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Negotiating Infant Welfare: The Plunket Society in the Interwar Period

Maureen Hickey

A thesis submitted for the degree of
Master of Arts
at the University of Otago,
Dunedin, New Zealand

May 1999
Abstract

This thesis considers the Plunket Society during the interwar period. The Plunket Society, a voluntary infant welfare organisation in New Zealand, was established in 1907 to 'help the mothers and save the babies'. Plunket pushed motherhood into the public sphere, providing advice on 'scientific motherhood' through a home visiting scheme, mother and baby care centres and advice literature. This thesis is concerned with the process by which the Plunket Society became the contested domain of infant welfare reformers, nurses, the medical profession and the Health Department in the interwar period.

This thesis provides an institutional history of the Plunket Society within three intertwining themes: the Society's relationships with the state, the medical profession, and the development of its own organisational structures. It studies the impact of the Government's endorsement of the Plunket Society in the 1920s and 1930s, particularly the benefits and limits of closer relations with the Health Department. From its establishment the Society relied on Truby King's authority and this thesis traces the internal politics of the Plunket Society in a period of transition from the charismatic leadership of its founder to a more bureaucratic system by the end of the 1930s. At the same time - and complicating the period of transition - medical research on infant health developed rapidly and New Zealand's child-health specialists challenged the Society's artificial infant feeding prescriptions and dominance over infant welfare in the interwar period. King's methods had become institutionalised by the 1930s and this, combined with the limits of its internal structures, shaped the Society's response to pressure from the medical profession to modernise its methods.

This thesis concludes that despite considerable internal upheaval, and external pressure from the Health Department and the medical profession, the Plunket Society's prescriptions and services changed little over the interwar period. Despite constant challenges the Plunket Society grew into a truly nationwide organisation which dominated infant welfare in New Zealand in the interwar years.
Acknowledgments

Having the opportunity to thank everyone who helped along the way must be one of the pleasures of finishing a thesis. My debts are many. Dr Barbara Brookes pointed me towards this topic and later acted as my supervisor along with Professor Erik Olssen. I am grateful to them both for their amazing forbearance, good humour and especially their speed at editing in the final stages of this thesis.

The Plunket Society kindly allowed me open access to their archives, held at the Hocken Archives. The fabulous Hocken staff, especially David, Kirsten and Louise, have provided a friendly, professional service in a great environment. Alison Midwinter shared her comprehensive knowledge of the Plunket archives and pointed me towards the best sources (in the most obscure places). I also appreciated the assistance of the staff at National Archives in Wellington, who were unfailingly patient with a stranger to their system.

The ever changing and ever expanding Caversham 'crew', especially Shaun, Jeff, Hamish, as well as all the 'residents' of the History postgraduate suite and indeed the History Department have at various times encouraged, listened, scoffed, shared resources and ultimately supported me through the research and writing process. My thanks also to Bill, Asma, Vernon, Pete, and everyone else who have so generously offered their spare room or couch at various times.

Over the period I've worked on this thesis many friends and flatmates have offered both crucial support, and often welcome distraction and I am grateful to them all. Special thanks to Margot and Michelle who have always listened and, when needed, given me a new perspective. Penny Isaac and Megan Cook have shared their thoughts on history, Plunket, the Depression and many other topics, as well as their experiences of the writing process. They have inspired and motivated me, provided practical assistance in countless ways, and been great friends.

My family have put up with this thesis for a number of years and have supported me in a myriad of ways. Thanks to Shaun (for his great e-mails), Rae (for explaining breastfeeding to me), Isaac, Alli, Brian, Luke, Jake, Delwynne and Jordan, whose support and interest has been much appreciated. Thanks also to Jo, Gary, Tessa, Amy and Rory for sharing their home and the final stages of this thesis with good cheer. My father Denis Hickey saved me from becoming an infant mortality statistic when I was born and I am immensely grateful for that, and for his encouragement in the early stages of this thesis. Finally my mother Eileen Hickey's consistent emotional and financial support has sustained me throughout my university life. Because I have enjoyed the freedom to return home to complete parts of this thesis she has, at
times, literally lived with it (and shown great tolerance at the inevitable disruption to her life). Her encouragement and support have been an inspiration and I appreciate her contribution to this project.

Thank you all.
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# APPENDIX A

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Where articles include more than one subject, they have been classified according to the dominant theme

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1. The theory and application of techniques. In the 1990's there are more articles on electronic records issues, most of which have been included in this category.
2. Includes articles on practical applications, usually of conservation or other technical matters.
3. Includes articles on historical surveys, professional development and obituaries.
### Abbreviations

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<td>Appendix to the Journals of the House of Representatives</td>
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<td>CBR</td>
<td>Crude Birth Rate</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
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<td>MLC</td>
<td>Member of the Legislative Council</td>
</tr>
<tr>
<td>MP</td>
<td>Member of Parliament</td>
</tr>
<tr>
<td>NZBMA</td>
<td>British Medical Association (NZ branch)</td>
</tr>
<tr>
<td>NZJH</td>
<td>New Zealand Journal of History</td>
</tr>
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<td>NZMJ</td>
<td>New Zealand Medical Journal</td>
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<td>NZPD</td>
<td>New Zealand Parliamentary Debates</td>
</tr>
<tr>
<td>RNSHWC</td>
<td>Royal New Zealand Society for the Health of Women and Children</td>
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INTRODUCTION

I.

In the twentieth century mothering and the welfare of infants has become a public health matter, of interest to both the medical profession and the state. In 1905, when Dr Truby King publicly turned his attention to New Zealand’s infant mortality rate, the largely private work of mothering began to be redefined as a public matter of national importance. Highlighting the threats posed by high maternal and infant mortality rates and a falling birth rate to the future of the nation as a solution to the problem of a seemingly degenerating society. In 1907, with the assistance of his wife Bella, he drew together a group of wealthy Dunedin women to form the first branch of the Plunket Society. Over the next two decades Plunket contributed to a process in which children came to be defined as 'social capital', national assets whose health and welfare in early life would shape the future of New Zealand society. Infant health and welfare was on the political agenda.

Almost a century later, in an era when mothering is undervalued and the dominant economic philosophy positions children as individual rather than community assets, it seems timely to examine the history of one of New Zealand’s most pro-natalist institutions, the Plunket Society. In 1993 Linda Bryder pointed out that ‘little attempt has yet been made to analyse the relationship between the society and the government’s agent, the Department of Health, or the society and the medical profession’. This thesis attempts that analysis for the interwar years. It places the Society within a social and political context, while acknowledging

1 The issue was first officially expressed in New Zealand five years earlier by the Chief Health Officer, Dr James Mason. He commissioned a short pamphlet on infant feeding and baby care, distributing thousands of copies in the following years. Derek Dow, Safeguarding the Public Health: A History of the New Zealand Department of Health, Wellington, 1995, p. 65.

2 In the period studied in this thesis the formal title of the Society is ‘The Royal New Zealand Society for the Health of Women and Children’ but ‘Plunket Society’ was also officially used. ‘Plunket’ came from Lady Victoria Plunket, wife of the Governor-General, who lent her name, social influence and considerable organising energy to the Society in its early years.


its organisational history. It is specifically concerned with the process by which the Plunket Society became the contested domain of women reformers, nurses, the medical profession and to some extent the state in the 1920s and 1930s. The conflicts between these groups determined both the nature of the services offered to women and their babies by the Plunket Society and perhaps ultimately their effectiveness.

Between 1919 and 1939, Plunket matured organisationally and came to dominate infant health provision in New Zealand. Its structures were formalised and the positions of nursing director and medical director developed. The integration of Plunket's ideology into Health Department policy in the 1920s is a striking example of the close ties between voluntary welfare organisations and government in early twentieth century New Zealand. In the late 1920s and 1930s advances in medical knowledge introduced new challenges in its relationship with the medical profession.

The Society's history invites a multifaceted approach, and medical history, welfare history and social history are intertwined here. Although this history is not comparative, an outline of developments in the international infant welfare movement is included where necessary. New Zealand doctors who undertook postgraduate training in infant health overseas bought back techniques and ideas which challenged the hegemony of the Plunket movement in the 1930s. It is only by evaluating the Plunket Society in its international context that we can grasp the uniqueness of some of the Society's organisational structures in this period and the extent to which Plunket was a distinctively New Zealand institution. Plunket's commitment to universal, free care of infants provided by nurses, in particular, created tensions with doctors seeking to establish the pediatric specialty in New Zealand. Finally, advances in medical knowledge, especially in infant feeding, are crucial to the Society's history in the interwar period and the hitherto neglected medical context is included.

A recent explosion of international historical interest in the contribution women made to the development of 'maternalist' state welfare policies challenges us to examine the relationship between Plunket and the state. Most of this work concentrates on the provision of cash benefits

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7 These titles were later amended to nursing adviser and medical adviser.
8 Tennant, Children's Health, The Nation's Wealth, p. 4.
for mothers and children but the United States infant and maternal welfare scheme has also been considered in this context. The basic argument is that women had more influence in shaping maternalist welfare schemes in 'weak' states such as the USA or Britain than in 'strong' states such as Germany or France. Much of this scholarship presents maternalism and paternalism as opposites, but in New Zealand the support of paternalist governments for the Plunket Society suggests paternalism and maternalism were seen as complementary constructs within the developing welfare state. This thesis examines state support for Plunket in terms of the 'mixed economy of welfare' in which voluntarism was integral to the provision of welfare. It also puts women's activism in the Plunket Society within a wider context of contemporary concern about demographic shifts, advancements in medical knowledge and the development of New Zealand's public health system.

The local historiography of infant welfare is, in New Zealand terms, reasonably developed. Recently there has been a revival of interest in the Plunket Society as historians respond to 'the orthodox and accepted view of Plunket - and by extension infant welfare' derived from Erik Olssen's critical analysis of the Society's prescriptive ideology, published in 1981. The emergence of women's and gender history has introduced new perspectives and Olssen's article (for many years the only scholarly analysis of the Plunket Society) has been criticised for concentrating on King at the expense of the women involved in the Plunket Society. Recent historical analysis has emphasised women's ability to exercise agency in their dealings with the Society. Elizabeth Cox, for instance, has argued that '[t]he focus that studies of the Plunket Society have traditionally placed on Truby King has obscured the impact of these women in the development of the Plunket Society's childcare message, and also the impact of their organisational skills on the Society.' Bryder, suggesting a framework for reinterpreting the Plunket Society between 1920 and 1950, argues the necessity of moving 'away from a view of the Plunket Society and King as synonymous, and [seeing] Plunket as an evolving institution responding to broader social changes.' Recent historical writing about Plunket has been preoccupied with the view from the 'grassroots level' and 'the relationship between Plunket and

11 Lewis, 'Gender, the Family and Women's Agency', p. 39.
13 Lewis uses the term 'mixed economy of welfare' to make the point that in Britain welfare has always been provided by the state, the family and voluntary organisations, see Lewis, 'Gender, the Family and Women's Agency', p. 40.
14 Linda Bryder, 'Perceptions of Plunket: Time to Review Historians', p. 97. Olssen's article is 'Truby King and the Plunket Society'.
15 Cox, p. 99.
16 Bryder, 'Perceptions of Plunket', p. 102.
the women it served.\textsuperscript{17} This type of analysis is a reaction to the dominance of the 'view from above' and is intended to counter the tendency in more general histories to 'discuss the Society as a form of social control over women without exploring this idea in any more depth'.\textsuperscript{18}

Plunket was a large, hierarchically structured organisation with opportunities for participation at many levels. One of the assumptions of this thesis is that women exercised agency in their day to day dealings with the Plunket Society, at all levels. Prescription, for example, did not necessarily mean practice. It was, after all, the mothers who decided whether to access the Plunket system, who chose whether to implement the Society's teachings.\textsuperscript{19} Equally, the women of Plunket's Central Council exercised agency, shaping the Plunket Society through their support and interpretation of the ideals of 'scientific motherhood' expounded most publicly by Truby King. In concentrating on the behaviour of the Society's Dominion Council, the state and the medical profession this thesis provides an account of the national context in which the experiences of the Society's branches and the women they served can be placed.

The Society and the man are not easily separated, and in part the interwar years are significant because they include the height and the decline of Truby King's power within the Society. This thesis suggests a complex understanding of the multiple roles played by King in the Society and the changing nature of the Society's relationship with him in the 1930s. It looks at power relations within the Society and the structures for making and changing the Society's policy. I will argue that King was dominant within the Society, shaping its prescriptive ideology and directing relations with the state and the medical profession. This reached its zenith in the 1920s when Truby King and by extension the Plunket Society ideology was coopted into the Health Department bureaucracy, and then began to unravel as his health deteriorated in the 1930s. The Society was ill equipped to cope without Truby King's medical authority and struggled to adjust to the demand for medical changes in the 1930s.

II.

\textsuperscript{17} Bryder, 'Perceptions of Plunket' p. 99; Cox, p. 14.
\textsuperscript{18} Cox, p. 9, (footnote 34) tracks the influence of this type of analysis in general histories such as Sandra Coney, 'To Help the Mothers and Save the Babies', in Sandra Coney (ed.), \textit{Standing in the Sunshine}, Auckland, 1993, pp. 64-66 and Sue Kedgley, \textit{Mum's the Word: The Untold Story of Motherhood in New Zealand}, Auckland, 1996. More recently, Helen May's \textit{The Discovery of Early Childhood: The Development of services for the care and education of very young children mid eighteenth century Europe to mid twentieth century New Zealand.}, Auckland, 1997, ch. 6 shows the same influence.
\textsuperscript{19} It is worth noting that although women exercised choice in accessing and using the Society's services, complex power relations are involved. As Annette Beasley's work as shown even today when parents have access to many different childrearing philosophies, rejecting the advice of perceived 'experts' involves some emotional trauma; see 'Breastfeeding and the Body Politic' in \textit{Women's Studies Journal}, 14, 1 (1998), pp. 61-81.
Although this thesis concentrates on the interwar period an understanding of the Society's ideology and the social context in which it was developed is useful. Chapter one gives an overview of medical knowledge about infant mortality in the early twentieth century and looks at the social and political context in which infant health became the focus of public attention in the 1900s. The systems that Plunket set up to publicize 'maternal responsibility' are outlined and their effectiveness critically evaluated. The impact of the ideology of 'scientific motherhood' on the nature of services and solutions offered to infant welfare problems is also examined.

Chapter two covers from the end of the First World War to Truby King's retirement as the Society's Medical Director and the Health Department's Director of Child Welfare in the late 1920s. It was a decade of rapid growth for the Society. Plunket rooms popped up all over the country, the nursing staff grew and the Society co-operated with the Health Department in a scheme to provide ante-natal care. This chapter looks at the Society's negotiation of infant welfare provision with both the Health Department and the medical profession in the 1920s.

The Plunket Society entered into a decade of change and uncertainty after Truby King's resignation as the Society's chief medical officer. Chapter three deals with the beginning of a transitional process within the Society, between 1928 and 1933, as it began to organise for a future without Truby King. It discusses the development of a new constitution and the appointment of first Dr Thomas Derrick and then Dr Martin Tweed as Medical Directors. At the same time the Society began to feel the impact of a growing interest in paediatrics by some members of the medical profession and this chapter outlines the start of a debate over the Society's infant feeding methods. The impact of the Depression and the Society's funding by Government and the Karitane Products Society are also covered in this chapter.

Chapter four focuses on problems within the Society signified by the resignation of the Director of Plunket Nursing, Anne Pattrick, in November 1933. This internal dispute raised questions about the Society's organisational structure. Branches opposed to Pattrick's resignation were concerned about the lack of democracy and transparency shown by the Dominion executive and argued that the nursing side of the Society's work was being downgraded.

Finally chapter five examines the Society's increasingly tense relationship with a vocal group of paediatricians between 1934 and 1938. Critical of both the Society's infant feeding methods and the independence of the Plunket nurses this group gained influence as the Society's Dominion Council lost confidence in Dr Tweed as its medical director. This chapter argues that the Society's reliance on Truby King in medical matters left it struggling to cope with medical criticism in the late 1930s. The appointment of Dr Helen Deem as Medical
Director, the first professional advisor in the Society's history not directly chosen by Truby King, provides an appropriate endpoint.
CHAPTER 1

SETTINGS AND SOLUTIONS

...the problem is - given a certain quality of science, how has that science been brought into context with the people, by what class of persons, by what institutions and with what effect.\(^1\)

In the early twentieth century the Plunket Society brought science into the lives of New Zealand mothers and children. It offered mothers a modern system of childrearing, based on 'scientific motherhood'. In accepting that system, white New Zealanders also accepted that motherhood had become a matter of public concern. Plunket's health program was shaped by both the social and material confines in which it developed. Plunket’s prescriptive ideology emerged, as Olssen has argued, in response to anxiety about societal changes particularly about the role of modern women and motherhood.\(^2\) But if reformers' social and political outlook was influential so too were the limits of scientific knowledge. Olssen dismisses the Society's medical advice as 'sound and sensible'; in doing so he subsumes the medical to the ideological and social.\(^3\) This chapter argues that locating the Society within its medical context gives a more balanced understanding of the Plunket Society, and clarifies the social and cultural context.

An oft quoted Plunket Society claim was that 'the fundamental principles upon which the work of the Society is based are unalterable' and this chapter establishes these basic principles and teachings.\(^4\) The context in which the organisation's ideology, prescription and services developed provides a necessary background for understanding the Society in the interwar period.

I.

Attitudes to infant mortality shifted significantly in New Zealand in the first decade of the twentieth century. When the Department of Public Health was established in 1901 infant mortality was not a key public health issue. In fact there seemed to be reason to celebrate. New Zealand consistently had the lowest recorded infant mortality rate in the world during the late nineteenth century, by a significant margin. Between 1896 and 1905 New Zealand’s average national annual infant mortality rate was 77, compared to 149 in France and 147 in England and

\(^2\) Olssen, p. 8.
\(^3\) Olssen, p. 19.
Wales. In addition although infant mortality fluctuated from year to year and between urban and rural areas, the national rate had shown a general downward trend since it peaked at 126 in 1875. The causes of this decline were not clear and even if health officials had wanted to specifically target infant mortality the medical profession had few effective weapons against the major causes of infant death, prematurity and infant diarrhoea. Medical officials could do little more than track the fluctuations in infant mortality and comment on the possible causes. It was only as politicians began drawing attention to New Zealand’s ‘high’ infant mortality rate, that what had previously been considered a relatively good health statistic was reinterpreted as a problem. By 1907, when the first branch of the Plunket Society was established, infant mortality was becoming the subject of considerable public concern. What prompted this interest in infant mortality and how did it and more broadly, infant welfare, come to be seen as major health and social problems in the mid 1900s?

The shifting meaning and increasing importance placed on the infant mortality rate was partially a response to growing international interest in infant mortality and its impact on national life. The new fervour with which infant mortality was studied and discussed by politicians, the medical profession and potential reformers in most western countries can be traced to the popularity of social darwinist ideas about ‘the struggle for existence between nations’. The contemporary belief that only the fittest, largest and most efficient countries or empires would survive and prosper in the new century sparked a widespread preoccupation with population statistics and eventually the preservation of infant life. The nature of population problems varied from country to country. The French, anxious about a rapid drop in the birthrate and the military threat posed by neighbouring Germany, worried that depopulation would leave the country open to external threat and diminish their international political position. French women were thus exhorted to bear more children to stop their country sinking ‘to the rank of a fifth-rate power’. In contrast, Ailsa Klaus has shown that the public in the United States were more concerned about the internal effects of immigration on the ethnic

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5 New Zealand Official Year Book, 1908 p. 273. The infant mortality rate refers to deaths in the first year of life per 1,000 live births. The French rate may be understated. M. Watson claims that international infant mortality rates were not strictly comparable because of different definitions of still births. France, Holland and Belgium classified babies dying within two days of birth as stillborns and excluded them from infant mortality figures, 'Infantile Mortality and Infant Feeding', Preventative Medicine Dissertation, Otago University, 1935, p.1.
8 The French birthrate declined rapidly from around 1800 becoming the subject of academic and political attention from the late 1860s. Ailsa Klaus, Depopulation and Race Suicide: Maternalism and Pronatalist Ideologies in France and the United States’ in Koven and Michel, Mothers of a New World, p. 189 and 194.
9 Milne, pp. 1-2.
balance than their birth rate. In 1903 President Roosevelt declared race suicide the most immediate problem facing the United States and reformers concentrated on "race betterment". English politicians, commentators and reformers also worried about racial fitness. Publicity about the poor standard of recruits during the Boer War seemed to indicate national degeneration, heightening alarm about the declining birthrate and a late nineteenth century rise in the infant mortality rate. In Australia where a large, white population was believed to be vital to the future productivity and security of both the nation and the Empire, the declining birth rate was a looming threat.

Strands of this discourse were evident in New Zealand as politicians and reformers began to focus on population issues. The long term drop in the birth rate was particularly concerning. By the turn of the century the non-Maori population was in the midst of what demographers now describe as a health transition. In effect between the 1870s and the 1930s epidemiological changes combined with a series of social, cultural, and behavioural shifts saw the country's demographic pattern change from high mortality and fertility to low mortality and fertility. While the positive effects of these shifts are obvious in retrospect, at the time the implications seemed entirely negative. Contemporary concern focussed on the speed and magnitude of the fertility decline: the crude birth rate of the non-Maori population fell 44 per cent between 1876 and 1901. Politicians took little cheer from slight rises in the birth rate in the early 1900s and the falling infant mortality rate (see Table 1) was generally ignored. Rather the Attorney-General, Dr J. G. Findlay, warned that if the birth rate continued to drop New Zealand could become 'like France - a rich country with a declining population'.
Table 1. Non-Maori crude birth rates (CBR) and infant mortality rates (IMR): absolute change between quinquennia, New Zealand, 1871-1940

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The falling birth-rate was conceptualised as a 'menace', a threat to population growth, national efficiency and imperial strength. In a 1904 letter to the Daily Express in London New Zealand’s Premier, Richard Seddon, outlined the issue in imperial terms:

In the younger colonies of the Empire population is essential, and if increased from British stock the self-governing colonies will still further strengthen and buttress our great Empire.... it is clearly undesirable that the colonies should become populated by the inferior surplus of peoples of older and alien countries.

The possibility of a legal influx of 'race aliens', was remote because New Zealand operated a de facto white immigration policy. Nevertheless immigration laws were tightened. In 1907 the Prime Minister, Joseph Ward, introduced legislation aimed at having 'the purity of our race maintained in our country' by restricting Chinese immigration. The Asian races by dint of their own population growth were believed to present the biggest threat, whether by immigration or invasion. The threat that they would seek new, emptier, lands like New Zealand for their 'surplus' people to settle by force could only be countered by population growth.

Politicians also conceptualised the falling birth rate in terms of national efficiency, productivity and power. Static population figures threatened industrial growth and the economic

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17 The figures are for non-Maori only because registration of Maori births and deaths was not compulsory until 1913. Maori infant deaths were not included in the national infant mortality rate until 1950.
18 Dr. J. G. Findlay, *NZPD*, vol. 140, 1907, p. 635.
19 Cited in Matrheus, p. 24.
20 *NZPD*, vol. 142, 1907, p. 838.
progress of the nation. Edward Tregear, the Secretary for Labour, warned that industry would shrink and eventually disappear if more workers were not found. The nation’s future, if the fertility decline was not checked, was bleak. But if the potential impact of a population decline was alarming it was the changing social patterns and behavioural mores behind the fertility decline which drew the most political comment.

‘[O]bservation and statistics' suggested women were intentionally avoiding maternity by using preventative devices. This wilful use of contraception, although not yet widespread, intensified conservative anxiety that the pursuit of higher education and paid employment before marriage was encouraging young women to reject domestic life. This fear was heightened by the growing numbers of young women opting for office or factory work over domestic service. Only the most liberal viewed fertility regulation as a positive byproduct of ‘education and enlightenment’, more typically it was believed to indicate ‘greed, love of enjoyment and a cowardly fear of natural responsibilities’. These selfish qualities were particularly attributed to the middle class women believed to be at the forefront of artificial contraception usage. Working class women were less culpable. J. G. Findlay argued that the desire to avoid the responsibilities of parenthood ... was mostly confined to what was known as the more comfortably off classes - it was forced as a necessity on the workers. Most politicians agreed financial pressure on ordinary families was increasing. Urbanisation with its attendant higher rents and household costs, together with low wages and rising child rearing costs were thought to be incentives for delayed marriage and fertility restriction, by whatever means, among the working classes. In short, contemporaries feared the birth rate was declining because ‘The rich will not have children, and the poor dare not.’

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24 Although the precise details of fertility restriction remain sketchy there is evidence to support some of the contemporary analyses of the trends behind the fertility decline. Modern demographers speculate that the increasing education and employment opportunities commentators were so wary of may well have contributed to women delaying or avoiding marriage and motherhood. Falling nuptiality - only 54% of women aged between 25 and 29 were married in 1901 compared to 81% in 1878 - certainly accompanied the shift to smaller families and Sceats and Pool suggest this was a primary factor in the pre-1890s fertility decline, Sceats and Pool, pp. 183-186. Improving maternal education may have contributed to the infant mortality decline, see J. Hobcraft, ‘Women’s education, child welfare and child survival: a review of the evidence’, *Health Transition Review*, 3, 2 (1993), pp. 159-175 and A. Gursoy et al, ‘Forum: Parental education and child mortality’, *Health Transition Review*, 4, 2 (1994), pp. 183-229.
28 *NZPD*, vol. 144, 1908, p. 331.
The reasons for the declining birth rate seemed clear enough but effective policies to arrest the trend eluded New Zealand's politicians. Banning artificial contraception had already been considered. In 1901 R. J. Seddon introduced a Bill aimed at preventing the sale of artificial contraceptives but it was withdrawn, for reasons which remain obscure, before it reached the debating chamber.\(^{30}\) In any case, politicians recognised that the issue was more complex than just the increasing use of contraceptive devices and Parliament continued to debate methods for encouraging parenthood over the next decade.\(^{31}\) In the meantime the focus of debate shifted from the birth rate to infant mortality.

Internationally politicians and reformers were concentrating on preventing infant mortality as a panacea to the effects of declining birth rates. Saving infant lives promised the same result as an increase in the birth rate: population growth. Australian officials had extended the brief of the 1903 New South Wales Royal Commission into the Decline of the Birth Rate to include infant mortality.\(^{32}\) Infant ill-health also threatened national efficiency. The British government's Inter-Departmental Committee on Physical Deterioration concluded that 'diseases in infancy yearly enfeebled thousands and condemned them to sickly and unproductive lives'.\(^{33}\) In New Zealand the general health and welfare of children also came under scrutiny. Children were increasingly seen as the nation's 'best asset', on whose health and welfare the social, moral and economic future of the nation depended.\(^{34}\) By 1904 Seddon had broadened his focus from the birth rate to infant mortality on the grounds that 'to bewail the want of a proper natural increase is pure hypocrisy unless we do something substantial in the way of saving the infant-life that is born into the colony'.\(^{35}\) For Seddon the issue was simple: 'if we lose our children we are losing our population'.\(^{36}\) Even New Zealand's comparatively low infant mortality rate was too high.

Seddon stimulated public discussion by distributing a paper, the *Memorandum by the Rt. Hon. R. J. Seddon, Prime Minister, on Child-Life Preservation*, to 750 community groups in 1904. It was a pragmatic eleven point proposal to encourage maternity and prevent infant death, particularly targeting those most obviously at risk such as illegitimate babies. Seddon suggested such wide ranging reforms as improving maternity care\(^{37}\), preventing the

\(^{30}\) Mattheus, p. 20.
\(^{32}\) Mein-Smith, *Mothers and King Baby*, p. 32. The Commission's key findings on the causes of infant mortality were printed in the *New Zealand Official Year Book*, 1905, p. 253.
\(^{33}\) Meckel, p. 102.
\(^{35}\) Cited in Mattheus, p. 24.
\(^{37}\) Mattheus argues convincingly that Grace Neill, Assistant Inspector in the Department of Hospitals, Asylums and Charitable Institutions, was the driving force behind the provisions to improve maternity care in the *Memorandum*, Mattheus, p. 21.
concealment of births, infanticide and babyfarming, providing some free nursing care for the sick, setting up 'day-homes' for children of working mothers and establishing 'infant-nursing homes and foundling hospitals'. He received feedback from women's groups, church groups, farmers' organisations, unions, health and welfare workers, the medical profession and members of the public. Seddon hoped to use the memorandum as the basis for a series of legislative reforms but his death in 1906 meant the only direct legislative outcome was the 1904 Midwives Act. Still his emphasis on the national ramifications of infant loss was successful. The infant mortality rate, now redefined as a problem rather than a success, was becoming a matter of public concern.

Dr Truby King, superintendent of the Seacliff Asylum near Dunedin, was also turning his attention to the issue. King's interest in infant welfare was partially inspired by social concern about the impact of modern ideals and lifestyles on national health and efficiency. During his university years he was influenced by the English sociologist Herbert Spencer's theories of the evolutionary order and was one of New Zealand's more outspoken eugenicists, although not the most extreme. While King firmly believed some children were 'better-dead' he was not strictly hereditarian in outlook. He distinguished between those he considered irretrievably marred by hereditary and those able to overcome slight hereditary defects or corrupting environmental influences such as bad feeding, lack of attention or inappropriate education.

Like many of his contemporaries King believed the fertility decline was a symptom of undesirable social changes encouraging women to reject their natural role as mothers. He campaigned for education reform arguing that at best the lack of domestic education in schools left girls entering the workforce ignorant of the principles of household management and healthy mothering and unwilling to enter domestic service. At worst New Zealand was in danger of following the American example of allowing the 'best and most capable girls to impair their physique and render themselves unfit for motherhood' by engaging in higher education. Academic life 'overpressed' young women, who tended when they eventually married 'to be sterile or to have puny children they cannot nourish'. In either case young women were generally ignorant of the importance of their duties in their natural, domestic sphere to the future of the nation. King, like Seddon, thought little could be done in the short

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38 Mattheus, p. 23 and ch. 3.
39 Mattheus, ch. 3.
40 NZPD, vol. 128, 1904, p. 70. This Act introduced the registration and formal training of midwives, and led to the establishment of the first state run St Helen's maternity hospital in 1905.
41 King decreed that 'mentally defective or abnormal' babies were not to be admitted to the Plunket Society's Karitane Hospitals. He argued 'it was the reverse of a kindness to these children and their parents to keep them alive in a hopelessly defective state; because in every sense of the word they were really the "better-dead"', King to Mrs M. Macdonald, 7 January 1933, PS AG7 5-18.
42 King, AJHR, H-7, 1906, p. 10.
term to improve the birthrate but he agreed 'we could do something locally to lower our infant death-rate, and to improve the mental and physical characteristics of our future generations'.

While Seddon can be credited with putting the spotlight on infant mortality it was King who, from his first public lecture on infant feeding in 1905, shaped New Zealanders understandings of the causes of and solutions to infant mortality. As the only doctor publicly speaking about infant health he quickly assumed the status of an infant welfare expert. His background in mental health lent credence to his authority. Politicians lauded him for his belief 'that if you can protect the infant-life even before the infant is born and go on protecting it after it is born there will be fewer cases in the years to come entering our mental hospitals'.

Although he preached that reducing infant mortality and improving infant welfare would have much the same benefits for society as Seddon had, King offered a simpler analysis of the causes of poor infant health. He argued that the core problem was ignorant mothers and the solution was maternal education. While mothering was 'woman's exclusive profession ... the "maternal instinct" needs training as much as any other'. Medical science offered the solution.

II.

By the time infant mortality became a political issue in New Zealand medical researchers in England, France, Germany and the United States had developed a significant literature on the subject. The emphasis was on prevention because scientists had yet to develop effective treatments, or even sound theories of causation, for most infant diseases. Even prevention offered no hope of eradicating a significant proportion of infant mortality. Neonatal deaths (those under one month), usually the result of prematurity, congenital debility or injury at birth, were generally considered non-preventable. Eugenic thought was also influential: deaths caused by congenital debility were generally accepted as a natural weeding out of the unfit. Still New Zealand echoed the international trend of higher infant deaths amongst post-neonatal than neonatal babies (aged between one month and one year) at the start of the twentieth century (see Figure 1.1) and it was these deaths infant welfare experts concentrated on.

The main causes of post-neonatal mortality, such as gastric and intestinal diseases, some respiratory diseases and epidemic diseases, were believed to be environmental and thus preventable. Of these one particular cause of death, diarrhoea (classified as a gastric and intestinal disease), became the focus of health officials' attempts to prevent infant mortality in the early 1900s. As Figure 1.2 shows infantile diarrhoea (represented as 'gastric and intestinal

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43 Cited in Mein-Smith, *Mother and King Baby*, p. 32.
44 King's medical training at Edinburgh University in Scotland also included female and childhood diseases and public health. Milne, p. 19.
46 Rita Snowden, *From the Pen of F. Truby King*, Auckland, 1951, p. 42.
diseases') declined rapidly in New Zealand between 1907 and 1916 and was under control by 1920. Even so, studying the early interest of infant welfare reformers in preventing infant diarrhoea provides important insights into the work of the Plunket Society in the interwar period. The solutions which evolved to prevent infantile diarrhoea shaped the Plunket Society's prescriptions and advice to mothers for much of the first half of the twentieth century.

Figure 1.1

![Graph showing New Zealand Non-Maori Infant Mortality 1900-1940](image)

Source: New Zealand Year Book

Infantile diarrhoea was also known as "cholera infantum", "enteritis" or "gastro-enteritis" and "summer diarrhoea" (which referred specifically to the epidemic levels of diarrhoea common in the summer months) in this period. It drew attention chiefly because it was second only to prematurity as a cause of infant death in the early 1900s. Infantile diarrhoea was also a particularly frightening disease. It struck apparently healthy babies, the onset was sudden and the disease process was visible and predictable. The first sign of the disease was persistent diarrhoea and within eight to twelve days the baby would also begin to vomit. Unable

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47 Doctors tended to use these terms synonymously but until health authorities began using the Bertillon Index of Diseases for classification in 1908 they were treated quite differently for statistical purposes. Diarrhoea and cholera infantum were classed as 'zymotic diseases' (which meant that local health officials had to be notified of any incidence) while enteritis and gastro-enteritis cases were classed as 'local diseases'. The distinction was often unclear in practice and Hugh Finch, the Canterbury District Health Officer, claimed that for statistical analysis the terms gastroenteritis and cholera infantum 'may be regarded as representing the same disease', *AJHR*, H-31, 1907, p. 38.
at this stage to retain any liquid the baby would be in considerable discomfort and would eventually fall into a coma and die. There was little parents or medical professionals could do.

Figure 1.2

Infant Mortality Rate For Principal Causes
1872-1941

Quinquennial Period

Epidemic Diseases
Infantile Convulsions
Gastric and Intestinal Diseases
Early Infancy
Tuberculosis
Respiratory Diseases
Malformations
Other Causes

Source: New Zealand Year Book

48 Dwork, p. 26 and Meckel, p. 42.
Infantile diarrhoeal deaths in New Zealand mirrored the pattern paediatric researchers had found internationally. It was highest in urban areas, predominant in artificially fed babies and its incidence increased during the summer months. The comparatively low national rate of infant mortality hid large variations between the main cities and rural areas. In 1902, when nationally 83 babies per thousand born died before their first birthday, the Auckland rate was 150 per thousand births, a figure 'approaching that of England and Wales'.

The medical profession were uncertain about the aetiology of infantile diarrhoea but the pattern of the disease implicated urban sanitation.

There were two main theories of disease causation available to public health officials in the early twentieth century. Zymotic disease theory, dating from the mid nineteenth century, combined contagionist theory with elements of miasmatic explanations of disease. Disease was believed to be contracted either through contact with an infected person or from exposure to fermenting poisons in the environment, such as those caused by the combination of heat and putrid matter. The advent of the science of bacteriology in the 1860s and the emergence of the germ theory of disease causation challenged zymotic theory. Germ theory linked specific diseases to specific micro-organisms rather than infectious emanations from general environmental filth. It reinforced rather than overrode traditional ideas about the prevention of disease.

Sanitation, long considered the most effective means of preventing the proliferation of zymotic diseases assumed new importance as a weapon against the spread of germs. Monitoring and improving sanitation were key aspects of preventative public health work under the 1900 Health Act. But if germ theory revolutionised understanding of diseases it was a slow process. Wood has argued 'There was no general acceptance of a single "germ theory". The meaning of each microbe and its relation to disease was debated individually. No microbe had been isolated in the case of infant diarrhoea in the first decade of the twentieth century and older theories of disease causation remained influential.'

