention through slaughterhouse and stock regulation. One particularly scathing report stated that butchers ‘with impunity feed the public on cancerous beef’.

Butchers were not alone in being condemned. New Zealand was becoming increasingly urban, and some commentars often viewed farmers as a group who excited blame and distrust. D.A. Robb, of Springvale, had to defend himself publicly because of a rumour that he had attempted to purchase medicine to treat a

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112 Ibid., 1 Mar., 1894, p. 2.
113 *Otago Witness*, 9 Sep., 1908, p. 37.
114 *Tuapeka Times*, 2 Nov., 1895, p. 3.
cancerous cow. Robb threatened to prosecute the persons who had put that report in circulation, while welcoming any member of the public to inspect his stock at any time.\textsuperscript{115} Popular fears impacted upon local businessmen, like Thomas Mitchell of Wanganui, who was in an ‘awkward place’ with local businessmen boycotting his trade because of allegations he sold cancerous meat, and these could not be verified because of the vacant post of the local inspector.\textsuperscript{116} It was reported that an ‘awakening intelligence’ of the public had developed, and following the 1890 Cattle Act they were ‘insistent that meat... shall be inspected by a competent officer’.\textsuperscript{117} It was encouraged that citizens should take action and ‘lose no time of apprising the police’ of diseased animals.\textsuperscript{118} Semi-heroic stories of citizen action were reported, with Mr. Liffton giving information to the police of milk being sold from cancerous cows leading to the destruction of the disease-causing cows.\textsuperscript{119} This evidence reveals the fact that cancer and diseased cattle was an area that caused a great amount of anxiety to many members of the public. Some individuals felt so strongly that they were prepared to instigate significant action against those perceived to be endangering the public’s health.

One common popular belief that circulated in the 1890s was the idea that Jews were relatively free from the scourges of cancer. The belief in diseased cattle as the cause of cancer led to the spread of discussion about popular stereotypes to reinforce popular beliefs. A claim in The New Zealand Tablet, a Catholic paper, that ‘cancer is unknown among Jews’ led to differences between Jews and that Gentiles being examined.\textsuperscript{120} One commentator on the front page of Fair Play, an illustrated monthly serial, wrote that the ‘Jews never get cancer’ as they always get someone to inspect meat for them; whereas Gentiles ‘go on devouring meat which ought to be burnt or buried’.\textsuperscript{121} Such conceptions were only developed further with anecdotal evidence. It was reported that the chief rabbi of New Zealand had stated that there had not been a single case of cancer in Wellington Hospital over the previous eight

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\bibitem{115} Wanganui Herald, 2 Oct., 1891, p. 2.
\bibitem{116} ibid., 1896, 23 Dec., p. 2.
\bibitem{117} ibid., 2 Oct., 1891, p. 2.
\bibitem{118} Tuapeka Times, 27 Jan., 1894, p. 2.
\bibitem{119} Hawera and Normamby Star, 19 Mar., 1896, p. 2.
\bibitem{120} New Zealand Tablet, 22 Apr., 1898, p. 28.
\bibitem{121} Fair Play, 1 Nov., 1894, p. 1.
\end{thebibliography}
years (1886-94) who was Jewish. In addition to direct ingestion of cancerous cattle, there were reports of diseased livestock being sold for pig food, and that it was through the pigs that cancer was spread. It was also pointed out that gentiles ate the ‘unclean thing’, the pig. In a report on ‘slaughterhouse horrors’ it was stated that diseased meat was being transferred via the ‘carnivorous pig’. Another article left its ‘pork loving reader to draw their own sweet conclusions at their leisure’.

Popular beliefs were also reinforced by evidence from medical authorities. Often these reports were vague. For example, according to an article in the Otago Witness ‘One councillor, of the medical profession, stated that there were an excessive number of cases of cancer in Auckland, and that this probably was due to the consumption of unsuitable meat.’ It was also vaguely claimed that ‘some of the highest medical authorities hold that pork is a frequent cause of cancer.’ Another report vaguely indicated that ‘medical experts tell us that fully one half of the cases they treat are due to the ingestion of diseased meats.’ There is no evidence in the discussion surrounding the 1890 Cattle Act that the inclusion of cancer had medical input. While the identities of these medical authorities are not discernible and were perhaps even fictitious, they acted to reinforce popular views about cancer and diseased meat.

In addition to vague medical authorities, there was also a range of specific testimony in support of the diseased meat theory from a range of experts. Some of these reports were local but international experts were also evident in New Zealand’s press. Dr Cook Adams, from the Chicago Board of Health, asserted that statistical investigation in Australia, Britain, Europe, and the United States, ‘fully corroborate’ the link between cancer and eating diseased meat.
veterinarian and public abattoir inspector for Dunedin City Council, explained the connection between the consumption of diseased meat and the prevalence of cancer: ‘it has now been clearly established that disease is readily communicable through the flesh and milk of cancerous cows’. In a lecture, Dr William Chapple, a Wellington medical practitioner, claimed that that seven per cent of sheep and cattle slaughtered for food had either cancer or tuberculosis. Such testimony indicates a complex and occasionally contradictory understanding of cancer. Despite the discovery of the tuberculosis bacillus in 1882, the two diseases continued to be linked together into the 1890s. Expert authorities were reported as a type of confirmation of the link between cancer and diseased meat.

Popular beliefs in the dangers of cancerous cattle were augmented by repeated reports of heroic stock inspectors protecting the public’s health. For example, an inspector, Miller, destroyed cows suffering from cancer in Totara and Livingstone; Mr Turner was ‘on the alert’ when he stopped the sale of cancerous cattle in Gore; and Mr Temperley, the inspector of stock for Hokitika, prevented sales of cancerous stock. Inspector R.H. Hassell, after finding some cases of ‘cancer’, wanted to muster all the cattle in Tuapeka and Waitahuna districts for a thorough inspection. The publication of actions by inspectors indicates that they were considered newsworthy events. In some instances, there was open praise for the inspector’s actions. After Mr. Orvell, a government stock inspector, condemned several cases one commentator wrote the following: ‘I am glad to see this, as there have been more cases of cancer for the last ten years in New Zealand than there have been in England, Ireland, and Scotland for the same period.’ While it could be said that this commentator may be exaggerating the case, it is evident that there were widespread concerns over the issue of diseased meat. Stock inspectors’ reports provided a type of expert opinion that confirmed the presence of cancerous meat in New Zealand.

130 Tuapeka Times, 2 Nov., 1895, p. 3.
131 Otago Witness, 11 May, 1893, p. 17.
132 Wanganui Herald, 5 Feb., 1895, p. 2.
133 Otago Witness, 1 Jun., 1893, p. 23.
134 Grey River Argus, 26 Feb., 1892, p. 2.
135 Otago Witness, 8 Mar., 1894, p. 11.
136 Taranaki Herald, 23 Jun., p. 2.
Government, Scientific, and Medical Reactions

The issue of cancer and cattle incited political, scientific, and medical reaction. The discussion on this issue reveals two important areas that were under debate: whether cancer was prevalent in New Zealand cattle and whether it mattered if it was. Political reaction to the issue manifested itself when it suited the best interests of New Zealand. Scientific and medical reaction attempted to counteract lay beliefs in an attempt to limit the publicity of what were perceived to be incorrect medical theories. Expert authorities attempted to control the debate about the cause of cancer. In 1893, Dr Robert Macdonald, a Scottish doctor in practice in New Zealand since 1882, argued that ‘flesh-eating cannot be put down as the origin of the evil’. This commentary was targeted at moving the issue of cancer causation away from bacteriological theories and categorically stating the fact that cancer was not infectious. Other commentators believed lay engagement with medical and scientific matters should be avoided altogether. Councillor McLean, a county councillor for Hawera, stated that ‘When doctors differed he did not think laymen should interfere’. In New Zealand, John Gilruth, the government’s chief veterinarian and a bacteriologist, was the official government expert who acted to try to counteract lay popular beliefs.

Throughout the 1890s, Gilruth attempted to challenge popular beliefs on numerous occasions. In 1893, he reported that he had not discovered a ‘true case of cancer being communicated from a beast to human being’. Gilruth claimed that public understandings of cancer were incorrect: he reported that one case of ‘so-called cancer’ was ‘simply a large knob of horn formed by the animal being branded too deeply’. In terms of popular understandings as well as understandings about the chronic irritation theory, these claims may have appeared to be contradictory. The effectiveness of Gilruth’s message must also be questioned, given its constant repetition throughout the decade: in 1894 it was...
reported he ‘ha[d] not yet found a genuine case of cancer in cattle’, but only 'cancerous looking tumours', and that ‘no authenticated case of cancer having been contracted by a human from a domestic animal.’\textsuperscript{141} Again, in 1895, Gilruth reasserted this belief, stating publicly:

I am happy to inform you that I have not seen a single case of true cancer, in spite of the many assertions that such a disease exists to an alarming extent among horned cattle. Cases reported to me as cancerous I have found, on examination, to be either actinomycotic... some common neoplasm, or a mere ulceration of the skin....not a single instance of cancer in man has been or is at all likely to be traced to a similar disease in butcher meat.\textsuperscript{142}

This public message was largely in vain. A newspaper report about an inspector Miller ordering the destruction of a ‘cow suffering from cancer’ was used as evidence to counteract Gilruth’s claims.\textsuperscript{143} The repeated messages by the likes of Gilruth, and contradictory forms of evidence, meant the issue of cancer and diseased meat had no consistent or clear message of authority.

By 1897, the issue of cancer in meat in New Zealand came to British attention. Felicity Barnes has pointed out that the formation of the United Press Association in 1897, which pooled telegraph costs, meant that news from London became more quickly accessible.\textsuperscript{144} Wingfield Digby, a British parliamentarian for North Dorset, was reported in New Zealand as claiming that frozen meat was ‘valueless’ and left consumers vulnerable to cancer.\textsuperscript{145} Britain had been New Zealand’s primary destination for its frozen meat industry since the 1880s which was an important part of New Zealand’s economy.\textsuperscript{146} While the New Zealand newspapers had been prepared to revel in scandals about cancerous cattle in New Zealand, their reaction to British claims was hostile. ‘A Baseless Assertion’ was the title of one article in the Wanganui Herald. This challenged the basis of medical facts used by Digby in

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\textsuperscript{141} Otago Witness, 20 Dec., 1894, p. 42.
\textsuperscript{142} Tuapeka Times, 5 Jan., 1895, p. 4.
\textsuperscript{143} Otago Witness, 24 Jan., 1895, p. 27.
\textsuperscript{144} Barnes, ‘New Zealand’s London’, p. 224.
\textsuperscript{145} Otago Witness, 15 Apr., 1897, p. 14.
\textsuperscript{146} Belich, pp. 54-8.
\end{flushleft}
respect to both frozen meat and cancer, and pointed out that those who partake of ‘prime Dorsetshire beef’ were not ‘disease proof’. The article asserted that New Zealand flocks were comparatively free from disease compared to those from the ‘Home Country’.\(^\text{147}\) This reinforces the potential links in Britain with cancer and patterns of concern about food safety. It reveals the fact that concerns about cancer were related to broader international trade issues.

The responses from the Australasian colonies are evident in New Zealand’s press. In Australia, the Victorian Superintendent of Exports presented evidence to the United Kingdom House of Commons showing that colonial meat was free from disease.\(^\text{148}\) The New Zealand Farmers Cooperative Association instructed their London manager to ‘publicly contradict’ the statements,\(^\text{149}\) while New Zealand’s Agent-General, William Pember Reeves, denied the ‘ridiculous assertions’ and called for a Royal Commission of inquiry.\(^\text{150}\) Such a reaction was predictable given the increasing importance of frozen meat to New Zealand’s economy.\(^\text{151}\) Despite such denials, in early 1898, it was believed by one commentator that to keep the colony free from diseased meat ‘much more drastic measures than those now in force will need to be taken’.\(^\text{152}\) The aim of this was to give reassurance to safeguard export markets.

With the colony’s international reputation potentially being affected, the fight against lay conceptions of the causality of cancer from diseased meat was given a stronger sense of urgency. At this time, reports from government inspectors were of a more uniform opinion. Mr Reakes, a government veterinary surgeon, pointed out that there was ‘no malignant cancer amongst livestock in New Zealand’. Yet, assertions like this did not go unchallenged. Mr Murtagh contradicted this assertion: ‘If Mr Reakes was as long in practice in New Zealand as I have been, he would change his opinion. I would like to ask Mr Reakes, if his theory is right, why

\(^{147}\) Wanganui Herald, 10 Apr., 1897, p. 2.
\(^{148}\) Evening Post, 29 Jul., 1897, p. 5.
\(^{150}\) Hawera and Normandy Star, 15 Apr., 1897, p. 2.
\(^{151}\) Belich, Paradise Reforged, pp. 54-8.
\(^{152}\) Marlborough Express, 22 Mar., 1898, p. 4.
is cancer amongst humans so prevalent in New Zealand.' Popular beliefs were reinforced by the inability to categorically explain the perceived increase in cancer or identify the cause of this increase. The repeated attempt to correct popular beliefs in the papers is also indicative of the fact that such lay perceptions were commonplace.

Attempts to counteract lay beliefs about the relationship between cancer and meat continued into the late 1890s. Dr Harry de Latour, the medical superintendent of Oamaru hospital, undertook an investigation into cancer in the Tapanui district. This was in response to concerns about New Zealand’s national food supply. Tapanui was selected because it had the highest cancer incidence in the country at the time. He concluded that his investigations had proved that the origin of the high cancer rate did not have anything to do with the supply of meat. Latour had no other answers to explain the region’s unnaturally high level of cancer incidence. Thus, a failure of medical authorities to explain the cause of the increase of cancer gave strong grounds to question expert opinion. In 1898, Gilruth also undertook investigations into cases of cancerous cattle. He declared that the result of this investigation was that only one or two cases of real cancer were found amongst hundreds of cases of ‘so-called cancer’. Gilruth also stated that the ‘flesh of animals affected with such alleged cancer was perfectly innocuous as human food, and they were prepared to back their opinion by eating the flesh’. In his report from the Joint Agricultural, Pastoral, and Stock committee Gilruth responded to a question by William Massey, the member for Waitemata and future New Zealand Prime Minister, about the infectiousness of cancer. ‘I do not know, nor does anyone else’, was Gilruth’s response. Gilruth did try to convey the point that cancer in cattle was not a significant issue in New Zealand: ‘I have never yet seen a case of true malignant cancer in any animal in the colony’. ‘For all practical purposes’, Gilruth claimed, there was ‘no cancer in the colony’. He further added that ‘It is the people who do not know anything about cancer who most frequently use the term’. Perhaps the message may have had more force if it had been conveyed consistently.

153 Wanganui Herald, 5 Feb., 1898, p. 3.
154 Bay of Plenty Times, 11 May., 1898, p. 2.
155 Wanganui Herald, 6 Feb., 1898, p. 3.
While there were reports of Gilruth questioning the causal link of cancer and diseased meat, some newspapers presented his perspective as the opposite: the *Otago Witness* reported that Gilruth had declared there to be cases of cancerous cows in Wellington, using the fact that he was a man of repute to make a case for what he had in fact been arguing against.\(^157\) It seemed that despite the efforts of medical authorities, understandings of cancer causality were contested territory, where lay perceptions reigned.

In the first decade of the twentieth century, concerns about meat quality continued to be a recurring theme. In 1901, a British newspaper correspondent suggested cancer was linked to frozen meat, and that excessive branding had caused it. A group of colonial representatives ‘took up the cudgels on behalf of the colonies, repudiated the statements, and threw ridicule on them’.\(^158\) In this instance, as in 1898, it is interesting to see that the defence was a joint venture by several of the Australian colonies and New Zealand. The issue of cancer, disease, and frozen meat came up again in 1904. It was reported that another British parliamentarian, Alfred Davies, made renewed claims about the public health risks of frozen meat. New Zealand’s press presented his commentary in a less than favourable light. It was reported that ‘The blending of butter and milk long worried him’ but now ‘frozen meat griped him... and he is sorely perturbed whether it may not be a possible source of cancer’.\(^159\) In a public health statement, Joseph Ward, the Minister of Public Health, stated that what was understood to be cancer in cattle ‘is totally different from that as seen in man.’\(^160\)

In 1909, the issue of frozen meat came up yet again. Allegedly a pamphlet entitled, ‘Cancer! Frozen Meat! Public Warning!’ had been in circulation around Britain. It consisted of an opinion by a medical professional stating that frozen meat caused cancer. Thomas Mackenzie, New Zealand’s Minister of Agriculture from 1908-1911, brought the issue to the public and tracked down the alleged

\(^{157}\) *Otago Witness*, 18 May., 1899, p.14; *Wanganui Herald*, 10 May., 1899, p. 2
\(^{158}\) *Evening Post*, 28 Sep., 1901, p. 5.
\(^{159}\) ibid., 30 Apr., 1904, p. 9.
medical authority and received a categorical denial of supporting such allegations. It was thought that an international conspiracy was afoot. The chilled meat lobbyists from the United States were the suspected culprits. Yet, in this instance, Cameron, a veterinarian and Dunedin City Council inspector, stated that as well as being factually nonsensical, he had never seen such a poster or heard anything quite like what Mackenzie had said. The origin of the rumour may have had some suspicious contexts as at this time in relation to North American refrigerated meat. This was reflected through widespread concern in New Zealand over the British frozen meat market. Yet, there are also reports that Mackenzie presented the poster at an agriculture conference stirring up scandal. What is important is the impact that cancer could have. One report on the scandal stated that ‘the very mention of the dread disease of cancer is sufficient to set up a quickly-spreading scare amongst the public’. Such commentary indicates that the influence of expert opinion, even in 1909, was not extensive enough to quell panic.

In the early twentieth century, despite efforts to the contrary, there had been little change to the climate of popular conceptions. The Observer wanted to know ‘whether the sanitary commissioners are going to have a look at the colony’s abattoirs and see if anything can be done with the cancer plague’. If anything, the scandal of the continual spread of cancer gained more attention as medical understandings became more solidified. The Observer was particularly concerned with this issue, stating that ‘One of the contributing causes is assuredly meat unfit for human food, while another is milk which has come to the table from uninspected dairies.’ Cancer and meat also became the subject of bad satire: ‘They say that those cancer statistics from the hospital are not reconciling the public to their milk and sausages’; ‘They say that the hospital report in connection with cancer may be a startling one, but a report on the number of cancerous cows would be a staggerer’. In 1904, it had to be once again refuted by local medical

161 Hawera and Normanby Star, 3 Aug., 1909, p. 7.
162 Evening Post, 12 Aug., 1909, p. 3.
165 Observer, 5 May., 1900, p. 9.
166 ibid., 27 Oct., 1900, p. 4.
167 ibid., 21 Apr., 1900, p. 3.
168 ibid., 14 Apr., 1900, p. 3.
professionals to try to combat public assumptions. The conclusion from interviews with Christchurch medical professionals on the association between meat and cancer was that ‘there was not the remotest possibility of this occurring’.\footnote{Evening Post, 19 Mar., 1904, p. 2}

Despite such pronouncements, around the turn of the century, pressure for some type of action started to build and the issue of meat supply became an important topic at both a local and a national level. At a ‘special meeting’ of the Waimoto County Council in 1901, it was noted that the slaughter yards were in a ‘beastly state’ and that this was the cause of disease, ‘especially cancer’.\footnote{Otago Witness, 23 Jan., 1901, p. 5.} One commentary summed up the developing opinion: ‘there is no doubt that what we may call the cancer scare contributed to arouse public attention to the necessity for amended slaughterhouse legislation’.\footnote{Timaru Herald, 6 Aug., 1900, p. 2.} After the committee on the Slaughterhouse Inspection Bill made their report in 1900, Seddon moved for it to be adopted:

Both Parliament and the public are agreed that the law relating to slaughtering requires considerable amendment. This feeling has gradually grown up during the last few years. And stronger still by reason of repeated statements, apparently well grounded, that cancer was largely on the increase, many experts being of the opinion that the disease was spread by the consumption of the flesh of beasts suffering from cancer.\footnote{ibid., 6 Aug., 1900, p. 2.}

It is clear that government action associated methods of reducing contagion as an appropriate response to popular fears over cancer. In 1909, there was a report of a court case involving a cow with a malignant growth in the eye. The defendant, John Wilkinson, a farmer, tried to hide the infected cow from the milk factory inspector. It was found to have a growth about an inch and a half beyond the eye socket, and in effect, the eye had become a cancerous growth (the eye was preserved and produced in court as evidence). The defendant was fined over five pounds.\footnote{Bay Of Plenty Times, 8 Mar., 1909, p. 2.} With newspaper reports of examples like these, it is clear that despite certain medical authorities and government representatives trying to deny the link
between meat and bacteriology with cancer, such perspectives continued to be widespread.

While scientific and medical authorities attempted to counteract popular beliefs, there were a number of forms of evidence and belief systems that restricted the persuasiveness of their arguments. The context of the increase in cancer and the inability of scientific medicine to confirm cancer causation that created a climate that encouraged lay speculation. The belief in the link between cancer and meat was based on an amalgamation of scientific theories, anecdotal evidence, beliefs about the nature of cancer as a tumour growth, and concerns about the changing habits of civilization. Evidence in support of the theory was drawn from a wide variety of sources including stereotypes about Jews and clean food, concerns over the motives of farmers and butchers, the use of vague medical authorities and commentary from a variety of experts. When such commentary related to New Zealand’s export trade, it took on political associations that led to strong criticism. However, the continual efforts to try to counteract popular beliefs associating the meat with cancer are indicative of the widespread nature and persistence of this belief. The issue did not disappear after 1910, but nor did it continue to be prominent or occur at the same frequency.

The inclusion of cancer in a list of enforceable diseases in the Cattle Act of 1890 served as a precursor to a series of debates and concerns over cancer in cattle throughout the 1890s and 1900s. By examining popular beliefs outside a framework of ignorance and gullibility, it is possible to consider the influences and contexts that shaped popular beliefs. While this section has focussed on the case study of cancer in cattle, evidence of a diverse set of understandings in relation to cancer causation can be found in many areas. In 1903, in Hamilton, ‘on the advice of medical men’, ‘the jury and Mayor ... concurring’, a dwelling of a cancer sufferer who died was ordered by the coroner to be set on fire and for the body to be cremated. \(^{174}\) In 1907, an officer from the DPH ordered the books of a library that had three people develop cancer to be ‘burnt by my own observation’. An

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\(^{174}\) *Evening Post*, 10 Aug., 1903, p. 5.
insightful citizen had written in wanting to know why, as his actions pointed ‘to the fact that cancer is infectious’, yet medical authorities stated the opposite. One 1905 hospital report indicates that cancer patients continued to be segregated from other ailments. Despite attempts to counteract popular beliefs and control medical knowledge, such actions only supported the weight of evidence in favour of the infectious nature of cancer.

175 Taranaki Herald, 18 Jun., 1907, p. 7.
Conclusion

This chapter has examined the significance of a range of different theories about cancer’s causation. It built on Chapter Two’s discussion of concerns over cancer’s increase and popular dread through discussing the mysterious and uncertain nature of cancer causation in the late nineteenth and early twentieth century. The first section focussed on the most significant medical understandings of causation. It argued that the failure to find a definitive cause of cancer helped cancer to become a mysterious disease and it also created a climate that allowed popular theories to proliferate. This uncertainty over cancer causation created a climate of confusion in New Zealand’s press with contradictory reports. In 1913, N.Z. Truth reported that ‘not a glint of light’ was thrown onto the cause of cancer and this uncertainty meant that cancer was ‘shrouded with obscurity’. In the context of increasing expectations of scientific medicine to discover cures, increasingly critical commentary influenced public health responses from medical professionals and the DPH. Despite uncertainty, the position of the medical profession increasingly solidified in favour of the cellular theory of cancer.

Nevertheless, conflict continued to occur and the inability to definitively provide answers about cancer’s causation resulted in the proliferation of alternative theories. Like the scientific theories, New Zealand also imported and exported news and information about popular beliefs on cancer causation. These were predominantly focussed on civilization, diet, and morality. Despite attempts to discredit certain perspectives, the position of popular cancer theories remained significant and were often reinforced by and derived from ostensibly scientific and medical opinion. The case study of cancerous cattle exemplifies how popular theories about cancerous cattle were a combination of scientific theories on cancer causation and popular understandings about the nature of cancer as a growth in the context of the increasing cancer rate. This chapter demonstrated how both medical and popular perspectives interacted and that popular theories warrant more significant historical attention because of their intimate relationship with more

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orthodox viewpoints. It was in this context of confusion that the DPH and the medical profession sought to educate the public about prevention and early detection, the subject of the following chapter.
Section B

Responses to the Cancer Problem
Chapter Four

‘A Message of Hope’: Cancer Treatment and Education in New Zealand, 1870-1939

A growing historical literature has developed on responses to cancer in different national contexts over the twentieth century. Recent historical revisions have challenged interpretations that presented cancer responses, early detection and treatment in a uniform and standardized way.¹ Instead, as David Cantor argued, a number of broad similarities and significant differences developed between countries in respect to the role of public education; how cancer services developed over the century and the types of services offered; and the methods employed to encourage early medical interventions.² Building on this recent scholarship, this chapter examines how New Zealand’s responses to the cancer problem resemble developments in other countries while possessing distinct differences. Like other countries, New Zealand had a strong focus on conveying a message of hope to counteract popular assumptions about the nature of cancer and its treatment. New Zealand drew on different international responses to cancer control but was greatly influenced by Britain. This includes a strong focus on early detection and treatment, prioritising surgical treatment methods, and the use of education campaigns.

Responses to cancer in America, Britain, and to a lesser extent Australia and Canada provide useful points of comparison with New Zealand. In America, since 1913, the American Society for the Control of Cancer (ASCC), a national charity that was dedicated to the fight against cancer, was the main focal point of cancer education and publicity. The ASCC used large-scale education campaigns that

focussed on identifying early symptoms and encouraging early medical consultation.\(^3\) The ASCC acted as a dedicated cancer institution with a strong focus on publicity and education. The focus of other countries was significantly different. In Canada, as Charles Hayter argued, there was no equivalent national organization dedicated to cancer until the 1930s and the ASCC had considerable influence.\(^4\) It was not until 1929 that some Australian states began establishing organizations dedicated to controlling cancer and a national cancer conference was instituted.\(^5\) Britain was dominated by cancer charities that were focussed on cancer research — the Imperial Cancer Research Fund (ICRF) and the British Empire Cancer Campaign (BECC).\(^6\) Ornella Moscucci argued that the ICRF and BECC, considered education campaigns to be ‘an unnecessary diversion’ to their main fundraising aims for research purposes.\(^7\) In Britain, both Elizabeth Toon and Moscucci argued that a more cautious and paternalistic approach was taken than in North America. This involved focussing on physician education and localized and low-key educational efforts by local public health bodies.\(^8\) Like Australia and Canada, New Zealand did not possess dedicated cancer institutions until around 1930 and this meant that New Zealand’s organizational approach to cancer control was haphazard.

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\(^7\) Moscucci, p. 358.

In America, Britain, and Canada hope was the central message of anti-cancer campaigns but the influences and methods used to convey this message varied.9 ‘Hope’ was used to counteract negative impressions of cancer and surgery, and to encourage early detection and treatment. New Zealand also focussed on conveying ‘hope’ in relation to cancer. This chapter focuses on three stages of responses to cancer in New Zealand that promoted the message of hope. First, this includes the promotion of surgical progress by the medical profession. Secondly, was the initiation of educational efforts by the New Zealand Branch of the British Medical Association (NZBMA) and the Department of Public Health/Department of Health (DPH/DOH). Finally, this chapter discusses the establishment of the New Zealand Branch of the British Empire Cancer Campaign (NZBECC) in 1929, and the role it played in combating cancer. New Zealand’s responses were shaped by international influences and possess many similarities with other countries. However, from an organizational and administrative perspective, there are some distinct differences in respect to the timing of some developments and the extent of efforts, as well as some institutional differences.

Surgery was the main method of cancer treatment from the late nineteenth century right up to 1939 (radiotherapy became increasingly important from the 1920s and this is the subject of Chapter Five). As discussed in Chapter Two, popular impressions of surgery, and particularly cancer surgery, were often negative in the early twentieth century. Surgery was considered a dangerous undertaking and cancer was dreaded as it was associated with a painful death with little hope of recovery. This section examines a more positive view of surgery and focuses on how the medical profession represented the progress of surgery in the first decade of the twentieth century. Around the turn of the twentieth century, two impressions of surgery were conveyed: a negative impression of 1870s surgery, and the success and progress of surgery by the twentieth century. Such presentation of surgery may have been contrived in the sense of promoting the image of the medical profession, but the motives also include a desire to be informative and to reassure the public about the efficacy of surgical treatments.

In the 1870s, the public generally considered cancer surgery dangerous and was sceptical of the medical profession’s claims for surgery. Surface cancers could be surgically removed but any internal cancer posed numerous risks, including postoperative complications. Newspaper reports and correspondence indicate a strong climate of pessimism towards cancer surgery. One contemporary commentator, named ‘Critic’, wrote a letter to the editor in 1875 to convey his views on surgery. Critic claimed that surgeons were prone to exaggerate and that the ‘word successful is often misapplied to surgical operations’. He was critical of one surgical case that claimed that a female patient had a successful operation for cancer. This claim, Critic pointed out, ‘omitted to relate that she was successfully buried a few days after’. Another letter in 1876 reported how Mr Connelly was ‘butchered’ by eleven doctors at Alfred Hospital in Melbourne in an attempt to cure stomach cancer. To this observer, surgery was more akin to butchery than it was

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10 Otago Daily Times, 6 Apr., 1875, p. 2.
11 Clutha Leader, 1 Dec., 1876, p. 7.
to heroism. Read in conjunction with the evidence about popular impressions of
cancer surgery discussed in Chapter Two, this newspaper evidence is indicative of
a climate of scepticism about the efficacy of surgery. Of interest is the fact that
these critiques of 1870s surgery possess strong similarities with the critiques of
1870s surgery by early twentieth-century surgeons who sought to stress progress.

Around the turn of the twentieth century, both locally and internationally,
medical professionals started looking back at the progress that surgery had made.
The timing of this focus can be placed in a more general context of developments in
bacteriology and surgical advances including asepsis and anaesthetics. However,
in the early twentieth century, there was increasing public disillusionment with the
progress of scientific medicine in responding to cancer in an era that has been
categorized as the beginning of a ‘golden age of medicine’. In response to this,
surgeons created a separation between the backward surgery of the 1870s and the
progressive surgery of the twentieth century. In 1902, Dr F.D. Bird, a Melbourne
University lecturer on anatomy, gave an address at the Inter-Colonial Medical
Congress in Hobart that reiterated these perspectives of 1870s surgery. The Inter-
Colonial Medical Congress was a significant forum for New Zealand’s medical
community, and New Zealand medical professionals regularly attended and
presented there. In addition, New Zealand’s press picked up on commentary about
cancer from forums like this. Bird claimed that the ‘fog of hopelessness’ had
always ‘dimmed the horizon’ of surgeons in the 1870s and that all cases of cancer
had been ‘unpromising’. He gave the likelihood of cancer cures from early surgery
to be around three per cent. While looking back at the 1870s from a twentieth
century perspective, Bird also emphasized the progress of modern surgery. He
noted that surgeons were continually ‘perfecting’ their techniques and increasing
their percentage of cures and that even in the ‘most hopeless areas’ ‘steady progress

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Bynum and R. Porter, eds, Companion Encyclopaedia of the History of Medicine, 2 vols, London:
13 Moscucci, p. 358; Allan M. Brandt and Martha Gardner, ‘The Golden Age of Medicine?’, in Roger
Cooter and John Pickstone, eds, Companion to Medicine in the Twentieth Century, London: Routledge,
2003, pp. 21-37.
15 Address by Dr F.D. Bird, in Gregory Sprott, ed., Transactions of the Intercolonial Medical Congress of
Australasia. Transactions of the 6th Session Held at Hobart, Tasmania, February 1902, Hobart: John Veil
Govt Printer, 1903, pp. 108, 111.
is being made’. He contended that in the twentieth century the success of surgical cures could reach as high as fifty-five per cent.\textsuperscript{16} An abridged \textit{Evening Post} article on Bird’s address reported a similar positive message on the progress of surgery. It was reported that surgical interventions had ‘greatly advanced’ and that the public needed to be ‘greatly educated’ on the fact that many cancers were ‘perfectly and permanently curable’. In 1902, \textit{The Evening Post} claimed that in the past ‘cancer cases seemed almost hopeless’; in present day, ‘hardly any case could be labelled as hopeless’.\textsuperscript{17} Through medical forums and the press, the medical profession espoused the progress of modern surgery at the turn of the twentieth century in an effort to counteract negative impressions of surgery.

Cable news articles from Britain also emphasized this representation of 1870s surgery. For example, one article, written by two British surgeons, Drs A.C. Seely and Leroy Scott, that was disseminated into New Zealand’s press in 1905, contrasted 1870s surgery with twentieth-century surgery. It claimed that a ‘resurrected surgeon of the seventies, if shown how his twentieth century brothers are baulking disease and death, would be able to think of nothing but miracles.’ Modern surgery was doing what ‘God alone’ could have done in the 1870s — it would have been considered ‘murder’. 1870s surgery was represented as a disease in itself. In the 1870s, it was claimed, surgeons had worn bloodstained black coats; hospitals and instruments were ‘germ-infected’; and simple operations led to serious complications. In contrast, following developments in bacteriology, twentieth-century surgery was represented as being progressive. In the 1870s, cleanliness was ‘hardly thought of in surgery’ but now in the twentieth century it was surgery’s ‘first law’ that was ‘second not even to godliness’. This cleanliness included disinfected operating rooms; boiled instruments prior to operation; and the sterilisation of dressing, sponges, operating tables, and patients. According to twentieth-century contemporaries, developments in anaesthesia were also the foundation of modern surgery as they allowed patients to experience operations free from pain and surgeons could undertake internal operations with less risk. It was claimed that in the 1870s an operation on the stomach meant death, but in the
\begin{flushright}
\textsuperscript{16} ibid. \\
\textsuperscript{17} \textit{Evening Post}, 15 Mar., 1902, p. 7.
\end{flushright}
twentieth century it was ‘bloodless’: ‘A patient can be opened and his stomach taken out, and yet hardly lose more blood than if he had accidentally cut a finger.’\textsuperscript{18} International reports like this that were disseminated into New Zealand’s press acted as evidence to reinforce localized representations of surgical progress.

In a similar way to international reports, New Zealand’s medical professionals also represented 1870s surgery as backward and turn of the century surgery as progressive. In 1902, at the Inter-Colonial Medical Congress in Hobart, Dr Louis Barnett, the first New Zealander to become a Fellow of the Royal College of Surgeons in England, read the presidential address of the surgical section. Barnett claimed that in recent times surgery had progressed in ‘leaps and bounds’. In Barnett’s view, advances in surgery were indebted to two ‘mighty discoveries’ — anaesthesia and asepsis.\textsuperscript{19} A London correspondent published an interview with a prominent but unnamed New Zealand doctor who was visiting London to learn more about developments in surgery. The doctor pointed out that the advances in surgery led to ‘many lives being saved’ and ‘much illness and suffering averted’. He noted that operations that were likely to result in death in the past, like appendicitis or removal of the tonsils, had become simple everyday procedures. The doctor claimed that in the past such operations meant sufferers were ‘doomed to death or prolonged misery’, but now ‘modern surgery’ provided ‘safe and simple’ operations.\textsuperscript{20} In response to earlier pessimistic perspectives of surgery, twentieth century medical practitioners created associations between surgery and success. This would become a central part of medical responses to the cancer problem. My interpretation of these representations is that they contained both exaggerated and realistic elements: while there was definitely a greater chance of surgical success in cancer treatments, the positioning of surgery as ‘safe’ and ‘simple’ is exaggerated.

The main problem for surgeons was convincing the public to put aside their beliefs about surgical inefficacy. This problem is best encapsulated by the example

of a patient named McKinnon. In 1908, Dr James Young, an Irish-educated practitioner in Invercargill, wrote to Dr James Mason, the Chief Health Officer for the Department of Public Health, for advice about McKinnon. The problem for Young was that McKinnon ‘doesn’t believe ... in surgery’ and wanted to order patent medicines from Britain that had been recommended to him by his brother.21

McKinnon’s case also highlights one key issue for medical professionals: that popular fears of surgery led to individuals seeking out alternative treatments. In the 1900s, the issue of quackery became prominent, and cancer was part of the discussion surrounding restrictions on alternative practitioners. Mason claimed that cancer patients in fear of surgery either delayed intervention or sought out alternative remedies.22 Cancer was important in the discussions leading to the 1907 Quackery Prevention Act.23 In 1907, Dr James Cahill, a Wellington surgeon and New Zealand Branch of the British Medical Association (NZBMA) President, claimed in no uncertain terms the problems of delay and alternative treatments:

A poor girl goes first of all to a doctor, who diagnoses cancer. This doctor tells her to consult another doctor, which is usually done in such cases, and he diagnoses cancer which is operable. Then she goes to one of these persons we have been speaking off, is told she has not got cancer, is put under one form of treatment or other, and dies some months afterwards — of course, of cancer.24

As well as having an economic impact on medical practitioners, alternative remedies also meant that patients were abandoning what was believed to be the best chance of effective cure. The mission of medical professionals was to convince a sceptical public that their fears were unfounded and surgery was the best chance

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21 The outcome of McKinnon’s case is unknown: James Young to James Mason, 6 Aug. 1908, Diseases Cancer, H1 1957 131/16, Archives New Zealand Head Office (Wellington) (ANZW).
22 Report of the Quackery Prevention Bill Committee together with Minutes of Evidence, AJHR, I-14 1907, p. 12.
24 Report of the Quackery Prevention Bill Committee together with Minutes of Evidence, pp. 44-45.
of cancer cure. The promotion of surgical success and progress formalized itself in the 1910s into concentrated efforts to educate the public and to convey the message that cancer was curable.
Hope and Education: ‘Cancer: Is it Curable?’

From 1910, unified action by the NZBMA and the DPH attempted, through education, to overturn public conceptions about cancer and surgery. This section examines what medical authorities believed were popular misconceptions about cancer and their attempts to educate the public about cancer up to 1929. Cancer was a low priority in comparison to infectious diseases, but it increasingly became an issue of strong public importance from 1914-1916 when, according to Derek Dow, cancer began to ‘overshadow’ tuberculosis. In particular, debate over cancer led to the DPH taking action by producing the educational pamphlet, ‘Cancer: Is It Curable?’ in 1916. The timing of this education campaign fits into a general trend of cancer education as the beginning of American and some localised British education campaigns started from 1914. This section examines the background and influences that led to the inception of this DPH pamphlet.

From 1910, strong interest by the public and the medical profession in addressing the cancer problem led to a range of suggestions from doctors, public health authorities, and others. Proposals discussed in the press included the establishment of a radium bank, establishing specialised cancer hospitals, setting up an independent research programme, and educating the public. In 1910, Dr James Robert Purdy, the NZBMA President, publicly declared the need for education. Purdy stated that sufferers needed to be ‘acting promptly’ to get symptoms looked at because cancer ‘at its onset’ was ‘curable by complete excision’. Purdy pointed out that the ‘sooner the public mind was disabused of the idea that cancer was at all stages a painful malady’ the ‘more successful’ treatments would become. In 1912, Mr Ell, Liberal member for Christchurch, felt that the matter was ‘too grave’ to merely be referred to hospital authorities and some form of national effort was

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26 Evening Post, 10 Aug., 1910, p. 7.
27 ibid., 22 Feb., 1910, p. 3.
needed. Ell declared that there should be at least one specialist cancer hospital in each island and that this would be ‘commended’ by the medical profession. He thought that the responsibility for the hospitals should be undertaken by the DPH.\textsuperscript{28}

The most publicized proposal was the plan to establish a radium institute; this will be addressed in detail in Chapter Five. Some brief context on the proposed radium institute is important, however, because of its influence in the inception of the pamphlet, ‘Cancer: Is it Curable?’. The introduction of radium in the 1910s was contentious, with a number of medical professionals and public health authorities advocating radium investment, and others, particularly the DPH, opposing it. The central issues related to efficacy and expense: critics of radiotherapy argued that it was still experimental and too costly and advocated that early prevention through early surgical intervention was the best hope for curing cancer.

From 1915, debate about cancer and education came to prominence in New Zealand. The timing of this discussion about cancer education links with the establishment of the American Society for the Control of Cancer (ASCC) in 1913 and its education campaigns; the timing also links into a period of localized cancer educational efforts in Britain in the 1910s. In December 1915, a letter from Dr W.E. Herbert, shortly to become Chairman of the NZBMA council (1916-7, 1921-4), in the \textit{New Zealand Medical Journal} claimed that the ‘bugbear of the surgeon is the patient who will not go to the doctor’. To Herbert, the ‘dread of cancer is the dread of ignorance’ and he claimed that ‘early cancer is a curable disease’ and that this message needed ‘to be shouted from the housetops’.\textsuperscript{29} He believed that messages about cancer should not be left to the press, whose ‘proverbial ignorance’ could distort the issue.\textsuperscript{30} This began a heated public debate once it was picked up by the newspapers. Herbert advocated a campaign to educate the public and encourage them to seek out medical advice. Herbert also strongly advocated the primacy of

\textsuperscript{28} Grey River Argus, 9 Sep., 1912, p. 8; William Herbert, letter to the editor, \textit{New Zealand Medical Journal (NZMJ)}, 15 (1916), p. 293.

\textsuperscript{29} W.E. Herbert, ‘Some Facts Regarding Cancer,’ \textit{New Zealand Medical Journal}, 15 (1916), p. 98; see also Herbert, letter to the editor, p. 292.

\textsuperscript{30} Herbert, ‘Some Facts Regarding Cancer,’ p. 99.; Herbert, letter to the editor, p. 293.
surgery in cancer treatments and claimed that radium was ‘worthless in the
treatment of cancer’.31

The debate was particularly heated in the *The Press*, which published a series of
opinions by medical practitioners in March 1916 on the subject. *The Press* believed
Herbert’s article to be a ‘very striking and remarkable paper’.32 The debate once
again examined different approaches that could be undertaken to address the
cancer problem: a radium institute, setting up independent research laboratories,
better equipping of hospitals, and education. The concluding opinion was that
independent research would be pointless in a small dominion and that
collaboration with international research organizations would be preferred, and the
expense and unproven nature of radium ruled that out as a viable option.33

The debate centred on the ‘question of publicity’: that is, whether it was
beneficial or not to try to educate the public. These reservations are also present in
America and Britain but New Zealand’s response was a national campaign (unlike
Britain’s localized education). It was reported that ‘some doctors object to publicity
as it may create undue alarm’, which was the dominant view in Britain. One
response to Herbert’s call for education was that patients who self-diagnosed
themselves with cancer had their ‘mental balance’ ‘severely shaken’. It was
believed by one anonymous medical respondent that attention to cancer will
‘needlessly alarm’ or cause ‘unnecessary terror’ in symptomatic individuals. The
contrasting opinion was that although education on cancer may cause alarm, its
benefits through early diagnosis outweighed any distress. Aid to early diagnosis
was welcomed by several ‘leading medical men’ who were happy for the public to
be educated on cancer provided it was done in a ‘cautious manner’.34 The content
of this discussion indicates that there were reservations about lay cancer education
in New Zealand that compares with Britain. However, the strength of this concern
was limited to a minority opinion.

