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‘THE BACILLUS OF WORK’

MASCULINITY AND THE REHABILITATION
OF DISABLED SOLDIERS IN DUNEDIN 1919 TO 1939

PETER J. BOSTON

A THESIS PRESENTED IN PARTIAL FULFILMENT
OF THE DEGREE OF BA(HONS) IN HISTORY
AT THE UNIVERSITY OF OTAGO, DUNEDIN,
NEW ZEALAND.

1993
Miracles do happen! This work could not have been completed without the help and warmth of many people. I would like to thank my supervisor, Dr Barbara Brookes, for her support and editing skills over the last six months - any deficiencies in this thesis are due solely to my own limitations. I also wish to express my gratitude to Lewis Lowery whose guidance and friendship during my years at university has been valued and empowering. To my friends and classmates, I owe an equally large indebtedness. I particularly wish to thank (in no order of preference) Vicky Tine, Andrew B, SHJ, Andrew F, Gabrielle, Michelle, Vernon, Michael, and Rachael for their constructive criticisms and understanding.

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The title 'The Bacillus of Work' is a quote from George Barton, one of the founders of occupational therapy in North America during the early decades of this century.

Correction: The captions to figures 2. 2 and 2. 4 should read 1919 rather than 1918.
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LIST OF ABBREVIATIONS

ADMS  Assistant Director of Medical Services
CPDI  Cardiac Pulmonary Disease Indeterminate
DAH  Disordered Action of the Heart
DGMS  Director General of Medical Services
DMH  Director of Military Hospitals
DRCS  Dunedin Red Cross Society
DRSA  Dunedin Returned Soldiers' Association
DSRL  Disabled Soldiers' Re-establishment League
DSS Act  Discharged Soldiers' Settlement Act
E & VT Branch  Education and Vocational Training Branch
GSW  Gun Shot Wound
MO  Medical Officer
NZAMC  New Zealand Army Medical Corps
NZEF  New Zealand Expeditionary Force
NZRSA  New Zealand Returned Soldiers' Association
O/C  Officer in Charge
OP&GWA  Otago Patriotic and General Welfare Association
SWFA  Southland War Funds Association
TB  Tuberculosis
VAD  Voluntary Aid Detachment
VD  Venereal Disease
This is a work about perception and experience. It examines the way in which men disabled both by combat and disease incurred during their war service viewed themselves and their society. It is also a work about that society and how it collectively viewed the men who sacrificed the relative security and stability of civilian life for the rigours of war, and the efforts made by the state and voluntary groups in Dunedin towards their rehabilitation, or repatriation as it was more commonly termed at the time.

In 1937, war service statistics compiled by the New Zealand Returned Soldiers’ Association (NZRSA) found that of the 98,950 men who had served overseas with the New Zealand Expeditionary Force (NZEF), 77,965 had been discharged upon their return to New Zealand, and 5822 had subsequently died. According to the 1936 census, 10,057 of these surviving men lived in the Otago and Southland areas. For the same year, census data found that the combined population of the provinces was 224,069. Returned servicemen therefore accounted for approximately 5% of the total provincial populations. Given that the casualty rate amongst the NZEF was 58% during the course of the war, it is reasonable to assume that at least 6000 Otago and Southland men had received some form of medical or rehabilitative care as a consequence of their war service.

The major theme this thesis addresses is whether or not disabled men attached their postwar identity to the values for which they had fought once they began to experience the long-term physical, emotional, and economic losses wrought by their war service. To develop this theme, it has been necessary to examine a complicated array of sub-questions: what disabilities did men experience and was any particular medical or economic category of disabled men especially disadvantaged; how did medical knowledge affect the treatment and experience of men’s disabilities; what impact did disability have on men’s economic and family lives; what role did the symbolism attached to wounding by soldiers and society have upon the readjustment of men to their civilian lives; did the concept of the ‘digger spirit’ of comradeship, self-sacrifice, and duty create a collective identity amongst returned servicemen in postwar society; did war foster a sense of New Zealand national identity amongst the country’s combatants; finally, upon whom was the responsibility of long-term rehabilitation placed?

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1 'NZEF Statistics 1936-37', Dunedin Returned Soldiers’ Association (DRSA) File 2664.
2 Dominion of New Zealand Population Census 1936: Appendix B War Service, Wellington, 1938, p. 3.
3 Dominion of New Zealand Population Census 1936, Wellington, 1938, p. 2.
The interpretation offered in this work is based on an analysis that regards all individual identity as fragmented and in a state of perpetual crisis. An individual man has no one masculine identity, but rather several based upon his varying levels of perception, his experience of events, and the ways in which these are defined by the realities and mythologies of group and societal consciousness. Identity is the result of a discrete series of events selected by individuals on both a conscious and an unconscious level. The mind continually interweaves these events to create the continuity of personality that is seen by the individual and society as his identity. Yet, this process is in part achieved by the individual defining himself in terms of other people. He thus creates a dichotomy between his own perception and experience by internalising the values and beliefs of a system beyond his creation, beyond what he can know personally by direct experience. As a consequence, he attempts to establish systems of power based on sexual, ethnic, and economic difference through which identity can be stabilised. The establishment of universal codes, expectations or stereotypes out of these systems of power becomes a triumph of unstable identity as change is effectively denied because it is based upon the ‘necessary delusion’ of social organisation. Masculinity and society become victims of the process by which they reproduce themselves.

The following example integrates some of the questions offered above with this type of analysis. The creation of societal expectations can be expressed in terms of the interrelationship of four concepts. Firstly, the mythology of national identity based upon a belief in the pioneering spirit of the New Zealand male securing manhood/nationhood in the eyes of the Empire at Gallipoli. Secondly, the societal obligation of the civilian man to sacrifice his individual identity in times of war for the belief that he is protecting his family, the state, or the Empire. Thirdly, the economic realities of New Zealand society during the interwar era and the prevailing attitudes these entailed regarding the role of citizens and industrial efficiency. Finally, the role of the individual’s ethnicity, religion, age, economic class, and wartime experience in filtering the above factors. Masculine identity therefore depends upon a complex grid of beliefs. What elements an individual consciously and subconsciously internalises will determine the degree of their social adjustment and their position within society.

To explore these concepts I have chosen to examine a specific group of individuals. I took a random sample of seventy-five men from the welfare records of 225 ex-servicemen who received aid from the Red Cross Society or the Returned Soldiers Association in Dunedin during the 1920s and 1930s. From this sample, three categories of men were then culled for the following reasons. Those men who had served in the Imperial Army during the war were

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6 To preserve the confidentiality of the men sampled, I have used false names in the text. With regard to footnoting, I have used the following method to avoid the usage of regimental or war pension numbers. If the source cited is from a pension or defence department file, I have been cross referenced it to a file about the same man that was based on an arbitrary numerical system. For example, NZEF Personnel File (DRSA File 1234).
omitted primarily for the purposes of simplification. Men who served in the Imperial Forces who were resident in New Zealand were in receipt of British War Pensions, and their welfare was administered separately from that of their New Zealand counterparts. Men who were invalided from camp in New Zealand or from camp overseas before they saw active service have also been excluded to ensure clarity. While the fact that these men received welfare after the war raises interesting questions about the basis of care, I decided that it was more appropriate that they be regarded separately from men invalided from active service in order to provide a relatively homogeneous group from which to draw conclusions. Finally, men whose disabilities were due to postwar civilian accidents apparently unrelated to any former disability attributable to war service were excluded. Once these men were omitted from the sample, a total of fifty-six men who had seen active service with the New Zealand Expeditionary Force was left. The experience of these individuals provides the focus of this thesis.

The men sampled were typical of the population of Otago and Southland during the first quarter of the twentieth century. As far as is known, all the men were of European descent. The religious profession they stated on enlistment correlates proportionately with 1911 census data for the provinces, the majority of the men having claimed presbyterian allegiance (29 men) followed by Anglican (14 men) and Roman Catholic (9 men). Approximately 80% (46 men) resided in an urban area while the most common occupation stated by these individuals upon their enlistment was labouring. Only seven of the men were married prior to their enlistment in the army reflecting the comparatively young age of most of the men during their war service while thirty-seven of men are known to have been married after the war. The average year of birth for the sampled men was 1889 with the range of birth years running from 1876 to 1897.

There were a number of possible ways in which these men returned to New Zealand during the course of their war service. To perform a special duty for the military within the country was one instance. If judged medically unfit due to either wounds or sickness they could be returned, or, they could have arrived back in New Zealand to receive quarantine treatment for venereal disease. A further group were those awaiting military punishment. Finally, there were those men awaiting demobilisation. Of the sampled men, sixteen were discharged fit on the termination of their period of engagement in the forces, eighteen were discharged unfit on account of wounds received on active service, twenty returned to New Zealand as a result of sickness attributable to active service, and two men were invalided home on account of both wounds and illness.

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7 1911 census figures found the numerical strengths of the three denominations in Otago and Southland to be: Presbyterian 60,807; Anglican 30,521; Roman Catholic 15,342. Census 1911, Wellington, 1912, p. 105.

8 These figures were calculated from NZEF Personnel Files. I have cross-checked the birth years with Department of Internal Affairs death notifications of each man to attempt to ensure accuracy.

9 New Zealand Defence Forces, Returned Soldiers' Handbook, First Demobilisation Edition (Revised to 30th November 1918), Wellington, 1918, p. 6.

10 NZEF Personnel Files.
It is difficult to quantify the relationship between the war disabilities incurred by the sampled group with those experienced by the total disabled serviceman population. In 1925, the Pensions Department claimed that out of a total of 12,834 men receiving war disability pensions, 53% were for the after-effects of gunshot wounds (GSW), 17.6% for respiratory conditions including pulmonary tuberculosis, while shellshock and insanity pensions accounted for 5.4% of payments. Reference to the disabilities faced by the men sampled highlights discrepancies in the payment of pensions and the prevalence of specific disabilities. During their wartime service, 41% of the men received treatment for a GSW, 48% at some time suffered from a respiratory ailment, 30% had gastro-intestinal disorders, and 14% had some record of psychological disturbance. Upon their return to New Zealand, the same men were classified at varying times by the medical profession for the following disabilities: respiratory 48%, psychological 42%, gastro-intestinal 29%, effects of GSW 21%. Official returns of war disability pensions therefore appear to have been biased in favour of impairments that could be easily proved to be related to war service. GSW sufferers and amputees represented the visible after-effects of war; men with 'invisible wounds' - a degree of psychoneurosis or a medical condition that fluctuated in its symptoms over the course of time such as respiratory or cardiac cases - appear to have been disadvantaged in their treatment by the state.

The rehabilitation of all ex-servicemen by the state and voluntary organisations can be seen in terms of a societal rehabilitation pact comprised of medical care, convalescent care, vocational training, and employment and welfare provisions. This pact expressed the social commitment given to disabled servicemen upon their return to New Zealand society. Insight into the structure and values underlying this rehabilitation pact allows analysis of the process elaborated above by which masculine identity was constructed in postwar Dunedin society. My thesis focuses upon three aspects of the pact: medical and convalescent care, and vocational training provision. Chapter One examines the pact of medical care and its relationship to men's experience of their disabilities. Chapter Two focuses upon the convalescent care pact offered to men at Montecillo Home by the Red Cross Society and the formation of a collective returned soldier identity. Chapter Three analyses the provision of vocational training and its relationship to concepts of masculine citizenship, industrial efficiency, and the overall pact of rehabilitation. Given the omission of a detailed analysis of welfare and employment provisions, I have provided, for the benefit of the reader, a brief outline of the interaction of the various elements involved in the rehabilitation of first world war servicemen.

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12 NZEF Personnel Files.
13 These figures are a synthesis of various sources: DRSA War Pensions Appeal Case Files; Montecillo Home Medical Files; New Zealand Income Support Service War Pension Files; Otago Patriotic Association Case Files; Seacliff Mental Hospital Case Files.
The medical care of returned servicemen remained the responsibility of the Defence Department until their discharge from the forces. The Defence Medical Services were organised under the authority of the Adjutant General, Colonel R. W. Tait, and consisted of the Director General of Medical Services (DGMS), R. S. F. Henderson, the Director of Military Hospitals (DMH), Honorary Colonel T. H. Valintine, and three staff concerned with dental care and camp sanitation. In addition, the Consulting Surgeon to the Forces, Colonel J. McNaughton Christie, inspected all returned soldiers in public hospitals and sanatoria and reported to the DGMS on matters relating to treatment and medical boards. At a local level, four district Assistant Directors of Medical Services (ADMS) in Auckland, Wellington, Canterbury, and Otago co-ordinated the care of ex-servicemen in the military hospitals in their respective areas. This arrangement continued until 1922 when the military began to divest its authority regarding medical care to the Pensions Department. From 1924, the Pensions Department took full financial responsibility for the medical treatment of men who could prove that their disabilities were attributable to or aggravated by their war service. Men who could not persuade the Pensions Department about this linkage met the costs of their treatment themselves or became dependent upon bodies such as the Red Cross Society.

War pensions were payable to ex-servicemen, their dependents, and the dependents of deceased servicemen. Under the 1915 War Pensions Act, all men suffering from injury or disease incurred during war service were entitled to a universal disability pension. The existence and extent of disability was determined by the War Pensions Board who also decided whether or not a man should receive a permanent or temporary pension, or no benefit at all. An amendment Act passed in 1917 set out a schedule that fixed the value of a man’s disability; the loss of two limbs was deemed to be a 100% disability pension while the loss of an index finger was estimated at 20% impairment. The level of a man’s pension was also determined by his rank upon leaving the military; in 1923 a 100% disability pension for an enlisted man was £2. Thirty-six of the sampled men are known to have been in receipt of a war disability pension.

Changes to the war pensions system were made during the early 1920s. From 1922, ex-servicemen could take pension applications declined by the War Pensions Board to an Appeal Board consisting of a judge and two medical practitioners (one of whom was nominated by the

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15 Ibid.

16 Ibid., p. 516.


18 Ibid.

19 Ibid.
Two types of cases were involved - assessment and ‘attributability’. Assessment cases arose over disputes about the disability level assessed on a granted pension; attributability cases were related to men attempting to prove the role of war service in their impairments. During the early 1930s, the Board sat in Dunedin three times a year. At the same time as the establishment of the appeal board, wider social concern about economic hardship amongst disabled soldiers led to a Commission of Inquiry in 1923 under a stipendiary magistrate, J. Bartholomew. As a consequence of his recommendations, an ‘economic pension’ worth £1110/- per week was created to supplement the income of men already in receipt of disability pensions. Unlike the disability pension, the economic pension was means-tested to the financial circumstances of the recipient.

The Great Depression brought the need for further changes to the system as hardship among returned soldiers again captured the public eye. During late 1929, an Ex-soldiers’ Rehabilitation Commission was created with funding from the NZRSA and the National War Funds Council. The report of the chairman, J. S. Barton, recommended changes to the war pensions legislation but due to cutbacks in state expenditure, including a 10% cut in war pensions themselves, these were never enacted. The Commission did however, raise the issue of premature ageing amongst returned soldiers and this led to the introduction of a Private Member’s Bill by John A. Lee in 1933. The result was the War Veterans’ Allowance Act of 1935. Ex-servicemen who could satisfy the War Pensions Board that they were unfit for permanent employment due to physical and mental disability, regardless of its relation to war service, were entitled to a small means tested allowance. Eleven of the sampled men are known to have received a War Veterans’ Allowance. The election of the first Labour government in 1935 and the passage of the 1938 Social Security Act also affected War Pensions legislation but the practical implications of these events lie outside the time scope of this thesis.

From December 1918, the employment of returned soldiers was arranged by the Repatriation Department. The Department was administered by a Repatriation Board comprising four ministers of the crown under J. R. Samson. Local Boards were created in the cities and towns. Their function was to liaise with the community to find work for returned men, offer employers subsidised wages and ex-servicemen unemployment relief, establish vocational training schemes, and advance loans for establishment of businesses and the purchase of furniture by returned soldiers. By August 1919, the Dunedin Branch of the


Memo from the secretary of the DRSA, O. L. Ferens, to the secretary of the Southland War funds Association, J. Tait, dated 9/10/34. DRSA File 2254.


NZRSA Review, Vol. 8, No. 4, May 1932, p. 5.

NZRSA File 7.

Repatriation Department, under H. D. Tennent, had found employment for 1,100 men and advanced 150 business loans.\textsuperscript{26} The government closed the Department in August 1922 in the belief that its function had been fulfilled - most of the men registered with the Department had found employment. The repayment of loans made by the Department to ex-servicemen was organised through the State Advances Corporation.\textsuperscript{27} As mentioned above, concern about the employment position of disabled ex-servicemen mounted however, during the late 1920s as the economic circumstances of the country worsened. In 1929, the recommendations of the Barton Commission led to the creation of the Disabled Soldiers Civil Re-establishment League in 1931. The League was essentially a resurrection of the old Repatriation Department, but its formation during a time of depression and governmental indifference over funding hampered its activities.\textsuperscript{28}

The re-settlement and employment of men on the land was the responsibility of the Lands and Survey Department under the Discharged Soldiers Settlement (DSS) Act of 1915 and its various amendments. The Act enabled returned men to acquire land owned privately and by the Crown by ballot, provided finance for single unit farm properties, and offered advances for the purchase of equipment and the erection of dwellings.\textsuperscript{29} In 1923, the economic recession and consequent repayment difficulties faced by returned servicemen led to the passage of an amendment Act that set up a revaluation board to revalue and readjust the capital charges on properties. A further piece of legislation was passed in 1936. The Mortgagors and Assessors Act gave men resident in DSS settlements further financial concessions.\textsuperscript{30} Of the sampled men, only three are known to have acquired land under the provisions of the DSS Act reflecting the urban bias of the sample population.\textsuperscript{31}

The NZRSA was heavily involved in employment programmes for returned servicemen. Throughout the interwar period, the Association unsuccessfully called on the government to establish a roll of disabled soldiers who could then be matched to suitable jobs in industry and the public service.\textsuperscript{32} From 1922, the NZRSA operated a subsidised work scheme with other local bodies and other welfare organisations. The funds for the work came from the sale of silk poppies on ANZAC day. ‘Poppy Day’ work, as it was known, was provided on a priority scale to non-pensioned married men with children and was then filtered down to single pension

\textsuperscript{26} ‘Memorandum Regarding the Organisation and Operations of the Repatriation Department’, AJHR H30, 1919, p. 13.

\textsuperscript{27} NZ Rehabilitation Board, History, p. 5.

\textsuperscript{28} NZRSA, NZRSA Handbook, Wellington, 1937, p. 20.

\textsuperscript{29} NZ Rehabilitation Board, History, p. 1.

\textsuperscript{30} Ibid, p. 2.

\textsuperscript{31} New Zealand National Archives (hereafter NZNA) LS 34/1 Register of Returned Soldiers’ Holdings 1916-1930. The files of the men in question are: HQ 26/475, HQ 26/27977, HQ 26/ 289544.

During the depression, the Dunedin RSA provided employment relief in the parks and reserves of the city, and, in 1934, 140 men were employed weekly by the Association constructing the municipal golf links at Chisholm Park. Local RSAs also ran their own employment programmes. In 1934, the DRSA acquired 170 acres of land near Roxburgh in Central Otago for the purpose of establishing an afforestation scheme. By 1939, over 55,000 trees had been planted by ex-servicemen on the site. The Dunedin Association also pressured central government to hire ex-servicemen on public work schemes, although with little success.

The administration of patriotic war funds for welfare purposes was loosely controlled by the Department of Internal Affairs. Under the 1915 War Funds Act, patriotic organisations were responsible for the welfare of men who enlisted in their local area. Thus, if a man resided in Dunedin after the war but had enlisted in Auckland, the Auckland body was responsible for his upkeep. If the patriotic body responsible had gone out of existence or lacked funds, men could look for assistance from the National War Funds Council which sought to secure efficient administration and control of war funds. Patriotic funds were intended to provide temporary relief for ex-servicemen rather than to constitute fulltime support. The Otago Patriotic and General Welfare Association (OP&GWA) provided men with clothing and work tool allowances upon their return to New Zealand, as well as interim financial support through its Soldiers’ and Dependents’ Welfare Committee while employment or a war pension was procured. During the 1930s, the OP&GWA was also involved in ‘Poppy Day’ employment schemes with the DRSA. The DRSA itself operated a series of welfare funds. The most notable was the Grace Lillian Mitchell Fund for the purpose of ‘assisting persons adversely affected by the Great War of 1914-1918’. Other welfare funds available to the DRSA included the Selina Broderick Fund ‘for the benefit of disabled soldiers’, and the New

34 ‘RSA Letters to Soldiers’, Otago Patriotic Association (OPA) File 7818.
35 Memo DRSA to Lands and Survey Department, dated 10/3/34. DRSA File 2272.
36 Memo Minister of Public Works, J. Bitchener, to NZRSA regarding the employment of ex-servicemen on the Omakau Irrigation scheme in Central Otago, dated 20/9/35. DRSA File 2473.
37 NZRSA Handbook, Wellington, 1937, p. 34.
38 Ibid, p. 35.
40 Ibid, p. 127.
41 Memo Perpetual Trustees to the Secretary of the DRSA, J. M. White, regarding the Grace Lillian Mitchell Fund, dated 5/6/29. DRSA File 1447.
Zealand Canteen and Regimental Trust Funds which were used for ex-servicemen suffering from ill health and unemployment. The Dunedin Centre of the British Red Cross Society provided welfare for ex-servicemen receiving medical care from its Joint-Council Fund. The OP&GWA, the DRSA, and the Red Cross Society all kept in constant communication to coordinate the expenditure of local welfare funds. A number of specialised funds were also available to specific groups of ex-servicemen. For example, the Commercial Travellers’ and Warehousemen’s Blind Soldiers’ and Sailors’ Fund tended to the needs of men in this category.