49 AJHR, H-31, 1902, p. 4.
50 In fact the precise cause or causes of these outbreaks of infantile diarrhoea remains ambiguous. Rotaviruses and various bacteria, such as E. coli, have been suggested. There is general agreement that 'whatever the precise cause...infection probably resulted from ingestion of infected matter and was transmitted by unclean hands, linen or bottles, or through contaminated milk, water, and food'. Meckel, p. 42. See also Mein-Smith, Mothers and King Baby, pp. 38-40.
51 Meckel, p. 16.
55 This supports the revisionist argument that the 'arbitration and assimilation of the germ theory of diseases in the late nineteenth and early twentieth centuries' was more fragmented and less linear then historians have traditionally believed, see N. Tomes and J. L. Warner, 'Introduction to Special Issue on Rethinking the Reception of the Germ Theory of Disease: Comparative Perspectives', Journal of the History of Medicine and Allied Sciences, 52, 1 (1997), pp. 7-15. The quote is taken from p. 8.
With the contagions and mode of transmission of infantile diarrhoea unknown, Health Department officials drew on miasmatic explanations. A combination of hot, dry weather and polluted soil were usually implicated. Auckland's high infantile diarrhoea mortality rate between December 1901 and April 1902, for example, was attributed to 'telluric conditions', as 'a loose porous soil with much organic pollution is the factor which sanitary authorities are agreed on as favouring the outbreak'.56 Two years later R. H. Makgill, the Auckland District Health Officer, explained his city had a higher infantile diarrhoea rate than the capital because 'the best-recognised cause of infantile diarrhoea - pollution of the soil with sewage, &c., - is to be found in Auckland to a far greater extent than in Wellington'.57 Hot weather exacerbated sanitation problems. Frank Ogston, the Otago-Southland District Health Officer, attributed the large number of infant diarrhoea cases in Invercargill during the first quarter of 1904 to a combination of causes including 'the condition of the ditches' and 'hot and dry weather'.58

The Department of Health was also concerned about the sanitation of the milk supply. One contemporary estimate held that over 80 per cent of infants were not breastfed and milk was thought to be a major component of many infants' diets.59 Health authorities regarded milk as a potentially dangerous food. 'Impure' milk had already been implicated as a vehicle for diseases such as typhoid, scarlet fever and tuberculosis. Makgill declared that 'as a medium for assimilating an emanation and for propagating infection there is no food-stuff to compare with milk'.60 Quality varied from area to area but generally the purity of the milk supply could not be guaranteed. The Wellington supply was condemned in 1905 for 'the unsatisfactory condition under which the cows are milked, the general insanitation of the dairies and byres, and the filthy condition of many of the cans in which the milk is conveyed to the city'.61 Even if the sanitation of the dairy was fine the cartage system could be problematic. Milk was generally 'carried in ordinary luggage-vans, and very often manipulated on the open station or public road'.62 Finally, milk might be adulterated, by either unscrupulous suppliers or retailers, before it was sold. Tests on six samples from the Nelson milk supply in 1903 revealed one sample had curdled in transit and four others had been watered.63 Once the milk had reached the household domestic sanitation could be problematic. Makgill complained in his 1905 report that 'it is quite

56 AJHR, H-31, 1902, p. 4.
57 AJHR, H-31, 1904, p. 3.
58 AJHR, H-31, 1904, p. 50.
59 W. E. Collins, NZPD, vol. 140, 1907, p. 632. Dr Collins did not give a source and we can only speculate as to the accuracy of his estimate. At around the same time Dr Agnes Bennett claimed that bottle feeding was uncommon in the state run St. Helen's hospitals, Baby's Welfare: practical tips to mothers, Wellington, 1907, p. 4.
60 AJHR, H-31, 1905, p. 23.
61 AJHR, H-31, 1905, p. 22.
62 AJHR, H-31, 1907, p. ix.
63 AJHR, H-31, 1904, p. 32.
usual to find milk stored in the larder with meat and other foods. Little wonder then that in the summer the milk is often found to contain putrefactive organisms.\textsuperscript{64}

New Zealand medical authorities were aware that infant welfare reformers in Britain, America and the Continent were concentrating on schemes to provide pure milk for infants. Improving the quality of milk had been isolated as a preventative measure because there was a higher incidence of infantile diarrhoea amongst artificially fed babies. In his 1904 annual report the Chief Health Officer, Dr Malcolm Mason, enviously described an English project whereby several local authorities retailed milk for infants which was already 'pasteurised and humanised in bottles of a size and shape somewhat like the ordinary feeding-bottle'. He had little hope of duplicating the scheme in New Zealand; the standard of milk was too variable and Mason could not envisage the milk supply improving until it was placed under municipal control\textsuperscript{65}

Politicians, possibly inspired by the 1903-4 New South Wales Birth Rate Commission's finding that improper feeding was responsible for a large proportion of infant deaths, were also commenting on the link. The problem was not just quality of milk but also what non-breastfeed infants were being fed. While debating the Midwives Bill in 1904 T.E. Taylor claimed that 'Women become mothers of children and do not know anything of the rudimentary art of preparing food for their offspring in the event of their being unable to nurse them naturally.'\textsuperscript{66} Maternal ignorance was the problem. T. Kelly concurred, citing mothers who fed their babies on condensed milk and starchy foods.\textsuperscript{67} He recommended the distribution of leaflets on 'how infants should be fed' to young married women.\textsuperscript{68} Others agreed that education about infant feeding was needed and favoured including it in midwives duties.\textsuperscript{69} The idea lapsed and neither politicians or medical authorities had acted on the link when Truby King became involved.

III.

King entered the public debate on infant mortality as politicians and medical authorities were drawing on the examples set by infant welfare movements overseas and moving their focus from the insanitary environment in a broad sense to individual behaviour. Consequently ideas about how infant mortality could be reduced were changing. In 1904 medical officials and politicians recommended reforming and regulating the milk industry, reforming drainage and refuse removal and even raising 'the condition of the working-classes' by providing 'steady work and fair wages' or 'cheap sanitary homes for the poor'.\textsuperscript{70} Improving sanitation and

\begin{thebibliography}{99}
\bibitem{64}AJHR, H-31, 1905, p. 23.
\bibitem{65}AJHR, H-31, 1904, p. ix.
\bibitem{66}NZPD, vol. 128, 1904, p. 77.
\bibitem{67}NZPD, vol. 131, 1904, p. 481.
\bibitem{68}NZPD, vol. 131, 1904, p. 482.
\bibitem{69}NZPD, vol. 131, 1904, p. 482.
\bibitem{70}AJHR, H-31, 1902, p. 4; AJHR, H-31, 1904, p. 9 and T. Kelly, NZPD, vol. 131, 1904, p. 482.
\end{thebibliography}
reforming the material conditions in which the country’s workers lived was a long term, expensive solution which required government support or funding. This type of reform still featured in political debate around the 1907 Infant-Life Protection Bill but the focus had shifted to maternal ignorance. The logical solution, education in 'scientific motherhood', was not necessarily a cheap option but it was compatible with its proponents social views and aspirations.\footnote{C. Comacchio, ‘Nations and Built of Babies’: Saving Ontario’s Mothers and Children 1900-1940, Montreal, 1993, p. 13.}

King’s initial interest in infant feeding was personal. For many years he had experimented with scientific principles to systematise the process of feeding the livestock on the Seaciff asylum’s 1,000 acre farm. His success prompted his wife Bella (Isabella) to suggest in early 1905 that he use his experience to devise an appropriate food for their newly adopted baby, Mary, who was not gaining weight. King’s interest was aroused and he delved into the international literature on infant feeding. He became convinced that incorrect feeding was one of the main causes of infant mortality in the Dominion. He also found support for his belief that the quality of nutrition in the early years influenced later mental and physical well-being.

King drew on the work of experts like Professor Pierre Budin in France and Dr Thomas Rotch and Dr E. Holt in America to construct his own theory of scientific infant feeding.\footnote{Milne, p. 22-27.} It was science based on ‘Nature’s Laws’. The first principle of his theory was that all mothers could and should breastfeed. We know little about infant feeding before the advent of the Plunket Society but contemporaries thought, or feared, that breastfeeding was declining. Again this was taken as a symptom of the degeneration of modern life. Modern women, especially middle class women, were thought too selfish to breastfeed, put off by the inconvenience and the prospect of putting ‘their figures out of shape’.\footnote{S. T. George, NZPD, vol. 140, p. 660.} Others speculated that the increased athleticism of young women may have developed their ‘muscles and frame at the expense of other organs’, lessening their ability to breastfed.\footnote{W. E. Collins, NZPD, vol. 140, p. 632.} King countered any idea that women could not breastfeed with the axiom ‘every mother can nourish her offspring in the natural way’.\footnote{Snowden, p. 46.} Breastmilk, he argued, was the only perfect food for human babies. Moreover it was every child’s ‘birthright’.\footnote{F. T. King, Feeding and Care of Baby, London, 1921, p. 3.} And, unlike cow’s milk or other common infant foods such as barley water, the hygiene of breastmilk was guaranteed. Breastfeeding was the simplest way to prevent the scourge of infantile diarrhoea.

Where breastfeeding failed King argued that infants fed cow’s milk, chemically modified to resemble human breastmilk, were less at risk of infantile diarrhoea. He adapted
Rotch's method of modifying milk to suit New Zealand conditions and called it 'humanised milk'. In devising humanised milk King was adhering to a theory, propagated by infant feeding specialists since the 1870s, that infantile diarrhoea could be caused by indigestion from overfeeding. King's theories are covered in more depth in chapter two but in short he believed babies fed unmodified cow's milk were overfed protein. This overworked their immature digestive systems causing indigestion and eventually diarrhoea. For breastfed babies the danger was being fed too much milk. An international infant welfare conference King attended in London at the end of the first world war resolved that 'over-feeding of the baby, especially in the first fortnight of life, is one of the commonest and most serious mistakes of nursing mothers, often upsetting the child and leading to the early abandonment of suckling.

Philippa Mein Smith has argued that 'rather than germ theory it was this ancient, physiological conception of disease that blamed diarrhoea on indigestion which justified the feeding routines and timetables popularised in the first half of the twentieth century'. The emphasis King and his contemporaries put on regularity of feeding and the amount to be given at each feed was motivated by late nineteenth century research into the size of babies stomachs and the time taken to digest milk. Dr E. Holt led this research in America, constructing detailed timetables for infant feeding. The explanations derived from this physiological research were resilient. Even after germ theory gained ascendancy, the Plunket Society warned that 'indigestion due to overfeeding, or to unsuitable food or irregular feeding is the main predisposing cause of diarrhoea.'

Routines and timetables were thought to limit the chances of inadvertently overfeeding and enable mothers to ensure their infants' delicate digestive (and mental and nervous) systems were not unduly disrupted. The harmful effects of indigestion were not just physical. King

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77 The term 'humanised milk' is a misnomer. The dynamic nature of human breast milk makes it impossible to duplicate.
78 Mein Smith, *Mothers and King Baby*, p. 45.
79 Harvey Levenstein, "'Best for Babies' or 'Preventable Infanticide'? The Controversy over Artificial Feeding of Infants in America, 1880-1920', *Journal of American History*, vol. 7, no. 1, 1983, p. 82 points out that infant feeding experts had a plethora of theories regarding exactly what made cow's milk indigestible and dangerous to infants in the early twentieth century. While King adhered to the protein theory at various times his peers in America and the Continent focussed on the effects of fat, carbohydrate, sucrose and lactose.
80 Annual Report, 1920 p. 24, PS AG7 1-3-1.
81 Mein Smith, *Mothers and King Baby*, p. 51. The influence of the germ theory can be seen in the emphasis on domestic hygiene and pure milk.
82 This research was inspired by the contemporary practice of giving babies 8 ounce long tube feeding bottles for long periods of time, or every time they cried. J. L. Morse, 'Recollections and Reflections on Forty-five Years of Artificial Infant Feeding', *Journal of Pediatrics*, 7, 3 (1935), p. 305.
83 Morse, p. 306. Plunket initially advocated 2-hourly feeding in the first month, gradually decreasing to 3-hourly feeds in the 5th month, as recommended by Holt. Night feeds were only cut out in the 3rd or 4th month, F. T. King, *Feeding and Care of Baby*, Wellington, 1908, pp. 11-12. The 1910 edition of *Feeding and Care*, p. 9, recommends 3 hourly feeding until the fifth month when it moved to 4-hourly feeds and none between 10pm and 6 am. By the 1920s it was recommending 4-hourly feeding. See Annual Report, 1920, p. 25, PS AG7 1-3-1.
warned that 'early indigestion ... is a prime factor in the vices of puberty and adolescence, besides rendering the individual an easy prey to vice and insanity throughout life'. As Olssen has noted 'submission to the discipline of the clock guaranteed sound health and sound character.' In 'scientific motherhood' King had found and modified an ideology which promised to fulfil both his goals: reducing infant mortality and improving the mental and physical characteristics of New Zealand's future generations.

King did not pioneer the idea that infant mortality could be reduced by educating mothers about 'scientific' methods of feeding and caring for babies, but he did follow his rhetoric with action. He began publicly campaigning about infant welfare in 1905. His lectures got good press coverage and two broadsheets detailing his feeding methods were circulated. He tried to form a committee of doctors to organise public education in scientific methods of infant care, but insufficient interest forced him to drop the idea. Instead he continued his public campaign and hired a 'community nurse', Joanna McKinnon, to work with mothers in their homes, teaching them how to modify cow's milk to his specifications. He also turned his attention to the poor quality of milk in Dunedin and arranged to supply the Taieri and Peninsula Dairy Company with an assistant, who supervised the company's production of humanised milk. The modified milk was bottled and delivered to mothers. By 1907 King was ready to seek the support of the Dunedin community to form an infant welfare organisation. He called a public meeting and in May 1907 the first committee of 'The Society for Promoting the Health of Women and Children', largely handpicked by King himself, was elected. The new Society quickly concentrated on the legislature, campaigning for changes to the regulations governing children in licensed homes in the Infant Life Protection Act. Infant welfare and more specifically the potential benefits of educating women in 'scientific motherhood', was on the political agenda and in the public spotlight.

'Scientific motherhood', as taught by King and the Plunket Society, was education in general household hygiene, scientifically supported principles of child management and infant feeding. King initially tried to provide simple, authoritative advice encapsulated in a list of 10 basic essentials. They were regular fresh air and sunshine, water, breastfeeding for nine months or where this was impossible using humanised milk (modified by the mother in her own home),

85 *AJHR*, H-7, 1910, p. 17.
86 Olssen, p. 7.
87 Milne, p. 39 suggests the Dunedin doctors King approached were preoccupied with an anti-tuberculosis campaign and may also have been reluctant to disseminate their knowledge about infant health to the public.
88 The 'community nurse', Joanna McKinnon, had been a staff member at the Seacliff Asylum but was not a registered nurse. Under King's supervision she quickly learnt the feeding schedules and infant care principles which were to become the Plunket twelve step programme, Milne, pp. 40-43.
89 Milne, pp. 50.
90 Milne, pp. 53-59. The Infant-Life Protection Act also provided for notification of births within 72 hours in a city or borough or 21 days in rural areas. In 1915 the regulations were amended to 48 hours in a city or borough, *New Zealand Official Year Book*, 1915, p. 173.
ILLUSTRATION 1.1  Matron teaching mothers at the Karitane-Harris Hospital, Dunedin. (n.d)
'What Every Baby Needs' condensed 'scientific motherhood' into 12 essentials. These essentials were taught to mothers in Karitane Hospitals, Plunket Rooms and through the Society's advice literature. Source: Plunket Society Collection, Hocken Archives.
non-constrictive clothing, regular and quick bathing, muscular exercise and sensory stimulation, warmth, regularity of all habits (including feeding, sleeping and even defecating by the clock), cleanliness, rest and sleep. From 1913 appropriate mothering and management, which in short meant learning not to spoil a baby, were added to the essential list. Following King's 12 step plan was the key to raising a healthy, well disciplined baby instilled with 'good character' for later life, that is, a Plunket baby.

Despite being presented as a modern solution to the problem of infant mortality, with the added benefits of elevating the status of motherhood and ensuring the physical and mental fitness of the race, 'scientific motherhood' was something of a paradox. Through the thin veneer of science the modern, educated mother was, in almost every sense, the traditional mother of the late nineteenth century cult of domesticity. Traditional gender roles were unaltered. According to Plunket literature fathers, as breadwinners, were 'obliged to provide and maintain the home' while mothers took responsibility for the managing the house and the care of children. The application of scientific rationality to childrearing was presented as a revolution in the household. In reality it endorsed the existing power structure of the family and society while offering reassurance to mothers that they, through science, could ward off infant mortality and ensure the health, happiness and good character of their children.

The construction of mothers as both the problem and the solution to infant illness and consequently infant mortality, set new public standards for motherhood. Mothers became the main focus of reform efforts and reached a new level of importance. Mother was 'the central figure in the home and the health and happiness of the family depend to a great extent on her knowledge and efficiency'. Even in the face of problems such as poor housing and poverty the mother could, with the benefit of education in 'scientific motherhood' reach the required standard of knowledge and hygiene which would protect her child from disease. Responsibility for infant mortality was individual rather than societal. Hugh Finch, the Canterbury district health officer, blamed infantile diarrhoea deaths 'on the mothers, who, from carelessness, ignorance, or selfishness, do not feed their children at the breast, or, on the rare occasions when this is impossible, do not use the best substitutes in the best way'. By 1919 Plunket was making this explicit: 'it is not Nature or Providence that inflicts the curse of summer

91 See Snowden, pp. 117-126 and Mein-Smith Mothers and King Baby, p. 95.
92 Our Babies', Otago Daily Times, 19 May 1935; see Olssen, pp. 13-20 on this point.
94 RNZSHWC, The Care of Babies, p. 5, PS AG7 8-27.
95 The irony was that Plunket invoked collective community action in the effort to educate individual mothers about infant welfare.
96 AJHR, H-31, 1907, p. 39.
The best way for mothers to avoid inadvertently inflicting disease on their infants was to follow the teachings of the Plunket Society.

IV.

Women do not know they are ignorant; therein lies the trouble.98

Lynne Milne has argued that the Plunket Society 'met a need for a national organisation which could give authoritative advice on infant care'.99 Although the growth and success of the Plunket Society affirms Milne's analysis what is unacknowledged is that this need was at least partially created by the infant welfare reformers themselves. In its pioneer years the Plunket Society had two main tasks. The first was to convince the public, and more specifically mothers, that they were dangerously ignorant of the principles and methods of modern motherhood. Having denigrated traditional means of acquiring mothering skills as inadequate and possibly harmful, the Society then aimed to raise the status of motherhood and make it a more desirable option for women, by teaching 'scientific motherhood'. King and his followers wanted to 'make every woman in the community, without any exception, the most competent executive in her own household'. They argued that 'doctors are only casual visitors ... nurses are required, but not for long .... It is the mother who has to have the knowledge. She must know all the simple details: absolutely simple and not beyond the powers of any woman.'100

Those simple details were transmitted to women in a variety of ways. From 1907 a weekly newspaper column, Hygeia, often written by Bella King, propagated the Society's message; by 1913 it was published in about fifty newspapers.101 The Society also published its own literature including King's The Feeding and Care of Baby, a comprehensive and ever expanding guide to bringing up baby the Plunket way. Although we can only speculate as to how many women read and followed King's written advice religiously, the literature itself sold extremely well.102 The 1912 annual report noted that the fifth edition of The Feeding and Care of Baby, sold out all 5,500 copies in a little over a year.103 King's ideas also received state support; he was commissioned by the Government to write Baby's First Months and the

99 Milne, p. 113.
100 King quoted in Snowden, p. 66.
101 Olssen, p. 11. The Society's literature was particularly important in encouraging mothers to breastfeed because Plunket Nurses seldom saw mothers in the first few weeks after the birth. Annual Report, 1908, p. 3, PS AG7 1-3-1, p. 5 notes that Bella King was also responsible for much of the work of disseminating information and correspondence.
102 We do know that Plunket infant feeding methods did not always impress. In 1908 Nora Fitzgibbon, a Dunedin Plunket Nurse, reported being told by a grandmother that 'no doubt humanised milk was a great boon with the nurses to instruct the mothers etc. She considered that a diet of Neave's food with the supervision of nurses would have much the same result', District Nurses Reports 1908, PS AG7 11-2.
103 Annual Report, 1912, p. 5, PS AG7 1-3-1.
Government also distributed his larger work *The Expectant Mother and Baby's First Months* to everyone requesting a marriage licence from 1916.104

The Plunket message was also spread through home visiting by Plunket nurses and mother and baby visits to Plunket rooms, at which mothers were given practical advice. This system was entirely voluntary. New mothers were sent a congratulatory card asking them if they would like the Plunket Nurse to visit. If they agreed a preliminary visit to the home followed at which the Nurse gave the mother one of the Society's books and explained 'how to give the baby the purest and freshest air day and night, how to prepare and how and where to keep its food (if artificially fed), how to bath and dress it, make its bed'.105 These visits also had other practical functions. Plunket nurses, for instance, were known to distribute donated baby clothing to the needy.106 Within a few years branches also began to provide Plunket Rooms where mothers could bring their infants to be seen by the nurse, at an appointed time. This cut down on the nurse's travelling time and saved the mother the inconvenience of long waits. The Plunket Rooms contained 'all that nurses require for the instruction of the mother in the care of herself and the baby'. The function of the Liverpool St rooms in Dunedin was described in that branch's annual report:

Here the ordinary weighing of babies is done, and the nurses teach such matters as the best ways of nursing, how to get rid of “wind”, and how to overcome undue sleepiness during nursing; how to weigh before and after nursing; the use of the breast pump etc.

In this room there are on exhibition a baby’s pram with ventilating Plunket hood, a cradle with which the nurses can teach mothers the best way to make an infant’s bed, a handy mackintosh bath, specimens of simple hygienic (sic) baby clothes etc. Special importance is attached to a series of striking wall diagrams illustrating in a graphic way the essentials for Pre-natal care and Breastfeeding, and showing the health and growth of the baby depend on proper care and attention.107

It is worth noting that neither the systems used to spread the message or indeed scientific motherhood itself were unique to New Zealand. King was, as Mein Smith has noted a 'systematiser'.108 He picked ideas from infant welfare movements internationally which fitted with his own belief system and adapted them to New Zealand conditions. The three thronged approach of the Society's preventative work, that is the advice literature, domiciliary visiting and infant health clinics, was used by infant welfare organisations throughout the western

104 30,000 copies of *Baby's First Month* were printed. Olssen, p. 11. Previous governments had already endorsed the notion health authorities could and should provide childrearing advice. In 1900 when Dr James Mason, the Chief Health Officer, commissioned a short pamphlet on infant feeding and baby care which was delivered to thousands of new parents, Dow, p. 65.

105 Annual Report, 1914, p. 24, PS AG7 1-3-1.

106 Annual Report, 1912, p. 11, PS AG7 1-3-1.

107 Annual Report, 1917, p. 23, PS AG7 1-3-1.

ILLUSTRATION 1.2   Plunket Nurse Weighing a Baby During a Home Visit. (n.d)
Monitoring weight gain (or loss) was an important part of the Plunket Nurses' work.
Source: Plunket Society Collection, Hocken Archives.
world. Neither did King pioneer this approach by himself. Lady Victoria Plunket, the Governor General’s wife and patron of the Society, insisted that the Society’s nurses should be professionally trained nurses and gave them the name Plunket Nurses.109

The Plunket Society also had some distinctively New Zealand features. It established Karitane Hospitals, initially in Dunedin but by the mid 1920s there were five other facilities. These small hospitals were initially established to treat sick babies, but by April 1908 could only take ‘babies suffering from effects of wrong feeding and poor hygienic conditions’.110 They were staffed by honorary physicians, Plunket Nurses and Karitane Nurses.111 As the Society developed it also established ‘mothercraft cottages’ in the hospitals where mothers could take their healthy babies for a few days or a week to get hands on instruction and support with breastfeeding and scientific motherhood.112

Perhaps the most distinctive feature of the Plunket system was the authority and independence it gave to its nurses and subsequently the level of autonomy it maintained from the wider medical profession for much of the interwar period. Plunket Nurses were required to concede to a doctor’s authority if one was involved, but this was usually only in the case of illness because New Zealand doctors rarely saw infants for routine monitoring of health. King and the Plunket Society put infant feeding in the hands of nurses and mothers. This was in sharp contrast to infant welfare clinics in the United States, Canada where doctors presided over the nurses’ work and especially guarded the task of ‘prescribing’ infant feeding.113 New Zealand was a young country with a developing health bureaucracy which allowed the Plunket Society to dominate infant welfare work.

In essence the Society had one supreme medical authority, Truby King, and entry into the Plunket fold was largely dependent on acceptance of his methods. Dr Doris Gordon, for instance, was asked to resign the presidency of the Stratford Branch because she differed with

109 Annual Report, 1908, p. 3, PS AG7 1-3-1. Lady Plunket was also instrumental in founding the Christchurch branch and all of the North Island branches (Wellington, Auckland, Napier and New Plymouth) before she left the country in 1910, Annual Report, 1913, pp. 3-4, PS AG7 1-3-1.

110 Milne, pp. 71-72.

111 Karitane Nurses completed one year training in mothercraft in the Karitane Hospitals and were then qualified to work as live in baby nurses for those who could afford to hire them.

112 The Karitane hospitals were named after Karitane, near Dunedin, where Truby and Bella King first established a home for babies. The babies cared for at Karitane were moved to a house, donated by Wolf Harris, in Anderson’s Bay, Dunedin in 1907, which became known as the Karitane-Harris Hospital. On the establishment of that hospital, which became the training facility for all Plunket nurses see Milne, ch. 4, Bryder, Not Just Weighing Babies, ch. 3 discusses the establishment and work of the Auckland Karitane Hospital. By 1925 the Plunket Society had Karitane Hospitals in Dunedin, Christchurch, Auckland, Invercargill, Wanganui and Wellington. These hospitals were not just for sick babies. Mothers could take their healthy babies there for a few days or a week to get hands on instruction and support with breastfeeding and scientific motherhood, Annual Report, 1929, p. 18, PS AG7 1-3-1.

King on obstetrical practices. Doctors did fulfil a role in the more curative arm of the Society’s organisation, the Karitane Hospitals. The daily medical functions of these hospitals were overseen by voluntary medical practitioners, often of extremely high calibre, but the Karitane Hospital rules only allowed methods approved by Truby King and the Society to be used. In the Society’s first decade this seems to have been uncontroversial; King’s methods were in line with international research and generally accepted.

This is not to suggest the Plunket Society was welcomed uncritically by the medical profession. Certainly doctors around the country had initially been dubious about the need for such an organisation and wary that Plunket was infringing on their territory. There were occasional complaints about Plunket nurses’ overstepping their authority and in 1910 Plunket and the New Zealand Branch of the British Medical Association (NZBMA) agreed on rules to govern the relationship between the nurses and the medical profession. By the start of the first world war Plunket seems to have had the tacit support of many general practitioners and relations between Plunket nurses and their local doctors were, as Linda Bryder noted in the Auckland context, ‘generally cordial’. A census of the branches in 1914 shows that most branches had at least one doctor on their advisory board if not on the branch committee itself. If the doctors themselves were not directly involved their wives usually were; the Westport branch committee boasted five doctors’ wives.

Although King eventually favoured broad based committees with wide representation from all classes of occupations he and his wife Bella actively sought the support of sympathetic doctors and prominent citizens when they toured the country to set up Plunket branches. In 1914 at least, using the occupations of committee members’ husbands’ as an indicator, while rural and small town committees were most likely to have some diversity, committees generally consisted of the local elite. Wives of politicians, newspaper editors, judges, lawyers, runholders, and business men all feature, and their husbands often sat on branch advisory boards. The support of politicians and newspaper editors were particularly crucial to the Society’s early development. The relationship between the state and Plunket is discussed further in chapter 2, but political support was crucial to the society’s growth. For instance the government subsidised Plunket nurses’ salaries and the Kings’ 1913 lecture tour of New Zealand, promoting the Plunket

115 See Milne, pp. 96-101 on the rules and the relationship between Plunket and the medical profession more generally.
117 Twenty-nine branches, not including the Dunedin headquarters branch, replied to the census, giving committee members or their husbands occupations and religious affiliation. Survey of Plunket Branches, PS AG7 2-76. Plunket could claim 72 branches in 1914 but most had been formed within the previous 18 months and the majority did not have their own Plunket nurse.
118 Ibid.
119 The reality contradicted the Plunket Society’s claim that ‘emphasis was laid on the necessity of members being as widely representative as possible’, *Annual Report*, 1913, p. 6, PS AG7 1-3-1.
ideology, was government funded. The enthusiastic response from the public resulted in the establishment of over forty new branches. Likewise the support of newspaper editors gave Plunket ready access to the press, which through the 'Our Babies' columns became a forum for dissemination of its teachings.

The elite nature of the committees did not, as Linda Bryder has pointed out, mean that they were a 'social club for the idle rich'. Many of the women involved were already experienced social campaigners. The first Plunket branches spun off existing women's groups like the Christchurch Mothers Union and the Wellington Society for the Protection of Women and Children. Building the Plunket Society involved a significant investment of time and resources in terms of campaigning, propaganda, fundraising and eventually supporting the work of a Plunket nurse. Committee women became involved at every level and King credited the organisation's success to this. Writing to Bella about the differences between the New Zealand and English infant welfare movements he lamented that organisations were 'patronised, rather than run or supported' by society women in England. He added that 'nothing corresponding to our New Zealand work can be carried out in England'. King believed the more egalitarian nature of New Zealand society and consequently the Plunket Society was the key to success.

Plunket’s approach to infant welfare was intentionally egalitarian. From the outset the Society’s members argued it was a not a charity, but a 'mutual aid' organisation, because ignorance of the importance and functions of modern motherhood was universal. The Society recognised that 'there was as much need for practical reform and "going to school" on the part of the cultured and well-to-do as there was on the part of the so-called "poor and ignorant."' This was a response to the fear that middle class women were rejecting maternity in favour of modernity and unshaping themselves, physically and practically, for motherhood. Out of this philosophy arose two of the defining features of the Plunket Society in this period. The first was, that to ensure universal access to the Society's services it would be free to all. Funding for the new Society would come from membership subscriptions and donations and, almost immediately, government subsidies. This meant, as an American commentator Robert Woodbury noted, that 'mothers in all communities where Plunket nurses are stationed have ... free for the asking, trained and skilled assistance in regard to all matters relating to the health and welfare of their babies.' Secondly to ensure that the Society's nurses would be welcome in all homes the work would remain outside the control of the state.

121 Mary King, pp. 256-257.
122 *Annual Report*, 1926, frontispiece, PS AG7 1-3-2.
123 Plunket offered the first universal and free service in New Zealand’s welfare history.
Propaganda was also a crucial element of the Society's success before the first world war. King, once described as possessing 'a skill in propaganda which would have obtained him high office in a totalitarian State' used statistics to prove the Society produced results.\textsuperscript{125} Infant mortality figures were the measure of success and King ensured Plunket got the credit for declining mortality. The annual statistics were the tangible outcome of the Society's work and consequently the rationale for ever increasing state funding and support from the public. Indeed, King was known to declare that Plunket was the 'one essential cause' of New Zealand's declining infant mortality rate and few challenged him publicly.\textsuperscript{126} The Society's claims were acknowledged in official records. Government statisticians endorsed King's analysis of the causes of infant death by explicitly linking infant death to maternal behaviour. In the 1910 Year Book 'the faults of ignorance and wilfulness' were cited as contributing factors to the infant mortality rate.\textsuperscript{127} There was also international endorsement. In a 1922 report on New Zealand's infant welfare system for the Children's Bureau of the United States Department of Labor, Robert Woodbury concluded that 'the most important influence in the reduction of the infant mortality rate is undoubtedly the work of the Royal New Zealand Society for the Health of Women and Children.'\textsuperscript{128} What seemed obvious at the time is less so now.

Traditionally historians have implicitly accepted King's analysis, arguing that 'the Society achieved success by cutting the rate of mortality for infants between one and twelve months of age.'\textsuperscript{129} More recently the Society's self proclaimed success in lowering the infant mortality rate, always doubted by contemporary medical officials, has been questioned.\textsuperscript{130} Philippa Mein Smith has cynically proclaimed that 'the infant welfare myth lives, especially in New Zealand.'\textsuperscript{131} The 'myth' according to Mein Smith is the popular belief that the Plunket Society and other infant welfare organisations were responsible for reducing infant mortality in Australia and New Zealand in the early twentieth century. While there is insufficient information to draw any firm conclusions about what caused the drop in infant mortality in the early twentieth century the evidence suggests that the Plunket Society's impact was not as significant as it claimed. The infant mortality rate was already declining when the Society was established and even by the end of the first world war the Society's coverage in terms of access to babies, while significant, was not large enough to have been responsible for the total mortality decline. In 1919 43.4 per cent of babies in Dunedin, Christchurch, Wellington and Auckland and 18.6 per cent in the rest of the country. In total 26.4 per cent of all New Zealand babies were seen by

\textsuperscript{125} Obituary, \textit{NZMJ}, 37, 200 (1938), p. 185.
\textsuperscript{126} Mein-Smith, \textit{Mother and King Baby}, p 103.
\textsuperscript{127} \textit{New Zealand Official Year Book}, 1910, p. 359.
\textsuperscript{128} Woodbury, p. 33, PS AG7 8-25.
\textsuperscript{129} Olssen, p. 18.
\textsuperscript{130} By 1930 Health Department officials were questioning the assumption that Plunket was the main cause of the infant mortality decline, see chapter 3.
\textsuperscript{131} Mein-Smith, \textit{Mothers and King Baby}, p.139.
a Plunket nurse. Plunket clearly had some effect on the infant mortality rate, but its propaganda probably overstated its contribution.

Most contemporaries, however, did not doubt the efficacy of Plunket's work. That work was broad. The infant mortality statistics, while comforting, were only one of the reasons mothers used the service and thousands of women served on committees around the country to provide it. The Society continued to prosper, even after the infant mortality rate had reached a stable low of around 3–4 per cent in the 1920s, because women valued having access to free parenting and health advice. A grateful mother wrote to the Christchurch nurses that I always come away from Plunket feeling much brighter and happier and knowing that in you I have someone who understands. To the outside world I have always been "quite well thank you", but when I have not been at my best, you seem to be the only one I confide in. We can also speculate that many women agreed with the primary importance of mothering which the Plunket Society so effectively asserted, even if they did not follow the Society's advice.

The Plunket Society used the war years to consolidate pre war interest in infant welfare and develop a new constitution and organisational structure. Previously the Society had, at the suggestion of Lady Plunket, consisted of a loose federation of branches with the Dunedin branch at the centre. Rapid expansion in the number of Plunket branches prior to the outbreak of war had resulted in the need for a more formal structure to manage the organisation at a nationwide level. The Society's 1917 conference accepted a new constitution and elected a Central Council consisting of Truby King as general president and fifteen general members, including representatives from the Auckland, Wellington, Christchurch, Timaru and Invercargill branches. The new constitution required that seven of the Council members be from the headquarters Dunedin branch and serve on an Executive Committee. This Committee was responsible for overseeing the day to day running of the Society, including the appointment of Plunket nurses and the administration of government grants. In recognition of the increasing administrative workload Gwen Hoddinott was employed as the Society's secretary. When Plunket was again able to consider expansion at the end of the first world war, the structures to develop a nationwide society were in place and the Society's second major growth spurt began.

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132 Woodbury, pp. 51-52.
133 Undated letter from 'a grateful mother', Plunket Nurses' Reports 1933-36, Christchurch branch records PS AG 63-6.
134 Annual Report, 1930, p. 64, PS AG 7 1-3-2.
135 Central Council meetings were held half-yearly in Dunedin or Wellington while Executive Committee meetings usually held fortnightly or as needed.
CHAPTER 2

PLUNKET, THE STATE AND THE MEDICAL PROFESSION 1919-1928

The destiny of the race is in the hands of its mothers. Today our historians and politicians think in terms of regiments and tariffs and dreadnoughts; the time will come when we must think in terms of babies and motherhood.¹

Truby King’s exhortation to focus on ‘babies and motherhood’ was realised in the aftermath of the first world war. The 1920s was a decade of intense pronatalism in New Zealand. Public support for the Plunket Society’s work, already strong, grew as the war and the 1918 influenza epidemic heightened fears about declining national and imperial fitness. Plunket propaganda highlighted the issues: an appeal for financial support for the Karitane-Harris Hospital lamented that ‘40 per cent. of our Men offering for the Expeditionary Forces have been Refused as Medically Unfit’ and linked the Plunket cause to ‘the Advancement of Dominion and the Honour of the Empire’.² As wartime restrictions were lifted, enthusiasm for infant welfare rejuvenated. Within a decade the Plunket Society grew from a fledgling infant welfare movement with a basic infrastructure and a presence in the main towns and cities into a nationwide organisation of more than 70 branches.

It was a period of internal stability. Margaret Johnstone became the Society’s President after the death of Amy Carr in 1919 and held the position until 1933. This chapter examines the Society’s growth in the context of the formalisation of the relationship between Truby King (and by implication the Plunket Society) and the state, the reaction of dissenting doctors and assesses the impact on Plunket’s work.

I.

In 1920 at the Plunket Society’s General Conference C. J. Parr, Minister of Health, summed up the prevailing view and his Government’s response.

Many young mothers do not know how to bring up children, many others are careless and indifferent, and the results are seen today in having so many young people who are only fit for C3 camp. Now I come to the remedy for these evils - the creation of a Bureau or Department of child welfare. Can we get a man with the necessary enthusiasm to direct this campaign and launch the Department of Child Welfare? I think we can .... The man for the job is Dr Truby King."³

With this announcement Parr indicated the future direction of the government’s child health policy. Plunket had been pressuring the Government since 1918 to release King from his mental health work and pay him to concentrate on mothers and babies and the Government

¹ F. T. King, Feeding and Care of Baby, Dunedin, 1910 edition, p. 140.
² Karitane-Harris Hospital Appeal, 20 May 1915, cited in K Duder, p. 32.
³ Annual Report, 1921, p. 5, PS AG7 1-3-1.
wanted to include child health in its Health Department. As Philippa Mein Smith has noted, Parr’s choice of expert for Director of Child Welfare was significant in that it formally aligned the Health Department with both the Plunket Society’s ideology and their chief ideologue. This association between the Government and Plunket was not entirely new; it formalised and extended the existing system.

Margaret Tennant’s argument that ‘voluntary ... welfare organisations have always had close ties to government in New Zealand’ holds true for the Plunket Society. Plunket benefited richly from wealthy benefactors and hardworking fundraisers but it also relied on considerable financial support from the state almost from the outset. When Plunket was established the Health Department had only existed for six years and had few resources to devote to infant welfare. The Plunket Society plugged the gap and effectively defined the provision of infant welfare services. In 1908 the Government agreed to contribute £100 to the Plunket branches in the 4 main centres and £100 to the Karitane-Harris hospital. This was extended in 1909 to a £50 subsidy of each Plunket nurse’s salary. The government’s financial support was ostensibly a seal of approval for the Society’s work but the relationship between state and Society was often fraught with tension. Delays in funding and repeated attempts by the Health Department either to limit the Society’s growth or gain control of its services were the main causes.