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31 Herbert, letter to the editor, pp.290-4.
32 *The Press*, 14 Mar., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
33 ibid.
34 *The Press*, 31 Mar., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
The Press called for some type of action by the government and the DPH as it believed more needed to be done. The editor of the The Press, Mr Triggs, wrote to G.W. Russell, the Minister for Public Health. He informed Russell of Herbert’s letter and asked for action against cancer. In response, Russell indicated he had not yet seen Herbert’s letter and that on account of the war a detailed conference to discuss the issue could not be organised. Given the continued publicity across March and April, Dr Thomas Valintine, the Chief Health Officer of the DPH since 1909, wrote to Triggs to defend the DPH. Valintine stated that he did not think the The Press was being ‘just’ to the DPH and that on account of the loss of medical professionals and extra duties to the war, the DPH struggled to get through an ordinary day’s work. Valintine did say that he would write to the NZBMA to get advice on an education campaign. In response, Triggs was partially sympathetic to the workload but felt that the DPH only took action to stop the spread of epidemics, and that the ‘lay public’ thinks ‘not enough is done on prevention or education’.

Medical and public support for establishing a radium institute were influential in initiating and shaping the wording of the 1916 pamphlet. Valintine and several other medical experts had tried to play down the relative importance of radium and wanted to discourage the risk of what they believed was excessive investment in an experimental radium institute. Moreover, the 1910s was a period when there was increasing public pressure on medical authorities to demonstrate some form of response to the increase of cancer. Valintine’s lack of support ensured that an expensive radium institute did not proceed, but the need still remained for the DPH to be seen to be taking action against cancer. The pamphlet acted as a symbol of action to combat cancer as well as being propaganda to downplay the importance of radiotherapy. The pamphlet itself included specific commentary against radiotherapy: ‘There is only one cure for cancer, and though in early stages some

35 Mr. Triggs to G.W. Russell, 30 Mar., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
36 G.W. Russell to Mr. Triggs, undated draft, in Diseases Cancer, H1 1957 131/16, ANZW.
37 T.H. Valintine to the editor of The Press, 4 May., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
38 Mr. Triggs to Colonel Valintine, 7 May., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
good results have been brought about by X-rays and radium, it is to surgical methods that we must look as the most certain means of curing this terrible disease.’\(^3\)\(^9\) The DPH’s opposition to radiotherapy as a cancer treatment meant the pamphlet was used as an opportunity to discourage any further interest in spending money on a radium institute.

There were also strong influences that reassured Russell and Valintine of the value of an educational pamphlet. The Auckland Branch of the NZBMA advised in July 1916 that the dissemination of information about cancer to the public would be beneficial and should focus on encouraging early diagnosis. It also added that a draft should be submitted to all of the divisions of the NZBMA.\(^4\)\(^0\) Advice confirming this course of action also came from abroad. A memorandum for Russell from Valintine stated that advice from Britain claimed that it the ‘highest degree absurd’ for New Zealand to undertake its own independent investigation into cancer. It suggested that action could be taken to educate the public but warned that this may cause ‘some harm’ by ‘unduly emphasizing’ cancer’s ‘terrors’.\(^4\)\(^1\)

The success of a local pamphlet in Palmerston North helped quell any concerns about spreading undue alarm. In 1916, Dr Leonard Whitaker, a London-trained ophthalmic surgeon at Palmerston North and opponent of radiotherapy, informed Russell of the success of a Palmerston North pamphlet produced two years earlier. The pamphlet had been disseminated around the local community, including being posted on the borough council door, railway stations, and in the public library. The result was a ‘great number of people obtained early advice’. Whitaker claimed that there had been ‘no complaints of anyone being frightened or hurt’. Moreover, he stated, the Secretary of Palmerston North Hospital believed it to have had the opposite effect and it encouraged more people to consult their physician. He added that he was not a supporter of Dr Arthur Martin, an Edinburgh-educated surgeon.

\(^3\)\(^9\) ‘Cancer: Is it Curable?’, in Diseases Cancer, H1 1957 131/16, ANZW.
\(^4\)\(^0\) Auckland NZBMA to Minister of Public Health, 6 Jul., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
\(^4\)\(^1\) Memorandum for G.W. Russell, 26 Apr., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
and senior surgeon at Palmerston North Hospital, who regularly tried to get a radium institute established in Palmerston North. Whitaker claimed that the radium scheme was not worth it because it was a ‘doubtful and untried treatment’. Russell was ‘glad’ to hear of the success of the pamphlet and its author’s scepticism over radium.

Following consultation with the divisions of the NZBMA and several medical officers, the pamphlet ‘Cancer: Is it Curable?’ was completed and sent to local hospital boards. A memorandum asked hospital boards to publicize the pamphlet and if possible to help give public lectures to educate the public. The consensus was that the boards were happy to help disseminate the pamphlet but lacked sufficient resources to take the time out to give lectures. The publication of the pamphlet was a much-anticipated event and a number of hospital boards requested copies of the pamphlet in late 1916 and in 1917. The subject also gained the attention of newspapers with one district health officer wanting information on cancer, as the public were ‘very anxious to get in something on cancer’.

An examination of the ‘Cancer: Is it Curable?’ pamphlet demonstrates that it served multiple purposes. It was a small two-page pamphlet intended to educate the public and inspire hope. Its aims were twofold: to address public misconceptions about the nature of cancer as a disease and to publicise the efficacy of the types of cancer treatments that were available. The pamphlet was publicized as a symbol of action by the DPH. The memorandum circulated to hospital boards was even published in the papers. Valentine’s memorandum pointed out that cancer was ‘preventable’ and he wanted to encourage patients to use the outpatient

42 Dr Whittaker to G.W. Russell 21 Jul., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
43 G.W. Russell to Dr. Whittaker 3 Aug., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
44 Memorandum for the Minister of Public Health, 26 Apr. 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
45 Coromandel Hospital and Charitable Aid Board to Inspector-General of Hospitals, 28 Nov., 1916, in Diseases Cancer, H1 1957 131/16, ANZW; Auckland Hospital and Charitable Aid Board to Inspector-General of Hospitals, 11 Dec., 1916, in Diseases Cancer, H1 1957 131/16, ANZW; James Beadle to Chief Health Officer, 28 Oct., 1917, in Diseases Cancer, H1 1957 131/16, ANZW.
46 Memorandum for Deputy-Chief Health Officer, 13 Dec., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
47 ‘Cancer: Is it Curable?’, in Diseases Cancer, H1 1957 131/16, ANZW.
sections of local hospitals to get their symptoms assessed. Valintine claimed that ‘many cases of this terrible disease could have been prevented had it been taken in time’. It was hoped that such education would bring about the ‘diminution of the death rate’.48

In particular, the pamphlet addressed the long-standing popular belief in the infectiousness of cancer, a subject introduced in Chapter Three. Examples of concerns over the infectious nature of cancer included discussions around cancerous cattle, the reuse of hospital bedding for cancer patients, the burning of books used by cancer sufferers, and the need to white wash and sanitize cancer sufferers’ houses. The dominant medical opinion at the time was to the effect that cancer was not infectious but was of cellular origin. Valintine had asked his medical officers for advice regarding what information needed to be included. Dr Robert Makgill, trained in medicine at Edinburgh and public health at Cambridge, former government pathologist, and the medical officer for Auckland since 1909, recommended that the pamphlet include something to educate the public over the causation of cancer. He wanted to make it clear that ‘the cause is unknown’. Commenting on one of the drafts, Makgill concluded something needed to be ‘put on record’ due to the ‘misapprehension in the public mind as to the danger of infection’ in relation to cancer.49 In an additional section added to the end of the pamphlet, this message was put on record: ‘There is no evidence to support the impression of some people to the effect that cancer is infectious and can be transmitted person to person’.50 The pamphlet acted as a form of official commentary to formalize a response to the issue of cancer causation.

The pamphlet addressed popular understandings that associated cancer with pain and the diagnosis of cancer as a death sentence. Dread was based upon popular assumptions about the experience of cancer. To counteract this, notions of cancer being associated with long and painful suffering that offered little hope of

48 Evening Post, 22 Feb., 1917, p. 22.
49 Robert Makgill, Memorandum for the Chief Health Officer, 25 Oct., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
50 ‘Cancer: Is it Curable?’, in Diseases Cancer, H1 1957 131/16, ANZW.
cure, the pamphlet stated that ‘Cancer in its early — and therefore curable — stages is unattended with pain and sometimes occurs without any signs of ill-health’. The description of symptoms and the nature of cancer were discussed to encourage potential sufferers to seek out early medical advice.

The pamphlet also attempted to counter pessimistic beliefs surrounding the efficacy of surgery. Surgery did not always earn good will with numerous reports of unsuccessful operations, deformities, and unpleasant sounding surgical marvels. Many cancer sufferers refused to be placed under ‘the knife’. This led to many turning to alternative treatments. Medical professionals and public health authorities labelled alternative practitioners as a public menace. Makgill also recommended that a clause be added to try to counteract any quack claims. The pamphlet strongly discouraged quack cures: ‘But above all, place no faith in the various vaunted cures and nostrums or the advertisements of the unscrupulous and ignorant persons. There is only one cure for cancer’. In terms of treatment, surgical methods were presented as having the greatest chance of success.

‘Cancer: Is it Curable?’ was a formalisation of ideas that had already been recited publicly in newspapers. It acted as a symbol that the DPH was taking action on the issue of cancer. It was reported that the DPH was on the ‘warpath’ against cancer. It is clear that counteracting the problem of delay was considered a significant issue in respect to responses to cancer. For example, Truth, a newspaper that often quoted doctors’ perspectives to support its own views, complained that the central problem for surgeons was patients’ delay: ‘Victims of the scourge cancer eventually offer themselves up as sacrifice to the knife, and are told it is too late.’ This meant that the primary focus of education was to consult a registered medical practitioner at the earliest opportunity. Thus, a central motivation for undertaking

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51 ibid.
52 Report of the Quackery Prevention Bill Committee together with Minutes of Evidence, AJHR, I-14, 1907, pp. 3, 44-45.
53 Makgill, Memorandum for the Chief Health Officer, in Diseases Cancer, H1 1957 131/16, ANZW.
54 ‘Cancer Is it Curable?’, in Diseases Cancer, H1 1957 131/16, ANZW.
55 Auckland Star, 29 Sep., 1916, in Diseases Cancer, H1 1957 131/16, ANZW.
56 N.Z. Truth, 10 Nov., 1906, p. 5.
an educational campaign was to try to counteract public misconceptions about cancer and to convince the public that cancer was curable through surgery. This motivation can be seen clearly in the pamphlet when it claimed that ‘delay is not only dangerous — delay may mean death’.57

The same messages that were espoused in ‘Cancer: Is it Curable?’ continued to be reaffirmed in pamphlets and the press through to 1929. Regular lectures by a variety of medical professionals tried to encourage early diagnosis. In a lecture to women organised by the Workers’ Educational Association in Auckland in 1919, Dr Florence Keller, a Chicago-trained doctor and member of the Auckland Hospital Board (1913-19), in similar rhetoric to the DPH’s education campaign, indicated the ‘great importance’ of early recognition and encouraged early diagnosis. Keller stated that delay was not only dangerous but was ‘often deadly’.58 Dr Kenneth Mackenzie, a gynaecologist at Auckland Hospital since 1914, gave a lecture to the Auckland Institute in 1919 and tried to convince his audience that it was a ‘harmful’ and ‘popular fallacy’ that cancer remained incurable.59 These examples indicate the continued localized response in discouraging delay in cancer diagnosis that built on the messages espoused in the national campaign.

In addition to this, hospital boards also took it upon themselves to distribute literature and this acted to further augment the central message against delayed diagnosis. For example, an undated pamphlet, also entitled ‘Cancer is Curable’, found in a nurse’s journal from the Canterbury Hospital and Charitable Aid Board, indicates continued circulation of educative pamphlets: ‘You know that cancer is a terrible disease that kills people with much pain’ .... [it] begins [with a] small lump or sore. If anything happens like this go to the doctor ... cancer is generally easily cured in the beginning. Always go to the doctor, never consult a chemist.’60 This illustrates that it was not just alternative practitioners being targeted but all forms

57 ‘Cancer: Is it Curable?’, in Diseases Cancer, H1 1957 131/16, ANZW.
59 New Zealand Herald, 1 Jul., 1919, in Diseases Cancer, H1 1957 131/16, ANZW.
60 Chief Nurse’s Miscellaneous Records, CAWU 3593 CH698/Box40, Archives New Zealand Christchurch Office (ANZC).
of medical consultation without a registered medical practitioner. This pamphlet contained similar messages to ‘Cancer: Is it Curable?’ but reveals an attempt to educate the public through simpler and more informal language.

On a number of occasions the use of ‘Cancer: Is it Curable?’ was re-endorsed as the primary educative response to cancer. In 1925, it was noted that the pamphlet was still being circulated at railway stations. As late as 1928, the Department of Health’s (DOH) report indicated that its primary action against cancer was a national campaign against cancer through education. The focus remained on informing the public of early symptoms and encouraging them to consult their physician regularly. This was, in effect, a continuation of the distribution of the ‘Cancer: Is it Curable?’ pamphlet with only minor adjustments to the text.

The DOH also continued its cancer education message to the public. The DOH publicized cancer pamphlets with the aid of the press, display posters, and the circulation of leaflets. These continued to focus on educating the public about the early signs and symptoms of cancer to encourage early treatment. In 1931, the same method of publicising through the press, and display posters at post offices to educate the public on early treatment was still being undertaken. The material remained very similar to the original campaign in ‘Cancer: Is it Curable?’. Dr Walter Gilmour, a Glasgow-trained pathologist and the director of Auckland Hospital’s Pathology unit from 1920, asked Valintine about providing information to Queensland medical professionals requesting information. Valintine included a copy of the DOH’s report and a copy of the educative pamphlet, ‘Cancer: Is it Curable?’.

This indicates continuity in terms of education. Throughout the interwar period, the DOH focussed on publicizing educative cancer pamphlets. ‘Cancer: Is it Curable?’ acted as a message of hope in an attempt to educate the public and counteract popular misconceptions about cancer and its treatments.

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61 New Zealand Medical Journal, 26, (1925), pp. 29-30
63 ibid., 1929, H-31, p. 2.
64 T.H. Valintine to Dr Gilmour, 4 Mar., 1930, in Diseases Cancer — Cooperation with London re incidence of cancer in Maoris, H1, 1363 131/16/7, ANZW.
The New Zealand Branch of the British Empire Cancer Campaign

In 1929, a dramatic shift occurred in New Zealand’s response to the control of cancer. The establishment of the NZBECC brought into existence a dedicated organization that became central to developments in cancer control in New Zealand. The BECC was primarily focused on fundraising for research in Great Britain, and New Zealand participated in this through the provision of funds and cancer statistics. The NZBECC was fundamentally involved in every area of response to cancer and oversaw the management of cancer treatment and the development of research programmes in New Zealand. This section examines the establishment and organization of the NZBECC, and the publicity of the message of hope it conveyed. In particular, the NZBECC focused on conveying its message of hope through radiotherapy. The following two chapters build on this section by discussing the NZBECC’s role in respect to research and radiotherapy. The NZBECC was the first voluntary institution in New Zealand that was dedicated to the control of cancer. In relation to most other countries, the timing of its inception is late. The NZBECC contributed to the centralization of cancer treatment in major cities and oversaw the establishment of cancer clinics and fundraising activities for investment into combating cancer.

The NZBECC was inspired by Dr Sampson Handley, an eminent British authority on cancer from Middlesex Hospital and member of the Grand Council of the BECC, who came to New Zealand with the purpose of encouraging the institution of a local society in New Zealand in January 1929. This indicates a continuation of British ties in New Zealand. Handley’s first major public address was at the annual conference of the NZBMA. His speech was reproduced in the Evening Post and elicited positive reaction in the media. Handley brought with him ‘a message of hope’. He wanted to promote a few basic facts to the public to help them change their attitude towards cancer. Handley believed successful treatment of cancer would be realized if the public overcame their fear that cancer was

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incurable and stopped treating the subject of cancer with ‘horror and disgust’. He proclaimed that the ‘actual danger of operation is nowadays small’ and believed that early detection of symptoms and early surgery would help prevent a large number of deaths from cancer.67

Handley’s message inspired one wealthy donor and some members of the medical profession to take action in establishing the NZBECC. In March 1929, Mrs Dwan donated £1,000 after being ‘impressed’ by Handley’s ‘message of hope’.68 Following this initial donation, a special meeting was called to establish the NZBECC. Those in attendance included the Prime Minister, Sir Joseph Ward, Peter Fraser, Labour member for Wellington Central, Handley, Sir James Elliott, a former NZBMA President and Chairman of Council, and Herbert, the key protagonist in New Zealand’s early cancer education campaigns. The NZBECC had strong backing from the NZBMA and the Governor General, Sir Charles Ferguson, occupied the position of patron.

Following this meeting, a central committee was formally established which included twenty members: the mayors of the four major metropolitan areas (Auckland, Christchurch, Dunedin and Wellington), and prominent medical professionals like Elliott who became its president. It was hoped that a separate local division would be established in each of the four main metropolitan areas and that each of these regions would raise £25,000 for investment into the control of cancer. In addition to this, the NZBECC was promised the ‘full cooperation’ from New Zealand’s DOH.69 The DOH reports regularly praised the actions of the NZBECC: in 1930 it was stated in the DOH annual report that the NZBECC made an ‘excellent beginning’ and showed promise of becoming a ‘real force’ in the fight against cancer.70 Similar words of praise were given in 1931 and 1934, with the NZBECC being described as ‘a very active force’ whose work was ‘worthy of well

67 Handley’s address to the NZBMA quoted in Evening Post, 19 Feb., 1929, p. 9.
68 Evening Post, 8 Mar., 1929, p. 8.
deserved appreciation’.\textsuperscript{71} In 1939, the DOH’s annual report stated that the NZBECC continued ‘as a live force in the control of cancer’.\textsuperscript{72} The establishment of the NZBECC allowed the DOH to take less responsibility for the investment into cancer treatment and the provision of other related services and it allowed the NZBECC to act as the main organization that directed the development of cancer responses in New Zealand from 1929-1939. The NZBECC presented a strong united front and acted as the central authority on cancer. The establishment of the NZBECC can be situated in relation to a secondary wave of national cancer institutions. While America, Britain, and a number of European countries had established institutions dedicated to combating cancer from before World War One to the early 1920s, Australia, Canada, and New Zealand all established their initial institutes from the late 1920s to the 1930s.

From 1929-1930, each of the four divisions was established. Auckland was the first to take action in September 1929 but took issue with the control of funds by the central committee. Auckland wanted a large proportion of the funds that it raised to be used to buy equipment for Auckland Hospital.\textsuperscript{73} Auckland’s attitude can be explained through its difficult financial position from the late 1920s and into the early 1930s because of the economic depression.\textsuperscript{74} In November 1929, the central committee agreed to the proposal that twenty-five per cent of the money raised by local divisions would be pooled with the central division. Local divisions, to establish cancer consultation clinics and to purchase equipment for treatment with radiotherapy, would use the remaining seventy-five per cent.\textsuperscript{75} In October 1929, the Otago and Southland Division was established and in November the Wellington Division was established.\textsuperscript{76} The first general committee meeting of the NZBECC with all four provincial divisions was in March 1930.\textsuperscript{77}

\textsuperscript{71} ibid., 1931, H-31, p. 2., 1934, H-31, p. 5.  
\textsuperscript{72} ibid., 1939, H-31, p. 8.  
\textsuperscript{73} Evening Post, 26 September 1929, p. 10.  
\textsuperscript{74} Denis John Fabien Cross, ‘The Auckland Hospital Board and Charitable Aid During the Depression of the 1930s’, Research Essay: The University of Auckland, 1978, pp. 3-7.  
\textsuperscript{75} Evening Post, 19 Nov., 1929, p. 10.  
\textsuperscript{76} Evening Post, 18 Oct., 1929, p.8; 30 Oct., 1929, p. 12.  
\textsuperscript{77} ibid., 8 Mar., 1930, p. 9.
Christchurch was the last of the local divisions to be founded. Its foundation acts as a useful case study of the role the NZBECC played in portraying a message of hope. Dr Percival Clennell Fenwick, head of Christchurch hospital’s X-ray Therapy and Radium Department, focused on the importance of the message of hope in encouraging patients to seek early medical intervention. Fenwick claimed that the ‘first priority’ for the medical profession was to ‘fight fear’ of cancer and this was primarily conveyed through publicising the message of hope. It was hoped that establishing a consultation clinic would encourage potential cancer sufferers to seek out diagnosis and treatment at an early stage. In October 1929, the North Canterbury Hospital Board posted a notice of a meeting in the Christchurch mayor’s office, Rev. J.K. Archer, with the intention of establishing a local division of the NZBECC. On November 29, an initial fundraiser was held at the Civic Theatre and included addresses from both Archer and Fenwick, to an audience of over two hundred people. Archer emphasized the fact that cancer would affect one in seven people. In a similar way to the representation of surgery in the 1900s, Fenwick emphasized the progress of surgery. Fenwick stated that for the ‘first time in history’ the medical professionals of the Dominion had asked the public to ‘join us in a fight for great hope’. Fenwick, like Handley, delineated the fact that thirty years ago, he viewed cancer cases as an ‘incurable disease’, but over the last five years, his opinion had improved with Fenwick’s personal treatment of over 2,000 patients with radium. The advent of radium as a major treatment and as the centre of the new ‘hope’ will be further discussed in the next chapter.

Publicity and fundraising were central to the success of the NZBECC. Fundraising efforts created a strong public profile for the NZBECC to deliver its message of hope. A diverse range of mediums was used for promotion including the press, radio, theatres screenings, and community events. Public

78 Christchurch Times, 30 Nov., 1929, in British Empire Cancer Campaign Society — Dominion X-ray and Radium Laboratory — Miscellaneous Files — Equipment wat — wilt, 1934-1951, CABI — CH56, ANZC.
79 North Canterbury Hospital Board notice of meeting, 30 Oct., 1929, in British Empire Cancer Campaign Society — Dominion X-ray and Radium Laboratory — Miscellaneous Files — Equipment wat — wilt, 1934-1951, CABI — CH56, ANZC.
80 Christchurch Times, 30 Nov., 1929, in British Empire Cancer Campaign Society — Dominion X-ray and Radium Laboratory — Miscellaneous Files — Equipment wat — wilt, 1934-1951, CABI — CH56, ANZC.
announcements through the press were made to convey the message of hope against cancer and to disseminate to the public messages of education. There were sporadic talks over the radio on subjects relating to cancer, education and the cancer campaign: for example, Mr Wallace, chairperson of the Auckland Hospital Board, gave a radio talk about the cancer campaign; and Fenwick gave cancer talks over the radio. Motion picture events displaying the growth of cancer cells and the effect of radium on those cells were shown in theatres as both fundraising events and to demonstrate the effectiveness of new cancer treatments.

The campaign was promoted in a number of ways through the press. The Waipu Church Gazette published prayers for the cancer campaign. R. Darroch, the secretary of the NZBECC, intentionally used newspapers to help encourage donations. For example, Darroch requested the Evening Post to publish a letter from a donor to encourage all citizens to contribute. The letter was from a widow donor who gave ten shillings in spite of her hardship in supporting her brother who was sick with cancer and who had received radium treatment in Christchurch. She wrote that without radium her brother would be a ‘doomed man’ and asked that if thousands of people made such small contributions then it would help in saving many lives. Other forms of encouragement were used by the regular publication of the individuals who donated every few weeks in the Evening Post. In addition to this, key individuals involved in the campaign also acted to promote the NZBECC. Dr Andrew Begg, New Zealand’s Director of Cancer Research from 1930-1948, gave addresses at university luncheons to try to raise the profile of the cancer campaign.

Newspapers were used to publicize a wide range of different fundraising events. The range of events deemed newsworthy included naval concerts, street-day events, and other public gatherings.

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81 Evening Post, 14 Oct., 1930, p. 5; Evening Post, 14 Oct., 1931, p. 3.
82 ibid., 1 September 1930, p. 10.
83 Waipu Church Gazette, 1 Dec., 1930, p. 16.
84 Evening Post, 3 Sep., 1930, p. 13.
85 ibid., 14 Sep., 1930, p. 10.
86 ibid., 18 Aug., 1930, p. 10.
collections, matinee theatre productions, 500-card ladies evenings, and women’s organizations fundraisers that included ‘great cakes’. One of the larger cancer fundraising events was the Dunedin Manufacturer’s Association Carnival and Exhibition of 1930 which was dedicated to cancer fundraising. This included ‘practically’ every manufacturer in the district; it needed 400 workers to run the event. Entertainments included an array of musical concerts, ‘blazing lights’, and confectionary making. The carnival succeeded in raising in excess of £3,000 pounds. An exhibition sketcher was published of the event. Even small donations from local clubs were enough to attract attention from New Zealand’s press. For example, the North Hastings Heretaunga Club donated one pound. All of the actions of fundraising helped raise the profile of the NZBECC and acted as a platform to deliver their message of hope.

The region of Ellesmere in Canterbury acts as an example of how fundraising for the cancer campaign could be a source of district pride. Regular totals were recorded in the Ellesmere Guardian of those who donated to the campaign and how much had been raised. The enthusiasm generated from such efforts only further developed the prominence of the NZBECC and its efforts. By April 1930, a total of £217 had been raised. In support of the fundraising, Fenwick, Christchurch Hospital’s radiotherapist, gave an address to aid the local objective of raising £450. This address included pictures of magnified cancer cells and the effects of radium on the cells. Fenwick’s address included discussing the ‘mysterious’ nature of cancer as a disease, the fact that one person in every ten would be affected, and one in every seven over forty would die from cancer. Unfortunately, for the campaign, the number of attendees was not what it was hoped to be and the local hall was

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88 Evening Post, 29 Jan., 1938, p. 11.
89 ibid., 5 Dec., 1931, p. 7.
91 ibid., 13 Dec., 1930, p. 18.
92 ibid., 17 Nov., 1930, p. 11.
93 ibid., 1 Dec., 1930, p. 11.
95 North Hastings Heretaunga Club, 27 Jan., 1938, in Medical Research — Cancer — New Zealand Branch British Empire Campaign, 1925-1936, H1 1971 148/12/1, ANZW.
97 ibid., 1 Apr., 1930, p. 4.
only half full. Despite this, a total of £369 had been raised and a list of all donations were published.98

Early fundraising efforts were encouraging, despite the economic depression and it seemed that the NZBECC would reach its target of £100,000. Each division had been set a target of £25,000. By March 1932 Wellington had raised £13,000; Christchurch £21,000; Dunedin the full quota of £25,000; but Auckland had only raised £5,000. The total amount raised at this point was £64,000. The comparative fundraising also had some correlation to the amount of radium: Dunedin had 875 mg; Wellington 750 mg; Christchurch 659 mg; and Auckland only 350 mg.99 Fundraising continued after 1932 but slowed. Both fundraising fatigue and the economic depression are possible explanations. It would not be until the government announced that its jubilee gift to the King in 1935 would be a donation to the NZBECC that another significant cash injection occurred. The New Zealand government pledged £5,000 and the amount raised from all sources totalled to £15,000.100 By the end of 1935, the capital accumulated by the NZBECC had reached £85,000.101

Key members of the NZBECC provided information of the progress and actions that the fundraising would achieve. Sir Louis Barnett, who had been appointed as the head of the medical section of the NZBECC at its inception, emphasized the increasing success of radiotherapeutic treatments. He indicated that it was important for New Zealand to contribute to the research community internationally. In addition to this, the money would be spent on setting up cancer clinics at each of the main centres to aid diagnosis and recommend treatments to ensure a more accurate registering of all cancer cases.102 By centralizing cancer diagnosis in main centres, particular medical practitioners could specialize in

98 ibid., 4 Apr., 1930, p. 5.
101 ibid., p. 42.
102 Evening Post, 17 Sep., 1929, p. 10.
cancer diagnosis and draw on their experience and expertise to make better recommendations.

The promotion of X-ray and radium treatment in public forums was another method used to try to raise the profile of the cancer campaign. Before the 1920s, the DPH was sceptical about investment in radiotherapy; in the 1920s, as radiotherapy became increasingly legitimized, the DOH allowed investment but restricted this to major centres; and in the 1930s, backed with the financial support of the NZBECC, investment in cancer treatment became focussed on radiotherapy. The NZBECC used the hope that radiotherapy inspired as a seemingly miraculous scientific technology to aid its fundraising efforts (details on radiotherapy and hope are further discussed in Chapter Five). For example, in May 1929, Dr Percival Cameron, a radiologist at Dunedin Hospital (1910-23) and Wellington Hospital (1926-45), gave an address in Wellington illustrated by X-ray photographs and examples of radium applicators which demonstrated the work that Wellington Hospital’s 650 milligrams of radium had achieved. In 1934, Dr H.M. Moran, a Sydney expert in new methods of treatment with radium, travelled to New Zealand to aid NZBECC fundraising and also to advise on radium. Moran was given the benefit of a free rail pass by the government. Begg, as Director of Cancer Research, also enlisted the newspapers to convey this message. Begg was quoted as claiming that the position in respect to cancer was not one of ‘complete failure’ but of ‘increasing hope’. There is also evidence of a number of irregular radio talks. New Zealand’s cancer campaign used experts to encourage fundraising and to discuss the campaign’s developments.

The NZBECC also built on earlier educational efforts. One of the central purposes of the local divisions of the NZBECC was to control publicity methods and focus on early prevention and treatment. The Otago Division had a publicity

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103 ibid., 14 May., 1929, p. 10.
104 M.H. Watt to the Secretary of Treasury, 30 Jul. 1934, in Diseases — Cancer, H 1 1958 131/16, ANZW.
105 Otago Daily Times, 11 Aug., 1937, in Diseases — Cancer — Conference 1939, 1937-1940, H1 1299 131/16/10, ANZW.
106 Elliott, p. 43.
committee that recommended what type of information to disseminate.\textsuperscript{107} The groups targeted included the medical profession, medical students, and the general public. In terms of public education, the position of the NZBECC was to be cautious in publicising cancer and that any messages needed to ‘be careful not to scare them’ as it might lead to ‘panic and cancerphobia’.\textsuperscript{108}

The NZBECC used publicity to focus on inspiring hope in the public and to counteract popular fears of cancer and its treatments. In December 1930, at a NZBECC general meeting, Elliott reaffirmed the message that the campaign aimed to ‘eliminate all unnecessary and unhelpful worry’ and instead wanted to convey a ‘message of hope’ that cancer could be successfully treated.\textsuperscript{109} In July 1934, Elliott repeated this message when he proclaimed at the annual meeting of the NZBECC that the medical profession was ‘slowly but surely winning its fight against cancer’. Elliott proclaimed that the ‘battle cry’ of the NZBECC was that ‘cancer is curable’.\textsuperscript{110}

Publicity and education continued to be promoted through forms of media including the press and the radio. For example, in December 1933 there was a radio talk entitled, ‘Cancer is Curable’.\textsuperscript{111} The NZBECC brought a change in the way that information was brought to the public. The focus changed from education to publicizing a message of hope in order to encourage people to seek medical advice at the earliest possible stage. This involved promoting the message that cancer was curable and that action was being undertaken to respond to cancer in New Zealand, particularly through radiotherapy.

\textsuperscript{107} Evening Post, 9 Jun., 1936, Medical Research — Cancer — New Zealand Branch British Empire Campaign, 1925-1936, H1 1971 148/12/1, ANZW.
\textsuperscript{108} Elliott, p. 42.
\textsuperscript{109} ibid.
\textsuperscript{110} Evening Post, 12 Dec., 1930, p.10.
\textsuperscript{111} ibid., 6 Jul., 1934, p.4.
\textsuperscript{111} ibid., 19 Dec., 1933, p.6.
Conclusion

Ornella Moscucci described Britain’s responses to cancer as a ‘regime of hope’.\textsuperscript{112} In a similar way, New Zealand’s responses to cancer constituted ‘a message of hope’ against negative popular associations with cancer and surgery. Before 1910, this message of hope was informal and was conveyed through the promotion of surgical progress through medical commentary and the press. This was often derived from medical authorities from Australia and Britain and was augmented by commentary by New Zealand medical professionals. It was hoped, that the promotion of surgical progress in combating cancer would counteract popular assumptions about cancer and surgery.

A more formalized approach was undertaken throughout the 1910s and this fits into a general international pattern of cancer education developments through the creation of an educational pamphlet. While America, Britain, and New Zealand all possessed reservations about lay education, the approaches in response to cancer education varied. Unlike Britain, whose education in this period was localized, New Zealand launched a national effort in educating the public about cancer. Despite this, educational efforts in New Zealand did not reach the large-scale American cancer campaign undertaken by the American Society for the Control of Cancer. This included frequent dissemination of educational materials that targeted specific cancers, gendered forms of cancer and included movie productions. Unlike America and Britain, which had established dedicated cancer institutions in the early twentieth century, New Zealand did not possess national institutions until the establishment of the NZBECC in 1929. However, New Zealand did possess a centralized DPH/DOH that was influential in promoting the surgical agenda in the 1910s when radiotherapy was still an unknown quantity.

Like the establishment of the ASCC in America and the ICRF and BECC in Britain, the establishment of the NZBECC in New Zealand was significant. It acted

\textsuperscript{112} Moscucci, p. 370.
as a national institution that was dedicated to cancer. However, the timing of the NZBECC’s establishment was relatively late in comparison and its scope was far larger. While the establishment of the NZBECC was greatly influenced by the BECC, its relative role in cancer responses in New Zealand was greater than its British counterpart which was primarily focussed on fundraising and research. The NZBECC focussed on publicizing a message of hope that cancer could be cured and that progress was being made in the fight against cancer, particularly in respect to radiotherapy. The following two chapters examine how the NZBECC backed up its rhetoric of hope with action through the development of radiotherapy and research in New Zealand. Through this examination, it will be evident that the NZBECC was fundamentally integrated into every aspect of cancer control in New Zealand from the establishment of treatment centres, to investment in radiotherapy, to the establishment of research programmes.
Chapter Five
Radiotherapy in New Zealand, 1896-1939

Historiography on cancer and radiotherapy focuses primarily on comparative institutional developments in the interwar period. David Cantor’s discussion on cancer control programmes introduces the thesis that while countries often followed similar trajectories, the organization, and approaches varied. John Pickstone argued that in the development of cancer institutions, it is through the modality of radiotherapy that national differences became most apparent and institutionalized and the timing of these institutional developments was placed in the interwar period. New Zealand historiography on the issue of cancer and radiotherapy is limited and this thesis corroborates the broad models adopted by Cantor and Pickstone. This chapter will show that there are many broad similarities to other countries in respect to developments in radiotherapy and the timing of the institution of new radiotherapeutic technologies; however, New Zealand also diverges from other countries in respect to administrative and organizational differences in the establishment of radiotherapy as a treatment for cancer.

There are two broad international models on the development of radiotherapy relating to the relative importance of the state in control and investment. In the United States, there was a focus on a market driven approach in relation to the treatment of cancer. This resulted in significant variations based on geography, economics, and the perceived value of radiotherapy. There was no federal agency, and investment was based on individual institutions’ funding and philanthropy. From the 1920s, there was a large expansion of specialized cancer clinics in the

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4 Pickstone, p. 164; Cantor, pp. 6-7.14.
United States in response to the increased legitimizing of radiotherapy as a cancer treatment. From the late 1930s, the new National Cancer Institute provided greater access to radium by acting as a source of purchasing and distribution for hospitals that did not possess enough funding to invest significantly in radium.5

In contrast to the United States, in Britain and Canada there was a stronger involvement by the state in healthcare. Initially in Britain, individual institutions and philanthropy were influential in purchasing radium. This resulted in a fragmentation in radiotherapy services with key centres like Manchester dominating.6 In 1929, the Radium Trust and Radium Commission were established for the centralized purchase and distribution of radium. This provided the opportunity for the government to influence and shape services.7 A similar situation is evident in Canada where there was initially a fragmentation in cancer care between different provincial districts but federal involvement in healthcare during the 1930s brought a strong degree of centralization and developed a national approach.8

The interwar period was also significant in institutional developments in Europe and Australia. Belgium and France established strategic sub-centres to provide radiotherapy. Denmark, Italy and Germany established National Radium Institutes (Austria and France already possessed them). In Australia, by 1924, Queensland had established sub-centres for radium distribution; New South Wales invested over £120,000 into radium for research and treatment; and Victoria and Western Australia had begun investing in radiotherapy. From 1924, the Commonwealth government began subsidising state purchases of radium and from 1927, it began acquiring a central stock of radium, over ten grams worth, to be distributed around

7 Murphy, pp. 10-14; Pickstone, pp. 176-177.
the country. In 1929, the Commonwealth Radium Laboratory was established to oversee this supply of radium.⁹

New Zealand has a number of similarities and differences with other countries in respect to the organizational developments in radiotherapy. New Zealand was initially different to some countries as its approach to cancer control was haphazard but over time the organization of cancer control became more centralized. Like other countries, radiotherapy transformed from an experimental therapy into a legitimized and common treatment for cancer. In addition, like other countries, large levels of investment and organizational developments occurred in the interwar period. New Zealand followed broad trends in the development of radiotherapy but it also possessed some divergent administration differences from other countries. A combination of local hospital boards, the Department of Public Health (DPH)/Department of Health (DOH) and the New Zealand Branch of the British Empire Cancer Campaign (NZBECC) were the institutions that shaped the development of radiotherapy in New Zealand. Of central importance is the fact that New Zealand possessed a centralized DPH/DOH from 1901 and this was influential in influencing purchasing decisions surrounding radiotherapy.

The development of radiotherapy in New Zealand can be divided into three phases: early radiotherapy from 1896-1917; localized radiotherapy from 1917-1928; and nationalized radiotherapy from 1929-1939. From 1896-1917, there were several failed attempts to establish radium institutes but local hospital board rivalry and the DPH’s opposition scuppered large scale investment in radiotherapy. From 1917, significant investment in radiotherapy began sporadically with local hospitals taking advantage of government subsidies. Once large-scale investments began to develop from the mid-1920s, the DOH imposed limitations restricting radiotherapy for cancer treatment to the four main centres. In 1929, with the establishment of the NZBECC, a new type of organizational method was established that involved a partnership between the DOH and the NZBECC. This partnership entrenched the

centralized system based in major hospitals. This saw the institution of a National Radiation Laboratory with specialist physicists to oversee medical radiotherapy in New Zealand and the establishment of cancer consultation clinics that contributed to centralizing cancer diagnosis and further entrenched radiotherapy in the main centres. This chapter is the first significant historical work on the history of cancer and radiotherapy in both pre-war and interwar New Zealand.

Statistical Context

![Crude and Standardized Cancer Rates](image)


It is important to consider the statistical context of cancer in relation to the development of responses to the ‘cancer problem’ across the interwar period. The above table represents the crude and standardized rates. As will be discussed in the following chapter on research, the application of standardized rates began from 1916. Across this period, the crude death rate from cancer continued to increase but at a relatively slower rate than in the late nineteenth century and the first decade of
the twentieth century. When the rates are standardized, it is evident that the actual trend in the death rate from cancer remained relatively consistent. The growing discrepancy between the rates can be largely explained by shifting demographics of an ageing population, particularly in light of the large loss of life from the Great War and the 1918 influenza epidemic. The investment and actions in response to cancer in the interwar period developed when the increasing crude rate of cancer was slowing and the standardized rate was static. While statistical reporting and public impressions were primarily based upon crude rates, alarm generated from statistics, as argued in Chapter Two, is not sufficient to explain the development of responses to cancer. The cancer problem was a result of an intersection of differing factors and the same can be said for the responses to cancer, including radiotherapy.
Early Radiotherapy and the X-ray

When considering early radiotherapy in New Zealand, the image presented by the press and by medical professionals is significant. In his history of radium in Canada, Charles Hayter placed a strong focus on the importance of imagery and perceptions. Hayter argued that radium was ‘more than technology’; it was a ‘magical element’ and symbolized scientific progress.\(^{10}\) Likewise, the medical profession and the press in New Zealand monitored developments in radiology enthusiastically. This enthusiasm related to scientific prestige rather than the efficacy of radiotherapy. Hayter argues that radium possessed the ‘aura’ of science, but its application actually ‘ran counter to the values of scientific medicine’.\(^{11}\) Before World War One, the practical impact of these new technologies for cancer treatment was small in New Zealand. However, the importation of ideas surrounding these new technologies was influential in inspiring a strong sense of hope in the fight against cancer. Radiotherapy acted as a significant metaphor of hope against the dread disease cancer from the turn of the twentieth century.

In the 1890s and 1900s, regular cable news reports on the X-ray and cancer cures reached New Zealand’s newspapers.\(^{12}\) The primary use of the X-ray lay in its diagnostic functions but it was also used as an experimental cancer treatment. New Zealand’s initial experience of the X-ray, starting in 1896, is a mixture of imported news from abroad and local purchases. New Zealand, as a small and isolated country, relied on reports for news on radiotherapy. New Zealand looked abroad for confirmation of success and the geographic origin of news about radiotherapy was predominantly from America, Australia and Britain. The purchase of X-ray apparatuses was the first step towards specialised radiology in hospitals and it acted as an important forerunner to radium.

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\(^{10}\) Hayter, p. 6; Murphy, p. 2.41.
\(^{11}\) Hayter, pp. 15, 19.
\(^{12}\) William Rontgen discovered the X-ray in late 1895 and this received international attention from 1896.
The impression formed of the X-ray from the cable reports was that it seemed magical with 'unlimited' 'potentialities'. American reports claimed the rays could turn one African American 'as white as an albino'. Two months later, the colour changed to a grey colour, leaving the afflicted neither black nor white. Another American report, entitled, 'Cancers Disappear before the X-Ray', exemplified the hope for cure the X-ray inspired: the X-ray caused cancer to 'pass out of the tissue, leaving it healthy and sound'; 'the evanescence of the disease itself — a kind of absorption'. Such reporting inspired hope in the cancer-destroying properties of radiotherapy. In contrast to surgery, the X-ray was accompanied with 'no pain' or 'any danger' and this only increased the popular appeal of the X-ray. In conjunction with magical associations came optimistic medical commentary. One letter in 1902 from a London surgeon that was widely disseminated in New Zealand’s press claimed that 'medical science has at last found a remedy for that dreaded disease, cancer'. The X-ray was undoubtedly a new and exciting phenomenon and it was hoped radiation would be successful in combating cancer.

The optimistic cable reports sourced overseas contrast with New Zealand-based medical opinion that played down the X-ray’s possibilities. In 1902, Louis Barnett, New Zealand’s first member of Britain’s Royal College of Surgeons, a practising surgeon and lecturer at Otago University, presented at the Inter-Colonial Medical Congress in Hobart. Barnett indicated that the X-ray could cure some cases of superficial surface cancer but it was a long way from being a definitive cure for cancer. In an interview with a ‘well-known New Zealand doctor’ in London, the diagnostic value of the X-ray was characterised as an ‘immense’ advance on surgery but the X-ray had not cured ‘true cases of carcinoma’. In 1903, Dr Harry Archibald de Lautour, a prominent Oamaru practitioner who actively used X-rays in his practice as a diagnostic tool, set out his views on the efficacy of the X-ray to cure cancer in a letter to the Otago Witness. Latour wanted to rebut a report from

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13 Otago Witness, 7 May., 1902, p. 64.
14 Taranaki Herald, 15 Sep., 1908, p. 4.
15 Hawera and Normanby Star, 30 Mar., 1900, p. 4.
16 ibid.
17 Grey River Argus, 14 Feb., 1902, p. 4.
America over X-ray cancer cures. He stated that Americans were an ‘imaginative people’ and he claimed that no ‘authentic case’ of cure by X-ray existed. The X-ray remained predominantly an experimental therapeutic intervention before World War One. Local medical opinion on the efficacy of the X-ray in cancer treatment tended to be more cautious than the optimistic news reports.