This is the complex framework against which the needs of returned servicemen were to be met. There was a clear social commitment to rewarding such men for their service to the country, but this was a partial commitment cobbled together from voluntary and public sources and was always harassed by financial constraints. It was also partial because it was contingent on views of deservedness which were based on current perceptions of masculinity and citizenship within New Zealand society. Ultimately, these perceptions would create a dichotomy between the experience of those involved in the provision of rehabilitation and the social realities faced by the ex-servicemen whom they was sought to aid.

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43 Ibid, p.46.
44 Dunedin Branch of the New Zealand Red Cross Society (hereafter DRCS) Executive Minute Book 3, entry dated 1/6/36.
CHAPTER ONE
MEDICAL TREATMENT AND
THE EXPERIENCE OF DISABILITY

The arrival of the S. S. Willochra at Port Chalmers on 15 July 1915 brought the first group of sick and wounded soldiers back to their home province. Prior to disembarkation, military procedure required that each man appear before a medical board on ship which classified him as either requiring no treatment or needing care as a hospital inpatient or outpatient. Inpatients were treated at the expense of the Defence Department unless they suffered from a disease contracted through their own actions - a discreet way of signifying venereal cases - in which case 2/- per day was deducted from their military pay. A travelling warrant was issued to the soldier’s next of kin, and, if he was in a critical condition, a half price fare issued once a month for as long as circumstances demanded. Outpatients were issued with an attendance card which was to be signed by a medical officer each time they received treatment. They were also given a certificate indicating treatment and provided with two blue stars to attach to their uniforms to signify their status to the public and the military police.

This chapter examines the relationship between medical treatment and the manner in which men experienced their disabilities. Part One focuses on the pact of medical care offered to disabled servicemen by the state and local health authorities in the Dunedin area. Between 1919 and 1922, the military offered disabled servicemen an extensive range of medical services in conjunction with the facilities of the Otago Hospital Board. The existence of a medical school in the city, and the specialists associated with this teaching function, meant that orthopaedic and plastic surgery, along with institutional treatment for respiratory conditions and venereal diseases, was able to be offered to disabled servicemen in the Otago and Southland areas. From 1922, the range of medical services available to ex-soldiers became more limited as the state reduced its responsibility regarding medical care by shutting-down the specialist institutions established by the military. Moreover, the Pensions Department takeover of financial responsibility for the medical treatment of disabled soldiers further lessened state responsibility by requiring men to prove that their impairment was attributable to war service to gain state-sponsored treatment. Part Two examines the impact of disability upon individual identity. It asserts that war disability resulted in a fragmentation or discontinuity of the


3 Ibid, p. 27.
conscious and unconscious series of events that formed a man’s identity. Disability forced a man to rearrange the social, and economic aspects of their lives that they had taken for granted before their handicap occurred.

(I) THE MEDICAL PACT

From March 1918, all medical treatment given at institutions for returned soldiers was controlled by the Defence Department. Before this date, the military and the Public Health Department exercised dual control but this arrangement was found to be cumbersome with regard to the transfer of soldier patients between institutions and disciplinary control of the men. Under military control, men who had been previously discharged in New Zealand were re-attested to bring them under army disciplinary regulations. Overall authority for their treatment lay with the DGMS Surgeon-General R. S. F. Henderson who co-ordinated their medical care at specialist medical institutions established by the army. The most notable of these were the King George V Orthopedic Hospital in Rotorua, Queen Mary Military Hospital at Hamner Springs for neurological cases, and one sanatorium in each island - Pukeora in Waipukurau, and Cashmere Hills in Christchurch. At a local level, the Dunedin ADMS, together with the Officer in Charge (O/C) of the military section at the civil hospital, arranged the transfer and medical care of men in Dunedin Hospital, Woodside Jaw Hospital, Pleasant Valley and Wakari Sanatoria, ANZAC House and Seaciff Mental Hospital, Port Chalmers Military Hospital, Montecillo Home, and a small military convalescent hospital in Timaru.

In 1918, the military established a specialist orthopaedic centre in Dunedin Hospital under Lt. Col. L. E. Barnett. An additional storey known as Alexandra Ward was built on the third level of the King Edward VII Pavilion at a cost of £1544/14/6. This extension together with the Batchelor and Sidcup Wards formed the nucleus of the military section at the Hospital. In June 1919, combined with a twenty-five bed Jaw Hospital, the military section could accommodate 111 servicemen. In association with orthopaedic treatment, a gymnasium was

5 Ibid.
6 Ibid, p. 514.
7 Ibid, p. 505. Barnett was the holder of the Chair of Surgery at the University of Otago Medical School.
8 NZNA AD 1 49/755v1 Memo O/C War Expenses to the Secretary of the Otago Hospital Board dated 22/4/20.
9 NZNA AD 1 43/617 Memo O/C Military Section Dunedin Hospital, Lt. Col. H. P. Pickerill to the DGMS, Brigadier General Sir D. McGavin dated 12/8/19.
opened in the old nurse’s home, and a splintmaking workshop established in the Hospital grounds.\textsuperscript{10}

Medical care was given by both military doctors and honorary staff from the civil hospital. The military establishment of the hospital in July 1919 consisted of the O/C, Lt. Col. H. P. Pickerill, two orthopaedic surgeons - Majors Thomas Fergus and J. Renfrew White - and two physicians - Captains M. Marshall and R. Fitzgerald. In addition, the facial and jaw section under Pickerill comprised four technical staff - a modeller, photographer, dental mechanic, and artist. Sixteen nursing sisters, thirty-one masseuses, five Voluntary Aid Detachments (VADs), and twenty-four Non-Commissioned Officers (NCOs) and men of the New Zealand Army Medical Corps (NZAMC) completed the military hospital’s complement.\textsuperscript{11} Twelve specialists from the civil hospital also made their services available to the military. The most notable of these were the Director of Tuberculosis Treatment, Dr. C. Ernest W. Lyth, and a Bacteriologist, Dr. Champtaloup, who aided the military in its treatment of venereal disease.\textsuperscript{12}

In line with Dunedin’s role in medical education, the Defence Department co-operated with the Medical School and used the facilities available at the Hospital to train masseuses for other military hospitals. Instruction was given to students in massage, faradic and galvanic electrical treatment, and Swedish remedial exercises over an eighteen month course period.\textsuperscript{13} Trainees paid the military £57 for the instruction and were indentured to the army for the duration of the war and two years after its conclusion. In January 1919, Miss J. Knox Anderson, along with Miss E. Nelson and Sister Gertrude Petre, instructed thirty students.\textsuperscript{14}

The Defence Department began to sever its medical links with Dunedin Hospital in July 1920. The military section was handed back to the Hospital Board with the Defence Department agreeing to pay the Board 6/- per diem for inpatients and 1/- for each outpatient treatment whether this was for massage, medicine, or dressings.\textsuperscript{15} Servicemen continued to use the military’s garrison dispensary for some medicines until 1922 however, when the Hospital Board assumed full responsibility for their care.\textsuperscript{16} The Department maintained control


\textsuperscript{11} NZNA AD 1 43/617 Memo O/C Military Section Dunedin Hospital, Lt. Col. H. P. Pickerill to the DGMS, Brigadier General Sir D. McGavin dated 8/7/19.

\textsuperscript{12} NZNA AD 1 43/617 Memo O/C Military Section Dunedin Hospital, Lt. Col. H. P. Pickerill to the DGMS, Brigadier General Sir D. McGavin dated 9/7/19.

\textsuperscript{13} \textit{Kai Tiaki}, Vol.1, No. 3, July 1918, p. 120. For further information on the training of physiotherapists in Dunedin at this time see: L. Taylor, ‘Dunedin School of Massage: The First Decade of the Otago Polytechnic School of Physiotherapy’, unpublished Post Graduate Diploma thesis, University of Otago, 1986

\textsuperscript{14} \textit{Ibid.}

\textsuperscript{15} NZNA AD 1 49/755v1 Memo DGMS, Brigadier General Sir D. McGavin to the Chief Health Officer, Public Health Department Wellington dated 27/4/20.

\textsuperscript{16} \textit{AJHR H19}, 1922, p. 7.
of the splint workshop under the ADMS until 1922, and a complete set of massage equipment was transferred to Montecillo Home for the use of the inmates there. The Hospital Board purchased all the equipment used by the military except for that designed for jaw and facial surgery in use at Woodside Jaw Hospital. Pickerill and White were appointed to the Honorary staff of the Hospital, and White set up the civil hospital’s orthopaedic department in 1920.

The closure of the military section was part of a wider series of reforms that redefined the Defence Department’s responsibility in the care of disabled soldiers. In May 1919 Brigadier General Donald McGavin took over from Henderson as DGMS. In a series of administrative changes, McGavin replaced senior public health officials loaned to the military during the war with returned men from the New Zealand Army Medical Corps (NZAMC), closed small hospitals and concentrated disabled servicemen in specialised military institutions. Following on from this he began to close the larger military hospitals, so that, by June 1922, they had all been either shut-down or placed under the jurisdiction of the Public Health Department. From June 1922 until December 1924, McGavin acted as Medical Administrator of Pensions in order to facilitate a smooth transition between the military and the Pensions Department who took over financial responsibility for the medical well-being of disabled ex-servicemen. The basis of the McGavin’s reforms appear to have been a belief that the duty of the state was to facilitate the long-term care of disabled men by local health authorities rather than that the state should provide medical services itself. The transition to the Pensions Department set clear guidelines to public health authorities about the limitations of governmental fiscal responsibility in medical rehabilitation. However, if the relationship between the Defence Department and the Otago Hospital Board was typical of the Department’s handling of medical rehabilitation, then the local Hospital Boards involved in the care of ex-servicemen may not have regretted the demise of the military in this capacity.

The relationship between the Defence Department and the Otago Hospital Board over the military section had not been a happy one. Despite the view proffered by A. D. Carbery in 1924 that the Hospital Boards, imbued by patriotism, co-operated energetically with the Defence Department, the army in Dunedin complained of professional jealousy between the civilian doctors and the military medical staff at Dunedin Hospital. For its part, the Hospital Board expressed frustration at what it perceived as the high handedness of the army. In August 1919 the local Red Cross Society organised a ‘Peace Celebration’ in one of the military wards of the

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17 The Board later acquired this equipment in 1922 when Woodside closed - see Chapter Two.


19 Carbery, pp. 508-509.

20 DRCS 2, 26/1/25.

21 Carbery, p. 504.
Hospital. The mayor and all the leading citizens except for the representatives of the Hospital Board were invited to the function raising the ire of the Board towards the army. Matters came to a head in July 1920 when the military closed down its section of the Hospital. The Board attempted to charge the army for £18 worth of damage to one of the wards appropriated by the Defence Department. The military held an internal court of inquiry which exonerated the Department of any responsibility by determining that the damage represented ordinary depreciation. McGavin wrote to the Otago ADMS that 'in the meantime Woodside and Montecillo should be fully employed as much as possible to avoid sending men to the Civil Hospital' while he also wrote to the O/C of Administration that 'I strongly recommend that no further benefits or other material concessions be made to this Board which has profited so enormously in its connection with this Department.'

Part of the squabble lay in the abolition of dual control and the structure of the Public Health system in New Zealand. It is hardly surprising that the Otago Hospital Board resented having no control over a section of its base hospital from 1918 onwards as the relationship between the military and civilian medical staff threatened to undermine the Board's operations financially. Under the 1909 Hospitals and Charitable Institutions Act, New Zealand hospitals were funded from a levy upon local ratepayers which was matched by central government, and by fees paid by the institution's patients. The employment of some of the specialist staff of the Dunedin Hospital on an honorary basis reflected the fragility of this financial position. While these staff, like most medical practitioners, had other medical positions in the city to supplement their incomes, the development of a parallel medical system by the military that offered an opportunity to practice new and challenging surgical techniques upon disabled servicemen, and the promise of an additional source of guaranteed income for specialists, threatened to undermine the civil hospital's staff infrastructure. However, due to fiscal limitations and the number of men requiring treatment, the Defence Department continued to utilise existing medical institutions in addition to establishing its own services. The military's medical care of pulmonary tuberculosis reflected these circumstances.

Although the Defence Department designated Cashmere Hills Sanatorium in Christchurch as the official treatment centre for South Island cases of pulmonary tuberculosis, the number of servicemen diagnosed with the illness meant that the military paid the Otago Hospital Board to


26 Carbery, p. 504.
treat consumptive servicemen at the Board's facilities at Pleasant Valley and Wakari. Between May 1916 and December 1918, 960 servicemen were invalided from the forces with pulmonary tuberculosis. In October 1919, the DGMS Brigadier General Sir Donald McGavin informed Dr. Ernest Lyth that, nationally, 232 of these servicemen were currently inpatients at sanatoria, and 106 were receiving outpatient care. Cashmere Sanatorium, McGavin wrote, could only accommodate fifty patients so that the Defence Department was unable to transfer any soldier patients receiving treatment in Otago to Christchurch. In addition to those men receiving medical treatment, a further 554 ex-servicemen were pensioned for the illness. Of these ex-servicemen, McGavin noted that there were a considerable number who had probably never never had phthisis. These men also threatened to burden the sanatoria system.

Diagnosis of the pulmonary tuberculosis was not clear cut. Clinical examination involved the physician detailing the patient's personal and family history, a study of the outward appearance of the chest, percussion and auscultation, and an inconclusive sputum test by the Ziehl-Neelsen method; x-ray was not widely used during the inter-war period. Aside from a diagnosis of pulmonary tuberculosis proper, the military also classified doubtful cases as CPDI (Cardiac Pulmonary Disease Indeterminate) and many of these men received sanatoria treatment when they were in fact suffering from other respiratory or psychological ailments. In 1920, the president of the NZRSA, Ernest Boxer, expressed concern at the number of CPDI men who were ending up in sanatoria. One of the most frequent categories amongst these men were those suffering the after-effects of poison gas. In 1931, W. N. Abbott reported in the New Zealand Medical Journal that 17% of men who had been gassed were likely to develop pulmonary tuberculosis while the same men also suffered from a much higher incidence of other respiratory ailments than the civilian population. Diagnostic difficulties, together with latent physical effects of gassing meant that the military lacked the institutional capacity to treat all servicemen solely by their own authority.

The treatment of pulmonary tuberculosis in Dunedin was based upon a dispensary system linked to the Hospital Board sanatoria. The Dispensary service at Dunedin Hospital regulated

28 NZNA AD 1 49/854 Memo DGMS, Brigadier General Sir D. McGavin to Dr. C. E. W. Lyth dated 16/10/19.
29 Ibid.
30 Ibid.
31 N. W. Pryde, 'A Study of the Construction, Methods, and Results of Waipiata Sanatorium, Central Otago', unpublished fifth year preventative medicine dissertation, University of Otago Medical School, 1932.
32 Stout, p. 588.
the treatment of all suspected phthisis sufferers in Dunedin. Patients, including ex-servicemen, regularly attended the clinic for medical examinations by Dr. Lyth, who classified them as requiring sanatorium, hospital, or home treatment. Those diagnosed as suitable for home care received visits from a district nurse who supplied disinfectant, sputum flasks, and, if necessary, liaised with official and private charities on the sufferer’s behalf.35

After home care, Pleasant Valley Sanatorium represented the next medical step in the treatment of Otago consumptives. Opened in August 1910 with a capacity for thirty-eight patients, Pleasant Valley hoped to treat sufferers in the early stages of the affliction.36 Treatment emphasised the moral education of the inmates in a disciplined regimen of open air treatment. The sanatorium had been originally intended to run as a farm, and, even though this feature was reduced in size in 1918, tree-planting and poultry farming were still undertaken by the patients.37 Other treatment at the sanatorium consisted of a rigorous regime of fresh air, good food, and enforced rest and exercise. Patients rose at 7am for breakfast, helped clean up, and then followed an individually controlled programme of graduated work, exercise and rest. By November 1918, the Sanatorium had fifty-four inmates of both sexes.38 Seventeen of these consumptives were soldier patients.39 Treatment at the sanatorium remained largely unchanged throughout the postwar years.

From June 1919, chronically tuberculous servicemen received treatment at a new sanatorium at Wakari. Two wooden shelters accommodating eight men each were built to house chronic consumptives, and in the initial years of their use these largely contained soldier patients.40 Accommodation conditions at the sanatorium were austere reflecting the medical philosophy behind open-air treatment. In July 1923 however, the local Red Cross Society successfully petitioned the Hospital Board over inadequate heating in the shelters.41 The Red Cross also supplied the soldier inmates with a gramophone, wireless, and billiard table for their further comfort.42 Treatment at Wakari Sanatorium was in line with the official policy of the military regarding chronically tuberculous men that they should be cared for in their own homes or in hospitals near their homes.43 The Defence Department continued its association

35 Angus, p. 148.
36 Ibid, p. 147.
37 Ibid.
38 Ibid.
40 Angus, p. 150.
41 DRCS 2, 23/7/23.
with all tuberculous soldier patients until 1922 when the Pensions Department assumed financial responsibility for their medical care.

The treatment of shellshocked servicemen had been first discussed at a conference held in December 1915 by the DGMS, R. S. F. Henderson, the DMH, T. H. Valintine, and a neurologist, Lt. Col. T. Hope-Lewis. They proposed a three tiered system of treatment for men suffering from war neuroses upon their return to New Zealand. The first tier, which involved mild cases of neurosis being ‘farmed out’ into private homes, does not appear to have been enacted, but the remaining two aspects were implemented. In 1919, the Inspector General of Mental Hospitals, Frank Hay, described the treatment procedure in this fashion:

a house at Karitane belonging to Dr. Truby King was placed at our disposal, and this was strictly reserved for soldiers. Next, for the best mental patients received under Magistrate’s order the Reception Home was to be used. This building is known as Clifton House, and is beautifully situated on the Seaciff Estate. The next best patients were to be treated in the library ward at Seaciff...For patients whose mental condition debarrd them from admission to any of these three divisions the environmental factor would be negligible; but when upon improvement, a change could be appreciated, a change would be made, according to the mental condition of the patient, to one of these three divisions.

This system of reception remained until the opening of the Queen Mary Military Hospital at Hamner Springs in June 1919. Until this point, ANZAC House, as King’s cottage was known, together with Seaciff Mental Hospital received the majority the men admitted into institutions from the 1380 shellshocked soldiers invalided to New Zealand by December 1918.

ANZAC House attempted to treat ex-servicemen suffering from milder cases of war neurosis in a manner that avoided the stigma attached mental illness in the wider society. The military barred the usage of the name Seaciff when discussing the facility to avoid popular association with the nearby mental hospital, and, unlike Seaciff Hospital, the Home did not require a magistrate’s order for a patient to be admitted. To ensure disciplinary control of the soldier inmates, King was made an Honorary Major by the military, and the second Head Attendant at the Mental Hospital, Maurice Quill, was given the rank of Sergeant Specialist NZAMC. Treatment consisted of a form of ‘moral therapy’ that sought to guide ex-

46 AJHR H7, 1919, p. 27.
47 Stout, p. 758
48 Clarke, p. 54.
servicemen in their readjustment to civilian life. Daily life was organised around a blend of rest and exercise. Men took part in the housework of the institution while also going swimming and fishing.\(^{50}\) King made use of a middle-aged female nurse at dinner times to set a good tone to the men’s conversation and to inculcate acceptable manners.\(^{51}\) After the opening of Queen Mary Military Hospital, the type of patient accepted at Karitane changed to servicemen whose mental disability was more severe and who might require to be committed to the nearby Mental Hospital.\(^{52}\) ANZAC House closed on 6 May 1920.\(^{53}\)

The committal of soldier patients to Seac1iff Mental Hospital was a subject of public controversy. In 1917, a separate building for this purpose was opened in the Hospital’s grounds. Clifton House provided accommodation for six servicemen and six child convalescents whom King must have felt would benefit the health of the soldier inmates.\(^{54}\) In a further attempt to avoid imposing the stigma of mental illness upon returned servicemen, the DGMS advised King that he could hold all soldier patients at Karitane and Seac1iff Hospital under his authority.\(^{55}\) This circumvented the legal requirements for committal under the 1911 Mental Defectives Act which stipulated that a magistrate’s order and two medical certificates were needed to commit a person to a mental hospital. On 29 September 1920, the Otago Daily Times ran an article on allegations of patient abuse and the illegal committal of soldier inmates at the Hospital.\(^{56}\) The government was forced to admit that its actions were illegal but emphasised that they had been undertaken in the best interests of the men concerned. In July 1925, an Executive Standing Sub-committee of the NZRSA passed three resolutions.\(^{57}\) First, that the state remove the names of all servicemen admitted to Seac1iff in this fashion from the institution’s register. Second, that the men concerned receive compensation in the form of war pensions. Finally, that the 1911 Mental Defectives Act be amended to enable the men concerned to take legal action against the state. In September, the government capitulated to the first two demands of the Association.\(^{58}\)

\(^{50}\) Ibid, p. 54.