The most contentious issue was the amount of input the state could have in Plunket’s policy and work. The Plunket Society fiercely rejected any suggestion that accepting state funding gave the Health Department a right to meddle in the Society’s work. Independence from the state was a founding tenet of the Society, particularly endorsed by its first patron and namesake, Lady Victoria Plunket. Home visiting schemes traditionally had negative connotations associated with charity or state aid or inspection. Lady Plunket argued that Plunket Nurses would have easier and more universal admittance to the nation’s homes if they were not agents of the state. Politicians generally agreed with this stance. In 1920 the Prime Minister, W. F. Massey, told a Plunket delegation that he ‘would very much sooner see the work

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4 Parry, p. 76 and G. Rice, ‘The Making of New Zealand’s 1920 Health Act’, p. 20 suggests the structure of the New Zealand Health Department was modelled on proposals for the British Ministry of Health.
7 Milne, p. 102. Valintine was appointed Inspector General of Hospitals and Charitable Institutions in 1907 and became Chief Health Officer early in 1909.
8 Landmarks in the History of the Plunket Society, undated and unattributed document, PS AG7 5-14. A note, initialled JP, added to this document in 1936 implies it was written in the early 1920s, with comments in the margin added between 1922 and 1924. The facts given correlate with the official sources and the author of the document’s interpretation has been taken to represent the Plunket Society’s perspective of its negotiations with the Government and Health Department pre 1920.
9 Milne, pp. 102-103.
[Plunket] are doing done by a Society such as yours than that it should be done by a Department of the State' because Plunket could do the work 'more sympathetically' than the Government.\(^{10}\)

Plunket's policy of independence meant the Health Department had little input into the Society's and effectively the country's infant health policies or services. This situation was frustrating for some senior departmental officials. As early as 1908 Dr Valintine was advocating a District Nursing scheme for back-block areas, which had the potential to overlap with the Society's work. By 1910 Valintine was openly suggesting the two schemes merge. He wanted 'to submerge the Plunket Society, to make the Society's work as part of "District Nursing", and to bring its Committees under the local Hospital and Charitable Aid Boards'.\(^{11}\) Plunket argued that the preventative focus of its work amongst mothers and babies was vastly different to the District Nurses work with the sick and the two schemes were obviously incompatible.\(^{12}\) Under a combined District and Plunket nursing scheme the systematic, regular visiting of mothers and babies would be replaced 'by tending and waiting on sick people'.\(^{13}\) With the help of 'strong public feeling ... and the practically unanimous support by the Ministry and the Members of Parliament', Valintine's plan was defeated.\(^{14}\)

The Society's funding came through the Health Department's budget which did give the Department a lever to control the expansion of the Plunket nursing system. In 1910, for instance, Dr T. H. A. Valintine, now the Chief Health Officer, bound Plunket not to expand beyond its 8 existing branches and limited the state subsidy of £50 per nurse to a maximum of 16 nurses.\(^{15}\) This policy was reversed in 1912 by the Health Minister, G. W. Russell, apparently against the wishes of department officials.\(^{16}\) Government had decided it wanted the Plunket work to expand and Truby and Bella King embarked on a government-sponsored tour of the country between July and December 1912. They gave 100 public lectures and although they meet with resistance in some areas the tour inspired the formation of Plunket committees in more than 60 towns.\(^{17}\) Within a year thirteen of these new committees had raised sufficient funds to employ their own nurse, bringing the total number of Plunket Nurses to 27.\(^{18}\)

Russell lost his position with the change in government in 1912. The new Health Minister, R. H. Rhodes, negotiated a new funding arrangement with the Society. The

\(^{10}\) General Conference Report, 1920, p. 19, PS AG7 1-5-1.

\(^{11}\) Landmarks in the History of the Plunket Society, PS AG7 5-14 and Milne, p. 104.

\(^{12}\) Milne, p. 105.


\(^{14}\) Landmarks in the History of the Plunket Society, PS AG7 5-14.

\(^{15}\) Ibid. The existing branches were Auckland, Napier, New Plymouth, Wellington, Christchurch, Timaru, Dunedin and Invercargill, Annual Report, 1911, p. 6, AG7 1-3-1.

\(^{16}\) Landmarks in the History of the Plunket Society, PS AG7 5-14. Valintine wanted Plunket and District nursing functions to be confined in country areas, General Conference Report, 1914, p. 15, PS AG7 1-5-1.

\(^{17}\) Annual Report, 1913, p. 7, PS AG7 1-3-1.

\(^{18}\) Annual Report, 1914, p. 3, PS AG7 1-3-1.
Government agreed to subsidise Plunket's fundraising at a level of 24 shillings in every pound, up to £100 for each Plunket Nurse. In return the Society conceded to allow the Health Department to review its annual accounts, have its Plunket Nurses submit monthly reports to the District Health Officer and seek approval for any proposed new branches from the Government. These were not big concessions. The annual accounts were already public documents and forwarding the monthly reports was seen as a public health measure to allow the District Health Officers to monitor any incidence of contagious disease the Plunket Nurses picked up. Gaining Government approval for new branches formalised an existing arrangement.

When Russell regained ministerial responsibility for the Health Department in 1915 he again promoted the Society's work. In 1916 he accompanied King on another tour to promote scientific motherhood around the Dominion, but his support for the Society subsequently waned. Throughout 1917 and 1918 he publicly criticised the funding Plunket received, arguing that branch fundraising for Plunket rooms and cars showed the Society did not need any Government assistance. Further he incorrectly claimed that Plunket was only for sick babies and began advocating an alternative 'Mothers and Babies' scheme, which he proposed the Hospital Boards should run, to educate and assist the mothers of healthy babies. At the same time he began to talk about 'nationalising' the Society, raising suspicion within Plunket that he wanted to take over its services. Russell later claimed he meant 'nationalisation' only in the sense of expanding the Society but his constant attempts to persuade Plunket to allow its nurses to include district nursing in their job description in rural areas suggests otherwise. The Plunket Society discussed its relationship to the state at its 1917 Conference and decided to endorse the status quo. Making the branches directly subject to the control of the Health Department would depress the voluntary element of the work and diminish public enthusiasm and donations. It also rejected the notion that its nurses should undertake both district and Plunket nursing work, arguing that the educative and preventative nature of its nurses' work would be lost if combined with the demands of district nursing.

Again public support for the Plunket Society's work and Truby King's early policy of involving prominent women and men in his health mission was vital to the Plunket Society resisting attempts to subsume its work within the Health Department. Politicians such as J. A. Young, T. K. Sidey, M. Pomare and even the Prime Minister, W. F. Massey, were all active in the Plunket Society to varying degrees and encouraging the Society's development was part of

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19 Government grant for 1912-1913 was £650, Annual Report, 1913, p. 8 and p. 17, PS AG7 1-3-1.
20 Annual Report, 1913, p. 8, PS AG7 1-3-1.
21 Russell went as far as sending a circular to the Hospital Boards suggesting they form committees to look after the health of mothers and babies, Annual Report, 1919, pp. 8-9, PS AG7 1-3-2.
22 Annual Report, 1926, p. 5, PS AG7 1-3-1.
23 Annual Report, 1917, p. 5, PS AG7 1-3-1.
the election platform of the Massey government in 1919.\textsuperscript{25} Massey's appointment of C J. Parr as Minister of Health in April 1920 boded well for the Society. He had been a member of the Advisory Board of Plunket's Auckland branch.\textsuperscript{26}

The restructuring of the Health Department in the aftermath of the 1918 influenza epidemic again raised the issue of Plunket's role within the national health service, particularly the amount of input the Government subsidy allowed the Health Department in Plunket's administration. One of the principal architects of the new legislation, Dr R. H. Magkill, wanted the Plunket Society to be brought under the direct control of the Department 'in common with all other societies of a kindred character'.\textsuperscript{27} King resisted the notion. Instead from June 1920 negotiations centred on the Health Department's insistence that the £4,000 Plunket received annually from the Government for nurse's salaries and grants for the maintenance of Karitane hospitals entitled them to a "proportionate" level of control over the activities of the Society. The Health Department already monitored the Society's work through its monthly returns and annual reports. King challenged the notion that 'further control of supervision' was necessary arguing that the Society worked both efficiently and economically, but conceded that state goodwill was necessary for the continued expansion of the Plunket Society's work.\textsuperscript{28} Two-thirds of its funding came from branch fundraising but without the state subsidy most branches could not have afforded to employ a Plunket nurse or to have acquired and maintained Plunket rooms. The benefits were not one sided, however. King reminded Valintine the department had 'every reason' to provide for the 'further development and the future guidance and direction of the work the Society is doing'.\textsuperscript{29}

King outlined his own proposal for the Society's future relationship with the Health Department to Valintine. He wanted to restructure the Society, lessening his own role so that he could eventually become 'superfluous' to the organisation. King suggested that Dr A. T. M. Blair, a physician on the Seacliff staff with a special interest in children's diseases, be appointed the Society's Medical Director. He envisaged that Blair would be employed by the Health Department in a relatively independent role reporting directly to Valintine. At the same

\textsuperscript{25} Plunket Society \textit{Annual Report}, 1926, p. 6, PS AG7 1-3-2. For instance, Bill Massey was a longtime supporter of Plunket and often attended its conferences. His wife Christina was a Vice President from 1918 to 1928, when she was appointed an honorary Vice President. She was also President of the Wellington Branch for 4 of the 20 years she was a member. T. K. Sidey helped draw up the rules of the Society and his wife Helena, a longstanding member of the Society's Central Council, served as President of the Society during a key period between 1936 and 1937.

\textsuperscript{26} Survey of Plunket Branches, PS AG7 2-76. Parr's wife was also involved in the Auckland branch as a Vice President.

\textsuperscript{27} Plunket Society memorandum bearing on the Appointment of Dr Truby King as Director of Child Welfare, PS AG7 5-12. This is an unsigned and undated document which details King's appointment from the Plunket Society's perspective.

\textsuperscript{28} King to Valintine, 13 June 1920, PS AG7 5-12.

\textsuperscript{29} Ibid.
time the Society would employ Anne Patrck, who had assisted King in establishing the Mothercraft Centre in London, in the new role of Director of Plunket Nursing.

Both the Plunket Society and the Health Department were aware that the Plunket nursing work needed more expert supervision than it currently received. The Health Department monitored the appointment of Plunket nurses and received monthly reports on their work but the nurses' daily work was only supervised by Plunket's lay committees. An exodus of nurses during the war had increased the proportion of Plunket nurses with just midwifery and Plunket training rather than the more extensive general nursing and Plunket training to an unsatisfactory level. Hester Maclean, Matron in Chief to the Inspector General of Hospitals, was concerned that Plunket placed too much responsibility 'on young midwifery nurses with one year's training in maternity nursing, and six months in the care of babies suffering practically only from forms of malnutrition'.

Plunket wanted Patrck to liaise with branch committees, Plunket Nurses and the Karitane Hospitals, a role King described as undertaking 'the duties of advice, guidance, supervision, direction and co-ordination from the more intimate womanly and nursing standpoint'. This included supervising the work and training of the nurses both in the Karitane hospitals and in the branches. King proposed the Director of Plunket Nursing be formally responsible to the Medical Director, giving the Health Department more control over the medical side of the Society's work but at enough distance for the Society to continue to proclaim its independence. By associating the Society's methods with the national health policy King hoped to gain Government endorsement for further expansion of the Society's work.

Valentine and Parr, had other plans. They offered King control of all government functions related to child welfare. The precise status and scope of the position they offered is unclear and by August 1920 confusion reigned. King thought child welfare was to become a new Government department, but Valentine persisted in referring to it as a sub-Department of the Public Health Department. Given that in May 1920 the Health Department's proposal to Parr for its new administrative structure included a Division of Child Welfare it seems unlikely that the Government actually intended to create an entirely new department for child welfare.

30 As early as 1917 the need for a travelling Plunket nurse to oversee the work in the branches had been discussed by the Central Council and a remit endorsing the idea was passed at the 1917 General Conference. They finally agreed to create such a position in July 1919, Central Council minute book 16 July 1919, PS AG7 1-2-1.
32 AJHR, H.-31, 1920, p. 11.
33 King to Valentine, 13 June 1920, PS AG7 5-12.
34 Plunket memorandum bearing on the Appointment of Truby King as Director of Child Welfare, PS AG7 5-12 claims that Parr intimated at a meeting with King and some Health Department officials that he was splitting the Health Department into 2 departments - one dealing exclusively with child health.
evidence suggests that this is exactly what Parr offered King to get him to take the position, however. Throughout the negotiating process in June and July 1920 King, now aged 62, expressed reluctance to uproot himself and his family from their home at Seacliff to undertake a bureaucratic position in Wellington, but he was lured by the opportunity to direct all facets of child welfare. Parr's own announcement to the Plunket Society that King was to launch the Department of Child Welfare, reinforces the impression. At the very least King was under the impression that the new Child Welfare bureau would be 'as near as possible, a new State Department, ranking practically alongside Public Health rather than under it, - that, for official convenience it would be a sub-Department'.

King initially resisted the sub-Department title and informed Parr he would not be able to take the position until confusion over the status of the new position was overcome. King was also piqued that the salary for the child welfare position was only £1000. Parr set about easing King's concerns. He convinced him that the sub-Department title was only for convenience, assuring him he would have 'the necessary independence of status and position without setting up an entirely separate department'. He negotiated a deal whereby King was responsible only to the Minister of Health. The Child Welfare Division's subjugation to the Health Department hierarchy was to be titular only and King was to retain supervisory powers over Dr Wilkins, the Director of the School Hygiene Division. King was particularly concerned about ensuring the power and status of his new position because he knew there was bureaucratic resistance to the new Division. Valintine went out of his way to express his pleasure with King's new role but King knew that the Education Department had fought against the transference of the functions of the existing child welfare officers from their control. He also thought that Dr Wilkins was unimpressed that King's sphere of influence included his own School Hygiene Division. The aims of the new Child Welfare Division, as King defined them, were far reaching and he wanted the power to implement them.

King explicitly aimed to use his new position to extend the health principles he had been advocating for decades to all aspects of New Zealand childhood. He outlined several objectives for the Division to the Minister, which closely resembled the goals and aims of the Plunket

36 King to Parr, 14 September 1920, PS 89-098-68.
37 King to Parr, 31 August 1920, PS 89-098-68.
38 It was also a considerable cut from the £1250 he claimed he received annually for his work at Seacliff and his lecturing on mental health at the Otago Medical School (King included benefits like accommodation and discounted supplies in his salary estimate). It was also £50 less than Valintine earned. King was amenable to earning slightly less than Valintine but thought both of their salaries should be increased, King to Parr, 14 September 1920, PS 89-098-68.
39 Parr to King, 17 September 1920, PS AG7 5-12.
40 Ibid.
41 Valintine to King, 24 July 1920 and Plunket memorandum bearing on the Appointment of Truby King as Director of Child Welfare, PS AG7 5-12.
42 King later complained to Parr that Wilkin's wanted their positions to be on an equal footing, King to Parr, 4 May 1922, PS AG7 5-12.
Society. The first objective was to disseminate 'simple, uniform, authoritative advice' on the home and family to all New Zealanders regardless of station or class. He wanted New Zealand child health policy to avoid the pitfalls of the English infant welfare movement where 'some thirty Infant welfare Centres in the London area alone were found to be giving wildly conflicting and utterly irreconcilable instructions to mothers'. Educating mothers and training maternity nurses, midwives and monthly nurses in Plunket methods were the second and third goals. He wanted to implement and oversee more training for medical students in paediatrics and undertake education programmes for doctors to 'bring about harmonious and consistent teaching and practice with regard to the main essentials for the health of mother and child'. Finally he took on responsibility for conferring with education and dental authorities over child welfare policy and programmes. Parr greeted King's vision for the new Division enthusiastically.

II.

The reaction of the medical profession was more mixed. Dr W Young, the president of the New Zealand branch of the British Medical Association (NZBMA), welcomed the new Division of Child Welfare with the comment that it was the State's duty to 'endeavour to rear healthy children'. The implied expansion of the role and responsibilities of the State to include that which was previously defined as private was universally accepted. But a few remained wary of the alliance between the state and the Society, particularly King's appointment as head of the Division. Dr H. E. A. Washbourn complained that it was regretful that Plunket had 'received the seal of official recognition by the Government without, or practically without, criticism from that class best able to judge of its merits and defects, namely the general practitioner. He argued, in the New Zealand Medical Journal, against King's intention to establish a 'uniform and authoritative' advice about infant feeding. Washbourn considered that there could be no unanimity on the subject amongst the medical profession because work on the chemical and physiological basis of infant feeding was still being developed. Subsequently most doctors based their own practice in this regard on their clinical experience. Accusing the Society of ignoring the role of the general practitioner in infant welfare Washbourn concluded that 'fanatical attempts to browbeat the profession into a doubtful uniformity are seldom made, and when made are not apt to be successful'.

43 King to Parr, 26 August 1920, PS AG7 5-12.
44 F. Truby King, The Application of Science, Simplicity and Economy to the Everyday Practice of Artificial Feeding during Infancy, NZMJ, 20, 95 (1921) p. 35.
45 King to Parr, 26 August 1920, PS AG7 5-12.
46 Mein-Smith, Maternity in Dispute, p. 3.
48 Ibid, p.115.
The reaction of most doctors was muted but it was soon evident that King would never succeed in converting the entire medical profession to his methods. Within weeks of taking up his new position King became embroiled in a debate over his uniform and authoritative advice with Dr Bruton Sweet. Described by a contemporary as 'the first paediatrician to practise in New Zealand', Sweet was a graduate of Sydney University. He worked at the Whangarei Hospital before spending a year at the Great Ormond St hospital for sick children in London. On his return to New Zealand he set up his paediatric practice next door to the Auckland branch headquarters of the Plunket Society in Symonds Street. He later moved to the Lister Building and was also an honorary physician at the Auckland Hospital, specialising in pediatrics.49

Sweet dared to trespass on the Plunket Society's territory by publishing an infant welfare text, *The Management of Infants in Health and Sickness*, aimed at nurses and medical practitioners. Based on a series of lectures he gave to nurses at the St Mary's Home for Infants in Auckland, much of the book actually echoed King's approach to infant welfare. Like King, Sweet concentrated on maternal responsibility for infant health, arguing that 'standing between the infant and the environment was its mother'.50 He also believed in the importance of training in infancy to avoid bad habits in later life, advocated regularity of bowel movements and was firmly against the use of patent foods.

Sweet explicitly complimented much of the Plunket Society's work, including its emphasis on domestic hygiene. He was critical of its infant feeding methods, however. He critiqued King's 'humanised' milk from both a theoretical and a practical perspective arguing it was 'theoretically unsound', 'difficult to prepare' and 'costly'.51 King's response, published in the *New Zealand Medical Journal*, was long winded and explosive. He described the book as 'shallow' and 'full of mistakes', and damned Sweet's attacks on his method as a 'mischievous' attempt to shake public confidence in the Plunket Society's methods.52 He conceded that there would always be diversity of opinion amongst infant welfare experts but insisted on the value of Plunket's mission of establishing broad, uniform advice. King rejected Sweet's alternative feeding system, on the grounds that a baby could not be ideally fed on anything other than breastmilk or 'humanised' milk. An understanding of the theoretical basis of the Plunket Society's 'humanised' milk, as well as the practicalities of preparing it, is essential to understand the debate.

50 G. Bruton Sweet, 'Some Remarks on Infant Feeding. A Reply to Dr Truby King.' *NZMJ*, 20, 96 (1921) p. 100.
52 King, 'The Application of Science, Simplicity and Economy', p. 35 and p. 36.
'Humanised milk' was usually cow's milk, chemically modified to resemble milk from the mother’s breast. This approach to infant feeding was dubbed the 'percentage' method because it was based on manipulating cow's milk to achieve the equivalent percentage or ratio of protein, fat and sugar as in breast-milk. It had become popular in the latter half of the nineteenth century as medical researchers linked high infant mortality rates to poor diets and attempted to develop 'scientific' methods of infant feeding. By the 1890s American medical orthodoxy held that human milk was the standard set down by nature and where breastfeeding was not established paediatricians could and should imitate this standard. Percentage feeding was advocated from by some of America’s leading paediatricians in the 1890s. King combined elements of their theories with the caloric principles favoured by the German feeding expert, Von Reubener and the results of his own experimentation with animal feeding and his work with babies at the fledgling Karitane Hospital in Andersons Bay, Dunedin.

At the heart of the 'humanised' milk theory was the idea that cow's milk had too much protein, a factor King attributed to cows having a higher growth rate in the first few months than human babies. He believed that excessive protein overtaxed the digestive organs and caused the baby's whole system to 'revolt', and argued that 'nature...adjusts the proportion of protein in the mother's milk to the rate of growth of the progeny of the particular species'.

Noting that cow's milk contained nearly three times as much protein as human milk and that the proportion of fat and carbohydrate found in the two types of milk was virtually the same, King argued that maintaining the equivalent protein ratio was the most important factor in preparing humanised milk. To simplify calculations he settled on the figure of 1.4 per cent protein as being digestible by a four to six week old baby and also being sufficient to satisfy the needs of older babies. Sweet disagreed. He drew on recent American and European research to argue that the higher protein content of cow's milk did 'not give rise to harmful symptoms of indigestion' and was in fact 'a matter of little importance'. Instead he contended that

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53 King also provided recipes for the adjustment of dried milk, goats milk and condensed milk.
54 In America percentage feeding was integral to the development of the paediatric specialty. Although it had long been recognised that the artificial feeding of infants was problematic the simple rules of most of the feeding systems in vogue before percentage feeding became orthodox could be easily understood by general practitioners and nurses. Paediatricians claimed the percentage feeding method was a scientific procedure, a claim that was reinforced by the complexity of the method. This justified their argument that infant welfare was a specialised field and that infant feeding was a specialised subject. Harvey Levenstein, p. 80; Sydney Halpern, American Paediatrics. The Social Dynamics of Professionalism, 1880-1980, Berkeley, 1988, pp. 63-65; Meckel, pp. 45-56.
55 P. Mein-Smith 'Truby King in Australia. A Revisionist View of Infant Mortality', NZJH, 22, 1 (1988), p. 31. Halpern, p. 63 points out that there was never unanimity amongst American paediatricians about the percentage method; some like Abraham Jacobi never endorsed the method. Percentage feeding was most popular in America, where it originated, and European infant feeding researchers tended to concentrate on other theories. see Meckel, p. 59.
56 Mary King, p. 203.
57 King, 'The Application of Science, Simplicity and Economy' pp. 34 and 46.
58 It is an indication of the rapid advancements in infant feeding research in the early part of the twentieth century that Sweet was able to use the most recent research of one of King's favoured experts, Dr Holt, to reject King's methods. Sweet, The Management of Infants in Health and Sickness, p. 36.
increasing either the sugar or fat levels in cows' milk beyond an accepted level was more dangerous for infant digestion than excessive protein.

The protein debate was complicated. The medical profession did not have a large body of clinical work to draw on and, while they assured mothers they knew best, were still experimenting with infant feeding in the 1920s. Even so by 1921 King's belief that too much protein was the cause of gastro-intestinal disturbances, leading to diarrhoea and in some cases death, was out of step. The germ theory of disease was gaining ascendancy and the housefly had been suggested as a vector in summer outbreaks of infantile diarrhoea. Also from around 1910 most American researchers agreed that infantile indigestion, with its subsequent consequences, could be caused by protein, fat or sugar. Sweet favoured this view, arguing in his practice he saw a large number of babies, fed on King's methods, who had developed a fat-intolerance from an inability to digest the high butter-fat or milk sugar content in humanised milk.

King thought such suggestions were blasphemous. He was impressed with the naturalistic foundations of percentage feeding and proclaimed God had made cow's milk for cows. If it was not modified to replicate human milk divine punishment, in the form of infantile diarrhoea, would follow. Particularly adept at invoking the forces of nature as divined by the Lord, King argued there were no excuses for anyone, including Sweet, 'flouting Nature, Science, and rational practice' by promoting an alternative to Plunket's feeding regime. While Sweet agreed cow's milk had to be modified for babies he could not support King's beliefs about the effects of protein. The two men could not even agree that there was more than one way to feed a baby.

Sweet did not just critique the theory behind King's methods. He also claimed that at a practical level 'the elaborate methods necessary for the preparation of humanised milk and the cost of its production prohibit its use by the poor', adding that 'it is the infants of this class of the community before all others that we should try to save'. According to Sweet the complexity, cost and time consuming nature of humanised milk turned mothers to patent foods or simply unmodified milk and it would be better to recommend his own, simpler and cheaper method. King rejected this argument out of hand, but to evaluate the validity of their respective claims we need to compare their formulas.

59 Mein-Smith, 'Truby King in Australia', p. 35.
60 Sweet, The Management of Infants in Health and Sickness, p. 83.
61 Rima Apple, Mothers and Medicine, p. 34.
63 King, 'The Application of Science, Simplicity and Economy', p. 35.
64 Sweet, The Management of Infants in Health and Sickness, p. 6.
'Humanising' milk was most complicated in areas where fresh milk, less than 12 hours old, covered and stored at below 60 degrees Fahrenheit, was not available. In those cases the Plunket Society advised the mother to pasteurise the milk by heating it at a constant heat of 155 deg. F. (using a dairy thermometer) for ten minutes. It then had to be covered, cooled quickly and stored in a cool, clean place. Once the milk was pasteurised King originally advised mothers to leave it standing for between four and seven hours, depending on the age and condition of the baby it was for, after which the "top milk" was drawn off, using a spoon or a conical dipper. To lower the protein content of the remaining cow's milk the mother then had to dilute it with water and add a mixture of milk sugar and fat to raise the fat content. By the time Sweet's book was published in 1921 King had developed an emulsion of fats and oils called 'New Zealand cream', later marketed and sold under the name Kariol, which simplified this process. It allowed the mother to add boiled water, lime water, sugar of milk (lactose) and New Zealand cream directly to fresh or pasteurised milk. The boiled water diluted the protein level while the other ingredients restored the fat and carbohydrate content to pre dilution levels. The baby was introduced to humanised milk gradually in amounts calculated by their age although the recipe could be adjusted for individual conditions, under the supervision of a Plunket Nurse.

King believed ordinary New Zealand mothers had both the time and ability to follow his simplified humanising procedure but Dr Sweet was less confident. He advocated a slightly simpler and cheaper infant feeding system. The mother scalded the cow's milk to sterilise it, then diluted it with boiled water and added cane sugar to increase the carbohydrates. Sweet's formula was cheaper because he recommended cane sugar for carbohydrate supplementation. He argued that it was almost as efficient as the milk sugar King preferred and the reduced cost made modified milk more accessible to mothers. The quantity per feed was calculated by multiplying the baby's weight by 1.5, then dividing that by the number of feeds in a given day. This gave the quantity of milk (in ounces) for each bottle. The top up of water and sugar for each bottle was calculated according to a sliding scale. Sweet's formula was simpler and cheaper to prepare, but calculating the quantity was complicated.

It is unsurprising then that Dr Sweet argued mothers who used his methods still needed supervision. He argued that even with his 'simple' mixtures 'ludicrous mistakes are sometimes

66 King, The Feeding and Care of Baby, London, 1921, p. 20. Sweet was also unimpressed with this procedure; he declared he would not 'dare to feed infants on milk so imperfectly sterilised as that recommended by Dr King in "The Feeding and Care of Baby"', see Sweet, 'Some Remarks on Infant Feeding. A Reply to Dr Truby King', p. 109.
67 Sweet, 'Some Remarks on Infant Feeding. A Reply to Dr Truby King', p. 106
68 Sweet, The Management of Infants in Health and Sickness, p. 48. King recommended cane sugar only if milk sugar was not available.
made by mothers whom Nature has gifted with little intelligence'. Sweet's mothers needed both simplicity and supervision; in short they needed to be under the watchful eye of a doctor. Plunket nurse supervision was not adequate: 'the medical man who allows the entire supervision of the feeding of his infant patients to pass into the hands of nurses is not doing his duty or giving the babies a square deal'. Sweet was concerned that the medical profession's acceptance of Plunket nurses prescribing infant foods threatened the traditional demarcation between medical practitioners and nurses. This argument reflected Sweet's training in paediatrics in which the standard view was that artificial feeding was a medical function.

In New Zealand the paediatric specialty did not exist when Plunket was established and when King began to train infant welfare nurses the medical profession did not organise to prevent them prescribing infant food. Subsequently Plunket nurses were trained to 'prescribe' infant feeding, albeit only Truby King's methods. The exact length of their training, which was both lecture and ward based, depended on their nursing qualifications. The minimum requirement for entry into the Plunket nursing course was midwifery training but general hospital training was preferred. General nurses were required to complete a 3 month course at the Karitane-Harris Hospital to become Plunket nurses, while maternity nurses did a 6 month course. King passionately believed the Plunket nurses' training, combined with their constant work with infants, made them experts in their field. He lamented the attitude of doctors who felt they were 'the professional superiors of the nurses, and that there was a certain humiliation and condescension in deigning to recognise and admit that a Doctor could have anything to learn from a Nurse'.

Dr Sweet remained critical of the Plunket nurses' work. In 1928 he complained to the Society's Central Council that the Plunket nurses he dealt with in Auckland interfered in the treatment of babies under his care. He cited examples of nurses consistently criticising his feeding directions to patients, action he damned as 'gross impertinence' and 'libellous'. The Society was willing to investigate such a significant breach of the Plunket nurses' rules but

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70 Ibid, p. 46.
71 Ibid p. 6.
72 The Plunket nurses' rules, established in cooperation with the New Zealand branch of the British Medical Association (NZBMA) in 1910, clarified the lines of demarcation. Nurses had the power to prescribe Plunket feeding formulas, but where a doctor was in attendance they had to seek his consent. *Society for the Health of Women and Children (Plunket Society) Rules*, undated, p. 4, PS AG7 8-22.
73 The New Zealand medical profession was relatively late to embrace paediatrics as a distinct medical specialty, with specific qualifications and its own professional association. As an indicator, while the American Pediatric Society was established in 1887 its New Zealand equivalent started in 1947, see Ludbrook, p. 260. Plunket nursing work overlapped with the paediatric work in that they both defined supervision of the well child, including weighing, measuring and monitoring the health of infants, as their domain, see Halpern, p. 1.
74 The training included 3 weeks out in the district with the Dunedin Plunket Nurses, *Annual Report*, 1922, p. 14, PS AG7 1-3-1.
75 King to Helen Easterfield (later Deem), undated letter, PS 89-098-48.
76 Sweet to Hoddinott, 22 November 1928, PS AG7 11-9.
Sweet was unwilling to give names. Dialogue between Sweet and the Society reached an impasse but the latent tension remained.

III.

The formal alliance between the state and King, signified by the establishment of the Division of Child Welfare was meant to be mutually beneficial. King's ideology had already gained favour with Health Department officials and to have appointed anyone other than him would have risked the wrath of the thousands of men and women involved in Plunket work. His appointment was also official recognition of his international reputation as an expert in infant welfare, linking the Health Department with the internationally renowned Plunket Society. The Government was also hoping to achieve by osmosis what it had failed to do by negotiation, that is tighten the link between it and the Plunket Society. It became clear that the Government hoped this would be a permanent arrangement in 1925 when J. A. Young, argued that King's successor in the Plunket Society 'should be the official in charge of the Infant Welfare Department in New Zealand. The Government should place the services of that officer at the disposal of this Society, just as Sir Truby King's are today'. King, in turn, was anxious to ensure that the State's child welfare policy would be in line with Plunket ideology while retaining the Society's autonomy and protecting its future. His new position enabled him to maintain his role within the Plunket organisation while entrusting much of the professional development of the Society's work to Anne Patrick, the new Director of Plunket Nursing.

King used his position in the Health Department to create a supportive environment for Plunket's work. He actively pursued his goal of achieving unanimity, or as he wrote in an annual report, keeping 'invidious class and professional feelings and distinctions entirely outside the range of [New Zealand's] simple, practical project for "Helping the mothers and saving the babies"'. King stomped on dissenters like Sweet and the Health Department's Dr Michael Watt and Hester Maclean. Watt and Maclean were censured after King and some of the executive members of the Plunket's Central Council protested to Parr they had published articles which were unsympathetic to the Plunket Society. Parr warned them that the Health Department 'owes too much to the sacrifice and public spirit' of the women and men involved in Plunket to let it be said that the Department's attitude was negative. King also interfered with the promotion of patent foods. Glaxo complained to the Minister after King forbade the public health journal to carry its advertisements because they claimed their product was suitable for all infants, without modification. King countered that even Glaxo had to be 'humanised'.

77 General Conference Report, 1925, p. 17, PS AG7 1-5-1. Young was a member of both the Government and the Plunket Society.
78 AJHR, H.-31, 1925, p. 25.
79 Parr memorandum to Valintine, 23 June 1921, PS 89-098-68.
80 King memorandum to Valintine, 30 July 1921. Valintine had encouraged King to act on the issue, Valintire to King, 12 July 1921. Glaxo's lawyers also complained to Parr that King had made negative comments about
The Plunket Society boomed in this environment. The war and the 1918 influenza epidemic had again raised public concern about the fitness of the nation and Plunket, with the backing of the Government, benefited. The Government authorised expansion of the nursing staff to keep pace with demand. In a decade the number of branches more than doubled and the number of Plunket Nurses almost tripled. In 1920 there were 30 residential branches (that is, branches with a resident Plunket Nurse) and 46 Plunket Nurses. They covered the whole country, but the more remote areas like Northland, the West Coast and the southern coast of the South Island were not well served. The 1919 Annual Report noted that establishing residential branches in these areas would mean that 'nearly every mother in the Dominion would be within reasonable distance of a Plunket Nurse'.

By 1930 the Society had achieved its aim of having residential branches within reach of almost all mothers. The expansion was both geographical and physical. Plunket branches and sub-branches proliferated in the suburbs and in rural areas in the 1920s. Plunket Rooms became a source of civic pride, a physical 'tribute to honour and respect to motherhood'.

Behind Plunket's expansion was steadily increasing Government funding. In 1922 Parr increased the annual subsidy of nurses salaries from £100 per nurse to £125. The Health Department also refunded the Society for their nurses' travel expenses, the Railways...
ILLUSTRATION 2.1 The Plunket Rooms, Gore. (n.d)
Plunket branches put considerable effort and resources into fundraising and building Plunket Rooms in the 1920s and 1930s. Plunket Rooms enabled the Plunket Nurses to see more babies, provided public facilities for mothers and were a physical 'tribute to motherhood'. Source: Plunket Society Collection, Hocken Archives.
Department provided free train passes and the Karitane Hospitals relied on substantial
Government grants for their maintenance. With the exception of the train passes all of this
financial assistance came out of the Health Department estimates. Much of this funding
assistance had been in place before the creation of the Division of Child Welfare but the
Government's willingness to fund the Society's growth meant that funding levels increased
significantly.\(^{88}\) In 1914 Plunket got £3,500 in subsidies from the Government; by 1925 its
state funding had reached £30,000.\(^{89}\) King lauded the Government's 'wonderfully liberal
increase in pecuniary support' for the Plunket Society in his Child Welfare Division Report for
1925, but noted even this amount was relatively economic.\(^{90}\) He compared the financial
support the Government gave Plunket with the Australian scheme of a £5 motherhood bonus.\(^{91}\)
A similar scheme would cost £125,000 in New Zealand and such bonuses conferred 'no
necessary benefit on the child and may be dissipated at once by either the father or the
mother'.\(^{92}\) The mix of Plunket's voluntary work and state funding provided an effective, but
cheap, means of supporting motherhood.

Plunket also expanded the scope of its work and developed its standards in the 1920s.
The Plunket nursing work became more professional and more uniform under Anne Patrwick's
tenure. She introduced a uniform record keeping system for the Plunket branch work with
Plunket nurses keeping detailed records on feeding prescriptions and history, height and
weight, home conditions and family history. Baby Record books, better known as 'Plunket
Books' were also introduced in the early 1920s for mothers to keep record of their baby's
progress and the nurse's advice.\(^{93}\) From 1928 all Plunket nurses had to be 'treble certificated'
with Plunket, general and midwifery qualifications, in total over four years training.\(^{94}\) Patrwick
encouraged the professional development of her nurses, by running refresher courses and
arranging provincial meetings for the Plunket Nurses. The Plunket nursing service also
broadened its sphere of interest in the 1920s as the Society tried to encourage mothers to bring
their pre-school children in for health checks and advice.

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\(^{88}\) The Government's financial support did have limits, albeit temporary. Parr had warned the Society that
financial constraints would restrict increases its funding and in April 1923 King complained to Parr that Plunket
subsidies were not coming through, King to Parr, 5 April 1923, PS AG7 5-14.

\(^{89}\) Annual Report, 1926, p. 6, PS AG7 1-3-2.

\(^{90}\) A Government grant of £12,000 in 1925 for Plunket to build a special training facility for maternity nurses at
the Karitane-Harris Hospital accounts for the huge jump in government funding between 1922 and 1925.

\(^{91}\) The Australian Maternity Allowance, introduced in 1912, was equivalent to 3 weeks wages for a factory
worker. It was not a universal benefit: Aborigines, Pacific Islanders and Asians were excluded, Marilyn Lake,
'Mission Impossible: How Men Gave Birth to the Australian Nation: Nationalism, Gender and Other Seminal

\(^{92}\) Untitled address, Truby King, 1924-1925, 890-098-48. King first made this point at the Society's 1915
General Conference, Annual Report, 1915, p. 6, PS AG7, 1-3-1.

\(^{93}\) Central Council minute book, 24 November 1921, PS AG7 1-2-1.

\(^{94}\) In 1934, 79 of the 125 Plunket Nurses were treble certificated, Hoddinott to Keisenberg (Secretary Department
of Health), 19 December 1934, PS AG7 2-256.
There was one major gap in the service, however. Plunket saw very few Maori babies. The need was clear. Ian Pool has pointed out that the Maori demographic transition did not start until around 1945 and in the 1920s Maori infant mortality was high. In 1925 for instance 10.7% of Maori infants died before their first birthday, compared to 4% of non-Maori infants. The main causes were 'epidemic diseases, tuberculosis, respiratory diseases and diarrhoeal diseases.' About four fifths of these deaths occurred after the first month of life, so were during the period Plunket claimed its methods were so successful for. Plunket branches recognised this and throughout the 1920s and 1930s delegates at the General Conference regularly proposed that the Society pay more attention to Maori infants. The remits ranged from proposals that notice of Maori births be sent to Plunket Nurses to proposals that Maori Health nurses be given Plunket training. The remits came from a different branch each time and the wording was different each year but their intention was consistent, and consistently thwarted, by King, Patrictick, Hoddinott or J. A. Young. For instance Young addressed a 1928 Ngaruawahia branch remit that 'Native Health Nurses be given Plunket training in order to teach the work to the Maori race' with a warning that 'any remit to teach Plunket work to Maori's would fail awhile yet', but promised to give it sympathetic consideration. Delegates passed the remit anyway but no action was taken.