Despite these reservations, from 1896 the medical profession took a keen interest in the X-ray as a diagnostic tool. Private practitioners purchased X-ray apparatus and the New Zealand Branch of the British Medical Association (NZBMA) held demonstrations. The enthusiasm of the medical community is reflected in its quick uptake of the X-ray. Dr W.H. Hosking, a Masterton medical practitioner trained in London in the 1870s, was the first known importer of an X-ray apparatus in 1896. Two other private practitioners followed suit in 1897. These private investments were a precursor to institutional investment. Interest in the X-ray by the medical profession is evidenced further through NZBMA presentations. The first known demonstration was at a Dunedin meeting of the NZBMA on the 26 August 1896. Dr William Ovenden, a Kaiapoi medical practitioner, also gave a practical presentation on the use of the X-ray to members of the Christchurch NZBMA in 1900. From 1898-1900, Lautour X-rayed 157 patients. In 1900 he published the results of his experiences in the first article on radiology in New Zealand, a technical piece describing methods of using the X-ray. Lautour believed the X-ray served an important diagnostic function but was not at present a miracle cancer cure. In addition to medical interest, the public also shared this enthusiasm. Lautour also gave community demonstrations, for example, at Anderson’s Bay Church, to the Sunday school children in the afternoon and to the congregation in the evening. The marvels of the X-ray were presented to the public with a florescent screen and audience interaction to display bones and any anomalies, like lead pellets.

20 ibid., 6 Dec., 1903, p. 43.
21 Rex Earl Wright-St Clair, Medical Practitioners in New Zealand from 1840 to 1930, Hamilton: R.E. Wright-St Clair, 2003, p. 86; McEwan, p. 27.
23 McEwan, p. 27.
An X-ray machine increasingly became an essential part of major New Zealand hospitals. In 1898, Auckland, Wellington, and Christchurch each purchased an X-ray apparatus; followed by Dunedin in 1904 and New Plymouth in 1907. Hawera Hospital’s purchase in 1908 was reported locally as an event of ‘considerable importance’. The X-ray’s diagnostic ability and potential to cure was emphasized, including its ability to locate a bullet or broken needle and being able to combat skin cancer. The importance of the X-ray grew and in 1910 Dunedin Hospital set up an X-ray department, with Dr P.D. Cameron, an Edinburgh-trained medical practitioner, as the first radiologist. This acted as a forerunner to specialist cancer facilities. The first reported X-ray cure of cancer was made by Dr James Reid, a New Zealand-trained doctor and an honorary surgeon of Wanganui hospital. Reid reported in 1911 that he cured a case of skin cancer. The X-ray provided a strong sense of hope for a cancer cure but practical application by private individuals and hospitals was based more on its diagnostic value than its ability to cure cancer. Nevertheless, the investment into more advanced X-ray technology in the interwar period built on these hopes for the X-ray.

27 Hawera and Normanby Star, 3 Nov., 1908, p. 5.
29 Wright St-Clair, p. 318; Evening Post. 20 Jul., 1911, p. 3.
Radium

‘And now you are holding in your hands the most wonderful discovery of science’.

These were the words remarked to an *Auckland Star* representative by Clement Wragge, a touring astronomer and meteorologist, who had produced his exquisite specimens of the marvellous metal radium — the wonder of the mineral kingdom. At first glance this extraordinary metal lying at the bottom of a tiny sealed tube, the eye, unseeing to the radiant beauties, ... notices nothing more than a few hundred minute grains of pale green hue, approaching almost a greenish-white.

‘That which you hold in your hand is pure radium and worth 3,000 times its weight in gold .... As you hold that in your hand at present, the powerful ether rays from the radium are passing right through the glass and then through your hand. If you were to keep it there for an hour or two, although you feel no effects at first, a brown spot, itching painfully, would appear by the end of a week in the palm of your hand. A little later a painful ulcer would form, perhaps several, and would take long to heal.’ (The reporter nearly dropped the tube).30

Contemporaries conceived the battle against cancer in the first decade of the twentieth century as a ‘fight in the dark’: ‘in spite of ... the searchlights of science’, cancer ‘still walks in darkness’. Contrastingly, radium provided ‘more than a ray of hope’ for cancer cure.31 New Zealand’s initial experience of radium was predominantly shaped by the impressions received through reports from abroad. In a similar way to the X-ray, radium inspired hope through the magical feats of science. Hayter argued that radiation was associated with powers that ‘transcended reality’.32 As the following section argues, the representation of radium and its successes were exaggerated and the image of radium began to take

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30 *Hawera and Normanby Star*, 13 Jan., 1909, p. 6.
31 *Evening Post*, 29 Dec., 1908, p. 6.
32 Hayter, p. 6.
on a series of magical connotations. The opening quote of this section is from a report on the New Zealand tour of the scientific lecturer, Clement Wragge, an English meteorologist. Wragge’s commentary exemplifies the type of representation of radium that is evident through reports in New Zealand and cable news from abroad. Everything about radium was mystifying: from its pale green hue, to its incredible value, to its dangerous ability to cause harm. Science, equipped with radium, was believed to possess powers of almost biblical proportions: ‘It will destroy life; it will prolong life; it has been alleged that it will create life’. There were only several tiny local purchases of radium in New Zealand before 1917. The importance of radium in New Zealand prior to 1917 was based more on representation than experience.

Radium’s abilities were believed to exceed the powers of the X-ray. According to London cable reports, it possessed ‘beautiful consistency’ and its rays ‘exceed the best achievements of the X-ray’ in cancer treatment. It was remarkable for its ability in proportion to its size. While an X-ray possessed a focus-tube the size of a football, radium consisted of a glass tube smaller than a toothpick. Radium had the advantage of being able to fit into small cavities. It was boldly claimed in one news article in 1908 that the discovery of radium ‘will rank as one of the greatest boons that science has given to mankind’.

Cable news reports made bold claims about radium. It was described as a ‘mysteriously fascinating substance’ and it captured the interest of the press. Radium was the ‘last miracle of science’ and the tenth wonder of the world. It ‘upset’ the known laws of nature: the conservation of energy and the persistence of matter. It seemed that radium would give off energy from ‘nowhere’. Opinions of the time stated that the rays travelled at 186,000 miles per second (the speed of light); would last from 2,000 to 5,000 years; could decompose water; turn glass

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33 Hawera and Normanby Star, 13 Jan., 1909, p. 6.
34 Otago Witness, 11 Nov., 1903, p. 64.
35 Evening Post, 26 Sep., 1903, p. 12.
36 ibid., 29 Dec., 1908, p. 6.
38 Poverty Bay Herald, 30 May., 1903, p. 1.
violet; and according to experiments by New Zealand’s own Ernest Rutherford, one of the world’s foremost experts on radioactivity, one gram had enough energy to raise 500 tons a mile high, and an ounce would drive a 50 horse power motor car at 30 miles an hour around the world.\footnote{Hawera and Normanby Star, 13 Jan., 1909, p. 6; West Coast Times, 15 Apr., 1909, p. 2; Evening Post, 26 Sep., 1903, p. 12.}

Newspapers saw no limit to the potential benefits of radium. Details on radium water concluded it would do everything from improving blood pressure to aiding digestive activity to curing arthritis.\footnote{Evening Post, 14 Mar., 1914, p. 10.} Radium reportedly prolonged the life of a caterpillar for several weeks past its natural existence. In the future, one report claimed, some people, ‘whose lives are worth keeping’, would be made ‘radioactive’, ‘so that they might live to the age of Methuselah’.\footnote{Methuselah lived until he was 969 years (Luke 3:37 (27)); Hawera and Normanby Star, 13 Jan., 1909, p. 6.} The seemingly exaggerated reports on radium did not avoid having a little fun poked at them. In an article entitled ‘Too much Radium’, it was reported that, ‘within the last five months radium has killed every known microbe and bacillus …. Consumption and cancer …. As if all this were not enough …. Radium will determine the sex of unborn children, cure mad dogs, convert any old metal you please into gold, and revolutionize warfare’.\footnote{Grey River Argus, 13 Apr., 1904, p. 3.} Hopes that radium was a miracle cure for cancer were abundant.

Reports in the \textit{Evening Post} from Vienna in 1903 instigated excitement about the prospect of a radium cure. A thirty-seven year old man received radium treatment and it was confirmed that the cancer growths exposed to radium had ‘totally disappeared in a month’. According to the reports, the rays ‘destroyed’ the tumour cells, but ‘hardly affect a healthy human skin’.\footnote{Evening Post, 8 Aug., 1903, p. 13.} This spurred a flurry of optimism over the potential success of radium. Any information about its success was enthusiastically published in New Zealand’s newspapers.
In June 1905 Rutherford briefly returned to New Zealand to visit relatives in the South Island. The local press interviewed him to get insight into radium from one of the world’s foremost experts. When questioned about its potential cure, he stated, ‘All that I can say is that, though the evidence so far looks promising, it is not conclusive.’ He commented on the Vienna cases and warned they had not been confirmed as malignant growths or checked for recurrence. The direct newspaper reports from scientific and medical authorities were more conservative in their claims. Despite ‘no authentic case of the successful curative action of radium on cancer’, the continued widespread experimentation around the world still gave cause for hope. A small number of ‘authenticated radium cancer cures’ from London in 1905, gave hope that ‘science may at last have found a way to the conquest’ of cancer. As time wore on, an increased number of radium cure cases gave legitimacy to radium as an experimental treatment.

Despite these guarded comments, positive reports encouraged an interest in radium banks around the world. In 1908-9 it was reported that ‘Progress seems to be undoubtedly made’ by the French Anti-Cancer League. It was reported that 56 out of the 62 cancer cases treated with radium were confirmed as successful after three years. As time wore on, the extent of recurrence of cancer from radium treatment could be more accurately assessed. This occurred in conjunction with philanthropy and patrons, such as Kind Edward VII, who was successfully treated with radium for a lesion and consented to be Patron of the newly established Radium Institute in Britain from 1909 (opening in 1911). The issue of establishing a radium bank in New Zealand came to the fore after reports that Sydney, with £5,000 already raised, was considering radium investment. Sydney proposed to make radium available for hospitals and private practice. In light of this news, the New Zealand press ‘sincerely hoped’ for a local radium institute.

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45 Hawera and Normanby Star, 7 Jun., 1905, p. 3.
46 New Zealand Tablet, 19 Dec., 1907, p. 9.
47 Wanganui Herald, 11 Feb., 1909, p.4; Evening Post, 28 Dec., 1908, p. 7.
49 Hawera and Normanby Star, 1 Oct., 1910, p. 4.
A few medical practitioners and institutions purchased radium for the treatment of cancer. In 1908 Hosking, the first New Zealander to import an X-ray apparatus, was the first medical practitioner to procure radium. He used radium jointly with surgical operations, and patients from around the country travelled to Masterton to be treated.\(^50\) Hosking also claimed the first cure of cancer with radium in New Zealand but Barnett claimed the cure was a fraud (a decade later Barnett would turn out to be a supporter of radium).\(^51\) This indicates an early scepticism by the medical profession. In 1912, Cameron, Dunedin Hospital’s radiologist, purchased a small supply.\(^52\)

The first reported institutional purchase of radium was by the Waipawa Hospital Board. In 1909 it had purchased 10mg of radium for £200. The precious commodity was funded by a donation and government subsidy. The role of the government subsidy in respect to radium was a significant issue for hospitals wishing to purchase radium.\(^53\) Since the 1885 *Hospitals and Charitable Institutions Act*, the government provided a subsidy to hospitals and charitable relief for donations. Over time, the amount of this subsidy increased from ten shillings per pound to a pound for pound contribution. Historian Margaret Tennant observed the fact that in the absence of extensive private wealth in New Zealand, the state came to be New Zealand’s greatest philanthropist.\(^54\) In 1909, ministerial power was granted to withhold subsidies but this power was not exercised until 1920, after the significant restructuring of public health in New Zealand. Margaret Tennant has also indicated that from the 1910s-1920s Dr Thomas Valintine, the Chief Health Officer, became less enthusiastic about charitable aid contributions and that Dr Michael Watt, as Director-General of Health from 1930, was even less enthusiastic.\(^55\)

\(^{50}\) Ibid., 4 Oct., 1910, p. 4.  
\(^{51}\) Probert and Atkinson, p. 481.  
\(^{52}\) McEwan, p. 32.  
From late 1910, New Zealand began to make moves towards establishing a radium institute. The timing of this interest can be linked to moves to open a radium institute in Britain. The Palmerston North Hospital and Charitable Aid Board, whose main protagonist was Dr Arthur Martin, trained in Edinburgh in the 1900s and a senior surgeon at Palmerston North Hospital, made the first large-scale attempt to secure radium supplies. Martin aimed to raise £6,000 to provide free treatment nationally. Martin believed radium would become a replacement for surgery: there was ‘no doubt that in the early cases of cancer of the lips, cheek, tongue, etc., it was a certain cure’. He confidently asserted that ‘The sooner the knife was done away with the better and radium would assist this’. Martin appealed to popular fears regarding surgery and the relatively non-invasive nature of radium treatment to gain support.

However, Martin’s view was not a unanimous position. Dr Leonard Edgar Whitaker, a senior surgeon at Palmerston North hospital who trained in London in the late 1890s, claimed radium was a doubtful and untried treatment. In response, Martin pointed to his consultation with experts, such as Sir Malcolm Morris, a renowned dermatologist based in London and an early expert on radiotherapy, who had encouraged the procurement. A hospital collection day was arranged to try to raise funds for the radium purchase but a ‘dilemma’ occurred — the collection day was cancelled owing to bad weather. In the aftermath of this, it was reported that the ‘Palmerston North medicos fell out over the matter’. The establishment of a radium bank was to be delayed until it was considered in more detail.

Enthusiasm for the new treatment ensured it became a topic in a hospitals conference in Wellington in 1911. James Wilson, a former member of parliament for Palmerston North and a member of the Palmerston North Hospital Board, brought up the subject of radium. He asserted that ‘no hospital could be regarded as properly equipped unless a supply of radium was available to afford treatments.

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56 Evening Post, 9 Dec., 1910, p. 3.
57 ibid.
58 ibid.
to patients suffering from cancer’. Due to the expense of radium, he advised that hospital boards should join in the purchase of radium, as larger quantities had demonstrated greater prospects of success. Wilson moved a motion to establish an institute in a central place in both the North and South islands. Opinion at the conference was divided. Dr Hardwick Smith, the superintendent of Wellington Hospital, claimed the X-ray and surgery achieved the same results as radium and that radium was ineffective on ‘malignant growths’. Dr Alexander Falconer, the New Zealand and London-trained medical superintendent of Dunedin Hospital, and Dr Thomas Valintine, the Chief Health Officer and organiser of the conference, agreed with Smith. Valintine added that ‘money was wanted for more pressing things than experimental purposes’ and that an institute should be based at the medical school in Dunedin. A motion of compromise was passed that recommended one institute for each island.\textsuperscript{59} Valintine’s opposition, effectively the DPH’s opposition, significantly impacted New Zealand’s lack of investment into radiotherapy. It meant that New Zealand’s investment into radiotherapy was delayed until the 1920s.

The radium issue reached parliament in August 1911. Mr Hanan, member for Invercargill, inquired about the government ‘procuring a supply of radium’. Public Health Minister George Fowlds replied that the possibility of the matter was for individual hospital and charitable aid boards to administer and any expenditure would receive a government subsidy. It is important to note that Fowlds made no endorsement of such investment but simply stipulated the potential entitlement for subsidy. Fowlds referred to Valintine’s position of the conference, that if a radium institute was established it should be linked with Otago Medical School, the only medical school in the country.\textsuperscript{60}

Dunedin Hospital institutional investment into radium began from 1910. It already possessed an X-ray department in 1910, and Cameron, went on to procure a small supply of radium in 1912. Like Palmerston North, the investment into

\textsuperscript{59} \textit{Evening Post}, 1 Jul., 1911, p. 9.
\textsuperscript{60} \textit{New Zealand Parliamentary Debates} (NZPD), vol. 154, 1911, p. 644.
radiology was an area of conflict. Some parties viewed the appointment of an assistant to Cameron to expand the department as ‘wasted expenditure’.

In 1914 Martin once again pushed for the establishment of a radium institute. He claimed New Zealand was the only country with no radium in bulk and he asked Robert Heaton Rhodes, the Minister for Public Health from 1912, for confirmation that a government subsidy would be available. Rhodes ‘could not make any definite promise on a subsidy’. Rhodes’ response is potentially indicative of the fact that the government and DPH were hesitant in investing significant sums of money into radiotherapy. Palmerston North Hospital launched an appeal from February 1914 to try to raise the funds and asked for subscriptions across the country. A circular was published in the newspapers that radium was ‘far beyond’ the experimental stages and in the future the absence of radium ‘would be as rare as the absence of an operating table’. Fundraising targeted the North Island and Martin argued that such an institute should be in a practical location central to the North Island to service a broad geographic area. The projected amount of funding for the institute increased to £12,000.

The main North Island centres, Auckland and Wellington, did not support Palmerston North’s proposal. In addition to the DPH’s opposition, the lack of unified action by hospital boards was also a contributing factor in delaying radium investment and in establishing a national programme. Wellington Hospital had ambitions to procure a supply and Hardwick-Smith put forward the case for a Wellington radium institute. In 1911, Hardwick-Smith believed radium was too experimental, but in 1914 he believed it had ‘advanced greatly’. Smith proposed a sum of £5,000 to purchase 200mg of radium. Clearly attacking the Palmerston North proposal, Smith wrote that anything above £5,000 would be ‘gross extravagance’. He claimed that Palmerston North was not as well equipped as the

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61 Proctor and Atkinson, p. 481.
63 ibid., 13 Feb., 1914, p. 3.
four main centres (Auckland, Christchurch, Dunedin, and Wellington) to host the radium institute and it would be easier to raise funds in Wellington.64

In contrast, Auckland opposed the establishment of any radium institute. Dr C. E. Maguire, the medical superintendent for Auckland Hospital, disputed the claims of Palmerston North and pointed towards the highly experimental nature of radium. He reported that expert advice from London advised him that the ‘time was not yet ripe’. The cost of radium, £1,000 for 50mg, as the minimum quantity for effective cancer treatment, meant a massive investment would be needed to cover the North Island effectively. Maguire described such expenditure as ‘unjustifiable’.65 Nothing came from the attempted radium institute in 1914.

New Zealand’s experience of radiology and hope before World War One predominantly derived from cable news reports. These reports, in exaggerated fashion, touted the merits of radiology and the prestige of science. The strong hope that radium inspired, in conjunction with transnational influences, namely international investment in radium, inspired local authorities to invest in a radium institute. Conflicting interests between different local hospital institutions and the DPH’s lack of enthusiasm contributed to the failure of a radium institute. This failure to invest in the latest scientific technologies for combating cancer received some negative publicity. In 1913, a front-page story in the NZ Truth, critically attacked New Zealand’s lack of action against cancer. Truth stated that ‘intelligent countries’ had already taken action, and the ‘procrastinations of the past will become the most insidious and potent factor in the death rate and the downfall of the race’. Truth pointed out that the world’s leading countries had institutes. The article bemoaned the practical radium monopoly of two private practitioners, ‘far beyond the purse of the average victim’.66 Despite efforts to establish a radium institute, significant investment into radiotherapy for the treatment of cancer would not happen until the interwar period. The establishment of radium institutes around the world gave significance to Truth’s condemnation. In Britain, it was

64 ibid., 19 Mar., 1914, p. 8.
65 Evening Post, 24 Jul., 1914, p. 11.
called a ‘temple of hope’; and in New Zealand, there were a number of calls for one of its own.67

67 Grey River Argus, 26 Sep., 1911, p. 8.
Localized Radiotherapy

Throughout the 1920s, New Zealand’s four largest hospitals invested in radiology. The legitimating of radiology as a cancer cure internationally was significant because New Zealand looked abroad for knowledge of advances and for advice and procurement. Newspapers, like the *Evening Post*, played an important role in fundraising for radiology services and profiling developments. Radiology’s scientific prestige motivated hospitals to invest in radiotherapy for the treatment of cancer. The international developments in radiology increasingly meant that such investment was necessary for up-to-date hospitals as a places of scientific healing. Both Otago and Wellington had initial hopes of forming a national institute to distribute radium emanations, but the system of autonomous local boards meant that a local approach dominated. The DOH played an important role in the restriction of local institutions. Its recommendations reduced the amount of subsidy provided in some instances and it limited the opportunities for smaller hospital boards to undertake large investments into radiology.

The purchase of radium and the existence of a radiology department symbolized a modern hospital as Hayter argued for Canada.68 Across America in the 1920s, an ever-increasing proportion of cancer sufferers were treated with radiotherapy.69 In the case of France, Patrice Pinell argues that the international position on radiology was integral to internal challenges.70 While New Zealand was relatively delayed in its institutional investment into radiology for cancer treatment, the timing of its investment in the 1920s fits into an international trend that involved renewed interest in significantly investing in radiotherapy.

During the 1920s, radiology became legitimized as a treatment method in New Zealand as elsewhere. In the 1910s, Valintine had viewed radium as experimental but his attitude softened in the 1920s. A 1923 revision of the New Zealand

68 Hayter, pp. 6, 26, 52, 58, 65  
69 Patterson, pp. 49, 66, 94.  
educational pamphlet, ‘Cancer: Is it Curable?’ indicated the success of radiology in treating cancer; previously x-rays and radium were described as experimental treatments. The local press continued to push for further investment, claiming ‘no hospital of standing’ could be ‘complete without radium’. By 1923, success using radium in Dunedin resulted in a report to the Minister of Health, Maui Pomare. From 1917-1927, four major hospitals established radiology departments. Each of these included at least 350mg of radium and deep X-ray therapy equipment.

Otago, as the centre of the country’s only medical school, was the first region to move to raise funds to establish a radium institute and this developed in a haphazard way. Cameron, Dunedin Hospital’s radiologist, had regularly used miniscule amounts of radium since 1911. In 1917, a public appeal raised £1,000 for a ‘radium institute’ and the government matched this amount. In 1918, the £2,000 was spent to acquire 180mg of radium for Otago Hospital. Patients from across the country travelled to Dunedin to receive treatment. This initial investment was a combination of a local board decision and the influence of Cameron as a radiology practitioner. There was no central government direction for the investment into radiotherapy.

In 1920 a renewed appeal aimed to supply more radium to Dunedin Hospital. Barnett was the chief publicist for the campaign and he travelled around New Zealand raising funds for Dunedin as the only major hospital with radium. Barnett claimed that while radium was costly, in terms of cancer treatment, it was now necessary. Dunedin hoped to raise a further £4,000 to increase its supply from

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71 New Zealand Branch of the British Medical Association to the Minister of Health, Dec. 1923, in Diseases Cancer, H1 1957 131/16 3823, Archives New Zealand Main Office (Wellington), ANZW.
72 The Press, 25 Aug., in Diseases Cancer, H1 1957 131/16 3823, ANZW.
73 P.D. Cameron to Maui Pomare, Nov. 20, 1923, in Diseases Cancer, H1 1957 131/16 3823, ANZW.
75 McEwan, pp. 30-1.
76 Probert and Atkinson, p. 481.
the 180mg bought in 1918 to 500mg and to purchase an up-to-date X-ray plant.\textsuperscript{77} By the end of 1923, it had raised the necessary funds.\textsuperscript{78}

Cameron hoped funds would also be used on an emanation plant that could transport radium emanations around the country. However, the Otago Hospital Board disagreed and only used the funding to increase radium supplies.\textsuperscript{79} This action reinforces the point that local boards were often focussed on responding to their region rather than providing a service for other regions. This disagreement played some part in Cameron moving to Wellington at the end of 1923. In May 1924, Cameron was replaced by Dr Colin Anderson as the radiologist for Dunedin Hospital. He believed the department needed expansion, including a new plant and two X-ray rooms. Another effort was made to raise a further £5,000 but this fell short of expectations by raising only £3,614.\textsuperscript{80} Nonetheless, by 1927, Otago had over half a gram of radium valued at over £5,000 and had spent nearly another £5,000 in establishing a new X-ray plant with up-to-date equipment. The timing of Otago’s investment coincides with a more general trend of increasing hospital investment in radiotherapy for the purpose of cancer treatment internationally.

Unlike Otago, the other major hospitals did not invest in the early 1920s. After Cameron moved to Wellington in 1923, fundraising for radiology in Wellington began. It is also an indication of the influence of individuals, like Cameron, in encouraging investment into radiology. The initial plan included a national radium institute in Wellington that would include an emanation plant to produce radium emanations for the whole country. In August 1923, Stuart Wilson, a member of the Wellington Hospital Board, indicated that New Zealand’s ‘appalling’ death rate from cancer meant a radium institute was needed. It was hoped that £36,000 could be raised.\textsuperscript{81} \textit{The Evening Post}, a Wellington daily newspaper, took a keen interest in the developments and enthusiastically reported on the proposed investments.

\textsuperscript{77} \textit{Evening Post}, 29 Dec., 1924, p. 2.  
\textsuperscript{78} McEwan, p. 29.  
\textsuperscript{79} Probert and Atkinson, p. 481.  
\textsuperscript{80} \textit{Otago Daily Times}, 10 May., 1924 in Diseases Cancer, H1 1957 131/16 3823, ANZW.  
\textsuperscript{81} \textit{Evening Post }, 20 Sep., 1923, p. 7.
National lecture tours tried to elicit funds. One tour, by Dr Edward Morgan, a Scottish-trained surgeon at Wellington Hospital, went as far as Northland. During his tour Morgan promoted Wellington’s cause and claimed a national radium institute should be established there because of its central location. Morgan even suggested that Dunedin’s radium supply should be co-opted for the cause. Due to the limited life of radium emanations, it was argued that Wellington was the only suitable location to ensure the emanations could be distributed nationally. Morgan, perhaps disingenuously, placed the raising of radium funds in terms of national importance not petty local rivalry.

In September 1923, a deputation was made to the Wellington Mayor, R.A. Wright by a number of Wellington hospital medical practitioners, representatives of radium suppliers, and Cameron, Dunedin Hospital’s former radiologist. A series of public meetings were organised by members of the deputation in conjunction with Wright, with the aim of establishing a national radium institute. Cameron provided evidence of past success in Dunedin. He indicated that radium helped lessen pain and in some cases, radium was better suited than surgery. Cameron’s role in the deputation was significant as he reported of his success in Dunedin.

In October 1923, Wellington’s fundraising changed from a national to a provincial focus after other hospital boards were not motivated to support the initiative. In an October health week, a meeting on radium attracted a thousand in attendance. The proposal aimed to raise £20,000 to support the region surrounding Wellington. The meeting included Cameron discussing the benefits of radium. In a meeting with the Mayor of Wellington, it was argued by F. Castle, a member of the Wellington Hospital Board, that no hospital could be considered up to date without radium. The linking of radium, medical progress and the modern hospital

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82 ibid.
83 ibid., 24 Sep., 1923, p. 6.
84 ibid., 26 Sep., 1923, p. 6.
was a common justification for and outcome of expenditure. However, while radium was increasingly legitimized, contemporaries exaggerated its necessity. The plan included the purchase of a gram of radium for £16,000 and a deep X-ray apparatus for £4,000. The acting Superintendent of Wellington Hospital, Dr B. Ewen, indicated that the medical practitioners unanimously supported the investment in radium. This contrasts with the conflicting opinions that hampered the earlier Palmerston North attempts.

By mid-October 1923, an official appeal began to raise funds. The aim of the appeal was to raise £10,000 that would be matched by the government to supply the 'middle belt' of New Zealand, including New Plymouth, Napier, Nelson, and Marlborough.\textsuperscript{86} This move can be linked to a national and international trend of increasing radium investment. Due to the large-scale expenditure required to fulfil the proposal, an eighteen-month fundraising campaign, including medical professionals and newspaper publicity, commenced.

Across this fundraising period, continuing investigation into radium treatment and arrangements for procurement were made in Britain and America by key medical staff. Dr D. MacDonald Wilson, the medical superintendent of Wellington Hospital, visited America, and Hardwick-Smith visited Britain to view the methods and successes of radium treatment. This was reflective of the point that New Zealand was drawing on expertise from abroad and seeking overseas about the procurement of equipment and radium. Details from these trips were publicized in the press and this helped to maintain a strong public profile for the fundraising efforts. Both Wilson and Hardwick-Smith impressed upon the public the success of radium as a cancer cure and its necessity to the hospital.\textsuperscript{87} In addition to this, presentations were made around local municipalities to try to encourage other regions to support the venture. For example, Cameron and Wilson gave lectures to the Oriental Bay Municipal Electors’ Association to gather support for a radium institute. Emotive language was used to try to elicit donations. The great suffering

\textsuperscript{86} \textit{Evening Post}, 17 Oct., 1923, p. 5.
\textsuperscript{87} ibid., 13 Nov., 1923, p.7; 14 Nov., 1923, p. 6.
cancer caused was emphasized, as was the relief that radium treatment could bring.\textsuperscript{88} Dr Charles Hector, a government pathologist, gave a lecture to the Red Cross Society and strongly supported the purchase of radium for Wellington.\textsuperscript{89}

The \textit{Evening Post} took up the cause and actively promoted the need for radium. It used alarmist cancer statistics to gain attention, claiming there had been a four-hundred and fifty per cent increase and that the rate had risen from 2 per 10,000 people to 9 per 10,000 people. In addition, the \textit{Evening Post} used the awful nature of cancer to encourage donations. According to the \textit{Evening Post}, cancer was a disease that had many people suffer ‘years of agony’ while the ‘insidious’ cancer ‘slowly but surely’ reduced sufferers to a ‘living skeleton’.\textsuperscript{90} It was conceived as a ‘mysterious disease’ that killed over one thousand individuals a year.\textsuperscript{91} Cancer stereotypes, which had been prevalent around the turn of the century, as discussed in Section A, were played on to try and encourage donations. One advertisement stated that ‘Cancer is a dreaded enemy that casts its shadow over every home. None know where it may strike’.\textsuperscript{92} This evidence emphasizes the continuation of many of the cancer conceptions discussed on Section A into the 1920s.

Eventually, the relationship between the DOH and Wellington Hospital became strained as a desire for fiscal prudency met the desire to establish a well-equipped radium institute. The premise behind the fundraising was that the government would match any raised funds with a pound-for-pound subsidy. From 1909, ministerial authority could deny this subsidy but it was not until 1920 that this power was exercised. Despite the strong enthusiasm of the medical profession and local hospital authorities, government funding was less forthcoming. Delays in getting confirmation of the subsidy caused anger. In May 1924, no response had been given to the subsidy request of £5,000 in January. Mr Appleton, a member of the Wellington Hospital Board, condemned the government’s inaction and claimed

\textsuperscript{88} ibid., 29 Nov., 1923, p. 7.
\textsuperscript{89} ibid., 31 Oct., 1923, p. 7.
\textsuperscript{90} ibid., 2 Nov., 1923, p. 7.
\textsuperscript{91} ibid., 16 Nov., 1923, p. 2
\textsuperscript{92} \textit{Evening Post}, 19 Nov., 1923, p. 2.
that the amount was entitled under statute.\footnote{ibid., 23 May., 1924, p. 11.} Valintine’s response was that the board should continue to raise more funds. This attitude was described as ‘discouraging’ and as a breach of faith. This indicates continued caution by Valintine in what he thought was excessive spending on radium, despite the fact it was increasingly legitimized. This is also indicative of the relatively low priority the DOH gave to cancer generally. The conclusion of the meeting suggested that should the board ask for a reasonable sum the government might accept it.\footnote{ibid., 27 Jun., 1924, p. 1.} In the end, the Government paid a partial subsidy of £5,000. This was added to the sum of £11,557 that was raised from donations. The DOH opposed excessive investment, as it believed the money could be better spent elsewhere.\footnote{On the focus of the DOH see Derek Dow, Safeguarding the Public Health: A History of the New Zealand Department of Health. Wellington: Victoria University Press, 1995; On the importance of tuberculosis to the department of health see Linda Bryder, ‘If Preventable, Why not Prevented?: The New Zealand Response to Tuberculosis, 1901-1940,’ in Linda Bryder, ed., A Healthy Country: Essays on Social History of Health in New Zealand, Wellington: Bridget Williams Books, 1999, pp. 109-28.} In 1924, the DOH’s annual report claimed that ‘radium is still in the experimental stage’ and that it did not ‘justify’ any claims to a definitive cure.\footnote{Department of Health Annual Report, AJHR, H-31, 1924, p. 4.} In 1926, the DOH annual report explained that both Valintine and Watt had investigated the subject of radium. They concluded that ‘it was still undecided as to the value of radium in the treatment of cancer’.\footnote{ibid., 1926, p. 2.} The investment included a gram of radium for £12,000 and an up-to-date deep therapy apparatus for £4,000.\footnote{L. Barber and R. Towers, Wellington Hospital, 1847-1976, Wellington: Wellington Hospital Board, pp. 62-3; McEwan, p. 32.} Despite the increasingly legitimized nature of radium as a cancer treatment, Valintine and the DOH actively imposed limitations on how much it was prepared to subsidize.

Christchurch began considering the purchase of radium around the same time as Wellington. The Evening Post also took considerable interest in radiology in Christchurch, presumably as a comparison to Wellington’s developments. Dr P. C. Fenwick, a consulting surgeon and radiologist at Christchurch Hospital, had purchased £500 of radium in June 1923 and had treated a hundred patients with mixed results. For some patients, Fenwick claimed, radium had ‘marvellous value’
and to others it was ‘not worth a postage stamp’. Despite this, localized success with radium encouraged the Christchurch Hospital board to invest further in radiology.

From 1923 to 1925, Christchurch invested in radium and deep X-ray therapy. In December 1923, the Christchurch Hospital Board proposed raising £10,000 for radiological equipment. As was the case with Wellington, the board sent Fenwick to Britain to investigate radium, receive training, and to arrange purchases. Fenwick returned with a deep X-ray apparatus and 45mg of radium. He reported witnessing some ‘striking’ results and recommended further investment. In January 1925, an additional 458mg was purchased. In November 1925, Fenwick published his results of treatment using radium. Of the 77 cases of cancer treated with radium, 53 were discharged, 21 were still undergoing treatment, and two ‘elderly’ patients died. By December 1925, over 90 radium and 40 deep x-ray therapy treatments for cancer were undertaken. These numbers indicate that a large proportion of cancer sufferers were receiving radiological treatment.

Auckland’s interest in radium was delayed because of waiting for other fundraising appeals to finish. As discussed earlier, in the pre-war period, Auckland was also the most resistant to spending money on radium or supporting a radium institute and as news of investment in other main centres occurred, Auckland’s slow action began to be criticised as ‘pitiful’. In late 1925, in line with the previous actions of other hospital boards, Maguire visited Britain with the

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99 *Dominion*, date unspecified, Jun., 1923, in Diseases Cancer, H1 1957 131/16 3823, ANZW.
101 ibid., 27 Nov., 1924, p. 7.
102 ibid., 8 Nov., 1924, p. 7.
103 ibid., 26 Dec., 1925, p. 6.
104 ibid., 26 Nov., 1925, p. 22.
105 ibid., 26 Dec., 1925, p. 6.
106 ibid., 5 Jan., 1924, p. 6.
107 ibid., 18 Sep., 1924, p. 4.
purpose of securing radium. He secured £5,000 of radium for 1926. This brought Auckland’s radium supply in line with Otago and Christchurch.

Following the lead of major hospitals, provincial hospitals attempted to raise funds for radium investment. An Invercargill committee organised a plan to raise £2,500 to be matched by government subsidy to help parts of Southland and Otago. In July 1924, Wanganui indicated its interest in establishing a local radium fund. It had £384 in term deposit and attempted to raise money from a ‘radiumgram’ competition. Unfortunately, only £8 was made from 73 entries, a sum little in excess of the £7 worth of prizes on offer. Circulars were distributed around the district but it was suspected that the majority were thrown away. It was hoped that a radium fundraising week would raise public enthusiasm. However, after Auckland’s purchase, any hopes other hospitals had were quelled when the DOH decided to restrict the purchase of radium to the four main hospitals, particularly as Valentine was still uncertain over the value of radium relative to its cost. This action effectively centralized radiology in the four main centres.

Throughout the 1920s, changes in the international intellectual climate regarding radiology influenced investment decisions in New Zealand. Internationally, both radium and deep X-ray therapy were increasingly considered as proven and legitimate cancer treatments (as opposed to being experimental). In the 1920s, breakthroughs in radiotherapy treatments, like radium puncture and radium bombs, and X-ray apparatuses capable of large voltages at consistent levels, increased radiotherapy’s credibility as a successful cancer treatment. Through radiology, the rise of ‘heavy’ technologies and the transformation of hospitals into places of scientific healing developed in New Zealand as elsewhere.
Nationalized Radiotherapy

The establishment of the New Zealand Branch of the British Empire Cancer Campaign (NZBECC) in 1929 meant a more consistent and centralized approach to cancer was undertaken. As discussed in Chapter Four, the NZBECC oversaw the establishment of cancer consultation clinics in each of the main centres and acted as a central body that directed cancer control in New Zealand. In addition to this, it also oversaw and partially funded radiotherapy in major hospitals across New Zealand. The institution of cancer consultation clinics meant diagnosis and radiotherapy treatments were further entrenched and centralized in the four main centres. The establishment of a National Radiation Laboratory, funded by the NZBECC, and participation in Australian Cancer Conferences, which began in 1929, with New Zealand being represented by the NZBECC, led to the formalization of centralized policies and regulation of radiation dosages across the country. As discussed in Chapter Four, this was part of a secondary wave in international responses to cancer that resulted in the establishment of cancer institutions in Australia, Canada, and New Zealand.

Between 1929 and 1931, New Zealand’s main urban centres each established cancer consultation clinics. They acted as strategically placed treatment centres across the country and came to dominate all forms of cancer diagnosis and treatment. The only way cancer sufferers could gain access to deep X-ray therapy and radium treatment for cancer was through these clinics. The establishment of the clinics was newsworthy and the Evening Post, a strong supporter of the NZBECC, regularly published reports on the progress of the cancer campaign. The first clinic was established in March 1929 in Wellington. This was followed by Dunedin in May 1929, and Auckland and Christchurch by the end of 1931. Evidence suggests New Zealand looked to Australia for guidance on running the clinics. Wellington wanted to establish a committee that followed the example set by the Royal Prince Alfred Hospital in Sydney that had specialists meet regularly to

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114 Department of Health Annual Report, AJHR, H-31, 1940, p. 4.
diagnose and treat cancer cases.\textsuperscript{115} In 1930, Dunedin requested patient forms from Sydney to send to each local division in New Zealand to get opinions and create a standardized form for recording diagnosis and treatment of patients.\textsuperscript{116}

The roles of the regional clinics were multilayered. They acted as a forum where suspected cases of cancer were diagnosed by a committee of experts. Cancer cases from smaller hospitals and private practitioners were referred to the clinics. Dr James Elliott, a Wellington surgeon and president of the NZBECC since its inception in 1929, wanted all cancer patients to receive the benefits of the cancer consultation clinics.\textsuperscript{117} The expense for those unable to pay for travel was subsidised by the NZBECC to encourage all cancer cases to go through the clinics.\textsuperscript{118} In 1930, Valintine sent a hospital circular encouraging hospital boards to help pay for transport for cancer sufferers to attend the clinics.\textsuperscript{119} New Zealand’s participation in the 1937 Australian Cancer Conference reinforced the aim to have all cancer patients attend the clinics. In Fenwick’s conference report to the DOH he noted that subsidization was encouraged in Australia, particularly in Queensland and Western Australia where large distances had to be covered.\textsuperscript{120} It became an important goal for the NZBECC and the consultation clinics that every case of cancer would go through the expert committees and provide patients with the option to receive modern radiological treatment for cancer.

The second major function of the clinics was to advise on the method of treatment. The consultation clinics were not the final authority on cases but acted in an advisory role.\textsuperscript{121} If the recommendation of the consultation committee was for surgery, then the patient would be referred back to their original hospital and their

\textsuperscript{115} Evening Post, 25 Mar., 1929, p. 12.
\textsuperscript{116} ibid., 8 Mar., 1930, p. 9.
\textsuperscript{117} James Elliott was also a former NZBMA President (1919-20), Chairman of Council (1914-15, 1924-6), and NZMJ editor (1911-1933).
\textsuperscript{118} Evening Post, 20 Feb., 1937, in Diseases Cancer — Imperial Cancer Research Fund, H1, 1958/131/16/1 3826, ANZW.
\textsuperscript{119} Hospital Boards Circular, no.1 1930, in Disease Cancer, 1927-34, H1 1958/131/16 3825, ANZW.
\textsuperscript{120} P. C. Fenwick, ‘Report on the Eighth Australian Cancer Conference’, in British Empire Cancer Campaign Society — Dominion X-ray and Radium Laboratory — Miscellaneous Files — Equipment wat-wil, 1934-1951, CABI CH56 1/, Archives New Zealand, Christchurch Regional Office, ANZC.
surgeon to determine if surgery would proceed. If radiotherapy was needed, the patient stayed in the main centre where deep X-ray therapy and radium were available. The establishment of the clinics meant that cancer sufferers from around the country had access to radiotherapy for the treatment of cancer for the first time.

The third role of the clinics was to regulate the admission of cases requiring radiotherapy. If the committee recommended radiotherapy and the surgeon in charge agreed, then the patient would be admitted into the main centre for treatment. The cancer consultation committees also acted as an official forum for accurate record keeping of cancer cases for statistical investigations. The accumulated knowledge could be used to learn more about the effectiveness of treatment types. Maguire, the superintendent of Auckland Hospital, believed these statistics would be a ‘great help’ in combating cancer. It was claimed that ‘complete uniformity’ in documentation and an ‘effective’ follow-up system was instituted. If the original physician or hospital rejected the recommendation for treatment, then this would be reflected in the official records.

The final function of the consultation clinics was to provide education. The consultation clinics were used in medical rotations to aid teaching medical students. In addition to this, at Auckland any medical practitioner was ‘entitled to and encouraged’ to attend the clinics. This helped expose a range of medical practitioners and medical students to the new developments in radiotherapy.

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125 Elliott, p. 42.
126 ibid., p. 43.
127 Craven, p. 12.
The make-up of staff varied but a standard committee included surgeons, a radiotherapist, a pathologist, and a registrar. In addition, Dunedin included the chief of staff of Dunedin Hospital, a gynaecologist or other relevant specialist on its committee, and the Director of Cancer Research at the Cancer Research laboratory in Otago Medical School, Dr A.B. Begg. Clinics in Christchurch, Dunedin, and Wellington were held one afternoon a week on average. Auckland conducted two clinics a week to handle the demand. This required two separate surgical teams with an honorary surgeon trained in the use of radiotherapy and a surgical assistant trained in radiotherapy in each surgical team. This development of specialists treating cancer can be seen as the origins of radiation and surgical oncology in New Zealand. The introduction of the clinics brought in a collaborative process and led to an increase in specialized practitioners.

A high percentage of cancer patients attended the clinics. Anecdotal evidence praised the success of the clinics. Sir Louis Barnett, chief of the medical section of the NZBECC from 1929, claimed patients came ‘willingly, in ‘large numbers’, and with the knowledge that the clinic offered a ‘valuable service’. In July 1936, at a meeting of the Wellington Division of the NZBECC, Dr Thomas Duncan Stout, a Wellington surgeon and former NZMBA Chairman of Council, reported on the success of the consultation clinic. Stout indicated that patients from all over Taranaki, Poverty Bay, and the north of the South Island attended the Wellington clinic. New Zealand’s clinic attendance rate, according to the local press, compared favourably with Australia. According to a report in The Taranaki Daily News, from 1928 to 1933 Australia’s consultation clinics saw 3,081 patients. New Zealand compared better with 2,800 patients being seen by the clinics from 1930 to 1933. Given New Zealand’s smaller population base and length of time, the comparison of these figures indicates a strong participation rate. Statistics also showed that attendance rates at the clinics increased over time. One potential

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129 Elliott, p. 42.
130 Craven, p. 12.
131 Evening Post, 20 Dec., 1933, p. 15.
133 Taranaki Daily News, Sep., 17 1937, in Diseases Cancer — Conference 1939, 1937-1940, H1 1299 131/16/10 9304, ANZW.
The patient demand for cancer consultations meant that more frequent meetings were required, as Auckland had already decided. Wellington addressed this by establishing separate regional sub-centres to cope with demand. Palmerston North had a sub-centre established that had deep X-ray therapy treatment available. In addition, Taranaki, Stratford, and Hawera received sub-centres from 1937. Radium remained centralized in the main centres but deep X-ray therapy and diagnosis were spread out in rural regions to encourage cancer sufferers to visit the clinics and to aid in postoperative care. In Wellington, the clinic expenditure from increased consultations led to concerns over finances once the estimated expenditure outweighed the income from investments.