\(^{51}\) Ibid, p. 57.

\(^{52}\) Quick Marc\(\acute{\text{a}}\), Vol. 2, No. 19, November 1919, p.50.

\(^{53}\) AJHR H19, 1921, p. 15.


\(^{55}\) Clarke, p. 135.

\(^{56}\) Ibid, p. 136.

\(^{57}\) Ibid, p. 141.

\(^{58}\) Ibid, p. 142.
Between 1915 and 1935, 222 ex-servicemen are known to have been committed to Seaciff Mental Hospital. These men were integrated into the daily life of an institution which did not substantially change during the interwar period. From Truby King's time as medical superintendent, treatment had centred around work in the Hospital's wards, farm, orchards, and fishing station. King was deeply suspicious of Freudian psychotherapy and occupational therapy and saw outdoor treatment as a more natural form of therapy. There is little evidence to suggest that psychotherapy made significant inroads into treatment at Seaciff during the period. Nor were many drugs used in the treatment of patients at Seaciff between 1919 and 1939. Epileptics were sedated with bromides while paraldehyde was also used as a sedative throughout the postwar years. During the 1920s, the hospital also co-operated with the Medical School in testing malarial treatment on syphilis sufferers who had developed General Paralysis of the Insane with limited success. Mechanical restraints do not appear to have been important in treatment. Throughout the 1920s and 1930s, a small number of patients were placed in canvas restraining jackets to inhibit violent behaviour (during 1930 seven inmates were restrained in this manner) but out of a hospital population of approximately 1300 people this form of treatment was largely insignificant.

In 1925, a psychopathic outpatient clinic was established at Dunedin Hospital under Dr. W. Marshall Macdonald and Dr. H. Buchanan. By the early 1930s, the clinic operated twice weekly. In 1937, 158 new cases were observed including 5 war neuroses, and another six cases who had been referred to the Hospital by the Pensions Department. Many of the patients came from the psychiatric ward at Dunedin Hospital which essentially fulfilled the role of accommodating patients before their transfer to Seaciff.

The growth of the psychopathic clinic reflected the extent to which the economic and social hardships of the 1930s exacerbated emotional strains amongst many New Zealanders. In these societal circumstances, some ex-servicemen felt the need to become voluntary boarders at mental hospitals under the provisions of the 1911 Mental Defectives Act. Whereas in 1924, 45 people had taken advantage of this arrangement, by 1936, 84 voluntary boarders admitted themselves to Seaciff Mental Hospital. It is unclear how many of these were ex-servicemen.

60 Fennell, p. 51.
61 Ibid. p. 53.
62 Ibid. p. 56.
63 Ibid. p. 54.
64 Angus, p. 155.
65 AJHR H7, 1937, p. 10.
66 Fennell, p. 74.
but in 1926 thirty-one ex-servicemen were inmates in the Hospital while ten years later, in 1936, this number had risen to sixty-four men.68

In March 1919, the Defence Department estimated that nearly 16,000 cases of venereal disease (VD) had been contracted by members of the NZEF either in New Zealand or abroad.69 From 1916 to 1919, 785 of these men were treated by the military at a small hospital on Quarantine Island in Otago harbour. Of these cases 591 were for gonorrhea and 194 for syphilis.70 The Port Chalmers Military Hospital, as it was known, comprised a staff of eight NZAMC men under the control of Captain W. H. Borrie.71 Syphilis treatment at the Hospital consisted of several injections of arsenobenzol or salvarsan together with eight injections of mercury over a period of fifty days, after which the men were given the Wasserman test. If they were still found to be Wasserman positive, treatment was continued and they were retested after eighty-two days. Patients, when free of active symptoms, were given leave without pay and required to sign a declaration stating they would report weekly to the District Health Officer in Dunedin for six months. Failure to do so resulted in men being returned to the island.72 From 1918 onwards, undischarged soldiers suffering from venereal disease also received treatment from the military at Featherston in the Wairarapa, and the Quarantine Island hospital was gradually shut down.73 In June 1919, VD outpatient clinics were established for the public in the main centres by the military in conjunction with the civil hospitals. The O/C of the Dunedin Clinic in March 1920 was Dr. A. G. McClymont.74 Given the lack of sophisticated treatment, these measures had moderate success but some unfortunate men with tertiary syphilis developed general paralysis of the insane (GPI) and ended their days in Seacliff Mental Hospital or similar institutions.

From June 1922, the Pensions Department undertook financial responsibility for the medical care of all disabled soldiers except for venereal cases if they could prove their disability was attributable to war service.75 When an ex-serviceman required medical treatment he now

68 DRCS 2, 25/1/26; DRCS 3, 3/3/36.

69 NZNA AD 1 24/46/13 Memo Capt. T. Thompson to the Chief Health Officer, Public Health Department Wellington dated 4/3/19.

70 NZNA AD 1 49/553 Return of military establishment for Port Chalmers Military Hospital dated March 1918.

71 NZNA AD 1 24/46/13 Memo DGMS, R. S. F. Henderson, to the Chief Health Officer, Wellington dated 29/3/19.

72 Carbery, p. 511.

73 War Pensions legislation excluded state financial responsibility for the medical treatment of venereal disease on the basis that the men concerned had become infected through their own actions.
made an application to the local Registrar of Pensions either by himself, through his doctor, or through the medical superintendent of the institution where he was gaining treatment. Applications were decided upon by the District Pensions Officer, in Dunedin's case Dr. W. Marshall Macdonald until 1932 and then his successor, Dr. Thomas Fergus, who, if information was insufficient, referred the application to the Medical Administrator of Pensions in Wellington. If the Pensions Department found in a man's favour he became known as a 'service patient' and his pension was increased while he received treatment, or, if he did not have a pension, he was provided with a temporary one. In 1938, the Minister of Defence explained in a letter to a disabled man the procedure for outpatient care in Dunedin under the Pensions Department:

an ex-soldier reports to the Pensions MO who attends at the Registrar's office every day except Saturday between the hours of 11am and 12 noon. That officer prescribes medicine for the ex-soldier's war disability and the latter takes the prescription to the dispensary at Dunedin Hospital where it is made up... I understand that when an outpatient requires a further supply of the same medicine it must be authorised by the Officer in Charge of the Outpatients' Department and this may occasion some delay.

In addition, the Pensions Department could compensate men for loss of wages and travelling expenses incurred in medical treatment. In 1937, a maximum of 10/- a day was payable for these costs provided a man furnished a return to the Department within a month. The Department also offered special concessions to amputees and pulmonary tuberculosis sufferers. Amputees were supplied with two artificial limbs by the Department, a pair of light boots, and stump socks. In the case of double amputees, a wheelchair was provided. From 1927 onwards, the NZRSA succeeded in obtaining a yearly clothing allowance of up to £5 for amputees from the Pensions Department. The grant was payable at the discretion of the War Pensions Board. The standard artificial limb issued to ex-servicemen was, from 1924, the McKay Limb - an aluminium appliance designed by a New Zealander. Before this date wooden legs and arms were manufactured and repaired often by disabled men themselves. The introduction of aluminium limbs met with considerable resistance from returned men involved in the manufacture of artificial limbs who feared that they would lose their source of

77 Ibid.
80 Ibid., p. 15.
81 Ibid.
employment. A centralised artificial limb factory was established in Wellington in 1924, and amputees travelled there to obtain fittings and new appliances during the inter-war period. Few innovations were made in limb technology except for the development of the Forth Limb for above-knee leg amputees in Dunedin in 1927. This appliance offered greater mobility to these men than the McKay limb. It is unclear how widespread its usage was.

Men suffering from pulmonary tuberculosis were entitled to a tent to be used as an open air shelter or £20 worth of structural alterations to their homes. The Department also offered tuberculous men a cash grant not exceeding £5 for the furnishing of shelters. In Dunedin, the local Red Cross Society often provided phthisic ex-servicemen with blankets and other bedding on behalf of the Pensions Department. Most tuberculous men were placed on temporary war disability pensions due to the fluctuating nature of the affliction.

For men who suffered chronic disability but were unable to gain a war pension from the state, continued hospital treatment must have constituted a considerable financial hardship. Soldier patients who could not afford to pay fees became a liability on the Hospital Board or other welfare organisations such as the Otago Patriotic and General Welfare Association and the Red Cross Society. The Hospital Board ran one ‘benevolent’ institution for the sick and indigent, Talboys Home, at the Parkside Hospital site in Caversham. By the mid 1930s many elderly disabled soldiers ended up in this institution. Montecillo Home, run by the Red Cross Society, fulfilled a similar function in providing accommodation for many ageing ex-servicemen in poor health.

Between 1919 and 1939, the provision of medical care for disabled ex-servicemen in the Dunedin area became more limited. Prior to 1922, the military operated an independent system of medical care based upon specialists associated with the city’s medical school and the facilities of the Otago Hospital Board at Dunedin Hospital. Fiscal limitations combined with the large number of soldiers diagnosed as consumptive by the military meant that the Defence Department also required to use the Otago Hospital Board’s sanatoria. Moreover, the military continued to use the Seacliff Mental Hospital for the treatment of severely shellshocked soldiers. The transition from Defence to Pensions Department financial responsibility for medical care in 1922 led to the state limiting its involvement in the medical treatment of ex-servicemen as men were now required prove their disabilities were attributable to their war service to gain assistance. The availability of medical care to many ex-servicemen who could not prove ‘attributability’ therefore became determined in part by the ex-serviceman’s ability to pay hospital fees and the existence of voluntary bodies prepared to finance the medical care of

85 DRCS 2, 19/2/23.
86 During July 1938, seven ex-servicemen were resident in Talboys Home. DRCS 3, 4/7/38.
the indigent. Part Two examines the relationship between medical care, and in the manner in which men experienced their disabilities further. It discusses the physical and psychological symptoms of GSW, pulmonary tuberculosis, and neurosis, and their long-term effects. Moreover, it suggests that impairment created a profound discontinuity between men’s prewar and postwar experience resulting in a need to totally reorder previous lifestyle patterns and, indeed, to fundamentally alter their masculine identities.

(II) EXPERIENCE OF DISABILITY

The understanding and classification of disability by the state, medical profession, public, and the individual varied substantially. State and voluntary organisations defined disability in terms of the financial cost of an ex-serviceman’s lost economic capacity. Military medical Boards were required to state in terms of a percentage estimate the extent of economic impairment that a man was likely to face in the conclusion of their examination.

The development of the war pensions system in New Zealand upon an arbitrary disability schedule connected to a man’s rank further reflected an assumption by the state regarding an individual’s future earning capacity. Moreover, the division of pensions by the state into permanent and temporary categories indicated the potential economic cost of war disablement upon the taxpayer rather than the degree of incapacity experienced by men. Medical classification of disability also embodied these difficulties. The process of labelling disability legitimised the impairment in terms of welfare spending. The effect the label had upon a disabled man’s perception of himself meant that the role of the doctor did not rest solely on the clinical diagnosis and treatment of diseases. In some cases, such as tuberculosis and psychological difficulties, classification of disability also had connotations of social deviance. The societal stigma attached to sufferers of these ailments led them to be seen as groups placed outside the ‘normal’ social order, an isolation reinforced by treatment in sanatoria and mental hospitals. Above all, the manner in which an individual perceived his disability was dynamic. The interaction of medical knowledge, social stigma, and economic aspects of disability with a man’s emotions, meant that his understanding of his handicap shifted through time as his circumstances led him to reappraise his past and its significance. Disability therefore required a complete reordering of identity around the impairment itself and the meanings it held for the sufferer over time.

87 NZISS War Pension File (Seacliff Mental Hospital Case File VB 798).
90 Ibid, p. 12.
The after-effects of GSW experienced by disabled servicemen were in part a result of the limitations of medical treatment during wartime. John Keegan has expressed the result of a bullet or shrapnel fragment entering the body in this manner:

The effects of a tumble produced by striking bone were enhanced by the bone's splintering under the impact, its own fragments then becoming secondary projectiles which produced massive damage to the tissues around about. Some bullets also set up hydraulic effects, their passage driving body fluids away from the wound track at pressures which the surrounding tissues could not withstand.91

The fracturing, splintering, and thinning of bone caused by GSW along with damage to arteries, veins and nerves in the body all presented challenges to medical therapeutics. Wound treatment during the war had been based firstly upon the control of anaerobic infection or gas gangrene, and then upon the treatment of the wound proper. Infection was controlled by use of the Carrel-Dakin method. The wound was radically excised, small rubber tubes with lateral holes were inserted and gauze placed over the open wound. Dakin's solution was then introduced into the tubes every four hours until the infection cleared at which stage suturing would occur.92 The GSW itself usually healed approximately two weeks after suture leaving a scar that was sensitive to muscular movement in the affected area and to cold weather.93

One of the most lasting effects of GSW was paralysis or deformity of the affected body part caused by damage to the nerves in the area. During the war, splints were used to prevent stretching paralysed muscles and the overaction of muscles that might result in deformity to joints, as well as to provide the optimum position for the recovery of nerves in the affected area. The splint was then removed daily while the patient received physiotherapy treatment to stimulate the nerve by electric current and massage treatment to encourage the circulation of blood in the affected part.94 However, if damage to the nerve was extensive these measures had little effect. For example, throughout the 1920s, Bruce McMurran suffered from severe deformity in one of his feet due to GSW related nerve damage and eventually was forced to have the foot amputated to avoid discomfort.95 Amputation did not, however, necessarily relieve the discomfort of mangled nerves. Amputees occasionally suffered from causalgia in which the damaged nerves would cause the stump to tremble violently accompanied by burning

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92 Stout, pp. 3-5.

93 NZISS War Pension File (OPA File 35).

94 Stout, pp. 166-67.

95 New Zealand Income Support Service (hereafter NZISS) War Pension File (OPA File 9681).
Various surgical techniques were developed in an attempt to overcome this, although they met with only limited success.

The treatment of GSW during the war had been dependent upon the location of the wound. Wounds to the spinal column were rarely operated upon other than to relieve pain while abdominal, chest, and head wounds all entailed high elements of surgical risk. As a consequence, doctors often chose to leave the bullet or shrapnel fragment in the patient's body in these categories of wounds. The retention of a foreign body (FB) had mixed long-term repercussions for ex-servicemen. In the case of head injuries, it was found in postwar medical studies that men who retained a FB were less prone to epilepsy as an after-effect of wounding. However, the physical discomfort occasioned by the retention of a FB in various parts of the anatomy could also lead to the eventual development of a degree of neurosis. For example, during the 1930s, Bruce Alston received a pension for neurasthenia related to this consideration.

The effects of ageing also exacerbated the damage done to men's bodies by GSW. Henry Hobson found that he suffered from spinal degeneration in his back in the area in which he had been wounded. Joseph Williams developed rheumatoid arthritis in joints where shrapnel had penetrated. Men also developed muscular pain or myalgia as a consequence of bullet wounds. Medical treatment of these conditions was limited. In the case of rheumatoid arthritis, splints, massage, 'radian heat', and various oil foments were used by doctors along with orthopaedic appliances such as surgical belts and boots as palliative measures. The aetiology of the affliction was thought to lie in the retention of septic foci in the large intestine. Therapeutics therefore also focused upon the patient's diet along with fasting and colonic irrigation. The success of these measures was limited. As in the case of FB, chronic physical discomfort was likely to lead to the development of neurosis. In 1932, Dr. Thomas Fergus commented to the War Pensions Board about the condition of one man: 'There is a functional [neurosis] element present and I know of no treatment which will improve his condition.'

Men suffering from pulmonary tuberculosis were among the most seriously disadvantaged ex-servicemen. Not only did they have to contend with the debilitating effects of the disease, they also had to endure being ostracised from society due to public fear of the
disease’s infectious nature. Public horror at the affliction was exacerbated by the fact that tuberculosis usually struck young adults. Its physical symptoms included fever, night sweats, coughing and dyspnoea (shortness of breath), haemoptysis (blood-spitting), and emaciation. Kirk Woodward displayed typical tuberculous symptoms. His doctor reported to the War Pensions Board:

he is liable to giddy turns and sometimes falls down; he has a chronic cough with a little sputum; in last October he had a bout of pleuritic pain; he has frequent night sweats having to change his pyjamas as a result sometimes.

As has been noted, medical treatment of tuberculosis centred around sanatoria care. The function of the institutions was both curative and educational. As environmental factors such as urban overcrowding and poor nutrition were seen as aiding the spread of the tubercle bacillus, the open air treatment and solid well balanced diets embodied in sanatoria treatment were seen as effective countermeasures. Furthermore, it was believed by the medical profession and public health reformers that the disciplined regimen of sanatoria would inculcate healthy lifestyle habits into the sufferer which would be continued once they were discharged from the institution. Sanatoria also provided therapeutics based upon thoracic surgery. Throughout the 1920s and 1930s, the practice of collapsing a lung for a period of up to three years, known as Artificial Pneumo-Thorax (ATP) was used by doctors. ATP embodied the same principles as sanatoria care in that it aimed to rest the affected area. Despite these measures, the fluctuating nature of phthisis meant that sufferers were continually prone to relapses of the condition. The uncertainty associated with a possible relapse probably exacerbated the detrimental psychological effects associated with the ailment and almost certainly enhanced the social stigma experienced by the phthisis sufferer.

Public concern at the menace posed by tuberculous ex-servicemen was high. In 1919, the NZRSA sent a deputation to see the DGMS, Brigadier General Sir Donald McGavin, about the treatment of consumptive soldiers. The deputation expressed concerns that no sufferers be discharged from sanatoria until the disease was totally arrested, and, that once discharged, the consumptive be required to receive outpatient care for at least twelve months due to the threat of a relapse. At the same time as seeking assurances from McGavin about the safety of the community from tuberculous ex-servicemen, the NZRSA also pressured government for

104 NZISS War Pension File (OPA File 8187).
105 Bryder, p. 4.
alleviation of the employment difficulties faced by consumptives. The Association noted that consumptive servicemen were disadvantaged in employment by three factors. Firstly, tuberculous men were often the last to face rehabilitation into the labour force so that most employment had been already taken. Secondly, the nature of the affliction limited the type of employment suitable for men. Finally, consumptives faced prejudice from employers and the wider community. The government argued that tuberculous servicemen were catered for by a farm colony administered by the Repatriation Department in the Wairarapa and by the ballot provisions of the DSS Act. Nonetheless, Repatriation Department officials noted the psychological affects consumption and its social implications had upon men. In 1920, the national director of the Department, J. R. Samson, claimed that aside from their disability phthisics were 'often of peculiar temperament' while H. F. Titchener, the Department's vocational training officer in Dunedin noted: 'their whole outlook in appears to be altered'. Titchener's comment also referred to another group of disabled ex-serviceman - those suffering from shellshock.

The mythology that the soldier by virtue of his medical selection and protective social function represented the finest specimen of New Zealand manhood formed the basis of public debate about war neurosis. In May 1918, the Minister of Public Health, George Russell, commented in the House about reports suggesting a low incidence of war neurosis amongst soldiers in the NZEF. 'The simple truth', Russell claimed, 'is that the best of the country's manhood (in brain as well as brawn) has been drawn into the war. One expects better statistics of sanity amongst robust manhood than amongst the medical rejects.' The social and medical belief that madness was the domain of those constitutionally unfit was reiterated in a more subtle form by the Inspector General of Mental Hospitals, Frank Hay, in 1919. Hay wrote: 'A man of sound mind fighting honestly for a cause will face great dangers without losing his mental balance...It is not so with those predisposed to mental illness.' The addition of a moral element to the aetiology of insanity was in keeping with prevailing psychiatric opinion, and provided a useful caveat for the military when explaining the breakdown of troops in the frontline - the horrors of war were not the cause of neurosis but rather its genesis lay in the tainted hereditary of men who would have eventually manifested the symptoms of nervous disorder in civilian life.

111 AJHR H30, 1920, p. 7.
112 NZNA T 65 1 Evidence of H. F. Titchener presented at the Ex-soldiers' Rehabilitation Commission, Dunedin, dated 30/10/29.
114 AJHR H7, 1919, p. 27.
While the state and military authorities ensured that the public did not associate the war or military life with the stigma of insanity through the provision of institutions such as ANZAC House, medical understanding made no distinction between the maladies collectively termed shellshock and the position of 'neuropath inferiors' in the wider society. Dr. W. Marshall Macdonald, who had served as the Consulting Neurologist to the Forces in France during 1917 and 1918, wrote to the DGMS, Sir Donald McGavin, about the treatment of shellshocked soldiers in October 1920. His analysis reflected a token acceptance of Freudian beliefs regarding the repression of the unconscious and was based largely upon the remnants of late Victorian psychiatric belief. Macdonald believed three forms of shellshock - hysteria, psychasthenia, and neurasthenia - were related to depletion of the fixed energy supply the body was thought to possess. The condition of men suffering from these afflictions was essentially one of failed hereditary. Their lack of energy, phobias and obsessions were constitutionally related and therefore not attributable to war service. They needed to be treated, in Macdonald’s view, by the ‘moral therapy’ of discipline and work embodied in institutions such as ANZAC House. Macdonald distinguished another category of neurosis - hyperemotives. These men, he argued, suffered from hormonal imbalances due to the abnormal stimulation of war service. Again, the emphasis placed upon the physical cause of the affliction implied that the sufferer had an inadequate constitution. Macdonald held little hope for the recovery of men in this category. The final group that Macdonald analysed were those men suffering from anxiety conditions related to the repression of strong instinctual feelings such as sexuality or forgotten painful experiences of combat represented Macdonald’s sole concession to the value of psychoanalysis as he saw no physical basis to their affliction.