Throughout the 1920s and '30s, the leadership of the Society subverted efforts from Plunket's lower echelons that would have resulted in more attention to Maori. It was common for 'authorities' like King or J. A. Young to unilaterally amend branch remits. For example, in 1930 Truby King amended a remit from the Lyttelton branch that the Society pay more attention to Maori infants, to say that more work on the lines of the Plunket work needed to be done amongst Maori. King declared that Maori infant welfare work was the responsibility of the Division of Maori Hygiene. Given that the Government's Native Health Nursing Scheme started in 1911 it is possible that the Government insisted that Plunket not compete directly with this scheme. King was meant to write a pamphlet for Maori mothers in the mid 1920s but, after he still had not produced it by 1927, the Government reprinted Maui Pomare's Ko Nga Tamariki Me Nga Kai Ma Rata pamphlet with an addendum. This is not a reliable indication that King was avoiding the issue, he also failed to complete a textbook for medical students which was due while he was Director of Child Welfare.

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98 General Conference Report, in Annual Report, 1928, p. 65, PS AG7 1-3-2.
99 General Conference Report, in Annual Report, 1930, pp. 72-73, PS AG7 1-3-2. These examples also illustrate the hierarchical nature of the Plunket Society in the 1920s.
101 'Maori Pamphlet - infant feeding 1913-1934', H1 127/30 National Archives.
102 Mary King, pp. 292-293.
Plunket did react to another trend in the mortality statistics. The decline in mortality from infantile diarrhoea meant that by 1920 two thirds of the infant mortality rate was in the neo-natal age group and mostly attributable to the 'early infancy diseases' of prematurity, congenital debility and birth injuries.\textsuperscript{103} In effect neo-natal mortality had hardly decreased since the 1870s. In 1917 King signalled that the Society wanted to put more emphasis on reducing neo-natal infant mortality by 'devoting more attention to advising and helping women throughout the whole of the important epoch in the life of a child preceding its birth'.\textsuperscript{104} The alliance between Plunket and the Government enabled Plunket to put more resources into the prevention of infant mortality in the first month of life.

While the Plunket Society could recognise shifts in the infant mortality pattern it was not well equipped to deal with them. Until 1921 when the Registrars in the four main centres were authorised to send daily notification of births to their local Plunket secretary, Plunket nurses had little access to neo-natal babies. The scheme enabled Plunket nurses to make contact with new mothers and babies in the second week after the birth. It was extended to all branches in 1922 by W. Dowaie Stewart, the Minister of Internal Affairs and a staunch supporter of the Plunket movement.\textsuperscript{105} Despite the Plunket Society's high hopes its nurses still did not see many babies within the vital first month. Statistics for 1935 showed that breast fed babies were first seen, on average, at 4 weeks of age and bottle fed babies at 9 weeks.\textsuperscript{106} The Society's advice literature was still its best mechanism for educating mothers about babies in the first month. The extension into ante-natal work was advanced considerably in 1921 when King got Parr's agreement for 70,000 copies of his pamphlet *The Expectant Mother, and Baby's First Month* to be printed and distributed by the Government. A copy was sent to every married women under the age of 35 and Registrars were also supplied with copies to give to every man applying for a marriage licence.

Internal debate over this pamphlet showed the first cracks in King's relationship with key health officials. Parr, constrained by finances, baulked at the demand made on the health budget for printing and distributing the pamphlet for uncertain results. King was unimpressed by the timidity of bureaucracy and took Parr's questioning of the usefulness of the pamphlet as a slur on his methods. When Parr rejected King's offer to pay for the pamphlet's distribution himself, King complained about his attitude to the Prime Minister.\textsuperscript{107} Parr protested vehemently, claiming he had consistently gone out of his way to accede to King's demands.\textsuperscript{108} The task of preparing each of the 40,000 pamphlets for post was eventually undertaken by


\textsuperscript{104} Annual Report, 1930, p. 46, PS AG7 1-3-2.

\textsuperscript{105} General Conference Report, July 1922, p. 32.

\textsuperscript{106} Central Office Nursing Report, November 1935, PS AG7 2-280.

\textsuperscript{107} King to Massey, 26 July 1922, PS AG7 5-12.

\textsuperscript{108} Parr memorandum to Massey, 11 August 1922, PS AG7 5-12.
volunteers from the Wellington, Hutt and Petone branches, but the relationship between King and Parr was permanently strained.\textsuperscript{109}

It was through attempts to improve the provision of ante-natal care more generally that the limits of the alliance between the Plunket Society and the Health Department were revealed. The Census and Statistics Office had collected statistics on the deaths of women during childbirth since the 1870s but it was only in 1921, after Parr discovered New Zealand had the second highest maternal mortality rate amongst the developed nations that the Health Department made a concerted effort to address this problem.\textsuperscript{110} Parr enlisted King to find the causes and cure for maternal mortality despite his lack of experience in obstetric medicine. With his background in mental health, King was most interested in birth injuries and began to campaign through the Plunket Society's propaganda against 'meddlesome midwifery', characterised by the excessive use of forceps.

In 1924 the Health Department launched a 'safe maternity' campaign at an annual meeting of the Plunket Society using King's slogan 'Perfect motherhood is perfect patriotism'.\textsuperscript{111} King saw Plunket's public link with this new campaign as a commitment on the Society's part to doing absolutely 'everything in our power...to wipe out the vile abuse which has killed so many women, ruined so many others for life and killed and ruined so many children'.\textsuperscript{112} But the Plunket Society and King had substantially less input into the maternal mortality campaign than King had hoped. The campaign's focus, on midwifery training, asepsis, hospital policy and ante-natal care, was developed by Health Department officials. It was in the provision of ante-natal care that Plunket had its most significant role.

Mein-Smith has argued that King, lacking influence over actual childbirth, used his position in the Health Department to 'expand the Plunket Society's role in the preventative aspects of maternal care'.\textsuperscript{113} He certainly capitalised on the opportunities his departmental position provided to promote the Plunket Society's ante-natal service. King believed that safer maternity would naturally lead to an increase in the birth rate and the Plunket Society had been providing ante-natal care, on a limited basis, since at least 1917. His aims were consistent with the Health Department's. Since at least 1909 it had been trying to establish ante-natal services for women, through the St Helen's hospitals, but with limited success. The advantages of the Health Department and Plunket Society cooperating to provide ante-natal care seemed obvious to both parties. The Society's infrastructure of Plunket Rooms and its access to women through propaganda compelled the Health Department to enlist the Society's co-operation in developing

\textsuperscript{109} Annual Report, 1922, p. 5, PS AG7 1-3-1. Parr's tenure as Minister of Health finished in June 1923 and King's friend Maui Pomare took over.
\textsuperscript{110} Mein Smith, Maternity in Dispute, p. 7.
\textsuperscript{111} See Mein Smith, Maternity in Dispute, ch 2, on this campaign.
\textsuperscript{112} King to Mr Hardcastle, sub-editor of the New Zealand Herald, 5 June 1925, PS AG7 5-14.
\textsuperscript{113} Mein Smith, Maternity in Dispute, pp. 9-10.
ante-natal clinics. Financially this decision also allowed the Department to recoup a greater benefit from the funding the Government gave to the Society.\textsuperscript{114} Dr Helen Gurr, was appointed the Department's Officer in Charge of Ante-Natal Clinics and given the responsibility of negotiating with the Plunket branches to train their nurses in ante-natal work and establish ante-natal clinics in their rooms.

Used to significant power and the ability to command a willing team of committed volunteers to action in the Plunket Society, King was becoming increasingly unhappy in the bureaucracy. His daughter, Mary King, champions her father's perspective on his time as Director of Child Welfare, arguing in her biography that his representations were either ignored or given scant consideration. The authorities and powers so necessary for the efficient discharge of his duties were restricted and curtailed, and grave and persistent difficulties were placed in the way of the performance of his duties.\textsuperscript{115}

For their part, Health Department officials found King autocratic, difficult to work with and fixed in his defence of the Plunket Society's autonomy. In either case the confusion over the status of King's position and his sensitivity to any perceived slurs on his methods exacerbated tension with his colleagues in the Health Department. His role as Director of Child Welfare was also increasingly unclear. In 1925 when the Division was returned to the Education Department, King retained his position but at the same time some of his energy was diverted into a new role as Inspector-General of Mental Hospitals, an appointment made in 1924.

By 1927 Gurr had established a series of ante-natal clinics in the four main centres but relations with Truby King were becoming tense. The previous year King had been outraged Dr Henry Jellet, the Department's Consulting Obstetrician, and Gurr had revised Jellet's textbook \textit{A Short Practice of Midwifery for Nurses} and had not devoted all of the infant feeding section to Plunket methods. King was convinced the text was a slight on him and became sensitive about receiving due credit for his work.\textsuperscript{116} In 1928 he stalled the development of ante-natal clinics in Plunket facilities in Auckland because, he claimed, Dr Gurr was not giving enough credit to Plunket for initiating the ante-natal work. He warned Gurr not to start clinics in the area without his permission, claiming he wanted to explain the scheme to the Auckland branches himself.\textsuperscript{117} King eventually backed down and an Auckland ante-natal clinic was established.

\textsuperscript{114} Ibid, p. 26.
\textsuperscript{115} Mary King, p. 290.
\textsuperscript{116} Mein Smith, \textit{Maternity in Dispute}, pp. 26-27.
\textsuperscript{117} Elaine Gurr to Dr T. Paget (Inspector of Private Hospitals), 8 December 1928, H1 127/54/5 National Archives.
There were other problems, however. The government had given £14,000 in 1925 to build a training annexe at the Karitane-Harris hospital in Dunedin. This facility was to be used for a short training course the Health Department was coordinating with the Plunket Society aimed at maternity nurses and midwives. Funding difficulties and disagreement between the Society and the Department over the administration of the course caused delays. At a meeting between Plunket representatives and J. A. Young, the Minister of Health, in January 1928 the course was put on hold because the estimated £6,000 per annum needed to run it was not available. In the meantime the new annexe was used by nurses training at the Karitane-Harris hospital. Ten months later the Plunket Society was notified that the proposed course would be approved by the Minister of Health on two conditions. The Government would only provide additional funding for the course when its success at attracting practising nurses and midwives had been proven. More controversial for the Plunket Society was the condition that the Committee, which was to be appointed to oversee the administration of the course, was to consist of three members nominated by the Health Department, three members nominated by the Plunket Society, with the Committee to be chaired by one of the Government nominees.

The strained alliance between King and the Department ended with King's resignation in 1927. Margaret Johnstone, the President of Plunket, Anne Pattrick and Gwen Hoddinott (the Administrative Secretary) continued negotiating with the government over the ante-natal course but to little effect. In 1929 the proposal was abandoned completely after the Department and the Society failed to reach an agreement over the teaching of the course. Fearing that the conditions proposed by the Health Department would have given them some control over teaching in the Karitane Hospitals, the Society elected to run its own short courses. Despite the Society and the Department's common ideological perspective they had differing agendas. Wary of being co-opted, the Plunket Society continued to define ante-natal work as part of their nurses work, but limited their involvement with the Health Department's scheme. In 1929 only 6 of the Health Department's 19 ante-natal clinics were in Plunket Rooms. The alliance between Plunket and the Health Department in ante-natal work was only a partial success. By 1935 Plunket ran 11 of the Health Department's 37 public ante-natal clinics but their difficult working relationship meant that the Health Department was unable to capitalise on Plunket's resources in the multitude of small towns and country regions with Plunket branches.

King did not achieve all his aims as Director of Child Welfare: he failed to have any significant impact on medical training in paediatrics and the petty jealousies that dominated his relations with Health Department officials limited Plunket's input into the ante-natal scheme.

120 Stallworthy to Hoddinott, 22 January 1929, PS AG7 1-2-3.
121 That year Plunket nurses saw 28% of new ante-natal cases in the scheme, AJHR, H.-31, 1929, p. 40.
122 Mein Smith, Maternity in Dispute, p. 99.
Even so his term in the health bureaucracy was largely a success for the Plunket Society. The supportive environment King created for the Society's work, especially in emphasising the need for authoritative, uniform mothercraft advice, boosted the Society's work. Plunket also succeeded in retaining the benefits derived from Government support while maintaining autonomy over its work. For the Health Department the alliance was less successful. It never gained the degree of control over the Society's work that key officials desired and from the late 1920s its links with the Society loosened. By 1931 the Plunket Society could no longer rely on uncritical support from the Health Department.
CHAPTER 3

SOCIETY IN TRANSITION

The early 1930s were described by Margaret Johnstone, the President, as 'the most trying period in the history of the Society'. After the relatively untroubled growth and prosperity the Society experienced in the 1920s it struggled to adjust to the financial pressures of the Depression and a more openly critical attitude from the Health Department. At the same time the Executive faced 'a crisis in regard to the internal affairs of the Society' because of the actions of an increasingly ill and difficult Truby King. Finally, the emergence of a new breed of paediatric specialists challenged the Society's dominance in infant welfare prescription. Their criticism of Plunket's methods forced the Society to strengthen its own structures for medical advice.

I.

Ensuring adequate funding for its routine work was an ongoing issue for the Plunket Society in the early 1930s. At a branch level the effect of the Depression varied but branches generally reported poor returns from their usual fundraising ventures. Branch membership dropped in some areas and the acquisition and building of Plunket Rooms slowed, but did not stop completely. Some branches, like Opunake, had considerable reserves and went ahead with plans to build a Plunket Room. Others like Thames took advantage of low building costs and the No 10 scheme for the unemployed to build their rooms. Universally the Plunket nurses and the local committees saw the evidence of financial stress in their rooms. Patricket reported to the Central Council that the nurses were coming 'into direct contact with more cases than usual of hardship and suffering amongst the Mothers'. She reported spending a day at the Grey Lynn Plunket Room during which 'twenty four mothers with babies attended for advice from the Plunket nurses between 1.30 and 4 p.m; of this number eighteen were wives of relief workers'.

At a national level the Depression threatened the Society's work when in 1930 the Government attempted to cut its subsidy of the Karitane Hospitals and Plunket nurses salaries. The Society fought the first suggestion of cuts vigorously and the dispute which followed

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2 Annual Report, 1930, p. 8, PS AG7 1-3-2.
3 The Opunake branch had bank balances of £434 and its Plunket Room, built in 1933, cost £228, PS AG7 2-252.
4 A. Mackay (Secretary of Plunket Society, Thames branch) to Gwen Hoddinott, 12 June 1933, PS AG7 2-252.
5 Central Office Nursing Reports, 1930-1934, PS AG7 3-394.
brought the Health Department's continuing frustration at its lack of influence over the Society's work into the open. Without Truby King in the health bureaucracy Dr Valintine, the Director-General of Health, was willing to question the Society's right to funding from his Department's budget while refusing any supervision.

The lack of Health Department control over the work of the Plunket Society became an issue in the 1930-31 funding round. In June 1930 A. J. Stallworthy, the Minister of Health, proposed bulk funding the Karitane Hospital maintenance grant at £5,500, a shortfall of £1,250 on the previous year's grant. He also warned the Plunket Executive that there would be difficulty funding salary subsidies for the projected increase in the nursing staff by nine new Plunket Nurses in the next year. The Executive replied that it would not cooperate with any Government plan to curtail the Plunket Nursing work by not funding expansion. It also sought a guarantee that the shortfall in the Karitane funding would be made up on the Supplementary Estimates. Otherwise, the Executive threatened, it would have to place Stallworthy's suggested cuts before its branches and all Ministers of Parliament. The threat and the Society's lack of cooperation angered Stallworthy. He replied with a terse letter of his own questioning whether the Society thought it could demand 'an indeterminate amount of money over an indefinite period for unlimited expansion ... without regard to Government direction or exigencies of Government finance?'

Stallworthy also included for the Council's information a copy of a letter from Dr. Valintine giving the Health Department's perspective. It recommended Stallworthy ignore Plunket's 'virtual threat ... to indulge in propaganda' and reduce the Government's grant. Valintine supported this recommendation by reviewing the Society's work and assessing its role and contribution to the health system. There were three main issues. First, the health budget had been capped at £240,000 and the issue for the Government to decide, Valintine advised, was 'whether increasing assistance can be given to the Plunket Society at the expense of related health and social welfare activities'. Valintine's second concern was that the Health Department lacked of control over the Plunket Society's work. Plunket's nurses were 'neither working under the smallest supervision of nor in co-operation with the Department' and the branches were almost totally independent. Third, Valintine emphasised the need to view Plunket's work and by implication, its results, with a 'due sense of proportion'. A critical assessment of the Society's impact on infant mortality showed 'reductions in the infantile death rates of this country were brought about before the [Plunket] Society was founded and long before its activities could have had a very considerable effect'. Valintine concluded that although the Plunket nursing work had some impact, improvements in sanitation, housing and the milk

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7 Hoddinott to Stallworthy, 10 June 1930, pp. 3- 4, PS AG7 1-2-4.
8 Stallworthy to Hoddinott, 18 June 1930, PS AG7 1-2-4.
9 Valintine to Stallworthy, 16 June 1930, PS AG7 1-2-4.
Plunket rejected Valintine's analysis of the situation. The Executive denied that it expected or desired its work to be maintained at the expense of the Health Department. It considered the responsibility for its funding of rest with the Cabinet, not the Health Department. It also rejected Valintine's analysis of its effectiveness, restating its view that its work was the 'special factor' in New Zealand's infant mortality decline. In any case, it reminded Stallworthy, the Society was 'less concerned in reducing the death-rate than in improving the health of the people' and it based its claim to funding on 'public appreciation of the services given'. This public support was its 'special claim' for funding because the work of its volunteers relieved the Government of most of the expense and responsibility of infant welfare work. Finally it refuted the notion that in proposing to discuss the predicted cuts with all Members of Parliament it was making a 'political threat'; all members were entitled to know the Society's position before they voted.12

Valintine's advice to adhere to the planned funding cut proved futile in the face of pressure from the Plunket Society and its supporters. The reduced funding was approved in the Main Estimates but the Government assured the Society that it would attempt to make up the shortfall in the Supplementary Estimates. The Society pressed the issue. On 12 August 1930 a deputation led by Peter Fraser, Labour M.P., and including Mr G. A. Troup, the Mayor of Wellington, the Hon. Sir James Allen, M.L.C. and an elder statesman of the Reform Party, and members of the Dominion Council of the Society, put the Society's case directly to Stallworthy and the Prime Minister, the Hon G. W. Forbes. Introducing the deputation Fraser claimed that he thought all Members of Parliament would feel that 'they were doing a wrong thing' if they did not supply the funding required by the Society to maintain and extend its work.13 Speaking for the Plunket Society, J. A. Johnstone, a member of the Advisory Board, argued that while the Society was asking for funding for nine additional nurses that year, at the usual rate of £125 each, this growth was regulated by public demand for the Society's services.14 The delegation left with an assurance from Stallworthy that both he and Forbes supported the Plunket Society's work and would endeavour to provide it with the level of funding it needed.15

The debate was also carried into the House of Representatives and the public eye by Plunket supporters. On the same day that the Plunket delegation met with the Forbes and

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10 Ibid.
11 Ibid.
12 Hoddinott to Stallworthy, 1 July 1930, PS AG7 1-2-4.
13 Report on Deputation to Prime Minister, 12 August 1930, p. 1, PS AG7 1-2-4.
14 J. A. Johnstone was also the husband of the Society's President, Margaret Johnstone.
15 Report on Deputation to Prime Minister, 12 August 1930, PS AG7 1-2-4.
Stallworthy, the Hon J. A. Young, a member of the Hamilton branch of the Society, raised the issue in the House. He was supported by G. R. Sykes who argued that the Plunket Society and the Karitane Hospitals were 'the most important activities of the State'. Forbes replied that the Minister of Health had assured a delegation from the Society that provision was being made on the supplementary estimates, which would bring the Society's funding close to previous years. Ambiguity remained about how many nurses' salaries the Government would subsidise because Forbes questioned the necessity of extra Plunket nurses. Again the Central Council of the Plunket Society sought an assurance that provision would be made in the Supplementary Estimates to bring the level of funding to that requested by the Society. On 19 August 1930 a deputation of politicians representing the whole house, led by Peter Fraser and J. A. Young, won an assurance from Forbes and Stallworthy that the additional nurses would be funded in the Supplementary Estimates. The final allocation of funds gave the Society £100 less than they had requested.

Plunket Society’s public support and its ability to pressure the Government ensured it maintained its subsidy in 1930 but it was a temporary reprieve. In April 1931 the Government announced it was cutting all civil service salaries, including its subsidy of Plunket nurses salaries, by ten percent. Recognising the universality of the cuts and the Government’s financial constraints the Council did not object but did delay passing the cut on to the Plunket nurses until September of that year. Within months of the April announcement the Government advised the Executive that further cuts were necessary and the Executive entered negotiations with the Department of Health to gain some control over the process. It was jointly decided to make cuts of between 20 per cent and 25 per cent to the Karitane Hospital maintenance grants for the 1931-32 year. Plunket still had to trim another £900 from its budget and the Health Department pointed out that the only other part of the budget to be economised on was the Plunket Nurses’ salaries. The Executive was reluctant to impose two salary cuts on its nurses in one year especially when only one salary reduction had been made in the Public Service. The alternatives, however, were a rise in revenue from fundraising and subscriptions, which seemed unrealistic as the branches were already complaining about the burden of raising money, or to retrench some nursing staff. In October 1931 Plunket sent its Administrative Secretary, Gwen Hoddinott, to Wellington to meet with the new Minister of Health, J. A.

17 Ibid, p. 145, Sykes was the M.P. for Masterton.
18 Ibid, pp. 150-151.
19 Hoddinott to Forbes and Hoddinott to Stallworthy, 16 August 1930, PS AG7 1-2-4.
20 Report on Deputation to Prime Minister, 20 August 1930, H1 127 (B 18) National Archives and Stallworthy to Hoddinott, 19 August 1930, PS AG7 1-2-4.
21 J. A. Young to Hoddinott, 20 August 1930, PS AG7 1-2-4.
22 The Central Council decided to reduce all salaries and wages by ten per cent, including administrative staff. Annual Report, 1933, p. 30, PS AG7 1-3-3.
Young and representatives from the Health Department to discuss funding options.\footnote{Annual Report, 1932, p. 9, PS AG7 1-3-3. J. A. Young had a long association with the Plunket Society. He became a member of the Hamilton branch in 1917 and joined the Central Council’s Advisory Board in September 1933, Executive Council minutes 1933-1946, PS AG7 1-2-12.} Retrenchment of nursing staff was rejected on the grounds that any decrease in nurses would markedly impact on the efficiency of the Plunket Society’s work. The Government was eventually satisfied with a Plunket proposal to temporarily reduce its nurses annual holiday leave, from 30 days to 15 days, and halve the graduated scale of paid sick leave entitlement.\footnote{Annual Report, 1933, p. 31, PS AG7 1-3-3.}

The prospect of further salary reductions for Plunket nurses loomed in April 1932 when the Government cut the salaries of all civil servants by another ten per cent. The Central Council deliberated on whether to pass the corresponding cut in the Government subsidy on to nurses. Comparison of the current minimum Plunket nurses’ salary with those paid to the Health Department’s district nurses after the second salary reduction showed the district nurses were still better renumerated. Taking into account the previous reduction in their nurses’ annual leave, and their suspension of salary increments since 1931, the Central Council of the Plunket Society decided to absorb the cut and maintain the competitiveness of Plunket nursing with other branches of nursing.\footnote{Annual Report, 1933, p. 32, PS AG7 1-3-3.}

The continual funding difficulties peaked for the Society in 1932 when the Government appointed a National Expenditure Commission to review public expenditure and recommend where reductions could be achieved. The Plunket Society came under the Commission’s hammer. Its final report noted the ‘considerable cash resources’ held by the Society and recommended the Government immediately cut the Society’s grants for the 1932-33 year by £7,250 and aim to reduce public funding of the Society’s work by 50 per cent over a two year time period.\footnote{On 31 March 1931 Plunket’s branches collectively held £29,657 and the Karitane Hospitals £3,375, which it claimed was finance raised by each branch to meet its share of the nurses salaries and other operating costs, Parry, pp. 101-102.} The Commissioners also argued there was ‘no reason why such an extensive service should be provided on an entirely gratuitous basis’ and recommended the introduction of user charges for those who could afford to pay.\footnote{Final Report of the National Expenditure Commission, AJHR, B.- 4A, 1932, p. 72. The Society did impose charges in the Karitane Hospitals. In 1933 it was £3 3s a week for a baby and £4 14 s 6d for a mother and baby, but no one was ever refused treatment because of inability to pay the fee, Annual Report, 1933, p. 37, PS AG7 1-3-3.} For the second time in two years the Society’s right to the level of public funding it received was challenged with the Commission concluding that it is a striking commentary on the extent to which the State is now providing social services for the community generally that an organisation which started on a purely...
voluntary basis should now be receiving State assistance to the extent of over £20,000 per annum.\textsuperscript{28}

New Zealand, the Commission argued, could not afford the cost.\textsuperscript{29} The Plunket Society issued a spirited rebuttal of the Commission's recommendations and found support amongst politicians.\textsuperscript{30} The defence of Plunket's right to state funding was led by J. A. Young, the Minister of Health, who was vehemently opposed to the suggested introduction of a user pays system. He was supported by the Plunket Society and the public. The Government decided the cuts Plunket had already submitted to were sufficient and the Commission's recommendations were not implemented. The phenomenal support Plunket received, not least within all political parties, during the Depression shows the centrality of mother and children within New Zealand society.

Plunket's continual uncertainty about government funding was alleviated somewhat by a series of donations from the Karitane Products Society between 1932 and 1934. Since 1927 the Karitane Products Society oversaw the manufacturing and distributing of Truby King's infant foodstuffs and dietary supplements. King had begun producing Kariol, an emulsion for adding the fat content of humanised milk, in 1920. The factory was unprofitable under King's management and in 1927 a group of businessmen and Plunket supporters formed the Karitane Products Society and took over the responsibility.\textsuperscript{31} The Society was run entirely separately from the Plunket Society, although they often worked together, and all its board members served in a voluntary capacity. Freed from the worry and day to day management, King now developed a sugar of milk mixture, called Karilac, which was available in three strengths. Karil, a cod liver oil based emulsion for children, was added to the Karitane stable of products in 1928.\textsuperscript{32} The Karitane Products Society board expanded the operation and Karitane products came to be sold through chemists and grocers in a number of countries including England, Canada, South Africa, Australia as well as New Zealand.\textsuperscript{33} The aim was to keep products as cheap as possible with any surplus profits distributed for the advancement of the mothercraft movement wherever Karitane products were sold.\textsuperscript{34} The Karitane Products Society openly subsidised the salaries of some of Plunket's administrative and professional staff.

\textsuperscript{29} Ibid.
\textsuperscript{31} Mary King, p. 311, gives the members of the original Directorate as Sir Truby King, Mary King, The Hon. Mr Justice Blair, Dr. T. Derrick, Mrs Derrick, Dr, T. G. Gray, Mrs Gray, Mrs Hall, W. D. Hunt, Anne Patrick, Percival Patrick and Dr M. Tweed. The manufacturing plant was originally at Seacliff but King moved it in 1924 to his 10 acre property in Melrose, Wellington where he also built his own home. He later donated land on the same hilltop site to the Plunket Society to build the Truby King Karitane Hospital.
\textsuperscript{32} \textit{Annual Report} 1929, pp. 36-37, PS AG7 1-3-2.
\textsuperscript{33} Karitane products were originally only sold through Plunket nurses in New Zealand and only became more widely available in the early 1930s.
\textsuperscript{34} \textit{Annual Report}, 1935, pp. 8-10, PS AG7 1-3-3.
It is difficult to assess the exact amount the Karitane Products Society donated to Plunket during the Depression because many of the payments were made secretly. The records are patchy but the donations were significant. In 1932, for instance, it was at least £6,000, some of which was tagged for specific schemes. For instance, over £3,000 was used to give 'assistance to the poor and needy by supplying the Society's foodstuffs free or at reduced rates, according to the circumstances, to necessitous and deserving cases'. All recipients had to be under the care of a Plunket nurse and branches were not allowed to advertise this service for fear it would be taken advantage of and would depress fundraising efforts. Plunket had to be careful not to move into the realms of charity work. The remainder of the money was deposited with the stock firm Wright Stephenson and Co (Sir William Hunt was both the Managing Director of this company and the Chairman of the Karitane Products Society). These clandestine donations were also used to assist branches to meet their share of contributions to the nurses Superannuation Fund.

Plunket's Council had two compelling reasons for keeping this arrangement secret. First, it disproved the Society's claims that two thirds of its funding came from voluntary effort. This funding ratio was regularly used by Plunket to support its claims that the Government contribution to the Society's work was minor compared to the support it received from the public. Second, the news that the Plunket Society was relying on funds from the sale of the only foodstuffs its nurses recommended would have raised an outcry about conflicts of interest from the medical profession and the Health Department. Dr Lawrence Ludbrook, an Auckland doctor, was already suspicious of the relationship. In 1931 the Acting Matron of the Auckland Karitane Hospital, Joan Carmichael, reported to both Truby King and Anne Pattrick that Ludbrook thought Plunket 'advocated Kariol merely to increase the profits of the Karitane Products Society'. Moreover Plunket's primary purpose was to promote breastfeeding and its public supporters could well have looked askance at it receiving significant funding from the profits of artificial feeding supplements. Likewise the Karitane Products Society's official

35 Only 4 payments ever went through branch books and some of these were allowed to 'drop out of the published accounts'. Executives of the branches were told to include the payments among general donations, Circular, 29 March 1934, Ref no 94, PS AG7 1-7-23. Parry, p. 93, notes that all of the Karitane Products Society's surplus profits were given to the Plunket Society but does not comment on the secrecy surrounding the payments.
36 Hoddinott to Sir William Hunt (Chairman of the Karitane Products Society), 3 March 1937, PS AG7 2-200.
38 Circulars to branches, Ref no 65, 26 July 1932, PS AG7 1-7-23.
39 Hoddinott to Hunt, 3 March 1937, PS AG7 2-200. This account eventually became a trust fund and by the end of March 1933 it held £4,504.2.6, Hoddinott to Tweed, PS AG7 2-305. By June 1933 the Karitane Products Society was depositing £500 a month in another account, Secretary of Karitane Products Society to Hoddinott, 20 June 1933, PS AG7 2-305.
40 Hoddinott to Hunt, 1 June 1933, PS AG7 2-305.
41 Examination of Nurse Carmichael, PS AG7 11-10 and Carmichael to Pattrick, 23 May 1931, PS AG7 11-10. This impression was not uncommon. In Australia Dr E. Sydney Morris, the New South Wales Director of Maternal and Baby Welfare, considered Truby King's nurses were 'merely sales representatives for his emulsion and his sugar, who if admitted to the baby health centres would "push these things"', Mein Smith, Mothers and King Baby, p. 129
ILLUSTRATION 3.1  Karitane Products Factory, Wellington. (n.d)
The profits from the sale of Kariol, Karilac and Karil, manufactured by the Karitane Products Society in Wellington, supplemented the Plunket Society's income from donations in the 1930s.
Source: Plunket Society Collection, Hocken Archives.
mission was to provide its products 'at the lowest practical rates', not at a profit which enabled the disbursement of almost £9,000 in a given year (see figures for 1934 below).42

By 1934 there was a high level of dissension and dissatisfaction within the branches and Council of the Plunket Society, albeit over unrelated issues which will be analysed in the next chapter. This increased the risk of the funding arrangement being revealed and the Plunket Executive and the Karitane Board decided to announce that year's donation publicly in order to disarm their critics.43 Sir William Hunt told Plunket's General Conference that the Karitane Products Society had surplus profits, mostly from its overseas sales 'owing to the favourable rates of exchange'.44 He announced the Karitane Products Society was donating £1,000 to each of the 6 Karitane Hospitals, to be used for capital purposes only. A further £1,407 was allocated to provide a £10 bonus for all members of staff who had been in service at least 12 months.45 Both payments went some way towards bolstering areas which had suffered from the Government's funding cuts. These donations were augmented by another £1,522 11s 1d which supplemented administrative salaries, travelling expenses of various committees and studies into the Society's effectiveness.46 Although Hunt implied the payment was a one-off it was followed in 1935 with a donation of £7,000 to be invested to offset the cost of running the Plunket's Dominion Training Centre.47 This time the announcement stressed that the donation was not necessarily entirely from that year's profit, and was mostly due to 'extraordinary demand' for Karitane Products overseas.48

The Plunket Society would have had difficulty absorbing the financial setbacks of the 1930s Depression without the benefit of the Karitane Products Society's financial assistance. As it was the funding debates of the early 1930s revealed the limits of the Health Department's support and the depths of political support for the Society's work. Plunket's effective political lobbying made the National Expenditure Commission's and Valintine's assessments of its role within the health system and its right to state funding irrelevant. The fact that it fell to the Society's Executive and its Advisory Board to handle the issue was also significant. In the past Truby King had generally led the Society in any fight, but as Mein Smith has noted, the Society's path had begun 'inevitably to diverge from King's' in the late 1920s.49

42 For comparative purposes the total Government allocation for the year ended 31 March, 1935 was £20,005 9s 9d, Annual Report, 1935, p. 64, PS AG7 1-3-3. The idea of explaining the Karitane funding in this manner came from Dr Martin Tweed, Medical Director to the Plunket Society, Tweed to Hoddinott, 22 June 1934, PS AG7 2-260.
43 The possibility of a leak was expressed in an unsigned letter to Tweed, 22 April 1933, PS AG7 2-281.
44 Hunt to General Conference, August 1934, in Annual Report, 1935, p. 9, PS AG7 1-3-3.
45 Annual Report, 1935, p. 66, PS AG7 1-3-3.
46 Annual Report, 1935, p. 65, PS AG7 1-3-3.
49 Mein Smith, Maternity in Dispute, p. 28.
Truby King began lessening his involvement in the day to day functioning of the Plunket Society in 1928. His partial withdrawal was prompted by the death of his wife and most stalwart supporter, Bella, the previous year. Bella had worked in close partnership with her husband, writing the 'Our Babies' columns and acting as general secretary and organiser. Her death was a loss King's contemporaries felt he never recovered from. Having retired from the Health Department the previous year King sought new challenges. He focussed on spreading his infant welfare message and lived a nomadic existence for much of the next three years. Between 1928 and 1930 he travelled regularly between Australia, where he and his daughter Mary were setting up a Karitane Products factory, and New Zealand. He also took two trips to England, where he spoke at the National Conference on Maternity and Infant Welfare in London in 1928 and 1930, and toured the Continent. He continued to keep tabs on the New Zealand organisation but his primary interest was establishing the Sydney factory and promoting his infant welfare system in Australia.

King's dream of building the movement in Australia ended in September 1931 when the Directors of the Karitane Products Society called him home to account for the Sydney factory's lack of profits. His friends and colleagues in the Karitane and Plunket Societies were also concerned about his mental health and its effect on his work. He was in his early 70s and had become cantankerous and aggressive. His ability to concentrate for long periods of time was declining and he was becoming increasingly inclined to emotional outbursts. As a result his efforts to represent Plunket internationally were proving unsatisfactory. King's 1930 address at the National Conference on Maternity and Infant Welfare in London was a case in point. His old charisma on the podium was gone and he was long winded and repetitive. Some, according to Mary King, thought this appearance did the infant welfare work he had devoted over two decades of his life to 'untold harm.' In Australia King had picked fights with other infant welfare organisations and stirred up controversy on infant feeding, a subject he was becoming
increasingly dogmatic about. The Karitane Products Society decided to close its Sydney factory and supply the Australian market from New Zealand. King never returned to Australia.

The Plunket Executive found King difficult to manage on his return to New Zealand because he could not accept the waning of his authority. In his absence the confidence of the Executive had grown and the power balance had shifted. In the past King had never encountered significant opposition from within the Society but now the Executive, mindful of his age and diminishing mental powers, sidelined him. He took over writing the 'Our Babies' columns and by April 1932 was causing havoc with his rash announcements. Without consulting the Council or the Minister of Health he appeared to 'forecast' a new scheme of establishing maternity wards at Karitane Hospitals. In his article King only stated that if babies were born in maternity wards attached to the Karitane Hospitals none would die. In correspondence with the sub-editor of the *Sun*, however, he apparently implied there would be 'a new move in regard to establishing Maternity Wards at Karitane Hospitals'. The *Sun* printed the leader 'Sir Truby King forecasts new scheme. Hopes to reduce infantile mortality to one per cent'. King was used to making unilateral announcements for the Plunket Society and he clearly thought he could circumvent the Council by announcing his scheme directly to the press. This tactic would have gone unremarked when his leadership was unquestioned and the idea itself may have obtained a better reaction. As it was Margaret Johnstone conveyed the Council's strong opposition to the scheme, which she described as 'impracticable', and the Council scrambled to correct the impression he had created. King tried to absolve himself of responsibility. He claimed the sub-editor had jumped to conclusions, possibly from a conversation with Iris Wood, and assured the Council that he would correct the misleading impression.