The evidence presented suggests that the investment in radiology was successful. The actual use of radium in the treatment of cancer and the method of its introduction varied across types of cancer. Wellington Hospital used methods including radium needles, particularly for breast cancer; the use of 2cm thick radium collars for around the neck; interstitial radium treatment where needles were circumferentially placed around the tumour; and radium used with dental applicators. Deep X-ray therapy was usually used postoperatively rather than as a treatment by itself or preoperatively. The success rate of treatments can be gleaned from a report of cases of cancer in the lip at Wellington Hospital in 1934.

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134 Dominion, 25 Aug., 1938, in Medical research — Cancer — New Zealand Branch British Empire Campaign, 1925-1936, H1 1971 148/12/1 4825, ANZW.
136 Taranaki Daily News, Sep., 17 1937, in Diseases Cancer — Conference 1939, 1937-1940, H1 1299 131/16/10 9904, ANZW.
137 Evening Post, 30 Jul., 1936, p. 20.
success rate of treatment between radiology and surgery was compared. From thirty-three surgical cases, there was a seventy one per cent success rate without any recurrence after three years; and from fifty-six radiological cases, there was a success rate of seventy four per cent. The fact that radiology received a higher proportion of cases with advanced cancer meant that these statistics indicated a strong success. The full advantage of this statistical collection would not be realized until after 1940 once a statistical research department was established at Auckland but the success of radiotherapy was beginning to be charted locally.

The clinics were central to New Zealand’s approach to radiology, but one of the major influences in shaping thinking of treatment practices was the Australian Cancer Conferences, occurring annually from 1929. In April 1933, Dr Eric D’Ath, a professor of pathology, and Dr Philip Lynch, a pathologist at Wellington Hospital, reported to the DOH on their attendance at the Fourth Australian Cancer Conference. New Zealand had not participated in the first conferences and only had observing delegates at the third one. The conference focussed on radium and the position of New Zealand was compared to Australia. The authors of the report claimed that New Zealand had purchased a sufficient amount of radium, and that the conference justified New Zealand’s actions by indicating the increasing usefulness of radium in cancer treatment. In cancer of the cervix, they noted that radium was now preferred over surgery. As Ornella Moscucci argued, this legitimating of radiotherapy as a treatment for cancer of the cervix also developed in Britain from the 1910-1930. In practical terms, from the early 1920s, Moscucci explained, suggestions of cervical treatment without surgery began and from 1925 reports of low mortality meant that by 1930 radiotherapy had become the treatment of choice for cervical cancer. In addition, Australia had centralized radium and it was only used at approved centres spread throughout the Commonwealth. The report concluded that it was ‘good sense’ to keep the status quo in New Zealand by

\[138\] Papers Relating to the Treatment of Cancer –Miscellaneous Papers Relating to Courses at Wellington Hospital, 1929-1937, Stout 3/1, ANZW.

limiting radium distribution to the main centres. In short, the authors found that New Zealand was heading in the right organizational direction and that the current level of radiology investment was justified. However, some unfavourable comparisons did emerge. New Zealand fell short in respect to the employment of specialized physicists. The feedback from the conference was that expert physicists should be employed to look after Wellington’s radon emanation plant and another to calibrate the X-ray dosimeters in major hospitals around the country.

At the Fifth Australian Cancer Conference in 1934, Elliott, the President of the NZBECC, proclaimed that New Zealand came to the conferences as a younger brother would to an elder knowing that knowledge would be given freely. D’Ath presented a paper at the conference that detailed the changes New Zealand had made. In response to the need to improve the organisation of physics and radiotherapy in New Zealand, J.A. Strong, a Victoria physics graduate, was appointed as a full-time physicist to oversee radiotherapy in New Zealand in 1933. Strong’s role was to ensure the proper use of radium and X-rays and to ensure that they were being used safely. Strong discussed his actions and role at the Tenth Australian and New Zealand Cancer Conference in 1939. He organized a primary standard for radium and the dosimeters on the X-ray plants. Strong also conducted regular inspections of all hospitals’ X-ray plants and supervised the electrical and radiation protection of radium storage and handling. While in earlier periods New Zealand sent medical practitioners to Britain to train in the use of radiotherapy, New Zealand now followed Australia’s lead in emphasizing specialist physicists in radiology.

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140 Professor D’Ath and Dr Lynch to M.H. Watt, Report of the Fourth Australian Cancer Conference, 12 April 1933 in Diseases Cancer, 1927-1934, H1 1958 131/16 3825, ANZW.
141 Ibid.
142 Elliott, p. 6.
144 D’Ath et al., ‘Report on the Fifth Australian Cancer Conference’.
145 Department of Health Annual Report, AJHR, H-31, 1934, p. 5.
Despite these achievements, new challenges emerged in respect to the outdating of equipment. Advances in X-ray technology meant increasingly more powerful apparatuses were available for treating cancer. At the 1935 Hospital Boards’ Conference, Elliott called for the need to install up-to-date deep therapy X-ray plants in each of the main hospitals at a cost of approximately £2,500 each. Deep therapy apparatuses had initially been installed in the main centres from the mid to late 1920s. A letter to the editor of the Evening Post supported Elliott and believed New Zealand should possess the most up-to-date plants to aid the ‘unfortunate people’ who had cancer. In 1936, Dr Michael Watt, Director-General of Health, wrote to Elliott indicating the need for the major hospitals to update their deep X-ray therapy apparatuses. Watt indicated that he believed the cost of these were legitimate expenses that could be incurred by the hospital boards but hoped the NZBECC would pay £1,000 for each of the apparatuses with the government and the hospital boards fronting the rest. The investment into radiotherapy was negotiated between the NZBECC and the DOH.

As part of this upgrade, it was proposed in 1936 that a specialist laboratory should be established in Christchurch for both treatment and experiments. The impetus for this came from a £1,750 gift. It would be the most powerful plant in New Zealand and was estimated to cost £3,750. In 1937, the National Radiological Laboratory (NRL) was established in Christchurch. This included two rooms that had deep X-ray apparatuses. One was 200kv while the other was 300kv.

The new advanced facilities and a concern for employing appropriate experts meant more physicists were needed. In 1938, Strong received an appointment of an

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149 M.H. Watt to James Elliott, 6 Jul., 1936, Diseases Cancer — Imperial Cancer Research Fund, H1, 1958/ 131/16/1 3826, ANZW.
150 Evening Post, 25 Jul., 1936, in Diseases Cancer, 1935-1941, H1 1295 131/16 9156, ANZW.
151 Report of the Travis Radiological Laboratory, April 1937, in British Empire Cancer Campaign Society — Dominion X-ray and Radium Laboratory — Miscellaneous Files — Reports and Minutes, 1939-1950, CABI CH56 1, ANZC.
assistant in Mr Roth, an MSc in physics.\textsuperscript{152} Roth was trained to use every piece of equipment to fulfil his duties in regulating the radiotherapy apparatuses around the country.\textsuperscript{153} In addition to Roth, the NZBECC Medical and Research Committee suggested more physicists were needed. It was hoped that part-time physicists could be employed in each of the main centres to oversee radiotherapy.\textsuperscript{154} It was during this period that non-medical specialists in radiotherapy began to enter the realm of medical radiology.

Throughout the 1930s, the organization of radiotherapy changed dramatically. The NZBECC brought an unprecedented level of cohesion between local institutions and the DOH, and entrenched a policy of centralization of cancer treatment. It worked in a coordinating role in conjunction with the DOH to direct cancer control and provide financial support. Hospitals became specialized places of scientific healing in respect to cancer: they possessed specialized cancer clinics; they had networks to subsidize patient travel; they possessed advanced medical technologies that were maintained by scientific experts; and the treatment of cancer, using radiology, became an increasingly specialized discipline. In developing this, New Zealand and the NZBECC looked to Australia for guidance. The Australian Cancer Conferences acted as a transnational forum that justified the investment into radiology; confirmed the appropriateness of organizational structures; and suggested advice to increase the number of experts.

\textsuperscript{152} Minutes of the NZBECC Annual Meeting, 1938, in Medical Research — Cancer — New Zealand Branch British Empire Campaign, 1925-1936, H1 1971 148/12/1 4825, ANZW.
\textsuperscript{153} Travis Radiological Laboratory Supplementary Report, June 1939, in British Empire Cancer Campaign Society — Dominion X-ray and Radium Laboratory — Miscellaneous Files — Reports and Minutes, 1939-1950, CABI CH56 1, ANZC.
\textsuperscript{154} Report of the NZBECC Medical and research Committee, 11 May 1938, in British Empire Cancer Campaign Society — Dominion X-ray and Radium Laboratory — Miscellaneous Files — Reports and Minutes, 1939-1950, CABI CH56 1, ANZC.
Conclusion

From the 1890s to 1939 there was a dramatic transformation in radiotherapy for cancer treatment in New Zealand. In the 1900s and 1910s, New Zealand’s experience of radium was predominantly through looking abroad at treatment successes, institutional investments, and cable news reports. Suggestions to establish a radium institute resulted in conflicting viewpoints and a lack of support from the DPH, and limits to fundraising efforts resulted in no significant investment into radium. From 1917, as radiotherapy became increasingly legitimized internationally, significant localized investment began. However, the lack of enthusiasm of the DOH over the cost of radium caused tension and actively limited radium to the main hospital centres. Despite this, each of the major centres eventually invested in both radium and deep X-ray therapy as a means for treating cancer. From 1929, after the establishment of the NZBECC, the development of cancer control in New Zealand became a negotiation between local hospital boards, the NZBECC, and the DOH. The role of the press publicized and popularized the new developments in radiology; it was also used by groups and institutions to encourage fundraising, and acted as a critical mouthpiece. The NZBECC entrenched the centralization of radiotherapy in the major centres through the establishment of a National Radium Institute and cancer consultations clinics.
Chapter Six
Research Responses to the Cancer Problem, 1915-1940

From 1915 to 1939, cancer research in New Zealand transformed from sporadic and isolated publications by medical professionals to formal government investigations and dedicated cancer research programmes. The most powerful influence that shaped this transformation was the pressure increasingly exerted over time on the medical profession and public health authorities to respond to public perceptions surrounding the increasing prevalence of cancer. As discussed in Section A in respect to early statistical research and commentary on causation, there were increased expectations of scientific medicine to combat cancer. The previous chapters in this section discussed the use of education and publicity, and radiotherapy as responses to address the cancer problem and inspire hope. This chapter examines research undertaken by the medical profession and public health authorities.

Research responses to the cancer problem follow a similar trajectory to educational responses. Cancer research in New Zealand can be divided into two eras. The first was an era of statistical research before the establishment of the NZBECC (1917-28); and the second era had a more multifaceted research programme under the NZBECC (1929-1940). From around the turn of the twentieth century, cancer research became increasingly important internationally. This resulted in the establishment of dedicated cancer research institutions in the pre-war period.1 In Britain the Imperial Cancer Research Fund (ICRF) and in America a number of specialized research institutions had already been established prior to 1915. Research in New Zealand up to 1928 was more limited. Like early methods of public education, it aimed to play down alarmist interpretations of the cancer

problem. It focussed primarily on statistical analysis and argued that the cancer problem was a myth. It was mooted that changing demographics could be used to explain the incidence of cancer. In addition, during this period, it was considered to be wasteful to invest large resources into experimental research as that was already being undertaken abroad.

After 1929, a research programme developed that included statistical research; experimental research using radiotherapy; and experimental research investigating the pathology of cancer. In terms of research, Canada and New Zealand are alike in the sense that both fell behind other countries as dedicated cancer institutions were not established until the late 1920s and 1930s. In Canada, across the 1930s provincial institutions were established and in 1938 the Canadian Society for the Control of Cancer was established. After the establishment of the New Zealand Branch of the British Empire Cancer Campaign (NZBECC) in 1929 and the public interest surrounding this, greater impetus was given to local research. The NZBECC helped fundraise and lobby for New Zealand to make a greater research contribution to the international community. The result of this was the establishment of a cancer research laboratory, a National Radium Laboratory (NRL) for radiation research, and a statistical research division. This chapter examines this transformation through three sections: an examination of pressure for research responses to cancer from 1915 and into the 1920s; statistical research responses from 1917-27; and New Zealand’s research responses under the NZBECC from 1929-1940.

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Pressure for Research Responses

Statistical research was often used in the early twentieth century as an attempt to explain and play down the cancer problem. Barbara Clow claimed that in Ontario in the early twentieth century there were two contrasting interpretations of cancer statistics: that the mortality was more apparent than real as a result of improved diagnosis and registration of death or that it reflected an alarming spread. 4 In New Zealand, the former tended to be an approach taken by the medical profession and improvements in scientific medicine was a common explanation. For example, Dr Kenneth Mackenzie, a noted Auckland surgeon, announced in a 1919 public lecture at St Andrew’s Hall in Auckland that the increase in cancer could mostly be attributed to better diagnosis and more accurate registration of death. 5 This interpretation was challenged in the media. For example, in 1918, Truth announced that it was ‘tired of the old cry’ that better diagnosis and registration of death accounted for the increase in cancer. 6 One of the roles of statistical research was that it acted as a means to counteract alarmist statistical interpretations while also acting as evidence of the advances of scientific medicine and the medical profession. It served as a formal response to counteract the cancer problem.

In New Zealand, from the 1910s, there was strong public concern about the relative rise of cancer incidence. There is a clear link between the timing of statistical research responses and voices calling for action. The intensity of concern in New Zealand was potentially greater than other countries due to the fact that cancer incidence in New Zealand overtook tuberculosis at an earlier stage than most other countries, as discussed in Chapter Two. 7 While cancer overtook tuberculosis in New Zealand in 1910, this did not happen in most other countries until the 1920s. 8 As already discussed, the 1910s was also a period that involved

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5 Auckland Star, 1 Jul., 1919, in H1 1957 131/16, Archives New Zealand Head Office (Wellington), ANZW.
6 NZ Truth, 2 Feb., 1918, p. 2.
The first suggestion that the government should set up a panel of experts to investigate cancer came in 1915. This suggestion emanated from Dr Alfred Newman, a registered medical practitioner and member for Wellington East. The response to Newman from G.W. Russell, the Minister for Public Health in the Liberal government in 1912 and 1915-1918, was unenthusiastic. Russell pointed out the fact that in Britain the ICRF undertook statistical and experimental investigations with the best-known specialists. The government believed the best course of action was to await further reports rather than set up a special commission for New Zealand. In effect, New Zealand opted to do nothing and looked to Britain for cancer research. This method was fiscally prudent and more practical than setting up an independent research programme. In effect, the response was to maintain the status quo and rely on information from the ICRF.

A 1918 University of New Zealand Senate meeting, the proceedings of which were published in The Evening Post, discussed the issue of New Zealand making a greater research contribution to cancer. In this forum it was proposed that funds

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10 New Zealand Parliamentary Debates (NZPD), 172, 1915, p.17.
11 ibid.
12 Annual reports from the Imperial Cancer Research Fund are evident throughout several series in the DPH/DOH archives.
should be made for scientific research into cancer. It was hoped that a research fellow who would visit every cancer case in New Zealand hospitals could investigate the follow-up history of discharged patients. The impact of statistical interpretations on demographics could be seen during the debate when W.H. Seager, an Auckland professor of mathematics, criticised comments that used statistics in an alarming way. Alluding to his earlier statistical study in 1902, Seager pointed out the fact that demographics were largely able to explain the increase. Russell’s response to this discussion was quoted in the Poverty Bay Herald. He indicated that any research should be coordinated with Britain, and that the Department of Public Health (DPH) already collated any details from pathological examination of cancer cases. The official response was to continue to look to Britain and that the collation of cancer statistics was an adequate response for New Zealand.

Discussion of cancer research continued in 1919 and 1920. In 1919, Henry Ell, a Liberal member for Christchurch South since 1899, brought up the issue of cancer research in parliament. Ell wanted to know if there was a dedicated hospital that specialized in cancer treatment and research in New Zealand. The response from William Massey, Reform Prime Minister from 1912-1925, was, if anything, consistent with previously expressed government opinion. Massey replied that a special hospital was not necessary as the treatment could be met by the general hospitals. Massey claimed that the preference for cancer treatment was to rely on surgical methods and special research was being undertaken in Britain. He considered undertaking an independent research programme imprudent. In 1920, Newman asked for a commission of experts to inquire into the causes and treatment of cancer to try and counteract its ‘alarming’ spread. C.J. Parr, the Reform Minister of Health, reaffirmed that the ICRF was undertaking research and it would be better to work with them and not create a separate investigation.

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13 Evening Post, 23 Jan., 1918, p. 3.
14 Poverty Bay Herald, 26 Jan., 1918, p. 6
15 NZPD, 185, 1919, pp. 656-7.
16 ibid., 186, 1920, p. 309.
In 1921, Dr William Herbert, Chairman of the NZBMA Council (1916-17, 1921-4) and a driving force behind the inception of a cancer education campaign in New Zealand, attempted to give impetus to the idea of New Zealand producing independent research. In a Wellington lecture, Herbert called for New Zealand to initiate its own cancer research. He claimed that there was ‘scant wisdom’ in ‘merely waiting’ for results from abroad.\(^{17}\) The same year, Dr Thomas Valintine, the Director-General of Health (1920-1930), responded to the repeated calls for research into cancer. He believed that such a programme was not practical. He highlighted the fact that the London Institute of Cancer at Middlesex Hospital had 100-200 beds for cancer patients, whereas in New Zealand there were only a few cases per institution.\(^{18}\) Valintine also noted that the DOH remained ‘in touch’ with the ICRF.\(^{19}\)

Despite Valintine’s opposition, the issue of developing a research programme in New Zealand resurfaced in 1923. Newman continued to harangue the government and asked if the DOH would collect cancer statistics and pass this information onto Britain. Francis Bell, the Attorney-General and a key member of Massey’s Reform government, explained that statistics on New Zealand’s cancer incidence were already being transmitted to Britain.\(^{20}\) In August 1923, a deputation that included Herbert and Dr James Elliott, editor of the NZMJ (1911-1933) and a former NZBMA Chairman of Council and President, went to Sir Maui Pomare as Minister of Health (1923-6). The deputation claimed that apart from heart disease, cancer was the most alarming killer. Herbert asked for the government’s support in setting up a foundation for cancer research. Pomare responded by saying that if the profession put money in the government would likely subsidise it. In response, Dr J. P. Frengley, the Deputy Director-General of Health, noted that the DOH lacked specific data about cancer deaths to send to Britain and suggested that someone should write up all the cases.\(^{21}\)

\(^{17}\) The Press, 17 Aug., 1921 in Diseases Cancer, 1921-1924, H1, 1957, 131/16, 3823, ANZW.
\(^{18}\) Ashburton Guardian, 30 Aug., 1921, p. 4.
\(^{19}\) The Press, 27 Aug., 1921 in Diseases Cancer, 1921-1924, H1, 1957, 131/16, 3823, ANZW.
\(^{20}\) NZPD, 202, 1923, p. 414.
\(^{21}\) Deputation to Pomare, 5 Aug., 1923, Diseases Cancer, 1921-1924, H1, 1957, 131/16, 3823, ANZW.
New Zealand’s official statistical research began with the publication of a special study into the statistics on cancer in 1917. The study was collated in 1916, the same year that ‘Cancer: Is it Curable?’ was published. This study introduced the use of standardised cancer statistics and more detailed comparative analysis. The research was presented in the form of a special report into cancer and was published by J. W. Butcher, Chief Compiler in the Government Statistics and Census Office, in the New Zealand Official Yearbook. While cancer statistics had been used in the past, this was the first report that provided comprehensive statistics and a more detailed type of analysis. Before 1917, statistics had only been presented in the form of raw data or crude rates. Butcher opened his special report in 1917 by pointing out that the increase of cancer had attracted alarm since it overtook tuberculosis as New Zealand’s second greatest killer. He aimed to standardize the statistics in relation to the changing population’s demographics. This had also been cited as a reason to play down the alarming increase but Butcher was the first to express a standardized rate statistically. It is important to note that Butcher looked to Britain’s vital statistics reports as a guide for explanations and methods and made frequent reference to them.

One prominent area of consideration in the Butcher report was the comparison between different seats of cancer and gender. Since the quinquennial period from 1892-1896, male cancer rates outstripped female cancer rates, whereas prior to this, female rates had exceeded male rates. The following table shows the comparative cancer rates between males and females:

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Male and Female Cancer Rates in New Zealand per 10,000 People

<table>
<thead>
<tr>
<th>Quinquennial Period</th>
<th>Male Rates</th>
<th>Female Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1882-1886</td>
<td>3.05</td>
<td>3.43</td>
</tr>
<tr>
<td>1887-1891</td>
<td>4.38</td>
<td>4.44</td>
</tr>
<tr>
<td>1892-1896</td>
<td>5.65</td>
<td>5.05</td>
</tr>
<tr>
<td>1897-1901</td>
<td>6.35</td>
<td>5.77</td>
</tr>
<tr>
<td>1902-1906</td>
<td>7.14</td>
<td>6.44</td>
</tr>
<tr>
<td>1907-1911</td>
<td>7.61</td>
<td>7.18</td>
</tr>
<tr>
<td>1912-1916</td>
<td>8.28</td>
<td>7.19</td>
</tr>
</tbody>
</table>


Butcher found that there were significant gender differences in cancer rates in respect to stomach and liver cancer and cancers of the buccal cavity. In other forms of cancer, like skin cancer and intestinal or rectal cancer, the gendered difference was statistically insignificant. For the buccal cavity, male rates were eight times higher than female rates on average from 1908-1916; for stomach and liver cancer, male rates were approximately thirty-five per cent higher than female rates for the same period. In explaining the greater buccal cancer rates, Butcher suggested that tobacco should be considered as a causative or contributing factor. He also suggested that the relatively clean and healthy habits of women, particularly in terms of oral hygiene, were another influential factor. In terms of stomach and liver cancer, Butcher suggested that greater male consumption of alcohol was a plausible explanation. In terms of cancers specific to women, Butcher observed that from 1900-1907, rates of cancer in the womb were higher among married women than single women. In contrast, he indicated that single women possessed higher rates of breast cancer than married women. Butcher suggested that there was a relationship between cancer in the womb and childbirth. He indicated that the decreasing trend of cancer in the womb correlated with a decrease in New Zealand’s overall birth rate.²⁴

²⁴ Butcher, pp. 791-2.
In addition to gender, Butcher also commented on cancer and geography. However, due to the potential variety of factors, he did not make any strongly worded conclusions about potential causes that affected regional differences in cancer rates. The following table expresses regional cancer differences in New Zealand from 1904-1913:

<table>
<thead>
<tr>
<th>Province</th>
<th>1904-1908</th>
<th>1909-1913</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>6.02</td>
<td>7.03</td>
</tr>
<tr>
<td>Taranaki</td>
<td>5.90</td>
<td>5.82</td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>6.25</td>
<td>8.24</td>
</tr>
<tr>
<td>Wellington</td>
<td>6.46</td>
<td>7.38</td>
</tr>
<tr>
<td>Marlborough</td>
<td>7.52</td>
<td>6.88</td>
</tr>
<tr>
<td>Nelson</td>
<td>5.97</td>
<td>5.98</td>
</tr>
<tr>
<td>Westland</td>
<td>10.63</td>
<td>12.73</td>
</tr>
<tr>
<td>Canterbury</td>
<td>7.58</td>
<td>8.43</td>
</tr>
<tr>
<td>Otago</td>
<td>8.30</td>
<td>9.31</td>
</tr>
</tbody>
</table>


Butcher found the rates in the South Island (Westland, Canterbury, and Otago) to be higher than many North Island regions. Butcher noted that this needed to be weighed against the fact that these regions had an older population. For example, Westland, which possessed the highest cancer rates, also possessed the greatest proportion of residents over the age of sixty. Butcher hesitantly speculated about other factors that might have affected regional cancer rates. These included Auckland and Nelson’s favourable climates and anecdotal evidence of Westland being well known for alcohol consumption. According to Butcher, Westland had a high proportion of public houses with one licensed house for every 154 people (compared to a Dominion average of one for every 920 people).\(^{25}\)

\(^{25}\)ibid., pp. 795-801.
Butcher only briefly discussed cancer and Maori. The system of registration for Maori deaths began in 1915-1916 and from these statistics only 1.10 per 10,000 of the population was recorded as dying of cancer (compared to 8.23 for the New Zealand European population). Comparative racial demographics were not considered in detail due to the unreliability of Maori statistics and Butcher excluded Maori statistics from the general population statistics. Butcher pointed out that there was no system of registration for Maori death over the last three years and this prevented reliable comparison between European and Maori rates. Despite this, he pointed to racial stereotypes: ‘Coloured races are generally considered to be much less liable to cancer than the white races’. He pointed out that Maori statistics may be ‘a little’ understated but that it was reasonable to conclude that cancer was rarer among Maori. It is important to note that Butcher’s statistical conclusions about Maori cancer rates were based on the recording of an incomplete system where there was often no cause of death stated. In addition, it included a small sample of only eleven recorded deaths.

The following graphs are derived from statistics from Butcher’s report and demonstrate the same pictorial trends displayed in his report.

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26 ibid., p. 802.
27 Ibid., p. 777.
28 ibid., p. 777.
From the graphs, it is evident that there had been a continual increase in cancer deaths and an increasing rate of death from the crude figures. The standardized rate, reflecting population changes (based on 1911 population demographics), depicts a milder comparison. The crude rate roughly quadrupled over the period while the standardized rate only doubled. Butcher argued that it was ‘unfair’ to come to conclusions from crude rates and that by standardizing the rates the
increase was ‘less formidable’. This meant that around half of the perceived increase could be explained away in relation to demographic changes. Butcher concluded that cancer should not give rise to the same national concern as tuberculosis despite the statistics. Before his conclusion, Butcher suggested that if tuberculosis rates were standardised as well it would indicate a greater threat than cancer as it hit those in the middle ages of life. Action to combat tuberculosis was a major priority of the DPH and Butcher’s reports only encouraged the continuation of prioritising tuberculosis.

In 1918, Dr Michael Watt, the District Health Officer for Wellington (1916-20) and later Director-General of Health, published an article entitled ‘Cancer in New Zealand’ in the New Zealand Health and Hospitals journal. He was eager to assert that concerns surrounding cancer incidence were exaggerated. The information from the Butcher Report provided the statistics for Watt to use to criticize alarmist opinions. Watt developed the ideas that Butcher initiated and played down exaggerated interpretations of ‘the cancer problem’ through cancer statistics. He acknowledged that a lot of attention had been given to the rising cancer statistics and that these statistics could be interpreted as being alarming. He claimed that any conclusions drawn from the death rate of cancer were ‘fallacious’ and caused ‘unnecessary distress’. The increase, Watt claimed, could ‘in a great part’ be accounted for by changing demographics. He then pointed out several key statistics: the increase in the proportion of the population over 45 from over 10 per cent in 1875 to over 18 per cent in 1915; and the fact that 87 per cent of cancer deaths occurred in those above 45. He argued that the statistical increase in cancer was in fact a testament to the success of improved sanitation throughout the country that enabled a high proportion of the population to live longer. In short, Watt claimed that the increase in cancer was simply a consequence of the ageing population. In making such a claim, he was only telling a half-truth. Changing demographics did account for a large proportion of the increase but not all of it. There is no clear

29 Butcher, pp. 778-9.
30 ibid., pp. 804-6.
31 M.H. Watt, ‘Cancer in New Zealand’, New Zealand Health and Hospitals, 1 (1917-18), p. 146
32 ibid., pp. 146-7.
33 ibid., p. 148.
evidence that explains the changes in cancer rates apart from the ageing population. Despite this, this acts as an indicator that a new type of statistical interpretation that took into account changing population demographics was being used.

For medical research relating to cancer, New Zealand collaborated with the ICRF. From 1905 to 1912, New Zealand sought out the latest research developments from the ICRF; the ICRF sought samples from New Zealand to aid its investigations; and New Zealand sought out samples from medical practitioners and sent them in coordination with the ICRF.\textsuperscript{34} In the 1920s, New Zealand continued to coordinate with the ICRF. The DOH followed the work of the ICRF with ‘great interest’; it believed New Zealand should wait for relevant reports and was actively ‘keeping in close touch ‘with key research bodies around the world’. In terms of research, it was believed that New Zealand could act in a data gathering capacity in conjunction with the ICRF. This approach is confirmed in the DOH annual reports that indicated that New Zealand’s research contribution should focus on gathering data to coordinate with other research efforts.\textsuperscript{35}

The focus on data gathering resulted in further statistical studies. In 1923, the DOH sent Dr William Mercer, the Medical Officer of Health for Wellington, to Britain to find information about combating cancer.\textsuperscript{36} The results of this trip included a recommendation that Butcher should update his statistical investigation.\textsuperscript{37}

\textsuperscript{34} Despatches from the Governor of New Zealand to the Secretary of State for Colonies, AJHR A-01 23.10 (1905), p. 10; Despatches from the Secretary of State for the Colonies to the Governor of New Zealand, AJHR, A-02, 1910, p. 40, no.62; Despatches from the Secretary of State for the Colonies to the Governor of New Zealand, AJHR, A-02, 1912, pp. 69-74.
\textsuperscript{36} Dow, p. 114.
In 1926, Butcher published another special article on cancer incidence in New Zealand.\textsuperscript{38} The report, in effect, indicated the same trends evident in 1917: that demographics accounted for a large proportion of the increase. In the period since the Great War, this was particularly marked, given the fact that a large proportion of the young men died in the war.

Continuing from the previous investigation, the long-term impact of demographic changes from the Great War meant that the crude rate increased while the standardised rate decreased. This meant, statistically speaking, that the rate of death from cancer was decreasing. Butcher found that the increases in the death rate from cancer were occurring in ages above sixty. In short, death from cancer was, on average, occurring at a later stage of life.\textsuperscript{39} In addition, Butcher analysed the comparative ages of those who died and concluded that the average age at death of cancer sufferers was increasing.\textsuperscript{40}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{CancerDeathRates.png}
\caption{Crude and Standardised Cancer Death Rate Per 10,000}
\end{figure}


\textsuperscript{38} ibid.
\textsuperscript{39} ibid., pp. 891-893
\textsuperscript{40} ibid., pp. 895-6.
Butcher also addressed the issues of gender, geography, and race. Butcher’s conclusions in 1926 were similar to his 1917 study and much of the material was quoted verbatim. Butcher discussed the continuing trend of male cancer death rates exceeding female rates. From 1875 to 1924, male death rates from cancer increased from 3.5 to 8.3 per 10,000 people. Across the same period, female rates increased from 5.2 to 7.7 per 10,000 people. Butcher used the same explanation for these differences as his 1917 study: that greater levels of smoking and alcohol consumption in men and cleaner personal habits, particularly oral hygiene, in women accounted for this difference.\(^41\) In terms of geography, the same trends as in 1917 were evident but in a more exacerbated form. Cancer rates in South Island regions, like Westland, Otago and Canterbury, continued to outstrip other regions. Butcher observed the fact that there existed migratory trends from south to north and that it was younger people who tended to migrate to the larger cities in the North Island. Butcher concluded that this had resulted in a rapid increase in the proportion of old people in particular South Island regions and that this change in age distribution largely accounted for regional variation. In addition to this, Butcher suggested that the favourable climate in northern regions may have an impact on the rates.\(^42\) Also, Butcher examined Maori registered deaths from 1920-4. Over this period, there were 69 recorded deaths at a rate of 2.6 per 10,000 people (compared to 8.8 per 10,000 in the European population). Butcher made no mention of any potential effect of age distribution difference. Instead, he relied on stereotypical assumptions about ‘coloured races’ being ‘less liable to cancer than white races’. Butcher could still not attain credible statistical information for Maori. He noted that not much information existed on the subject and that the registration of unspecified or vaguely termed deaths for Maori was ‘considerably higher’ than among European death registrations.\(^43\)

In summation, Butcher claimed that the increase was largely apparent as a result of several factors including improved registration of death, improved diagnosis, and most importantly, the changing population demographics. Additionally,

\(^{41}\) ibid., pp. 912-916.  
\(^{42}\) ibid., pp. 916-921.  
\(^{43}\) ibid., p. 921.
Butcher indicated that the numerical increase could be attributed to the improvements in health and sanitation that led to more individuals living and entering into older age groups that were more susceptible to cancer.\textsuperscript{44} His report was picked up on in several forums. The \textit{Evening Post} reported a less alarmist interpretation of statistics and commented on the new standardized rates.\textsuperscript{45} In addition, Butcher’s 1926 report was also used by the DOH to play down the need for alarm in its annual report.\textsuperscript{46}

Butcher’s 1917 report highlighted the need for more detailed statistical research into cancer. In a memorandum to Russell, Malcolm Fraser, the Government Statistician, asked if some more details on the pathological type for cancer could be added to the return discharge cards of hospitals. This recommendation had developed after Butcher’s 1917 report had drawn the attention of Dr Leonard Whitaker, a London-trained senior surgeon at Palmerston North Hospital and opponent of radiotherapy. Whitaker suggested that any research programme into cancer would need to have a new form of tabulation to provide more detailed information for a research scholar in the future.\textsuperscript{47} These developments formed the backdrop for the appointment of Dr Noel Fulton, an Otago-educated medical practitioner registered in 1924, to a position as a cancer research fellow at Otago medical school from 1927.

Fulton investigated hospital records, funded by private donations and a government subsidy.\textsuperscript{48} He began his investigation by collecting statistics from the Government’s Insurance Department and collected information on cases from New Zealand’s public hospitals.\textsuperscript{49} In 1927, Fulton made his first and only report to the Minister of Health, R.A. Young. Fulton provided a statistical analysis and categorisation of all cancer cases in New Zealand in 1926. He examined 1,285 cases

\textsuperscript{44} ibid., p. 932.
\textsuperscript{46} Annual Report of the Department of Health, AJHR, H-31, 1926, p. 3.
\textsuperscript{47} Memorandum to G.W. Russell from Malcolm Fraser, 20 Oct. 1918, in Diseases cancer.
\textsuperscript{48} \textit{Evening Post}, 11 Oct., 1927, p. 11; Dr Noel Fulton, Annual Report, 1927 in H1, 1363 131/16/7, ANZW.
\textsuperscript{49} Fulton to government actuary, Government Insurance Institute, 19 Aug. 1927, in Diseases Cancer.
of which 1,179 were confirmed as cancer, 91 were uncertain, and 15 were not cancer. Fulton called for more ‘definite’ reporting and registration of death. In respect to Maori deaths from cancer, Fulton concluded that the certification of death was ‘extremely unsatisfactory’ and that he could not draw any conclusions as the statistics were ‘unsound’. In addition, Fulton called for all hospitals to have a common form of reporting and certification. He called for a questionnaire for medical professionals to fill out to provide more accurate details. Fulton’s research commented on the same trends that Butcher observed: the death rate for cancer rose with age; the death rate was higher in ‘civilised’ races and less in ‘primitive’ races; and that male incidence exceeded female incidence.\(^{50}\)

From 1917 to 1927 statistical research in New Zealand responded to growing public and political concerns about cancer. The responses to this pressure were, in general, to play down the relative significance of the cancer problem. For guidance, the government and the DPH/DOH looked to Britain because of its large investment into research, its established programmes, and issues of practicality. Despite this limited enthusiasm for research, statistical research was undertaken as a research output. This research played a role in the sense of collecting more detailed and useful information about cancer, acting as an example of action in response to cancer, and as a method for playing down alarmist interpretations of cancer statistics.

\(^{50}\) Fulton, Annual Report.
Research and the NZBECC

The establishment of the NZBECC in 1929 brought with it a strong rhetoric of action. It was a beacon of hope and promoted the message that ‘medical science refuses defeat’ against cancer.\(^{51}\) The NZBECC provided both funding and impetus for establishing a comprehensive research programme in New Zealand. This programme included statistical research, experimental research with radiotherapy, and experimental research into cancer pathology. One of the central figures of the NZBECC was Sir Louis Barnett, the president of the medical section of the council from its inception in 1929. That year Barnett pointed to the need for New Zealand to make a greater contribution to the fight against cancer. In an *Evening Post* interview in 1929, he pointed towards the increasing success of radiotherapeutic treatments. He hoped New Zealand would raise a large amount of money to allow the cancer campaign to undertake its work. Barnett also indicated that it was important that money was raised so New Zealand could contribute to the research community by funding some of its own research.\(^ {52}\)

One of the first NZBECC actions was to establish a research base for cancer in Dunedin, the location of New Zealand’s only medical school.\(^ {53}\) In 1930, Dr A.M. Begg, a New Zealand qualified doctor who had conducted cancer research with the ICRF, was appointed as Director of Cancer Research and held this position until 1948.\(^ {54}\) Begg began New Zealand’s first experimental investigations into the cause of cancer. He was appointed for an initial period of three years to undertake cancer research at Otago University’s medical school.\(^ {55}\)

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\(^{51}\) *Dominion*, Sep., 4 1929, in Diseases Cancer; *Evening Post*, 17 Apr., 1935, p. 4.

\(^{52}\) *Evening Post*, 17 Sep., 1929, p. 10.

\(^{53}\) *Dominion*, Sep., 4 1929, in H1, 1363 131/16/7, ANZW.

\(^{54}\) NZBECC Secretary to Director-General of Health, 8 Jan., 1930, Diseases Cancer.

\(^{55}\) NZBECC Central Committee meeting minutes in *Evening Post*, 30 Jul., 1929, p. 11.
Begg had proven pedigree as a cancer researcher and had published in the ICRF’s scientific reports and the *Lancet* on experiments with fowl.56 In September 1930, H. Hall was appointed as Begg’s assistant. Hall had worked with Begg at the ICRF and had specialist skills in charting the results of Begg’s experiments. In May 1931, Begg reported to the Medical and Research Committee of the NZBECC that he had been investigating the effect of repeated application of disinfectants on mice. All attempts to induce cancer from disinfectant were unsuccessful.57 In addition to this, he began publishing in the *New Zealand Medical Journal*. Begg published a review of cancer research to help explain the purpose of different types of research investigations.58 In June 1932, it was reported that both Begg and Hall were appointed to an additional three-year term.59 By then, the focus of Begg’s research had changed to investigating a serum to cure cancer. The causal assumption of this investigation was that cancer was a virus.60 In the annual NZBECC meeting of 1934, it was decided that the terms of Begg and his staff should be offered to be further renewed for seven years.61 Begg’s efforts were recognised in Britain when in 1935 the *British Listener* pointed out that imperial research centres had been established throughout the homeland and the empire, including New Zealand.62 From 1936, Begg’s research focussed on the growth of tumours and provided suggestions to the medical profession to help improve treatment.63 In 1938, given their relatively isolated position, Begg and Hall returned to London to continue their research while Begg maintained his position as Director of Cancer Research in New Zealand on a half salary.64 This in effect saw Begg return to working with the ICRF but it also meant New Zealand was making a partial research contribution.

59 *Evening Post*, 25 Jun., 1932, p. 15; *Dominion*, 25 Jun., 1932 in Diseases Cancer H1, 1363 131/16/7, ANZW.
64 Canterbury, Marlborough, Nelson and Westland Division of the NZBECC to President and members of the Central Branch, 10 Nov., 1939, British Empire Cancer Campaign Society Files, Records and Minutes, 1939-50, box 1, a963ch, ANZC; T. Stout, ‘Review of Developments in Connection with Cancer Control in New Zealand for the Year 1938’, British Empire Cancer Campaign Society Files, Records and Minutes, 1939-50, box 1, a963ch, ANZC.
The significance of Begg’s research is that it acted as part of a coordinated transnational investigative effort into the cause of cancer. While there was nothing ground-breaking in Begg’s studies, its negative correlative conclusions still acted as a contribution to international research.

The second area of research that New Zealand participated in following the establishment of the NZBECC was statistical. More detailed statistics on cancer had been collected since Butcher had instituted a record system in each New Zealand hospital in 1923.65 Butcher was still producing statistical reports in 1929. For example, in 1929 he provided the DOH with an additional statistical analysis of cancer cases in mental hospitals during the period from 1924 to 1928.66 In reality, though, little progress had been made in the field of statistics. In 1935, the DOH still referenced the decade-old 1926 Butcher report as the main statistical authority.67 It was not until 1937 that the official recording of cancer statistics in the New Zealand Official Yearbook included both crude and standardised rates. The standardized rates indicated a decreasing death rate and it was also pointed out that in 1935, 90 per cent of cancer deaths were over the age of 45 and 62 per cent above 60.68

The collection of statistical data was considered by the NZBECC from its inception. In the inaugural bi-annual meeting of the Medical and Research Committee of the NZBECC in 1929, it was concluded that it was desirable to collect statistics on every case that went through the consultative committees.69 More detailed statistical records increasingly became available as a result of the cancer consultation clinics set up by the NZBECC. The clinics began keeping detailed records of diagnosis and treatment of every cancer patient they saw or treated. One of the key aims of the NZBECC was to appoint research officers at each of the main public hospitals for collecting statistics.70 The result of this was that each

65 Evening Post, 10 Jan. 1933, in Diseases Cancer.
66 J.W. Butcher to Director General of Health, 19 Oct., 1929, Diseases Cancer.
69 NZBECC Minutes, 19 Dec., 1929, British Empire Cancer Campaign Miscellaneous Files, 1934-51,
70 NZBECC Secretary to Director-General of health, 8 Jan., 1930, Diseases Cancer.
cancer consultation committee included a registrar who was responsible for keeping the records. In 1932, Dr Roland Fulton, a surgeon at Dunedin Hospital (1924-51), was appointed to correlate the statistics for the NZBCC and visited the other main centres.\textsuperscript{71} Fulton saw the need to set up a department of records, and a uniform system. New measures were to be put into effect after consultation with the government’s statistical department to allow the central committee of the NZBECC to produce a report including the combined work of each of the main centres.\textsuperscript{72} One result of such statistical research was the ability to compare the effectiveness of different treatments. For example, the success rate of treatments can be gleaned from a report of cases of cancer in the lip at Wellington Hospital. From 1929 to 1931, the success rate of treatment without any recurrence after three years for 33 surgical cases was 78.7\% and for 23 cases of radium treatment 73.9\%.\textsuperscript{73}

A proposal to establish a statistical research department at Auckland Hospital was considered in July 1938 at the annual meeting of the NZBECC. Auckland would collect, collate, and report on the consultation clinic records for all divisions. It was envisaged that it would balance the special contributions from each local division: Wellington as the central administration for the NZBECC, the laboratory work in Dunedin, and radiophysics, discussed later in this section, in Christchurch.\textsuperscript{74} In May 1939, a provincial appeal for the establishment of an Auckland statistical research department began with the aim to raise £1,500.\textsuperscript{75} The appeal successfully raised £1,387 and moves were made to employ a statistical research officer, who was a medical professional, to carry out the work.\textsuperscript{76} By November 1939, a total of £1,647 had been raised and Dr F.F. Silberstein, a former professor of pathology at the University of Vienna, was appointed to the post in 1940.\textsuperscript{77}

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\textsuperscript{71} There is no evidence to suggest that Dr Roland Fulton was a relation to Dr Noel Fulton
\textsuperscript{73} Stout 3 Papers Relating to Treatment of Cancer- Miscellaneous Papers Relating to Courses at Wellington Hospital, 1929-1937, ANZW
\textsuperscript{74} Evening Post, 6 Jul., 1938, p. 19.
\textsuperscript{75} ibid., 1 May., 1939, p. 10.
\textsuperscript{76} ibid., 1 Jun., 1939, p. 22.
Radiotherapy was the final area of research activity. The details of the establishment of the National Radiation Laboratory (NRL) in 1937 were detailed in Chapter Five. The NRL was used to help standardize the treatment of cancer with radiotherapy across the four main centres in New Zealand.\textsuperscript{78} The NRL included two rooms that each had deep X-ray apparatuses; one was equipped with a 200 kilovolt apparatus and the other with a 300 kilovolts apparatus.\textsuperscript{79} Research undertaken in the NRL included collective research on the clinical effects of treatment, the development of physical methods of dosage, and biophysical research examining the reaction of living tissue to radiation. The researchers collaborated with staff from other hospitals with facilities for radiotherapy (whose calibration was managed by the laboratory’s physicists), the Cancer Research Laboratory in Dunedin, and with the University of New Zealand’s Department of Biology at Canterbury College. The scope of the research was broad and included experiments undertaken to develop precise measurements of radiation; overseeing the recording on physical treatment data to ensure standardized measurements and ensuring appropriately calibrated dosages; radiological experiments on plant membranes and animal tissue; examining the role of depth-dosage measurements and their correlation with absorbed energy and quality; and developing effective methods of radium distribution, and calibration of low-voltage X-ray therapy.\textsuperscript{80}

\textsuperscript{78} *Dominion*, 4 Sep., 1929, Diseases Cancer.