The experience of war neurosis by ex-servicemen and their families was therefore exacerbated by the hereditary stigma attached to its aetiology. Richard Black, felt himself to be wrongfully committed to Seacliff and spent his days writing letters to the authorities protesting his incarceration with the insane and the venereally afflicted. Other men denied that they or their family had any previous psychiatric history. When a family member was committed to Seacliff during the Second World War, Bruce Alston denied any history of psychiatric illness in the family despite the fact that he was receiving a pension for war related neurosis. Emotional pain and social stigma meant families also attempted to hide the presence of a mentally ill relative. Martin Goodfellow’s family were shocked to hear that their relation had been transferred from ANZAC House to Seacliff Mental Hospital and they withheld this information from his mother to spare her the shame.

116 Seacliff Mental Hospital Case File 6198.
117 Seacliff Mental Hospital Case File 9311.
118 Seacliff Mental Hospital Case File 6167.
The physical and emotional symptoms associated with neurosis were very wide ranging. A doctor described Warren Jacobs' neurasthenic condition in 1929 in the following terms:

- Becomes tired easily
- Contracts colds easily
- Has recurrent sore throats
- Very poor appetite
- Perspires at night time
- Feels he has lost weight lately
- For the last six years has been subject to pains
- Throbbing in various parts of the body
- When he shuts his eyes he tends to fall over
- Also unsteady on feet
- Always complaining of his back

In addition, men suffering from neurasthenia and hysteria often suffered from a rapid and irregular heart beat (tachycardia) and precardial pains. Dyspepsia was also a common feature of men suffering from anxiety related conditions. The plethora of physical ailments associated with neurasthenia and similar neuroses were accompanied by phobias, bad dreams and feelings of persecution. Alan Scott spent his days inside, often crying, due to his fear of traffic noise while Brett Gordon reported to a doctor that he had terrifying dreams of himself in the role of a murderer. Alec Jones felt that people were continually talking about him and attempting to do him harm. Men who were committed to mental institutions usually also suffered from delusions. Martin Goodfellow believed that syphilis had been injected into his foot as well as feelings that the staff and inmates of ANZAC House had been attempting to poison him.

Aside from the competency of medical knowledge and therapeutics, the social and economic position of doctors also affected how ex-servicemen experienced their impairments. As medical practitioners usually came from the wealthier sections of society, this often worked against lower class men receiving sympathetic treatment. A doctor treating Alec Jones at Seacombe Hospital during the 1930s commented about the socio-economic status of his patient:

He has a solution for the cure of the world depression which is not original. His regarding himself as the champion of such a scheme is scarcely incompatible with his standard of education. Other working men can be frequently heard airing the same views.

The same gulf between the values of many doctors and the realities faced by disabled ex-servicemen was apparent in medical examinations for war pensions. A doctor appraising

119 DRSA File 1506.
120 NZISS War Pension File (OPA File 4856).
121 Seacombe Mental Hospital Case File VB 798.
122 Seacombe Mental Hospital Case File 17188.
123 Seacombe Mental Hospital Case File 6167.
124 Seacombe Mental Hospital Case File 17188.
Henry Hobson's chronic back disability for a pension appeal adjudged: 'I consider his present pension is extraordinarily generous for his degree of disability, I cannot recommend any increase'.

Doctors faced with a clinical disease identity or quantifiable injury were frequently unwilling to view the impairment in terms of its total impact upon men's lives. To do so would have required recognition by the practitioner that all aspects of men's lives were affected by disability and by the doctors decisions.

Disability therefore created the need for a complete reordering of old lifestyle patterns. Sporting pursuits were often the first to be sacrificed. Prior to the war, Frank Edwards had been a keen athlete. A friend described him in a testimonial as a 'strong healthy chap; a good oar and a good man in the...team. Rowing is a strenuous exercise and it was no trouble to him.' Yet, Frank developed a cardiac condition during active service in France and upon his invaliding home was advised by his doctor to give up his sporting activities. Warren Jacobs was forced to give up a promising career as a football player after suffering gastro-intestinal disorders and neurcsis as a result of war service. In his case, the loss of a valued activity was exacerbated by the gulf between his past life and how physicians now viewed him. Despite evidence from past employers, and friends that he had led a fit and active life before enlisting, a doctor examining him for a pension appeal for neurasthenia in 1932 commented that he was a 'constitutionally nervous man' whose war service had accentuated his condition.

In their adjustment to disability, men attempted to remain as physically independent as possible. Men suffering from respiratory and gastro-intestinal conditions frequently turned to patent medicines in a desperate effort to help themselves. Warren Jacobs commented to the War Pensions Appeal Board: 'I have spent pounds besides [prescription medicines] on so called cures to get relief' while another man suffering from dyspepsia noted to the WPAB: '[my] state of health [was] only fair; managed to carry on but used to buy Antiacido. I suffered from what I thought was indigestion'. Frank Edwards consumed several bottles of Lanes Emulsion every winter in his attempts to ward off respiratory infections that might inflame his heart condition.

Attempts by men to try and regain their health were matched by their efforts to be economically independent. In 1920, Victor Gow wrote proudly to the OP&GWA about his employment despite the impact of his mutilated hand: 'Yes I have incurred permanent physical impairment through war service...However, I am earning full pay just now although working

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125 DRSA File 4360.
126 DRSA File 2131.
127 DRSA File 1506.
128 Ibid.
129 DRSA File 2486.
130 DRSA File 2131.
under difficulties in as much as my hand troubles me in cold weather'. However, pride over self sufficiency was not enough. Men who attempted to return to their pre-war occupations often found that disability meant their efforts to be self-supporting were not compatible with their impairments. Bruce McMurray found that a deformed foot due to nerves damaged by a GSW severely inhibited the personal mobility he required to pursue his occupation as a painter while Andrew Moffat found his work as a fibrous plasterer incompatible with his tuberculous condition. In Moffat's case, his attempts to gain a more suitable occupation were thwarted by the unwillingness of others to employ him due to the social stigma attached to tuberculosis sufferers and his inability to persuade the OP&GWA to advance him funds to establish a more suitable business venture. Disability provided a constant reminder to men that the life skills they had experienced prior to the war no longer held the same utility to them in postwar society.

Despite men's attempts at independence, periods of chronic disability and frequent hospitalisation were consistent features of their lives. For example, during 1932 Warren Jacobs was off work due to illness from 21 April to 1 May, 16 May to 25 May, 2 June to 11 June, and 29 July to 14 September. Another man, Michael Williment, wrote to the OP&GWA 'I have been in hospital for the last 16 months suffering from TB spine & will be in hospital for sometime yet'. Men with chronic fluctuating conditions were the worst affected. Ted Willis' tuberculous condition meant that he was incapacitated for eight months during 1931 while, in 1925, a man pensioned for neurasthenia claimed to the OP&GWA that he had been unable to do any hard work since his discharge from the army in 1915. Frequent hospitalisation and periods of associated unemployment removed steady employment as a source of stability in disabled ex-servicemen's lives. This in turn exacerbated stresses on another potential source of stability in their lives - their families. Disability in the family entailed both economic and emotional hardship for all directly concerned. The financial burden of medical care meant men who were unable to convince the Pensions Department regarding 'attributability' made significant material sacrifices to meet doctors' costs. For example, James Rooney developed arthritis shortly after his discharge from the forces and was unable to gain financial assistance from the state. To meet the costs of his medical care he was forced to sell his furniture. If an ex-serviceman had sick family

131 OPA File 35.
132 NZISS War Pension File (OPA File 9681).
133 OPA File 3139.
134 DRSA File 1506.
135 OPA File 4521.
136 OPA File 1435.
137 OPA File 9086.
138 OPA File 9189.
members as well as his own impairment to contend with, matters could be even more dire. Moses Wilkins was forced to mortgage his house to meet medical expenses for himself and his wife.\textsuperscript{139} Financial stress combined with chronic disability led, in some cases, to an increasing sense of despair amongst disabled men. In 1932, Warren Jacobs wrote to the secretary of the DRSA:

I have tried to be independent up till 2 years ago of the pension hoping that I would get better but now I seem to have lost all hope and courage. I feel I am a bore to my dear wife & children she having to do much of the home work that a man should do and it is upsetting her nerves. I feel that if a change some way or other doesn’t come soon-well I’m afraid to say. I am afraid of myself sometimes.\textsuperscript{140}

Life with men suffering from precardial pains, tuberculosis, and varying degrees of neurosis was too much for many families to survive. While postwar newspaper articles called on the power of women 'to strengthen the will of...[the] wounded'\textsuperscript{141}, the daily grind of caring for a chronically disabled spouse, father, or brother must surely have taken its toll. Five of the sampled men are known to have separated from their wives, and it is reasonable to assume that the breakup of these marriages was related in part to the stresses associated with chronic disablement.

Financial stress, the breakup of families, and hopelessness led some men to feel embittered towards the wider society. Angus Frasier, a survivor of a gas attack at Passchendaele wrote in 1935 that ‘[my] pension does not compensate me for all my suffering, and...further, while I was away at the big conflict, [I] lost all my property & have had nil compensation whatsoever’.\textsuperscript{142} Alec Kilroy wrote to the editor of the \textit{Evening Star} during the second world war about the struggle to be independent made by disabled men, who:

on returning, after being wounded, faced life again, but after five or 10 years of active life began to feel the strain and lose heart. I myself, besides others, had to take to my bed for months...and did not get a single penny from patriotic societies.\textsuperscript{143}

The sense of having been forgotten by the society for which they had fought, the loss of their health combined with financial and family pressures left men in a position of profound

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\textsuperscript{139} OPA File 4074.
\textsuperscript{140} DRSA File 1506.
\textsuperscript{141} Quick March, Vol. 2, No. 17, p. 63.
\textsuperscript{142} DRSA File 2383.
\textsuperscript{143} OPA File 9473.
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dependence. In a society in which independence was a highly sought after masculine value, the reliance of disabled ex-servicemen upon state and voluntary welfare provisions represented the ultimate ignominy.

SUMMARY

Between 1919 and 1939, the provision of medical care for disabled ex-servicemen in the Dunedin area became more restricted. Prior to 1922, the existence of a separate system of medical care under the authority of the Defence Department enabled the treatment of a wide variety of medical conditions in the city. Specialists attached to the civil hospital through the University of Otago Medical School gave the Defence Department the human resources necessary to provide orthopaedic and facial surgery, along with laboratory facilities required for the treatment of venereal disease. This system was not entirely autonomous however of the treatments offered by the Otago Hospital Board at its institutions. The fiscal limitations imposed upon the military together with the large numbers of tuberculous ex-servicemen needing medical treatment meant that the Defence Department required to use the Board’s sanatoria until the end of the period of military medical control. The treatment of shellshocked ex-servicemen lay with the Defence Department in conjunction with the Department of Mental Hospitals until 1922 when the military divested their responsibility. The military ran ANZAC House until 1920, and oversaw the committal of men to Seaford Mental Hospital until the transition to Pensions Department authority changed the basis of medical care. At this point, ex-servicemen in Mental Hospitals were placed under the responsibility of the Department of Mental Hospitals while state financial responsibility for their medical care along with that of other ex-servicemen became based upon a man’s ability to prove his disability was attributable to his war service. This limited the medical care available to many ex-servicemen. For these men, access to specialist medical services became determined either by the ex-serviceman’s ability to pay hospital fees or by the existence of voluntary bodies who were prepared to finance his medical care.

The manner in which men physically and emotionally experienced their disabilities was in part contingent upon the standard of medical knowledge and the efficacy of therapeutics that this embodied. The treatment of GSW, pulmonary tuberculosis, and war neuroses naturally embodied the medical paradigms of their day and the limitations these imposed upon successful treatment. These limitations meant that the disabled ex-serviceman often faced chronic impairment. Damage to nerves, the retention of foreign bodies, and arthritic conditions as a consequence of GSW, along with the inability of doctors to cure Tb and psychoneuroses, all left men with long-term disability. In the case of tuberculosis and war neurosis, medical diagnosis also imposed a stigma upon the afflicted because both conditions were seen as ‘dangerous’ to society - consumptives because of their potential to infect the fit and war
neuroses sufferers by their hereditary taint and psychological instability. Men suffering from these afflictions therefore had to face both the effects of ill health and the social stigma related to their conditions. Chronic disability resulted in the fragmentation of men’s lives. Disabled men were required to give up sporting pursuits, and frequently found that their previous employment no longer suited their impairment. While they attempted to be independent, frequent hospitalisation, and the unemployment associated with this, placed financial and emotional stresses upon ex-servicemen and their families. In these circumstances, some men became disillusioned with their ability to be independent economically productive members of society while other men became increasingly embittered.
During the war a private convalescent home accommodating fourteen men existed at Waikouaiti at the estate of the Edmond family. Here disabled men recommended by the medical superintendent of Dunedin Hospital and Otago District ADMS, Dr. A. R. Falconer, took part in the daily chores of the Home while partaking of the recreational facilities the institution offered in fishing, bowls, tennis, and golf. Local residents provided food and firewood, while additional costs were met by the Soldier’s Welfare Committee of the Otago Patriotic and General Welfare Association. Medical care was provided by two VADs and twice weekly visits were made to the men by Dr. Ernest Lyth of Pleasant Valley Sanatorium. This scheme was in many respects indicative of the general tone of the convalescence that would be offered during the inter-war period. Voluntary provision of convalescence in which the state and the military played little role reflected a society in which the accepted purpose of government was to facilitate the social and economic conditions under which voluntary groups and the wider community could attend to social problems.

Voluntary schemes for the care of the disabled serviceman represented part of an implicit pact between the disabled man, the state, and the voluntary groups established to care for his welfare based on the validation of his wartime experience. Furthermore, through this validation of experience, the pact of convalescent care expressed acceptance of societal concepts of martial masculinity, of the need for military self-sacrifice for the betterment and protection of the whole community. This chapter examines that pact in relation to the provision of convalescence by the Dunedin Centre of the New Zealand Branch of the British Red Cross Society, an organisation whose express aim from its formation in October 1915 was the care of sick and wounded servicemen in both New Zealand and abroad. Part One examines the pact itself, arguing that the period from 1919 to 1922 represented an extension of the values of the Society’s wartime role, and that the years from 1922 to 1939 were shaped by the economic realities of post-war New Zealand society, an ageing ex-serviceman population, and the changing peacetime function of the Red Cross Society. In doing so, it discusses the basis of care given by the Red Cross Society at Montecillo Home during the period and the type of ex-servicemen resident in the institution at this time. Part Two analyses how the pact validated martial masculinity by examining the relationship between the daily running of Montecillo Home and entertainments offered to the inmates. It attempts to place these activities within contemporary writings about wounding and the ‘digger spirit’.

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1 NZNA AD 1 49/310 Memo Lt. Col. T. Hope-Lewis to Col. T. Valintine DMH dated 31/1/16.

2 Clause 2a Rules of Incorporation for the Dunedin Centre of the New Zealand Branch of the British Red Cross Society and the Order of St. John of Jerusalem, circa 1916. The surviving copy of the rules is attached to the land deed of Montecillo War Veterans’ Home held by the Home.
(I) THE CONVALESCENT PACT

Until 1917, the organisation of the Dunedin Red Cross Society (DRCS) was based on an explicit sexual division of labour reflecting traditional assumptions about gender in society. A women's committee co-ordinated the efforts of the Women's Patriotic Societies of Otago and Southland who produced over 5000 cases of garments to send overseas, ran a shop and kitchen in the Old Post Office buildings in the Exchange, and visited and gave tobacco, fruit, and other small comforts to soldier patients in Dunedin Hospital. A men's or finance committee co-ordinated with central government in raising over £67,000 in Red Cross special appeal funds, and oversaw the shipping of the garments made by the women of the southern provinces. In addition, the Society also supplied VADs to the military authorities for the medical care of the disabled soldier.

The Red Cross, through its committal to caring, portrayed itself in a feminine role; in the words of one of its promotions as:

*The GREATEST MOTHER in the WORLD*

Ready and eager to comfort when comfort is most needed. Reaching out her hands to No Man's Land; warming, feeding, and healing thousands of suffering men.

Moreover, the image accompanying these words represented a Madonna like nurse cradling a tiny stretcher-borne soldier in her arms with a large red cross behind her. The religious overtones of the image suggest that he is her saviour through his sacrifices at the Front, but at the same time her comforting seems almost aggressive in its protectiveness by the figure's overwhelming size. An inversion of traditional gender roles seems to occur in which the feminine appears to be portrayed as immensely powerful, while the masculine is seen as having spent its energies on the battlefield so as to be now passive and willing for succour. Yet, through its religious imagery the opposite is actually implied, for this is a moral spiritual power related to motherhood and the sphere of domesticity in which the male as saviour is clearly superior. By injury the soldier is returning to the peace of the home, to the mother's arms where maternal strength epitomises his sacrifice. It is hardly surprising then, that, in 1923, H. T. B. Drew described the wartime role of the New Zealand Red Cross Society in terms of 'the pathetic story of the unfaltering memory of New Zealand's women of their men

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3 *The New Zealand Red Cross Record,* April and May 1919, p.11.
5 *The New Zealand Red Cross Record,* 27 August 1918 p. 7.
on active service.’ As will be seen, even after the two DRCS committees combined in early 1917 a gendered division of activities persisted establishing a reflection of societal gender roles within the organisation.

Throughout the inter-war period the DRCS executive was remarkably stable in terms of its membership and their class backgrounds. Of the original executive formed in 1915 four still remained in 1936 including the past and current president of the Society. The first president of the Society, Miss Frances Rattray, held her position for the course of the war while her successor, an Anglican minister, V. G. Bryan King, remained in charge of the Society throughout the 1920s and 1930s. The male members of the executive tended to be from the city’s professional and mercantile class if for no other reason than this group could afford the time and money needed to be involved in a welfare organisation. Three founding members - Robert Conn, Ernest Rosevear, and Charles Smith - were a chemist, an accountant, and a company director respectively. The female members of the executive including Frances Rattray, Isobel McLean, and Gara Graham were middle class spinsters, or, as in the case of Mrs. Lindo-Ferguson, the wives of prominent Dunedin citizens. For these women, the DRCS offered a respectable and rewarding way in which to devote their considerable energies in a time when middle class women’s employment was frowned upon.

In January 1918, the DRCS offered to establish a convalescent home for the use of the military authorities. A meeting at the Technical College attended by the Minister of Defence, Sir James Allen, the Consulting Surgeon to the Forces Colonel J. McNaughton Christie, and the DGMS Surgeon General R. S. F. Henderson agreed to the establishment of a Home, Henderson claiming such a Home was ‘badly needed in Otago.’ As a consequence, the Society established a sub-committee of men under the Reverend V. G. Bryan King to find and purchase a suitable property, a public appeal raised £7550, and on 27 June 1918 Allen opened the Red Cross Military Convalescent Home at Montecillo estate in Dunedin containing accommodation for twenty-six men.

Like the DRCS executive, the composition of key staff at Montecillo Home showed remarkable continuity throughout the years between the wars. The original Matron of the Home, an ex-army nurse, Agnes Macmillan, held her position until December 1935 when she

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9 DRCS Minute Book 1 (hereafter DRCS 1 etc...) entry dated 14/1/18.
10 DRCS 1, 18/2/18.
11 *The New Zealand Red Cross Record*, April and May 1919, p. 11.
12 Most of the evidence for this paragraph is gleaned from photographs held by the Home in the Recreation Hall. Agnes Macmillan had spent one year in France during the war with the army nursing corps, and was well known in Dunedin for her work at Prospect House Private Hospital before she became Matron of Montecillo; *Kai Tiaki*, Vol. 11, No. 3, July 1918, p. 118.
was replaced by the Sister directly under her for the previous ten years, Amelia Douglass (Matron Douglass was in turn responsible for the Home until 1950). It is unclear how many medical officers were responsible for Montecillo prior to 1925, but there were at least two - Dr. R. Fitzgerald, and the Otago ADMS from 1922, Dr. M. Marshall. Between 1925 and 1939 however, Dr. Thomas Fergus of Dunedin Hospital was the Home’s doctor. In addition, the staff consisted of a varying number of VADs, an orderly, gardener, chauffeur, and, from 1920 until 1925, two Sisters trained in massage.