The Council began vetting King's columns by asking newspaper editors not to print anything he wrote as General President of the Society without the Council's permission. This was not always successful, but did limit his access to the media. King continued to use public announcements to pressure the Society to attach maternity wards to the Karitane Hospitals. In July 1932 he announced his intention to donate his own home, adjacent to the Wellington

57 Iris Wood (Secretary of Christchurch Branch of the Plunket Society) to Hoddinott, 13 April 1932, PS AG7 2-246.
58 Ibid.
59 Ibid, and Hoddinott to Young, 14 April 1932, PS AG7 2-246.
60 Hoddinott to Young, 14 April 1932, PS AG7 2-246.
61 Hoddinott to Wood, 15 April 1932 and Hoddinott to Young, 14 April 1932, PS AG7 2-246.
62 This is referred to in Wood to Hoddinott, 3 June 1932, PS AG7 2-246 and Tweed to Hoddinott, 31 May 1932, PS AG7 2-246.
63 The Dominion printed an unauthorised article from King in June. Tweed to Hoddinott, 6 June 1932, PS AG7 2-246. In July 1932 the Executive delegated the writing of "Our Babies" articles to the Sister Tutor at the Karitane-Harris Hospital, Central Council minute book, PS AG7 2-246.
Karitane Hospital in Melrose, to be used as a maternity hospital.\(^{64}\) The head of the Karitane Hospital would also head the proposed maternity hospital. The Central Council was alarmed by the proposal but decided to humour King, hoping the idea would die a natural death.\(^{65}\) Instead it sparked an offer to the Society from an anonymous source to donate the cost of establishing a new joint Karitane Hospital and Maternity Home in Hastings. The offer was rejected both because it was outside the scope of Plunket’s constitution to run a maternity home and there was no prospect of government funding for the ongoing costs of the project.\(^{66}\)

King was resorting to the press because he had no other opportunity to put his ideas directly to the Society. In June 1932, six months after King returned to New Zealand permanently, Margaret Johnstone, declared to a meeting of the Central Council that the internal affairs of the Society were in crisis.\(^{67}\) In 1931 the Society’s annual conference had approved a new constitution, which enlarged the size of the Council, ensured even geographic representation and clarified nomination procedures.\(^{68}\) In theory the new constitution made the Society more representative but in reality it had little immediate effect because the Executive delayed implementing it. No meetings of the Central Council were held between August 1931 and June 1932, which Johnstone implied was due to ‘Sir Truby’s advancing years and attendant failings’.\(^{69}\) A series of Provincial Conferences which were meant to elect the new Council were also delayed. The Executive suspended the usual democratic functions of the Society because it feared King could convince the unknowing delegates to endorse his maternity ward scheme.\(^{70}\) While it was common knowledge in the upper echelons of the Society that King was suffering ‘the gradual disintegration of a great mind’, the state of his mental health was not widely known outside those circles.\(^{71}\)

\(^{64}\) Mary King, p. 341, recounts her father announcing his intention ‘to hand over his beautiful home, “Mount Melrose”, to the Plunket Society, to be used in any way it was thought fit, for the benefit of mother and child’ at the Annual Meeting of the Wellington Branch.

\(^{65}\) Margaret Johnstone to Miss Williams (President of the Hastings Branch of the Plunket Society) 25 July 1933, PS AG7 2-252.

\(^{66}\) Johnstone to Williams, 25 July 1933. Another offer of an estate in New Plymouth for a mothercraft home was also rejected because of a lack of funding for ongoing costs, PS AG7 2-252.


\(^{68}\) As it stood the constitution, passed in 1917, was considered unrepresentative because it required seven of the fifteen members of Council to be from the Dunedin branch. The new constitution increased the size of the Council to fifteen general members in addition to the seven Executive members drawn from the Dunedin branch, one of whom became the Society’s President. Sir Truby King was given the title General President. The Society was geographically divided into five groups of branches, which met in Auckland, Wanganui, Wellington, Christchurch and Dunedin respectively. Each of these groups held a biannual Provincial Conference to elect three representatives to the Central Council. Only one member of a branch could be elected to the Council and sub-branches remained part of their branches for the purpose of Provincial Conference. These Conferences were designed to encourage branch interest in Plunket’s work and had no policy making functions. General Conferences remained the supreme decision making body of the Society, giving direction to both the Central Council and its Executive. The Central Council was to meet at least every six months and the day to day running of the Society remained in the hands of the Executive Committee, Annual Report, 1930, p. 4-6, PS AG7 1-3-2.


\(^{70}\) Ibid.

\(^{71}\) Mary King, p. 334.
The Executive finally decided to face the issue and called a meeting of the Central Council in June 1932.\textsuperscript{72} The issue of Truby King's behaviour was discussed 'in camera', so the full extent of those 'failings' and their impact on the Society are unknown. After discussing the situation the Council voted to delay holding the large General Conference which was due to be held before March 1933.\textsuperscript{73} It also drafted a resolution, to be conveyed to King, suggesting his retirement. It read

Being most deeply concerned as to the welfare of the Plunket Society and being genuinely solicitous of upholding the reputation of the Founder of the Society, the Council has given the gravest consideration to the question whether the Founder by reason of weight of years and recent occurrences of a painful nature in the highest degree derogatory to the worldwide reputation of the Founder, should any longer be required actively to interest himself in the affairs of the Society. The Council feels that if it be required from the Founder that he still concern himself actively in the affairs of the Society his health and reputation will be gravely imperilled. The Council after most earnest consideration feels that it would be failing in its duty to the Society and to the Founder himself if it neglected at this juncture to direct the attention of the Founder to the above position and it earnestly requests the Founder for his own sake and for the welfare of the Society to give earnest consideration to the question of resigning from active participation in the affairs of the Society.\textsuperscript{74}

The resolution was approved by Council's Advisory Board and delegated to two of its members, Judge A. W. Blair and Sir William Hunt, to convey to King.\textsuperscript{75} There is no record of this meeting but it did not secure King's resignation. In September 1932 Sir William Hunt advised the Society that King's affairs were now in the hands of the Public Trustee. Hunt had 'no doubt [King] must eventually go into a Mental Home' and added that in the meantime the Karitane Products Society had shut off King's interference. He advised the Plunket Society to do the same.\textsuperscript{76} The Council did not act quickly enough.

There was a period of calm because King suffered some cracked ribs and bruising in a fall outside the Karitane Hospital in August.\textsuperscript{77} But as Mary King noted, her father 'undoubtedly...found it hard to give up completely the reins of management of the Society he had founded'.\textsuperscript{78} By October he was ready to assert his influence and had found the vehicle to do it. He announced that he supported the 1932 National Expenditure Commission's

\textsuperscript{72} King, as General President of the Society was entitled to attend all meetings and his absence from this meeting suggests the Executive seized an opportunity to meet without him.
\textsuperscript{73} Central Council minute book, 14 June 1932, PS AG7 1-2-3. Instead a small formal Interim Conference was held to fulfil the legal requirement for a conference. The first Central Council elected under the 1931 constitution took office at this Conference in March 1933, \textit{Annual Report}, 1933, p. 29, PS AG7 1-3-3.
\textsuperscript{74} Central Council minute book, 14 June 1932, PS AG7 1-2-4.
\textsuperscript{75} Hoddinott to Blair, 4 July 1932, PS AG7 1-2-4.
\textsuperscript{76} Quoted in Mr. J. A. Johnstone to Hoddinott, 7 September 1932, PS AG7 2-242.
\textsuperscript{77} Mary King, p. 344.
\textsuperscript{78} ibid, p. 341. King acknowledges her father's declining mental health but does not give details of his dealings with the Plunket Society, p. 334 and ch. 33. The official history of the Plunket Society, ignores these issues entirely and merely comments that King, in failing health, turned his energy to encouraging Mary in her Australian work, see Parry, p. 104.
recommendation that the Society should begin charging mothers for its services. This was a complete reversal of opinion and contradicted the policy of the Society as decided by General Conferences. King had always stressed the importance of the Society's services being universally accessible and free to all. Now, in a rambling press statement he declared that those who could pay should, because the modern habit of 'taking everything as a right and giving nothing in return' threatened the Society's fundraising efforts. The media, used to treating King's words as gospel, latched on to his statement. One paper announced that 'A complete reversal of its policy not to charge for educational work is likely to be made by the Plunket Society in the near future.'

That King's public announcement was motivated by the Society's request that he resign seems reasonably clear. Judge A. W. Blair attributed King's change of heart to an 'event or events' which were 'quite irrelevant to the proposal but in Sir Truby's present state of mind they appear to him to justify the adoption of a course of action which a few years ago he would have repelled with horror'. He suggested that the most sympathetic way for the Council to view his change of opinion was to assume that when he talked to the press '...Sir Truby had completely lost his grasp of the Society's aims.' The Council denied any intention of changing the Society's policy regarding user charges and succeeded in lobbying the Government not to reduce its funding.

King never resigned from the Society he founded but the Council did succeed in controlling the public effects of his erratic behaviour. From 1933 his physical health fluctuated and he spent long periods confined to bed. Ill health seems to have forced him to accept his diminishing role in the Society. In 1934 he declared that he intended to give up all work and spend his final years in his garden. The Council continued to use King as a figurehead for the Society but his input into the Society's work was largely confined to its medical direction. Even as the Executive was struggling to deal with King it was becoming aware that it needed the mantle of his authority to bolster the Plunket cause against attacks from the medical profession.

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80 Ibid.
81 Blair memorandum to Dr Tweed, 25 October 1932, PS AG7 1-2-4.
82 Kings outbursts did continue, for instance at the Society's 1933 interim conference he made 'a violent, personal attack' on Gwen Hoddinott. These incidents were kept strictly 'in camera', amongst people who knew the state of his health and were anxious to protect his reputation. Gwen Hoddinott, Plunket Society and National Expenditure Adjustment Statement for Mrs McGeorge, Acting President (2nd April 1933), H1, 127 (B81) National Archives.
83 In his last years King suffered from red neuralgia, the symptoms of which were swelling and extreme pain in the feet after walking. Mary King, p. 348.
84 King to Miss Brandon, 26 April 1934, PS AG7 5-18.
ILLUSTRATION 3.2  Plunket Society Central Council c. 1935.
The names of those in the back row are unknown. The front row (from left to right) is: Gwen Hoddinott, unknown, Kate McGeorge, Sir Truby King, J. A. Young, Lady Helena Sidey, unknown, Miss E. Johnstone. By 1935 Truby King was frail and unwell and this was one of his last public appearances with the Plunket Central Council. Source: Hocken Archives
III.

Although King tried to cling to power in the early 1930s he had at one point recognised the need to provide for an orderly transfer of power, at least on the medical side of the work. In light of his imminent prolonged absence from the country in 1928 King recommended the Society appoint an understudy and successor for his position as Medical Director of the Society. Although he had often described the Society's mission as woman's work and Anne Pattrick 'as his virtual successor' King sought a medical man for the job, arguing the public believed it was 'a man's job to maintain and ensure the continued success and progress of the Plunket Society.' Perhaps more significantly the medical profession would have been outraged if a nurse, even one as well qualified as Pattrick, had been appointed King's successor.

In October 1928 King introduced his choice, Dr Thomas Derrick, to the Central Council of the Society and it appointed him Medical Director of the Plunket Society. Derrick, a graduate of Edinburgh University, came to New Zealand in 1913 to work as a general practitioner in Thames and at the time of his appointment was in private practice in Auckland. He was deeply interested in infant welfare and both he and his wife were founding members of the Thames branch of the Plunket Society. His duties as Medical Director were never officially defined but included the routine work of visiting the Society's branches, liaising with the honorary physicians on the staffs of the Karitane hospitals and with Anne Pattrick, giving lectures and setting and marking exam questions for the Plunket nursing courses. King delegated the practical work but continued to actively oversee the Society's medical direction whether he was in New Zealand or overseas. As is shown in correspondence between Derrick, Anne Pattrick and her assistant Challis Hooper, Derrick sought and deferred to King's opinion and in the short time he had the position did not take over the leadership role. Derrick's performance in the position was affected by 'protracted ill-health'. In April 1930 King brought Derrick's 'inability to carry out the exacting work of the Society' before the Central Council and was authorised to select a replacement for him during his forthcoming trip 'home' to England. Derrick's resignation was announced in May and he finally gave up his duties two years after he started, at the end of October 1930. His impact on the Society's medical direction was negligible.

85 General Conference Report, July 1922, p. 46 PS AG7 1-5-1.
86 King to Sir James Barrett, 2 November, 1928, PS AG7 5-18.
88 Annual Report, 1929, p. 15, PS AG7 1-3-2.
89 PS AG7 2-84.
91 Annual Report, 1931, pp. 9-10, PS AG7 1-3-2.
King chose Derrick’s replacement too. He presented Dr. Martin Tweed for formal approval at the General Conference of the Society in November 1930. Tweed was born and grew up in New Zealand but did all his medical training in England. When he returned to New Zealand after the first world war he went into general practice in Wairarapa and the Hutt Valley. Like Derrick he showed an interest in the Society’s work and was known within the medical profession as one of King’s ‘disciples’. Derrick’s position had been fulltime but Tweed was appointed only to act as the honorary Medical Adviser to the Council in a part time capacity during King’s absence. King’s trip to England and his appearance at the National Conference on Maternity and Child Welfare in London were not a success. While due respect was given to his past achievements, particularly his work as a 'nursery hygienist', his views on infant feeding were disparaged as out of date. Finding a suitable replacement, that is one who was committed to the humanised milk method, would have proved impossible, if indeed King tried. The experience made it clear that his international reputation as an infant welfare expert was declining and at the same time he received word from New Zealand that the Directors of the Karitane Products Society were considering closing the Sydney factory. King felt under threat and when he returned to Sydney from London in December 1930 he drove himself to consolidate the work in Australia. His physical health suffered as a consequence but in May 1931 he was well enough to travel to New Zealand for the annual Plunket conference.

In New Zealand King was confronted with problems in the Auckland branch. Tension had been growing between the Plunket staff and a few members of the medical profession since Dr G. B. Sweet complained to the Society about nurses attitudes to his work in 1928. Anne Pattrick reported that ‘the feeling of criticism and misunderstanding from the medical men has been growing consistently during the last two or three years’. The strained relations were beginning to take a toll. Joan Carmichael, the Acting Matron at the Auckland Karitane Hospital, complained in March 1931 that the state of affairs with regard to the medical profession in that city was ‘intolerable’ because of the ‘undercurrent of opposition’. Dr Sweet was no longer the main protagonist, although Plunket stalwarts were sure he was influential.

An incident in the Karitane Hospital brought the tension out into the open in Auckland. Each Karitane Hospital was staffed by Plunket nurses and a team of honorary physicians, who oversaw the treatment of babies admitted to the Hospitals mainly for dietetic related illnesses. The Honorary Medical staff’s main duties were to authorise cases as suitable for admission to

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92 Annual Report, 1931, p. 10, PS AG7 1-3-2.
94 Mary King, pp. 330-335.
95 Ibid.
96 Ibid, pp. 338-339.
97 See chapter 2.
98 Pattrick to Johnstone, 28 May 1981, PS AG7 3-223.
99 Carmichael to Pattrick, 31 March 1931, PS AG7 3-223.
the hospital and to supervise all medical treatment. All Honorary Medical staff were expected to adhere to Plunket methods, particularly the diet. In the late 1920s Dr W. H. Parkes, the Senior Physician at Auckland Karitane, considered adding Dr Lawrence Ludbrook, a young doctor with a special interest in paediatrics, to the staff. Ludbrook had 'set off to London with the ambition to become a paediatrician' in 1923. His overseas experience culminated with an 18 month stint at Shadwell Children's Hospital. He returned to New Zealand in 1925 and combined his own practice 'as a consulting physician with a special interest in paediatrics' with part-time work on the children's ward at the Auckland hospital. Parkes learnt Ludbrook was not a supporter of the Plunket Society and postponed asking him to join the Karitane staff for a couple of years while he gained more practical experience. Ludbrook was eventually accepted on to the honorary medical staff at the Auckland Karitane Hospital in 1931 but there was little evidence he had changed his views. He was known amongst the nursing staff to dissuade mothers from using the Karitane Hospital when they sent cases to him for an admission slip and Joan Carmichael regarded him as being 'the mouthpiece of Dr Sweet'.

Ludbrook revealed almost immediately that he had little faith in the Society's methods and had joined the staff to challenge the system. In February 1931 he took a nurses' training lecture at Karitane for Dr Gunson. During the lecture he declared that the deficiency diseases rickets and scurvy were prevalent in New Zealand and attributed this at least in part to the use of the Plunket emulsion Kariol. Carmichael questioned him after the lecture about his deviation from Plunket teaching and challenged his assertion that New Zealand had a rickets problem. Ludbrook was adamant he came across children with flat feet and other symptoms of rickets in his practice and confirmed he considered the use of Kariol to be responsible.

Carmichael and Ludbrook clashed over the feeding of the first malnourished infant Ludbrook saw at the Karitane Hospital. Although the baby had already been seen by another Karitane physician, Dr T. H. Pettit, Carmichael showed Ludbrook the baby because it was a difficult case and he had not yet seen any babies in the hospital. Carmichael believed the baby was not eating because its digestive system was over-taxed. She thought it needed to be fed less than the theoretical requirements to allow its system to recuperate. Ludbrook disagreed, arguing that the baby needed twice the calories it was being given and prescribed a low fat, high

100 They were also called on to lecture Karitane nurses and to examine all candidates for Karitane training for physical fitness, Hoddinott to Mrs Allan, May 9 1933, PS AG7 2-260.
102 King to Partridge, (Honorary Secretary of the Auckland branch), 31 May 1931, PS AG7 11-10.
103 Carmichael to King, 19 May 1931, and King's examination of Lucy Goulstone, Charge Nurse of the Auckland District of the Plunket Society, 19 May 1933, PS AG7 11-10. The Plunket rules decreed that its nurses had to be completely neutral in regards to doctors and could not recommend doctors or direct mothers away from those they knew to oppose the Society's methods or work. Ludbrook was a supporter of Sweet and after Sweet's retirement set up his practice in Sweet's old rooms, Obituary, NZMJ, 84, 576 (1976), p. 415.
105 Carmichael to Patrick, 23 May 1931, PS AG7 11-10.
protein and sugar formula of evaporated milk, karo syrup, lactic acid and water. Carmichael reminded Ludbrook that human milk was the standard on which Plunket based its artificial feeding regime and pointed out that his 'acid milk' prescription was not part of the Society's routine teaching. She refused to carry out his orders and informed him her responsibility as Matron of a Karitane hospital was to uphold the teachings of the Plunket Society, with Sir Truby King as her authority. In taking this stand Carmichael may have been deliberately provocative. Dr Pettit later assured King that his orders had always been followed, even when they prescribed other milk formulas than humanised milk. If their dietetic problem warranted it babies were sometimes treated with other formulas in the Karitane Hospitals but it was standard to reintroduce humanised milk as they recovered and before they left the hospital.

Ludbrook raised Carmichael's refusal to follow his orders at a meeting of the Honorary Physicians to the hospital. Carmichael had already informed Anne Patrick, Dr Parkes, and Eileen Partridge, the Honorary Secretary of the Auckland branch of the Plunket Society, of the situation but Ludbrook's open discussion of her refusal to carry out his orders forced her resignation. The Society's rules prohibited nurses from refusing to carry out a doctor's orders even if they contravened the Society's teachings, but the issue had never arisen in a Karitane Hospital before. Carmichael stood by her actions but resigned because hostility from medical men in the city was so strong that she believed 'no loop hole of adverse criticism can be given to those who are looking for any weakness in the Society'. Patrick agreed Carmichael had to resign, but thought the situation needed to be clarified. She warned Margaret Johnstone, that 'the future welfare and efficient running of our Karitane Hospitals is bound up in this difficult situation'. The question was whether the Matron was 'to obey the doctor, or to uphold the teachings of Sir Truby King?'.

Ludbrook denied he ever intended Nurse Carmichael to resign. He had no personal problem with her but rather disagreed with the management of the Karitane Hospitals. Specifically, he objected to the requirement that doctors adhere to the Plunket standard in regards to feeding. He thought the hospital should be run on a system where doctors have their own cases and increased their knowledge through their own experiments. Ludbrook was not alone in advocating change. Dr Edward Gunson, another consulting physician at the Karitane Hospital, informed the Secretary of the Auckland branch that he thought the Society needed to

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106 Report of Sir Truby King’s examination of Nurse Carmichael, 19 May 1931, and Carmichael to Patrick, 23 May 1931, PS AG7 11-10.
107 Pettit to King, 18 June 1931, PS AG7 11-10. King also claimed in a letter to Partridge, 31 May 1931 that Dr Gunson had given the Senior Honorary Physician at the hospital, Dr Parkes, the same assurance, PS AG7 11-10.
109 Carmichael to King, 17 June, 1931, PS AG7 11-10.
110 Patrick to Johnstone, 30 May 1931, PS AG7 2-231.
111 Carmichael to King, 17 June 1931 and Ludbrook to Partridge, 1 June 1931, PS AG7 11-10.
112 Report of Sir Truby King’s examination of Nurse Carmichael, 19 May 1931, PS AG7 11-10.
modify the direction of its work and its medical control if it wanted to retain the support of the medical profession. 113

The feeling within the Plunket hierarchy was that Ludbrook had deliberately planned the incident to 'best Matron'. 114 Truby King called a meeting of the Auckland Karitane Hospital in late May. The minutes of this meeting have not been found but within a few days Ludbrook resigned from the Karitane Hospital, an action Dr Montgomery Spencer later claimed 'was required by Truby King'. 115 His resignation did not resolve the situation, however. Gunson made his support for Ludbrook clear and refused to act as Senior Medical Officer while Dr Parkes went abroad. 116 King tried to get Ludbrook and Gunson to attend a meeting of delegates from all Karitane Hospitals, in Wellington, to discuss their concerns. 117 His efforts were unsuccessful, possibly because it was already clear he was not going to alter the Hospitals' rules, and King left for Sydney soon after.

Tweed was still officially the Society's Medical Adviser, albeit in an honorary capacity, and in August 1931 the Council negotiated to formalise this arrangement. After some discussion about the scope of his appointment it decided to pay him an honorarium of £300 to compensate for the effect of the Plunket work on his medical practice. 118 When King returned to New Zealand permanently in September 1931 he and Tweed worked together. Tweed saw his role as upholding King's teachings. He consulted King often and thus King retained his dominance over the medical direction of the Society's work.

Ludbrook remained critical of the Society's methods but retired from the fray as he became increasingly involved in more general medical politics. 119 Others took up the fight to convince Plunket to modernise its methods. The most fervent critics were a small group of doctors interested in developing paediatrics as a specialty in New Zealand. The main protagonists had undertaken postgraduate study in infant health overseas and returned to New Zealand to set up practice in the late 1920s and early 1930s. Their training varied. Dr Montgomery Spencer, an Otago graduate, spent three years studying overseas. He had a

113 Dr. E. B. Gunson to Partridge, 30 May 1931, PS AG7 11-10.
114 Patrick to Johnstone, 25 May 1931, PS AG7 2-231.
115 Ludbrook to Partridge, 1 June 1931, PS AG7 11-10. Medical Advisory Committee meeting report, June 1938, PS AG7 11-16.
116 Gunson to Partridge, 30 May 1931, PS AG7 11-10.
117 King to Gunson, 6 June 1931, PS AG7 11-10.
119 By 1933 he had the position of Honorary Secretary of the British Medical Association (N.Z.) Branch, Hoddinott to Ludbrook, 19 May 1933, PS AG7 2-260. Between 1935 and 1938 he was the Auckland representative on that organisation's National Health Insurance Committee, which campaigned against the Labour Government's scheme of medical social security, D. G. Bolitho, 'Some Financial and Medico-Political Aspects of the New Zealand Medical Profession's Reaction to the Introduction of Social Security', NZ IH, 18, 1 (1984), pp. 42-43.
Rockefeller Scholarship at the Children's Hospital at Harvard University in America and also spent time in England and on the Continent. He finally settled in Wellington where he set up in practice as a children's specialist. Dr Cronin also spent three years abroad, doing postgraduate work in America and London. Dr Elspeth Fitzgerald, who concentrated on children in her Oamaru practice, undertook her postgraduate training in the 1920s in Edinburgh and London. According to Fitzgerald, most of the New Zealand doctors who spent time studying paediatrics overseas returned to New Zealand profoundly dissatisfied with the Plunket system. These doctors opposed Plunket's attempts to impose uniformity in artificial infant feeding, the level of protein in the Plunket diet and were concerned about the role of Plunket nurses. Underlying their opposition was displeasure at Plunket's dominance of infant welfare. The Society came under attack, internally and externally, as these doctors vied for more control over infant welfare.

In late 1932 and early 1933 Drs Spencer, Fitzgerald and Cronin all published papers advocating changes to the current infant feeding system in the *New Zealand Medical Journal*. As Truby King had before them, they drew on theories promulgated by international infant feeding experts. They were particularly influenced by Dr McKim Marriott, Professor of Pediatrics at Washington University and author of *Infant Nutrition*. Marriott was an enthusiastic advocate of evaporated milk and concentrated on developing simple, digestible and affordable infant feeding methods rather than imitating human breastmilk. Fitzgerald also drew on the work of Dr Donald Paterson of the Great Ormond Street Hospital for Sick Children in London, whose book, *Modern Methods of Infant Feeding*, encouraged an earlier introduction of mixed feeding than the Plunket dietary allowed.

Spencer, Fitzgerald and Cronin were united in opposing Plunket's low protein formulas. Their concentration on the protein level in Plunket's diet partially reflected changes in infant mortality patterns. By the late 1920s infantile diarrhoea deaths had been 'practically wiped out'. Concern amongst the medical profession shifted from infantile diarrhoea to malnutrition in New Zealand schoolchildren. Underfeeding and 'protein starvation' were highlighted as the new dangers by the new experts. Fitzgerald, for instance, claimed that evidence of malnutrition was not found in the infant mortality statistics but in 'the poor muscle tone, carious teeth and bony deformities so frequently seen'. Although the infant mortality

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123 Dr Elspeth Fitzgerald, unattributed press clipping, 'Support for Dr Spencer', PS AG7 11-24.
125 King to Barrett, 2 November 1928, PS AG7 5-18.
126 Fitzgerald, 'Some Practical Experiences in Modern Infant Feeding', p. 23.
rate was low, 'developmental defects of structure and the prevalence of dental caries in our school children' pointed to problems with the current artificial feeding system.\textsuperscript{127}

In many respects the arguments Spencer, Fitzgerald and Cronin used echoed Dr Sweet's earlier criticisms of King's methods. The detail of the criticism had developed however. They argued that Plunket's percentage based method, which attempted to imitate the chemical composition of breastmilk, considered only the gross amount of protein required and ignored vital differences in the type of protein present in human and cow's milk. As early as the 1890s there was firm scientific evidence that milk proteins consisted of both whey protein or lactalbumin and curd protein or casein. By 1897 scientists agreed that cows' milk had a high ratio of casein to lactalbumin, but the precise composition of protein in human milk remained uncertain for the next two decades.\textsuperscript{128} Lactalbumin was considered more important than casein because it was more easily assimilated and contained more amino-acids. In the 1930s there was general medical agreement that cow's milk contained approximately 15 per cent lactalbumin compared to about 60 per cent in human milk. High protein advocates argued this proved that percentage feeding methods did not provide sufficient protein because 'in artificial feeding with cow's milk more total protein must be supplied than with breast feeding'.\textsuperscript{129}

United in opposing Plunket's low protein formulas, these critics advocated a number of alternative feeding methods. This emphasised their point that although King had attempted, through the Plunket Society, to impose one system of artificial infant feeding on the nation's mothers there was no unanimity on the subject amongst the medical profession. Both Fitzgerald and Spencer promoted calculating an infant's dietary requirement by caloric need, age and weight, with a higher proportion of protein than the Plunket formulas provided.\textsuperscript{130} Cronin recommended the routine use of lactic acid milk (whole cow's milk or evaporated milk modified to increase digestibility by the addition of lactic acid rather than dilution with water), a low fat, high protein mixture sometimes prescribed for malnourished babies at the Karitane Hospitals. The new experts touted their feeding systems as fulfilling the latest scientific criteria of cleanliness, digestibility of food, correct composition (which had to include 'sufficient protein, carbohydrate, fat, mineral salts, water and vitamins A, B, C and D') and correct caloric value, for successful artificial feeding of infants.

Their proponents claimed these feeding systems were simpler for mothers to prepare and more easily adjusted to the needs of individual babies than Plunket's diet. Defence of the

\textsuperscript{127} Ibid, p. 21.
\textsuperscript{129} Fitzgerald, 'Some Practical Experiences in Modern Infant Feeding', p. 24 and Cronin, 'Lactic Acid Milk in the Feeding of Infants', p. 150.
\textsuperscript{130} Fitzgerald, 'Some Practical Experiences in Modern Infant Feeding' and Spencer, 'Modern Principles in Infant Nutrition'.
Plunket system fell to Dr Ernest Williams, the lecturer in children’s diseases at Otago University and an Honorary Physician at the Karitane-Harris Hospital in Dunedin. He argued that the Plunket system was responsive to the needs of individual babies. Williams also argued that the Plunket system was no more complicated than the methods its critics sought to replace it with. He pointed out that all the feeding methods discussed involved measuring ingredients by either spoonfuls or ounces adding that 'one is no more complicated than the other'. Whichever system was chosen the mother still had to boil the milk, dilute it with water and increase the carbohydrate content by adding a sugar mixture. Advocates of higher protein formulas could claim they were slightly easier to prepare than the Plunket formula because the milk did not have to be diluted to the same extent and thus did not need to be supplemented with additional fat. But the Plunket recipe for humanised milk had also been simplified. It could be made by simply adding Karilac and Kariol to milk which had been boiled and diluted with water. King had claimed these products 'render[ed] mistakes by Mothers almost impossible', adding 'it reminds one of the great Kodak advertisement, "You press the Button and we do the Rest!". This volley of articles in the New Zealand Medical Journal increased the pressure on the Plunket Society to clarify its own medical direction. In February 1933 Dr Tweed wrote to Hoddinott that the Society would have to take action to counter the 'growing outcry carefully fostered by practising Pediatrists...that Plunket methods are out of date'. In an effort to responsibilities within the Karitane Hospitals clear the Society reissued the rules for Honorary Medical Staff in the Karitane Hospitals. The standard edict that the medical staff were responsible for 'all medical treatment...apart from dietetic' sparked complaints from doctors who worked within and largely supported the Plunket system. Some of the Auckland

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131 Percentage methods of feeding were developed on the theory that cow's milk should and could be individualised to meet the differing digestive capabilities and metabolism's of artificially fed infants, see Rima Apple, Mothers and Medicine, pp. 24-29 and 34.
134 Ibid.
135 King to Dr Ellison, 18 May 1933, PS AG7 5-18.
136 Tweed to Hoddinott, 22 February 1933, PS AG7 2-281.
137 Original emphasis. Hoddinott to Mrs Allan, May 9, 1933, PS AG7 2-260. Dr. W. H. Parkes wrote to Tweed that it was humiliating that doctors did not have a say in the diet of babies under their care. Parkes to Tweed, 24 May 1933, PS AG7 2-260.
doctors complained that Plunket Matrons had 'too much power and liberty of action'.

Plunket nurses in a few areas confronted role definition issues daily in their interactions with doctors who were suspicious that they crossed the line into medical treatment. The Plunket Society tried to ease the problem by issuing its nurses with forms to give to mothers they advised to seek medical attention. This protected its nursing staff from accusations that they treated sick babies instead of referring them on to doctors.

The growing dissension from the medical profession was impossible for the Society to ignore. Tweed thought the criticism had to be met and advised the Executive that 'to meet it properly the scientific advisers of the Plunket Society will have to be organised and made to speak up in no uncertain manner in favour of Plunket Methods'.

It seemed obvious to Tweed that once King's mantle of authority was gone 'the Public would demand some other supreme authority for the teaching of the Society's methods'. He formally proposed setting up a Medical Advisory Board to advise on controversial points about infant feeding. The Executive had already been considering the idea and were anxious that it be 'set up in Sir Truby's life-time and with his backing and approval as a means of ensuring the future'.

In September 1933 representatives of each of the Karitane Hospitals and Dr Tweed met for two days in Wellington and decided to officially form a Medical Advisory Committee. Membership consisted of the Medical Adviser, a representative from each Karitane Hospital and, from 1934, the Society's Nursing Adviser. The Committee's functions included considering alterations to the Society's feeding regime, revising the Society's pamphlets and discussing staffing issues and the annual reports from each of the Karitane hospitals. Meetings were to be held annually.

The 1933 meeting formulated a uniform protocol for appointments to the Honorary Medical staffs of the hospitals. It clarified the duties of the medical staff and reiterated that all physicians were required to adhere to the use of standard Plunket diets for normal cases. On the vexed issue of the Plunket diet the Committee decided that 'in view of conflicting and indefinite

138 Eileen Partridge, attributed these complaints to the agitation of Dr Sweet, Partridge to Hoddinott, 11 May 1933, PS AG7 2-281.
139 Hoddinott to Ludbrook (Honorary Secretary of the NZBMA), 19 May, 1933, PS AG7 2-260.
140 Original emphasis, Tweed to Hoddinott, 22 February, 1933, PS AG7 2-281.
141 Tweed to Dr Ernest Williams, 5 June 1933, PS AG7 2-281.
142 Central Council minute book, 25 May 1933, PS AG7 1-2-12.
143 Kate McGeorge to Tweed, 26 May 1933, PS AG7 2-281.
144 The representatives were Dr Harold Pettit (Auckland), Dr Helen Deem (Wanganui), Dr T. H. Corkill (Wellington), Dr E. Widdowson (Christchurch), Dr E. H. Williams (Dunedin) and Dr Stanley Brown (Invercargill), PS AG7 11-16.
145 Annual Report, 1935, p. 16, PS AG7 1-3-3. Tweed had initially suggested including representatives from the Otago Medical School and the Bacteriologist from the Karitane Products Society, Executive Council minutes 25 May 1933, PS AG7 1-2-12.
CHAPTER 4

A Nursing Society?

At its November 1933 meeting the Central Council moved 'in camera' and after some discussion voted to demand Anne Pattrick resign as Director of Plunket Nursing, 'in the best interests of the work of the Society'. The Council appointed an informal committee consisting of Kate McGeorge, Margaret Harding and Elsie Williams from the Central Council and Mr Justice Blair, from the Society's Advisory Board, to act on the motion. The committee deputed Blair to discuss the matter with Anne Pattrick's brother, Percival Pattrick, a Wellington accountant and member of the Karitane Products Society, in the hope that he would advise his sister to hand in her resignation. When this did not eventuate the Executive committee decided to employ a more direct approach. Anne Pattrick received a letter from Gwen Hoddinott, Administrative Secretary of the Society, relaying the Council's decision that her retirement was necessary and outlining the generous compensatory salary and superannuation package she would receive if her resignation was tendered within the next two days. If she failed to resign her employment would be terminated by the Council anyway. Pattrick was stunned but faced with no real alternative reluctantly tendered her resignation as Director of Plunket Nursing the following day, while pledging her ongoing devotion to 'the welfare of mothers and babies and also the nursing service of the Truby King system'. A few days later branch committees were notified about Pattrick's resignation in a terse circular signed by Hoddinott on behalf of the Council.

No reason for what was effectively Pattrick’s dismissal was ever officially given. The evidence suggests that it was demanded by a group within the Council who were seeking to establish their control of the Society. As the matter was never discussed out of camera, it is impossible to tell exactly who was and was not behind the push to get rid of the Director of Nursing, but it is clear that those involved included members of the Society’s Dunedin based Executive, and Administrative Secretary Gwen Hoddinott. The background to the affair included the Council's history of relative quiescence in the 1920s, when King was dominant. With the gradual sideling of King, it is possible that the Council perceived Pattrick as competition for leadership. Unlike members of the Executive Pattrick was in close contact with both branches and staff, and had always enjoyed wide popularity. In addition, when the

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1 Central Council minute book, Central Council meeting, 2 November 1933, PS AG7 1-2-3.
2 Hoddinott to Pattrick, 30 November 1933, PS AG7 11-11.
3 Pattrick to McGeorge, 1 December 1933, PS AG7 11-11.
4 Circular to branches, ref. no. 81, 5 December 1933, PS AG7 2-311.
Society's medical direction was stagnating during the early thirties, Patrrick showed considerable progressive drive.

The Patrrick affair highlighted the control the Executive had come to wield over the Society. The Executive was drawn from the Dunedin branch and controlled the day to day running of the Society. Its members were drawn from the Central Council, composed of sixteen representatives from the five provincial areas, which met once every six months. In the early 1930s, as a result of the Depression and the on-going difficulties with Truby King, the Executive suspended the Society-wide conferences which had been held biennially. As a result the Council and in particular the Executive were not being held accountable to the Society as a whole. As a result of the Patrrick affair the branches challenged the authority of the Executive and the Council.

I.

Reaction to Patrrick's resignation from branches and Plunket nurses was swift. The national office received many letters, generally expressing both their appreciation of her work as director of the Society's nursing service and their dismay at her resignation. The depth of feeling on the issue, particularly amongst the nurses, was strong. The Plunket nurses of the Wellington district wrote of their 'consternation and concern', adding that

Miss Patrrick has been guide, philosopher and friend to each and every nurse, and we can scarcely contemplate the effect of her loss as Director of Plunket Nursing upon the nursing work in general and ourselves as Plunket Nurses.

Patrrick, with her vast practical knowledge of the complexities of Plunket nursing and her readiness to offer friendly guidance on professional matters, was a trusted adviser and mentor to the nursing staff. In comparison to hospital nurses most Plunket nurses worked in isolated

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5 Patricia Sargison implies that a 'new' Executive was behind the antagonism toward Patrrick (Notable Women in New Zealand Health Te Hauora Ki Aotearoa: Ona Wahine Rongonui, p.44). The only significant change in the composition of the Executive was the accession of Kate McGeorge to the presidency a few months prior to Patrrick's dismissal. McGeorge had been vice-president for a number of years previously. Bryder characterises the matter as a power struggle between the voluntary members of the Executive and the salaried health professionals, Dictionary of New Zealand Biography, vol. 4, 1921-1940, Wellington, 1998, p. 400. As will be seen this was not the case.

6 Although this decision was clearly made by the Executive and not the Council, it is not always clear which body is responsible. Decisions made by the Executive were not identified to the branches as such. The Executive officially represented the Council but it is often clear that not all Council members had been consulted or agreed with the decisions they made. From a researcher's point of view this problem is compounded by the fact that both bodies used the same minute book (from 1934 it was called the Dominion Council book). Because the Central Council only met at 6 month intervals reference to Central Council minute book usually refers to an Executive meeting.