\textsuperscript{79} Travis Radiological Laboratory Report, Apr. 1937, British Empire Cancer Campaign Society Files, Records and Minutes, 1939-50, box 1, a963ch, ANZC.

\textsuperscript{80} ibid.
Conclusion

Across the 1910s and 1920s concerns over cancer led to public and political pressure for action against cancer. In response to this pressure, the government and the DPH/DOH played down the need for extensive investment into research. It advised that New Zealand needed to look to Britain, and particularly the ICRF, as the best place for research resources to be focussed; and that it was neither prudent nor practical for New Zealand to develop an independent research programme.

The development of a research programme in New Zealand occurred later than many comparable countries. As New Zealand was a small and isolated country, its initial level of research engagement was through statistical research and this later developed into a multifaceted research programme under the NZBECC. Partly this was because New Zealand did not possess any dedicated cancer institutions until 1929. The role of the DPH/DOH in directing responses to public health was also influential in shaping the research direction of New Zealand. From 1917-1927, a number of statistical research outputs were undertaken. The establishment of the NZBECC saw greater investment into research and a more multifaceted contribution to research. This remained, however, under the auspices of the NZBECC, as part of a global British Empire research community. Begg worked in tandem with British research agendas (and even in Britain from 1938) through his investigation of cancer causation. In addition to this experimental research, the NZBECC oversaw the establishment of a statistical research unit and cancer consultation clinics that included detailed recording of cancer cases in New Zealand; and finally, the NRL served a dual purpose as a cancer treatment centre and as a research centre in radiotherapy.
Section C

Alternative Responses to the Cancer Problem
Chapter Seven
Alternative Cancer Practitioners in New Zealand 1883-1907

If it is the era of surgery’s highest triumphs, it is also the golden age of the quack and charlatan.¹

The history of cancer has typically been written in institutional terms.² In response to physician-based history, social history positioned the medical profession in terms of social, economic, and cultural influences that shaped the rise of the medical profession to a position of significant influence over healthcare.³ However, as Judith Walzer Leavitt has argued, without a stronger inclusion of alternative medicine, there is a ‘distorted’ picture of the realities of medical treatments.⁴ Two American historians writing on alternative medicine, James Harvey Young and James Patterson presented a skewed perspective of alternative treatments and popular responses. They constructed alternative medical treatments in terms of deviance and quackery. The popular appeal of alternative medicine was explored through a framework of gullibility and ignorance.⁵

Other historical accounts have pushed the role of alternative medicine to the outside. Paul Starr argued that in America from the 1890s to the 1920s the medical

¹ New Zealand Tablet, 19 Feb., 1903, p.2.
profession gained hegemonic control over healthcare. In New Zealand, Michael Belgrave contested that from the late nineteenth century to 1939 the medical profession monopolized medicine through restricting professional membership, marginalizing non-professional practice, increasing its status and cultural authority, and forging strong political relationships. Belgrave also argued that alternative therapies were ‘pushed to the outside’ and ‘continued to survive but did not flourish’ and that the medical profession was not significantly challenged by alternatives until the 1980s. Barbara Clow, in her history of cancer in Ontario, suggested that this type of focus follows a traditional narrative that includes the rise of the medical profession, the decline of alternative medicine in the interwar period, and the ‘revival’ of alternative medicine from the 1960s. This is also the type of approach that has been used in studies of alternative medicine in New Zealand.

Recent historiography has pointed to a number of flaws with such perspectives: rather than decline it was argued that alternative medicine changed. In response to the relative exclusion of alternative medicine from historical accounts, or its biased representations, a number of historians have argued for a more balanced picture that presents the plurality of medicine. The predominant focus of much of this history has been on medical sects, like homeopathy, chiropractic, and osteopathy. Yet, little attention has been given to the role of lay practitioners and even less to popular experiences and beliefs in relation to their treatments. In addition to this, Clow argued that histories that solely focus on alternative

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7 Michael Belgrave, “‘Medical Men” and “Lady Doctors”: The Making of a New Zealand Profession, 1867-1941, PhD Thesis: Victoria University, 1985, p. i.
9 Clow, p. xv.
practitioners and their relationship to the medical profession marginalized the role of patient perspectives. 13

My approach to the history of cancer and alternative medicine has drawn on several key frames from Clow’s work. Clow argued that the traditional narratives of alternative medicine indicating an interwar decline are wrong. Indeed, alternative therapies were a ‘persistent phenomenon’ throughout the twentieth century. 14 I argue that the concept of the rise in the medical profession is overstated and that alternative practitioners, particularly lay practitioners outside the sphere of medical influence, were a persistent phenomenon throughout the early twentieth century. A model of decline is insufficient; however, a model of continuity is more appropriate given the prominence and popularity of many alternative cancer theories and cures. I also argue that the examination of alternative practitioners has the advantage of considering the plurality of cancer treatment. More importantly, though, it illuminates the dynamics between the medical profession, health institutions, governments, and alternative practitioners. Of particular importance in this thesis is what Clow has termed a ‘confrontation between perspectives’. The encounter between medical professionals, government authorities, and alternative practitioners indicates that there were ‘incompatible interpretations’ and approaches to disease and treatment. 15 This section argues that it is necessary to look beyond idiopathic frameworks of gullibility and ignorance and the decline of alternative medicine, to create an inclusive account that examines the interactions of different perspectives. In order to achieve this, I discuss a broad range of perspectives relating to alternative medicine including those from the medical profession, alternative practitioners, the press, and patients. It reveals a series of different interpretations of cancer and its treatments, including conflicting encounters between the medical profession and alternative practitioners; patient

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15 Clow, Negotiating Disease, p. xi.
motivations for seeking out alternative therapies and avoiding surgery; and provides a more balanced representation of alternative practitioners.

This chapter focuses on the role of non-sectarian lay practitioners in New Zealand in the 1890s and 1900s. It seeks to explain their interactions with the medical profession and patients; their popular appeal outside of negative frameworks; and to establish the prominence of alternative medicine. In doing so, it acts as the first part of an argument for continuity in alternative medicine. The chapter is divided into three sections. The first section uses the case study of Milner Stephen, a magnetic healer, to introduce key themes relating to alternative medical treatments of cancer during this period. These themes are developed and expanded on in two more detailed case studies on Thomas Hullett and William Stanton, prominent alternative practitioners who were also involved in cancer treatment.
Milner Stephen and Conflicting Perspectives

In 1883, Milner Stephen, a former barrister turned magnetic healer, came to New Zealand from Australia to promote his methods of cancer cure. He had previously been touring Australia purportedly curing cancer patients. His methods were described as including red flannels and vials of healing liquid. It was reported that Stephen’s story was one of divine providence. After praying to God to give him the power to do wonderful work, he found himself able to heal.16 This ‘laying on of hands’ had no shortage of testimonials from Australia and according to reports Stephen had an affidavit from Melbourne medical officers at St. George Hospital confirming his ability to cure cancer.17

The case of Stephen can be linked with Clow’s concepts of conflicting perspectives, where ‘incompatible interpretations’ of disease and its treatment interact.18 Through examining the encounter between the medical profession and Stephen, a series of different interpretations are revealed. Medical professionals were prepared to actively confront Stephen’s public performances in an effort to discredit him but their efforts only aided Stephen in gaining notoriety.

In 1884, after Stephen had been touring New Zealand for a year and while he was in Invercargill, some local medical professionals publicly challenged him to prove he was bona fide produce confirmation of his work. In an effort to discredit Stephen, a hospital surgeon, Dr Joseph Wardale, produced a patient for Stephen to heal and offered to pay his full fee. Wardale believed that ‘seeing is believing’ and that Stephen should ‘do something local’. Stephen did not comply and continued with his show. He repeated his testimonials and produced a phial containing some ‘roots of cancer’, appealing to metaphorical associations with cancer being an

16 Hawera and Normanby Star, 10 Jan., 1883, p. 4
17 Grey River Argus, 8 Jan., 1883, p. 2; on other tours see the Wanganui Drill Hall: Wanganui Chronicle, 13 Feb., 1883, p. 2; and the Christchurch Academy of Music: Christchurch Star, 26 Feb., 1883, p. 3.
18 Clow, Negotiating Disease, p. xi.
insidious disease that created a vice-like death grip. According to reports of this encounter, Wardale proclaimed, that ‘No medical man on earth that knows his profession would say that a cancer has roots’. Stephen appealed to his audience by combining a physical object with metaphorical understandings of what cancer was like. In contrast, Wardale appealed to the authority of scientific medical knowledge based on his medical training. Stephen’s response was hostile: ‘Am I to stand upon my defence before a board of doctors?’ This appeal by Stephen was intended to draw on popular suspicion of the motives of the medical profession. This theme is teased out below in respect to commentary by medical professionals concerned about public scepticism of their motives.

In August 1884, the conflict between Stephen and the medical profession reached its peak. When Stephen was in Dunedin, the ‘medical men’ of the city challenged him to prove that he had cured internal cancer by his healing power. Dunedin surgeons, Dr Ferdinand Batchelor and Dr John Brown, and professor of anatomy and physiology at Otago Medical School, Dr Miller Coughtrey, represented the medical profession. The doctors brought their own patient but ‘neither the patient nor ... Stephen w[ere] ready to acquiesce [to] this’. Instead, the doctors agreed to assess an alleged case that Stephen had cured. After ‘considerable persuasion’, indicative of Stephen’s resistance and concern over being set up, Stephen consented. After Brown examined Stephen’s patient he proclaimed that the case ‘was cancer, that it is cancer, and that it is not cured’. Brown drew on his own authority as a medical professional with appropriate expertise to conclude that in fact the ‘cancer has increased considerably’. The reporting of the incident in the papers was damning. An article entitled, ‘Milner Stephen’s Humbug’, argued that in this encounter Stephen was put to ‘great shame’.

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19 For examples of cancer roots see Otago Witness, 3 Sep., 1881, p. 28; Otago Daily Times, 28 Jul., 1884, p. 3; the description of cancerous roots can be traced far back in Western intellectual traditions, Patrick Fitzgerald, From Demons and Evil Spirits to Cancer Genes: The Development of Concepts Concerning the Causes of Cancer and Carcinogenesis, Washington: American Registry of Pathology, 2000, p. 29.
21 Hawera and Normanby Star, 5 Aug., 1884, p. 2.
22 West Coast Times, 16 Aug., 1884, p. 3.
The fact that this negative publicity aided Stephen is indicative of a current of popular support for alternative remedies that was sceptical of the medical profession’s methods and motives. It was reported that as a result of the publicized encounter, far from affecting Stephen’s business, it ‘brought him new notoriety’. Stephen decided to stay in Dunedin after receiving an influx of patients. In 1886, there continued to be reports on Stephen’s actions in Dunedin and it seemed he had set up permanent residence. Stephen gained success and notoriety through an incident that allegedly discredited his methods. This reflects the fact that despite the disapproval of the medical profession, many individuals continued to seek out alternative practitioners.

Stephen’s patients wrote to newspapers telling their stories of miraculous cures. Through patient testimonials, it is possible to gain insight into patient motivations for seeking out alternative practitioners and popular beliefs about the medical profession and their methods. For example, Margaret Farquhar recounted her perceived experience of cancer in the womb from 1879 to 1884. In 1884 she claimed that she had consulted five medical professionals (including Brown and Coughtrey) who indicated that surgery was her only chance. Farquhar was informed that, given the fact that she was 55, she would probably not survive the operation, a common feature of cancer surgery in the 1880s. She resolved to seek out Stephen who used a magnetic salve, oil, and water with his healing hands (possibly massage) to draw out over two quarts of cancer. The swelling went away and Farquhar believed that the ‘cancers are conquered’. Cancer sufferers, like Farquhar, were motivated to seek out alternative practitioners. Of importance is the fact that these motivations link with the theme of hopelessness discussed in Chapter Two. In particular, patients either abandoned the medical profession in favour of alternative treatments or were abandoned by the medical profession as hopeless cases. The influences that drove patients to seek out alternative practitioners are also a prominent area of discussion in the case studies that follow.

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23 ibid.
24 North Otago Times, 3 Apr., 1886, p. 3.
In Stephen’s case, the medical profession was prepared to challenge the efficacy of alternative practitioners’ treatments. Stephen is not an isolated case and criticism of quackery by the medical profession was a persistent phenomenon. The medical market place and the motives of the medical profession are areas that have been well addressed in historiography. Roy Porter argued that in the late eighteenth century and early nineteenth century alternative practitioners and the medical profession were in ‘collusion’ rather than ‘collision’.26 Across the late nineteenth century and into the twentieth century this changed and there was a shift towards a competitive model. New Zealand’s medical profession increasingly attempted to monopolize medical treatments.27 The medical profession often openly criticized alternative practitioners citing facts to show that they believed these individuals were hoodwinking the public.

Perhaps the best testimony of the success of alternative therapies in the medical marketplace — and many were successful — is the response by medical professionals and public health authorities. Important medical professionals were outspoken against the prominence of all forms of quackery. In terms of cancer, contemporary definitions of quackery from medical and public health authorities could encompass all manner of treatments outside of the domain of the medical profession. Folk remedies, both honest and dishonest practitioners, popular beliefs, and patent medicines were all considered forms of quackery that potentially resulted in delay and even death for cancer sufferers. Dr James Mason, the Chief Health Officer in the Department of Public Health (DPH), in a 1906 lecture in Wellington, referring to the prominence of alternative remedies in newspaper advertisements, claimed that ‘a future archaeologist would think they were a race of fools’.28 In 1907, Dr Louis Barnett, a noted surgeon and the current President of the New Zealand Branch of the British Medical Association (NZBMA), had an equally negative view:


There is in New Zealand a large body of people whose serene simplicity affords a comfortable and luxurious living to the ... horde of quacks.... [and the people] prefer the treatment of the quacks to that of orthodox practitioners.29

Unfortunately, as Barnett pointed out, for registered medical professionals, there would always be a ‘brisk demand’ for alternative treatments and ‘the supply will meet the demand’.30 Mason’s response to different promises of cure was clear: ‘they are all liars.’31 It was in proving that they were liars that led to conflicts. The problem for the medical profession was that their opinions were regularly perceived as self-interested. Barnett commented that any ‘denunciations’ by orthodox medicine ‘fall upon unsympathetic ears’ as doctors were regarded as ‘biased’, ‘jealous’, and ‘self-interested’.32 One cynical article reported that if one of Stephen’s patients died, his response would be, ‘I told you so. You have been calling in a doctor again, and this is the result’.33 Criticisms of the medical profession and their treatment methods are a prominent theme which will be explored throughout the remainder of the thesis. This section argues that in addition to perspectives like those of Barnett, which portray quackery in terms of gullibility, the popularity of magnetic healers, like Stephen, could also be viewed as a rational response.

29 New Zealand Tablet, 7 Mar., 1907, p. 23.
30 ibid.
32 New Zealand Tablet, 7 Mar., 1907, p. 23.
33 Otago Witness, 1 Apr., 1887, p. 21.
In the 1890s, New Zealand had its very own famous cancer curer: Thomas Hullett, a grocer in Armagh Street, Christchurch. This case study examines a diverse range of perspectives in relation to Hullett’s treatments. The medical profession’s criticism of Hullett, Hullett’s criticism of the medical profession, and patient perspectives reveal a contradiction in sources surrounding the manslaughter trial of Hullett. Newspapers condemned Hullett, and typically described him, like most alternative practitioners, as a quack. In contrast to this, other sources indicated that Hullett was highly regarded. In addition, patient testimonials reveal a negative perspective on surgery. This contrasts with the positive representations of surgery made by medical professionals discussed in Chapter Four. In many instances, surgery was not progressive but, like the theme of hopelessness discussed in Chapter Two, it often led to failure and there were negative perceptions over its efficacy.

Hullett’s own personal experience is what motivated him to become a cancer curer. In 1892, he discovered a pimple developing on his lower eyelid and an unnamed Christchurch doctor diagnosed it as cancer. The doctor’s recommendation was ‘the knife as soon as possible’. Hullett underwent surgery but the cancer returned before the wound healed properly. When Hullett returned to the doctor, he attempted to remove the grains of sand from Hullett’s eye and claimed that ‘it would be all right now’. When this failed, a second operation was undertaken unsuccessfullly. Following this, another doctor was brought in to consult on the case. It was suggested that ‘there was no hope but in another operation’. The operation that the doctors suggested was radical: one doctor ran his finger around Hullett’s eye and suggested ‘that all this must be

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34 Thomas Hullett, Cancer Is Curable. Being References to the Recent Trial of Thomas Hullet of Christchurch, for Manslaughter, Christchurch: Russell, Willis & Aiken, 1897, p. 2.
35 ibid., p. 2.
removed’.\textsuperscript{36} After suffering from three failed medical interventions, and the prospect of another dangerous operation, Hullett, following two days of deliberation, ‘decided to die’.\textsuperscript{37} Like many of his future patients, Hullett lost faith in the medical profession’s ability to cure his ailment: ‘the knife only aggravated the disease’. From this account, negative experiences relating to orthodox medical interventions are evident. Not only did surgery fail to cure Hullett’s cancer but according to his narrative it made the condition worse. Hullett considered his experience with surgery to be so terrible that death was a better option.

After resolving to give up on surgical intervention, Hullett sought out alternative remedies to cure his cancer. According to his own account, in 1893, in Honolulu, a non-professional man cured Hullett of cancer.\textsuperscript{38} Hullett obtained this ‘secret’ remedy and returned to New Zealand in 1896 to cure others of cancer.\textsuperscript{39} A letter from Hullett’s grandson, A.G. Hullett, to G.W. Russell, the Minister of Public Health, in 1917 reveals the nature of this secret remedy: ‘Chromic acid diluted with Vinegar, equal parts, apply with camel hair brush two or three times weekly’.\textsuperscript{40}

Upon his return to New Zealand, Hullett unsuccessfully attempted to get registration as a medical practitioner. The issue of Hullett’s practice reached a parliamentary level in 1896 and received a referral to the government by the petitions committee, with the strong support of Russell, member for Riccarton at the time. Hullett’s petition asked for an amendment to the current law to enable the medical registration of non-professional individuals to practise the cure of cancer. One petitioner ‘prays’ for the law to be amended to allow Hullett to practise as ‘an expert’; and another petition was made in 1897 that asked for an amendment to give a license to ‘any person’ ‘capable of curing cancer’.\textsuperscript{41} The basis of this was that Hullett claimed he had been ‘indisputably’ successful in a number

\textsuperscript{36} ibid.  
\textsuperscript{37} ibid.  
\textsuperscript{38} ibid.  
\textsuperscript{39} Evening Post, 8 Oct., 1896, p. 2.  
\textsuperscript{40} A.G. Hullett to G.W. Russell, Diseases Cancer, H1 1957/131/16, 1908-1920, Archives New Zealand Head Office (Wellington), (ANZW).  
\textsuperscript{41} Reports of Public Petitions A to L Committee, AJHR, I-01, 1896, no. 140, p. 5; Reports of Public Petitions M to Z Committee, AJHR, I-02, 1897, no 194, p. 5.
of cases and that a ‘non-professional’ practitioner in Honolulu had a similar license granted.\textsuperscript{42} Political commentary indicates that some quarters of New Zealand society believed that the medical profession was motivated by monopolizing treatment practices. Russell wanted the government to look into the matter but was sceptical about the bias of the medical profession. Russell warned that ‘enquiries should not necessarily be made by a medical man, as unfortunately medical men were extremely jealous of interference by amateurs’.\textsuperscript{43} Unfortunately for Hullett, the Medical Practitioners Registration Bill in 1896 reinforced the legitimacy of formally qualified practitioners and further restricted medical practice.\textsuperscript{44} Hullett was not given registration but he could continue to practise until it was proved that he contributed to the death of a patient.

Things came to a head in 1897 when a patient, William McAliece, a commercial traveller, died.\textsuperscript{45} Hullett was charged with manslaughter for administering chromic acid to the external skin around the tumour.\textsuperscript{46} Newspapers condemned Hullett and focused on his lack of expertise and official registration. The headlines from the \textit{Poverty Bay Herald} made its opinion clear: ‘A Quack Arrested’, ‘A Christchurch Quack’, and ‘Improper Treatment of Cancer’.\textsuperscript{47} Others labelled Hullett ‘an unqualified practitioner’ who ‘had been practicing without a certificate’.\textsuperscript{48} The coverage of the trial focused on the medical testimony relating to Hullett’s treatment. Dr William Symes, a Christchurch practitioner and former navy surgeon, concluded that ‘the chromic acid treatment hastened [McAliece’s] death’.\textsuperscript{49} According to Symes, ‘such treatment in cases of cancer was dangerous’ and McAliece would have lived for four more years had he not received improper treatment.\textsuperscript{50} The reporting of the trial in the press focussed on Symes’ testimony which gave a perspective that condemned Hullett’s treatment despite the fact that Symes had not observed the treatment or the patient before his death.

\textsuperscript{42} Hullett, p. 1.
\textsuperscript{43} \textit{Evening Post}, 8 Oct., 1896, p. 2.
\textsuperscript{44} \textit{New Zealand Parliamentary Debates}, NZPD, 92, Wellington: Govt. Printer, 1896, pp. 218-9.
\textsuperscript{45} Marlborough Express, 11 Aug. 1897, p. 2.
\textsuperscript{46} ibid., 4 Aug., 1897, p. 2.
\textsuperscript{47} \textit{Poverty Bay Herald}, 3 Aug., 1897, p. 2; 11 Aug., 1897, p. 2.
\textsuperscript{48} \textit{Timaru Herald}, 30 Jul., 1897, p. 2; ibid., 3 Aug., 1897, p. 2.
\textsuperscript{49} \textit{North Otago Times}, 3 Aug., 1897, p. 3; \textit{Evening Post}, 3 Aug., 1897, p. 5.
\textsuperscript{50} Marlborough Express, 11 Aug., 1897, p. 2.
Some of Hullett’s patients, by contrast, wrote to defend him, including Margaret McAliece, the wife of William McAliece. Hullett published a pamphlet, entitled, ‘Cancer is Curable’, with testimony from the trial and letters from his patients in support of his methods. Four people gave evidence in favour of Hullett, but as a letter to the The Press from J.L. Wilson reads, ‘he could have got scores and scores of them’. Of importance is the fact that many of the media reports of the trial ignored the testimony of Margaret McAliece. She wrote to the The Press and rebutted the medical evidence: ‘In reply to this I would state that in my opinion instead of “shortening life” it was prolonged. Don’t you think it would have been more to the benefit of the public in general if you had given both sides of the question?’ Hullett’s pamphlet published these letters and the sworn evidence given in court.

William McAliece’s account, as given by his wife Margaret, detailed the experience of his cancer treatment from the medical profession and Hullett. Margaret McAliece told the court that her husband had been suffering for twelve months from a tumour in his neck. In February 1896, Brown, a Dunedin Hospital surgeon, operated on it. A second operation left William’s neck ‘terribly cut about’ and the tumour grew very fast after this operation. The tumour grew towards his throat and caused a great choking sensation, ‘greater pain’ than he had suffered before. Since the second operation, he was unable to take solid food. On September 11, the doctors went to attempt a third operation but concluded that ‘if they had performed it her husband would never have left the table alive’. Surgery had not improved things for William. If anything, Margaret claimed, the operation made things worse. The tumour was initially on the left side of the neck behind the ear and ‘caused no pain and little inconvenience’. After the wound had healed from the operation the tumour began to grow again ‘from the size of a pea to a good sized orange’ ‘spreading towards the jaw and round towards the front of the

51 Hullett, p. 23.
52 ibid., p. 22.
53 ibid., p. 9.
54 ibid., p. 7
throat’. The impression from her testimony indicates that surgery made the condition worse: after the operations, there was a ‘greater pain, in fact, than he had suffered before’. This experience can be read in parallel to Hullett’s experience. Surgery was often ineffective and sometimes appeared to make things worse.

William McAliece travelled to Christchurch in November 1896 and sought Hullett’s care. This was not a case of an alternative practitioner preventing medical practitioners from curing cancer. The reality was the surgeons had abandoned William McAliece as incurable. Margaret was ‘very glad for anyone to undertake the case when the doctors refused to attend it further’. The tumour growth had been ‘pressing on his windpipe’ and William was afraid of ‘being choked’ before he reached Christchurch. On arrival he was ‘in good spirits’ and ‘very hopeful’ of a cure. Hullett’s system consisted of painting the tumour with a dark liquid. This was meant to ‘draw the tumour away’ and ‘for some months it had that result’. It drew out the tumour ‘in the shape of decayed flesh and matter’. Hullett painted it three or four times a week, and then this declined to about once a fortnight. The painting caused ‘very severe’ pain for a short time in the first month or two but ‘gradually lessened’ over time. Margaret, on Hullett’s instructions, used to wash the tumour four times a day in warm water, which was followed by a cloth covered with lard or vaseline. The effects of this washing ‘kept the tumour sweet’ and ‘kept the smell away’. ‘He always seemed better when the pain had subsided’ claimed Margaret. ‘Relief’ was the result of Hullett’s treatment and William could ‘always swallow better after the painting’. While Hullett’s treatment did not affect a cure, it did relieve some pain with ‘no pressure on the windpipe after the first three months’. It is evident from the reporting on the trial that a one-sided picture was presented. By looking at patient perspectives

55 ibid., pp. 8-9.  
56 ibid., p.7.  
57 ibid.  
58 ibid., p.9.  
59 ibid.  
60 ibid., p.10.  
61 ibid., pp.8, 10.  
62 ibid., p.11.  
63 ibid.  
64 ibid., p.8.  
65 ibid., pp. 8-9.
in Hullett’s publication, it is possible to see a more complete picture from the differing perspectives.

Some important points are evident in Margaret’s testimony. The effects of surgery were unsuccessful and made life for William more painful and difficult. In desperation to try to improve his condition after the medical profession abandoned him, William sought out an alternative practitioner renowned for cancer cures. While the treatment was not ultimately successful in the removal of the disease, it was successful as a palliative. Clow argues that in the popular mindset, pain was the primary symptom that defined being sick or well. Disease associations, particularly cancer, were commonly associated with pain and suffering. Hullett’s treatment alleviated the pain and, for some time, improved the condition.

After the trial, which resulted in a not guilty verdict, Hullett refused to continue practising. He did not want to risk a guilty verdict the next time someone under his care died. A number of cancer sufferers pressured the government and the issue of Hullett’s medical registration came to parliament again in 1897. Joseph Ward, Liberal member for Awarua since 1887 and a former minister and colonial treasurer, received a letter from a Christchurch family who wanted the government to allow Hullett to practise because the medical profession had given up on one member suffering from cancer. The Premier Richard Seddon replied that one of his oldest and dearest friends had ‘begged and prayed’ the government to allow the ‘cancer expert’ to take his case. Seddon stated that he would be happy for a clause to be added to the 1896 Medical Practitioner’s Registration Bill, but warned that if it met strong opposition, ‘it would be useless to bring it forward’. Hullett’s attempt to be registered was seen to be a battle not worth fighting in the face of strong medical opposition. While the registration did not go forward, it is clear that significant politicians were not opposed in principle to Hullett’s practice. This links in with Michael Belgrave’s commentary on this time period when governments

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67 NZPD, 100, 1897, p. 661.
were wary of giving the medical profession excessive and exclusive authority.68 While this ended Hullett’s practice as a cancer curer, his pamphlet provides some interesting evidence of patient experiences.

Thomas Kenshaw’s testimonial is reproduced in Hullett’s pamphlet. It includes similar themes to Margaret McAliece’s testimony. It also provides some illumination into another significant theme: the role of informal networks in relation to sickness. Kenshaw began his account with his recollection of how it felt: ‘The sensation was very painful and peculiar’. Pain led to the suspicion of sickness and Kenshaw first consulted with a friend who had a relative afflicted with cancer. After listening to his description and seeing the pus that was evident from sores on his right cheek and eye, his friend concluded that Kenshaw had cancer.69 On the advice from his friend, Kenshaw consulted a chemist. The chemist confirmed it was cancer and insisted that Kenshaw see a doctor. Kenshaw then visited a medical professional of ‘great repute’ and he took some of the pus for microscopic examination. The doctor wanted to ‘cut the cancer out, scrape the bone and burn it with nitric acid’. ‘This I declined to submit to’, wrote Kenshaw. Kenshaw declined to accept the authority of the medical profession and refused to submit himself to the perils of surgery. Hullett also confirmed the diagnosis of cancer and Kenshaw claimed he was cured with only two scars left as evidence of his affliction.70

Informal networks such as friends and family were important factors in shaping sufferers’ responses to disease. Information from family, friends, and communities often took priority over medical professionals’ advice.71 Snippets of evidence, like the example of Kenshaw, indicate that informal networks existed and that consultation with friends and family and chemists were commonplace. This becomes more conclusive when considering the need for education campaigns to encourage sufferers to consult doctors at an early stage, as discussed in Chapter Four. These education campaigns responded to the fact that some sufferers sought

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69 Hullett, p. 19.
70 ibid.
71 Clow, Negotiating Disease, p. xiii.
advice on healing outside of the medical profession. There was no monopolisation of medical treatments and ‘having heard and seen’ some of Hullett’s cures, Kenshaw chose to favour an alternative practitioner.\textsuperscript{72} In addition to Kenshaw, other examples of Hullett’s patients also used informal networks to seek out alternative practitioners. For example, John Reeve came to Hullett through first-hand knowledge. He had witnessed Hullett’s successful treatment of William Craze, whose condition was worse than his, as well as Joseph James’ daughter among ‘others I could name’.\textsuperscript{73} Even Seddon has received word from friends of the success of Hullett the cancer curer. Hullett used individuals who had been successfully treated for advertising.

Another patient of Hullett’s, Elizabeth Clarke, also presents a story that gives a negative impression of the medical profession and a positive impression of Hullett. In 1894, she found a small lump, about the size of a pea, growing on her windpipe. After seeing a doctor for six months, her throat ‘continued to get worse’. By May 1895, it was as large as a marble but by November it had become ‘as large as a hen’s egg’. Descriptions of the size of a tumour are common, for cancer was a far more visible phenomenon at this time than in the present day. Despite some authorities’ explaining away cancer’s increase due to demographics, the reality of most people’s experience was that with its numerical increase cancer was more physically visible than ever before.\textsuperscript{74} Clarke was informed that her tumour was malignant but that operating on it was risky because the cancer was rooted to her windpipe, her jugular vein was in the way, and she had a weak heart. Clarke was told that she would die within three months if she did not take the operation. She refused and found herself ‘growing weaker and weaker’ and having to live on ‘sops, soup, broth, and boiled milk with an egg beat up into it’. She was scared of being choked and she wrote ‘it was terrible what I had suffered’. Clarke fell into a state of ‘despair’ and her friends believed he was at ‘death’s door’. In this state she tried Hullett’s cancer cure and in six weeks was able to take food and was ‘completely cured’ after three months, gaining twenty-one pounds. ‘I am sure it was he who

\textsuperscript{72} Hullett, p. 19.  
\textsuperscript{73} ibid., p. 23.  
\textsuperscript{74} On the visibility of cancer see Clow, Negotiating Disease, p. 14.
saved my life’, Clarke proclaimed. Clarke’s case also brings up some common points in the testimonials. The description of the tumour and suffering was common in patient accounts. In addition to this, the initial failure of surgery and her later refusal of surgery and fear of the knife are common themes.

A number of other similar cases reinforce these themes. Ruth Gerr indicated that over eight years she saw several doctors in Dunedin for her cancer, and had ‘taken chloroform’ forty times for operations. Her ‘sufferings were terrible’ and her ‘strength’ ‘greatly reduced’. Here surgery equated with failure and suffering. Margaret Douglas had consulted three doctors in Christchurch and had been operated on three times. For six years, she continued under their treatment unsuccessfllly. Lily James’ testimony also claimed that her doctor’s treatment ‘did no good’. Doctors abandoned William Craze, a farmer, after two operations. Craze went ‘through two surgical operations’, by Christchurch hospital surgeons, Dr Henry De Renzi and the late Dr Henry Prins: ‘They said it was a malignant recurrence tumour; there was nothing for it but to go through successive operations for the term of my natural life’. Thus, the failure of surgery and the nature of cancer as a recurring disease contributed to individuals seeking out less risky and less painful alternatives.

Some individuals refused surgery entirely. Robert Leask was told that his doctor could cure him of cancer of the lip, but he chose Hullett instead. Mrs McCaughan had trouble in her eye ‘which the doctors said was cancer’. They attempted several remedies before recommending an operation. Instead, she sought out Hullett’s treatment. J. James chose Hullett over surgery for his daughter’s tumour in the neck: ‘Some time ago my daughter suffered with a tumour on her neck. I consulted two local doctors who told me the only remedy was the knife. Hearing of your

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75 Hullett, pp. 21-22.
76 ibid., p. 12.
78 ibid., p. 13.
79 ibid.
80 ibid., p. 15.
82 ibid., p. 17.
treatment I brought her to you, and have now much pleasure in testifying that after three months' treatment the tumour came away.' From the testimonial evidence, it is clear that surgery failed for many patients and that other patients refused surgery and chose to try less invasive methods.

Hullett’s intervention was attractive because it offered a less invasive option to sufferers and was supported by testimonial evidence of successful cures. Margaret Douglas deposed in court that Hullett also ‘painted her face with a brown liquid’ and that the application was ‘not very painful’. Lily James had a lump by her right ear as big as a hen’s egg. For six months Hullett painted her, causing pain for half an hour after being put on, and it had been eighteen months since treatment ceased and she was ‘quite well ever since’. William Craze’s testimonial confirms a ‘dark liquid’ and a ‘stinging pain’ was used for a tumour in his hip that made the cancer ‘come to an ulcer and sloughed’ before coming off entirely. The message from this was, as John Reeve put it, after suffering and the failure of experts, like Sir Morell Mackenzie of the Golden Square Throat Hospital in London, that Hullett could cure ‘without resorting to the doctor’s knife.’

The case study of Hullett reveals a diverse array of conflicting perspectives relating to the efficacy of cancer treatments. Surgical methods and the medical profession, with the backing of newspapers, attempted to discredit Hullett’s cancer cure at trial. The other side to this was that Hullett’s patients and Margaret McAliece, the wife of William McAliece, gave sworn evidence, wrote to the newspapers, and gave testimonials to support Hullett. Hullett even received support from high places on the political spectrum. Through his own experience, his patients’ testimonials, and his publications to try to counteract criticism, Hullett challenged surgical intervention. In addition to this, this case study also demonstrates insight into patient perspectives of health. It is clear that there was a

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83 ibid., p. 18.
84 Hullett, p. 13.
85 ibid.
86 ibid., p. 15.
87 ibid., p. 23.
popular fear of the knife and people often favoured less radical treatments with less pain. The testimonials tie in with Chapter Two’s discussion of the theme of hopelessness that indicates the failure of surgery to combat cancer and often patients were abandoned by the medical profession altogether. What is also evident was the role of informal networks in advice. People chose to consult friends and family about illness and could visibly see cases of cancer and they based their decisions on this information.
The *Truth* about William Stanton, the ‘Hoary-Headed Holy Hypocrite’

Suck sickening slimy slush and silly nonsense is enough to make us wonder whether it was not intended for circulation inside a lunatic asylum, and even [they] would think twice before being taken in with such specious rot (*Truth*).

My Dear Stanton, I cannot allow you to leave Auckland without expressing something of the deep gratitude I feel to you for the good you have done me (Dr Robert Bakewell).

William Stanton reveals two competing stories over the efficacy of cancer interventions. Like the Hullett case study, one story has evidence that favours the medical profession and the other favours alternative practitioners. Stanton was a saviour on one side and a quack on the other. Stanton’s practice illustrates how alternative practitioners could be successful in a competitive medical market place. Advertisements, inquests, court cases, and *N.Z. Truth’s* campaign against quackery all provide evidence of how Stanton operated his practice.

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88 *NZ Truth*, 30 Mar., 1907, p. 5.
89 *ibid.*, 27 Apr., 1907, p. 8.
From 1895, Stanton practised in Auckland and promoted his practice through advertisement.\textsuperscript{91} He had previously been a clerk, schoolteacher, and a second-hand dealer.\textsuperscript{92} From 1898, there were regular advertisements promoting Stanton’s ‘massage infirmary’ in Hobson Street, ‘opposite St Mathew’s Church’, for both internal and external cancers. His practice acted as an infirmary and treated both outpatients and inpatients.

Stanton’s advertising took advantage of the local factor. Circulars were distributed that listed the names, and addresses of local patients that he claimed to have cured. This played on the role of informal networks through advertisement and this gave Stanton’s practice legitimacy through local successes. His advertising also drew on negative popular impressions of surgical intervention and emphasized the fact that he cured these ‘without the knife’.\textsuperscript{93} Stanton aimed to give the impression of legitimacy to his practice and referred to himself as a doctor.

In addition to his Auckland practice, Stanton toured the country offering his services. For example, in 1899 it was advertised that ‘Dr. Stanton of the cancer infirmary’ was coming to Thames and set out times for consultation.\textsuperscript{94} He continued his touring strategy when he moved his practice to Dunedin in 1902.\textsuperscript{95} For example, one advertisement stated that Stanton, the ‘cancer specialist’ was to visit Milton and included a warning that patients wanting ‘to avoid disappointment’ should ‘please call early’.\textsuperscript{96} He did not limit himself to places he could attend but also offered the option of consulting by mail through a questionnaire: ‘Patients at a distance wishing to be treated by Stanton ... will please write for a printed question form, and enclose a stamp for a reply. Medicine sent to all parts of the colony.’\textsuperscript{97} Stanton was an effective businessperson who managed to offer his services all around the country.

\textsuperscript{91} Otago Witness, 27 Feb., 1901, p. 24.
\textsuperscript{92} ibid., 20 Feb., 1901, p. 38.
\textsuperscript{93} Ohinemuri Gazette, 27 Aug., 1898, p. 2.
\textsuperscript{94} Thames Star, 28 Nov., 1899, p. 2.
\textsuperscript{95} Ashburton Guardian, 2 Jun., 1904, p. 3.
\textsuperscript{96} Bruce Herald, 16 Jun., 1903, p. 5.
\textsuperscript{97} Tuapeka Times, 18 Apr., 1903, p. 1.
Like most alternative practitioners, significant evidence about Stanton’s practice only becomes known in the face of controversy. In 1899, Stanton made the news after a fifty-year-old woman, Mrs Agnes Hayden, suddenly died at his infirmary.\textsuperscript{98} Through evidence of negative reports about Stanton’s practice, it is possible to draw out conclusions about his prominence and popularity. Hayden had been suffering from an incurable form of cancer, diagnosed by registered medical professionals, but was being treated by Stanton.\textsuperscript{99} Hayden had been an ‘indoor’ patient for two months and her cancer had reportedly been ‘progressing satisfactorily’.\textsuperscript{100} It was reported that Stanton ‘has had indoor patients from all over the colony’, and in addition to Hayden, he had other patients from Dunedin and New Plymouth at the same time.\textsuperscript{101} This suggests that alternative practitioners, like Stanton, developed a national level of prominence and attracted patients from across the country.

Stanton remained secretive about his treatment methods. At the inquest, he refused to divulge his secrets, but what we do know is that in this case he used two types of liquids. One burned the skin while the other soothed the skin afterwards.\textsuperscript{102} Like Hullett, much was made of the fact that he was not a ‘qualified practitioner’ and had no ‘medical certificates’.\textsuperscript{103} Despite this, the inquest’s jury found no evidence of fault in Stanton’s methods.\textsuperscript{104} In response to the case, James Mason, parliamentary secretary of the New Zealand Branch of the British Medical Association (NZBMA) and soon to be the first Medical Officer of Health in the DPH, took the opportunity to attack quackery. He stated that ‘despite many testimonials’ there was not a single authenticated case of a cure by these ‘vaunted remedies’.\textsuperscript{105} The strong antagonism against alternative practitioners from the public health representatives is perhaps the best testament to alternative practitioner’s widespread popularity.

\textsuperscript{98} Otago Witness, 18 May., 1899, p. 28.  
\textsuperscript{99} Poverty Bay Herald, 16 May., 1899, p. 2.  
\textsuperscript{100} Marlborough Express, 18 May., 1899, p. 4.  
\textsuperscript{101} ibid.  
\textsuperscript{102} ibid.  
\textsuperscript{103} Otago Witness., 18 May., 1899, p. 28.  
\textsuperscript{104} Evening Post, 23 May., 1899, p. 5.  
\textsuperscript{105} Poverty Bay Herald, 1 Jun., 1899, p. 4.
In 1901, Stanton returned to prominence in the press when the medical profession took exception to his use of the title of doctor. Even pictures of Stanton, as included at the beginning of this section, gave the impression of respectability and looked like an image of a doctor. At this stage, ‘Dr’ Stanton, the ‘cancer specialist’, had moved to High Street in Auckland. Stanton had been sending around ‘handbills’ stating that he was a ‘specialist of many years’. His advertising posits him as cancer sufferers’ last hope after the failure of the medical profession to affect a cure: ‘where Dr Stanton fails to relieve pain or cure diseases other medical men stand aside and weep.’

While the medical profession was unlikely to weep when Stanton failed, this language acts to position Stanton’s level of knowledge and skill above the medical profession. Such promotion of his expertise, to the denigration of his competitors, clearly hit a nerve. However, it was Stanton’s representation that he was a registered medical professional that gave leeway for him to be prosecuted. Thus, Stanton was not prosecuted for pretending to cure cancer but for misleading the public over his status as a doctor. Of significance was the fact that in the legal discussions, it was decided that the title of doctor was not allowed, but Stanton could use the alternative title of ‘professor’ without legal recourse. Thus, the ability to prosecute alternative practitioners was limited to misrepresentation as a registered medical professional but not as an expert in healing.

Stanton’s reaction to the trial is indicative of the level of success of his practice. Upon conviction, his lawyer asked for leniency, but Stanton received a £50 fine, the maximum penalty for the crime. Not too bothered by it all, with ‘cheerful alacrity’, Stanton simply drew out a cheque and paid for it on the spot. His reported brazen actions over what was a significant sum indicate that Stanton’s practice was financially successful. Further evidence of his wealth is discussed below in respect to his Christchurch practice.

107 ibid., 6 Mar., 1901, p. 41.
109 Otago Witness, 6 Mar., 1901, p. 41.
Like Milner Stephen’s conflict with the medical profession, the trial helped gain Stanton notoriety. Despite reportedly costing Stanton £50, the whole case was, if anything, a ‘splendid advertisement for him’. One unhappy commentator wrote that now ‘a very large section of the public ... being extremely credulous and gullible, would see nothing more in the case than a man who could cure cancer was fined because he wasn’t legally a doctor’,110 The medical profession was concerned that the public may view the prosecution of Stanton in terms of ‘jealousy’ and in doing so turn Stanton into a ‘persecuted’ martyr. It was feared that some members of the public might conclude that he had a secret cure of which the medical profession were ‘ignorant’.111 Such defensive commentary is symptomatic of a society that was wary of the motives of the medical profession.