From the beginning Montecillo Home was a military institution in its administration and its outlook, representing an amalgamation of the requirements of the Defence Department and the supportive and comfort-giving stance of the DRCS. Direct control of the Home fell under the authority of the DGMS\textsuperscript{13} while transfer of patients to and from Montecillo was the responsibility of the O/C of the Military Section of Dunedin Hospital, Lt. Col. L. E. Barnett, and, from June 1919, his successor Lt. Col. H. P. Pickerill (when the military section closed in July 1920 this responsibility passed on to the district ADMS). The men themselves were patients from the Alexandra and Batchelor orthopaedic wards at Dunedin Hospital, for whom the military paid the DRCS a set sum of 5/- per man per day for maintenance.\textsuperscript{14} The army arranged for a part-time medical officer who visited the men twice weekly and organised the men’s out-patient care at the hospital and massage treatment at the Home. In addition, the Defence Department also paid the Society for medical equipment and supplies as well as the wages of the Home’s staff.\textsuperscript{15} The military thus held control over who was admitted to the Home, and accepted financial responsibility on this basis.

For its part, the DRCS took responsibility for the routine administration of the Home via the Montecillo Committee made up of the president, chairman, secretary, and treasurer of the Society. This group arranged for the reimbursement of running expenses for patients and staff with the Defence Department, and organised the other members of the executive into three visiting committees which attended the Home weekly on a two monthly roster system.\textsuperscript{16} In running Montecillo, the Society was effectively fulfilling the same role as it did at Dunedin Hospital in supplying comforts and entertainments to patients. Its more formal relationship with the Defence Department was merely an extension of the moral obligation the Society felt towards disabled servicemen involved in its caring role.

In June 1919, the relationship was extended further with the opening of another convalescent home under Red Cross control. The twenty-five bed Woodside Jaw Hospital

\textsuperscript{13} A. D. Carbery, \textit{The New Zealand Medical Service in the Great War 1914-1918}, Wellington, 1924, p. 516.

\textsuperscript{14} NZNA H 89/27 Memo Secretary of Otago Hospital Board to Minister of Public Health, G. Russell dated 16/6/19.

\textsuperscript{15} DRCS 1, 14/2/18.

\textsuperscript{16} \textit{The New Zealand Red Cross Record}, April and May 1919, p. 11.
Figure 2.1: the Duke of York visiting Montecillo Home on the 18/3/27. He is accompanied by the Reverend V. G. Bryan King (foreground), Matron Agnes Macmillan, and Dr. Thomas Fergus (background).
was situated in the home of a deceased judge, H. S. Chapman, on the corner of Clyde St and Cemetery Road. Under Pickerill and Matron Gill, the hospital acted as a convalescent home for men recovering from or between plastic surgery operations performed there and at Dunedin Hospital. Woodside ran on identical lines to Montecillo in regard to the relationship between the army and the DRCS, except for the area of massage where the inmates would travel for treatment to Montecillo where facilities were available. Until its closure in 1922 due to the reorganisation of defence medical services and dwindling patient numbers, approximately one hundred men received care from the Red Cross at the hospital. On its closure, the Defence Department came to an arrangement with the Otago Hospital Board regarding surgical equipment and this type of work was continued at the civil hospital by Pickerill. From this point onwards, Montecillo Home received men convalescing from plastic and facial surgery.

From 1919 to 1922 Montecillo and Woodside were part of the network of Defence Department medical institutions. Just as the two DRCS run establishments catered for orthopaedic and facial injuries from Dunedin Hospital, the institutions were linked under the control of the ADMS to Pleasant Valley and Wakari Sanatoria run by the Otago Hospital Board and the psychiatric facilities at Seacliff and Karitane under the authority of the Department of Mental Hospitals. On a wider level, they were also connected to Defence Department institutions in other parts of the country such as Cashmere Hills Sanatorium in Christchurch, and the Queen Mary Military Hospital at Hammer Springs. The reorganisation of this system by the DGMS, Brigadier General Sir Donald McGavin, from May 1919 onwards reflected a policy of limited long term state involvement in the provision of rehabilitation facilities for returned ex-servicemen. The more restrictive powers embodied in Pensions Department administration of medical care had implications for the nature of convalescent care offered by the DRCS at its institutions both in terms of the type of disability catered for and the acceptance criteria for admission.

As part of his reforms, McGavin had written to the DRCS in June 1922 suggesting that they be responsible for all aspects of Montecillo Home except the appointment and payment of part-time medical officers, and the provision of technical, surgical, and medical control. In return the Defence Department would donate all its equipment at the Home to the DRCS, and arrange that the Pensions Department paid the society £2/7/6 per patient per week. The DRCS would furnish monthly maintenance vouchers to the Dunedin Registrar of Pensions, and medical supplies would be made from the Dunedin Hospital Dispensary. In September, an

18 NZNA H 1 89/27 Memo Minister of Defence, Sir J. Allen to the Secretary of the Otago Hospital Board dated 11/7/19.
19 J. Angus, Hospital Board, p. 153.
20 NZNA H 1 89/27 Memo Otago Hospital Board to all other Hospital Boards dated 5/2/21.
21 DRCS 2, 19/6/22.
agreed schedule of terms was forwarded to the Minister of Internal Affairs, and, in November, McGavin advised the Committee that Cabinet had approved the conditions and an Order in Council had been passed through the House.\textsuperscript{24}

It is difficult to ascertain what the immediate impact of Red Cross control was upon the running of Montecillo Home. Certainly, the shift from the Defence to the Pensions Department responsibility threatened to restrict the type and number of patients admitted to Montecillo on the basis that to receive medical treatment from the Department a man had to prove that his injury or sickness was attributable or aggravated by war service. This relied on the man’s military file providing sufficient evidence that illness or injury had occurred (a not altogether safe assumption given front-line circumstances where conditions such as ‘minor’ gassings were often not reported), and on the standard of medical knowledge and its application by the medical practitioner examining the man. The DRCS recognised these pitfalls and in 1923 passed a resolution allowing non-pension charges temporary rest and treatment at the Home on the recommendation of Medical Superintendent or House Surgeon of Dunedin Hospital.\textsuperscript{25} The Society would meet the cost of maintaining these men, who became known as Red Cross ‘Charges’, by mutual arrangement with the patriotic associations responsible for the man’s welfare. In 1929, an executive member, Mr. C. B. Smith, explained the Society’s position with regard to Red Cross ‘Charges’ to the Barton Commission. He argued that men who could prove their disabilities were attributable to war service were entitled to a pension and were less worthy of additional support from voluntary welfare bodies. If they gained financial aid they were thus, to an extent, a drain on the patriotic funds needed for ‘the benefit of ex soldiers whose broken health is probably due to the hardships of war though they are unable to prove that such is actually the case’.\textsuperscript{26} However, the six year gap between the passage of the resolution and Smith’s statement disguises the economic realities which combined with the Society’s rhetoric of moral duty to force the implementation of Red Cross Charges.

By November 1925, the administration and future of Montecillo Home were in crisis. Patient numbers had fallen from thirty-three at the end of military control in 1922 to just eight men.\textsuperscript{27} The DRCS held a special meeting on 10 November to address the issue. It was only then that the 1923 resolution was put into practice, with the DRCS agreeing to try and maintain the number of men in the Home at sixteen by taking ‘civilian’ patients and perhaps drawing men from the Southland area. Attempts were also made by the committee to attract pensioned men from other parts of New Zealand. The matrons of Evelyn Firth, Mowai, and Rannerdale

\textsuperscript{24} DRCS 2, 20/11/22.

\textsuperscript{25} DRCS 2, 26/3/23.

\textsuperscript{26} NZNA T 65 I Evidence of C. B. Smith presented at Ex-soldiers’ Rehabilitation Commission, Dunedin, dated 26/10/29.

\textsuperscript{27} DRCS 2, 10/11/25.
Red Cross Homes were unsuccessfully written to suggesting that four inmates of each Home might appreciate a two month stint in Montecillo. In addition, the Society cut the staff pay, required the nurses to live in, and, with regret, closed the massage department claiming that the men would benefit from the journey by car to Dunedin Hospital to obtain treatment. In January 1926, ten of the Home’s fourteen residents were Red Cross Charges suggesting that, in the short term at least, the implementation of the 1923 resolution was largely responsible for the continuation of Montecillo Home. Moreover, the DRCS had also in 1925 briefly investigated using the Home for its peacetime work suggesting that it held doubts about the need for the long term care of disabled men. It seems however, that the DRCS’s belief that it had a moral obligation to care for disabled men meant that it staved off any such decision on closure until all options had been investigated.

The fact that sufficient ‘civilian’ patients were found suggests that the decline in inmate numbers in 1925 can be assigned solely to the inadequacies of the pensions system. However, this offers only a partial explanation for the crisis the DRCS faced. In 1925 the single conscripts of 1916 were still comparatively young men just beginning to face the long-term effects of their disabilities and ageing both premature and natural. It is also likely that most major reconstructive orthopaedic surgery had been undertaken by 1925. Most importantly, the Home did not receive men suffering from one of the most predominant disabilities - pulmonary tuberculosis - thereby limiting its potential admissions. At the height of the committee’s efforts to procure new patients for the Home the DRCS was compelled to decline an offer of men from Cashmere Sanatorium in Christchurch. The comparatively cramped conditions of the Home presented a serious danger in that the disease was perceived as highly contagious, and Montecillo like other medical institutions was susceptible to epidemics; in 1923 three inmates and one VAD were hospitalised when diphtheria broke out in the Home.

The impact of the Great Depression upon inmate numbers at the Home appears to have been mixed. In terms of the average numbers of men in the Home, there was only a slight increase from fourteen in 1927 to nineteen by 1935, although in relation to the number of men going through the Home medical records reveal that sixty-four and one hundred men were admitted in 1932 and 1935 respectively. The average age of the nineteen men sampled known to have been in the Home during the 1930s would have been 51 years in 1935 with the range

28 DRCS 2, 11/12/25.
29 DRCS 2, 10/11/25.
30 DRCS 2, 27/7/25.
31 DRCS 2, 25/1/26.
32 DRCS 2, 25/6/23.
33 These figures may not be accurate. It is unclear whether the list of patients is merely an index to the files or a register in the true sense of the word. If the former is the case the number might be considerably larger.
of ages running from 43 to 62 years. This suggests that the stresses of the depression probably exacerbated natural aging and the long term effects of disabilities incurred in some cases twenty years previously. Certainly, the DRCS appears to have felt that it would have to provide accommodation for aging ‘diggers’. In 1937 it acquired a neighbouring property, ‘Broomlands’, apparently for this purpose.34

A comparative analysis of a subset of the men sampled with those admitted to Montecillo in 1932 provides an insight into the type of ex-serviceman in the Home by this time, and the criteria used in admitting men. Information for the seventeen men in the sample known to be at Montecillo in 1932 reveals that 58% (ten men) were pension charges, the remaining 42% (seven men) being maintained by the DRCS. For that year, a total of sixty-four men received medical care at Montecillo for whom the records of fifty-six remain. Of these, thirty-one men were admitted as pension charges and twenty-five at the expense of the DRCS and other welfare organisations. This is proportionately the same as for the sampled group, suggesting that by this time over half the men admitted to the Home were pensioned and that the Home was not as dependent on Red Cross charges for survival as it had been in 1925/26. Furthermore, from the service records of the sampled men, they were all enlisted men, generally of lower socio-economic background - the wealthier, which usually included officers, could afford private convalescent care (only one officer is known to have been in the Home between 1932 and 1935). At least one of the ‘Red Cross Charges’, Edgar Barclay, had a pensionable disability and paid the Society £1 per week from his war pension to use the Home as temporary accommodation when he was in Dunedin.35 It is difficult however, to extrapolate further from this as to how widespread this practice was.

The major factor in determining if these men received support from the Red Cross appears to have rested not so much on disability but on whether or not they were discharged fit on the termination of their period of engagement in the forces. In some cases, this did not imply that the man had not been disabled during the war and had received medical care, but rather that by having been boarded medically fit upon discharge he by implication no longer suffered any disability. Amongst the ‘Red Cross Charges’, six out of seven men sampled were discharged fit (comparable figures for all the 1932 inmates are unfortunately unavailable). Reference to Tables 2.1 and 2.2 shows that, except for respiratory conditions and gunshot-wounds (GSW) in Table 2.2, there is a rough parity in the types of disability and the number of men suffering from each:

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34 This is an extrapolation based on an auction poster dated April 1937, and an undated unknown newspaper cutting held by the Home.

35 NZISS War Pension File (OPA Case File 929).
TABLE 2.1
COMPARISON OF DISABILITIES FOR SAMPLED PENSION AND RED CROSS CHARGES ADMITTED TO MONTECILLO HOME 1932

<table>
<thead>
<tr>
<th>DISABILITY</th>
<th>PENSIONED</th>
<th>R.C.CHARGE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>respiratory *</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>dyspepsia</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>GSW</td>
<td>2</td>
<td>1**</td>
<td>3</td>
</tr>
<tr>
<td>neurosis</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>amputees</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>arthritis and</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>rheumatism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB spine</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>diabetes</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10</td>
<td>7</td>
<td>17</td>
</tr>
</tbody>
</table>

* This includes men suffering from bronchitis, asthma, and pleurisy.

** This is not an error. The man concerned had been wounded in the chest during the war and suffered aching and numbness in that area prior to his admission to hospital. He may not have received free medical care from the Pensions Department for a variety of reasons - for example, failing to make an application before treatment was received in hospital. He did however, receive a small pension for the effects of the wound: NZISS War Pension File (MHMR 1932 File 39).

Source: Montecillo Home Medical Files 1932
TABLE 2. 2
COMPARISON OF DISABILITIES FOR ALL PENSION AND RED CROSS CHARGES
ADMITTED TO MONTECILLO HOME DURING 1932.

<table>
<thead>
<tr>
<th>DISABILITY</th>
<th>PENSIONED</th>
<th>R.C.CHARGE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>respiratory *</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>dyspepsia</td>
<td>5</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>GSW</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>arthritis and</td>
<td>3</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>rheumatism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>epilepsy</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>amputees</td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>cardiac</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>neurosis</td>
<td>3</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>TB spine</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>diabetes</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>fractured femur</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>31</td>
<td>25</td>
<td>56</td>
</tr>
</tbody>
</table>

* This includes men suffering from bronchitis, asthma, and pleurisy.

Source: Montecillo Home Medical Files 1932.

A critical factor then was the ability to prove that a disability was attributable to war service if a man had been discharged fit. Certainly, dyspepsia (which forms the largest group in both tables) was related in part to the stresses of war and those caused by subsequent economic hardship, but it was almost impossible to differentiate medically between the two factors unless prior evidence existed. Similarly as we have seen, psychoneuroses and the popular medical perception that they were constitutionally based also worked against the man discharged fit yet disturbed by the war for it was believed by doctors such as Macdonald that heredity would eventually rear its ugly head.

Proof that disability was attributable to war service was not the only factor, however, in admissions to Montecillo Home. In both Tables, the Red Cross categories contain men injured in civilian accidents (the fractured femur is such a case\(^{36}\) ), and men who never left camp in New Zealand (a bronchitis case\(^{37}\) in Table 2. 2 ). These examples cannot be seen as clearly fitting Smith's explanation of the purpose of Red Cross charges unless either financial

\(^{36}\) Montecillo Home Medical File Register (hereafter MHMR), 1932, File 5.

\(^{37}\) MHMR, 1932, File 50.
expediency was important (which it clearly was not given that in both tables pension charges are predominant) or that the concept of self-sacrifice in war and its parallel in the care provided by the DRCS was understood by the committee as extending to all men who had shown a willingness to serve and protect their communities in time of war. Being a soldier, returned or otherwise, seems to have been the over-riding consideration in admission to the Home.

To uphold this stance, it was necessary for the DRCS to arrange maintenance for such men through the nation’s various patriotic associations. In the case of the OP&GWA, this was a relatively straight forward matter as that organisation also did not believe that proof that injury or sickness was attributable to war service should be the major factor in access to patriotic funds. It did, however, entail aspects of control on the part of the organisations financing the serviceman so as to avoid any taint of scandal regarding war funds being expended on unworthy cases. For example, Andy Gilchrist was admitted to the Home as a Red Cross Charge at the expense of the Southland War Funds Association (SWFA). Known by the secretary of the SWFA to be ‘a certain extent alcoholic’, it was arranged through the OP&GWA for Gilchrist to be provided with an imprest account controlled by the Matron of the Home. He could draw small amounts from the account to supplement the tobacco and other comforts given to him at the Home. Attempts like this to restrain unsavoury habits were also matched by measures to enforce more socially acceptable ones. As will be seen in chapter three, moral pressure of this type was also imposed by the DRCS regarding vocational training through a belief in the importance of self esteem based upon work. The values of martial self-sacrifice then did not come without some reciprocal obligations on the part of the disabled serviceman regarding what it meant to be a good citizen. Indeed, martial self-sacrifice was part of the basis for masculine citizenship.

As the inter-war period moved on, the the DRCS defined a new role for itself in its peacetime activities. In 1924 the national body had successfully resisted attempts by the government to centralise its funds under the National War Funds Council and the Department of Internal Affairs because the Society’s role in disaster relief, the training of VADs, and public health did not fit under the definition of a war fund in the 1915 Act. The pivotal year for change was 1931 and the Napier earthquake which led to the establishment of the New Zealand Red Cross Society in its own right. Amalgamation at the local level, however, appears to have occurred very slowly. The DRCS did not merge with the new body until 1937 because of its involvement with Montecillo Home. When it did so, it was on the understanding

38 Questionaire issued by the Department of Internal Affairs for 1936 Investigation into War Funds, OPA File 7711.
39 OPA Case File 4243.
that the centre had full control of the Home, its wartime work, and wartime funds. Aside from Montecillo Home, the DRCS increasingly turned its attention towards work with the Junior Red Cross, VADs, and public health education. Whereas in the 1920s, when the DRCS had supplied disabled men outside the Home (particularly those with respiratory conditions including pulmonary tuberculosis) with bedding and cardigans, by the mid 1930s it was referring men wanting these items and other welfare cases to the OPA and the DRSA. Finally, in October 1938, the Society recommended all ex-soldier applications for assistance unrelated to Montecillo be referred to the DRSA.

Between 1919 and 1939 the nature of convalescence offered by the DRCS therefore became more restricted in its nature. The existence of other welfare organisations and a changing peacetime function allowed the Society to focus its care of disabled ex-servicemen solely on Montecillo Home. On this basis, changes made in the Society’s relationship with the state combined with economic pressures and an ageing ex-servicemen population to necessitate the DRCS accepting non-pension charges. The means by which the Society implemented this step, however, suggests that moral beliefs about martial self-sacrifice and duty also played a part in the acceptance criteria for the Home. Part Two examines this latter aspect further by focusing on the interrelationship between the leisure pursuits of the men in the Home with discourse about wounding and the ‘digger spirit’.

(II) VALIDATING MARTIAL MASCULINITY

Post-war representations of wounding invariably focused on the psychological aspect of men’s experience. The wounded man was portrayed lying emotionally and physically shattered in no-man’s man, spending his hours in torment until he was eventually found by a fully laden stretcher party who would mark the spot where he lay and return when best they could. The cold, the isolation, and the pain became crucial in the portrayals presented of disabled men after the war. They exemplified the supreme sacrifice of the man and in doing so deified his pain. Other perceptions infantilised the soldier who was portrayed only by his concern with his present disability. Wounded men became in the H. T. B. Drew’s words ‘the children of the hour’ who required the nurture of VADs and nurses to restore their virility. In these images, the individual sacrifice of the man was also emphasised, and, as epitomised by the representation of the Red Cross Mother, reinforced the idea of a protective martial masculinity.

42 DRCS 3, 17/4/36, & 28/9/37. The Society’s administration of the Home and welfare was governed by a new body entitled the Great War Funds Administrative Committee of the Joint Council of the Order of St John and the New Zealand Red Cross Society.

43 DRCS 3, 31/10/38.


45 Drew, War Effort, p.135
As has been seen, the perception of disability by an individual had its own dynamics. The meaning that a man attached to his wounds or sickness varied through time as his perceptions of them were altered by his reinterpretation of past events on the basis of his present environment. The way that a man perceived his wound in 1918 was very different from his perceptions in 1936. John A. Lee touched on this aspect when he wrote:

As a rabbit sacrifices a limb to escape a trap, the sense of freedom gave a measure of happiness. They would in time brood over their disability, but at present if men had lost a limb they had regained life.46

Part of the individual's perception of wounding lay then in the sense of escape from death mentioned by Lee - to catch a 'blighty', a wound requiring treatment in England, was to temporarily or otherwise free oneself from the deprivations and horrors of the trenches. The wound or sickness in this sense became a ticket 'Home', an honourable scar, through which duty and self sacrifice had been fulfilled. Keegan, in The Face of Battle, mentions the case of a man who had been slightly wounded going 'over the top' at the Somme. The soldier immediately decided that his injury represented a moral way out of the battle as a mark of completed duty.47 The wound as escape, as part of a martial code of honour, can be seen most vividly in the case of self-inflicted wounds and psychoneurosis which received harsh treatment from the military because they were seen as representing an unmanly avoidance of duty. They threatened military esprit de corps and the most popular perception of the wounded presented in the writings of the journalists, front-line soldiers, and politicians of the time - that of cheerful stoicism in the face of adversity for the sake of comradeship and manly self respect.