7 Wellington district Plunket Nurses to Mrs McGeorge, 8 December 1933, PS AG7 2-311. This letter was signed by the Plunket nurses of the Wellington provincial district and the Plunket nurses at Fielding, Levin, Otaki, Pahiatua, Masterton, Carterton, Featherston, Blenheim, Nelson and Motueka desired that the Council be informed that they were fully associated with the contents of the letter.
conditions and regular interaction with the Director of Plunket Nursing was an essential professional support mechanism, particularly for nurses appointed to provincial towns and rural areas. Indeed, as the Plunket nurses of the Wanganui provincial district noted, few Plunket nurses had known the Society without Miss Pattrick and the prospect of her resignation caused both shock and a sense of personal and professional loss. They wrote to the Central Council that she had

held Sir Truby King's aims and ideals of the work ever before them and has inculcated in the mind of each nurse, the spirit of the Plunket Society, and the possibilities which can be, and so far have been achieved...she has shown in herself, and inspired in her nurses, the utmost loyalty and support of the Central Council, Committees, the Medical Profession and all bodies in any way connected with the work...[she] has called forth the best in her nurses, who are, one and all, glad and proud to have been associated with her.8

The nurses were unaware that Pattrick's resignation had been forced by the Central Council and hoped she could be convinced to reconsider her decision. They urged the Council to try to retain her services even if it was only 'for some little time'.9

There was also some hope among the branches that Pattrick could be convinced to reconsider her decision. As details of the circumstances of the resignation emerged, however, the focus and tenor of correspondence from branch committees changed. Within a fortnight of the Council announcing Patrick’s retirement the Thames branch wrote protesting her ‘virtual dismissal’ and calling for her reinstatement.10 An outcry from the branches about the treatment of Pattrick began to gather momentum with much of the impetus for formal protest and action coming from the Wellington branch.

On 13 December 1933 the Wellington branch convened a special urgent meeting of its sub-branch committees, Karitane hospital medical staff, the branch advisory board and Percival Pattrick to discuss the details of Anne Pattrick's retirement. Reports from Anne Tythe Brown, the local representative on the Central Council, had raised procedural issues about the methods by which Pattrick's retirement had been achieved. There were several disquieting factors. Tythe Brown had suggested during the November Council meeting that Pattrick be asked to attend the meeting to discuss the issues that had arisen about her performance but this failed to win favour.11 The denial of any opportunity for Pattrick to answer specific criticisms from those seeking her resignation, and the lack of any specific examples put before the Council meeting of behaviour necessitating her resignation, raised questions about the reasons for her retirement.

8 Wanganui district Plunket Nurses to Mrs McGeorge, 8 December 1933, PS AG7 2-311.
9 Ibid; Christchurch provincial district Plunket Nurses to Hoddinott, 10 December 1933, PS AG7 2-311.
10 Thames branch committee to Central Council, 14 December 1933, PS AG7 2-311.
11 Wellington branch minutes, 13 December 1933, PS 89-094-4 and Brown to McGeorge, 14 November 1933, PS AG7 11-11. Anne Tythe Brown had been matron of the Karitane-Harris Hospital in Dunedin, so brought a nursing perspective to bear on the matter.
Moreover two procedural decisions relating to the November Council meeting were viewed with scepticism by the Wellington meeting. Council members had not been given prior notice by the Executive committee that a motion in favour of the Director of Plunket Nursing’s retirement was on the agenda for the November meeting. As a result most Council members had no opportunity to consider the motion before the meeting. In addition the discussion of that motion was taken 'in camera', denying Council members the opportunity to consult with their branch executives either during or after the meeting.

The style in which Pattrick’s services were dismissed and the lack of transparency in the Council’s actions outraged the various representatives at the Wellington meeting. After a short discussion they decided the issues should be put before all the Society's branches through a General Conference. The rules of the Plunket Society allowed any two of its branches to requisition such a conference to consider urgent or special business. With this in mind the Wellington meeting drafted an open letter to the Central Council and all the branches, outlining their concerns and affirming their confidence in Pattrick. Calling the Council’s actions ‘arbitrary, unjust and utterly opposed to the best interests of the Plunket Society’, the meeting demanded an explanation for its actions from the Central Council and asked for her reinstatement pending a General Conference. Enclosing a copy of the Administrative Secretary’s letter relaying to Pattrick the Council’s decision that she should resign immediately, the Wellington branch asked all branch committees to discuss the matter and consider joining with them to ask for a conference to be held in February 1934.

Within days the Nelson and Auckland branches confirmed they were seconding the Wellington branch’s request for a February conference.

Confident of the support of at least two other branches the Wellington committee formally resolved to request the Council hold a special conference to consider both Pattrick’s retirement and the reinstatement of annual general conferences, the first to be held in July 1934. The latter request was made for a number of reasons. The Society’s rules gave the Central Council power to control the affairs of the Society subject to direction from General Conferences. The Wellington branch was of the opinion that the Council had acted within its legal power but exceeded its moral power by not seeking direction in its treatment of Pattrick from a Conference. It predicted that constitutional issues could arise at the Special Conference because ‘big issues of policy are involved, Miss Pattrick as a person, being simply the means of their coming into issue’. The reinstatement of annual conferences was put on the agenda.

13 The Administrative Secretary’s letter to Pattrick was given to the Wellington branch by Percival Pattrick but it is unclear who decided to distribute it to the branches.
14 The Wellington branch had earlier decided to ask the Nelson branch to join with them in requesting the conference. Wellington branch minutes, 13 December 1933 and 21 December 1933, PS 89-094-4.
because the Wellington committee wanted conference delegates to be free to consider Patrick's resignation, confident that there would be a forum for discussing policy issues at a later date.\(^5\) It specified July 1934 as the date for the next annual conference because branches would need an opportunity to discuss any issues or proposals at their Annual General Meetings.\(^6\)

The strategy of questioning the Council's actions and calling for a conference to address the matter worked. Branches began to criticise the Council's arbitrary actions and demanded the reinstatement of Patrick to the position of Director of Plunket Nursing.\(^7\) Momentum for the Special Conference gathered as Wellington petitioned other branches for their support, enclosing a copy of their resolution as a requisition form for branches to forward to the Council.\(^8\) In all twenty nine branches sent Council formal requests for a special conference to be held in February 1934. Council had no option but to accede.

As no full Central Council meetings were scheduled for another five months the Executive had to respond to the criticism of Patrick's resignation and to deal with the requests for a Special Conference. The Executive authorised McGeorge to send a confidential letter to all Council members reiterating the necessity of Patrick's retirement and the unanimity of its decision with the aim of clarifying the 'misunderstanding in Wellington in regard to the facts'.\(^9\) Dr Tweed was deputed to respond to a complaint from the Wellington Karitane hospital staff about the treatment Patrick received from the Council. No effort was made during December, however, to explain the Council's position to the wider, grass-roots members of the Plunket Society. Rather, apparently still hopeful that the dissension would fade away, the Executive devoted most of its energy to finding a replacement for Patrick.

In late December the Executive publicly announced that Nora Fitzgibbon, matron of the Auckland Karitane Hospital, had been appointed Nursing Adviser to the Plunket Society. This appointment, made with no consultation with the Central Council, further outraged those branches which considered the Executive inclined to overstep its authority.\(^10\) The announcement was ill conceived and premature. Fitzgibbon had not yet decided to accept the post and was consulting with Health Department officials. In the meantime she sent a telegram to the Plunket Executive stating that she was 'accepting conditionally - writing'.\(^11\) Without waiting for Fitzgibbon's letter the Executive announced her acceptance to the media. It is unclear who authorised the announcement. McGeorge, convalescing from a recent illness in

\(^{15}\) Bullock to Allan, 29 January 1934, PS AG7 11-11.
\(^{16}\) Wellington branch minutes, 21 December 1933, PS 89-094-4.
\(^{17}\) PS AG7 2-311.
\(^{18}\) Wellington branch minutes, 21 December 1933, PS 89-094-4.
\(^{19}\) Central Council minute book, 13 December 1933, PS AG7 1-2-5.
\(^{20}\) PS AG7 11-11.
\(^{21}\) Fitzgibbon had consulted with Mary Lambie, Registrar of Nurses who had discussed the situation with Dr Watt, the Director General of Health, PS AG7 11-11.
Queenstown, had been uneasy about revealing the appointment. She wired a warning to Hoddinott that the Executive's actions might be considered 'arbitrary, out of order', especially in view of the requests from the Wellington and Auckland branches for a special conference. She suggested that announcing the appointment immediately would prejudice Fitzgibbon's future working relationship with the branches. One of her fears proved well founded - the Wellington branch was shocked at the Executive's action and reacted immediately and publicly.

Having learned of the appointment through the press the Wellington branch decided to respond in the same medium. The branch committee wrote to the *Evening Post* to express surprise both at the appointment and at the downgrading of the position from Director of Plunket Nursing to Nursing Adviser. In a strongly worded protest it declared that, with other branches, it was deeply dissatisfied with the Dunedin headquarters and would continue to take the necessary steps to convene a special conference. Tythe Brown made a statement that despite being a member of the Central Council she had not been consulted and assumed that the decision had been made by the Council's executive. Fitzgibbon realised the level of dissension within the Society about Pattrick's retirement and immediately withdrew her acceptance of the position until the issue had been resolved. Discord within the Society was obvious as the Auckland branch, favouring Pattrick's reinstatement and outraged the Council had not consulted them before headhunting their matron, released for publication Fitzgibbon's telegram declining the post. The Executive had miscalculated; the decision to appoint a replacement for Pattrick backfired as the Society's battles were played out in the media.

Resigned to the prospect of a Special Conference the Executive tried to take control of the situation in the new year. It was decided, after receiving confirmation from J. A. Young that he would be available, to hold the conference on 22 February 1934. Wary of convening the conference in Wellington, which although geographically the most central branch was also at the heart of the agitation against the Executive's actions and more accessible for Auckland delegates, they decided to hold it in Dunedin. The size of the Auckland branch gave them considerable voting power and the Executive considered their supporters had more danger of being outvoted in a no-confidence motion if the conference was in Wellington. Protests about the venue, mainly on economic grounds, were received from branches around the country but the Executive refused to reconsider.

A circular announcing the date and venue of the Conference and outlining the Council's position was sent to all the branches in mid January. In its first official statement on the issue

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22 McGeorge to Hoddiaott, 27 December 1933, PS AG7 2-309.
23 *Evening Post*, December 1933, PS AG7 11-11.
24 Fitzgibbon undated letter to McGeorge, PS AG7 2-309.
25 Hoddinott to Young, 5 January 1934, PS AG7 2-309; Dominion Executive minutes, 9 January 1934, PS AG7 1-2-12.
the Council pointed out that they had a mandate from the branches and appealed for their loyalty until the matter was discussed at the Special Conference. In the only clear response to the requests for reasons why the Council had asked for her resignation the circular stated that Pattrick had 'given valuable service to the society and the community' during her time as Director of Plunket Nursing, but added that

for some years the Council has been concerned over Miss Pattrick’s actions and attitude towards it. Many instances have directly and indirectly made it clear to the Council that it was not receiving from Miss Pattrick the loyalty and obedience to its directions that it was entitled to expect from its officers.26

The circular was supported by a supplementary statement from some members of the Council's Advisory Board (the Council, like all Plunket branches, had a group of prominent men who advised them on business matters). Stating that they saw no grounds for questioning the Council’s treatment of Pattrick, they commented that their understanding of the situation was that from time to time since her return from England the Executive and General Council have taken steps to direct her as a salaried officer in the need for her to refrain from undermining and pulling against the Executive in the direction and management of the Society's affairs.27

Both statements implied that Pattrick had been disloyal to the Council and more specifically to the Executive. Examination of the reasons Council and Advisory Board members gave for attaching or withholding their signatures from these circulars' however, shows that at least some had no personal knowledge on which to base this assessment and had relied on the judgement of the Executive.

The Council’s statement did not reflect a united front. Only eighteen of the twenty-two Council members signed. Tythe Brown of the Wellington branch and Flora Sinclair-Lockhart of the Auckland branch had already publicly disapproved of the Council’s actions and refused permission for their names to be attached to the statement. The refusals of two newer Council members were less predictable but more telling. A. M. Bisley, elected to the Council in 1933, was not prepared to sign a statement accusing Pattrick of disloyalty.28 Mary Paterson claimed she had had no idea before the November 1933 Council meeting that the Council was dissatisfied with Pattrick’s performance and also refused to be personally associated with the statement.29 She had previously expressed to McGeorge her fear that the Executive had not had 'sufficient ground or complete enough information' for forcing Pattrick’s resignation. No specific charges of wrongdoing by Pattrick had been offered. Rather, according to Paterson,

26 Circular no 86, 16 January 1934, PS AG7 11-11.
28 Bisley to Central Council, PS AG7 2-311.
29 Paterson to Hoddinott, 16 January 1934, PS AG7 2-309.
Council members were swayed by assurances from the Executive that it and the Advisory Board considered Patrick's resignation was necessary.30

Yet it seems some members of the Advisory Board had little personal knowledge of the situation either. Peter Barr agreed to attach his name to the Advisory Board's statement but noted that he was 'of course, without any personal knowledge of instances of want of "loyalty and obedience to the directions of Council" on the part of Miss Patrick (sic)'.31 The factual basis for the Advisory Board's support of the Council's actions, which Paterson recalled gave Council members at the November meeting the understanding 'that there must be serious and sufficient cause for Miss Patrick's being asked to resign', seems to have been largely illusory.32 Another Advisory Board member, A. W. Blair, who had earlier been involved in the first attempts to negotiate Patrick's retirement and was generally supportive of the Council's action in the matter, did not sign the Advisory Board's statement because it was based on facts, upon which he considered the Board 'could not express any worthwhile opinion ... without hearing both sides.'33

The confusion and ignorance within the Central Council and the Advisory Board about the factors leading to the decision that Patrick's resignation would be 'in the best interests of the Society' raised several questions. What, specifically, had Patrick done to lose the confidence of some members of the Council and, more importantly, the executive committee of the Council? Who instigated the events which led to the request for Patrick's resignation? Was the decision aimed at Patrick personally? Or was it, as the Wellington branch feared and the attempt to replace Patrick with a Nursing Adviser might indicate, aimed at limiting the scope and status of the nursing side of the Society?

II.

Jessica Wickham, a member of the Wanganui branch, summed up a widespread view about the Executive's motives when she wrote:

It seems to me that underlying the whole trouble was the desire to abolish the very necessary and important position of Director of Plunket Nursing and apparently the only way to achieve this was to ask Miss Patrick to resign.34

This was the only reason those opposing Patrick's resignation could find for her dismissal. The motives of the Central Council remain somewhat obscure as they never fully and publicly

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30 Paterson to McGeorge, 20 December 1933, PS AG7 2-309.
31 Barr to Hoddinott, 15 January 1934, PS AG7 2-309.
32 Paterson to McGeorge, 20 December 1933, PS AG7 2-309.
33 Blair to Hoddinott, 15 January 1934, PS AG7 2-309.
34 Jessica C Wickham, PS AG7 2-310.
addressed the Wellington branch's challenge to furnish them with a justification for its action and no discussion of the decision to force Patrìck to resign was ever recorded in detail in the Council's minutes. Even so a review of the available evidence supports the view that the Council's demand for Patrìck's resignation was less a result of any specific wrong doing on her part and more to do with a series of misunderstandings and a growing disquiet amongst the Executive Committee of the Central Council about the autonomy of the nurses within the Society.

A month after her resignation Patrìck was convinced that problems had arisen because of 'the lack of adequate facilities for professional representation on the governing body of the Society'.35 The alterations to the Society's constitution, passed at the Interim Conference in June 1931, did not specifically include representation for the Society's nursing staff on the Central Council. This was the subject of some debate at the time as the Wellington committee was worried that the administrative side of the Society's work was being built up at the expense of the nursing side. The proposed amendments gave the Administrative Secretary the right to be present at all meetings of the Council and the Wellington branch intended to secure the same privilege for the Director of Plunket Nursing. They forwarded a remit along these lines to the Council, explaining that as Plunket was a nursing society the nurses should be represented at Council meetings. The Wellington committee was subsequently persuaded by a Council member to withdraw this remit. It replaced it with a remit which sought to limit an amendment to the rules which allowed Administrative Secretary's right to enter into discussion at Council meetings. Other branches alleged this remit was disloyal to the Council and it failed.36

The lack of provision for nursing representation on the Council was curious, especially when before 1931 it had been standard for the Director of Plunket Nursing to be notified of the meetings and to attend them when nursing matters were discussed. It seems, however that during the previous year the relationship between Patrìck and the Central Council had become strained. The record suggests no defining moment but a combination of events towards the end of 1930 may have been responsible for a change in the Council's attitude to Patrìck.

A meeting of the Central Council held in Wellington immediately before the 1930 General Conference discussed Patrìck's future as Director of Plunket Nursing. A recurrent health problem had made it imperative she lessen her workload and Patrìck had herself suggested that she might have to take a lesser position within the Society. President Margaret Johnstone reviewed Patrìck's working history with the Society. Continual ill health, mostly glandular problems, meant that between 1925 and 1930 the Society had given Patrìck more than a year of sick leave, on either full or half salary. In addition she had taken a year's leave

35 Patrìck to Maude Bullock, (Acting President of the Wellington Branch of the Plunket Society), 3 January 1934, PS AG7 11-11.
36 Wellington branch statement, 29 January 1934, PS AG7 11-11.
from June 1929 to travel overseas, visiting the Mothercraft movement she had helped Truby King establish in England and attending a nursing conference in Toronto, over which period the Society continued to pay its share of her salary. Johnstone was concerned that Truby King's failing health made it impossible to lighten the Director of Plunket Nursing's duties and the Council appointed a deputation to interview Pattrick about her health and report back to them. After an examination by her doctor it was agreed that Pattrick was now fit to resume full duties but this incident indicates the existence of doubt within the Council about Pattrick's ability to carry out her role.37

Even though it was ultimately Truby King and Mrs Hall, the president of the Wellington branch, who negotiated Pattrick's return to work after the 1930 Conference, at some point, and possibly around this time, King's attitude toward Pattrick underwent a dramatic change. Pattrick and King had shared a close working relationship since he appointed her as Sister at the Dunedin Karitane hospital in 1913. As late as 1928 he proposed a motion that the Central Council express a vote of appreciation of her work.38 Mary King confirms that these sentiments were typical of her father's 'REAL and BASIC feelings towards Miss Pattrick' (her emphasis).39 Reminiscing for Challis Hooper's brief biography of Pattrick, Mary King noted her father's change of opinion, sometime in the late 1920s or early 1930s was due

NOT to anything Miss Pattrick said or did, but to the gradual disintegration of his own complex mind, in which he came later to regret having delegated so much power to others - particularly Miss Pattrick.... The final "flare-up"...was over some circular which Miss Pattrick had prepared and sent out to all Plunket Nurses without T. K.'s consent. For days he stormed around the house. Miss Pattrick became "inept", "insubordinate", "unpredictable", "conceited", "pig-headed", and aspersions were even cast back to her "lack of education." Any upholding of Miss Pattrick's character by the unwary merely fanned the flames...it was as if a black cloud had settled over New Zealand.40

The change was readily apparent. By 1933 Anne Tythe Brown suspected that Margaret Johnstone and Kate McGeorge's opinion of Pattrick might have been influenced by King's 'inaccurate' statements about her, 'before anyone realised his failing health and through that, his not always fair judgements'.41 It was clear, to Pattrick at least, that a shift had occurred in the President and Vice-President's attitude towards her during her period of extended leave. Their wariness of the Wellington branch's attempts to secure nursing representation on the Council in the 1931 constitutional changes suggests they may have been influenced by King's belief that he had delegated too much power.

38 Central Council minute book, 1 September 1928, PS AG7 1-2-3.
39 Mary King to Challis Hooper, 22 January 1955, (original emphasis), PS AG 38 69, Plunket Society Papers. I would like to thank Alison Midwinter, Hocken Archives, for drawing my attention to this letter.
40 Ibid.
41 Tythe Brown to McGeorge, 14 November 1933, PS AG7 11-11.
The process of changing the Society's constitution had begun in 1930. Pattrick's absence denied her the opportunity to lobby the Council to specifically include the Director of Plunket Nursing in the Central Council under the new rules. King was actively involved in drafting the 1931 rule amendments and at this stage he still had enough mana within the Council that his support for the original Wellington remit would have assured the Director of Plunket Nursing's right to attend Council meetings. His support evidently was not forthcoming and while the degree to which King's attitudes affected the Council remains uncertain, on her return to work in October 1930 Pattrick noticed a 'marked' but 'impalpable' shift in the disposition of some members of the Central Council. The first real indication that the relationship between the Director of Plunket Nursing and the Society's governing body had changed came when Pattrick was notified that she was only to attend Council meetings at their request. Uneasy at the prospect of the Council discussing nursing matters which might require technical input Pattrick sought to address the issue in November 1930.

At the end of the 1930 Conference, within days of the Council discussing her future as the Director of Plunket Nursing, the Central Council gave Pattrick the opportunity to address them. Noting her desire to preserve the amicable working relationship between the Society's nursing and administrative departments she proposed the Society create a sub-committee to discuss and make recommendations on the organisation of the nursing side of the work. The sub-committee's responsibilities would include monitoring entry to the Society's nurse training schemes, curriculum and resource development, appointments of nurses to branches, and overseeing nurses' employment conditions, including salary issues and discussion of 'difficulties involving the professional work or status of the Nurses.' The Council refused to consider a nursing sub-committee with Mrs Johnstone indicating that Truby King and the Council's Executive Committee should be referred to in such matters.

The aim of Pattrick's nursing sub-committee proposal was to set up formal channels of communication between the nursing and administrative departments of the Society and to promote the professional development of the nursing work. Pattrick consistently supported the advancement of her nurses and to this end in 1926 she had participated in the establishment and promotion of the Plunket Nurses' Association. Full membership of the Association was open to any active Plunket nurse and its stated aims were to encourage the interchange of knowledge between nurses, to promote 'uniformity of teaching and teaching methods' within the Society, and to uphold the aims of the Plunket Society. The Society's Executive viewed this development with apprehension. In November 1930 Pattrick apologised to the Executive for

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42 Pattrick to Bullock, 3 January 1934, PS AG7 11-11.
43 Central Council minute book, Central Council meeting, 22 November 1930, PS AG7 1-2-3.
44 Annual Report, 1927, p. 73, PS AG7 1-3-2.
45 Rules of the Plunket Nurses Association, PS AG7 3-215.
promoting the Association without consulting them and tried to clear up some misunderstandings which had developed about the Association's objectives.\textsuperscript{46} Again the minutes do not record the exact nature of the misunderstandings but both the Plunket Nurses' Association and the proposed nursing sub-committee may have confirmed suspicions that the Director of Plunket Nursing was exceeding her authority. To put these developments in their historical context, the creation of professional organisations was a vital part of the ongoing professionalisation process and Plunket nurses were only keeping pace with developments within the wider nursing profession.\textsuperscript{47} Efforts to stimulate the professional development of the nursing side of the work seem to have been considered a threat to the Council's autonomy by some Executive and Council members. In her own analysis, soon after her resignation, Patrick was of the opinion that the Council may have inferred from the nursing sub-committee proposal that she lacked confidence in them, contributing to the deterioration of the relationship rather than clarifying the matter.\textsuperscript{48}

In addition to proposing the formation of a nursing sub-committee, Patrick requested a definition of her relationship to the Central Council. Mrs Johnstone assured her that there had been no alteration, that being able to attend Council meetings when invited was, in fact, business as usual. Despite this assurance over the next eighteen months the relationship between the Executive and its Director of Plunket Nursing gradually worsened. The Executive believed that the amount of time Patrick spent visiting branches meant she was neglecting teaching work at the training centre in Dunedin.\textsuperscript{49} The issue was discussed at an Executive Council meeting in February 1932, when Patrick was asked if she could cover some of the teaching load during a change over period before a replacement Sister Tutor was available to take up the position. Patrick, reluctant to commit herself to more work because her assistant, Challis Hooper, had recently been retrenched as a cost-cutting measure, eventually agreed to temporarily forgo branch supervision in favour of teaching. The discussion showed, however, that the Executive was unconvinced by Patrick's argument that supervision of the work at a branch level needed more attention, not less. McGeorge reminded Patrick of the amount of 'the actual work' being done by women in a voluntary capacity for the Society, suggesting some tension over the level of attention Patrick was giving to nurses at a branch level.\textsuperscript{50} It was a reminder that nurses were just one cog in the wheel of the Plunket Society.

There were other signs of the deteriorating relationship between Patrick and the Executive. In April 1932 the Executive decided to change the Society's letterhead and to direct

\textsuperscript{46} Central Council minutes 11 November 1930, PS AG7 1-2-3.
\textsuperscript{48} Patrick to Bullock, 3 January 1934, PS AG7 11-11.
\textsuperscript{49} Central Council minute book, Central Council meeting, 18 August 1931, PS AG7 1-2-3.
\textsuperscript{50} Central Council minute book, 2 February 1932, PS AG7 1-2-3.
all correspondence to the Administrative Secretary; previously nursing matters had been directly addressed to the Director of Plunket Nursing. When Pattrick questioned the decision she was reminded that the Council was responsible for all spheres of the Society's work and was told the decision was a minor administrative change designed to ensure greater co-ordination of the Society's work. In conjunction with evidence that the Executive was notifying the Society's Medical Adviser of its meetings but was not extending the courtesy to her, this decision confirmed Pattrick's impression that her role was being marginalised.

Unable to ignore the changes Pattrick outlined her general concerns about the state of her relationship with the Executive in a letter to Mrs Johnstone. Declaring that she felt that since her return in October 1930 she had lacked the 'sympathetic direction and confidence of yourself and Mrs McGeorge', Pattrick questioned their change in attitude. Outlining her understanding of her job description and asking them to specifically define her duties and responsibilities as Director of Plunket Nursing, Pattrick concluded that such a definition was not only 'very desirable for her own sake, but...is now essential for the efficiency of the work'. Conscious that her working relationship with the Executive Committee of the Council had altered Pattrick was concerned that Johnstone and McGeorge's dissatisfaction with her work was impacting negatively on the Plunket nursing work as a whole.

Pattrick proposed a number of changes which she hoped would help to solve some of the difficulties being experienced in her department and which illustrate the extent to which she had been sidelined. Her suggestions involved ensuring autonomy and representation for the nursing division in the Society. Pattrick requested the Council's permission to correspond directly with Karitane Hospital Matrons and District Nurses on nursing issues. She also wanted to regularly visit various Plunket branches in order to ensure the competency and efficiency of the nurses and to maintain a link between the Central Council and the work at the branch level. The retrenchment of her assistant the previous year had increased her administrative workload. Recognising the impossibility of visiting all the branches herself she recommended that the charge nurses from the four main centres assume a supervisory role and regularly visit the branches in their area.

Once again Pattrick suggested the Council establish a nursing committee to deal with professional matters. This time she proposed a committee consisting of the Karitane Hospital physicians, the Society's Medical Director, the Director of Plunket Nursing, the President of the Society and a representative of the Trained Nurses' Association. Pattrick recommended that one aspect of the committee's work should be overseeing the appointment of nurses. Before 1930

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51 Central Council minute book, 5 April 1932, PS AG7 1-2-3.
52 Pattrick to Johnstone, 12 July 1932, PS AG7 11-11.
53 Over the previous year the Council had wanted Pattrick to take on more teaching work at the Karitane-Harris hospital in Dunedin, at the expense of her branch visiting work.
this had informally been the domain of the Director of Plunket Nursing but Patrick's request to be consulted on nursing appointments suggests that by 1932 the Council were appointing nurses without considering her opinion. Patrick's proposal was turned down. The eventual approval of a medical advisory board, at the same Council meeting that decided to ask Patrick for her resignation, shows the Council was not adverse to seeking advice on professional matters. Rather, it was suspicious about the motives behind Patrick's suggestion of nursing representation. That Patrick's proposal was perceived more as a threat of further problems than a solution for existing ones is evidenced in correspondence between McGeorge and M. Cracroft Wilson (Christchurch branch). Writing in January 1934 Cracroft Wilson thanked McGeorge for information about Patrick's 'proposal to set up a board to control all matters connected with the Nursing side of the work' but added that it gave 'a more urgent reason than ever for the retirement of Miss Patrick'. It is clear that Patrick had indeed lost the confidence of the Executive of the Council.

It is unlikely that Johnstone or McGeorge appreciated Patrick's written attempt to engage the Council in a 'frank discussion' of their personal and professional criticisms. Although there is no mention of any discussion in the Council's minutes, correspondence between Johnstone and Anne Brown confirms that a couple of weeks before Johnstone received Patrick's letter criticisms of the Director of Plunket Nursing had been discussed by the Council 'in camera'. Brown urged that these criticisms be explained to Patrick with an opportunity for her to reply to them but Johnstone was satisfied that the Council had dealt with the issues at the time. Again, the lack of a written record leaves us uninformed as to the exact nature of the Council's complaints but it is clear that as Patrick was trying to clarify her role the Council was redefining it. Replying to a query about the role of a Nursing Director from an Australian correspondent Johnstone commented that 'we regret that in New Zealand we have found the term "Director" rather misleading, implying more power than it was ever intended should be given to this officer'. In requesting a definition of her role as Director of Plunket Nursing Patrick had considered this possibility, commenting that 'it has been suggested to me that perhaps I have assumed more responsibility than it was intended should be attached to my position'. Her work had grown with the Society and was not formally defined until April 1933 when the Council's written definition of her duties and responsibilities confirmed for Patrick that the work she had been doing was appropriate.

54 Patrick to Johnstone, 12 July 1932, PS AG7 11-11
55 Cracroft Wilson to McGeorge, 12 January 1934, PS AG7 2-311.
56 Brown to Johnstone, 2 July 1931; Johnstone to Brown, 6 July 1932, PS AG7 2-297.
57 Johnstone to Mrs Mather, PS AG7 2-297.
58 Patrick to Johnstone, 12 July 1932, PS AG7 11-11.
59 Patrick to Bullock, 3 January 1934, PS AG7 11-11.
With no line of communication between the Council and Pattrick the situation continued
to deteriorate. Pattrick noted that after her discussion with Johnstone and McGeorge she was
sometimes desired to concur in decisions already made by the Executive in regard to
affairs vitally affecting the Plunket Nursing Service but rarely to discuss, weigh pros
and cons, or advise; also, when requested to attend meetings I seldom received notice of
the matters to be discussed...at no stage have I been able to arrive at a clear
understanding of the reasons for the changed attitude of the Executive of the Council.60

Blair later explained to Patrick’s brother that he understood the Council had lost its trust and
confidence in Pattrick as Director of Plunket Nursing. He could not offer any reasons for the
change in attitude but added that if there was enough agitation for specific charges against
Patrick he had no doubt that ‘some could be conjured up’.61 The loss of confidence was not
just in Pattrick, it also impacted on the role of Director of Plunket Nursing.

In 1933 Pattrick’s schedule, decided by the Council, only enabled her to attend the
Dunedin Provincial Conference. Alarmed at what it saw as a trend to side-line Pattrick the
Wellington branch raised the issue at its Provincial Conference. It subsequently forwarded a
remit to the Society’s Interim Conference in March 1933 demanding the presence of the Director
of Plunket Nursing at all of the Society’s conferences. Pattrick had not been made available for
the Interim Conference and support for the Wellington remit was probably guaranteed by the
somewhat farcical situation which ensued. Questions from delegates relating to the nursing side
of the work could not be answered by the Executive at the Conference and were referred to the
Health Department’s Director of Nursing.62 Wellington’s remit, in an abridged form, was
passed but its support came too late. At its next meeting the Central Council was convinced by
its executive committee that Pattrick’s resignation was ‘in the best interests of the Society’.

Behind the Executive’s belief that Pattrick’s resignation was necessary was the intention
to downgrade the level of power implicit in the position of Director of Plunket Nursing.
Pattrick’s efforts to ensure the Society had formal nursing representation combined with the
effects of the lack of that representation, particularly the breakdown in communication between
Pattrick and the Executive, had added to a growing distrust between the nursing and
administrative branches at the headquarters of the Society. The issue became one of control.
The Executive wanted to ensure its continued control over the nursing work; the branches
which challenged the Council’s decision wanted to ensure the Executive and the Council did not
assume more power than they had intended. The decision for the conference was not whether
Pattrick had the support of the branches; she clearly did. Rather, according to Blair, the
question the Society might be compelled to address at the conference was ‘whether the Plunket

60 Pattrick to Bullock, 3 January 1934, PS AG7 11-11.
61 Blair to P. E. Pattrick, 15 February 1934, PS AG7 2-309.
62 Wellington Branch statement, 29 January 1934, PS AG7 11-11.
Society should be governed by the Council or governed by the nurses or by some of the branches'. The issue became whether the Council had the confidence of the Society.

III.

The announcement of the date of the conference and release of the Council's statement prompted a new flurry of activity as both sides lobbied for support and tried to set the terms of reference for the conference. Before the conference the Wellington committee sent all branches a copy of Pattrick's letter to Johnstone asking for an explanation of the Council's attitude towards her and a copy of Pattrick's letter to Maude Bullock, the Acting-President of the Wellington branch, explaining her understanding of the situation. Further, Tythe Brown challenged the Council's insistence that the motion in favour of Pattrick's resignation was unanimous, claiming that she did not actually vote on the resolution. A statement from the Wellington branch urged delegates to support Pattrick and act 'in the interest of justice, with which is bound up the future of our Society'.

A circular, urging justice for the Council, also made the rounds of some branches. It claimed that support for the Wellington position was the equivalent of a declaration of no confidence in the Council and warned that the implications of such a decision would be the resignation of the Council and a resulting reluctance of any of the Society's members to place themselves in such a position in the future. The origin of this circular remains anonymous but it was an accurate guide to the Council's attitude to the conference. The Council had been assured by its legal adviser that the issue of whether the meeting approved or disapproved of the Council's actions would rest on its defence that it had acted properly under the Society's constitution. Disapproval of the Council's actions would, in such circumstances, denote a lack of confidence in the Society's elected representatives. Delegates were made aware from the start of the conference that the Council would consider 'a decision adverse to the course that it had taken as a vote of no confidence and that its resignation would follow'.

Ten speakers, including four Advisory Board members and the Minister of Health, spoke in support of the Council in the first session of the conference. J. A. Young reminded delegates of the importance of the Society's work and warned of the consequences of any disruption, noting that the Health Department could make good use of the Society's £20,000

63 Blair to P. E. Pattrick, 15 February 1934, PS AG7 2-309.
64 Brown to Auckland branch, 18 January 1934, PS AG7 11-11.
66 Ibid.
67 Paterson to Hoddinott, 24 January 1934, PS AG7 2-310.
annual grant. He was followed by Mrs Cracroft Wilson who argued that Council members made decisions as elected representatives, concluding that if the 'branches and sub-branches now condemned the council for what it had done there was nothing left but that the council should resign'. The terms of reference for the first session of the conference were set. Subsequent speakers defended the Council's intention to treat Pattrick fairly while acting within the constitution of the Society, but why her resignation had been considered necessary remained vague.

Only two of the Council's speakers addressed the issue in anything but the most oblique terms. Sir William Hunt, of the Advisory Board in Wellington, drew on past conversations with Margaret Johnstone (who had died before Pattrick was dismissed), stating that before her death she had been concerned that Pattrick was not consulting with the Council or keeping them informed. Hunt speculated that Pattrick may have acquired a tendency for autocracy from working with Truby King. The result, he claimed, was that Johnstone had concluded that Pattrick wanted the nurses to control the Society rather than the Council. Nina Reid, of the Dunedin branch, also saw the issue in those terms stating, in respect to Pattrick's contact with the branches, that 'the idea may be consciously or unconsciously conveyed that she [Pattrick] and they [nurses] are the Plunket Society, and that the council and its executive are of very minor importance'. Implied that this had been the source of the friction between the Council and Pattrick since 1930, Reid posed the rhetorical question of whether the women who volunteered for the Council had 'no claim to the right to be mistress in our own home?'.

Although speakers for the Council implied the problem was Pattrick's lack of loyalty to the Council, the nature of her position within the Society was inherently problematic for a governing body worried about power imbalances. The perception, particularly within the Executive, that the Council's control of the Society was threatened by Pattrick's constant contact with the branches and her advocacy of the nurses lends weight to claims the Council wanted to abolish, or at least redefine, the position of Director of Plunket Nursing. Over the previous three years the Council had attempted to do just that by limiting opportunities for Pattrick to give technical advice to the branches and the Council. Pattrick had resisted attempts to change her role and the Council had decided that her resignation was necessary. The effects of the policy to increase the Director of Plunket Nursing's administrative and teaching role while decreasing her advisory role were addressed by Pattrick in her reply.

In her thirty minutes on the floor Pattrick reassured the conference of her loyalty to the Society and appreciation of the voluntary work done by the branch committees, but reminded

69 Extract from *Otago Daily Times*, 23 February 1934, pp. 1-2.
70 Ibid, p. 2.
72 Extract from *Otago Daily Times*, 23 February 1934, p. 5.
them her concentration on the nursing work was natural given her position as Director of Plunket Nursing. She noted that she had always worked to maintain an efficient nursing service, a task made more difficult by the lack of nursing representation at Executive and Council meetings. In her opinion, without Truby King to ensure the ongoing development of the medical direction of the Society, 'a tendency to limit progressive thought, to be content with past standards, and to regard with distrust any reference to revision or change of methods', had developed in recent years. New Zealand's infant welfare policies were being determined at least partially by the relationships between infant welfare volunteers and nursing and medical professionals. In one of the few references to wider issues of professional development Pattrick implicitly challenged the Council about the effects of its unwillingness to be directed on professional matters. She had the support of Dr Corkill, Hon. Medical Officer at the Truby King Karitane Hospital in Wellington, who characterised the closing of opportunities for the Director of Plunket Nursing to give professional advice to the Council as 'unwise and dangerous'. For Pattrick's supporters, however, the immediate focus remained on challenging the Council over her resignation.

Speaking in support of Pattrick, several delegates confirmed their belief in her loyalty to the Society and noted that the Council still had not made any definite charges against Pattrick. Walter Nash, delegate for the Lower Hutt branch and a Labour M.P., gave a powerful speech deploring the Council's attempts to manipulate the conference by threatening to resign. As it had become apparent that not all members of the Council had been fully informed when they voted for Pattrick's resignation and that Advisory Board members had thrown their weight behind the Council without hearing Pattrick's side of the story, Nash suggested the issue before the conference was one of justice. The conference had to decide whether justice for Pattrick corresponded with the loyalty to the Council.