Around 1902, Stanton moved his practice to Dunedin and his advertisements in South Island papers continued to challenge the methods of the medical profession.112 He had set up a practice as a ‘magnetic healer’ and ‘cancer specialist’ opposite Trinity Wesleyan Church.113 One advertisement reveals how he tried to encourage patronage:

If you have hard lumps with sharp darting pains or open, running sores that will not heal; or if you suffer from internal darting pains and are losing flesh — beware! These are the symptoms of the much-dreaded disease, cancer. If you have any of the above symptoms, do not be surgically operated upon, as such operations usually cause a quicker growth and hasten death; but consult Wm. Stanton, the greatest Cancer Specialist of the age. Hundreds of patients given up as incurable by other medical men have been cured by Wm. Stanton, and are now in enjoyment of good health.114

110 ibid.
111 ibid.
113 ibid.
114 ibid.
Of particular interest here is the resemblance between Stanton’s criticism of surgery and the medical profession’s critiques of quackery. He indicated that surgery would ‘hasten death’. The emphasis this and other advertisements were on successful cures that were free from both operations and pain.

As was the case in his Auckland practice, Stanton used local testimonials to encourage potential patients. Often the methods were vague and they could have been a combination of faith healing, chromic acid liquids, magnetism and massage, and hypnotism. Mrs Geddis of South Dunedin had breast cancer that the ‘leading qualified medical men of Dunedin’ declared incurable. Stanton claimed to have cured the incurable in just six months. For Miss Alice Bates of Ratanui, a ‘legally-qualified medical man’ wanted to give her an operation but she declined. According to Stanton, she was cured in a few weeks ‘without any operation or pain’. Mrs G. Clark had been treated by the medical profession but had suffered constant recurrence of her cancer. Stanton claimed that in only a few weeks, she was ‘cured’ and ‘relieved from pain’. This evidence suggests that Stanton not only took incurable patients but also took patients currently under the care of medical professionals. He offered relief from cancer and emphasized that he could do this ‘without the use of the knife or injurious drugs’. This use of local examples attempted to play on informal community networks for promotion.

There were several different perspectives on the success of alternative cancer curers. *Truth* had a critical stance on how their testimonials were solicited: ‘there are plenty of mugwumps at large in New Zealand who will tell anybody they meet that Saintly Stanton, the criminal, had performed some almost miraculous cures of cancer’. *Truth* speculated on how Stanton managed to forge this reputation. It was reported that some time back a twenty-five year old women came to him and he diagnosed her with cancer of the kidney. He then promptly cured her and claimed success. ‘Friends blazoned his name abroad as a medical wonder’, but a doctor, after hearing of this wonder, went to examine this miracle. He concluded

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115 ibid.
that ‘the quack had told her she had cancer in order to obtain credit for a cure’.\textsuperscript{118} Truth concluded that two types of patients went to see quacks, the terminally ill and those who ‘imagine there is something wrong with them’. It was the latter, Truth asserted, that believed they had been cured and provided testimonials.\textsuperscript{119} Truth’s perspective on alternative practitioners is possibly legitimate but it clearly presents a one-sided perspective of Stanton through a negative lens.

In contrast to this position, it could be argued that patients made their own choices based on their rational judgements. Clow has argued that seeking medical alternatives because of popular dread of cancer and surgical methods was a rational decision; this contrasts with framing popular responses in terms of irrational fear, given the perceptions and realities of cancer treatment success.\textsuperscript{120} Surgery was often risky, ineffective and painful. Of particular interest is the fact that Stanton’s testimonials did not stop at citing lay individuals, but included testimony from Dr Robert Bakewell, a trained surgeon and controversial Auckland practitioner who employed advertising. Bakewell had been under a ‘sentence of death’ after confirming a diagnosis of a tumour in his larynx by three separate doctors. Bakewell was told that ‘nothing could be done’ and he ‘consulted’ his medical books and came to the same conclusion. After only a fortnight Stanton had cured Bakewell.\textsuperscript{121} Perspectives on alternative practitioners need to balance the excessive critiques of Truth with the miraculous curing stories of alternative practitioners through testimonials.

Truth’s interest in Stanton brings to light a significant amount of information about the nature of his practice. In March 1907, Truth began a crusade against Stanton, the ‘Worcester Street Wizard’. By this time, Stanton had moved his practice to Christchurch and expanded his curing repertoire to include faith healing. To Truth, he was a ‘fully-qualified bible-banger but a sadly unqualified medical practitioner’ who ‘calls himself a cancer-curer’, but ‘chances are he might

\textsuperscript{118} ibid., 23 Mar., 1907, p. 5.
\textsuperscript{119} ibid., 27 Apr., 1907, p. 8.
\textsuperscript{120} Clow, \textit{Negotiating Disease}, p.8; Patterson, p. vii.
\textsuperscript{121} Tuapeka Times, 17 Dec., 1902, p. 1.
do better at curing bacon’. Through Truth’s criticisms, it is possible to extract information relating to Stanton’s practice. Truth reported that it began its crusade after an ‘old lady Smith’ who wanted to warn the public about Stanton contacted them. Like many individuals who sought out alternative practitioners, Smith was informed by her doctors that she had cancer but was not strong enough to survive an operation. Through informal networks, ‘friends’ advised Smith to consult Stanton. This reiterates the examples from Hullett about the role informal networks and the importance of the local connections. Truth reported that Smith told Stanton that the doctors could do nothing and Stanton’s reported reply was that he was ‘glad the doctor said that ... those are the cases I like to get a hold of’. While Truth’s intentions were to portray Stanton as an individual who preyed on hopeless and desperate cases, the failure of the medical profession to attempt to treat cancer was a significant motivation for individuals to seek out alternative remedies.

Details about Stanton’s methods are brought to light through Truth’s close scrutiny of his operations. Stanton made weekly prayer visits and provided a preparation in a bottle which Truth described as shillings for a ‘rubbishy concoction in a bottle and petitions to god’. As Smith was getting worse, Truth reported that ‘slippery Stanton’ ceased his treatment, citing the fact that the job was not paying enough. Evidently, according to Truth, this ‘religious rogue’ had ‘a number’ of cancer sufferers under his care. This is indicative of his popularity but Truth believed his motives were more sinister: ‘This game of giving up patients when they become worse, and there is no chance of recovery is an old one with Stanton. He prays for (and preys on) his victims as long as his humbugging methods will allow’. Also evident from Truth’s account is the fact that Stanton had learned from his previous altercations with the medical profession. He only called himself a ‘cancer specialist’. In addition, Stanton allegedly avoided inquests by abandoning his patients before death. He was ‘too careful to actually kill any one of his

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123 ibid., 23 Mar., 1907, p. 5.
124 ibid.
hopeless patients’ claimed Truth. This meant he was not in breach of the law and could continue to practise.

Through Truth, it is evident that Stanton’s practice drew on religion as a form of promotion and his image was associated with respectability. Truth held nothing back in its negative opinion of him: ‘Stanton is a slimy, sordid, soulless, specimen of the worst of all quacks, the godly quack ’. For Stanton had diversified from his old business and had become a regular Sunday preacher, which, according to Truth, was to be used to provide him with more victims to ‘sponge’ off. It also meant he could pray and ‘put an extra few bob on the bill’. Truth claimed that he was ‘no ordinary quack who takes shop in an ordinary thoroughfare’ with ‘placards on the window with a number of impossible testimonials’. Such commentary indicates that Stanton was considered an exception to the rule; it also indicates that alternative practitioners were commonplace through setting up stalls in main thoroughfares. Stanton lived a respectable life on a good income. He was not a street peddler but was wealthy and successful. He lived in a ‘substantial residence’, which was a ‘fashionable house’ in the best residential part of Christchurch. He had a ‘large and varied assortment of beautiful furniture’. The opening image of Stanton is one of a respectable gentleman, perhaps even a well-to-do surgeon. He had worked out that informal networks were an excellent way to get patients. Since 1905, he had been holding services in order to bring in cancer sufferers. According to Truth, even when medical professionals later proclaimed patients had been tricked and never had cancer, it did not affect the ‘adoration and gratuitous advertisement of the “good” man from those he had claimed to heal’. Another reading of this commentary indicates that there was strong faith in Stanton as an alternative practitioner and scepticism towards surgery and the medical profession.

125 NZ Truth, 23 Mar., 1907, p. 5.
126 ibid.
127 ibid., 24 Aug., 1907, p. 5.
128 ibid., 30 Mar., 1907, p. 5.
129 ibid., 23 Mar., 1907, p. 5.
130 ibid., 30 Mar., 1907, p. 5.
131 ibid., 24 Aug., 1907, p. 5.
132 ibid., 30 Mar., 1907, p. 5.
Through the investigation of Truth’s reporter, some specific details on the nature of Stanton’s church services are revealed. His church, the ‘Progressive Thought Society’, was created solely in relation to Stanton’s own beliefs and Truth attempted to characterize the church’s service in a negative way. The reporter turned up late and was greeted with a ‘frown’ from ‘an aggressive looking female in the front row’. The service started with a blessing and was followed by a hymn ‘led by the aggressive looking female’ and the organ played by Stanton’s son. The sermon included Stanton attacking a London preacher for stealing his own theology for half an hour to what the Truth described as a ‘small and sleepy audience’. After this, for another half hour, Stanton discussed the fact that with faith one could perform miracles and related this to the miracles of Jesus, before the ‘wheezy organ’ began another hymn ‘led by the aggressive female’. At the end was question time, with some questions put forward by what Truth described as ‘posers’. According to Truth, these questions were answered in an ‘oily sincere tone which made Truth want to kick him’. This commentary by Truth suggests that Stanton possessed some level of charisma that attracted potential patients to pay him for his alternative treatments. Stanton wanted his congregation to believe in the possibility of miracles and this, undoubtedly, would help encourage people to seek his services for these miracles. He used religion as a platform to promote the possibility of miracles and as a medium to create informal networks.

In addition to this, some patient perspectives on Stanton’s treatment methods are evident in newspapers. Through these reports, which were predominantly aimed at discrediting him, further information about his practice can be gleaned. The Otago Witness reported a story of a carpenter named Christopher Brown. This example reveals more specific details about Stanton’s treatment methods and how he enticed clients. Brown’s doctor advised him to go to hospital. However, Stanton approached him and advised that he could guarantee a cure. Stanton refused to give a written guarantee of a cure and only conveyed a guarantee of cure verbally. He said ‘a doctor never gives a written guarantee but I guarantee it’. Stanton was still referring to himself as a doctor in person but avoided confirming such information in written form.
Stanton painted Brown’s face for several hours at regular intervals before sending him home. According to the report, Brown was made delirious as a result and returned in the morning. From his throat to the top of his lip a mass sore developed and this had dried up and been burned black. Stanton then proceeded with some sharp instruments, cut two openings in the sore, and put in a ‘crystal substance’. After three days at home, the burned flesh that had been skin dropped off. Stanton claimed it was a ‘beautiful case’ and Brown was given some powders and lotions to bathe the sore in.\textsuperscript{133}

Stanton’s reaction to the recurrence of cancer in Brown is of particular interest. After eight months, Brown’s lips began to swell again and the cancer was apparently coming back. Stanton wanted to be paid again, as he claimed to have cured it the first time and that this was a new instance. According to the report, Stanton likened this to the situation of when a doctor cured someone of bronchitis and then it was caught again later — it was two different instances.\textsuperscript{134} When Brown later heard that a man was being buried after being treated by Stanton for cancer in the throat, he went to hospital to consult with Dr Henry Thacker, a Christchurch surgeon.\textsuperscript{135} Thacker informed Brown that the cancer was ‘too deep’ and if he had come earlier, it may have been operated upon.\textsuperscript{136} Stanton had accrued £19 from treating Brown.\textsuperscript{137}

The other two patients whose experiences were brought to light in reports at this time also reveal information that confirms previous discussion on informal networks and popular attitudes towards surgery. Mrs Greenfield, who suffered from breast cancer, was directed to Stanton through ‘religious friends’. Stanton’s creation of an informal religious network was successful in helping spread word of

\textsuperscript{133} Otago Witness, 17 Apr., 1907, p. 16.\textsuperscript{134} ibid.\textsuperscript{135} NZ Truth, 30 Mar., 1907, p. 5.\textsuperscript{136} Otago Witness, 17 Apr., 1907, p. 16.\textsuperscript{137} NZ Truth, 30 Mar., 1907, p. 5.
his ability to cure cancer. *Truth* stated that ‘Mrs Greenfield no longer suffers from cancer (or any other complaint) having been dead for some time’. While treatment in this case was unsuccessful, *Truth’s* position assumed that Stanton could not cure cancer and that the medical profession could. Drawing conclusions on treatment outcomes from evidence like this alone is problematic. The lack of success of the medical profession in individual cases did not receive the same extent of public scrutiny. As Phillippa Martyr pointed out, if a ‘cure’ failed to prevent death, then was it justified to place blame or victimize the individual who attempted to treat cancer? This is an important issue to consider in relation to both the medical profession and in relation to historiography that presumes to condemn alternative treatment methods.139

Finally, there was a case of a man named Gordon who had cancer in the jaw and was treated by Stanton. Stanton treated Gordon until he got into a hopeless state and was abandoned, being told that he did not have ‘sufficient faith’. Such a charge could equally be lodged against surgeons, who, upon it appearing hopeless, would abandon their patients. The motives of the medical profession were made clear when Dr Albert Orchard, a Christchurch general practitioner, claimed ‘it was a pity a doctor had been summoned’.140 Had a doctor not taken over the case of the dying patient then Stanton would have had to defend himself at an inquest. There is a range of possible motives that the medical profession may have had, including wanting to protect the public from quackery and see that justice was done to more self-serving motives like eliminating the medical profession’s competitors.141

*Truth’s* investigations also discovered that Stanton ‘was not the only genius in the family’. J. Stanton, allegedly a brother, was a magnetic healer in Palmerston North. *Truth* proclaimed that he was a fraud like his brother, ‘that is, if they are brothers, and not merely trading under the name for business purposes’. Like

138 NZ Truth, 30 Mar., 1907, p. 5.
140 NZ Truth, 30 Mar., 1907, p. 5.
William Stanton, most of J. Stanton’s cases were for cancer. *Truth* proclaimed J. Stanton a ‘public menace’ and a ‘blood sucker’. Of particular interest, though, was the ‘wicked puffle’ that J. Stanton had been circulating and *Truth* reported and quoted the material. According to the evidence presented in *Truth*, J. Stanton advertised that ‘most diseases’ were ‘treated without a knife, and no injurious medicines used’. His advertisement also proclaimed that cases that ‘baffled’ the mere ‘ordinary skill’ of registered practitioners could be overcome as J. Stanton’s cures ‘never fail if you come in time’, a rhetoric not unlike the calls for early surgical intervention. This language indicates that alternative practitioners’ promotion appealed to individuals who did not want to submit to surgery. In addition to this, William Stanton’s Christchurch address was advertised as another place to go. Far from limiting themselves to patients who could travel, they included a question form for diagnosis and products by mail order. This form included questions like, ‘Is your complexion Florid or Yellow?’.

Alternative practitioners were competing strongly through a range of different modes. *Truth*’s uncovering of this sister business raises the point that there may have been many more practices not evident in the sources. If only the prominent and notorious practitioners got newspaper attention, then a key point, regarding smaller alternative practices and their number and popularity, is a question that can only be left to speculation.

In 1907, the death of Joseph Greeney under Stanton’s care meant that his practice came under legal scrutiny. It was reported that on Greeney’s death, Stanton concluded that the game was up. He had a patient die and as he was not a registered medical professional and could not produce a death certificate. It was reported that he proceeded to sell his furniture, land, and ‘odd things that have nothing to do with cancer cures’ in a bid to flee to England. He had allegedly been ‘at large for some time’ and had ‘accumulated a good worldly pile’. He was put on trial for manslaughter and had his bail doubled to £400 for his attempts to flee. Stanton was convicted of manslaughter. Greeney had been treated with powders dissolved in water, which became known in court of consisting almost entirely

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142 *NZ Truth*, 27 Apr., 1907, p. 8.
143 ibid., 15 Jun., 1907, p. 6.
sugar. Of significance is the fact that it was only at Greeney’s death that the family found out that Stanton was not a doctor. They had been addressing him as a doctor.\textsuperscript{145} This indicates that despite his earlier prosecution for using the title of doctor, Stanton still used the title verbally.

During the trial, Bakewell gave testimony in defence of Stanton. As discussed earlier, Bakewell had been treated by him for cancer in Auckland for an inoperable tumour and took a solution of white powder. After six weeks, Bakewell claimed the tumour disappeared. Three doctors had certified the existence of the tumour and two of them confirmed that it had disappeared. Of interest is the fact that the third refused to examine Bakewell because an unqualified practitioner had treated him. This indicates that there was resistance towards those who dealt with the medical profession’s competitors.\textsuperscript{146} Bakewell’s testimony was critical of the profession that he was a part of. He claimed that ‘a man is not endowed with superhuman wisdom because he has passed the exam of a medical corporation’.\textsuperscript{147} This statement challenged the primacy and legitimacy of the medical profession and its attempts to monopolize medicine. Bakewell was ‘most emphatic’ and ‘had not the slightest doubt’ that Stanton had cured him. Bakewell also relayed his own experiences as a doctor, where he had cured many cases but still had deaths. He claimed that had he not been a registered medical practitioner he could have been charged for manslaughter. Bakewell attempted to put Stanton’s practice as an alternative practitioner in the context of the medical profession. Bakewell suggested that Stanton was not necessarily to blame for the death of Greeney.\textsuperscript{148}

The result of the trial was that Stanton was imprisoned for four months, but the verdict needs to be put into perspective. For example, one report in the \textit{Taranaki Herald} discussed the punishment of a medical practitioner for undertaking an illegal operation (often a euphemism for abortion). The doctor received four years

\begin{footnotes}
\item[145] ibid., 29 Jun., 1907, p. 1.
\item[146] ibid., 24 Aug., 1907, p. 5.
\item[147] Grey River Argus, 22 Aug., 1907, p. 3.
\end{footnotes}
imprisonment and this was considered a lenient sentence because of his old age.\textsuperscript{149} Truth was not happy about the sentencing for Stanton. It claimed four years not four months would have been more appropriate. The judge had been impressed with Stanton’s demeanour in the dock in sentencing and referred to his respectability. Truth claimed the judge ‘practically begged the prisoner’s pardon in the most servile manner for having to send him to the gaol’. The ‘extraordinary leniency’ extended to Stanton being ordered to be kept apart from the other prisoners. Truth suggested the judge might have added a case of champagne or some women to go with the sentence. The result, Truth claimed, was that other practitioners would ‘sail closer to the wind as ever, and the grave digger would be kept unusually busy’.\textsuperscript{150} The lenient sentence of four months for manslaughter indicates the fact that the role of alternative practitioners was considered to be a legitimate option for the treatment of diseases. Despite the desire for a harsh sentence from some quarters, Stanton, as a respectable nonprofessional and alternative practitioner, was treated with leniency by the judge.

\textsuperscript{149} Taranaki Herald, 16 Aug., 1907, p.4.
\textsuperscript{150} NZ Truth, 24 Aug., 1907, p.5.
Conclusion

In the late nineteenth century and the first decade of the twentieth century, cancer sufferers had many different treatment options. Rather than portray alternative practitioners as quacks and their patients as gullible and ignorant, this chapter has focussed on medical encounters, the appeal of alternative medicine, and popular motivations. In competition with the medical profession was a range of alternative cures and differing alternative practitioners. The medical profession did what it could to discredit such practices and actively tried to discourage alternative practitioners in favour of its own methods. The realm of healing was a competitive arena of high stakes and both sides attempted to discredit the other. Doctors and the press were critical of alternative practitioners. At the same time, newspapers were in a contradictory position as they received a lot of income from medical advertisements in their advertisements column. Alternative practitioners were not pushed out into the margins but could run very popular and profitable practices. Alternative practitioners received patronage and support from all walks of society, including some parliamentarians and doctors.

The strong presence of alternatives to surgery is also indicative of popular scepticism of surgery. Testimonials indicate that surgery was often a failure, was perceived to be painful and risky, and that many patients chose to abandon or avoid surgery in favour of other methods. This strong popular fear of surgery meant many chose different options rather than resort to the knife, while for others death seemed like a better option. Alternative practitioners built on these perspectives and challenged the efficacy of surgery. A common feature of this emphasis was the fact that alternatives to surgery were often less painful and acted as an effective palliative.

It is also clear that patients did not automatically choose to consult a regular practitioner. Choice in healing was greatly influenced by informal networks, including advice from friends or first-hand knowledge of individuals who had been
cured. This choice was not an irrational one but was based on valid fears in respect to surgery and persuasive evidence from informal networks, testimonials, and advertisements.

Perhaps Martyr’s calls for historiography to consider an interpretation that privileges alternative medicine goes too far, but it is important to give more prominence to alternative practitioners.¹⁵¹ The history of cancer is not just a history of institutions and the medical profession. Alternative medicine is an area that should not be considered marginal or framed in terms of quackery and popular gullibility. Alternative medicine was a significant part of healing in the late nineteenth and early twentieth century. As a historical subject, alternative medicine needs to be treated in a more balanced way. In particular, greater attention needs to be drawn to popular perspectives and the reasons for the appeal of alternative medicine and fears of surgery. The following chapters in this section continue to focus on the role of alternative practitioners and popular beliefs about cancer and its treatments from the late nineteenth century up to 1939.

¹⁵¹ Martyr, pp. 8-18.
Chapter Eight


This chapter builds on popular beliefs systems about cancer and alternative treatments discussed in Section A and Chapter Seven. The continued failure to definitively identify the cause of cancer and find a cure opened up medical authorities to ridicule and led to the proliferation of alternative theories and cures. This chapter discusses two case studies of laymen who from 1916 to 1926 engaged with theories about cancer causation and promoted methods that they believed would cure or prevent cancer. These case studies are discussed in relation to the appropriation of scientific ideas, the continuity of alternative medicine, and the conflicting perspectives between incompatible interpretations of disease and its treatment.

Both case studies reveal the dynamics between conflicting perspectives about cancer’s cause and treatment and an appropriation of scientific ideas. The co-option of scientific prestige is one of the cultural influences that were used to explain the rise of the medical profession. Yet the appropriation of scientific thinking and authority is something that is not exclusive to the medical profession.1 Michael Ackerman argued that the lack of knowledge about disease etiology aided the scientific plausibility of alternative theories.2 Both of these case studies indicate the appropriation and adoption of medical and scientific theories as justifications for their theories about cancer. Both case studies also demonstrate a series of conflicting perspectives about interpretations of health illness and healing. In one case study, medical authorities were dismissive of the proposed environmental theories. Yet, these theories attracted the attention of a range of political and public health figures. The other case study provides an alternative characterization of the

2 Ackerman, p. 65.
medical profession and characterizes them as charlatans and their methods of treatment as dangerous.\textsuperscript{3}

In April 1918, a retired Balclutha farmer, named John Mosley, wrote to his parliamentarian, A.S. Malcolm, member for Balclutha, requesting investigations into his discoveries relating to the cause of cancer. Mosley referred to a theory by the Rev. E. Pocknell, an Australian Presbyterian Minister, who was characterised by the Australian medical profession as a man of ‘average sanity, but of inquiring mind’. According to the theory, cancer was a parasite that thrived in certain conditions. As discussed in Chapter Three, a range of divergent cancer theories were prominent in the 1890s but non-cellular theories had lost favour in medical and scientific spheres from the 1900s. Pocknell claimed that the parasite believed to cause cancer was only found on trees that were directly above an underground water supply. Mosley had been undertaking his own investigations into underground water supplies as a cause of cancer in his local district. Mosley had been practising water divining since 1908 as a method to find gold prospects. In 1917, he investigated houses that had cancer sufferers by using his divining rod to detect radioactive emanations from underground streams. At least seven of the cases of cancer had been verified by Dr Andrew Stenhouse, a Balclutha general practitioner, as being confirmed as a medical diagnosis of cancer. Mosley requested that the issue should be put before Cabinet. A week after this letter, Malcolm wrote to G.W. Russell, then Minister of Public Health, asking for the matter to be looked into and also confirmed that Mosley was a man of good repute and ‘much intelligence’.

In May, Mosley started writing to the *The Press*, Christchurch, and it published his comments. *The Press* reported that an ‘interesting discovery’ had been made. The report claimed that Mosley had traced the cause of cancer to hidden streams of underground water after testing areas with his ‘magic twig’. It was asserted that Mosley was an accomplished water diviner and could ‘speak with authority’ on the

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4 *The Press*, Christchurch, May 3 1918, in Diseases — Cancer — Alleged Cure by Mr Mosley, H1 1299 131/16/6, Archives New Zealand Head Office, ANZ/W (Hereafter Mosley, ANZ/W).
5 Letter from John Mosley to A.S. Malcolm, 10 May., 1918, in Mosley, ANZ/W.
6 Letter from A.S. Malcolm to G.W. Russell, 17 Apr., 1918, in Mosley, ANZ/W.
matter. Mosley claimed that cancer was more prevalent in New Zealand than the medical faculty was prepared to admit and that Russell had taken up the issue with a ‘broad-minded liberal spirit’. Mosley contrasted this with the attitude of the ‘narrow-minded bureaucrats’ at the Department of Public Health (DPH) that New Zealand was ‘cursed’ with.\footnote{The Press, 3 May, 3. 1918, in Mosley, ANZW.} Public health professionals who were medically trained dominated the DPH. They were continuously dismissive of the validity of alternative theories and relied on advice from the medical profession and the Imperial Cancer Research Fund (ICRF) in relation to cancer. This contrast, between public health officials and political individuals, defined Mosley’s relationship with the government and the DPH. Politicians were prepared to give Mosley’s ideas valid consideration but the bureaucrats from the DPH were strongly opposed to giving Mosley’s theories any shred of credibility. In response to Malcolm’s request, the DPH’s advice was that it believed the ‘flow of water below buildings would not affect the occurrence of cancer’.\footnote{Thomas Valintine to A.S. Malcolm, 10 Oct. 1918, in Mosley, ANZW.} Seemingly, the matter was at a rest, but this only marked the beginning of Mosley’s haranguing political authorities.

In July 1919, the \textit{Otago Daily Times} (ODT) gave its support to Mosley’s investigation after he wrote to them. They believed that Mosley’s theory ‘gives reason for cause, thought, and action’. The fact that he was a nonprofessional was a non-issue and the ‘medical faculty’ came under criticism. The \textit{ODT} complained that it had been ‘listening’ and ‘trusting’ ‘medical science for some time’. Despite this, cancer still ‘rapidly’ increased, and the ‘medical profession’ had not only failed to ‘discover a remedy, but even worse has apparently failed to discover the origin of the disease’. One letter to the editor by an author named ‘interested’ believed that it was ‘imperative’ that Mosley’s theory should be ‘inquired into’ and that ‘it is possible that what he advances may contain more than may be admitted by the medical faculty at first sight.’\footnote{\textit{Otago Daily Times}, 11 Jul., 1919, in Mosley, ANZW.} Commentary in the \textit{ODT} reaffirms my discussion in Chapters Three and Seven about lay engagement with cancer theories. The failure of scientific medicine to discover a definitive cure or cause for cancer, combined with the context of increasing expectations of scientific medicine, created an
environment that was conducive to strong public engagement by non-professionals with medical issues.

In 1920, Mosley made a renewed effort to get his cancer theory investigated and petitioned the new Minister of Health, C.J. Parr. Mosley pointed out his previous overtures with the Department of Health (DOH) and asked for some type of ‘scientific investigation’ to be made. Parr believed that the theory should receive some form of consideration and informed Thomas Valintine, the Director-General of Health, as much: ‘the claim made by Mr. Mosley seems a somewhat extraordinary one. In these days ... it would not be wise to reject any theory’. Mosley informed Parr that he had investigated seventy-seven cases of cancer and found ‘in every instance’ that the sufferers had been living in rooms situated over underground streams. The basis for Mosley’s claims was given political legitimacy in the context of the failure of scientific medicine to identify the causation of cancer. This created political pressure for the DOH to take action and to respond to Mosley’s claims. Valintine organised an investigation by the District Health Officer for Dunedin, Dr Thomas McKibbin, stating in an apologetic manner to McKibbin that he had promised several people that an investigation would be made.

McKibbin’s report was written and returned to Valintine in November 1920. From a ‘practical’ perspective, the report noted that any useful result from such an investigation ‘is not attractive’. The report stated that Mosley had identified a number of underground streams beneath houses occupied by cancer cases that had been diagnosed by a registered medical practitioner. According to the report, Mosley believed that radioactive emanations from these streams caused cancer in people who lived in such dwellings. The main problem was not the identification of cancer sufferers but the methods used to identify underground streams and their

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10 John Mosley to C.J. Parr, 29 Jun. 1920, in Mosley, ANZW.
11 C.J. Parr to Director-General of Health, 15 Jul. 1920, in Mosley, ANZW.
12 John Mosley to C.J. Parr, 29 Jun., 1920, in Mosley, ANZW.
13 Thomas Valintine to Thomas McKibbin, 18 Jul. 1920, in Mosley, ANZW.
14 Thomas McKibbon, Report to the Director-General of Health, ‘The Water Diviner and Underground Streams as a Cause of Goitre, Cancer, Rheumatics, ... etc’, 15 Nov., 1920, in Mosley, ANZW.
radioactivity. The report questioned whether those in parliament were prepared to approve the large expenditure required for such a study. It gave two options. The first option was that one of the established major research institutions in Britain, which were already spending enormous resources on investigating cancer, was in a better position to investigate than local bodies. The second option was to undertake an exceedingly expensive research project that would include among others, an important public health officer; an eminent judge or lawyer; an eminent geologist; an expert in physics with an intimate knowledge of radioactive emanations, meaning Dr Farr, a physicist at Canterbury College, was the only man in the country fit to carry out this duty; a psychologist; a pathologist; a skilled borer with a modern boring plant; and a sizable grant from Parliament. In addition to such proposals, Mosley’s methods came under criticism. It was claimed that Mosley’s views were ‘romantic in nature’ and that expert geologists ‘belittle the power and practical value’ of water divining. In late November, a letter was sent to Malcolm informing him of the report from the Director-General of Health. It reported that the outcome was to forward information onto the ICRF for further evaluation. Linking back to Chapter Six, this is indicative of a period when New Zealand looked to both Britain and the ICRF for cancer research. It also added that it was ‘out of the question’ for New Zealand to ‘face the expenditure’ to carry out a proper scientific investigation.

Despite another rejection of serious inquiry into his matter, Mosley took the matter to the Prime Minister, William Massey, in 1923. In June 1923, Massey interviewed Mosley. Mosley told Massey that he had made some discoveries through his scientific research but as a private individual could do little more. By this stage, Mosley claimed to have investigated over one hundred and fifty houses over water and had moved people off their properties. He would then insulate the floors with a mixture containing flour and sulphur. Mosley asked Massey for three men to aid him in drawing up an official report. When Massey asked whether

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25 McKibbon, p. 2.
26 ibid., pp. 2-3.
27 ibid.
28 ibid.
29 Thomas Valintine to A.S. Malcolm, 29 Nov., 1920, Mosley, ANZW.
Mosley wanted to recruit the services of the DOH’s medical professionals, Mosley replied he wanted ‘fair men’ (implying that the DOH’s representatives were not fair). At the conclusion of the discussion, like political figures before him, Massey was open minded about Mosley’s methods. Massey claimed that he was not ‘prepared to turn it down as a mare’s nest’, particularly as Massey had some experience with water divining, and he offered to get one or two men to look into the matter.  

The matter was passed down to the Minister of Health, Parr, and then down to an annoyed Valintine. In July 1923 Valintine wrote back to Parr and reiterated the point that Mosley’s theory was ‘fantastic’ and that it should not be given any Government support. It further stated that since the matter was concerned with geology it was suggested that the matter could be referred to the Mines Department.

In August 1923, Mosley sent a letter to the editor of the ODT that explained his methods. Of particular interest is the fact that this commentary drew on scientific terms. The basis of the theory was that hydrogen emanations from radioactive underground streams caused cancer. In order to identify these emanations Mosley claimed to use an ‘electronic indicator’ known as a ‘divining rod’. Mosley further noted that Massey had agreed to establish a commission to investigate ‘the science’ with Mosley. A few days later Massey sent a letter to Mosley indicating a rejection of any detailed investigation. Massey stated that the issue was given full consideration by the DOH but the opinion of the department was that Mosley’s theory ‘would carry little, if any, weight’. It is important to note here the scientific and technological terminology that Mosley used in describing his methods. This co-option of scientific terminology and ideas became an increasingly prominent feature in the interwar period.

21 T.H. Valintine to C.J. Parr, 31 Jul., 1923, in Mosley, ANZW.
22 Otago Daily Times, 6 Aug., 1923, in Mosley, ANZW.
23 William Massey to Thomas Mosley, 8 Aug., 1920, in Mosley, ANZW.
After the failure of the central government to investigate Mosley’s claims, Mosley lobbied the Otago Hospital Board in 1925. In September and October 1925 it was reported that Mosley appeared before the South Otago Board and presented his findings. Mosley had investigated over 300 houses between Riverton, a small town at the bottom of the South Island, and Christchurch. It was found that ‘in every instance’ underground water had been present in cancer cases. A more detailed account of Mosley’s methods was presented through the case study of Mrs McIntosh of Dunedin, a relative of Mosley who was on her deathbed with stomach cancer. Mosley discovered that her entire home, except the kitchen, was over an underground stream. McIntosh’s family doctor decided on surgery once McIntosh could not swallow as the doctor decided it was better to risk it than to die by starvation. During the operation, the doctor discovered a malignant tumour as large as a fist and decided against trying to extract it. Mosley took ten pounds of sulphur and spread it around her bedroom using his ‘sulphur insulation’ method. The result was that McIntosh was free from pain after ‘a few days’. The family doctor became ‘puzzled’ over McIntosh’s improvement over the following months. Mosley told the South Otago Board that surgery was not the answer to cancer, as ‘it does not attack the source’. Mosley claimed that the cause of cancer was from the environment, a subject area he believed to be ‘too much neglected’ by the department of public health and physicians. Mosley argued that three fifths of the battle against cancer was to do with the environment. Mosley initially sought the cooperation of public health authorities. Over time, this changed and Mosley became critical of their approaches to cancer. A strong focus on the role of the environment in cancer pathology is a subject that received greater attention in the post-war period.

The chairperson of the convening board, Malcolm, Mosley’s supporter since 1917, moved the following motion: ‘That the board distribute copies of Mr. Mosley’s report to each hospital board in New Zealand’. In support of this motion, he added that Mosley had dedicated a lot of his spare time to his investigations, was a ‘highly

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24 Evening Post, 22 Sep., 1925, in Mosley, ANZW.
respected gentleman’, and ‘had nothing to gain’. Malcolm further recommended that the board should set up its own investigation committee to try to substantiate Mosley’s claims. Several of the members rose in support of the motion and the motion was carried unanimously. It was further noted that the medical profession had been ‘rather slow’ in taking up the investigation. Of importance here is that prominent lay individuals were prepared to actively consider suggestions about cancer from non-professionals. The matter was passed on from the South Otago Board to the Otago Hospital Board for investigation. It was the opinion of the South Otago Board that the cost of such an investigation would be ‘trifling’ and the details of Mosley’s discoveries were passed onto the Otago medical staff. In March 1926, the matter had reached J.A. Young, the Minister of Health. Young forwarded the issue to the Director General of Health who forwarded it to Dr M.H. Watt, the Deputy Director General of Health. A reply was not forthcoming until July 1926 and Watt was dismissive of Mosley’s theories. Watt made his opinion of Mosley’s claims abundantly clear: ‘Mr. Mosley’s claims are so contrary to all that is known to science as to be fantastic, and in my opinion they are not worthy of being scientifically looked into.’

The last record of Mosley’s attempt to get his cure recognized appears in the newspapers in 1929. In early October 1929, Truth reported on Mosley’s methods of cure. In its usual style, and in contrast to other newspapers, it tended to denigrate any alternative type of medical practice (a feature previously discussed in Chapter Seven). Despite Truth’s critical account, it does provide useful information about how Mosley operated. Truth sent a representative to witness Mosley in action. Mosley took his ‘manuka prong’ and stepped over an area that had an underground stream. As he stepped over it the stick ‘made a deep obeisance’. Mosley then proceeded to enter a room that had been insulated with sulphur and the stick ‘lost its magic’. Mosley explained that the sulphur stopped the signal being sent up through his boots. Truth’s correspondent had some questions for Mosley regarding why areas without underground streams like Auckland did not

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27 J. A. Young to T.H. Valintine, 26 mar 1926, in Mosley, ANZW.
28 M.H. Watt to J. A. Young, 7 Jul., 1926, in Mosley, ANZW.
possess significantly lower cancer rates. Mosley explained that those who were local built up immunity to it and it was only those who moved from another district who were most at risk. Mosley had no answer when asked why Rotorua, a place with a lot of sulphur and underground streams, did not have any peculiar cancer rate. Mosley did indicate that there had been a number of instances where dogs had contracted cancer when their kennels were put above streams and how pigs removed from locations above underground streams had gotten fatter.29 Truth concluded that Mosley’s sulphur cure presented no harm to patients but the main issue was that ‘considerable harm’ could happen if people took Mosley’s advice to the exclusion of medical advice. Truth admitted that, unlike other practitioners, Mosley was ‘sincere’ and did not attempt to get money from his theory. However, as discussed in Chapter Four, any form of alternative treatment had the negative consequence of causing delay. Truth argued that cancer sufferers may lose out on appropriate medical care because they were chasing ‘the shadow of Mosley’s extraordinary theory’.30

30 ibid.
James Devereux and *The Green Leaf*

James Devereux, a Christchurch promoter of a natural diet and food reform, believed in the importance of nature and diet for good health. Devereux’s belief in a return to nature can be linked more generally to popular health reform movements and as part of a trend that saw the proliferation of dietary theories across the twentieth century.\(^{31}\) American historian James Whorton calls for a reinterpretation of the health fanatic as an individual distorting scientific thought.\(^{32}\) Indeed, Devereux actually co-opted aspects of scientific thought and, like Mosley, his methods can be viewed in terms of prevention.\(^{33}\)

In a similar way to *Truth*’s critical attitude towards a diverse range of alternative practitioners, Devereux critiqued the methods of the medical profession in respect to cancer. Devereux was a regular commentator in the *The Press* on issues of diet and published his own regular pamphlet entitled, *The Green Leaf*. This section’s focus is on Devereux’s critiques of the medical profession in respect to cancer and its treatment methods. Devereux’s views also engaged with the issue of cancer causation. In some ways, Devereux is a successor to the concerns surrounding the impact of meat on the increase of cancer discussed in Chapter Three. He also represents a sense of continuity in respect to alternative practitioners in the 1890s and 1900s. Devereux’s critiques are a continuation of public scepticism about the motives of the medical profession as well as concerns about the efficacy of treatment methods. Devereux’s significance as a commentator is evident in terms of the DOH’s concern about the nature of his commentary and in respect to the fact that he was a prominent and well-known figure in the letters columns in the *Press*. Like many alternative practitioners, Devereux is a difficult figure to track information on. He appears in the press contributing to controversial debates and I

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only discovered his periodical publication, *The Green Leaf*, because of concern from a medical officer of the DOH.\(^\text{34}\)

In 1923 and 1924, Devereux was involved in a debate in the *Press* about the cause of cancer. Around this time, there was renewed interest in issues surrounding cancer’s cause. This was predominantly the result of renewed claims about cancer being bacteriological in origin. Dr James Glover, a medical practitioner and researcher at McGill University, Canada, claimed to have discovered a serum and across the 1920s and particularly in 1924 when there were a series of medical investigations into Glover’s anti-cancer serum.\(^\text{35}\) Devereux’s discussion of diet and cancer in the *Press* demonstrates the continuation of lay engagement with theories about the nature and cause of cancer and how this engagement was shaped by the contexts surrounding cancer, as discussed in Section A. Devereux claimed that the ‘horrible scourge of cancer’ was ‘overwhelming our land’.\(^\text{36}\) Devereux also drew on commentary in the *New Zealand Medical Journal (NZMJ)* by William Herbert, a former president of the New Zealand Branch of the British Medical Association (NZBMA). Devereux quoted Herbert’s 1916 article, discussed in Chapters Two and Four, directly in relation to commentary indicating that New Zealand’s rate of cancer relative to tuberculosis was particularly concerning. It was within this context that Devereux could justify lay commentary on medical matters. He believed that ‘any reasonable’ theories should be given due consideration, ‘even by a layman’. Devereux believed scientific medicine had left a ‘hopeless blank’ in its response to questions about the cause of cancer.\(^\text{37}\) It was in this vacuum of knowledge that lay practitioners, like Devereux, could justify the legitimacy of their theories and gain publicity.

\(^{34}\) James Devereux, *The Green Leaf: Official Organ of the New Zealand Food Reform and Anti-Cancer League*, Christchurch: James Devereux, 1926, 2.41, in Diseases Cancer, 1921-4, H1, 1957, 131/16, ANZW; in addition to this, I have found two editions available for sale in the United Kingdom that I have the front page off: James Devereux, ed., *The Green Leaf: Official Organ of the New Zealand Food Reform and Anti-Cancer League*, Christchurch: James Devereux, 1926, 2.43; *The Green Leaf: The Dietetic and Good Health News*, Christchurch: James Devereux, 1927, 3.1.


\(^{36}\) Devereux, letter to the editor, *The Press*, 30 Jun., 1923, 30 1923, Diseases Cancer, 1921-4, H1, 1957, 131/16ANZW.

\(^{37}\) Devereux, letter to the editor, *The Press*, 4 Sep., 1923, Diseases Cancer, 1921-4, H1, 1957, 131/16, ANZW.
The idea of modern society and the role of civilization were significant in the make-up of Devereux’s theories, echoing evidence in Chapter Three. Devereux claimed that despite all the scientific investigations into the cause of cancer, there was only one fact that had been conclusively decided: ‘the higher the civilization the more the cancer’. This link with civilization and modernity included the development of cities: ‘the thicker the population in our civilized countries, the more the disease exists’. Devereux pointed to the fact that disease incidence in the country was less than urban areas as evidence in support of this claim. The explanation for this difference, according to Devereux, was that those living in the country are more likely to consume food that was ‘natural’ and ‘wholesome’. Devereux used the fact that Japan ‘had no cancer’ until it modernized and that it ‘established completely’ that tumors were ‘unknown’ in ‘native races’ as evidence to support his civilization thesis.

With these assumptions about the role of civilization, Devereux then extended this rationale to changes in dietary habits of modern civilization. In a letter to the editor of the Press, Devereux claimed that ‘meat eating is too prevalent’, ‘tea drinking should be abolished’, and sugar should be minimized. In Devereux’s opinion the greatest threat to individual health was the impact of white flour, ‘the chief and most terrible cause’ of cancer. Devereux attributed historical examples, like 4,000 deaths occurring during the construction of the Madeira-Mamore railway in Brazil, to the eating of white flour. ‘Where whole meal bread and flour have been used these tragedies did not occur’, Devereux wrote. The basis for the criticism of white flour was that it did not provide the necessary levels of nutrition for the body.

In his discussion of cancer and diet, Devereux drew on scientific theories as explanatory models to support his hypotheses. In particular, Devereux drew on

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38 Devereux, 30 Jun., 1923.
39 ibid.
40 4,000 deaths is Devereux’s figure; historical estimates range between 7,000-10,000 deaths; ibid.
41 ibid.
cellular theory to justify his explanations. Devereux claimed that the body was an ‘electrical machine’: ‘Each little cell is an electrical cell, a producer of energy and heat’. This machine, he claimed, required the ‘correct substances’ in the form of diet. If the body and cells were not getting the substances they needed, then ‘cell decay’ could occur. Central to his theory was that some diets lacked appropriate minerals. For example, cooked vegetables resulted in important minerals being poured down the sink. Devereux outlined his own household diet as an exemplar: all cooking was abolished; breakfast was a raw vegetable meal; lunch consisted of nuts and raisins; and raw fruit eaten at night. Devereux argued that pregnant mothers who had a natural diet avoided the ‘complications of civilized mothers’. In addition to this, he claimed that a return to a natural diet would see cancer rates return back down to levels that were found in Maori and other native races.