In January 1917, a New Zealand soldier wrote to his beloved about the aftermath of battle. He described the streams of wounded moving towards the Regimental Aid Posts as 'all quite happy... [for ] at last they were doing their bit for the flag.'48 Written for home consumption, this letter undoubtedly distorts the reality of the experience of battle, but it intimates the relationship between cheerfulness and the sense of duty fulfilled. The questions arising from this is are: what was the basis of that duty; what role did it play in the rehabilitation of disabled men upon their return to New Zealand; how did it alter their perceptions and identities? Bill Gammage in The Broken Years, discusses this interplay of wounding and duty amongst Australian soldiers in terms of the wounded expressing stoicism for the sake of their fit comrades by their courage and, when necessary, by dying well. In Gammage's words, they did so by 'showing their manhood to the world'.49 This description embodies two aspects

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46 J. A. Lee, Soldier, Wellington, 1976, p. 95. The original draft of this novel was written by Lee in 1918 while he convalesced from the traumatic amputation of a forearm.


48 Letter from 'Threepence' to Dorothy dated 1/1/17. This is held by the DRSA.

49 B. Gammage. The Broken Years: Australian Soldiers in the Great War, Canberra, 1974, p. 100.
which have been argued formed the part of the post war identity of New Zealand returned men and their society.\(^{50}\) First, the ‘digger spirit’ of comradeship, duty, and self-sacrifice, and second, the soldier as an icon for the birth of national identity. The transformation of these values into the civilian rehabilitation of disabled men becomes of critical importance.

Upon his return to New Zealand the serviceman invalided out of the forces was readily identifiable to the general populace. If he was an in-patient at a military hospital or convalescent home, he was required to wear the army regulation blue jacket. Out-patients were given two blue stars to attach to the peak of their dress service jackets, and a certificate authorising treatment which was to be shown at the request of the military authorities.\(^{51}\) The blue jacket was very unpopular amongst disabled men because of its poor fit, and in 1919 men throughout the country, including those at Montecillo, protested to the Defence Department. At the NZRSA conference that year, the O/C of the Chalmers Orthopaedic Ward in Christchurch, Colonel D. Wylie, commented ‘no man should object to his blue uniform if he realised it was a badge of honour’.\(^{52}\) Nonetheless, men, at least at Montecillo, took to the practice of wearing a band (presumably blue) around the left arms of their normal uniforms.\(^{53}\) This did not entail a rejection of the symbolism involved in the uniforms however, nor one of the men’s identification with their common bonds through war service; continued identification with soldier status by the residents of the Home meant that Wylie’s comment was far from misplaced.

Daily life at Montecillo Home was based on a hybrid of experiences involving the identities of the inmates as well as the views of the staff and the facilities provided for the men. The patients of the Home had an important impact in shaping the character of the institution. For example, during 1923 the DRCS fielded complaints from a neighbouring property about the noise emanating from the men’s quarters at night,\(^{54}\) while in 1924 the Montecillo Committee was compelled to remove the telephone from the recreation room because the men rather cryptically were using it for purposes other than intended.\(^{55}\) Stereotypical ‘digger’ traits such as smoking also played an important part in the lives of many men. Photographs of the early inmates frequently feature men, pipes in mouths, smiling cheerfully (figure 2.2). An advertisement in *Quick March* in 1919 referred to the ‘Montecillo Mixture’, a fine blend of

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\(^{50}\) The most notable historiographical example of this is Sir Keith Sinclair’s *A Destiny Apart: New Zealand’s Search for National Identity*, Wellington, 1986.

\(^{51}\) *The Returned Soldiers Handbook, containing instructions for returned soldiers of the New Zealand Expeditionary Forces First Demobilisation Edition (revised to 30th November 1918)*, Wellington, 1918, p. 27.

\(^{52}\) *Quick March*, Vol. 2, No. 15, July 1919.

\(^{53}\) This is based upon photographic evidence contained within Agnes Macmillan’s photograph album for the period 1918-1935. Hereafter cited as MPA.

\(^{54}\) DRCS 2, 24/9/23.

\(^{55}\) DRCS 2, 26/5/24.
Figure 2.2: Convalescent Soldiers in the Recreation Room, Montecillo Home circa 1918

Figure 2.3: First Sitting Room, Montecillo Home 1918
tobaccos ‘discovered by a “Digger” at Montecillo Home’. Comradeship was fostered by the men sharing dormitory style living quarters, and on the whole by the physical mobility of the men. As in their lives in the army, the inmates continually rubbed shoulders together in a largely male environment.

In 1919, the recreational facilities available to the men at Montecillo included at least two sitting rooms fitted with writing tables and cane chairs amidst a decor of paintings and flowers (figure 2.3). A large recreation room was opened in the March of that year and provided the men with a billiard table, piano, gramophone, and a library which was eventually supplied with all the official New Zealand war histories (figure 2.4). In 1923 a ‘wireless’ was also provided by the DRCS and a returned soldier, Mr. Arundel. The Home’s substantial grounds, which included a duck pond and gooseberry and blackberry bushes for the enjoyment of the men, were ably tended by another returned soldier, Mr. A. Moir. Supplies of mineral water for the residents were donated by a local firm Messrs. Thomson Ltd, tram passes issued by the Dunedin City Corporation, and film tickets supplied by a local cinema company Messrs. Fullers Ltd. Illustrated lectures for the men were arranged by members of the DRCS Executive from amongst themselves and their acquaintances; for example, in August 1922 Mrs. Lindo-Ferguson spoke on her recent visit to China and Japan with the aid of pictures thrown onto a screen. At the end of each year, a social was held for the men by the DRCS prior to the Home’s yearly closure for maintenance when the men returned to their family homes or, if necessary, were transferred to hospital.

From December 1922, the DRCS also held a garden fete each year in the grounds of the Home at which the public could inspect the facilities and purchase goods manufactured by the men in their vocational work. The ladies committee organised the catering and the sale of ice cream and afternoon tea with the aid of local secondary school girls. The men of the Executive saw to advertising, procuring marquees, trestles, and transport for the men in Dunedin Hospital and Wakari sanatorium. In 1938 the programme included ballet displays, and music from the Band of the First Battalion and the McGlashan College Pipe Band.

The DRCS also provided a car which, aside from transporting the residents to and from hospital for medical treatment, enabled men to be conveyed to sporting occasions, theatres, outings to the country, and under special circumstances, such as the Home’s yearly closure for a month, to the men’s homes in various parts of Otago and Southland. Picnics in popular

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56 *Quick March*, September 1919, p. 61.
57 MPA.
58 DRCS 2, 24/3/25.
59 DRCS 2, 26/3/23.
60 DRCS 2, 21/8/22.
61 DRCS 2, 24/11/24.
areas such as Brighton beach provided the men with an opportunity to socialise with their partners and families. From the 1930s these outings were supplemented by the Motor Circle of the Otago Women’s Club who also took men on trips to the country. The Society reported that these outings provided ‘a fine tonic for the patients’.

Between 1919 and 1939 the Home was regularly visited by dignitaries and members of the military. During their respective terms as Governor General, Lord Liverpool, Charles Fergusson, and Lord Bledisloe all accepted invitations to tour the Home, as did the Prince of Wales in 1920, and his brother the Duke of York in 1927 (figure 2.1). While under military control, Henderson and McGavin in their respective roles as DGMS inspected the Home, although the Prime Minister of the time, William Massey, seems to have shown a marked reluctance to visit Montecillo when his duties called him to Dunedin. The DRCS also extended invitations to naval vessels and expeditions currently in port. In 1925 the officers and bandsmen of HMS Dunedin visited Montecillo presenting a framed photograph of the ship and a silver tray to the inmates, while in 1930 Rear-Admiral Richard Byrd and members of his antarctic expedition called upon the residents. In 1926 the delegates of the NZRSA conference in Dunedin held a social at the Home.

The DRCS would appear therefore to have maintained links in entertainments and visiting engagements with the soldier identities of the inmates. Two further examples provide a more symbolic evaluation of the emphasis placed on the wartime experience of the men. In 1922, the DRCS arranged to have a field gun placed in the grounds of the Home. The allocation of the gun was changed to a trench mortar however, and then finally to a machine gun (presumably the gun currently in place at the Home). Moreover, in 1924 the DRCS organised the erection of a brass memorial tablet inscribed with the names of deceased inmates. In a sense, these constituted contrasting memorialis - the machine gun was as much a validation of the experience of the living as it was a reminder of the deceased friends of ‘diggers’ in the Home. The memorial tablet more explicitly stated the sacrifice of the men who had resided at Montecillo until their deaths caused by the physical and emotional damage of the war. No

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63 DRCS 3, 30/3/36.


65 MPA.

66 Massey declined three invitations to the Home during 1923 and 1924; DRCS 2, 28/5/23; DRCS 2, 25/2/24; DRCS 2, 23/6/24.


68 MPA.

69 DRCS 2, 29/1/23.
record exists regarding the men's feelings about the gun, but the residents contributed £5 towards the cost of the tablet.\textsuperscript{70}

The DRSA also maintained strong mutual links with the inmates. The Association's choir performed for the men at the Montecillo frequently during the 1930s with the concerts on occasion broadcast over 4YA, while the DRSA also issued Otago Rugby Football Union passes to men at the Home pensioned at 75\% disability and upwards.\textsuperscript{71} Furthermore, a photograph taken of the Home's residents in either 1922 or 1923 shows that of thirty men present nine are visibly wearing NZRSA badges (figure 2.5).\textsuperscript{72} Given that at this time the membership of the NZRSA had fallen from 57,000 in 1920 to 13,738 in 1923, the proportion of Montecillo residents who were members seems relatively high.\textsuperscript{73} Disabled men were however those most likely to stay with the DRSA during the period of decline for they were the men who most needed the organisation's aid in regard to pension appeals and welfare assistance. Two of the Association's most prominent members during the 1920s and 1930s were themselves seriously disabled - the secretary of the Association from 1925 to 1931, J. M. White, and a past president of the DRSA, the Employment Officer for the Disabled Soldiers' Re-establishment League, A. J. Gordon. The careers of these men and their non-reliance on welfare provisions emphasises the significance of economic and social status and skills when discussing the effect of disability upon individual identity.\textsuperscript{74}

During the 1920s and 1930s the DRSA was one of the strongest Associations in the country. The NZRSA Review of August 1924 attributed this strength to the comradeship and unity fostered by the club's social activities.\textsuperscript{75} At a sporting level the DRSA encouraged its members to play billiards, ping-pong, and bowls, as well as to 'keep their eye in' through the Club's miniature rifle club. Culturally, the sixty member DRSA choir and the Savage Club held dominance. The Savage Club included a Pierrot Troupe and Orchestra which regularly visited the hospitals and convalescent homes in the city. In addition to these activities, the regular smoko evenings and reunions held by the DRSA offered returned men the opportunity to perform skits, reminisce memories of lost times and friends, and sing the songs that had

\textsuperscript{70} DRCS 2, 26/5/24.

\textsuperscript{71} DRSA File 1389. Four of the sampled men resident at Montecillo received passes. In addition to the disablement requirement, the ORFU also stipulated recipients could not be in full time employment.

\textsuperscript{72} MPA. I have placed the date of the photograph as either 1922 or 1923 on the basis that after these years patient numbers never rose to thirty or above.

\textsuperscript{73} N. P. Webber, The First Fifty Years of the NZRSA 1916-1966, Wellington, 1966, p. 6.

\textsuperscript{74} Gordon was a double amputee, while White had also lost a limb - in his case his left forearm. Gordon was also for several years chairman of the Dunedin Limbless Committee. White had an exemplary career after he was wounded. Once invalided, he joined the army's forage corps, gained charge of a transport unit in Egypt, and, on his return to New Zealand, aided Clutha McKenzie in the rehabilitation of New Zealand's twenty-six totally blind servicemen.

\textsuperscript{75} NZRSA Review, Vol. 1, No. 1, August 1924, p. 16. The rest of this paragraph is based on a precis of the Review's Branch News for the 1920s.
Figure 2.4: Recreation Room, Montecillo Home 1918

Figure 2.5: Montecillo Home Inmates circa 1922 - note the NZRSA badges on the men's lapels
reverberated the *estaminets* of Flanders and France. Social evenings also provided a forum for the expression of political ideas based upon male comradeship and loyalty to the British Empire. Through toasts to the monarchy, discussions about defence, and the exclusion of women, the combination of recreational activities with political purpose represented a transformation of the masculine culture experienced by the men when in the military to a peacetime function.

The foundation of the leisure pursuits of the DRSA was then the collective identity embodied in the ‘digger spirit’ of the Great War. In 1930, the retiring Governor General, Charles Fergusson addressed the members of the DRSA with these words:

> In the trenches together they had all learned the absurdity of class distinction and of class jealousy. Let that spirit prevail through all their doings and through all their lives; it was the spirit of the trenches... They rubbed shoulders, shared the same horrors, and talked more or less the same language.\(^{76}\)

In a vision that blurred the economic and national differences between men on the basis of a perceived shared experience of the horrors of war, Fergusson’s speech pointed to the separateness of the returned soldier from the rest of New Zealand society. The ex-serviceman through his self-sacrifice had experienced the darker side of ‘human’ nature, and in doing so had found a common bond with other men through his suffering. Eric Leed has referred to this experience as ‘liminality’, that psychologically the world of conflict that the civilian soldier entered in the Great War represented estrangement not only from the society that they had left but also from the one they returned to at the end of the war.\(^{77}\) The violation of all social norms by death, disease, and the powerlessness experienced over destiny in the trenches left men with an almost religious sense of duty that they had been chosen to transform the world of peacetime. At an ANZAC day ceremony in 1929, a member of a North Island RSA called on the duty of the survivors of the war to ‘live in an enlightened manner, to promote the cause of peace, and to nurture the spirit of comradeship and interdependence’ produced by the war.\(^{78}\)

An ‘elite’ aspect of the NZRSA collective identity lay then in the sense of duty and comradeship created by the pain of war. By experiencing this pain, war had transformed New Zealand men into soldiers of maturity and wisdom to whom the nation should rightfully look for leadership. This sense of moral leadership was reinforced by the association in the popular mind of the rhetoric of nationhood with the triumph of the New Zealand male upon the battlefield. Masefield had proclaimed the ANZACs as the ‘flower of the world’s manhood’; the

\(^{76}\text{NZRSA Review, Vol. 6, No. 3, February 1930, p. 27.}\)

\(^{77}\text{E. Leed, *No Man’s Land: Combat and Identity in World War 1*, New York, 1979, p. 194.}\)

\(^{78}\text{NZRSA Review, Vol. 6, No. 1, p. 30.}\)
Empire and New Zealand had stood up and thrown plaudits at men who had shown their place in the world. Thus, the jingoistic Ormund Burton could write in *The Silent Division*:

> The time has come for the men who dug the trenches and put out the wire, and passed the great barrages, to run New Zealand. In the years of terror men learned brotherhood. In the years ahead can we practise it in making a better country? 79

The representation of an egalitarian sense of comradeship amongst men combined with a passage through suffering transcended through that brotherhood offered a potential empowerment to all returned men and perhaps especially to the disabled man who found himself socially and economically disadvantaged.

The ‘digger spirit’ therefore entailed traditional protective and paternal notions of masculinity. As men had gone forth to war on the premise of defending their Empire and thereby their loved ones, it did not require a major transformation of values for the same men to regard themselves as the guardians of peace. An editorial in *Review* in November 1924 discussed the need for an improved defence system. ‘An adequate defence system...’, it argued,

> does not mean the inculcation of militaristic thoughts in the minds of the young, rather does it show them how terrible warfare *can be* and that defence, or the ability to bear arms, *is* in reality a nation’s insurance policy and the most efficient means of warding off conflict. 80

In adopting a pragmatic position that conflict would inevitably occur because of a flawed human nature, the NZRSA held to a belief that the principle purpose of war was to create peace. The conflict inherent in a belief in ‘pacifism’ and the necessity for military preparedness reflected that without war the organisation, its collective identity, and the individual experiences of its membership would not have existed - to reject the need for war outright was to reject their own identity. Martial virtues in that ideal were inevitably reinforced.

Of course the ‘digger spirit’ and the DRSA were not integral features in the lives of all disabled men. Some men undoubtedly returned to New Zealand wanting nothing less than to forget the war and its effect on their lives. Yet the inculcation of martial beliefs in many disabled men remained strong regardless of whether or not they clung to old comrades and times in any explicit sense. Self-sacrifice, Duty, and Empire continued to be significant values for these men. With the outbreak of the Second World War in September 1939 many disabled men attempted to re-enlist. Of the sampled group, four men are known to have succeeded. 81

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79  Burton, p. 326.
81  NZEF Personnel Files (OPA Case Files 8187, 9683; DRSA Case File 2383; Seacliff Case File 8381).
In 1940, Walter Cameron re-enlisted despite having been war pensioned for pulmonary tuberculosis, not having worked for fifteen years, and having a wife and four children.\textsuperscript{82} Another pensioner, Angus Frasier, a victim of a gas attack at Passchendaele, explained his sentiments to the secretary of the DRSA in this manner:

\begin{quote}
I hear on the radio there are still men called up to fight the hun and his gun. It makes a fellow feel restless. How about a fellow joining the tank corps...I feel I would like to help good old Britain again same as the rest of you.\textsuperscript{83}
\end{quote}

\section*{SUMMARY}

Between 1919 and 1939 the founding role of the DRCS underwent a major transformation. An organisation first formed on the basis of caring for the disabled serviceman, it had shifted its activities more toward the health care and comfort of the wider community. The greatest mother in the world had not totally forsaken her sons as they had grown older but they were now only a small and more limited part of her overall activities. The pact established during the war had gone through many transformations based upon the needs of the times - the Society still comforted the disabled man but this was tempered by the need of the Red Cross to have a wider societal function, and the growth in importance of the DRSA's welfare activities. With regard to Montecillo Home however, the continuity and stability of the DRCS executive committee along with that of the Home's staff ensured that the underlying basis of care remained substantively unchanged. The period of military control from 1918 to 1922 was established upon the same pact of convalescent care that the Society had operated under during the conflict when it had provided comfort to disabled servicemen in other Dunedin medical institutions. With the transfer of Montecillo control to the DRCS in 1922, this position did not immediately change. An expansion of the caring role was only brought into play by economic pressures related to the Society's relationship with the Pensions Department, and the inability of Montecillo Home to cater for men suffering from pulmonary tuberculosis. This led the committee to admit Red Cross charges in 1925. As some of these men had never served overseas while others were suffering from the results of civilian injuries and conditions highly likely related to ageing rather than war service, it is probable that the Society's care for them was an expression of gratitude for all men who had shown a willingness to fight in the Great War. The Depression of the 1930s exacerbated the economic and emotional stresses felt by

\textsuperscript{82} NZEF Personnel File (Seacliff Case File 8381).

\textsuperscript{83} Letter from Angus Frasier to the Secretary of the DRSA, O. L. Ferens, dated 30/1/40. DRSA Case File 2383.
disabled men in the wider society, and this together with ageing led to more pensioned men being admitted to the Home than had been the case during the mid 1920s. The basic premise behind care at the Home had however, remained unaltered. Admitting Red Cross charges fulfilled the moral duty of the Society to all ex-servicemen, while taking pensioned men completed both this element and its financial obligation to the government via the Pensions Department in the pact of convalescent care. Moreover, the convalescent pact was based implicitly upon the Society’s acceptance of minimal state involvement in the welfare of disabled servicemen, and on social gratitude for martial and even potential martial self sacrifice that validated the experience of the combatants.

This validation was carried out as much by the disabled men themselves as it was by the DRCS and other groups concerned with convalescent care. The perception of wounds as honourable scars in the minds of the men and to an extent the public combined with the masculine culture embodied in the ‘digger spirit’ and the traditional protective and paternal masculinity this symbolised. Whether it was through the entertainments men enjoyed at Montecillo Home or other institutions where the DRCS had an influence, the identification of the wound with war experience, and the support that could be gained from other returned men estranged from their own society, strengthened rather than weakened perceptions of martial masculinity amongst disabled men.
Prior to their return to New Zealand, disabled men received vocational training from the army in the United Kingdom at the New Zealand General Hospitals (NZGH) and Convalescent Depots. For example, at No. 2 NZGH Walton-on-Thames, workshops were established in the Oatlands Park section by the Red Cross Society and administered by the Education and Vocational Training Branch of the Defence Department. Carpentry, metal work, and sign writing were taught to limbless men while agricultural training in bee-keeping, poultry raising and general farming techniques was provided for men suffering tuberculosis and other respiratory ailments. Once medically pronounced unfit for active service, soldiers were transferred to the evacuation depot at Torquay where the South Island men were accommodated at 'Daison' villa. While they waited to embark for home, men were 'loaned' to local industries to provide an education in a new livelihood and were expected to tend the substantial grounds of the villa. Vocational training was primarily based on a belief that the disabled man, regardless of his impairment, had a responsibility to be an economically productive member of society. It placed the pact of convalescent care and its implicit gratitude for martial self-sacrifice within the wider pact of rehabilitation to civilian life. In this pact, all but the most seriously disabled men would be expected to be relatively self supporting members of society who would not burden the taxpayer. Vocational training was integrally related therefore to perceptions that masculine self-esteem was based on employment, and the instructor’s views of the economic structure of society. The ‘world view’ of the instructors was itself partly a product of the relationship between the state, the military, and the Red Cross Society in the provision of training for it reflected the structures inherent in the provision of training. The Red Cross through its donation of equipment and buildings, provided the basis for short term instruction of the men by the military and, in the long term, a system of voluntary care requiring minimal governmental involvement.