As the evening session of the conference began C. R. Fell, a delegate from the Nelson branch, urged the delegates to attempt to find a middle ground because it had become obvious that neither side would completely agree with the views of the other. In that spirit J. A. Young put forward a five point resolution to the conference. The first three points, assurances that Pattrick's loyalty to the Society and her professional ability were unquestioned and an expression of regret from the Council if its method of seeking her resignation caused her pain, did not attract debate. The fourth point, requesting Pattrick to stay with the Society for six months to train her successor, was the subject of pedantic discussion as delegates sought wording which did not imply the Council was conceding to demands to reinstate her. The fifth point made provision for the next conference to consider rule changes. Pattrick agreed to the

73 Ibid, p. 6.
74 Wellington branch minutes, PS 89-098-4.
76 Extract from Otago Daily Times, 23 February 1934, p. 7.
fourth clause and the entire resolution was passed unanimously.\textsuperscript{77} A resolution that Annual General Conferences would resume in July was also passed unanimously and the conference ended.\textsuperscript{78}

The compromise decision was regarded as a successful conclusion to the conference by the Wellington branch which was satisfied they had protected Pattrick’s reputation and ensured that rule revisions were on the agenda for the next conference.\textsuperscript{79} The Council, satisfied that Pattrick’s resignation, although delayed, would be effective from September, appointed a Rules Revision Committee to consider and make recommendations on branch proposals for rule changes. Consisting of Kate McGeorge, Maude Parkes, A. M. Bisley, Mrs Hall, C. R. Fell, M. H. Godby, A. C. Cameron and Lesley Tuck, the committee was evenly split between those who had supported the Council and those who had supported Pattrick before the special conference.

Despite Council’s willingness to abide by the conference’s compromise decision some members remained wary of losing control of the Society. An unsigned letter to Dr Tweed in May 1934, probably from McGeorge, discussed the New Zealand Trained Nurses’ Association’s desire to have some representation in an advisory capacity on the Plunket Society’s Executive committee. That the issue of nursing representation was still the subject of some suspicion is shown in the writer’s comment about the ‘danger there was growing up within the Society of the Society being run by the nurses for the nurses, instead of for the mothers and babies’.\textsuperscript{80} The power and role of the new Nursing Adviser would be addressed at the Annual General Conference held in early August 1934.

Recommendations for changes to the Society’s rules were considered by the Rules Revision Committee in June 1934, which circulated its recommendations in a report to the branches before the August conference. The conference made several constitutional changes. These included all branches assuming responsibility for the national organisation of the work which had hitherto fallen to the Dunedin branch. Daily control of the running of the Society remained with the Dominion Executive but that body would no longer be solely made up of Dunedin executive committee members. Instead the seven Executive members would be elected from any branch within easy travelling distance of the headquarters branch, which remained

\textsuperscript{77} After her six months with the Society, Pattrick travelled overseas, advising infant welfare organisations in the United States and England. She died in London in 1937.
\textsuperscript{78} Extract from \textit{Otago Daily Times}, 23 February 1934, p. 7.
\textsuperscript{79} Wellington branch minutes, 6 March 1934, PS 89-098-4.
\textsuperscript{80} Letter to Dr Tweed, 7 May 1934, PS AG7 2-281.
Dunedin. Other administrative changes included changing the title of Administrative Secretary to Dominion Secretary.81

On the nursing side of the work the title Director of Plunket Nursing was formally changed to Nursing Adviser to the Council, after some debate from delegates who feared the change downgraded the position. The conference confirmed that the role of the Nursing Adviser was to supervise the Plunket Nursing and Karitane Hospitals' staffs and visit the branches. The means of ensuring nursing representation was more controversial. The Wellington branch proposed establishing a Nursing Advisory Committee but failed to win support because it was viewed as an unnecessary duplication of the newly established Medical Advisory Committee.82

The proposed Nursing Advisory Committee was smaller with the main difference being the Wellington branch's proposal that the nursing committee include nursing representation from outside the Society. They had arranged for the Council to receive a deputation from the Registered Nurses Association, which had resolved at its annual general meeting that approaches should be made to all voluntary organisations which employed nurses, asking them to consider having a representative from their association on their Executive.83 The Wellington remit was quickly dismissed and the Medical Advisory Board, consisting of representatives from the medical staffs of the Karitane Hospitals and the Society's Medical Director, was formalised. Nursing representation on the Council through the establishment of a post for the Nursing Adviser on that body was not considered. Rather, the rules were amended to state that both the Medical Adviser and the Nursing Adviser were to attend Dominion Council meetings. Before reaching any decision on medical or nursing matters the Dominion Council and Executive committee were to consult the Medical and Nursing Advisers.

These rule changes restored some nursing representation, which was given more weight with the co-option of Nora Fitzgibbon to the Medical Advisory Committee in 1934. Even so the nursing side of the work was subject to increasing scrutiny from experts outside their profession. Historians have commented on the increasing rigidity of Plunket nurses after Truby King's departure, attributing it to a desire to adhere blindly to the one true method of infant welfare nursing as defined by King. In light of the distrust of the motives of their top nursing staff shown by the Council and its corresponding reluctance to accept direction on nursing issues in the early 1930s, we can conclude that the unbending attitude of the Council contributed to this. Without the complete support of their Council Plunket nurses were wary of deviating from the Society's accepted methods. The problem became more pronounced as the Medical Advisory Committee resisted making major changes to the Society's feeding regime.

81 By-laws for nomination of the Executive were amended in 1935 so that all branches could make nominations from amongst the members of the Oamaru, Dunedin, Milton and Balclutha (and their sub-branches). Annual Report, 1937, p. 7, PS AG7 1-3-3.
82 Annual Report, 1935, pp. 49-50, PS AG7 1-3-3.
83 Wellington branch minutes, 26 July 1934, PS 89-098-4; New Zealand Nursing Journal, September 1934 p. 154.
Michael Belgrave has argued that 'Within the hospitals, as much as in the outside market for medical services, doctors were by the 1930s able to limit their competitors and treat the rest as subordinates, by an almost divine right to social, bureaucratic and scientific superiority.' Plunket was the exception: its nurses dominated the routine monitoring and supervision of healthy children. The mid 1930s were a period of activism generally for the medical profession as the NZBMA fought the Labour Government's plans to introduce comprehensive, free and universal health care. A small group of doctors, led by Dr Montgomery Spencer, were also fighting the Plunket Society to make a place for their specialty, child health. They used their concern over Plunket's artificial feeding regime to provide a medical justification for their claims that doctors should be more involved in the routine monitoring and feeding of New Zealand's infants. The medical profession was awakening to the opportunities presented by the emerging paediatric specialty and they forced the Plunket Society to respond.

I.

Within days of the Special Conference in March to address Anne Patrick's 'retirement' the Central Council informed the branches it had appointed Dr Tweed to the full time, paid position of Medical Adviser to the Council, as of 1 December 1933. The timing caused a stir. The Council claimed it delayed the announcement, on Tweed's request, until after 18 February in order to give him time to sell his medical practice. This still allowed time to make the appointment public before or at the Conference; that it did not added fuel to discontent about the Council's tactics. Disgruntled members, presented with a fait accompli, questioned the Council's authority to change the nature of Tweed's employment and commit the Society to his £200 salary without referring the matter to a conference for a mandate. The Council made a statement to the Society's August 1934 General Conference which rationalised Tweed's appointment, but not the method by which it was made. It argued that Sir Truby King's gradual

2 Elizabeth Hanson, The Politics of Social Security, Auckland, 1980, especially ch. 5.
3 Circular ref no. 90, PS AG7 1-7-23.
4 Annual Report, 1934, p. 4, PS AG7 1-3-3.
5 Remits for General Conference, August 1934, PS AG7 1-7-23. The funding of Tweed's salary came under scrutiny because £900 of it was being paid by an annual grant from the Karitane Products Society. Annual Report 1935, p. 65, PS AG7 1-3-3. The Patea branch forwarded a remit to the 1934 General Conference querying the wisdom of officers of the Society being paid by grants from this organisation. Hoddinott to Tweed, 25 June 1934, PS AG7 2-260.
withdrawal from active participation in the Society and the persistent criticism of his methods from some members of the medical profession made it imperative to appoint a full time Medical Adviser. Tweed was committed to King's methods and had his endorsement. For the Council, a lay body still used to relying on Truby King's expertise in medical matters, Tweed represented the hope of security and continuity. His appointment would help consolidate the Society's methods against medical criticism. The conference accepted the explanation.

Plunket's medical critics continued to lobby both Plunket and the wider medical profession to accept their criticism, that the Plunket infant feeding schedule was too low in protein. During the 'Modern Infant Feeding' session at the annual meeting of the New Zealand Division of the British Medical Association (NZBMA) in February and March 1935 Dr Elspeth Fitzgerald, Dr R. H. Howells and Dr F. Montgomery Spencer made forceful pleas for Plunket to modernise its artificial feeding schedule. The session was well attended and most present seemed to support the call for change. The New Zealand Medical Journal later reported that 'when the only remarks directly adverse to the Plunket Society were made there was applause all around the room'. The tight timetable left little discussion time but there was enough interest to prompt Professor Carmalt Jones, of the Otago Medical School, to arrange a roundtable meeting the following day. The aim was to encourage dialogue between Plunket and its critics about Plunket's infant feeding system. The meeting was well attended despite the short notice. Plunket was represented by Dr Tweed, Miss Fitzgibbon, Drs Stanley Brown, Ian Ewart and Ernest Williams (members of the Medical Advisory Board) and Dr Wyn Irwin, (a Lady King Scholar). Tweed set the tone by assuring the gathering that the Society's Medical Advisory Board wanted to foster better relations with the medical profession and would consider any 'constructive criticism' of its work they could offer. Dr Elspeth Fitzgerald, Dr Montgomery Spencer, Dr Howells, Dr Butler and Dr Ludbrook welcomed the opportunity and argued the case for modernising the Plunket diet.

Between the session of infant feeding and the roundtable meeting at the NZBMA conference Tweed and the other board members were left in no doubt about the main criticisms of the Society's work. Plunket's low protein diet resulted in underfed babies according to the

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6 Annual Report, 1934, p. 4, PS AG7 1-3-3.
7 The other speakers in the Modern Infant Feeding session were Dr Elizabeth Gregory (Faculty of Home Science, University of Otago) and Dr Bernard Myers (London), NZMJ, 34, 184 (1935), p. 387. Fitzgerald's paper was later published as 'Modern Infant Feeding', NZMJ, 34, 184 (1935), pp. 388-395.
10 The Lady King scholarship was established by the Plunket Society in 1926 in an effort to encourage postgraduate research in the infant health field. In the 1920s Truby King and the Plunket Society had pressured the Otago University to put more resources into training medical students in infant health to no avail. The £250 scholarship, which could be held for one year, was awarded through the Otago University. Annual Report, 1928, pp. 21-23, PS AG7 1-3-2.
11 Reported in Minutes of meeting of Medical Advisory Committee, June 1935, p. 7, PS AG7 11-49.
critics. They argued that the adverse effects of underfeeding were cumulative, starting with minor deviations from the norm in infancy and ultimately developing into malnutrition in childhood if left unchecked. Plunket Nurses had failed to link humanised milk with later childhood malnutrition because only doctors were trained to recognise and diagnose the earliest signs of malnutrition. Those symptoms, the critics claimed, were often present in artificially fed babies supervised by Plunket nurses but went unchecked because nurses lacked diagnostic skills. Plunket babies, they argued, might survive the first year but the Plunket diet produced less than physically ideal children. The low infant mortality rate had lulled New Zealanders into a false sense of complacency about infant health and deflected attention from other, negative, indicators. But did New Zealand infants really have a malnutrition problem and if so was it directly related to infant feeding? More specifically could it be proven to be related to humanised milk?

The belief that poverty invariably explained malnutrition was to the fore in the Depression years. Malnutrition was both topical and political. In his 1935 pamphlet, Guaranteed Prices - Why and How Walter Nash gave vivid examples of the problem, citing 'the five primary schools in Canterbury where, with 866 fathers unemployed 255 children were suffering from malnutrition and 618 were insufficiently clad'. He concluded, in a statement Spencer would later echo, that 'there were children in New Zealand who were literally being starved to death'. The Forbes Coalition Government conceded malnutrition existed but denied that the Depression was increasing the problem. Opening the new Eltham Plunket Rooms in July 1935 the Minister of Health, Sir J. A. Young, announced the latest school medical service figures showed a drop in malnutrition amongst school children from 7.06 per cent in 1929 to 5.46 per cent in 1934. Young, eager to combat 'the suggestion that malnutrition was prevalent amongst the children of New Zealand', also pointed to another recent study showing the average height and weight of New Zealand elementary school children had steadily increased over the previous two decades. The international comparison was also positive; Young reported that the study concluded 'that New Zealand children compare more than favourably with those in other parts of the Empire'.

Plunket's critics put another spin on the problem. Dr Spencer argued against the standard wisdom by claiming that malnutrition was not 'solely a matter of economics or poverty'. Rather, he claimed, the high rate of dental caries and the signs of malnutrition and other deformities in children examined by the School Medical Service all originated from underfeeding in infancy. Others agreed, using evidence from their own practices to illustrate.

14 Ibid.
Both Dr Howells and Dr Butler claimed they often saw Plunket babies 'go back' at six months, failing to gain weight because the Plunket system did not provide enough protein for growth.  

Spencer's claims that the health problems picked up by the School Medical Service were the result of Plunket advised underfeeding were difficult to prove or disprove. While the health of most infants and school children were officially monitored through the Plunket Society and the School Medical Service, children between the ages of one and five not monitored by any of New Zealand's health services. Plunket, which traditionally saw babies up to their first year of age, had been attempting to extend their services to cover children in this age group since the mid 1920s, with limited success. By the 1933-34 year it was still far from comprehensive; Plunket Nurses saw just 15,185 pre-school children compared to 48,274 babies. Routine state monitoring of child health was limited to school age children. Plunket countered that during the relatively unmonitored pre-school years parental vigilance slipped and defects developed.

Plunket and its critics could not agree on what was suitable research to prove or disprove the claim that the Plunket diet for artificially fed infants was inadequate. Tweed and the Plunket Council rejected international research which supported the use of simpler infant feeding methods because it claimed that the clinical evidence in New Zealand supported the Plunket system. On the other side Plunket's dominance in terms of access to infants prevented the critics from conducting their own studies to test their preferred methods in local conditions. Instead they relied on the large body of overseas literature supplemented with anecdotal evidence from their own practices to make the link between the Plunket diet and malnutrition in school children.

While the critics could only present anecdotal evidence to support their claims that Plunket babies were malnourished, Plunket had empirical research to support its methods. In 1934 the Executive authorised Tweed to commission Dr Wyn Irwin to investigate the nutrition of pre-school children who had been fed entirely on Truby King's methods. Irwin originally intended to examine 1,000 children but the study was scaled down to between 500 and 600 when he took up a job in the Department of Health. The results were never published but he concluded in a preliminary report that the 'pessimistic outlook as to the health of the coming

16 Reported in Minutes of meeting of Medical Advisory Committee, June 1935, p. 7, PS AG7 11-49.
17 Annual Report, 1934, p. 28, PS AG7 1-3-3.
18 Helen May, p. 149 reports that Kindergarten Association's had medical advisers. Medical inspections of kindergarten children were approved in 1929, but few children came under the auspices of a free kindergarten.
20 Tweed to Dr Wyn Irwin, 1 October 1934, PS AG7 2-260. This project was supervised by both Dr Tweed and Dr Hercus, Sub-dean of the Otago Medical School. The subjects of the study, chosen by Plunket Nurses in ten centres, included fully breastfed, partially breastfed and fully artificially feed infants. Irwin examined the children and took their infantile feeding history for the first twelve months of life.
generation as many from general practice, orthopaedia, and public health adult and school's surveys would opine' was unjustified. Rather, Irwin argued that

given good mothers and good stock the Plunket Society, through its nurses, produces good babies and, by systematic following-up, good older children, and they cannot be made responsible for the many who depart from this mean through maternal carelessness and ignorance.\textsuperscript{21}

Truby King had placed responsibility for childhood ill health at the mothers’ door in the 1900s and there it remained. Any malnutrition problem could be attributed to maternal deviation from the recommended feeding schedule rather than the Plunket diet.

The issue of whether the Plunket diet could be proven to cause malnutrition was complicated by the question of whether being 'under the care of a Plunket Nurse' ensured parental adherence to the Society's feeding methods. The relationship between prescription and practice was as unclear to contemporaries as it is to historians trying to assess the effectiveness of infant welfare movements. There was no argument that Plunket dominated infant welfare in the 1930s; in 1935 it could claim that approximately 70 per cent of non-Maori newborns were under its care.\textsuperscript{22} But there was considerable debate about whether all these babies could legitimately be called Plunket babies. Dr Butler argued that mothers who abandoned or deviated from Plunket's percentage method of feeding were reluctant to admit it to their Plunket nurses for fear of censure.\textsuperscript{23} This effectively obscured the true effects of Plunket's low protein dietary, giving the Society an unrealistic impression of its effectiveness.\textsuperscript{24} 'A grateful mother' highlighted the nuances in a letter to the \textit{Dominion}. She described herself as:

a real Plunket mother - not just one of the many so-called Plunket mothers I have met, who simply make a convenience of the Plunket Nurse by having their babes weighed free of cost each week and then go on their own sweet way regarding diet and other health habits.\textsuperscript{25}

Plunket used the fact that parents did not always follow its advice to advantage. The 1930 study by Dr Helen Dougall, the Lady King scholar, of 200 pre-school children from Dunedin Kindergartens illustrates the point. Study subjects had to be subdivided into non-Plunket, Plunket and strictly Plunket categories because

\textsuperscript{21} Annual Report, 1925, pp. 18a-19a, PS AG7 1-3-3.
\textsuperscript{22} Ibid, p. 45.
\textsuperscript{23} Editorial, 'The Plunket Society', \textit{NZMJ}, 37, 200 (1938), p. 186, reiterates the idea that mothers often deviated from the Plunket standard but did not tell the Plunket Nurse.
\textsuperscript{24} Minutes of meeting of Medical Advisory Committee, June 1935, p. 7, PS AG7 11-49.
\textsuperscript{25} Press clipping, \textit{Dominion}, 23 February 1934, PS AG7 5-25.
many of the mothers who claimed to have Plunket children, most emphatically did not, while many other mothers who had not had a Plunket nurse in attendance, trained and fed their babies according to Plunket methods.\textsuperscript{26}

Plunket nurses were already aware their prescriptions were not always followed. Miss Hitchcock, a Karitane Hospital matron in the 1930s, noted that Plunket nurses 'are not policemen ... we can't make people do as we say'.\textsuperscript{27} Perhaps unsurprisingly Dougall's study concluded that those who adhered strictly to its methods were rewarded. The 20 children verified by a Plunket Nurse to be 'strictly Plunket children' had 'a definitely higher standard of nutrition, teeth and tonsils'.\textsuperscript{28} The critics were sceptical. Spencer pointed out that the Society's studies would 'necessarily miss the majority of the children who have not done well under that system'.\textsuperscript{29}

Plunket also argued that the focus on its artificial feeding methods was misplaced and that having to refute the constant criticism of humanised milk drew resources and attention away from its primary focus of encouraging breastfeeding. Of the approximately 70 per cent of new babies seen by Plunket Nurses nationwide in the 1933-1934 year 87.75 per cent were either wholly or partially breastfed.\textsuperscript{30} If most babies were not artificially fed the contribution of Plunket's artificial feeding regime to childhood malnutrition, if it existed, had to be slight. This evidence was less conclusive than it seemed, however, because it was based only on the number of babies being breastfed at the first visit. A Plunket study of 1,873 Dunedin babies, collected over a 6 year period, showed that on average about 78 per cent of babies were fully breastfed while another 11 per cent were complemented, so had some artificial feeds.\textsuperscript{31} Most babies were weaned between their fourth and seventh month.

The critics had focussed on infant feeding but underlying this issue were more fundamental criticisms of the Plunket system. Those doctors, like Spencer and Fitzgerald, who had trained overseas were dissatisfied with the dominance of the Plunket Nurses.\textsuperscript{32} Their

\textsuperscript{26} Annual Report, 1934, p. 27, PS AG7 1-3-3.
\textsuperscript{27} Press clipping, New Zealand Observer, 28 July 1938, p. 7, PS AG7 2-281.
\textsuperscript{28} Annual Report, 1935 p. 19, PS AG7 1-3-3.
\textsuperscript{29} Spencer, 'Malnutrition and a C3 Population, Part I', pp. 5-6.
\textsuperscript{30} Annual Report, 1934, p. 29, PS AG7 1-3-3.
\textsuperscript{31} Annual Report, 1936, p. 12, PS AG7 1-3-3. Complementary feeding meant supplementing breastfeeds with artificial feeds and was usually recommended when Plunket Nurses were concerned that a baby was not getting enough breastmilk. The term 'complementary feeding' is something of a misnomer because rather than complement breastfeeding it depresses it. Breastfeeding operates on a demand and supply principle and as the demand from the baby decreases, the mother's production of milk declines. Subsequently complementary fed babies were weaned earlier than fully breastfed babies. M. I. Elliott and M. D. Rohan, 'Infant Feeding', Preventative Medicine Dissertation, University of Otago, 1940 p. 7 reported that the Auckland Plunket Nurses had observed this effect in their work. While Plunket did much to encourage breastfeeding some of its advice, like complementary feeding and encouraging mothers to 'toughen' their nipples by scrubbing them, was counterproductive.
\textsuperscript{32} Press clipping, unattributed, June 1938, PS AG7 11-24.
dissatisfaction can be attributed, at least in part, to differences between international infant welfare organisations and the New Zealand infant welfare movement. Most important of these was not the dominance of ‘modern simple methods of feeding’ particularly in America, although this clearly impressed, but rather the control of infant feeding. Specifically, their exposure to international infant welfare movements and paediatric specialists led the returning doctors to challenge the hegemony of Plunket’s methods had achieved and the control Plunket nurses had over infant feeding in New Zealand. To understand their concerns and their aims, we have to understand something of the different systems Fitzgerald, Cronin and Spencer came in contact with overseas.

The most noticeable difference between the New Zealand and international infant welfare movements was the role played by doctors. In North America by the 1930s paediatrics was an established specialty and the supervision of well children, through regular weighing, measuring, vaccinating and monitoring, was central to the paediatrician’s practice. Paediatrics was also a more important part of general practice than it was in New Zealand; as early as 1908 it has been estimated that paediatric work accounted for up to half of the practice of a typical American physician. Control of infant feeding was the key. American doctors, often working in alliance with patent food companies, effectively controlled the dissemination of infant feeding information. This control was important; by the 1930s around '25 per cent or more of the case loads of general practitioners was directing the routine feeding of infants'. The artificial feeding of infants had been established as a medical function and in both America and Canada it was common for infant welfare clinics to be attended by doctors and for doctors routinely to supervise the artificial feeding of normal infants. Infant feeding never assumed the same importance in Britain but there too doctors were more routinely involved in the work of infant welfare organisations. Fitzgibbon confirmed this trend on her return from her 1937 trip through America, the Continent and England.

The Plunket Society had taken control of the dissemination of infant feeding advice and placed it in the hands of one doctor and its staff of nurses. One of the Karitane physicians complained, as he resigned from the staff in 1938, that 'New Zealand was the only country where nurses prescribed for babies'. New Zealand’s Plunket Nurses and other Truby King based nursing schemes tended to have more independence from medical supervision and

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33 Halpem, p. 1.
34 Apple, Mothers and Medicine, p. 75.
35 For Canada see Comacchio, p. 51; for America see Apple, Mothers and Medicine, pp. 72, 102 and 169.
36 The British literature on infant welfare for this period lacks specific information on the demarcation of duties for doctors and nurses. Hilary Marland, 'A Pioneer in Infant Welfare: the Huddersfield Scheme, 1903-1920' in Social History of Medicine, 6, 1, (1993), p. 43, shows the first infant welfare scheme had 3 women doctors working in its clinics by 1915. See also Jane Lewis, The Politics of Motherhood, ch 2 and ch 3.
37 Annual Report, 1937, p. 25, PS AG7 1-3-3.
38 Dr Ewart (Honorary Physician to the Truby King Karitane Hospital, Wellington) quoted in Vida Jowett (President of the Wellington Branch) to Daisy Begg, 6 September 1938, PS AG7 2-282.
subsequently more authority than infant welfare nurses anywhere else in the world. This challenged the relative authority of doctor and Plunket nurse. The Plunket system raised medical eyebrows internationally and was a catalyst for infant-welfare warfare. The Toronto Mothercraft Centre in Canada became embroiled in controversy in the early 1930s for its adherence to King’s teachings, particularly the Plunket standard of allowing nurses to prescribe infant feeding for non breastfed babies. Toronto health officials disapproved, asserting that ‘artificial feeding in the first year of life must be accepted as medical treatment. Infants wholly or partly artificially fed should in every instance be referred to the family physician for the formula and directions’. The authorities recognised that allowing nurses control over infant feeding would have ‘serious portents for physicians involved in child welfare’.

New Zealand doctors could only look on in envy at such official support for doctors rights. Fitzgerald acknowledged the differences, noting that historically in New Zealand infant feeding did not have ‘the same importance for the medical profession that it has in other countries’. In 1907, when the Plunket Society was established, there was little interest from the New Zealand medical profession and few general practitioners involved infant welfare in their practices, or indeed had the training to do so. The opportunity may have been missed then, but now doctors wanted to recapture lost ground. New Zealand’s small group of child health specialists reacted to Plunket’s autonomy ‘with a hostility combining self-interest and social concern’.

Although economic motives were never explicitly articulated, these ‘child specialists’ needed a market for their work. Only Spencer (in Wellington) and Sweet (in Auckland) seem able to have limited their practice to paediatrics before 1938. In the late 1920s Dr Sweet charged mothers 2 guineas a year, which covered two visits a month. Ludbrook in contrast was not able to limit his practice to paediatrics until 1940. Fitzgerald was known for her infant work in Oamaru but generally the child specialists had a hard time luring patients way from Plunket’s free services. Plunket supporters suspected this was driving the criticism. One newspaper columnist caustically commented that ‘A few [doctors] quite possibly wish that the Plunket Society were not quite so free with its advice.’

Plunket’s dominance of infant welfare may not have irked its critics so much had there been more opportunities to have significant input into the Plunket system. At the 1935

39 Comacchio, p. 152.
40 Comacchio, p. 151.
41 Fitzgerald, ‘Some Practical Experiences in Modern Infant Feeding’, p. 21.
42 Michael Belgrave, p. 322.
43 Partridge to Hoddinott, 11 May 1933, AG 7 2-260.
roundtable meeting both Spencer and Fitzgerald argued for Plunket to involve doctors who had specialised in infant health in its medical structures. Spencer, suggested 'the Karitane Honorary Physicians should be people who had studied the subject of infant feeding and knew something about it'.\(^{46}\) Most of the senior Karitane medical staff had considerable experience with infant feeding, but had not formally studied the more modern methods. This was a problem of both age and the rapid advancements in the paediatric specialty in the early twentieth century. Dr Ernest Williams of the Dunedin Karitane Hospital, for instance, had been on the staff since 1908.\(^{47}\) As the lecturer in paediatrics at Otago Medical School he was, of course, well qualified for the position but the Society's critics felt that such experience was not being balanced by doctors with recent training in the latest methods.

This was to some extent the result of a deliberate policy on the part of the Plunket Society to hire only those who supported its methods.\(^{48}\) Since the Ludbrook incident in 1931 the Society had been wary of appointing doctors whose overseas experience had introduced them to different methods and the official policy was that only Plunket supporters would be hired.\(^{49}\) This was often difficult to judge in practice. Tweed, for instance, was reluctant to appoint Dr Cronin to the Auckland Karitane Hospital staff in 1933, despite Dr Parkes support, because he was unconvinced that Cronin believed in King's methods and feared that he was simply using the opportunity 'as a stepping stone to practice'.\(^{50}\) He was more reluctant to alienate a potential supporter and Cronin was appointed. Others like Spencer, who was on the Wellington Karitane Hospital staff, were accepted only with the endorsement of other honorary staff members.\(^{51}\) Once on staff the opportunities for advancing into policy making roles on the Society's Medical Advisory Board were scant however. Only the Senior Honorary Physician for each Karitane Hospital sat at the Board's annual meetings. So Spencer, one of the strongest critics of Plunket's artificial feeding regime, had little opportunity to present his views formally within the Society. Fitzgerald addressed this problem directly at the 1935 roundtable meeting. She declared that the Medical Advisory Committee should include doctors with international experience in infant feeding.\(^{52}\)

The issues of child specialists' power within Plunket and the relative authority of doctors and Plunket nurses simmered in the background in 1935. At the forefront was the infant feeding issue for in spite of Plunket attempts to downplay the issue the Society remained under pressure. An editorial in the December 1935 *New Zealand Medical Journal* ended with the plea,
'Will not the Plunket Society re-consider their standard teaching and be prepared to modify it in the light of recent investigation and experience?'\textsuperscript{53}

II.

The short answer was no. The 1935 NZBMA meeting, which ended amiably with Fitzgerald expressing the hope that it would 'lead to a better understanding all round', was little more than an opportunity for the critics to air their concerns.\textsuperscript{54} Despite assuring the meeting its views would be considered at the Society's next Medical Advisory Committee meeting in June, Tweed had no intention of altering the composition of the Plunket dietary. Increasing the protein level meant deviating from the human standard and thus from the main theoretical principle of King's humanised milk, a prospect Tweed and most within the Plunket Society found untenable. Public relations, however, demanded that he convey the impression to the public that the Society was not 'standing still', but was constantly open to new ideas and suggestions for improvement.\textsuperscript{55} Between the NZBMA conference meeting in March 1935 and a Medical Advisory Committee meeting the following June Tweed signalled the Plunket approach to the issue, by reassuring the Society's members it was open to constructive criticism, while refuting the content of that criticism.\textsuperscript{56}

At the annual meeting of the Medical Advisory Committee in June 1935 Tweed reviewed King's feeding theory and reminded members of their responsibility to ensure any recommended changes 'had been proved to be an improvement of present teaching, and would give uniformly better results in routine cases'.\textsuperscript{57} The emphasis on 'routine cases' was important. Tweed argued Plunket was the best judge of its diet's effectiveness, because its nurses saw more of the normal, healthy children than doctors, whose experience was dominated by 'the artificially fed child with an abnormal digestive capacity'.\textsuperscript{58} He reminded the meeting of reports of positive results achieved by overseas adherents of King's methods such as Dr Raymond Green in Australia and Dr Jewesbury of London and in the Karitane Hospitals in New Zealand.\textsuperscript{59} The Committee agreed there was insufficient evidence to support any alterations to the Plunket dietary and reaffirmed its belief that the 'percentage method of feeding was ideal'.\textsuperscript{60}

\textsuperscript{54} Reported in Minutes of Meeting of Medical Advisory Board, June 1935, p. 8, PS AG7 11-49.
\textsuperscript{55} Tweed to Hoddinott, 19 March 1935, PS AG7 2-260.
\textsuperscript{56} Annual Report, 1935, pp. 16-17, PS AG7 1-3-3.
\textsuperscript{57} Minutes of meeting of Medical Advisory Committee, June 1935, p. 9, PS AG7 11-49. This meeting was attended by Dr Tweed, Dr H. L. Widdowson (Christchurch), Dr T. H. Pettit (Auckland), Dr Ian Ewart (Wellington), Dr E. H. Williams (Dunedin) and Nora Fitzgibbon.
\textsuperscript{58} Ibid.
\textsuperscript{59} Ibid, p. 8.
\textsuperscript{60} Ibid, pp. 10-11.
The Society did move to appease the longstanding concern amongst the honorary medical staff of the Karitane Hospitals that their status and independence was undermined by their patients' dietary being officially in the hands of the matron.61 All doctors working within the hospitals had to adhere to the Plunket dietary for routine feeding. In 1933 the Executive issued a directive that the Honorary Medical staff were 'to undertake all such medical treatment apart from dietetic'.62 New bylaws for the hospitals, passed in September 1935, still stressed that doctors must follow the Plunket system but gave Matrons responsibility for 'routine' dieting only.63

This concession did not appease Plunket's critics and discontent continued to simmer, particularly in the Wellington Karitane Hospital. Many of the problems centred around implementing the rule that Matrons controlled the normal dieting of babies in the Hospital with doctors assuming control in cases of dietetic illness. The rule seemed simple but was complicated 'when a Dr takes as the broad view that "all treatment" is the prerogative of the Dr; rather than that of the Nurse'.64 Tweed complained that the medical politics were a minefield:

There has been a good deal of friction with Dr Spencer and it is most difficult to devise a way of putting things right without an open breach with Dr Spencer, making things uncomfortable with Dr Ewart, offending the Matron and the local Branch, or creating a situation where the Medical Advisory Committee may feel impelled to uphold the dignity of the Medical Profession.65

The friction had, of course, been growing for some time. The New Zealand Medical Journal, for example, contended that doctors who attempted to alter or deviate from the Plunket dietary had in the past

often met with antagonism from the Plunket Society, and in many cases with open hostility on the part of Plunket Nurses, who were so loyal to the teachings of the Society that they could not appreciate the fact that the doctor in charge of a case had the right to modify or change a regime - forgetting that the first duty of any nurse is to carry out the instructions of the doctor.66

It should be noted that the medical profession had a strong interest in cultivating this image of the dogmatic Plunket nurse, unable or unwilling to defer to doctor's instructions, or to the traditions of medical hierarchy. It is therefore difficult to assess the validity of these claims.

61 Dr W. H. Parkes to Tweed, 24 May 1933, PS AG 7 2-260.
62 Hoddinott to Mrs Allan, 19 May 1933, PS AG7 2-260.
64 Tweed to Hoddinott, 29 April 1935, PS AG7 2-260.
65 Ibid.
66 Editorial, NZMJ, 34, 184 (1935), p. 365. The editorial did note that the Plunket Nurses' attitudes had improved in the previous year.
Although Plunket Nurses, trained to believe in the superiority of Truby King’s methods, were undoubtedly reluctant to deviate from them, 'open hostility' was localised to the small, but vocal, group of critics. Sweet, Ludbrook and Spencer were the only medical professionals to make formal complaints to the Society about the attitude of its Nurses. Othertfes welcomed their help. In Te Awamutu, for example, the Plunket nurse was popular with mothers and 'the doctors have never objected and encourage and send mothers to her.' Even so as the feeding issue put nurses in direct conflict with doctors some nurses seem to have sought refuge in sticking to the rules. Certainly historians have been left with the perception that over time 'Truby King's rules, as he and the more dutiful of his nurses expressed them, grew more rigid.' The Society attempted to stave off contemporary medical criticism that its nurses adhered too rigidly to Plunket methods by regularly circularising its nurses with reminders to follow doctor's prescriptions in cases where a doctor was involved in the feeding of a baby.

By the mid 1930s the Plunket Executive were becoming more aware of the Society’s public image and tried to limit the possibility of negative publicity. From 1934, for example, Plunket nurses were ordered to exclude comments on illness or death of babies within their districts from Annual Reports, for fear of giving the wrong impression. But perhaps the most direct case of the Society attempting to control its image and gain favourable publicity was the treatment of the Johnson quadruplets, born in Dunedin Hospital in March 1935. The Johnson's were a working-class family from the Dunedin suburb Caversham, who already had two children and their quadruplets caused an instant sensation throughout the Dominion. They came under the auspices of the Plunket Society when they were transferred to the Karitane Hospital the day after their birth. Within a few months the children were healthy enough to be taken home but Plunket officials advised against it. Although their home conditions were regarded as excellent (apart, it was noted, from the extra difficulties that raising the children in a small four roomed house would impose), Dr Tweed was reluctant to discharge the quadruplets from the Karitane hospital because the attention of the media had focussed the 'eyes of the public of New Zealand on them.' He advised the Dunedin Committee that they should make every effort to convince the Johnsons to leave their children at Karitane because

67 Complaints from mothers were also quite rare, but one reinforces the idea that Plunket Nurses could be rigid in their adherence to Plunket methods. An Otaki mother reported that she had been turned away from the Plunket Rooms because she refused to give her baby Karilac as a complement to breastmilk. The Plunket Nurse reportedly told her that 'if my child was fed on cow's milk that he would grow up to have calf's brains', which she added, was an insult to her. Mrs H. Johnson to Pattrick, 17 January 1934, PS AG7 3-223. The cow's milk comment echoed Truby King's oft repeated saying 'cow's milk for calves'.
68 Central Office Nursing Reports (Pattrick), May 1933, PS AG7 3-394.
69 P. Mein Smith, Mother and King Baby, p. 110; see also E. Olssen, p. 16. Truby King did become more dogmatic and less tolerant of opposing views in the later part of his life.
70 The Plunket Nurses' rules also required nurses to maintain 'a perfectly neutral attitude towards the medical profession' especially in regards to recommending or commenting on doctors, Society for the Health of Women and Children (Plunket Society) Rules, p. 5, undated, PS AG7 8-22.
71 Hoddinott to Tweed, 30 April 1934, PS AG7 2-260.
72 Dr Tweed's memorandum for Executive re Johnson Quadruplets, 15 August, 1935, PS AG7 2-300.
should anything happen to the quadruplets if they go home at 6 months of age, it might just react very adversely towards the Society. One of the most unjust criticisms which is constantly levelled at the Plunket Society ... is that their artificially fed babies tend to go back after six months. There is no doubt that these babies will not go back at all if they remain at Karitane, whereas should they go back after they go home, from any cause whatever, the Plunket Society might be unjustly blamed.73

The Johnsons were eventually persuaded that it was in their children's best interests to allow them to remain at the Karitane Hospital, as the guests of the Dunedin branch, until their first birthday.74 The Plunket Society had its happy publicity coup but the outcome was less successful for the Johnsons. In the face of Plunket imposing increasing restrictions in access to their babies they withdrew the children from the Karitane Hospital after ten and a half months.75

Aside from attempting to minimise negative impressions of the Society's work the Plunket Council trusted Dr Tweed to deal with the criticisms. It was preoccupied with implementing the changes recommended by the 1934 Rules Revision Committee and separating the Dunedin branch and national office finances and functions. In the mid 1930s the Executive was also undergoing some important personnel changes. After a difficult three years as President, during the time when the Council 'suffered the loss of [King's] supreme ruling in matter controversial', Kate McGeorge resigned in October 1936.76 Helena Sidey stepped into the breach for a year, before Daisy Begg was appointed to the role in 1937.