In addition to his writing in the press, Devereux reiterated his beliefs through the publication of his own edited pamphlet, The Green Leaf, in 1923-4. However, unlike Devereux’s newspaper commentary that came across as relatively balanced, a series of articles in The Green Leaf were extremely critical of the motives and methods of the medical profession. The Green Leaf published articles that challenged medical treatment of cancer. The opening page of the March edition contained an article entitled ‘The Radium Cure Fraud’. Radium was believed by Devereux to be ‘One of the worst and cruelest hoaxes’, involving ‘unscrupulous members of the medical profession’. Devereux claimed that from ‘time immemorial’ the medical profession had attempted to control people’s ‘purses and lives’. The medical profession were characterized as ‘wholesale pirates and murderers, sailing under the false colours of public benefactors’. Devereux claimed that doctors had done this by writing prescriptions in a ‘mysterious language’ and by pouring ‘poisons’ down the throats of innocent patients. In the past, such concoctions had included ‘cat’s brains, dried and powdered blood of white puppy-dogs, old man’s urine, [and] sheep’s excrement’. In modern times ‘deadly

42 Devereux, 4 Sep., 1923.
43 Devereux, letter to the editor, The Press, 27 May., 1924, Diseases Cancer, 1921-4, ANZW.
mixtures’ including mercury, arsenic, and iodine were still used, and ‘excrement of typhoid patients’ for vaccines.  

According to Devereux, the most recent of the medical profession’s poisons was radium. It is interesting to note that at the time of writing this critique in the 1920s, the DOH still had reservations about the efficacy of radiotherapy, as discussed in Chapter Five. Radium was used, in Devereux’s opinion, ‘purely and simply as burners’. Devereux claimed that the average person had been tricked into believing the ‘sheer nonsense’ of the mysterious healing power of radium. The only difference between radium and a ‘red hot poker’ was that it was possible to regulate the damage done by the red hot poker, but it was impossible to ‘control the damage’ done by the deadly radium rays’. Radium rays, Devereux claims, had been responsible for cases of cancer in New Zealand. Devereux even cited the uncertainty of radium treatment from a report from the Middlesex Cancer Hospital, United Kingdom, that concluded radium as a cure when cancer was advanced was ‘rarely possible’. Devereux claimed that the treatment of cancer by radium was medical experimentation on ‘unsuspecting victims’ and a ‘crying shame’. There was no remorse from the medical profession in Devereux’s view as their medical training made them ‘callous to suffering and death’. Devereux claimed that one medical professional secretly admitted to him that he had killed so many patients that it ‘mattered little’ if a few more deaths were added to the list. It was also claimed that experimental surgery was done on patients near death in order to line the surgeon’s pocket.

As was the case in Devereux’s newspaper letters, The Green Leaf also claimed that a natural approach was the best way to combat cancer. This had included ‘pure nourishing and cleansing foods’. Ideal foods were uncooked foods like nuts, fruits (dried and fresh), salad, greens, tomatoes, whole meal bread, and a little butter and cheese. The ‘dismal failure’ of scientific medicine to find a cause of cancer was 

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44 Devereux, The Green Leaf, 2.41 (1926), p. 81.
45 ibid.
46 ibid., p. 82.
47 ibid., p. 83
‘convincing proof’ that there was something wrong with medical theories. This extended to the criticism that they still could not even cure the common cold that remained a ‘dark mystery’ to them. Devereux’s opinion was that disease came from a failure to comply with nature.48 The drinking of milk by cancer sufferers was believed to be suicidal by Devereux as it was intended to stimulate and speed growth.49 It was believed to be ‘harmful and dangerous’ to the human body.50 According to Devereux, life began from a single cell and the cause of cancer was the development of excess cellular growth in deteriorated organs. Those who had not looked after themselves properly risked putting their bodies into a weakened state and were unable to stop the growth. This explained why cancer was more frequent in those of older ages and it was ‘nature’s inevitable method of penalizing weakness’.51 Devereux blamed alcohol, sexual indulgence, or a wrongly balanced diet. Drugs, tea, sugar, white flour and meat were out, and fruit, nuts, and green leaves in a natural unspoiled and uncooked state were in.52 The cause of cancer was not some great unknown but merely a ‘law of the universe’. 53 Devereux’s approach was a mixture of cellular theory and theories relating to the impact of civilization.

Devereux’s views gained the attention of the DOH. Devereux attacked the NZBMA and doctors strongly. In response to some readers writing to The Green Leaf, who believed Devereux was too hard on the doctors, Devereux replied that he was merely ‘opposed to wholesale murder and slaughter’.54 As Devereux was based in Christchurch, Dr J. Fletcher Telford, medical officer of health for Canterbury and the West Coast, drew attention to Devereux. In 1924, Telford added a handwritten note for the Director-General of Health, Thomas Valintine. The note observed that Devereux was a ‘regular contributor in correspondence columns’ on the subject of diet and cancer.55 Devereux also courted the attention of the Prime Minister, William Massey, and forwarded a collection of his newspaper clippings and requested that they be forwarded to ‘appropriate officials’. Massey

48 ibid., p. 117.
49 ibid., pp. 180-181.
50 ibid., p. 84.
51 ibid., p. 180.
52 ibid., p. 178.
53 ibid., pp. 117, 180
54 ibid., p. 190.
55 J. Fletcher Telford to T.H. Valintine, 27 May., 1924, Mosley, ANZW.
replied that he had forwarded the articles to DOH officials.56 Concern about the strong critical tone of *The Green Leaf* led to Telford asking Valintine about the prospects of prosecution in 1926. Telford asked if section 23 of the *Medical Practices Act* could be applied. The standard of this section meant that it would need to be proved that Devereux was offering a cure under the deception that he was a qualified doctor. Telford warned that any failure on their part ‘would give him undue advertisement, and he would get an added list of sympathetic supporters, should it be considered that the department was endeavouring to victimize him’.57 Watt replied, that ‘it was inadvisable to take any action’.58 While the position of *The Green Leaf* and Devereux’s letters could be characterised as being part of the fringe, enough attention was created to cause concern for the DOH. It represented a strong voice of dissent against medical professionals and medical practice. In the large daily newspapers, medical professionals and their methods came under criticism but not to the extent of *The Green Leaf*. A focus on natural ways to combat cancer through diet is part of a continuing trend that goes on into the 1930s and beyond.

56 W.F. Massey to James Devereux, 15 Jul., 1924, Mosley, ANZW.
57 Telford to Valintine, 30 Mar., 1926, Mosley, ANZW.
58 M.H. Watt to Telford, 15 Jun., 1926, Mosley, ANZW; see also *New Zealand Statutes*, Wellington: Govt. Printer, 1914, no.74, s23.
Conclusion

Mosley scattering sulphur around homes and Devereux publishing venomous anti-medical establishment commentary and promoting a natural diet is part of a continuing tradition of alternative practice. While they represent the plurality of medicine, they also represent the continuity and prominence of alternative belief systems and treatments. These practitioners were not pushed out into the margins: in the case of Mosley, it was hoped that he would leave public health authorities alone, and it was decided that no action was the best response to Devereux. Alternative theories and treatment methods also received support from political figures and a lot of attention in the press. The failure of the medical profession and scientific authorities to find a cause or cure for cancer, in conjunction with increasing expectations of scientific medicine, created an environment that was conducive to allowing alternative beliefs and treatments to proliferate. These theories and treatments often contrasted and critiqued the methods of the medical profession and continued to challenge the rise of the medical profession’s status. In order to add legitimacy, such beliefs also drew on scientific theories and language and this also gave them a sense of scientific legitimacy. The rise of the medical profession and the decline of alternative medicine need reconsideration. Building on this chapter, Chapter Nine, develops this argument of continuity. By looking at alternative methods that never had associations with the status of the medical profession, the continued popularity and prominence of alternative practitioners means historians should not be too quick to assign the medical profession a monopolized status.
Chapter Nine

Alternative Cancer Practitioners in the Era of Medical Monopolisation, 1929-39

This final chapter on alternative medicine shows how the confrontation between medical professionals and alternative practitioners continued to play out. This problematizes Michael Belgrave’s argument that the 1930s was the time that the medical profession reached its zenith.¹ I argue that the prominence and practice of alternative practitioners remained relatively constant throughout the interwar period. Through two case studies, it will be seen that a number of themes and arguments from the previous Section C chapters continued into the 1930s. The first theme is the persistence of a counterculture that distrusted medical professionals and often feared and rejected orthodox medical treatments for cancer. The second is the continuation of public conflict between different modes of medicine and the antagonistic attitudes of medical competitors. Thirdly, the contrasting beliefs between medical and popular perspectives about disease and treatment remained. Finally, alternative medicine was not marginalised out of the medical market place but remained a prominent feature in an era when a plurality of treatments was on offer. This chapter examines these themes through two contrasting case studies, the first is of a lay practitioner and the second is of a qualified medical practitioner who abandoned orthodox medicine.

White’s Kerosene Cure

In May 1929, Louis Norman White, a forty-six year old railway labourer, wrote to the Minister of Health, A.J. Stallworthy, about his cure for cancer. White recounted that he had received an injury that developed into prostate cancer and was treated with surgery and radium. He claimed to have successfully treated himself with a kerosene cure for incurable cancer of the rectum and wanted his claims to be investigated by the Department of Health (DOH). White’s narrative is a tale that includes the failure of scientific medicine to cure cancer and the success of his own alternative therapy. The basis of White’s claim to success was evidence based on personal experience. There was a contrasting narrative from medical authorities. This indicated that White’s treatment with surgery and radium was a success and that the value of kerosene in the cure for cancer was limited. In short, the case study of White indicates a conflict between medical and alternative perspectives that were based around different approaches in proving the legitimacy of a cure.

In response to White’s request for an investigation, the DOH sent Dr Jonathan Boyd, the medical officer of health for Auckland, to inquire into the merit of his claims. Boyd’s report to the Director General of Health, Dr Thomas Valintine, was a narration of the facts from White’s perspective. It stated that White been a cancer patient at Auckland Hospital in 1927 and was discharged and told that he had one month to live. After being abandoned by the medical profession, White claimed to have suffered from ‘intense pain’. In an attempt to alleviate his suffering, White injected cold kerosene as an enema without success. He claimed to have successfully cured cancer after injecting heated kerosene at forty-eight degrees Celsius into his rectum. This was followed by olive oil to alleviate any pain the injection of kerosene may have caused. White claimed that the skin of the growth

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started to peel away. Using language that was reminiscent of the nineteenth-century magnetist, Milner Stephen, this eventually caused a ‘hard and solid tumour’ to break away ‘roots and all’. White’s description of events ties in with typical popular interpretations and beliefs about the nature of cancer.³

In October 1929, White’s cancer cure began to receive public attention through the media. The Dominion reported a version of events that indicated that he had successfully cured cancer. White had been sent to Auckland Hospital but had been sent away as being incurable. In dramatic fashion, the Dominion wrote that White had to ‘wait for death’ and in this desperate state, he tried the kerosene injections that cured him of cancer.⁴ After the initial newspaper reports, the Dominion informed its readers that White had been ‘inundated’ with inquiries into his cure. Reportedly, there were so many inquiries that he would not be able to reply to all of them.⁵ The evidence of his popularity indicates that the public continued to be enthusiastic to find out more information about alternative cancer cures. Even Dr C. E. Maguire, the medical superintendent of Auckland Hospital, received a letter from a South Island doctor who had an ‘insistent’ patient who wanted to try White’s remedy. Maguire warned that the excess publicity given was unwise at it built up false hopes in the public.⁶ From these reports, it seemed that lay reports of cures attracted a great deal of attention from cancer sufferers. It is likely that interest in such cures stemmed from the same motivations as always. This includes cancer sufferers in a hopeless state who had been abandoned by the medical profession and those who wanted to bypass the treatment methods of the medical profession.⁷

In the newspaper reports, the different approaches to ‘proof’ between medical and popular perspectives are evident. White’s claim to cure was based on evidence from his own experience. The basis of this is the fact that personal narratives or

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³ John Boyd to T.H Valintine, 7 Sep., 1929, in White, ANZW.
⁴ Dominion, 21 Oct., 1929, in White, ANZW.
⁵ Dominion, 24 Oct. 1929, in White, ANZW.
⁶ ibid., 26 Oct., 1929, in White, ANZW.
testimonials were accepted as a form of proof. White claimed that two doctors had examined him and declared that he was incurable. He then claimed that the simple fact that he remained ‘alive and well’ was ‘sufficient proof’ of a cure. In addition, White claimed that a medical officer from the DOH had inspected him and confirmed that the cancer was no longer present.⁸

It was reported that Peter Fraser, a future Minister of Health, had inquired on behalf of White to A.J. Stallworthy, the Minister of Health. Stallworthy’s response to Fraser’s questioning indicated that he was sceptical about the validity of White’s claims. It was based on a medical approach to proof. A more elaborate form of proof was needed that was based around current medical theories, the establishment of diagnosis by tissue examination, and evidence of cure and non-recurrence. Stallworthy claimed that the medical officer of health had not proclaimed a cure but only indicated the non-existence of cancer. In the nineteenth century, medical practitioners openly confronted alternative practitioners in the press and at their presentations. By the 1930s, the type of confrontation had changed. Alternative practitioners were to be discredited by a thorough medical investigation and Stallworthy announced that the Auckland Hospital Board had begun to make inquiries.⁹

Dr James Elliott, president of the New Zealand Branch of the British Empire Cancer Campaign (NZBECC), rectified any false inference from the public that White had successfully cured cancer. Elliott wrote that the cancer campaign had received communications ‘from several people’ claiming that private individuals had cured cancer. This fact itself indicates lay engagement with medical institutions in trying to find a cure for cancer. Elliott warned of the danger of the press giving publicity to such cures that had not been medically substantiated. He claimed that White used kerosene as a ‘destructive agent’ and this type of approach had been attempted before with caustics and arsenic. In Elliott’s view, these methods were ‘not equal to the knife’. He used the publicity of White’s cancer cure

⁸ *Dominion*, 24 Oct., 1929, in White, ANZW.
as a platform to forward the position of the medical profession and to denigrate alternatives. The use of kerosene and its ‘drawing’ effect were labelled as ‘unscientific’. Elliott was also careful in his wording, in order to try to prevent coming across as being too antagonistic, and he claimed that ‘reasonable suggestions’ should be made to the appropriate authorities. He believed that if the public were interested in the cancer problem, they could consider donating money to the cancer campaign to fund research. A gauntlet of proof was laid down for White to substantiate his claim, including a confirmation of diagnosis by microscopic examination.\textsuperscript{10}

Public health and medical authorities wanted to ensure that White’s claim of success was thoroughly disproved and they constantly challenged the validity of his claims. Valintine, writing to a medical colleague, indicated that White was diagnosed with cancer, but a microscopic examination was necessary for any form of legitimate confirmation.\textsuperscript{11} Maguire pointed out to the press that there were mistakes in White’s story. First, the medical records indicated that he had not been discharged from Auckland Hospital as incurable. Second, his own treatment was for a different body part than that examined by the hospital. Finally, it was believed that he had been cured of cancer with the removal of a tumour by surgery.\textsuperscript{12} This was corroborated in a report by Dr Neil McDougall, White’s physician, and Dr Frank Macky, White’s surgeon. It was asserted that he was ‘certainly suffering from a form of cancer’ but he was treated by surgery for this and received follow-up treatment with radium. McDougall testified that when White left them he was ‘fit and well’.\textsuperscript{13} Maguire wanted to discredit White’s cure and warned that the excess publicity given was unwise as it built up false hopes.\textsuperscript{14}

While the \textit{Dominion} provided White’s side of the story, \textit{Truth’s} view on the issue of White’s cancer cure was similar to the voice of the medical profession. \textit{Truth}

\footnotesize\textsuperscript{10} ibid., 25 Oct., 1929, p. 10.
\footnotesize\textsuperscript{11} T.H. Valintine to Dr Jamieson, 25 Oct., 1929, White, ANZW.
\footnotesize\textsuperscript{12} \textit{Evening Post}, 26 Oct., 1929, p. 10.
\footnotesize\textsuperscript{13} ibid., 28 Oct., 1929, p. 10.
\footnotesize\textsuperscript{14} \textit{Dominion}, 26 Oct., 1929, White, ANZW.
believed that there should be ‘reservations’ about the cure. Truth also stated that the ‘wide publicity’ given to White’s cure was ‘premature’ and would raise false hope in cancer sufferers. Along the same lines of Maguire, it claimed that White’s cure should not be seen as a ‘heaven-sent discovery’ until ‘proof’ was discovered. On the other hand, Truth also believed that the claims made by White as a nonprofessional were ‘worthy’ of investigation. It stated that ‘medical science’ owed a lot to ‘chance discoveries’ by laymen and it did not want to ‘belittle’ White’s claims as they ‘may prove’ to be a cure for cancer. In Truth’s opinion, it was the ‘duty’ of the DOH to ‘thoroughly investigate’ White’s claim. On the one hand, Truth was prepared to give some legitimacy to lay cures, but on the other hand, it was insisten that it needed to be confirmed by the medical profession, the cultural arbiters of disease.

While New Zealand’s health bureaucracy began to investigate White’s cancer cure, White himself began treating cancer sufferers around New Zealand. The Dominion reported that as a result of the wide publicity regarding White’s cancer cure, he had travelled to South Otago at the request of a resident to practise his cure. The sufferer passed away because of external complications. It was claimed that before these complications ‘success seemed imminent’ and the cancer had been ‘arrested and was headed towards cure’. In this report, some information on White’s methods was divulged. For external cancers, he used kerosene like a poultice and this would initiate the ‘drawing’ out of the cancer. Sulphur was added afterwards. For internal cancers, like stomach cancer, the sufferer was to drink as much hot water as possible and this was to be followed by at least an eggcup of kerosene. For cancer in the bowel, White recommended an enema that was undertaken through an injection of hot water through syringes, which was followed by kerosene. The kerosene was to be left in the bowels overnight.

Publicity for White’s treatment in action continued to spread. Another case that he was treating was a Wellington cancer sufferer who was considered to be

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15 NZ Truth, 7 Nov., 1929, p. 6.
16 Dominion, 20 Nov. 1929, in White, ANZW.
incurable. The progress of this case showed ‘signs of favourable improvement’. White made no claim to medical knowledge but continued to assert that the kerosene ‘draws out’ the cancer. He even treated an injured mare that had been given up by veterinarian surgeons and was going to be shot.\textsuperscript{17} White’s cancer cure went beyond his personal attendance and sufferers began to experiment with kerosene themselves. A Dannevirke man, who had read of White’s cure, tried it out for himself and reported that his growth was being made smaller as a result.\textsuperscript{18} An example like this provides a snippet of evidence in respect to self-medication by cancer sufferers. In general, only evidence of notorious cases reaches the public; how widespread such actions were is uncertain.

The spread of White’s cure was a concern to the DOH. In late November 1929, Dr M.H. Watt, the Deputy Director-General of Health, wrote to Maguire asking for the facts of the case to be brought to light: ‘I regret giving you this much trouble, but it is rather important to be able to correct the very wild statements being circulated. We are even receiving cables from Scotland on the subject’.\textsuperscript{19} Maguire’s reply in early December was to give an initial indication that there was no evidence of any rectal disease presented (as White had claimed) and that any statement to the contrary was ‘imaginary’.\textsuperscript{20}

Over time, \textit{Truth} increasingly took a hostile position against the spread of White’s unproven cure. It warned the public over the potential dangers and criticised the lack of action on the investigation front. A front-page story in early December 1929 warned sufferers to avoid treatment until an investigation by medical professionals had given its verdict on White’s claim to cancer cure. \textit{Truth} reported that White had been ‘besieged’ with letters from ‘hundreds’ of sufferers, indicating the popular nature of alternative cures as part of his investigation. \textit{Truth} interviewed him about some of his cancer cures in Wellington. White claimed he was personally treating two women who had been diagnosed with incurable

\textsuperscript{17} ibid.
\textsuperscript{18} ibid.
\textsuperscript{19} M.H. Watt to C.E. Maguire, 27 Nov., 1929, White, ANZW.
\textsuperscript{20} Maguire to M.H. Watt, 2 Dec., 1929, White, ANZW.
cancer. In both cases, he claimed there had been ‘remarkable improvement’ in less than a week and one case had the cancer ‘breaking up’. Truth investigated one of the cases and interviewed the sister and mother of one of White’s patients. The sister claimed that his treatment ‘made no difference’ and that he had been asked to leave the house; the mother told Truth that White’s claims were ‘absurd’ and believed it ‘wrong of him’ to ‘deceive the public’ that her daughter’s case had been progressing.

Truth also started questioning some of the evidence that White had presented about his own cancer cure. It asked how the statement that White had been treated for cancer with surgery and radium could be corroborated with White’s claim that he was informed that he had a month to live. Truth asked that an investigation into the facts by the DOH should be ‘immediately carried out’ and an investigation into whether any pathological examination of the growth was taken. Truth was informed by Watt that the DOH was awaiting information on the issue from Auckland Hospital.21

By mid-December, Truth was damning of the DOH over its lack of action. Truth claimed that the delay caused by the department was a ‘menace to the public health’. It could not work out why the DOH had approached the issue of White’s claims with such ‘casualness’ and believed some explanation from the Minister of Health was needed. Truth believed that the department was ‘as far away’ from making some ‘authoritative statement’ on the matter as ever. It characterised the speed of the Department’s response as being outstripped by a tortoise.22

Truth’s criticisms and the spread of White’s cure put pressure on the DOH to complete a full investigation promptly. The day after Truth’s criticism, a message from Watt was left for Mr Drake of the Auckland Hospital Board by a staff clerk. It indicated that Watt rang and wanted to make sure that certain particulars were

included in the final report of the investigation into White’s cure. Watt wanted to make it clear that White’s treatment of his rectum had nothing to do with the treatment he received for prostate cancer by medical authorities. Watt also wanted to reiterate the point that after the surgical removal from the prostate the treatment with radium would have remedied any recurrence.23

The final report on White’s cure by Auckland Hospital is located in the archives without a date. Its generation and publicity happened somewhere between a memorandum on 20 December 1929 and the newspaper publications on 8 January 1930. The report claimed that the following were the established facts: in 1926, White had a sarcoma of the right testicle; in 1927 he revisited Auckland hospital with a recurrence of this enlargement of the right testicle; the effect of the treatment was ‘most favourable’; and there was no evidence of any trouble in the rectum.24 As there was no tissue sample taken, it could not be concluded that White definitely suffered from malignant cancer.

On 8 January 1930, it was reported that Watt, now Director-General of Health, had submitted a final report on White’s alleged cancer cure to Stallworthy. The main message in this news report was the same as the important points that Watt had rung Auckland Hospital about. It was reported that White’s ‘satisfactory condition’ was because of the success of surgery and radium. Any evidence of the tumour had disappeared before White left the hospital or experimented with kerosene.25 On 16 January 1930, Truth reported that the DOH delivered a ‘K.O.’ to White’s claims. It was reported that the medical experts were ‘not impressed’ and that because of White’s notoriety, ‘hundreds’ of sufferers made inquiries about his suspect treatment. Truth believed that the lure of White’s offer was the fact that his assertions were put in ‘unequivocal terms’ with ‘no doubts or reservations’: ‘his method spanned the gap, however wide, disclosing vistas to unfortunate people,

22 Staff Clerk to Mr Drake, 20 dec., 1929, White, ANZW.
23 Report on the Cure for Cancer by Mr L. N. White, Hamilton: A Summary of Facts, nd, White, ANZW.
24 Evening Post, 8 Jan., 1930, p. 11.
buoying them with hope long since deferred’.\textsuperscript{26} Watt announced to the press that it could not even be proved that White had ever suffered from cancer.\textsuperscript{27}

White retaliated against these claims and reiterated his version of events through the press. He protested that Watt’s statement was ‘misleading and absurd’ and that he had been discharged as being incurable and the Railway Department had been notified of this fact. White further stated that patients under his care had shown ‘noticeable improvement’ but he was ‘too late’ to affect a ‘permanent cure’. In addition, he denied any claims that he was turning his treatment into a commercial venture.\textsuperscript{28}

Despite the investigation’s conclusion, White continued to treat patients and to harass the government into investigating his successful cures. This indicates a continuation of the limits of the DOH and the medical profession to restrict alternative medical practitioners. In February 1930, he wrote to Stallworthy, in response to an Auckland Town Hall meeting arranged by the NZBCC to encourage donations for a reward to cure cancer. In this letter, White attacked medical methods of treatment like radium and claimed that they caused ‘intense harm’.\textsuperscript{29} These comments tapped into public distrust of the motives and efficacy of medical professionals and were a prominent feature of the antagonistic conflicts between different medical modes of practice.\textsuperscript{30} The advice from the DOH to Stallworthy was that White’s case never benefitted from a kerosene cure. Stallworthy referred to the hospital records showing that any signs of cancer had disappeared because of the hospital’s treatment before White started using kerosene. In explicit terms, Stallworthy wrote, ‘You owe your state to the use of surgical treatment and radium’. Stallworthy stressed this point because he believed through White’s ‘ignorance’, he was ‘doing a great deal of harm’ to cancer sufferers by encouraging them ‘to put their faith in a useless treatment’.\textsuperscript{31} White, stubbornly refusing to

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  \item \textit{NZ Truth}, 16 Jan., 1930, p. 7.
  \item \textit{Evening Post}, 28 Jan., 1930, p. 12.
  \item \textit{Dominion}, 29 Jan., 1930, White, ANZW.
  \item White to Stallworthy, 4 Feb., 1930, White, ANZW.
  \item Gevitz, pp. 14-20.
  \item Stallworthy to White, 14 Feb., 1930, White, ANZW.
\end{itemize}
accept the official record of events that happened to him, replied to Stallworthy and reiterated his version of his treatment.\textsuperscript{32}

In March 1931, White stepped up his efforts to get his cure recognised by public health authorities. He wrote to Stallworthy informing him of his success in curing cancer cases with kerosene and asked for his treatment to be evaluated as it was for the ‘benefit of humanity’. His constant haranguing of medical authorities for recognition is indicative of a climate of plurality in the treatment of cancer. The medical profession could attempt to discredit White’s methods but they could not enforce a monopoly by stopping White’s practice. The matter was referred to the DOH who investigated White’s claims.\textsuperscript{33} In June 1931, Boyd interviewed two of White’s cancer patients. The first case, Mr S., was concluded not to be cancer.\textsuperscript{34} The patient had seen several doctors and received inconsistent diagnoses. White’s methods had diversified from kerosene alone. For Mr S., he used a ‘spray machine’ that included a mixture of kerosene and almond oil. This led to a lot of blood coming up and the patient feeling better. In terms of popular perspectives of healing, the experience of White’s treatment was a type of cure because it alleviated the symptoms and suffering. In addition to kerosene treatment, he had also prescribed a diet that included orange and lemon juice to drink, and fruit, eggs, and vegetables with the water they were boiled in.\textsuperscript{35}

Mrs M. was the second case of White’s that Boyd interviewed. In December 1930, Mrs M. had been told by her general practitioner, Dr Richards, to go to Auckland Hospital with suspected cancer of the cervix. Instead of following her doctor’s advice, she went to White for a cure. Mrs M. chose to bypass orthodox methods of treatment and avoided surgery. White stipulated that he would only take patients who had a written statement from a medical authority that they had cancer. In this case, Richards’ suspected diagnosis was enough for White to treat cancer. White prescribed ‘intra-uterine’ injections of hot kerosene, and hot packs of

\textsuperscript{32} White to Stallworthy, 21 Feb., 1930, White, ANZW.
\textsuperscript{33} White to Stallworthy, 15 Mar., 1931, White, ANZW.
\textsuperscript{34} Specific details of patient names have been omitted in compliance with archival access conditions.
\textsuperscript{35} John Boyd to M.H. Watt, 12 Jun., 1931, White, ANZW.
bran and kerosene externally. In addition, a tonic of lemon and orange, liquorice, and salt were to be taken regularly. In terms of diet, meat and starchy food were out, and eggs in orange or lemon juice beaten up with olive oil were allowed. When Richards originally examined Mrs M. he found that her cervix was ‘indurated’ and ‘craggy’ and had a ‘foul discharge’. After White’s treatment, Richards examined Mrs M. and concluded that the cervix had ‘cleaned up’ and was ‘no worse’. From a popular perspective, this result was an effective cure by improving the symptoms. Despite this, Richards still recommended that Mrs M. should go to hospital and have surgery. Boyd’s closing remarks indicate that he believed White was becoming a charlatan. Boyd believed if kerosene had any virtue, that its use should be limited to registered medical practitioners. Such a perspective ties in with the motives of the medical profession in attempting to impose medical monopolisation on all treatment or in an attempt to ensure patient safety.

A health inspector named Wykes had made further investigations. He interviewed another of White’s patients and his report was passed onto the DOH in July 1931. The patient, Mrs S., had been diagnosed as having a gastric ulcer in the stomach, and during an operation this was discovered to be cancer. The operation had made Mrs S. worse: before the operation, she suffered pains like a ‘cutting machine’ in her stomach; after the operation, she could not take any food and remained in hospital for eight weeks. Such experiences of surgery helped contribute to the continuation of popular dread of cancer and surgery. After being moved into a private home, White was brought in to try to remedy Mrs S.’s suffering. This example reiterates one motivation for seeking out alternative methods — the failure of surgical intervention to provide a cure. Within three days of White’s treatment, she claimed that all vomiting had stopped and vouched to continue White’s treatment until the pain had completely gone. The Auckland Hospital authorities wanted to get an X-ray of the condition as they had found a hard carcinoma growth and believed the alleged improvement was only temporary. The patient was not forthcoming in returning to the methods of the

36 ibid.
37 Herbert Chesson to M.H. Watt, 28 Jul., 1931, White, ANZW.
medical profession and refused to have an X-ray. By the end of July 1931, Watt was
going anxious and requested the completion of the report. The contrast between
medical and alternative approaches to healing appears again. To Mrs S. the
treatment was successful and alleviated suffering; while from a medical
perspective, any confirmation of a cure required a thorough medical examination.

In early August, a full report written by Dr Walter Gilmour, director of the
pathological department of Auckland Hospital, was sent to Watt. The report
discussed details of eight cases that White had presented to them across four
interviews. The first case of cancer of the testes was believed to be successfully
treated by radium before White applied his kerosene and there was no evidence of
recurrence. The second case was a Whangarei man with cancer of the chest wall
who was never seen by White and no name, address, and condition was provided.
This case is indicative of the spread of self-medication of cancer sufferers through
Correspondence. The fourth case was a patient from Wellington who had breast
cancer. Again, White had not given enough information for the investigators to
trace her whereabouts. The sixth case was one of cancer in the stomach. White could
not provide any details, including a name and address, except to say he believed
the man to have left the country. The seventh case was for cancer of the breast and
the medical authorities in Balclutha who had treated the patient described White’s
methods as unfavourable and informed the committee that the patient had died.
The lack of specific verification of details about the cases meant that none could be
considered legitimate cures.

Medical officials had interviewed the other three cases previously. Mr S. had
received several medical diagnoses but none were for cancer; Mrs M. presented
with a tumour of the uterus but there was no evidence of cancer; and Mrs S. had
inoperable cancer of the stomach and the effectiveness of White’s treatment had yet
to be verified by X-ray. The report presented a strong negative opinion of the
efficacy of White’s treatment. It concluded that his treatment had ‘no scientific

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38 M.H. Watt to the Secretary of the Cancer Committee, Auckland Hospital, 30 Jul., 1931, White, ANZW.
basis’, had not been proven to be effective in combating cancer, and that it was ‘against public interest’ to allow him to treat people. In short, the committee was ‘quite convinced of the entire uselessness’ of White’s method of cancer treatment. Despite negative conclusions, there is no evidence that could categorically deny White’s claims to truth. The process established to prove a cure was stringent, often more stringent than the medical profession applied to itself: a confirmed cancer diagnosis by tissue sample; examination of the treatment; and a final confirmation of cure and no reoccurrence.

The responses to the conclusions of the report was mixed. Watt thanked Gilmour for the report that corroborated what his medical officers had found and concluded that the claim of cancer cure by White was ‘groundless’. The New Zealand Herald reported that the medical staff could give ‘no credit’ to White’s cures and that the treatment may be ‘deleterious’ to the patient. The newspaper report highlighted the fact that there were three untraceable cases, White’s treatment had negative effects, and that most of the cases could not be confirmed as being a definite form of cancer.

In response to the report, both White and one of his former patients wrote into the Herald. This patient claimed that she had letters from her general practitioner that stated that she had cancer, that White successfully treated her, and that her doctors ‘got a shock’ when there was no sign of cancer being left. The patient claimed that ‘surely this is sufficient to prove my case’ and hoped that for ‘humanity’ White should be assisted. A reply to the letter from Gilmour stated that she had a tumour of a non-cancerous nature and that he doubted that she ever had cancer.

39 Auckland Hospital Pathological department Report to M.H. Watt, 5 Aug., 1931, Ref 131-72-33, White, ANZW.
40 M.H. Watt to James Gilmour, 7 Aug., 1931, White, ANZW.
41 NZ Herald, 28 Sep., 1931, White, ANZW.
42 M.A. Meader, letter to the editor, NZ Herald, 6 Aug., 1931, White, ANZW.
Writing the following month to the *New Zealand Herald*, White believed a ‘great injustice’ had been done. He was defensive about his methods and stated that he made no claim to cure cancer by kerosene alone and that his ‘natural’ methods had ‘surprising’ results. The shift in diversifying his treatment methods helped White appeal to the general public. He indicated that he had evidence, with former sufferers prepared to undergo medical examination and letters testifying to his successful treatment. The conflict in opinions can be understood in terms of the different perspectives relating to proof and cure. Experiences relayed through personal testimonial were appropriate to White; while medical perspectives required pathological and X-ray examinations.

In 1933 White made a final attempt to persuade medical authorities that his method of cancer cure was genuine. In March he wrote to Boyd informing him that a successful cure of Mrs F. had been affected. White recounted his version of events, that she had been turned down by ten ‘leading specialists’ as a hopeless case and was given six months to live. In this letter, there are some revealing attitudes about the medical authorities’ attitudes to White. White wrote that Gilmour had made it clear that he did not wish to see him ever again and claimed that Boyd’s belief that Mrs F. would die in two months was going to be proved wrong. In the same month, White wrote to the new Minister of Public Health, James Young, the Waikato member of the Reform Party and former Minister of Public Health (1926-1928). White still rebutted the claims by Gilmour that he had not suffered from cancer of the rectum and continued to promote his cure to the DOH and requested another patient of his be investigated.

A report to Watt from Dr Thomas Hughes, Medical Officer of Health, on the case of Mrs F. came at the end of March 1933. Baker had attended the cancer consultation committee’s outpatient clinic in April 1932. After not receiving a reply for a follow up examination, Boyd visited her in November 1932 and made a ‘superficial’ examination. The result of this examination was that Boyd discovered

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43 L.N. White, letter to the editor, *NZ Herald*, 28 Sep., 1931, White, ANZW.
44 L.N. White to Jonathan Boyd, 17 Mar., 1933, White, ANZW.
45 L. N. White to A.J. Stallworthy, 24 Mar., 1933, White, ANZW.
a ‘very large tumour’ in the lower abdomen. Mrs F. told Hughes that she had been treated by White for some time and that White claimed he was curing her and that the lumps that were felt were only muscle. She had previously been operated on and received a hysterectomy. Later the Auckland cancer consultation committee investigated her uterus. Owing to her condition, an operation was out of the question, and while radiology was considered, it was rejected as being too risky. As a ‘last resort’, some friends advised her to try White’s treatment. In this case, it was reported that White did not use kerosene but only lotions and dietetic advice. The credibility of White’s report was quickly under scrutiny when she wrote to Boyd wanting to ‘dissociate’ herself from some of White’s claims. She claimed that she had not seen ten doctors and that she did not know if any of them were leading specialists. Mrs F. claimed she did not know where White was getting his information from but she made it clear that it was not from her. In the final memorandum on the issue from Hughes, he pointed out to Watt that she ‘contradicts’ White’s statements and her case remained hopeless and that she would be dead in two months. The records do not state whether he was correct.

Continuing in the tradition of John Mosley, White harassed medical authorities to have his methods investigated and to try to get a sense of legitimacy. In the end, the medical authorities hoped that White would leave them alone. Despite the negative findings of the investigations into White’s methods, it appears that he not only continued to treat patients but also diversified his treatment plan to include diet. Alternative practitioners like White were successful in getting public attention and the public response was large. He was inundated with letters and this clearly indicates a climate where a plurality of treatments competed with each other. Cancer sufferers, whether through desperation or a rejection of medical authority or treatments, sought out a range of different practitioners. The method of medical antagonism by the 1930s was to try to discredit competitors through formal investigations. The extent that a monopolised position was established was questionable and there is a clear difference between medical and popular

46 Thomas J. Hughes to M.H. Watt, 27 Mar., 1933, in White, ANZW.
47 Francis Baker to Jonathan Boyd, 28 Mar., 1933, in White, ANZW.
48 I have been unable to locate a definitive obituary for ‘Mrs Baker’: Thomas J. Hughes to M.H. Watt, 29 mar. 1933, in White, ANZW.
perspectives of evidence and success. Medical authorities based their evidence on clinical, pathological observation, backed by rational medical theories. Popular perspectives of curative success were based on experience. Evidence of this could be provided through personal narrative and included testimonials of successful treatments that alleviated the pain and symptoms.

Dr Ulric Williams’ Biochemical Cure

In August 1938, a deputation was made to the Minister of Health Peter Fraser by Dr Ulric Williams, a New Zealand medical practitioner who had abandoned traditional methods, Dr McCulloch, an Australian trained homoeopathist, and Professor Brose, an Australian professor of physics. The deputation aimed to persuade Fraser to support a trial of the Baker and Koch treatments for cancer. The Baker treatment was a sclerotic agent that hardened the local area that it is applied to. The Koch treatment was a fluid that was injected into tissue and targeted cancerous tissue while leaving normal tissue alone. The trial was based at Williams’ practice, as he had a number of cancer patients under his care, and it used the Baker and Koch treatments. Williams advertised his treatment as a new ‘biochemical’ method of treating cancer. This new method was a combination of the treatments of both Baker and Koch that appealed to scientific authority but it also had a strong dietary element that appealed to nature. Patients were to go to Wanganui, where Williams was based, and enter a period of detoxification that included fasts, a rigid diet, and daily douches. Once prepared, the Baker and Koch treatments were used to destroy cancer tissue. The total cost of the treatment was around thirty pounds. In an advertising flyer, Williams emphasised the fact that this treatment did not involve X-rays, radium or surgery. McCulloch and Brose were concerned about the attitude of the medical profession to such a trial. Their

50 Deputation to Peter Fraser, 18 Aug., 1938, Diseases – Cancer – Alleged Cure by Dr Ulric Williams, 1938-1939, H1, 1295, 131/16/9, Archives New Zealand Wellington, ANZW (Hereafter, Williams, ANZW).
51 Ulric Williams to Lilian Smith, 6 Oct., 1938, Williams, ANZW.
experience in Australia was that the medical profession was ‘antagonistic’. Brose indicated to Fraser that all he wanted was an ‘unbiased’ test.

At the deputation it seemed that Fraser, Watt, and medical authorities were prepared to give the Koch and Baker treatments a chance in New Zealand. Watt had agreed to the test being conducted if it followed a ‘stringent, strict but fair test’. Fraser was also in favour of trialling such methods because Dr Andrew Begg’s research, at the cancer research laboratory in Dunedin, had indicated that there was an ‘advantage in diet’ for cancer sufferers.\(^{52}\) It was agreed that the trial would go ahead and Watt suggested that the Wellington Cancer consultation committee, with a pathologist, radiologist, and two surgeons, should observe the trial. The consultation committee would analyse each patient and give a recommended diagnosis. Brose made a minor objection about taking microscopic samples as he believed they helped promote cancer growth. Watt responded by saying that a number of the thirty patients under Williams’ care who were to be trialled had already attended hospitals and local cancer consultation committees.

Williams was sceptical about the trial receiving an unbiased opinion and evidence suggests that this was the case. Williams had a history of conflict with the medical profession because he regularly critiqued the profession in publications. In 1936 this eventually resulted in his expulsion from the NZBMA. Williams believed that the government was likely to be ‘misled’ by the ‘biased people’ of the medical profession whose aim was to always oppose treatments outside of the medical profession.\(^{53}\) Williams was right to be sceptical as Watt’s opinion towards Williams was strongly negative. In a ‘strictly confidential’ letter to Dr Morris, Watt made his opinion of Williams’ practice clear. Watt described Williams’ treatment as a ‘queer blend of religion and diet’. He further described Williams as a ‘crank’, a ‘not particularly well-balanced man’, and was unsure whether to describe Williams as a ‘knave or a fool’.\(^{54}\) In addition to Watt, Dr Thomas Ritchie, the Deputy Director-General of Health, also had a negative opinion of Williams. In a letter to Dr E.

\(^{52}\) Deputation to Peter Fraser.
\(^{53}\) Deputation to Fraser.
\(^{54}\) M.H. Watt to Dr Morris, 29 Jul., 1938, Williams, ANZW.
Sydney Harris of the American Medical Association, Ritchie noted that Williams had repeatedly breached the ethical rules of the NZBMA; played the role of a martyr being persecuted; published material that was critical of orthodox medicine; and believed that the cause of all disease came from bad diet and bad thoughts.55 Returning to the deputation to Fraser, Williams noted that if Watt or Ritchie were on the committee he had ‘no doubt at all’ what the conclusions were likely to be. Fraser, seemingly missing Williams’ meaning, indicated that the presence of Watt or Ritchie on the committee could be arranged.56

Once the decision for a monitored trial had been made, Ritchie and Watt corresponded with American doctors who were hostile to the treatments. Harris wrote to Watt in August about his knowledge of trial in Wayne County, Michigan, on the Koch treatment. Eleven physicians had trialled Koch’s treatment over five years and their conclusion was that it was ‘detrimental’. Harris also noted that Koch had been thrown out of the local Wayne County medical society in 1921 and had paid over $5,000 in a lawsuit taken against him for improper treatment in 1936. Harris also gave information over the nature of Brose’s expertise. He stated that he used a ‘chemical method’ of diagnosing cancer and had worked under the Cancer Research Committee at the University of Sydney. Brose’s connection with the committee had been recently severed.57 Ritchie wrote to Dr Morris Fishbein of the American Medical Association to gather information about the nature of the treatment to assist the writing of the final report. This was clearly aimed to discredit the treatment as the American Medical Association had attacked the merits of the Koch treatment.58 In short, because of the facts collected and their own beliefs both Ritchie and Watt were biased against the treatment method. Watt, writing to a colleague, documented his scepticism about the claims of a high percentage of cures.59

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55 Thomas Ritchie to M.H. Watt, 24 Aug., 1938, Williams, ANZW.
56 Deputation to Peter Fraser.
57 E. Sydney Harris to M.H. Watt, 23 Aug., 1938, Williams, ANZW.
58 The response included the following clippings: *Journal of the American Medical Association*, 76.7 (1921), pp. 466; 76.8 (1921), pp. 537-8. 86.19 (1926), pp. 1469-72, in Williams ANZW.
59 M.H. Watt to P. Stanley Foster, 29 Aug., 1938, Williams, ANZW.
A committee was appointed to investigate the claims and went to Wanganui in late August to examine the condition of the patients and confirm diagnosis. The committee included Ritchie; Dr James Elliott, head of the NZBECC; Dr John Mercer, a pathologist at Wellington Hospital; and Dr Hardwick-Smith, a prominent Wellington practitioner and former superintendent of Wellington Hospital. Brose observed that Elliott made the ‘most copious’ notes (they were moderately detailed) and these are in the DOH files and can be dated to early September. There were records of fourteen patients who were inspected by the committee. Of particular importance is the careful wording in the notes which do not confirm cases of cancer. It specifies observations and type of diagnosis, and, where possible, information from consulting physicians was sought. From Williams’ list of patients, a number of important points can be made. While there were a number of diagnoses of cancer by doctors around the country, only two of these were confirmed as cancer by pathological specimens. All of the patients listed had received the Baker and Koch treatments in late July.