This chapter examines the relationship between disability and vocational training in Dunedin from 1919 to 1939. Part One focuses on changes in the provision of vocational training and argues that even more so than convalescent care the role of the military and the state in the pact of rehabilitation was short term. After the closure of the Repatriation Department in 1922, the impetus for vocational training largely fell upon the DRCS and the medical superintendents running local institutions. However, the 1929 Barton Commission led to limited state involvement again with the establishment of the Disabled Soldiers Re-

1 Carbery, p. 370.
2 Ibid.
3 Drew, War Effort, pp. 271-73.
establishment League in Dunedin in 1931. The League was partly concerned with vocational training but its success was limited by its formation in a time of economic depression and many disabled men's disillusionment in their ability to lead a normal life. Part Two analyses the values inherent in vocational training through the evidence presented to the 1929 Barton Commission which emphasised the suitability of rural life for the disabled and industrial productivity. It examines the extent to which the societal acceptance and validation of martial self-sacrifice embodied in the pact of convalescent care was tempered by the values attached to industrial efficiency. Moreover, it attempts to gain an insight into how the popular perception of New Zealand as an agrarian country influenced the vocational training offered to disabled men and the expectations of masculine citizenship.

(1) EXTENDING THE REHABILITATION PACT?

Between 1919 and 1939, medical practitioners made a clear distinction between vocational training and occupational therapy. Speaking to the Barton Commission in 1929, Dr. Ernest Lyth argued that the aim of occupational therapy was to aid physical and psychological recovery whereas vocational training tended to be used at the end of occupational therapy to provide men with the initiative to work and to gain training in an employable skill. Occupational Therapy required a medical understanding of disability to aid recovery; vocational training assumed recovery had been achieved as best as possible and focused on utilising what earning capacity remained in a man. In practice the distinction was blurred however, with the two terms used almost interchangeably. Occupational therapy, in Lyth’s sense, did not become firmly established in New Zealand until the opening of a training school at the Auckland Mental Hospital in 1940. Until then, all instructors were either trained overseas or, as appears to have been more frequently the case, were voluntary workers who imparted their craft skills to the disabled.

Upon his return to New Zealand the disabled soldier continued to receive vocational instruction from the Army’s Education and Vocational Training Branch (E & VT Branch) until his discharge from the forces. After his discharge, the Repatriation Department offered him vocational training as part of its ‘after-care’ section. As in the United Kingdom, the workshops and equipment for vocational training were provided out of Red Cross Society funds while the Defence Department paid the wages of the instructors. At Dunedin Hospital, workshops, and a gymnasium were provided in the old nurse’s home, and a splintmaking workshop built in the hospital grounds. In 1920, the splintmaking workshop was the responsibility of Major J.

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4 NZNA T 65 1 Evidence of Dr. C. E. W. Lyth presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 31/10/29.


Renfrew White, while Colonel Thomas Fergus was in charge of the amputees learning to manufacture artificial limbs at the hospital.7

The E & VT Branch’s Vocational Officer for Dunedin, C. C. Ziesler, organised instructional courses for the men at Dunedin Hospital, Montecillo Home, and Woodside Hospital, as well as the Technical College, University, and School of Art. In August 1919, a total of 208 men received instruction from the Defence Department in Dunedin.8 The most popular classes were those in motor engineering, wool-classing, and commerce run at the Technical College but the range of subjects taught extended to all areas considered to make men employable. At Montecillo Home ex-servicemen were shown how to manufacture basketwork, leatherwork, woodwork, jewellery and enamelling while men at Dunedin Hospital learnt these skills as well as boot repair, and (as mentioned) splintmaking and artificial limb manufacture and repair.9

Tuition was given by two female instructors, Miss M. Barron, and Miss Macassey who was a member of the Toymakers Guild.10 In addition, Mr. J. F. Garside taught the men at Dunedin Hospital the necessary skills required to repair surgical appliances and splints11 while the manager of the Dunedin City Corporation’s Parks and Reserves Department, David Tannock, imparted his knowledge in poultry farming, bee-keeping and small-scale vegetable growing to the men resident in Woodside Jaw Hospital.12

In February 1920 the Defence Department extended its vocational training activities to Pleasant Valley Sanatorium in response to requests from the seventeen soldier inmates.13 An instructor was arranged to visit the Sanatorium once a week and give tuition in basketwork and leatherwork. In a situation reflective of the Defence Department’s poor relationship with the Otago Hospital Board, the medical superintendent, Dr. Lyth, was not consulted about the provision of vocational training. As a result, Lyth wrote to McGavin suggesting that ‘real’ vocational training should be offered rather than ‘fancy work’ as the patients tired easily and stated he could not send a car to the Palmerston railway station to meet the instructor. In March 1920, lectures were started in poultry farming in addition to the instruction in basket and leather

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9 Ibid.

10 NZNA AD 1 74/17 Memo M. Montgomery, O/C Education and Vocational Training to Col. T. W. McDonald, Commandant Otago Military District, dated 31/3/19.

11 Ibid.

12 NZNA T 651 Evidence of David Tannock presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 29/10/29.

13 NZNA AD 1 49/854 Memo Dunedin Vocational Training Officer, C. C. Ziesler to the Director of Vocational Training, Wellington, dated 9/2/20.
work. It is unclear however, if this was in response to Lyth’s request, and, on the whole, the arrangement suggests lack of understanding between the military and Dr. Lyth regarding whether the training was supposed to be therapy or employment orientated.

With the closure of the military section of Dunedin Hospital in July 1920, the Education and Vocational Training Branch attempted to wind up its operations. In August, the medical superintendent of the hospital, A. R. Falconer, wrote a letter of protest to the Minister of Defence supported by a petition from thirty-four of the soldier patients. They wrote about the threatened closure of classes: 'if this is done it will entail a very heavy hardship upon us as this work is our chief recreation and pleasure in our weary time of suffering.' As a consequence, classes continued under the control of the Repatriation Department, and, from March 1921, the Otago District ADMS assumed responsibility for splintmaking, surgical bootmaking, and artificial limb repairs. In the case of artificial limb manufacture, three power driven machines were installed at the hospital to aid the work carried out by the men. The impetus for the provision of vocational training by the military lay, therefore, as much in the wishes of disabled men to receive instruction as it did in the departmental bureaucracy.

The Dunedin Repatriation Department’s role in ‘after-care’ combined with the comparative ease with which the Department found employment for able-bodied returned servicemen meant that the distinction between discharged men and those still in the forces became confused with regard to vocational training. In August 1919, the Repatriation Department’s Vocation Officer, H. F. Titchener, reported to the Dunedin Director, H. D. Tennent, that the majority of the eighty-eight men who received instruction five hours a day in courses offered by the Department at the Technical College were in fact undischarged men from Dunedin Hospital, Montecillo, and Woodside. Furthermore, the courses themselves were virtually identical in content to those offered by the E & VT Branch suggesting the Repatriation Department picked up the overflow of men wishing instruction from the military. Given that the Repatriation Department was incorporating the work of the E & VT Branch, the Dunedin Branch’s closure became a formality in the context of McGavin’s reform of defence medical services.

A further aspect of ‘after-care’ by the Dunedin Repatriation Department was the establishment of the Moa Seed Farm at Dumbarton, Central Otago, and two afforestation schemes at Ranfurly and Tapanui to provide work of a light nature for the disabled. The Moa Seed Farm occupied 450 acres of land and aimed to provide a ‘congenial occupation for a

14 NZNA AD 1 49/854 Memo Dr. C.E. W. Lyth to DGMS Brigadier General Sir D. McGavin, dated 18/2/29.
16 NZNA AD 1 74/17 Petition from Soldier Patients in Dunedin Hospital to Sir J. Allen, Minister of Defence, dated 1/8/20.
18 NZNA T 69 ACC 2666 4 Memo H. Titchener to H. D. Tennent, dated 21/8/19.
number of returned men'. According to one of its organisers, David Tannock, it was envisaged as a central station where disabled men would sell the seed they produced to the soldier settlers in the district. Thirty men received vocational instruction at the farm although only one of these continued on in the venture after his training had been completed. In 1929, H. D. Tennent, informed the Barton Commission that the scheme had never been intended to train men for employment and had been perceived only as occupational therapy. At the Wellington session of the same Commission, the ex-national Director of the Department, J. R. Samson, dismissed Tennent's claim and stated that the Moa Seed Farm scheme only became occupational therapy when the venture was found to be a commercial failure. Once again, the difference between occupational therapy and vocational training appears to have been confused in the minds of the people administering the schemes.

In August 1922, the government closed down the Repatriation Department considering that it had fulfilled its function. The responsibility for the vocational training of disabled men fell upon the DRCS and the discretion of the medical superintendents of the institutions the ex-servicemen attended. The DRCS's Vocational Instructor, Miss Miller, undertook to train the men in Dunedin Hospital, Wakari Sanatorium, and Montecillo Home in basketwork, leatherwork, enamelling, and textiles. During 1922, Miss Miller visited the Hospital on Sundays and Thursdays, Wakari on Wednesdays, and spent the remainder of her week with the inmates of Montecillo. The DRCS also arranged with A. R. Falconer for a member of the Society's vocational staff, E. J. Coxhead, to continue the workshops at Dunedin Hospital for the benefit of the men. In 1929, the DRCS was pleased to announce that Miss Miller continued to aid the men in workshops at the public hospital and Wakari with the 'men spending many happy and profitable hours' in the work.

Vocational training at the Hospitals and Montecillo Home was based on a formal relationship between the men and the DRCS. Items manufactured by the inmates were sold and the proceeds paid into a fund used for the benefit of the men. While vocational work was voluntary, the DRCS exerted considerable pressure on the patients to manufacture goods.

19 AJHR H30, 1920, pp. 5-6.
20 NZNA T 651 Evidence of David Tannock presented at the Ex-soldiers' Rehabilitation Commission, Dunedin dated 29/10/29.
21 NZNA T 651 Evidence of H. D. Tennent presented at the Ex-soldiers' Rehabilitation Commission, Dunedin dated 30/10/29.
23 DRCS 2, 19/6/22.
24 DRCS 2, 18/9/22.
26 New Zealand Red Cross Record, April and May 1919, p. 11.
When in 1923 Mrs. Lindo-Ferguson advised the DRCS that the men at the Home were not inclined to increase their current workload, the Executive voiced their disappointment to the men. The DRCS sought to provide motivation for the men's activities by arranging displays of their work in shop windows around the city, as well as organising its sale at the annual Garden Fete and the Winter A & P Show. Given that the Society made no material gain out of such pressure, it is reasonable to assume that it was based on a belief that the men should work for their own peace of mind and self-esteem.

The New Zealand and South Seas Exhibition held in Dunedin during 1925 and 1926 offered a further opportunity for disabled men to dispose of their handiwork. In anticipation of Dunedin becoming the 'Mecca of all holiday makers', the DRCS and the DRSA organised a stall occupying 400 square foot to handle the goods manufactured by men throughout the country. In a show of parochialism, the Society arranged for the Montecillo inmates to receive extra instruction in enamelling to boost the quality of local goods sold. The stall, which employed a disabled soldier and an assistant, achieved good sales for the duration of the exhibition, and several men were compelled to gain additional raw materials from the DRCS to refurbish their stock in the stall.

The Society regarded the function of Miss Miller's instruction as both occupational therapy and vocational training. In 1936, Miss Graham responded on behalf of the Society to criticism from some Montecillo Home inmates that pensioned men should not receive payment for their work with the comment that sick men required activities to distract them from their disabilities. From 1936 onwards however, the DRCS limited the value of the goods produced by men outside the Home to £3 per sale.

In 1925 the DRCS expanded its vocational training activities to Pleasant Valley Sanatorium, and in 1936 to Seacliff Mental Hospital at the request of the respective medical superintendents. Vocational work at the sanatorium however, appears to have been short-lived. The 1929 DRCS Annual Report makes no mention about vocational work being carried out at Pleasant Valley by the Society, and in the 1930s the DRSA was paying the Hospital

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27 DRCS 2, 24/9/23.
28 1929 Annual Report, p.5.
30 DRCS 2, 25/5/25.
31 DRCS 2, 25/1/26.
32 DRCS 3, 23/10/36.
33 DRCS 2, 10/11/25.
34 DRCS 3, 3/3/36.
Board to provide work for tuberculous soldiers in the sanatorium’s garden. No evidence exists but it is likely that the isolation of the sanatorium was an important factor in limiting vocational facilities offered there - societal stigma regarding the disease appears to have been relatively unimportant given that Miss Miller gave instruction to the chronic tuberculous soldier patients at Wakari Sanatorium. A similar situation existed at Seaciff Mental Hospital. Limited occupational therapy had been undertaken at Seaciff during the 1920s possibly by the Dunedin branch of the National Council of Women who later aided Miss Miller in her work with soldier patients in Clifton House ward from 1936. The medical superintendent of the Hospital, Dr. H. D. Hayes, was very enthusiastic about occupational therapy and suggested to central government that it should be extended to the other patients at the Hospital. After Hayes' untimely death in 1937, his successor, Dr. Malcolm Brown, ensured that occupational therapy was eventually used in the treatment of all the patients; in 1939 a female occupational therapy block was established based on strongly gendered activities such as hair dressing. The work of Miss Miller and the DRCS along with the National Council of Women therefore lay the ground work for the foundation of an organised occupational therapy profession in New Zealand.

The Barton Commission of October 1929 to January 1930 addressed the vocational training and general rehabilitation of disabled men in the wider community. Established in response to pressure from the NZRSA, the Commission’s brief was to investigate and report upon the economic position of disabled soldiers, and the adequacy of welfare and training provisions for them. The Commissioners - J. S. Barton, J. P. Luke, and the secretary of the NZRSA, S. J. Harrison - met in Dunedin from 25 October to the 1 November 1929, and in the process heard evidence from all the major individuals and organisations involved in rehabilitation as well as some disabled men sponsored by the DRSA. The report of the Commission recommended the formation of a Disabled Soldiers’ Civil Re-establishment League operated through the Pensions Department with branches in all the major cities and towns of the Dominion. In 1930, the government passed an act through the House which created the League.

From 1931 the Disabled Soldiers’ Re-establishment League (DSRL) was involved in the vocational instruction of unemployed disabled men in Dunedin. The League was essentially a resurrection of the old Repatriation Department. Like its predecessor, it was empowered by

35 DRSA File 2599, Correspondence between DRSA and the Otago Hospital Board 1936-39. For example, a letter dated the 18/7/36 from the Hospital Board thanked the DRSA for £10 to be used for this purpose.

36 AJHR H7, 1938, p. 12.

37 DRCS 3, 22/3/37.

38 AJHR H7, 1939, p. 11.

39 AJHR 1930, H39, ‘Report of the Ex-soldiers’ Rehabilitation Commission’, p. 27. The Commission was funded by the NZRSA, and the various patriotic welfare associations through the National War Funds Council.
legislation to subsidize the wages of disabled soldiers, supplement their pay, and establish and carry out schemes of vocational training. The Dunedin advisory committee of the DSRL arranged for training courses at the Technical College, and investigated seed farming, poultry farming and beekeeping schemes. This aspect of the League's work however, was highly unsuccessful; in September 1934, out of a total of 417 disabled men on their books, the DSRL reported that only sixteen men had received some training at the Technical College and of these only three had continued in their studies.

In 1933, the DSRL extended the principles involved in its vocational training programmes by establishing a leatherwork factory to provide employment for disabled men. The factory, situated in Carroll St, traded under the name 'Disabled Soldier Products' and produced suitcases, hatboxes, coats and other similar goods. It employed six men full-time on a profit-share basis as well as several part-time and voluntary workers. The men were often inmates of Montecillo Home who had experience in the skills required through the vocational training taught at the Home. It became a successful venture and encouraged the League to open a woodwork operation employing a similar number of men in 1935. The Pensions Department, however, proved intractable regarding the adjustment of the supplementary economic pensions of the men, and, by 1939, men working at the factory were effectively dependent upon their disability pensions and the income brought in by their work. Moreover, in the overall context of unemployed disabled soldiers, both factories represented ineffectual solutions. Throughout the 1930s, the League was compelled to dramatically increase the number of men on its lists that it regarded as unemployable. In January 1933, the League held that 100 of the 393 men on its lists were unemployable; by September 1934, the number of men considered unemployable had risen to 150 while the total number of registrations had only increased by twenty-four to 417 men.

The failure of the DSRL's vocational training and employment efforts was partly related to the economic circumstances surrounding the formation of the League. On its formation the DSRL was operated through the local Registrar of Pensions without any central organising body.

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Wellington with the Commissioner of Pensions regarding the League’s activities but these appear to have been little more than regional reports. It seems the Pensions Department received little or no state funding for the DSRL. Financially the League was dependent on grants from the Department of Internal Affairs through the takings of Art Union lottery tickets reflecting the token effort the government was prepared to make towards the rehabilitation pact. State commitment to the League was in fact so limited that in 1934 the NZRSA took responsibility for its administration although funding continued through Internal Affairs. With effectively no central control or funding the League could not financially afford to be involved in extensive training programmes. Furthermore, its formation at a time when the state was cutting its expenditure in the face of worldwide depression meant the DSRL was, from the outset, hamstrung in its powers.

Even if the League had received adequate funding however, the general position of disabled men would have made its efforts in rehabilitation difficult. By 1931, many men had experienced chronic disability for at least thirteen years. Moreover, continued medical treatment, ageing, economic hardship through unemployment or loss of earnings, and the stress on the family caused by these factors exacerbated both the psychological and physical condition of the men. In 1929, Dr. W. Marshall Macdonald identified the men he regarded as particularly economically disadvantaged as those suffering from neurasthenia, tachycardia, psychasthenia, healed pulmonary tuberculosis, hyperthyroidism, and commotional syndrome (shellshock). Macdonald’s emphasis on the long term psychological impact of disability coincided with that of the other Dunedin specialists who gave evidence at the Barton Commission. Dr. Thomas Fergus told the Commission that he felt that virtually all men who had seen active service suffered some form of psychological damage as a result of their war experiences while Dr. A. R. Falconer, by now medical superintendent of the private mental hospital at Ashburn Hall, noted that psychological factors were the most important in the rehabilitation of men into civilian life. The previously discussed predominance of dyspepsia, neurosis, and cardiac

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49 NZNA T65 1 Evidence of Dr. W. Marshall Macdonald presented at the Ex-soldiers’ Rehabilitation Commission, dated 33/10/29. Neuroasthenia and Psychasthenia were both constitutional conditions related to a belief that the body had a fixed amount of energy and that once depleted this manifested itself in assorted psychosomatic ailments such as tiredness, dyspepsia and cardiac pains. The distinction between the two conditions was that psychasthenia involved obsession dreams. Commotional Syndrome or shellshock ( in Macdonald’s definition) was believed to involve repression of traumatic events leading the mind to disassociate its previous personality. Tachycardia was characterised by a rapid and irregular heart beat and was also classified as DAH (disordered action of the heart) and essential hypertension. Hyperthyroidism was a disturbance caused by excessive secretion of the thyroid gland believed to induce madness, while healed pulmonary tuberculosis also involved psychological elements due to the debilitating nature of the disease and the stigma attached to sufferers by society.

50 NZNA T65 1 Evidence of Dr. T. Fergus presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 1/11/29.

51 NZNA T65 1 Evidence of Dr. A. R. Falconer presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 25/10/29.
sufferers at Montecillo during 1932 in Chapter Two appears to justify the emphasis on psychological stress made by these practitioners.

Between 1919 and 1939 the pact of rehabilitation between the disabled man, the state, and society changed very little with regard to vocational training. The state intimated its limited involvement and lack of recognition of disabled men's long term difficulties by the closure of the Repatriation Department in 1922 and by the military concurrently divesting itself of any responsibility for the long term medical care of disabled soldiers. The burden of care fell on the discretion of medical superintendents in the civil health system, and voluntary organisations such as the DRCS and the DRSA to fill the gap vacated by government. The need to convene the Barton Commission of 1929 and the limited establishment of the DSRL once again showed the failings of the pact and the government's lip service towards and reticence about social problems. Without adequate state funding the League was impotent. The pact was in crisis. How could self-sacrifice in war be valued when the men disabled by it were required to live in poverty in the world of peace where industry and money held sway? What does this tell us about how the state and voluntary organisations perceived their society and the place of disabled soldiers within it? To what extent did vocational training represent an extension of the pact or was it really a betrayal of it and the experience of the men? Part Two addresses these issues further by examining the evidence given at the 1929 Commission, and other contemporary discourse. The evidence of the medical profession was crucial in that these men held the main authority in determining programmes of vocational training within their respective institutions.