In addition to consulting American expertise, the DOH also corresponded with Dr E. Henty Smallpage, a Sydney medical professional who was considered an Australian expert on the treatments and was sceptical of the treatment method. Smallpage had corresponded with Baker and Koch about the nature of their treatments as the New South Wales government was investigating it at the time. In July 1938 Koch informed Smallpage that the American Medical Association never actually investigated his treatment. In 1919, the Wayne County Medical Society started an investigation which included ‘genuine’ cancer patients that Koch believed was aimed to be a frame-up. Koch claimed that they attempted to harm the patients by delaying access to treatment for two weeks. Once the patients started showing signs of successful treatment, the committee became ‘panicky’ and closed the investigation. Koch was happy to have a proper investigation carried out by a government if ‘no meddling’ medical opposition was involved.

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60 James Elliott to J.H.L. Cumpston, 25 Oct., 1938, Williams, ANZW.
61 Professor Brose to Peter Fraser, 1 Sep., 1938, Williams, ANZW.
62 W.F. Koch to E. Henty Smallpage, 14 Jul., 1938, Williams, ANZW.
63 W.F. Koch to E. Henty Smallpage, 19 Jul., 1938, Williams, ANZW.
warned that only an approved person should run the trial. This was to ensure that the trial could be fairly validated by someone with ‘full experience’.⁶⁴

Smallpage also corresponded with Baker. Baker indicated that the methods that McCulloch was using were outdated compared to their newer products.⁶⁵ In September 1938, Smallpage offered his advice on the treatments to Watt as he claimed to be the only medical man who was a member of the British Medical Association with experience using both of the treatments. He indicated that the Baker treatment had been discarded for a new one by its inventors. Smallpage further stated that his own personal experiences with the Koch treatments were not satisfactory and that they deteriorated in long periods of transit to Australia.⁶⁶ He went further than Watt and voiced his concerns directly to Fraser. Smallpage noted that Brose was not a graduate in medicine, that Baker had discarded the products that Williams was using, and that Koch did not want a trial to go ahead without his supervision or with deteriorated products.⁶⁷ Koch also went out of his way to express this opinion directly to Watt. Just as he had told Smallpage, Koch told Watt that any test of his remedy was invalid and would be a ‘great injustice’ without someone who can use it ‘expertly’.⁶⁸ New Zealand collaborated with other medical professions and institutions in their organization of a medical trial of the alternative treatment methods. Building on the case study of White, this indicates a more active attempt by the medical profession to discredit alternative treatment methods through formal investigation.

On September 19, Williams informed Fraser of the progress of four of his breast cancer patients. They had all received the Baker treatment and one injection of the Koch treatment. Williams claimed that one patient’s breast cancer was gone and that the wound was healing ‘rapidly’. Mrs N. had been diagnosed by Dr Peach at Palmerston North Hospital but refused to submit to an operation. Another patient,

⁶⁴ W.F. Koch to E. Henty Smallpage, 5 Aug., 1938, Williams, ANZW.
⁶⁵ N Baker to E. Henty Smallpage, 5 Aug., 1938, Williams, ANZW.
⁶⁶ E. Henty Smallpage to M.H. Watt, 12 Sep., 1938, Williams, ANZW.
⁶⁷ E. Henty Smallpage to Peter Fraser, 13 Sep., 1938, Williams, ANZW.
⁶⁸ W.F. Koch to M.H. Watt, 12 Sep., 1938, Williams, ANZW.
Mrs A., had her breast cancer ‘completely come out’ after sixteen days. The Wellington Cancer Consultation Committee had diagnosed Anderson. Mrs K. also had her cancer successfully disappear with only a ‘tiny softening’ remaining. From my review of Elliott’s notes, there were no patient details of Mrs K. in Elliott’s patient notes. This suggests that not all of the patients were considered or that the write up of notes was selective. Williams also claimed a Mrs U. had her growth completely removed. She was also unlisted on Elliott’s patient notes. Williams also indicated that one sufferer had died from a lack of vitality and that another five were ‘moribund derelict’.69

Central to the conflicting opinions is the fact that Williams believed that the investigators were biased. After Williams presented to Fraser his favourable findings, he reemphasized his scepticism over the bias of the investigators and criticized orthodox medicine. Williams wrote that it was hard to know when these cases could be claimed as complete cures but he sarcastically noted that he believed it would coincide with Elliott’s ‘final pronouncement of the worthlessness of our methods’. He then went on to attack ‘orthodox medicine’. Williams drew on Koch as an authority who claimed that the use of the X-ray and radium ‘heavily reduced’ the chances of survival. Williams backed this up with some of his own cases. He claimed Mrs H. was ‘literally battered to death’ by the use of X-rays and radium. Williams claimed that another patient, Mrs A., had been ‘thrown out to die’ by several medical professionals and two hospitals. Williams also revealed his frustration at the lack of cooperation from doctors who refused to send him case notes.70 The exclusion of certain practitioners and types of healing was a fundamental part of establishing a professional association.71 He concluded his letter by suggesting that one day an investigation into the ‘results of orthodox medicine’ should be made. Here he was clearly implying that the success rate of orthodox treatments was not as effective as claimed.72 This indicates that the parties involved in the investigation had opposing perspectives on the value of orthodox and alternative treatment methods.

69 Ulric Williams to Peter Fraser, 19 Sep., 1938, Williams, ANZW.
70 ibid.
71 Gevitz, pp. 14-16.
72 Ulric Williams to Peter Fraser, 19 Sep., 1938, Williams, ANZW.
By the end of September, Brose was starting to get concerned over the lack of news concerning the patients in the treatment after returning to Australia. In a letter to Fraser, Brose communicated the fact that Williams had turned on them because of his ‘violent’ opposition to orthodox medicine and Brose and McCulloch’s desire to have the cooperation of the medical profession. Brose believed that Williams wanted to sabotage the report of the treatment in order to prevent the New Zealand Government from adopting it. Brose indicated that he learned that Williams had recently cabled for a further eighty ampoules of the Koch treatment, which Brose claimed was the ‘best valuation’ of the treatment. Brose asked if the committee could present their findings separately from Williams. The explanation for the estranged relations was found in a letter from Williams to R.A. Shore, the acting Director-General of Health. In this letter, Williams claimed that Brose ignored Williams ‘completely’ and was an uninvited observer. The visits from the investigating committee were at the invitation of Brose who ‘acted on his own authority’ against Williams ‘expressed wishes’.

Williams had his own opinions about the bias of the investigating committee and conveyed his concerns to Australia’s Minister of Health, Mr Herbert Fitzsimons. Williams indicated that he was in a unique position of being able to assess the trial having been an ‘orthodox’ medical practitioner for twenty years and also having four years of ‘intensive training’ in ‘nature-cure’ methods. Williams stated that he did not believe ‘orthodox’ medical practitioners understood the principles that Williams’ methods were based on. According to Williams, as a result of this, ‘orthodox’ medical practitioners were ‘incapable of forming a worthwhile opinion’. Williams explained that from his past four years’ experience he has learned that ‘orthodox medical men’ were ‘invariably biased’ and ‘bitterly so’. Williams also brought Fraser’s autonomy into question and indicated that he was a ‘close personal friend’ with the ‘king-pin’ of orthodox medicine — Elliott — and was

73 Professor Brose to Peter Fraser, 30 Sep., 1938, Williams, ANZW.
74 Ulric Williams to R.A. Shore, 12 Oct., 1938, Williams, ANZW.
'incapable' of perceiving orthodox medicine’s strong opposition to unorthodox views.75

From October 20, the investigative committee became increasingly frustrated with their inability to continue monitoring Williams’ cancer patients. In an undated letter to Ritchie from the secretary of the Wellington Hospital Cancer Consultation Committee, it was indicated that Williams no longer wished to cooperate. The secretary of the committee informed Ritchie that Williams ‘definitely refuses to receive the committee or to co-operate further in the investigation’. The problem cited by Williams was a refusal to accept clinical diagnosis of cancer and to insist on a histological examination to test tissue samples. The secretary stated that Williams ‘doubts the honesty and purpose of the committee’.76 ‘This message was relayed from Ritchie to Fraser. Ritchie stated that Williams ‘definitely declines’ to co-operate with the investigation. Ritchie indicated that there was nothing they could do as the cancer sufferers were Williams’ private patients. Ritchie reiterated the point that Williams’ complaints against orthodox medicine were ‘unfounded’.77 The position regarding tissue samples was confirmed in a letter from Elliott to John Cumpston, the Director-General of the Australian Department of Health. Elliott indicated some cases under Williams’ care were cancer as they had been confirmed by a tissue sample; but, as a biopsy had been refused for the others Elliott claimed these were ‘definitely not’ cancer.78 Williams developed further reasons for not cooperating by indicating that Koch did not want the investigation to proceed. Koch cabled, ‘No Government investigation unless I am present’. Williams believed that Koch’s wishes should be respected.79 This indicates that alternative practitioner were very aware of the motives of the medical profession and public health authorities towards their treatment methods. The discrediting of investigation methods and not cooperating also restricted the impact of interference by the medical profession.

75 Ulric Williams to William Fitzsimmons, 16 Oct., 1938, Williams, ANZW.
76 Secretary of the Cancer Commission to Thomas Ritchie, undated, Williams, ANZW.
77 Peter Fraser to Thomas Ritchie, 20 Oct., 1938, Williams, ANZW.
78 James Elliott to J.H.L. Cumpston, 25 Oct., 1938, Williams, ANZW.
79 Ulric Williams to Peter Fraser, 25 Oct., 1938, Williams, ANZW.
It is important to place the New Zealand investigation into a wider Australasian context as there was an investigation being undertaken in Western Australia around the same time. In July 1938, there was a proposed trial of the treatment in Western Australia.\textsuperscript{80} It was undertaken by the Western Australian branch of the BMA and included surgeons, pathologists, radiologists, and one general practitioner who claimed to have experience with the treatment.\textsuperscript{81} There were some issues over the supervision of the treatment and there was discussion of Koch going to Australia himself. Koch indicated that he only wanted someone approved to oversee the treatment and that the only individual in Australia who fitted that level of expertise was McCulloch.\textsuperscript{82} In the end, Koch cancelled his trip to Australia,\textsuperscript{83} and the trial ended badly with the reporting of five patient deaths in November 1938.\textsuperscript{84} The Western Australian trial ended in the negative but the failure to include a person approved by Koch with appropriate expertise meant that there were still some unanswered questions about the Koch treatment.

The New Zealand Baker and Koch trial attracted a lot of interest in Australia and New Zealand. R. Darroch, the secretary of the NZBECC, wrote to Fraser about the strong interest. Darroch wanted an interim report as he had been contacted by ‘various parts of New Zealand’, the Australian Government and the University of Adelaide.\textsuperscript{85} The DOH also had to respond to requests about the treatment. In response to an enquiry from Auckland’s Devonport, Ritchie stated that the DOH had no information to indicate that the treatment would result in a cure and did not ‘feel justified in advising you on the matter’.\textsuperscript{86} Lilian Smith wrote to the Prime Minister, Michael Joseph Savage, asking for help to get access to Williams’ cure. In this letter Smith stated that Williams ‘guarantees’ a cure and that the family involved were ‘good honest worthy people’. Smith also asked the government to not leave Williams’ cure unrecognised as the ‘orthodox doctors have failed’.\textsuperscript{87}

\textsuperscript{80} *The Courier Mail* (Brisbane, QLD), 25 Jul., 1938, p. 2.
\textsuperscript{81} *Northern Standard* (Darwin, NT), 2 Aug., 1938, p. 8.
\textsuperscript{82} *The West Australian* (Perth, WA), 4 Aug., 1938 p. 21.
\textsuperscript{83} *Sydney Morning Herald* (Sydney, NSW), 16 Dec., 1938, p. 13.
\textsuperscript{84} *The Advertiser* (Adelaide, SA), 11 Nov., 1938, p. 31.
\textsuperscript{85} R Darroch to Peter Fraser, 21 Nov 1938, Williams, ANZW.
\textsuperscript{86} Thomas Ritchie to Mr V Blick of Devonport, 21 Nov., 1938, Williams, ANZW.
\textsuperscript{87} Lilian Smith to Michael Joseph Savage, 18 Oct., 1938, Williams, ANZW.
Shore wrote a memorandum to Fraser indicating that the Prime Minister had received two letters asking for aid to treat a cancer sufferer. Shore did not feel ‘justified’ in recommending financial assistance because Williams’ ‘antagonism’ had prevented further investigation. Writing to Smith, Shore indicated that the Government had appointed a committee to investigate Williams’ treatment and if that proved successful, the Government would be only too ‘happy’ to make it available to all cancer sufferers.

The lack of a complete investigation became an issue when speculation about the results began to develop. Darroch advised Fraser that the BMA of Western Australia had asked him for a copy of the report and that they had received information that the New Zealand investigating committee was ‘satisfied’ with the treatment and four cancerous growths had disappeared. Darroch reiterated this point to Ritchie that there was information circulating that the committee ‘commends’ the treatment. He recommended that the true information about the committee’s findings be put into the public sphere.

All parties were getting frustrated with Williams’ lack of cooperation. Fraser informed Brose that Williams had refused to receive the committee and believed the committee was hostile because of their rejection of a diagnosis by clinical observation. Officials began communicating explanations for the lack of progress. Shore wrote to Dr Morris, the acting Director-General of Health of New South Wales, and informed him that Williams took exception to the committee’s rejection of diagnosis by clinical observation. Shore believed that given Williams’ ‘uncompromising’ position towards ‘orthodox medicine’ that he was ‘not hopeful’ of a change in attitude.

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88 R.A. Shore to Peter Fraser, 5 Nov., 1938, Williams, ANZW.
89 R.A. Shore to Lilian Smith, 16 Nov., 1938, Williams, ANZW.
90 R. Darroch to Peter Fraser, 30 Nov., 1938, Williams, ANZW.
91 R. Darroch to Thomas Ritchie, 15 Dec., 1938, Williams, ANZW.
92 Peter Fraser to Professor Brose, 21 Nov., 1938, Williams, ANZW.
93 R.A. Shore to Selwyn B Morris (Acting Director-General of Health), 28 Nov. 1938, Williams, ANZW.
By December 1938, Fraser started to become increasingly antagonistic towards Williams. Fraser informed the Minister of Customs to reinstate a customs duty on his imports.\footnote{Peter Fraser to the Minister of Customs, 13 Dec., 1938, Williams, ANZW.} He then informed Williams that he had no other option but to inform the investigating committee about his lack of cooperation and that Williams’ role in the impasse would have to become public information. Fraser made one more plea for Williams to cooperate and stated that he would change his mind for the sake of his own future reputation.\footnote{Peter Fraser to Ulric Williams, 14 Dec., 1938, Williams, ANZW.} Williams’ reply praised Fraser’s efforts to help ‘gain recognition’ for the ‘enlightened’ methods of the Baker and Koch treatment. Unfortunately, as Williams wrote, both Baker and Koch had ‘written in the strongest terms’ that their products were not to be tested in their absence.\footnote{Ulric Williams to Peter Fraser, 16 Dec., 1938, Williams, ANZW.} It was at this point that any continued investigation into the treatments was at an end. Ritchie informed Darroch that Williams had been informed of the consequences of the lack of cooperation and that it would become public knowledge that the investigation had been discontinued.\footnote{Thomas Ritchie to R Darroch, 16 Dec., 1938, Williams, ANZW.}

In January 1939, the final report from the committee was given to Fraser. The report claimed that the members of the committee approached the investigation with an ‘open mind’ and hoped that some ‘efficacy’ could be found in the cures. Fifteen cases had been examined and it was decided that six of the patients probably had malignant cancer. Of the six, only two had been proven cancer by pathological examination. As the patients had already been treated, the committee was unable to see the actual treatment being undertaken. It was the general opinion that the patients ‘showed no improvement’ and that two out of the four breast cancer patients were ‘markedly worse’. It was also noted that there was a great amount of ‘mutilation’ and the breasts of the women were ‘completely gangrenous, black and malodorous’. The report stated that Williams ‘unexpectedly’ indicated that the investigation was to cease and his final communication suggested that both Baker and Koch did not want their treatment tested in their absence.
The committee based its findings on its own observations and information procured from America. The committee concluded that the Baker treatment caused ‘great local destruction’ and, compared to surgery was ‘like a reversal to the treatment of the middle ages’. The committee believed the Baker treatment caused unnecessary distress and posed great risk of infection. It concluded that the Baker treatment was ‘very far from a cure’. It also concluded that there was no evidence to indicate the Koch treatment had ‘any effect’. The committee ended by indicating that lives could be ‘greatly prolonged’ by surgical and radiological means. The committee also warned that such alternative treatments posed a risk if they caused delay and gave cancer the opportunity to advance further. In conclusion, the committee stated that Williams’ claims to cure were ‘illusory’ and that the ‘high fees’ for such ‘doubtful’ treatments was unjustified. The findings of the committee were reported in American and British medical journals.98

From this case study of Williams, a conflicting set of perspectives over the treatment of cancer is evident. As was the case with White, there were different interpretations about proof: the medical authorities insisted on confirmation by tissue examination; Williams believed clinical diagnosis to be satisfactory. It is also evident that the medical profession could not enforce a monopoly. Williams had been expelled from the NZBMA but he continued to practise freely and could exclude unwanted interference from the investigating committee.99 The transnational nature of cancer treatments is also on display through the importation of products, the international communication networks, and interest from across the world. The methods that the medical profession used to discredit cures had changed from the ambushing in the nineteenth century to a formal investigation that publicly and officially discredited alternative cures.


Like Thomas Hullett and *The Green Leaf*, Williams acts as another piece of evidence of a counterculture against orthodox medical methods. Williams was particularly difficult for the medical profession to deal with as he had been an orthodox practitioner for twenty years with proper qualifications and accreditation. Despite this, Williams questioned the success rate of orthodox medical methods in the treatment of cancer and also had strong negative opinions about the motives of prominent medical professionals. Some of Williams’ patients also experienced the negative side of orthodox medical interventions through being abandoned or suffering through surgery or radium. Others simply chose to avoid or bypass orthodox treatments altogether. It is clear that the medical profession wielded great influence in important medical institutions and had forged close political relationships. Perhaps the best indicator of the failure of the medical profession to impose a strong monopoly is the fact that Williams continued to practice his treatments and openly defy the medical profession into the post-war period. It is also important to mention that in 1941 the NZBMA council convicted Williams for ‘infamous conduct in a professional respect’ following the death of one of his patients. However, the attempt to deregister Williams failed after Henry Mason, the Attorney General, refused to sign off on it.100

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100 For a series of letters, biography, and details of Williams’ theories see Brenda Sampson, *New Zealand’s Greatest Doctor: Ulric Williams of Wanganui: a Surgeon who became a Naturopath*, Wellington: B Sampson, 1998; Sampson’s work consists of some factual inconsistencies, see Hamilton for the correct dating of events.
Conclusion

Across this section, it is evident that continuity in alternative medicine is more prominent than decline. The rhetoric of rise of the medical profession into a politically powerful organisation that held a large amount of cultural prestige into the 1930s needs to be balanced against the realities of the medical market place. The same mechanisms that helped the medical profession attain a strong level of cultural prestige, an appeal to scientific prestige and new types of technologies, could all be co-opted by alternative methods too, for example, new types of cures like kerosene, or an appeal to a new bio-chemical method. In addition to this, alternative practitioners could also use savvy marketing skills in the press or in advertising. They also appealed to the fact that their cures caused less suffering than orthodox medical treatments. On another level, alternative practitioners had a more common appeal to cancer sufferers and also appealed to traditional authority through more natural approaches to cures. In short, alternative practitioners continued to compete in a medical marketplace that provided opportunities for cures from a range of different practitioners.

The central dynamic in the case studies presented in this chapter is the relationship between the medical profession, government authorities, and alternative practitioners. This relationship is best defined as a conflict between incompatible perspectives of disease and treatment. The type of proof that medical and alternative perspectives claimed as legitimate was different. A popular perspective of proof relied on testimonials of experience that could be spread through advertising or informal networks. Medical perspectives of diagnostic proof required a pathological examination of tissue samples. This is partly hypocritical. The gauntlet of proof for cancer for alternative practitioners was based on this level of diagnosis, but the basis for applying orthodox medical treatments could be based on clinical diagnosis alone. The medical profession, in a bid to try to counteract alternative methods, sought to try and discredit alternative cures through formal investigations. Such an approach was not proactive but was reactive to requests by alternative practitioners for their treatments to be given
some form of legitimacy. Government authorities were prepared to consider perspectives from outside of the medical profession. However, the path towards legitimating the cure was through the medical profession.

In addition to the dynamics between the medical profession and alternative practitioners is the patient. Evidence suggests that the medical profession was concerned about the spread of publicity of successful alternative cures and sought to publicly counteract such claims. However, patronage of alternative practitioners and the great interest surrounding the cures in the press indicates that patients could still exercise the choice of different medical modes. The motives were wide ranging from abandoned cancer sufferers who sought every cure out of sheer desperation, to those who refused to submit themselves to medical treatments by the medical profession. Patronage of alternative practitioners is indicative of an era when the medical profession could do little to alleviate the suffering of many cancer patients, and a climate of distrust of medical treatments and the medical profession itself. Notions of cure remained different: medicine treated symptoms using a prescribed treatment that was based on assumed knowledge; cure from a popular perspective remained as the alleviation of pain.
Chapter Ten
Conclusion

In 1938, New Zealand’s Prime Minister, Michael Joseph Savage, was diagnosed with colon cancer. After an unsuccessful operation in August 1939, he found out that he was terminally ill. Barry Gustafson’s biography of him traces the last moments of Savage’s political career as he combated cancer, political rivals, and the significant issues of war ‘down to the grave’. Savage’s experience of cancer was something that undoubtedly would have fitted into Chapter Two of this thesis. In trying to perform as many Prime Ministerial duties as he could in his condition, Savage often bent over as a result of stabs of pain in his stomach and frequent spasms that prevented him from sitting for long periods. Over time, Savage became increasingly incapacitated and one political rival, John A. Lee, in his infamous publication, ‘Psychopathology in Politics’ questioned Savage’s capacity to lead after discussing how severe physical illnesses manifested themselves through mental conditions.1 For Savage, like the Liberal Prime Minister John Ballance, the treatment of cancer by the medical profession failed and he was left in a hopeless situation. The words of a 1908 article in The Evening Post still rang true in 1940 when Savage died. While the fight against cancer was ‘not hopeless warfare’, it remained a ‘standing illustration of hope deferred’. 2 As David Cantor described, during this period cancer was not a disease that could be eradicated but it would always need to be managed or controlled.3 In this context, this history of cancer in New Zealand has focussed on institutional responses to cancer, and the role of popular beliefs and alternative practitioners. This thesis has argued that these three areas cannot be viewed in isolation and that the significant connections between them need to be given more weight in the histories of cancer.

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1 Barry Gustafson, From the Cradle to the Grave: a Biography of Michael Joseph Savage, Auckland: Reed Methuen, 1986, pp. 255-60; see also John A Lee, Expelled from the Labour Party for Telling the Truth: Psycho-Pathology in Politics, Auckland: s.n., 1940.
2 Evening Post, 29 Dec., 1908, p. 6.
This thesis has entered uncharted territory, as the history of cancer in New Zealand has not been told before. I have attempted to balance the need to provide a narrative of significant developments in respect to cancer with a desire to encapsulate the diversity of perspectives and experiences relating to cancer. In achieving this, the thesis has introduced a variety of different understandings about the nature of cancer, its cause, and its treatments. First, the thesis has taken an institutional approach that focussed on the significant public health responses undertaken by the medical profession, New Zealand’s Department of Public Health/Department of Health (DPH/DOH), and the role of the New Zealand Branch of the British Empire Cancer Campaign (NZBECC). In addition to this, it has also included significant discussion about popular perspectives and alternative practitioners. This inclusion is not based on creating a pluralistic account for its own sake; it is because alternative medicine and popular beliefs are intimately intertwined with institutional responses and this reveals significant information about the interactions of varying groups. Through my discussion of these different areas, the thesis makes a significant contribution to the historiography of cancer, alternative medicine and New Zealand medical historiography. The thesis acts as a starting point for the history of cancer in New Zealand that can be used to help inform New Zealand’s historiography and be compared with key issues in international historiography.

The thesis intentionally began with two chapters on the development of cancer into an important social and public health issue. Not only do they act as important chapters that set the context for the rest of the thesis, they also demonstrate the interrelationship between a series of competing perspectives and themes. They introduced New Zealand into an international context both comparatively and in terms of influences. New Zealand’s statistics were compared with other countries and theories on causation were negotiated between different groups’ perspectives and international trends. It immediately introduced the diverse range of perspectives within and between groups, including the medical profession, public health authorities, newspaper reports, popular perspectives, and alternative practitioners. A series of key themes are also introduced, including the idea of scientific progress and potential challenges to it; the role of conflicting
interpretations of information and ideas; and the discussion of popular beliefs, acting as a reference point for the remainder of the thesis. In addition to this, it argued that the merging of incidence, scientific and popular theories of causation, and feelings of dread helped transform cancer into an important social and public health problem. A combination of these factors explains why cancer came into prominence and why alternative diseases, like heart disease, did not. It also demonstrated the intellectual climate in New Zealand that allowed alternative practices and lay ideas relating to the nature of cancer and its treatments to proliferate. One area of historical debate that this chapter also engaged with is the role that metaphorical associations had in the construction of popular beliefs. I argued that constructing popular beliefs in terms of cancerphobia, which is representative of an opinion from a medical professional perspective, needs to be more appropriately balanced against the historical contexts of the perceived failure of scientific medicine as well as evidence of the horrible suffering and hopeless nature of cancer and its treatments.

Building on Chapters Two and Three, one of the central areas of focus of this thesis is institutional responses to the cancer problem. In many ways, the theme of popular beliefs pervades Chapters Four, Five, and Six because these institutional responses were influenced by public pressure and were often in reaction to popular beliefs. The representations of surgery, early educational efforts, the actions and the publicity of the NZBECC, and radiotherapy were all focussed on conveying another key theme, a message of hope. This focus on the theme of hope is directly related to counteracting popular understandings that were perceived to be incorrect. These chapters establish a base narrative of the history of cancer in New Zealand while contributing to international cancer historiography and aspects of New Zealand’s history. In particular, these chapters position New Zealand’s responses within broader international contexts and significant national contexts. This included comparing New Zealand to other countries and considering the impact of international trends and influences on New Zealand. In relation to these international contexts, broad national similarities are identified and distinct differences in how New Zealand’s responses were shaped and developed are also identified.
In terms of education and a message of hope, positive representations of surgery were promoted that emphasized the success and progress of surgery. This message of progress was a combination of local medical professionals’ commentary as well as the dissemination of cable news reports from Britain and Australia into New Zealand’s press. Like other countries, the central theme of these responses was that they acted to convey a message of hope against negative popular associations with cancer and surgery and to discourage the public from delay and seeking out medical alternatives. It was hoped that the promotion of surgical progress in combating cancer would counteract these issues.

Fitting into a more general trend of cancer education from the 1910s, New Zealand instituted a national education campaign that carefully crafted a series of messages to counteract a range of issues. A concern over causing undue alarm in the public is a broad issue that New Zealand shares with both America and Britain. Unlike Britain, which focused on low-key localised education, New Zealand instituted a national education response that was derived from New Zealand’s central medical institutional authorities, the Department of Public Health (DPH) and the New Zealand Branch of the British Medical Association (NZBMA). Unlike many other major countries, up to 1929 New Zealand did not possess dedicated institutions for the control of cancer. Instead, it relied on prominent members of the medical profession and the centralized DPH to direct action in response to cancer.

Like Canada, the establishment of a dedicated cancer institution, in the form of the NZBECC was relatively late in its timing. The courting of publicity by the NZBECC for the promotion of its message is comparable to American efforts but compared to Britain, which was dominated by major research charities, the NZBECC had a broader scope beyond research. It acted in a more integrated capacity and, in conjunction with the DOH, directed, and invested in all forms of cancer control in New Zealand. It took on a role as the primary authority on cancer. Through its fundraising efforts and general promotional activities, it focussed on
conveying a message of hope through publicity and through promoting the most promising treatment, radiotherapy.

One of the most prominent features of the period covered by this thesis is the introduction of radiotherapy for the treatment of cancer. In terms of radiotherapy, many of the themes relating to education are also evident. Following broad international trends, radiotherapy was transformed from a new and exciting experimental technology for cancer treatment into one of the primary treatment options for many forms of cancer. Initially, New Zealand acted as a spectator, and the role of the press and cable news was important in publicising the merits of radiotherapy for the treatment of cancer. Enthusiasm for radiotherapy manifested itself through pressure for institutional investment but this resulted in failed attempts to establish a radium institute. Local institutional interactions between rival hospital boards and the centralized influence of New Zealand’s DPH/DOH also shaped both investment and lack of investment in radiotherapy.

New Zealand did not follow a liberal, market-drive model like the United States but initially followed a provincial model like Canada and then a centralized model like Britain. Yet, at an early stage it was the centralized nature of New Zealand’s DPH/DOH compared to other countries that acted to limit New Zealand investment in radiotherapy. The DPH/DOH was hesitant to spend large amounts of money on what it perceived to be unproven treatments, and investment into radiotherapy became a negotiation between local hospital boards and the DPH/DOH. In the 1910s, the DPH strongly opposed investment in radiotherapy, and had the funds for a radium institute been raised, it would have tested ministerial powers for refusing subsidies at an earlier stage. Opposition to the experimental nature of radium also manifested itself through a national education campaign. In the 1920s, when a number of hospital boards began spending significant sums on radiotherapy, the DOH actively restricted the subsidies granted and limited the purchase of radium to the four major centres. The establishment of the NZBECC saw the DOH’s centralized policy further entrenched with the creation of cancer consultation clinics that aimed to have all cancer patients go
through them. All treatment with radium was restricted to these clinics. The NZBECC, in conjunction with the DOH, oversaw hospital board investment into increasing radium supply and acquiring up-to-date deep X-ray therapy apparatuses.

The final significant area of public health responses to the cancer problem that this thesis addressed was research. Compared to larger countries that established significant research programmes, New Zealand can be seen to be playing a more passive role as part of an overall British effort in researching cancer. In terms of research, the DPH/DOH repeatedly looked to the International Cancer Research Fund (ICRF) based in Britain. In response to growing public pressure, in the 1910s and 1920s there was a focus on statistical research in a data gathering role to support the work of the ICRF. The DPH/DOH actively played down the idea of New Zealand setting up an independent research programme and advised New Zealand to look to Britain.

After the establishment of the NZBECC, a more multifaceted research programme was established which involved experimental research at the Cancer Research Laboratory in Dunedin and the National Radiation Laboratory (NRL) in Christchurch. The NRL undertook some experimental research buts its focus was primarily on developing appropriate rates of dosage. In terms of radiotherapy, New Zealand increasingly looked to Australia, particularly through the Australian Cancer Conferences, for guidance on how to improve treatment methods and dosages. The appointments to the Cancer Research Laboratory in Dunedin were made from researchers who were previously involved with the ICRF and this research continued to work in tandem with the ICRF. Since 1938, the researchers were no longer located in New Zealand, but remained partially funded while they continued to work with the ICRF in Britain. The timing of the development of a more multifaceted research programme in New Zealand was later than many other countries. In addition, in some ways, it did not act in an independent capacity. However, this seemed the sensible option for a small nation unlike the needs of bigger Commonwealth nations.
In conjunction with examining New Zealand’s institutional responses, this thesis has also engaged with a number of contextual aspects of New Zealand’s historiography. This thesis’s significance can also be positioned in relation to historiography about New Zealand’s relationship with Britain, particularly London. It can also be positioned in relation to the history of public health in New Zealand. The relative exclusion of cancer from the focus of public health authorities can be considered in relation to the DPH/DOH’s focus on other areas of concern. In particular, methods of prevention, preventable diseases, and moral health issues occupied the priorities of the DPH/DOH and New Zealand’s medical historiography. In addition to this, the history of cancer can also be placed in the context of charitable aid and the DPH/DOH’s concerns over excessive expenditure. In a similar way, the DPH/DOH’s lack of focus on issues of gender and race relating to cancer can also be positioned in relation to more significant areas that were considered to be of greater importance. Two examples of this include infectious diseases for Maori and encouraging good parenting through Plunket for mothers.

The other main areas that this thesis contributes to is the history of popular beliefs and alternative medicine. Like the influence on public health responses to cancer, popular understandings were also significant in terms of alternative cancer medicine. Alternative cancer practitioners engaged with popular fears of surgery and cancer. They also promoted a message of hope that cancer could be cured. However, they drew on popular stereotypes to increase their popular appeal, and they also acted as critics of the medical profession and their methods of treating cancer. In particular, this thesis contributes to a growing international literature that challenges the extent of the rise of the medical profession and models of decline in alternative medicine. It revises current New Zealand historiography on alternative medicine and suggests that continuity is more prominent than decline. It does this by indicating strong continuities between alternative medicine around the turn of the twentieth century and in the interwar period. Perhaps the most noteworthy aspect of my exploration of alternative practitioners is either the
inability or lack of motivation of public health authorities and the medical profession to take strong measures to counteract alternative practitioners.

Despite official discrediting, alternative practitioners successfully competed in the medical marketplace. Indeed, official discrediting often helped practitioners attain a more prominent public profile. The practitioners surveyed in this thesis were not pushed out to the margins but continued to practise their treatments and received support and patronage. This thesis has also revealed the fact that the role of both publicity and informal networks helped alternative practitioners gain prominence. The popularity of alternative cancer practitioners, in many instances, was a negative reaction to the medical profession, in terms of scepticism of their motivations and the efficacy of their treatment methods. Alternative practitioners regularly acted in opposition to the medical profession and critiqued their motives and the efficacy of their methods. Like the medical profession, particularly from the interwar period, alternative medicine drew on scientific prestige through engaging with scientific theories and adopting scientific language. By examining the role of alternative cancer practitioners, the interaction and relationships between the medical profession, the public, politicians, public health authorities, and alternative practitioners reveals a set of incompatible perspectives.

Furthermore, this thesis, when sources allow, gives greater attention to the role of popular and patient perspectives. Histories of alternative medicine have tended to focus on the relationship between the medical profession and alternative healers and their treatment methods. This thesis has sought to bring the subject of patient experience, where possible, to the forefront. It also questions some of the ways that both popular beliefs and alternative medicine have been framed. By examining popular beliefs outside a framework of ignorance and gullibility, it is possible to consider the influences and contexts that shaped popular beliefs. This thesis challenges idiopathic stereotypes of those who seek out alternative remedies. Popular beliefs were derived from information that merged medical theories with popular stereotypes. This thesis has demonstrated how the issue of diet and the environment was significant from a popular perspective and in alternative
As the example of diseased cancerous cattle demonstrated in Chapter Three, scientific theories could merge with popular ideas, and medical and popular definitions of cancer varied. Popular views, like the belief in cancerous cattle, could also have significant impacts politically and in other areas like trade. Popular theories also act to compel public health authorities and the medical profession to try to counteract what they perceived to be misleading information. In addition to cancerous cattle, the prominence of the case studies of Ulric Williams and James Devereux indicate the prominence of dietary theories. The characterization of alternative practitioners as unscrupulous quacks is also problematic because the motivations and types of treatment models varied. Through the use of evidence about patient perspectives, this thesis has demonstrated that an illuminating dynamic can be added to the interactions between alternative practitioners, public health authorities, and the medical profession. What is evident is that there were a variety of different types of evidence and belief systems that interacted with each other in supportive, conflicting, and contradictory ways.

There is scope to extend areas of this thesis in future research. The most obvious method is to move the historical timeline forward into the post-Second-World-War world. This would provide the opportunity to develop both the institutional and alternative narratives of this thesis. While each of these areas could be pursued separately, and there is merit in this approach, I would suggest an approach that simultaneously considers developments in institutional public health history and alternative medicine together. This is because of the extent of interaction between different groups, and theories and understandings of disease that is evident in this thesis. Dr Ulric Williams’ continued practice into the 1960s provides a bridge between different periods. In addition, one area of interest may be to continue examining the theme of continuity in alternative cancer medicine into the period of its so-called revival up to the 1980s. One notable and controversial alternative practitioner that warrants further research is Milan Brych. This case study would enable a historical examination using many of the same themes adopted in this thesis in a different context. In particular, there are already conflicting narratives
present in the opinions of Phillip John Scott, Frank Quill, and Michael Guy. In the early stages of this research, I initially examined institutional and medical developments of cancer in the post-Second-World-War period. In particular, the work of Arthur Veale on heredity (particularly familial polyposis) and genetic cancer is another area that can be developed further. This also has the potential to be investigated in the context of developments in screening. In addition to this, research could also focus on the development of cancer education in relation to environmental factors and there are ephemera collection available that include relevant posters and pamphlets from 1945-1991.

There are a number of other areas that would result in fruitful historical investigation. The role of medical advertising in the nineteenth and twentieth century is an area that has a massive amount of primary source material available on cancer alone. This has the potential to be extended to other diseases but it could also encompass a discussion on patent medicines, local alternative practitioners advertising, and the restrictions on advertising for the medical profession. There is also potential in the post-Second-World-War period to evaluate the amount of evidence relating to cancer in relation to the themes of gender and race. In terms of race, more accurate Maori statistics and examining a period when cancer becomes statistically more prominent may yield more detailed information than this study has found. In terms of gender, the fragmentation in cancer specialities and changes in gendered statistics in the post-Second-World-War period may also provide adequate information for a gendered cancer analysis. In particular, this may highlight a transformation from New Zealand’s stereotype of cancer as an ‘old man’s disease.’ Another area of interest includes the transformation of the NZBECC into the New Zealand Cancer Society. This can be situated in the transformation of cancer organization and treatment from the institutional developments in the 1930s into the post-war period. In conjunction with this, the fragmentation of cancer charities, and perhaps cancer specialties more generally, and the development of the specialty of oncology in New Zealand are other areas that merit further historical research. Finally, I also believe that a detailed historical

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4 Both Frank Quill and Michel Guy’s books along with other information on Milan Brych is available at ‘Milan Brych Underground Website,’ online, available at: http://members.multimania.co.uk/mbuw/PAGES/MAIN.HTM
investigation into the history of cancer in Australia or one of its states would provide an interesting historical comparison. Moreover, it would enable a stronger focus on considering the importance of Australasian interactions.

This thesis acts as the first history of cancer in New Zealand and as such, it establishes a broad overview of cancer conceptions, cancer treatments, institutional developments, popular beliefs, and the role of alternative practitioners. The thesis has explored the nature of different perspectives relating to cancer and their relationships. In particular, it has focussed on how the themes of incidence, causation, and dread contributed to the transformation of cancer into a significant social and public health issue. Building on this, this thesis has scrutinized the significant institutional responses in New Zealand and situated these in relation to broad international trends, in comparison to developments in other countries, and in a national context. In particular, it has focussed on the introduction of radiotherapy, New Zealand’s research contributions, and the promotion of a message of hope through education. This showed that New Zealand can be positioned in relation to many broad international trends but still possessed some unique organizational and administrative differences. The thesis has given significant attention to the importance of popular perspectives and alternative medicine. It has showed how influential popular understandings were in shaping institutional responses, and in the methods and success of alternative practitioners. Finally, this thesis has argued that there has been significant continuity in the prominence and success of alternative cancer practitioners from the late nineteenth century to 1939, despite increasing pressures from the strengthening of the medical profession.
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1. **DAAZ D444**: New Zealand Department of Health, Dunedin District Office - Registered Files, Circular Memos, Dental Division Circulars, Clinical Service Letters, Appendices to the Department of Health Annual Reports, Melrose House Admission and Discharge Registers

   28 / c 8/4 R2474647 Diseases - Cancer - 17 October - 21 November, 1927-1949

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1. **ACGO 8333**: Central filing system

   IA1 3362 / 46/89/1 R12322754 Wildlife Act - Animals Protection and Game Act - Rats and Mice for cancer research Importation of - Otago Medical School, 1939-1939

2. **ABQU 632** Health central filing system

   W4452 4 / 2-1-1 R16646708 Cancer - Cancer Statistics - Collection of in New Zealand (B.E.C.C.S.) [British Empire Cancer Campaign Society (Incorporated)], 1939-1956

3. **ACGA 8280**: Registered correspondence

   IT1 151 / EX 8/27 1 R17962757 Cancer among native peoples - Information for International Pacific Health Conference, 1927-1931

   IT1 611 / IT 110/2/3 1 R17963600 Medical - Cancer, 1927-1937

4. **ADBZ 16163**: Registered Files

   H1 1473 / 131/16 R20954397 Diseases - Cancer, 1941-1947

   H1 1957 / 131/16 R20954401 Diseases - Cancer, 1908-1920

   H1 1957 / 131/16 R20954402 Diseases - Cancer, 1921-1924

   H1 1958 / 131/16 R20954403 Diseases - Cancer, 1924-1926

   H1 1958 / 131/16 R20954404 Diseases - Cancer, 1927-1934

   H1 1958 / 131/16/1 R20954408 Diseases - Cancer - Imperial Cancer Research Fund, 1903-1909

   H1 1299 / 131/16/6 R20954411 Diseases - Cancer - Alleged cure by Mr Mosley, 1918 - 1926

   H1 1363 / 131/16/7 R20954412 Diseases - Cancer - Cooperation with London re incidence of cancer in Maoris, 1925 – 1937
H1 1126 / 131/16/9  R20954413  Diseases - Cancer - Alleged cure by Dr Ulric Williams, 1939 – 1947
H1 1295 / 131/16/9  R20954414  Diseases - Cancer - Alleged cure by Dr Ulric Williams, 1938-1939
H1 1299 / 131/16/10  R20954410  Diseases - Cancer - Conference 1939, 1937 – 1940
H1 1302 / 131/72/33  R20954709  Diseases - "Cures" - Cancer - LN White, 1929 – 1933
H1 1970 / 148/12  R20955490  Medical Research - Cancer, no date – 1925
H1 1970 / 148/12  R20955491  Medical Research – Cancer, 1910 – 1925
H1 1971 / 148/12/1  R20955492  Medical Research - Cancer - New Zealand Branch British Empire Campaign, 1925 – 1936
H1 1347 / 148/12/5  R20955493  Medical Research - Cancer - TAF Stone, 1938-1941
H1 1971 / 148/12/5  R20955494  Medical Research – Cancer, 1929- 1941
H1 1493 / 240/13  R20960293  Medical Research – Cancer, 1936 – 1948

5. ACIE 8798: Registered subject files

EA1 1071 / 158/5/2 1  R18873810  Social Affairs - Health - Imperial Cancer Research Fund, 1927-1950

6. ADCB 16173: Subject Files

H-MHD1 57 / 8/942  R16195829  Visit by Dr Fulton and cancer research in mental hospitals, 1926-1935

7. ADOE 16612: Inwards letters and registered files

M1 123 / 2/7/121 1  R19978705  Sea Fisheries - Oysters - Man at Hazleton dying of cancer, 1914-1917

8. AEGP 19732: Papers regarding the treatment of cancer

STOUT3 1  R19816606  Papers relating to treatment of cancer - miscellaneous papers relating to courses at Wellington Hospital, 1929 – 1937

9. ABJX 20415: Government Life Insurance Archives Collection

W5542 318 / 122  R9593284  Cancer, 1893 – 1927

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