(II) INVALID(ATING) MARTIAL MASCULINITY

The belief that the disabled man should be made an economically productive member of society was widespread amongst those involved in rehabilitation. In 1924, the President of the NZRSA, Sir A. H. Russell, articulated the pact between the man and the rest of society in terms of duty. 'It was agreed', he argued

that there was a duty on the part of the disabled soldier to make use of his remaining earning capacity, and so assist in production; and a duty on the part of his fellow countrymen to provide the conditions under which he can discharge that duty.52

In a similar vein, the ex-director of the Repatriation Department, J. R. Samson, told the Barton Commission in 1929 that in the rehabilitation process 'the idea is to treat every man who can

52 NZRSA Review, Vol. 1, No. 1, August 1924.
undertake any work at all as a national asset. These ideas were twofold in nature. First, they were based on the economic cost the war incurred upon post-war New Zealand society in terms of lost manpower and the burden of war pensions upon the taxpayer. Second, they also entailed a belief that masculinity was epitomized by independence expressed chiefly through employment. State welfare policy reflected this understanding, and was based on an opinion that, while there were some men whose health had been totally destroyed by the war, these men were relatively few in number and did not have a long life expectancy. For example, as at 31 March 1929, 12,538 men were receiving war pensions estimated at £699,498. Of these pensions, roughly a quarter or 3400 were temporary in nature averaging for each man £72 per annum while payments to men receiving permanent pensions averaged only £50 for each disabled man. Given that the maximum war pension for a single ex-enlisted man (100% disability) in that year was £2 per week (excluding the economic pension) this indicates that the average disability assessment was only 50% for permanently pensioned men. The provision of vocational training was therefore aimed at the majority of disabled men who were ‘fortunate’ enough to be perceived as not totally incapacitated.

Individual responsibility was seen as the basis of vocational training and wider rehabilitation by all the Dunedin witnesses to the Barton Commission. Dr. Thomas Fergus believed that the purpose of training was to move men from dependence to independence as far as their disability allowed, while Dr. Marshall Macdonald tempered this view with his statement that no medical examination of a man could reveal an ‘indication of the man’s goodwill, desire to work, mental outlook, personal habits and general reaction to his environment’. Dr. Ernest Lyth commented to the Commission ‘“wishbone” has taken the place of “backbone”, and external assistance is required to stiffen the will.’ He distinguished partially disabled men into two categories - triers, and non-triers - and identified ill health, prolonged hospitalisation, unemployment, and the economic pension as the primary causes of dependency. Furthermore, he held that the men were reaching an age where new occupations could not be readily learned so that any new training would be required to be simple or similar to a previous occupation.

Doctors believed that the dependency connected with overhospitalisation was related more to psychological addiction to treatment than to the physical effects of war service. Both


54 AJHR 1929. H18, p.3.

55 NZNA T65 1 Evidence of Dr. T. Fergus presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 1/11/29.

56 NZNA T65 1 Evidence of Dr. W. Marshall Macdonald presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 30/10/29.

57 NZNA T65 1 Evidence of Dr. C. E. W. Lyth presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 31/10/29.
Lyth and Dr. Marshall Macdonald expressed fears concerning the dependency producing effect of institutions upon disabled men, Macdonald claiming that institutions were ‘becoming the curse of this country’. \(^{58}\) Dr. J. Renfrew White commented upon the problem of prolonged hospital treatment attributing it to the effects of economic stress upon both the mind and the body\(^{59}\), while Dr. A. R. Falconer took this interpretation a step further. By pointing out that there was no medical distinction between disability caused by war service and that in civilian patients, he intimated that the concerns of rehabilitation were in effect those of industrial society. Falconer called for a National Institute of Psychology and Physiology to address the issue of all occupational and industrial efficiency.\(^{60}\) Lack of medical distinction between the disabilities of ex-servicemen and the incapacity of civilians threatened to negate societal gratitude for the self-sacrifice of men during wartime by ignoring the experience of the men and the role it played in how they perceived their disabilities. Doctors, frustrated by their lack of success in cure, interpreted psychological dependency amongst disabled servicemen upon the profession as a cause rather than a symptom of men’s problems.

Part of the basis of this misunderstanding lay in the liminality of the returned soldier. Because his war experience was generally radically different from those involved in his rehabilitation, as they had mostly remained in New Zealand or worked in Base Hospitals overseas, a gulf existed in which doctors, politicians, and the public were required to base their expectations of treatment largely on a received mythology of combat experience. Censorship of the press during the war had meant portrayals of battle emphasised the heroism of the soldier and downplayed or totally deleted the horrific conditions that men experienced. The association of disabled men first, with a sense of national and martial achievement within the Empire, and second, with gratitude for the self-sacrifice made in that achievement did not seem to equate to the situation of men in post-war society. Confusion in the minds of the medical profession, the DRCS, the military, and the state with regard to the role of occupational therapy and vocational training reflected this polarity of experience. Occupational therapy was based on the function of nurturing a man back to health because society owed him this care out of gratitude for his self-sacrifice. Vocational training reflected society’s economic desire to return men to their pre-war lives. However, it lacked adequate comprehension of the difficulties presented by the men’s experience. In vocational training employment was the key to rehabilitation.

Unemployment was therefore seen as the major impediment to successful rehabilitation. ‘Idleness’, claimed Macdonald, ‘affects the mental state of a man and that reflects his physical

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\(^{58}\) NZNA T65 1 Evidence of Dr. W. Marshall Macdonald presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 30/10/29.

\(^{59}\) NZNA T65 1 Evidence of Dr. J. Renfrew White presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 30/10/29.

\(^{60}\) NZNA T65 1 Evidence of Dr. A. R. Falconer presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 25/10/29.
condition. The longer a man is out of employment the more he is apt to deteriorate.\(^{61}\) The payment from 1923 of an additional war pension for economic hardship was seen by Macdonald as 'a premium on idleness' as it was punitively adjusted if a man gained any temporary employment and therefore encouraged dependency on the state. Police surveillance of the employment position of 'economic' pensioners was also seen as undermining of a man's self esteem leading to a dissolute existence.\(^{62}\) Vocational training, it was hoped, would offer a transition between dependence and independence, between disability and the economic reality that men faced once discharged from medical institutions. In doing so, it sought to create useful citizens brimming with self worth. As the report of the Commission claimed there was 'among a very large body of men... a strong desire to know the security of life and the self respect that \textit{can only} be associated with steady work.'\(^{63}\)

Some rhetoric made links between the needs of industrial efficiency and the virtues required for war. A. J. Gordon commented in 1933 that to overcome the inferiority complex disabled men suffered relative to their fitter and younger counterparts it was necessary to arouse 'the competitive and combative spirit of the men'.\(^{64}\) The values seen as part of soldier identity were perceived then as part of the solution to the problems of disabled men. The Commissioner of Crown Lands for the Otago District, N. C. Kensington, evoked the 'digger spirit' at the Barton Commission in his vision of disabled soldiers working in a farm colony:

\begin{quote}
Under active service conditions a spirit of true comradeship prevailed, and the selfish wish of the individual was subordinated to the interests of the whole. I see no reason why such a spirit should not be revived among the men who tried it, practiced it, and found that it was good.\(^{65}\)
\end{quote}

Views that industrial society subordinated the individual to the economic need of the whole were naturally analogous to the concept of martial self-sacrifice for the protection of that society. Both emphasized individual responsibility and effort as part of the group in terms of disciplined co-operation. Both emphasised the protection and support of the 'family' unit whether that was defined as the nation, dependents, or fraternal brotherhood. An unrecognised distinction lay in peacetime society's emphasis on competition and hierarchy between members of the group as well as with competitors outside the nation whereas wartime experience focused upon solidarity for survival and its egalitarian quality for men within the ranks.

\(^{61}\) NZNA T65 1 Evidence of Dr. W. Marshall Macdonald presented at the Ex-soldiers' Rehabilitation Commission, Dunedin dated 30/10/29.

\(^{62}\) \textit{Ibid.}


\(^{65}\) NZNA T65 1 Evidence of N. C. Kensington presented at the Ex-soldiers' Rehabilitation Commission, Dunedin dated 31/10/29.
This connection struck at the heart of masculine stereotypes and the popular perception of New Zealand as an agrarian country. Jock Phillips has shown in *A Man's Country?* the relationship between the pioneering virtues of masculinity - physical and emotional hardiness, mateship, and ingenuity - and the creation of a code of martial masculinity within New Zealand society.\(^66\) By the process of medical selection the soldier represented all that was sturdy in the New Zealand male. The rural populism of Massey’s Reform Party with its emphasis on the pioneering spirit of the small land holder and its attacks on effeminate parasitic urban life embodied this ideal of the soldier into the politics of rehabilitation.\(^67\) The Discharged Soldiers Settlement Act of 1915 aimed to place the paragon of the country’s manhood on the nation’s crowning glory - the land. Some returned men certainly held the same values. One man wrote to the DRSA in 1937 about the ingratitude of the youth of the nation that if it had not been for the men of the first NZEF ‘there would be no exorbitant wages for workers; nor sustenance for jazz fans who won’t leave the towns nor work.’\(^68\)

Social perception of the relationship between pioneering and martial stereotypes and the reality experienced by disabled men on the land was mixed. N. C. Kensington commented to the 1929 Commission that a number of seriously disabled men had gone into sheep farming, and through their above average ability, resourcefulness, and self confidence had been highly successful.\(^69\) In 1919, *Quick March*, reviewed a book entitled *Physical and Occupational Rehabilitation for the Maimed*. The author, R. N. Castle, claimed that the land offered the wounded the best chance for an easy and happy life ‘as in agriculture all movements are less complicated than in most other callings.’\(^70\) The Moa Seed Farm run by the Repatriation Department embodied this belief and the unbridled optimism of men like David Tannock in the future of placing disabled men on the land. By 1929, government officials were however, less convinced. R. B. Tennent, the Otago and Southland Field Superintendent for the Department of Agriculture, stated to the Barton Commission that he was dubious about utilising the services of disabled men in primary production which he felt required able bodies, sound knowledge, and ample finance.\(^71\) In April 1932, the Minister of Lands wrote to the Minister of Pensions about the results of the DSS Act: ‘I am of the opinion that it should not be an

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69 NZNA T65 1 Evidence of N. C. Kensington presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 31/10/29.


71 NZNA T65 1 Evidence of R. B. Tennent presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 31/10/29.
economic proposition as far as the state is concerned to attempt to establish partially disabled men on small farming allotments'.

The Dunedin witnesses to the Barton Commission reflected this lack of unanimity regarding the ideal solution for the vocational training and employment of disabled men. Some furthered the agrarian mythology by advocating a farm colony with an attached industrial department where disabled men could be productive under economically sheltered conditions. Dr. Marshall Macdonald had articulated a similar scheme to his 1929 submission in October 1920 in a letter to the DGMS, Brigadier General Sir Donald McGavin. He had argued for a farm where neurasthenics would be treated with work, a moderate supply of beer or wine, and interesting recreations. The scheme, in his mind, offered men who wished to help themselves a good opportunity to recover, and could be extended to include epileptics, tuberculous, and limbless men. David Tannock proffered seed farming and sylviculture as potential activities for disabled ex-soldiers despite the earlier failure of such schemes. Dr. Ernest Lyth drew his vision from the United Kingdom, where sanatoria had been successfully combined with small factories for disabled men in the Preston Hall and Papworth Village schemes, but he feared that in New Zealand it would be too much like another institution, and his individualism made him urge the establishment of small ‘hygiene’ factories in close touch with local hospitals. R. B. Tennent called for men to be trained in light industry while those involved in the old Repatriation Department argued for subsidized employment in manufacturing. All of the testimonies intimated that the disabled man had a duty to work reflecting individual responsibility to the community, and all them called for a return to the conditions of training that had existed prior to 1922 when government had accepted more responsibility for training and economic circumstances had been better.

The long term failure of vocational training was then one of imagination. The emphasis placed in rehabilitation on individual responsibility and independence partly reflected a vision of pioneering masculinity, but it also intimated the duty of men to provide for their dependents and so regain their manly self respect. Martial masculinity and masculine citizenship were part of the same concept that involved a protective male identity. However, the same ideological links between martial masculinity and civilian masculinity that favoured individualism, self-help, and non-interference in the lives of individuals by the state partly formed the basis of the breakdown of the pact. When combined with a time of international economic depression, the

72 NZNA SS7 ACC2765 11/5/9 Memo Minister of Lands to Minister of Pensions, dated 7/4/32.
74 NZNA T65 1 Evidence of David Tannock presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 29/10/29.
75 NZNA T65 1 Evidence of Dr. C. E. W. Lyth presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 31/10/29.
76 NZNA T65 1 Evidence of R. B. Tennent presented at the Ex-soldiers’ Rehabilitation Commission, Dunedin dated 31/10/29.
state, groups and individuals involved in rehabilitation were unable to resolve a conflict between men whom they associated with masculine ideals and the reality that saw the same men deprived by social and economic circumstance of the personal power required to change.

SUMMARY

Between 1919 and 1939 the nature of vocational training offered in the pact of rehabilitation did not undergo any major transformation in terms of the type of instruction given or the basis on which that care was provided. The activities of the E & VT Branch of the military, the ‘after-care’ section of the Repatriation Department, and those offered by Miss Miller of the DRCS were not substantially different. Nor did the DSRL make any radical change to the traditional basketwork, leatherwork, and agricultural training emphasized in vocational training. The leatherwork and woodwork factories established by the League merely represented an extension of the ideology of vocational training into employment. Except for the DSRL, all these bodies appear to have been torn over whether the work should be therapeutically or employment based, and the implications this held for the meaning of rehabilitation. In the end, at least the DRCS considered the training fulfilled both functions reflecting a compromise between the gratitude implicit in the Society's convalescent care at Montecillo Home and societal desire that men be prepared for economic reality. The continued difficulties disabled men experienced with regard to overhospitalisation, changing disability, and economic hardship further reflected the contradictions and inadequacies of the pact, particularly those embodied in state non-involvement. Under pressure from the NZRSA, the government was forced to investigate the problem in the Barton Commission of 1929 leading to the establishment of the DSRL in Dunedin in 1931. However, as societal rhetoric of vocational training and rehabilitation was phrased in terms of the duty of disabled men to work, individual responsibility, masculine self esteem created by employment, and lack of distinction between war and industrial disability, the overall pact of rehabilitation contained inherent contradictions between martial self sacrifice and a desire for the civilian industrial efficiency of 'disabled' men. While both aspects relied on a protective concept of masculinity allied to individualism through backward looking agrarian discourse, this alliance also negated recognition of martial masculinity. Neither the economic position of the country nor the position of disabled men equated to the ideology held by those involved in the pact of rehabilitation.
CONCLUSION
SOLDIERS OF YESTERDAY

Soldiers of Yesterday,
How are you faring?
Soon we forget
When the red terrors cease;
Paint you in pictures
Of glory and daring
Leave you to starve
In the white days of peace.¹

Failing health associated with chronic disability and ageing meant that the ‘white days of peace’ had not been easy for the disabled ex-servicemen of Otago and Southland. By the close of the 1930s, there were more ex-servicemen in Dunedin medical institutions than there had been since the height of Defence Department medical treatment during the early 1920s. In October 1938, thirty-three men were patients in Dunedin Hospital whereas, in 1929, the number of ex-servicemen in that institution had averaged twenty men.² At the sanatorium at Wakari, six ex-servicemen were receiving treatment during October 1938 compared to an average of four men during 1925.³ Finally, the total of sixty-four men resident in Seacliff Mental Hospital during 1936 was more than double the total of thirty-one men in the institution during 1926.⁴

Ill health also claimed the lives of many ex-servicemen during the interwar period. In 1939, the NZRSA estimated that the life expectancy of the average returned soldier was 53.2 years compared to 59.14 years for their civilian counterparts.⁵ Of the fifty-six men sampled, twelve died prior to 1939. The ages at which these men died ranged from 29 years to 63 years. Their average age at death was 44 years. Ten of the twelve deaths were related either to pulmonary tuberculosis or to cardiac conditions.

Between 1919 and 1939, the societal rehabilitation pact was based upon a world view that accepted limited state involvement in the wider society. State provision of medical care, convalescence and vocational training reflected this. From 1919 to 1922, the Defence

² DRCS 3, 31/10/38.
³ Ibid.
⁴ DRCS 2, 25/1/26; DRCS 3, 3/3/36.
Department undertook the medical care, convalescent care, and vocational training of disabled servicemen in conjunction with the Hospital Boards and voluntary bodies (such as the DRCS) who would be eventually expected to meet the needs of ex-servicemen. The transition of financial responsibility for the care of ex-servicemen from Defence Department to the Pensions Department in 1922 further emphasised the ad hoc basis of rehabilitation in general. Under the new arrangement, all ex-servicemen, bar the most severely disabled, were expected by the state to utilise their remaining economic capacity in a rehabilitation system designed to encourage individual responsibility and self sufficiency rather than the adequate support of men maimed by war. Men who were unable to achieve these ideals were forced to rely upon patriotic funds and the welfare activities of the NZRSA and DRCS. This in turn placed pressure upon these bodies to meet the needs imposed upon them by inadequate state provisions. Yet, how did the experience of disability incurred during war service interact with the rehabilitation pact to affect men’s identities?

Men’s experience of disability was in part a product of the level of medical knowledge and the existence of adequate therapeutics based upon this. The limitations of medical treatment defined the long-term physical symptoms that disabled ex-servicemen endured. The after-effects of GSW, along with the chronic and fluctuating natures of pulmonary tuberculosis and war neurosis left many men permanently impaired. In the case of the latter two conditions, medical diagnosis also imposed a societal stigma upon the sufferer. Consumptives were feared by the community due to the infectious nature of the disease while men suffering from war neuroses were also made outcasts due to the hereditary taint associated with their conditions and misconceptions about madness in the wider society. The combination of limitations in medical treatment and societal stigma meant that tuberculosis and war neuroses were particularly debilitating for their sufferers.

Chronic disability resulted in a discontinuity between the prewar and postwar lives of men resulting in a fragmentation or disordering of identity. Disabled men were required to give up valued activities such as sporting pursuits while they also often found that their previous employment and other life skills no longer suited their impairment. While these men attempted to be independent, ill health, frequent hospitalisation, and unemployment placed financial and emotional stresses upon disabled ex-servicemen and their families. In these circumstances some men became disillusioned about their ability to fulfil their duty to be independent and economically productive members of society.

This disillusionment was in part countered by the gratitude for martial self-sacrifice embodied in the pact of convalescent care. During the 1920s and 1930s, the DRCS provided convalescent care for disabled ex-servicemen at the Society’s home at Montecillo estate. From 1925, with the acceptance of ‘Red Cross Charges’, the admission criteria for the Home was based upon social gratitude for all men who had shown a willingness to defend their society during times of war. Furthermore, the daily activities of the Home reinforced the soldier identities of the residents and through this validated the function they had fulfilled for society during wartime. The provision of military histories for the library, visits by military officials,
and the placement of a machine gun in the grounds of the Home all reinforced a collective soldier identity.

The formation of this collective identity was as much a product of the actions of ex-servicemen themselves as it was a result of the actions of the DRCS. The brotherhood the DRSA fostered amongst ex-servicemen through the ideals of duty, self-sacrifice and comradeship embodied in the 'digger spirit' represented a transformation of the masculine culture of wartime to a civilian function. The transformation of these values was based upon the liminality of the ex-serviceman, the difference of experience that separated returned men from others members of society by a perceived common experience of wartime. The emotional ties this experience created between men meant that the ideals of wartime could be ritualised in a manner that gave strength to the survivors of the conflict. For disabled men, the acceptance of their impairments as honourable scars, as symbolic of duty fulfilled and the value of their personal self-sacrifice, meant that the discontinuity to identity caused by disability was to a large extent counteracted by the support of other men.

The liminality of experience amongst ex-servicemen that produced collective identity however, also limited the success of rehabilitation overall. As state policy-makers, doctors, and those involved in patriotic relief organisations had no direct experience of war experience the societal expectations involved in rehabilitation reflected a received mythology about the men whom they sought to aid. Linkages between masculine pioneering values and the agrarian nature of New Zealand society combined with societal beliefs about individual responsibility, self-help, and the importance of work in maintaining masculine self-esteem, framed the rehabilitative provisions available to ex-servicemen. While the values embodied in the 'digger spirit' empowered many disabled ex-servicemen, they were also interpreted by the wider society as analogous to the demands of social and economic masculine citizenship. When combined with the harsh economic circumstances of the country during much of the postwar era, the dichotomy between the perception and experience of ex-servicemen and those involved in their rehabilitation meant that the effects of war service in a social context were profoundly emasculating.
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SS 5 5/21251 G. C. Fache Commissioner of Pensions 1889-1929
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SS 7 11/5/9 Disabled Soldiers Re-establishment League - Dunedin Branch
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NEW ZEALAND DEFENCE FORCE HEADQUARTERS, WELLINGTON

Personnel Files for Fifty-six First NZEF Men

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NEW ZEALAND RETURNED SERVICES ASSOCIATION, WELLINGTON

War Pensions Appeal Case File
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SECONDARY SOURCES: PUBLISHED


**UNPUBLISHED**