The Council did not fully investigate the criticism of the Society's methods in the mid 1930s because while it was persistent, it emanated from only a few doctors. Daisy Begg later wrote to Dr Ewart that Executive knew there were often differences of opinion on medical matters and claimed it had assumed 'that criticism was confined to a certain section, and was not general'.77 Traditionally the Council ceded control of medical matters to the professionals and placed faith in their advice. The Medical Advisory Committee, which only met annually never formally met with members of the Executive or the wider Central Council and any formal rumblings of medical discontent were channelled through Tweed. He consistently endorsed King's methods and the Council had no reason to doubt his medical judgement. In most cases doctors and Plunket nurses worked well together and the Dunedin based executive were geographically distant from the most vociferous critics.

73 Ibid.
74 Ibid.
75 Mrs Johnson felt so undermined and unwelcomed by the staff at the Karitane Hospital that she refused to visit the children after October 1935, Johnson Quads Report Book, 7 October 1935 - 24 January 1936, PS AG 38 77 and George Johnson to President of the Plunket Society, 10 February 1936, PS AG7 2-300.
76 McGeorge had been involved in the Plunket Society since 1912.
77 Begg to Ewart, 29 June 1938, PS AG7 2-281.
While Tweed remained loyal to King's methods, attitudes within the Medical Advisory Committee began to shift in the mid 1930s. The New Zealand Medical Journal later claimed that privately members of the Plunket Society often admit that revision of their feeding methods is desirable. It was common knowledge that King himself would not consent to any modifications and given his poor health no one wanted to force the issue. Individual members recognised that change was both desirable and necessary but the committee continued to stall on the issue. This suggests that the Plunket feeding schedule was not so much dangerous for infants as out of date with modern medical ideas.

While the Council never questioned Tweed's medical knowledge it was losing confidence in his administrative ability and his performance as Medical Director. Within a year of his appointment it was becoming evident that the Council had doubts about his suitability for the position. The first sign was the Council's reluctance to invest in his professional development. Throughout Tweed's tenure the Medical Advisory Committee attempted to improve his standing with the medical profession. Tweed and the Committee readily acknowledged that his lack of international experience hindered the Society's attempts to consolidate its teachings against unfavourable criticism. In a medical profession increasingly led by doctors with 'glossy postgraduate diplomas from overseas' the fact that Tweed had not studied overseas in over fifteen years was detrimental to the Plunket cause. Spencer, in particular, argued that as Tweed had no personal knowledge of "Modern Methods" of Infant Feeding overseas he was not competent to criticise them.

At its 1934 meeting the Medical Advisory Committee resolved that Tweed should be sent to Europe and America for 9 months to study 'the methods of infant feeding and the research work of this branch of medicine'. The Committee had no power to enforce its resolution; in reality it could only make recommendations for the Plunket Council to consider. The resolution did not make it to a full Council meeting that year. It was shown to McGeorge and Hoddinott who advised that it was unlikely the Society would be able to spare him so soon after Pattrick's departure and his appointment. The Medical Advisory Board persisted but the Executive consistently blocked Tweed's attempts at professional development. In 1935 the Council rejected a bid, supported by Truby King, for the Society to send Tweed to a conference in Melbourne. It advised him to consider funding his own attendance because the conference

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79 Tweed to Hoddinott, 18 June 1935, PS AG7 2-260.
80 Michael Belgrave, p. 165. Tweed had trained in England, before the first world war and was a member of the Royal College of Surgeons. The details of his medical training are not clear but he seems to have lacked the postgraduate training in infant welfare needed to impress his colleagues.
81 Tweed to Begg, 4 March 1938, PS AG7 2-282.
82 H1 127/5/6, National Archives and Tweed to Hoddinott, 18 June 1935, PS AG7 2-260.
83 H1 127/5/6, National Archives and Hoddinott to Tweed, 12 July 1935, PS AG7 2-260.
would be of great 'personal' advantage. This decision contrasted sharply with the Council's willingness to release Fitzgibbon for a 9 month study trip of infant welfare organisations in America, Canada, England and the Continent in 1936-37, funded through Karitane Products Society. The main purpose of Fitzgibbon's trip was to supervise the Plunket exhibit at the Canadian National Exhibition in 1936, but she also studied other infant welfare organisations while she was overseas. It is telling that the Council chose to send Fitzgibbon rather than Tweed in whom they did not have a great deal of confidence.

Just two years into Tweed's contract, at its March 1936 meeting, the Central Council decided not to renew his contract when it expired in December 1938. The Executive was now 'convinced that he has not the necessary qualifications for the position he occupies and we cannot justify the expenditure of £1,200 per annum, plus expenses, for the little real work he is accomplishing'.

Helena Sidey, the Acting-President from 1936 to 1937, attributed the Council's lack of confidence in Tweed to 'his indecision, procrastination and weakness generally whenever important matters crop up which make it necessary for his opinion to be given ... he lacks initiative, and we feel as a Council that in the long run we shall get nowhere with him as a Medical Adviser'. Tweed had failed to quell the persistent criticism from the medical profession about infant feeding and was not taking the Society forward.

The resolution was not acted on immediately. In October the Acting President, Helena Sidey, wrote confidentially to all Central Council members that various concerns had prevented the Executive from informing Tweed his contract would not be renewed. Difficulties over the publishing rights to the Society's main text, *Feeding and Care of Baby*, had confused the issue. The Council had been attempting to convince Truby King and his trustees to transfer the book's copyright to the Society since 1935. There had been no new publication since 1930 and Plunket was anxious to issue a new edition published as 'Revised by the Society under the direction of its Medical and Nursing Advisers (Dr Tweed and Nurse Fitzgibbon) with the approval of Sir Truby King'. The Council wanted to build public confidence in its medical and nursing officers by asserting their authority on the book before King died. Mary King and the Karitane Products Society were equally anxious that both the copyright and acknowledgment of authorship remained with Truby King while he was alive. The Executive were concerned that Tweed might attempt to stir up trouble if he was told immediately that the Council had no intention of renewing his contract. Tweed was facilitating the relationship between the Society, Truby King, his trustees, Mary King, the Karitane Products Society and the Council. The negotiations were delicate and Lady Sidey was worried that any upset would

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84 Sidey to Hunt, 8 December 1936, Ps AG7 2-261.
85 Ibid.
86 Sidey to members of Dominion Council, 12 March 1937, PS AG7 2-261.
87 Most of the revision work had actually been done by Fitzgibbon because Council lacked confidence in Tweed's abilities, C. B. Barrowclough (member of Plunket Executive) to Blair, 7 October 1936, PS AG7 11-21.
weaken the Society's position regarding *Feeding and Care*. The Society's vulnerability was increased because Miss Fitzgibbon was out of the country so that if Tweed did decide to 'forment trouble it would be hard to combat'.

A year after the Central Council had initially made the decision, Tweed was finally informed he no longer had the confidence of the Central Council and his appointment would not be renewed in 1938. He was not surprised. He had been aware that the Executive, particularly Lady Sidey, lacked confidence in him. The decision left the Council in a state of flux on medical matters. While Tweed remained in his position it was unlikely that the medical criticism could be effectively combated. Nor could the Council start trying to build public confidence in Tweed's medical authority when it was not renewing his contract.

III.

By the end of 1937 Spencer was fed up. Years of 'hammering away at Dr. Martin Tweed' about the Plunket diet had had no discernible effect. The Plunket diet was unchanged and so were the health statistics. Earlier that year in an article, 'Malnutrition and a C3 Population', published in the *NZMJ*, he had reiterated his view that New Zealand's infants had a malnutrition problem caused by the Plunket diet. In December 1937 he wrote directly to the Plunket Council, outlining the tensions between Plunket nurses and doctors in Wellington and their consequences for mothers and babies in the area. Noting that 'It is not at all uncommon for mothers to be told by Plunket Nurses that my methods of feeding will prove harmful to their babies', he outlined one of his recent cases of malnutrition. He had written in the hope of drawing the Council's 'attention to a state of affairs of which [it] ... may have been unaware' and to an extent he was. The letter generated action, albeit slowly. The Executive's long Christmas break delayed the Society's response and in early February Spencer was notified that his criticisms would be referred to the Society's Medical Advisory Committee 'as soon as possible'.

Truby King died on 10 February 1938 and his death seems to have cleared the way for the Society to clear up Tweed's position before the official end of his contract. It rejected a suggestion from Tweed that he delay his resignation until he had countered the criticisms of the Society's methods. Although his contract expired in December 1938, he reluctantly tendered his

88 Sidey to members of Dominion Council, 12 March 1937, PS AG7 2-261.
89 Ibid.
90 Blair to Barrowclough, 25 November 1936, PS AG7 11-21.
91 Spencer to Begg, 26 February 1938, PS AG7 11-24.
92 Spencer, 'Malnutrition and a C3 Population, Part II', *NZMJ*, 36, 191 (February 1937).
93 Spencer to Central Council, 18 December, 1937, PS AG7 11-24.
94 Ibid.
95 Begg to Spencer, 2 February, 1938, PS AG7 11-24.
resignation at the end of March.\textsuperscript{96} Mindful of the furore caused by Pattrick's 'resignation' the Society tried to thwart any attempts by Tweed to cause trouble, but were not totally successful. Tweed preempted the Executive's attempts to attribute his resignation to ill health by supplying the press with a statement of his own and a supporting tribute from Mary King.\textsuperscript{97} His statement, which was eulogistic of Truby King, drew the comment from Margaret Harding that he appeared determined 'to present to the public an exaggerated idea of Dr King's qualifications and services to the Plunket Society'.\textsuperscript{98} This shows the Council's sense of disillusionment with King in his later years. King's death and Tweed's resignation cleared the way for the Society to begin to move out of King's shadow. In the meantime Dr. E. H. Williams, lecturer in paediatrics at Otago Medical School and a member of the medical staff at the Karitane-Harris Hospital, was appointed Acting Medical Adviser in a temporary and part time capacity, pending the appointment of a replacement.

After a few months of respectful, public silence the pressure on the Society to make changes began to build again from a number of directions. At its May meeting the Wellington branch of the NZBMA formally requested its national Council approach the Minister of Health about appointing a Committee to investigate infant feeding in New Zealand. Criticisms of the Society's work were also appearing in the daily press. A cleverly written article in the Dominion on 'The Values of Proper Nutrition for the Young' outlined a case of childhood malnutrition caused by wrong feeding in infancy.\textsuperscript{99} Plunket was not specifically named but the article claimed this example illustrated 'the folly of accepting as gospel semi-expert advice which is best checked from time to time by the opinion of a fully qualified medical man'. The author conceded that New Zealand 'has one of the best child welfare services in the world' but the article firmly located the cause of childhood malnutrition with wrong feeding in infancy. Child specialists had to create a market for their advice and the article implied that the Plunket system was too homogenised and more obliquely that knowledge about infant feeding had become too democratised. The need for 'expert advice' was stressed. The article urged that 'the scientific study of the values of food is too deep and wide a subject to be studied by the average mother or housewife' as Plunket encouraged. Rather 'it is a subject for the chemist, the scientist, the economist and the medico'.\textsuperscript{100} The idea that infant nutrition was a specialist subject was carried further by the \textit{New Zealand Medical Journal} editor who claimed that 'No nurse has, or can be expected to have, any real grounding in infant nutrition as a science'. He did concede that an 'intelligent nurse' could develop 'great skill in baby feeding' however.\textsuperscript{101} These dismissive

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\textsuperscript{96} The exact mechanism by which the Council secured Tweed's resignation is unclear. It had previously offered him the opportunity of getting out of his contract as of 30 June 1938 but Tweed was clearly willing to stay on longer, Executive Council minutes, 28 September 1937, AG7 1-2-12. \\
\textsuperscript{97} Begg to Executive Council members, 5 April 1938, PS AG7 11-12. \\
\textsuperscript{98} Harding to Begg, 8 April 1938, PS AG7 11-12. \\
\textsuperscript{99} There was no byline but Plunket administrators believed it was written by Dr Spencer, press clipping, \textit{Dominion}, 20 May 1938, PS AG7 11-12. \\
\textsuperscript{100} Ibid. \\
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summations of the Plunket nurses' expertise combined a gendered view of human capacity with an attempt to extend the territory over which doctors had control.

The second part of Spencer's 'Malnutrition and a C3 Population' article was published shortly after. The timing was controversial enough for Spencer to specifically state that he had 'no wish to do discredit to the memory of Sir Truby King', but it was the most direct attack made on Plunket's diet yet. He argued for wide ranging reforms in the standards set for infant health, including the establishment of a New Zealand standard for weight curves and favoured having a segment marked in hachures rather than the thin black line of the Plunket charts. His main argument was more familiar. He reiterated that the one constant feature in cases of malnutrition seen in his practice was 'underfeeding during infancy' and concluded that Plunket's low protein diet was the cause. The same issue of the NZMJ carried an editorial on nutrition which clarified the perceived extent of the problem. New Zealand did not have a gross malnutrition problem, but rather 'calories being generally adequate, mild degrees but important qualities of malnutrition are those which require investigation'. Once more the finger pointed to the Plunket dietary and a challenge was issued:

There is in New Zealand a system of infant feeding which has gained exceptionally wide acceptance and its results in adult life should by now be capable of estimation; by such results the Plunket system must ultimately stand or fall.

Plunket was already taking action to stem the tide of criticism. It had called a meeting of its Medical Advisory Committee at the end of March 1938, which reported that it was unanimous 'that it is most desirable that an investigation of methods of infant feeding other than the Plunket method should be carried out as soon as possible, with the object of revising our standards if found necessary, and also with the idea of combating criticism that has been levelled against them'. For the first time, without concern about King to impede it or Dr Tweed to protest the Medical Advisory Committee clearly conveyed to the Council that action had to be taken, and that changes might be necessary. The Council established a sub-committee, which met in May 1938, to discuss the future medical direction of the Society. Sub-committee members decided that damage control was necessary when they discovered that Tweed had, on one occasion, subverted a Medical Advisory Committee recommendation. He was unwilling to put into effect a 1934 remit suggesting that alternative feeding systems be

104 Ibid, p. 112.
105 Statement re Medical Advisory Committee's Recommendation to Council to send Medical Adviser Overseas', unsigned and undated, H1 127/5/6 National Archives.
106 The sub-committee consisted of Daisy Begg, Lady Helena Sidey, Mesdames Reid, Cleghorn, Cox, McGeorge (Dunedin), Jowett (Wellington), Robertson (Wanganui), Allan (Auckland), Cracroft Wilson (Christchurch), Strang (Invercargill), Messrs. Cameron, Burgess and Barrowcliffe, Miss Fitzgibbon and Miss Hoddinott.
trialed in the Karitane Hospitals, so had deliberately withheld it from the Council.\textsuperscript{107} The committee decided that the medical profession had to be assured the Society was not ‘static’ on the infant feeding issue. It arranged for Dr Williams to call a meeting of the Medical Advisory Committee and any co-opted members of the Karitane Hospital staff he desired, ‘to take what steps they might think necessary for the Society to retain the confidence of the B.M.A.’.\textsuperscript{108} In the meantime the Executive started advertising for a new Medical Adviser.\textsuperscript{109}

The Medical Advisory Committee met in Wellington for a full day in June 1938.\textsuperscript{110} For Daisy Begg and C. B. Barrowclough (the Society’s lawyer and a member of the Executive), the two Plunket Executive representatives, this was their first meeting with most of the men on the Society’s Medical Advisory Committee. Both Begg and Barrowclough were anxious to stress the positive practical work being done by the Society. Begg opened proceedings by acknowledging the gravity of the criticisms but urging prudence. She reminded the gathered medical men that the Society saw the thousands of normal children while the medical profession tended to see only the few ill children; the totality of the Society’s work and record must be considered. Begg and Barrowclough knew that the criticism had to be dealt with because ‘this public criticism, undermines public confidence - it undermines the confidence of the mothers - it undermines the confidence of that public which subscribes to our funds’,\textsuperscript{111} but they were hoping to delay making decisions on changes until a new Medical Adviser was appointed.\textsuperscript{112} Begg cautioned that the Council would have to bear in mind the considerable practical difficulties of implementing any recommended changes:

When you consider that we have over six thousand women working on committees in the various branches of the Society, and that great numbers of these women had very personal friendship with Sir Truby and respect for his very compelling personality, you will realise that it is not an easy position for a Society depending on that voluntary help to move without very great care.\textsuperscript{113}

Begg’s desire for caution did not impress Dr Pettit. He was vehemently against delays because the public had become aware of the criticisms. Spencer’s article had been summarised in the press along with publicity about a B.M.A. Dominion Council’s request for an

\textsuperscript{107} Minutes of sub-committee meeting, 25 May 1938, PS AG7 1-25.
\textsuperscript{108} Ibid.
\textsuperscript{109} Dominion Council minute book, 9 June 1938, PS AG7 1-2-12.
\textsuperscript{110} Drs. E. H. Williams, Robertson, Ewart, Landreth, Pettit, Miss Fitzgibbon, Mrs Begg and Mr Barrowclough were present. Drs Cronin, Corkill and Widdowson, who had previously been members of the Advisory Committee also attended. Report of Medical Advisory Committee, 17 June 1938, p. 1 and p. 51, PS AG7 11-49.
\textsuperscript{111} Ibid, p. 6.
\textsuperscript{112} Ibid, pp. 5 and 10.
\textsuperscript{113} Ibid, p. 5.
investigation into child nutrition in New Zealand. Just the previous day the Christchurch Star-Sun had editorialised dramatically that

The urgency of the case is demonstrated by the fact that malnutrition in New Zealand is due not to starvation but to wrong feeding, and occurs among the children of the rich as well as of the poor. It has been described as a self-inflicted wound for which the parents are responsible, and for which the children suffer.

The adverse criticism reflected badly on the Medical Advisory Committee and they were unwilling to leave themselves open to an investigation by a public Commission. Pettit warned the meeting that if a Commission was held that day then the Committee would

be in a false position because we have been considering others’ opinions too long. We have considered Sir Truby and his feelings, and there has been misunderstanding between the Medical Director and the Executive and the Council... We have got a clear run, and it is for us to put our house in order before we are asked to do so by the Minister.

Pettit opined that any recommendations they made would have to be followed through quickly. Begg and Barrowclough left the meeting while the Committee discussed the issues.

Dr Williams, the Acting Medical Adviser, took control and outlined three issues for the meeting to concentrate on. The first was settled quickly. He called for and got an agreement that the Plunket Society served a purpose and should continue to exist. Next, Williams called for any advice the committee could give 'as to the more successful carrying out of [the Plunket Nurses] work, or restrictions that we think should be placed upon them - in fact any advice we can give in regard to the Plunket Nursing system as a whole'. Discussion focussed on relations between nurse and doctor, as doctors seized the opportunity to increase their profession's opportunities in infant welfare. Cronin led the charge. For the first time in the ongoing debate a doctor acknowledged that 'the trained Plunket Nurse who knew her job could manage an infant feeding case much better than the average practitioner'. But, Cronin added, that 'the general practitioner of to-day I think is becoming more interested in the question of infant feeding, and I think that we should ask for better co-operation between the medical men and the nurses in the matter of our Plunket work'. To achieve this he suggested establishing clinics in the Plunket Rooms, in the main centres at first, with a paid doctor in charge. The idea was that the doctors would be present a few days a week to deal with the difficult cases and refer them, where necessary, on to their own general practitioner or specialist. The advantage,
according to Cronin, was that 'these men then would become more interested in their work, and would be able to keep contact with the general practitioner in the town much better than the nurses would.' The scheme would allow doctors to flex their muscle, gain supervisory power over the work of the nurses and ensure that they were not being excluded. The average doctor's 'biggest grouse' about the Society, according to Dr Robertson, was 'that they are not getting the cases referred back to them, and are losing pounds, shillings and pence.'

Fitzgibbon's reaction to the proposal was lukewarm. She told the meeting that the Society had over 70 branches, not including the numerous outposts visited by Plunket nurses weekly or fortnightly, and it would be an impossible scheme to implement universally. She did however concede that some of her nurses would appreciate having a doctor on sight to refer difficult cases to and agreed with the proposal in principle. The meeting recognised that some doctors might have concerns about such a scheme undermining the relationship between the patient and their own medical practitioner and it was agreed to refer the matter to the NZBMA to canvass the opinion of the medical profession. This illustrates that the Plunket Society was not resistant to its nurses working more closely with doctors. For the Society the main issue was that it did not want to change its artificial feeding methods.

Finally, the meeting discussed what changes should be made to the Plunket dietary. In the absence of Tweed the Committee quickly reached a consensus that protein needed to be increased but could not agree on the extent. Could protein effectively be increased while retaining the percentage method or was a clean sweep necessary? The ensuing debate was less about scientific feeding theory than the medical profession's desire for simpler feeding methods and the Plunket Council's desire to minimise the impact of change.

The Committee members favoured simpler methods. For the first time they admitted that doctors found the percentage feeding method difficult to understand and use. Plunket had increased interest in infant welfare generally, creating a demand and now doctors wanted to be involved but the recommended feeding methods would need to be simplified. As Dr Pettit put it 'the ordinary practitioner doesn't know as much about the computing of food values as the Plunket nurse does. She can do it with her pencil in a few moments, because she is doing it all the time, whereas the practitioner has to work it out much more laboriously.' Plunket nurses were better trained in infant feeding than the average general practitioner. Cronin argued that 'the average man, when you talked to him about the percentage feeding of infants, thought he was in another world. If they had had it put forward in a simpler way, they would have had no difficulty in assimilating it.' One suggested remedy was a new text book. Plunket's

119 Ibid, p. 18.
120 Ibid, p. 21.
122 Ibid, p. 34.
traditional text, *Feeding and Care of Baby*, was used by both Plunket nurses and mothers. The committee sought to impose a demarcation; any new text would have to be 'something only for nurses and doctors, not for mothers'. A cynic later summarised the issue: 'Apparently the main complaint is...that the formulae can be followed by Mother and Nurse whereas the profession wd (sic) like something more mysterious and yet more easily followed by themselves.'

Williams and Fitzgibbon were both reluctant to change methods completely. Switching to a 'simpler' method would involve drastic changes for Society's training and textbooks and they were keen to solve the problem by adjusting the present system. They suggested to the meeting the earlier introduction of mixed feeding (at 6 months) and increasing protein by taking the dilutant out of the milk earlier. The Committee generally wanted bigger changes. They considered that one of the advantages of overhauling the whole system would be that Kariol would probably become obsolete. Most at the meeting regarded King's formula as an inefficient and expensive way of giving fats and favoured the use of the cheaper cod liver oil. Williams was the exception. He was vehemently opposed to dropping Kariol, arguing that most babies digested the formula well. The reason for his reluctance became clearer when he reminded the meeting of the Karitane Products Society's investment in modern equipment and plant. Williams knew the Karitane Products Society was a vital funding source, which had periodically saved the Society from financial ruin in the 1930s. Plunket could not afford to make one of its biggest sellers obsolete.

These issues were still unresolved when Spencer arrived to talk to the meeting. His attendance had been requested by Pettit and Landreth but was only reluctantly agreed to by Williams. He was only given a small amount of time to talk but reiterated that he thought changes had to be made to the feeding system. Williams politely but effectively dismissed him from the meeting before he had a chance to make specific recommendations and the meeting settled in to passing resolutions.

The final decision of the meeting was that the Society would have to change its standard and it noted that 'an alternative to this percentage method a simple system of diluted milk with added sugar based on certain scientific principles has been devised'. Although the Committee favoured changing to a simpler method of feeding a firm decision was postponed pending the appointment of the Society's new Medical Adviser. In the meantime the meeting

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123 Dr Robertson, Report of Meeting of Medical Advisory Committee, 17 June 1938, p. 28, PS AG7 11-49.
125 Spencer later sent the Committee a statement affirming that he was willing to make suggestions on how to change the Plunket artificial feeding but would need preparation time. He also expressed his support for a claim apparently made at the meeting that the Plunket Society had consistently ignored the views of post-graduates who had studied overseas, PS AG7 11-49.
126 Report of Meeting of Medical Advisory Committee, 17 June 1938, p. 51, PS AG7 11-49.
recommended the option Williams and Fitzgibbon favoured, 'an immediate increase in the protein content of the milk mixture and the commencement of mixed feeding at six months'.

This system, while no longer based on the 'human standard', allowed Plunket to make changes without departing radically from its traditional methods and keep recommending Kariol.

The ordeal was not over for the Plunket Society. The feeding issue hit the press within days of the Medical Advisory Committee meeting. The headlines said it all: 'Malnutrition in Dominion', 'Underfeeding in Infancy', 'Plunket System Attacked', 'Humanised Milk Said To Be Inadequate'. Spencer took centre stage and increased the pressure on the Society. He declared 'it is the opinion of specialists throughout New Zealand that the Plunket system of feeding does not supply even the bare minimum of food value required for a baby's perfect development and health'. He claimed he had the support of six New Zealand child specialists, none of whom agreed with Plunket's methods and none of whom were on Plunket's Medical Advisory Committee. His comments were publicly supported by Dr Marie Buchler (a recent Lady King Scholar) and Dr Fitzgerald.

It seems the majority of New Zealand general practitioners would have supported Spencer too. Without Plunket Nurses' case records it is difficult to assess the validity of Dr Spencer's claims about the inadequacies of the Plunket diet retrospectively. What is clear is most of the medical profession were convinced that Plunket methods were out of date. A survey of doctors conducted by the Health Department's Nutrition Committee showed that by 1939 most New Zealand doctors felt there was room for improvement. Around 80 per cent suggested changes to its artificial feeding system, along the lines the child health specialists had been pushing for the previous decade. Whether this was anything more than a response to changing medical fashions is unclear. What is clear is that, despite their desire for the modernisation of the feeding system, 70 per cent of the respondents thought that the Plunket Society's work was good.

Most of the Medical Advisory Committee's resolutions were passed on the recommendation of Dr Williams and the Executive, at a full meeting of the Central Council in Dunedin in July. The protein level was immediately raised slightly, from an upper limit of 1.7 per cent to 2 per cent, pending the appointment of the new Medical Adviser. In the meantime it fell to Dr Williams and Miss Fitzgibbon to convince the branches that raising the protein was

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127 Ibid.
129 Press clipping, unattributed, June 1938, PS AG7 11-24. Dr Ewart thought that Spencer went to the press because the way the dismissive attitude of the Medical Advisory Committee antagonised him, Ewart to Begg, 22 June 1938, PS AG7 2-281.
130 The Nutrition Committee sent out surveys to 700 doctors and 45 per cent responded, AJHR, H.-31, 1939, pp. 101-102.
'an amplification of, rather than a departure from Sir Truby King's teaching'. Some branches and some nurses were wary; one warned Dr Williams that the Society 'could never consent to a change to another method and remain the Plunket Society'. Some Council members had second thoughts about the new feeding schedule after it was put into action because it allowed Plunket Nurses to prescribe up to 2 per cent protein instead of the limit of 1.7 per cent Truby King established. The Executive, Williams and Fitzgibbon remained adamant that the changes were only slight and the Society had to bow to medical opinion and accept the Medical Advisory Committee's advice. The other controversial resolution, that clinics be staffed by doctors, was deferred until the next Council meeting in November, by which time the NZBMA had notified by the Plunket Society that its members were unable to entertain the idea of becoming involved in the scheme while the Labour Government's health reforms were being implemented.

The medical profession's preoccupation with the reforms of the Labour Government protected the Society from being forced into a closer partnership with doctors. Still, for the first time in the Plunket Society's thirty year history, it had been forced by a combination of medical pressure and internal changes to bow to the medical profession and adjust its infant feeding regime. 'Humanised milk' was formulated by King in an era when overfeeding, and its apparent consequence, infant diarrhoea, was the main dietary danger for infants. It was modernised in response to the demands of a medical community now more concerned with malnutrition. The break with Truby King's methods was slight but, together with the appointment of Dr Helen Deem as Medical Adviser, it indicated that the Plunket Society was ready to move in a new direction.

131 Harding to Dr Williams, 12 August 1938, PS AG7 2-281.
132 Iris Woods to Dr Williams, 18 August 1938, PS AG7 2-281.
133 Harding to Dr Williams, 12 August 1938, PS AG7 2-281.
134 See for instance Annual Report, 1939, pp. 16-17 PS AG7 1-3-4.
135 Helen Deem was appointed in November 1938.
Conclusion

The Plunket Society’s reputation for ‘helping the mothers and saving the babies’ has been remarkably strong in New Zealand. This central ideal has proved extraordinarily powerful and remains the basis of debate over provision for maternity today. Plunket has been described as part of ‘the very fabric of New Zealand society’ and most New Zealanders can identify with the term ‘Plunket baby’. The Plunket Society was established in 1907 in response to concern about the declining birth rate, the concurrent fear that women were rejecting the maternal role and medical advances which suggested the infant mortality rate could be successfully attacked by educating mothers in infant welfare. In promoting its ideology of ‘scientific motherhood’ the Society made motherhood and child welfare a public process, established the state’s interest in the work of mothering and in the process, and contributed to the medicalisation of childhood. The interwar period was crucial to this process because it was in the 1920s that the Health Department formally endorsed the Society’s infant welfare ideology and Plunket expanded to become a truly nationwide organisation.

The process of becoming a national institution was far from smooth however. Negotiation and resistance are major themes of the Plunket Society’s history in the interwar period. There was little unanimity amongst infant welfare reformers about who should control infant welfare. The Health Department, medical experts, Plunket nurses and administrators at various levels of the Society all brought particular agendas to the task they set for themselves. Their competing interests and ideologies helped shape the services Plunket provided for women and babies.

One of the themes of this thesis has been the Society’s negotiation of its relationship to the state and its agency, the Health Department. When it was established in 1907, New Zealand’s young state health bureaucracy allowed the women and men of Plunket a strong role in shaping and providing infant welfare services. This allowed a cult of personality to develop around King but also gave New Zealand women more influence in shaping infant welfare services than they would have otherwise had. That women were running what became a huge infant welfare organisation at a time when they were meant to be in the home contradicts the ideology of separate spheres but also illustrates that feminine activity in the public sphere was most acceptable when it involved traditional women’s work, such as the welfare of mothers and babies.

The Plunket Society also helped to shape New Zealanders’ conceptions of welfare. By separating welfare from notions of charity and insisting on the right of every mother to free advice, the Society demonstrated the principle of universal welfare provision. It was a distinctly
egalitarian system in theory. In practice while Maori women were never actively excluded the Society limited its efforts in their direction, leaving Maori infant health to the state. Still, the Plunket Society was a vital part of the New Zealand welfare system - an evocative symbol of the nation's commitment to supporting motherhood and children. It illustrates the central place of voluntarism in the development and maintenance of that commitment, and of the welfare system more generally.

Plunket transcended political boundaries. Politicians from across the political spectrum and at the highest level of government were actively involved in its work. It took advantage of those contacts and of the relatively open access to politicians available in a small country to directly pressure governments over funding. While governments' universally celebrated the strength of the Society's volunteer contribution to infant welfare Health Department officials tended to be less enthusiastic because they wanted more control over the Society's work. Truby King's appointment to the new Child Welfare Division in the Health Department in 1920 signalled both the Government's co-option of his ideology (and the acceptance it had gained) and the culmination of persistent efforts by Health Department officials and some Ministers to give the Department more input into infant health. Plunket retained the upper hand in its negotiations with successive governments in the interwar period, and more particularly the Health Department. Its voluntary base and successful fundraising in the 1920s allowed it to claim a high level of public support and interest. This support enabled the Plunket Society to successfully resist the first suggestion of cuts to its state subsidies in 1930. When the Government imposed funding cuts on the civil service in 1931 and 1932 Plunket had to submit but ameliorated the impact by accepting significant grants from the Karitane Products Society. By the late 1930s government subsidies had been restored; the overall effect was increased state funding for infant health.

Over the interwar period Plunket's work sparked the medical profession's interest in the welfare of healthy infants. At the same time, advancements in medical theory, research and knowledge, and the development of paediatrics as a medical specialty challenged the Society's dominance of infant welfare and health prescription. Truby King's medical theories had been orthodox when the Society began in 1907, and his belief in the naturalistic foundations of health and infant feeding in particular never changed. But by the 1930s the science of infant feeding had moved on and King's 'humanised milk' was considered out of date by the medical profession. A small group child health specialists, led by Dr Spencer, shaped the debate with their concern with artificial feeding and drove the lobby for change. They brought back ideas from their overseas postgraduate training that challenged the Plunket system. Plunket resisted change. Medical concerns shifted, from the infantile diarrhoea which initially prompted King's interest in infant feeding in the early 1900s to malnutrition in the 1930s, but the Society's prescription remained the same.
Plunket's response to the medical criticism of its artificial feeding regime was shaped by internal conflict which revealed the limits of the Society's structure. In a large measure the events of the 1930s were a result of King's earlier dominance and the Society's reliance on his charisma and medical authority. The decline of King's health forced the Central Council and its Executive to begin developing its own responses and policy in the early 1930s, rather than continue supporting King, whose medical expertise and personal vision had given him authority. The separation of the man and the Society, reluctant on King's behalf, was a long and painful process and the leadership vacuum left during and after his eventual exit in the transition years 1928-1933 was contested. The Central Council's arbitrary dismissal of Anne Patrnick in 1934 brought internal dissension over the direction of the Society and concern about its democratic processes to the fore. It highlighted both the Dunedin based Executive's dominance of the Council and concern amongst some branches that important decisions were being made without a mandate from the branches through a General Conference. Where King's authority had been tacitly accepted the Executive's was challenged from below and the Society's constitution was revised in 1934 in an effort to make the Executive more representative and to clarify the limits of its power.

King's declining involvement in the Society also created a vacuum in medical leadership. King chose replacements, Dr Thomas Derrick and Dr Martin Tweed, who supported his methods but were unable to duplicate his charisma and authority. Derrick's short lived role as Medical Director between 1928 and 1930 gave him little opportunity to contribute to the direction of the Society. Tweed's longer tenure in the fulltime position of Medical Adviser to the Council was more fraught. It fell to him to liaise between King, the Executive and the Central Council and between the medical profession and the Society in what was a difficult transition period. His failure to stem the tide of criticism and his less than authoritative manner meant he quickly lost the confidence of the Council. Tweed was instrumental in setting up the Medical Advisory Board, established to give the Society another medical authority when King died. Tweed controlled the Board's communication with the Council however and his loyalty to King's methods meant he only passed on decisions which endorsed the status quo. As a result the Council continued to resist medical change even after the tide of medical opinion amongst its own advisers had changed. In a sense King continued to dominate the Society's medical direction until his death in 1938. His methods had become institutionalised and some Council members feared any break with his methods would mean not being the Plunket Society.

If negotiation and resistance are important themes for Plunket in the interwar period, the Society's success at resisting the larger changes desired by the Health Department and the medical profession means that continuity is also an important theme. The dietary changes forced on the Society in 1938 were, to the modern eye at least, minor. At the start of the interwar period Plunket's artificial feeding recipes had 1.4 per cent protein, by the end of the period
Plunket Nurses could prescribe up to 2 per cent at their own discretion. This may have diverted slightly from King’s standard of attempting to imitate human breastmilk but the ingredients and methods of preparing the formula remained the same. The services Plunket offered to mothers also remained substantially the same and the Society’s success at negotiating funding meant those services became more accessible. The provision of Plunket Rooms in the suburbs and in rural areas allowed mothers to take their babies to visit the Plunket Nurse in ever increasing numbers. Driving this growth were the local branch committees.

By 1938 Plunket’s president, Daisy Begg, could claim that there were 6,000 women and men serving on its committees. This administrative history of Plunket tells only part of the Plunket story. Relations between Plunket, the state and the medical profession, as well as internal wrangling over roles and influence within the Society, provided the context in which the branches operated. How those branches weathered the 1920s and the 1930s, how mothers negotiated their relations with Plunket Nurses, and the extent to which Plunket shaped mothers practices remains to be seen.
Bibliography

PRIMARY SOURCES

Unpublished Official Records

NATIONAL ARCHIVES, WELLINGTON

Health Department.

Series 127 - Plunket Society.

- H1 127 (B18) General, 1929-33
- H1 127/4/5 Plunket Nurses, 1928-56
- H1 127 9251 General, General 1934-40
- H1 127/5/6 Criticism of Society's Methods 1938-40
- H1 127/30 Maori Pamphlet - infant feeding 1913-1934

Published Official records


Unofficial Records

HOCKEN ARCHIVES, DUNEDIN.

Royal New Zealand Plunket Society Headquarters, Dunedin.

Series One: Administration.

Subseries 2: Executive and Council Minutes
- AG 7 1-2-1 Central Council Minute Book 1917-1926
- AG 7 1-2-2 Loose items from 1-2-2 1917-1926
- AG 7 1-2-3 Central Council Minute Book 1927-1933
- AG 7 1-2-4 Items removed from 1-2-3
- AG 7 1-2-5 Dominion Council Minutes 1-298 1933-1937
- AG 7 1-2-6 Dominion Council Minutes 299-438 1938-1944

Subseries 3: Annual Reports of Council
- AG 7 1-3-1 Annual Reports of Council 1908-1923
- AG 7 1-3-2 Annual Reports of Council 1924-1931
- AG 7 1-3-3 Annual Reports of Council 1932-1937
- AG 7 1-3-4 Annual Reports of Council 1938-1952
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Lady King Scholarship
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AG 7 2-272 Secretary 1932-1941
Medical Adviser to Council
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Travel passes 1940-1941
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Sick leave 1931-1937

AG 7 2-301 Half yearly statements 1930-1932
Dr. Doris Gordon
Karitane Hospitals 1937-1941

AG 7 2-299 Secretary 1933-1941
from Justice Blair re Truby King's estate
Karitane Products Society "Feeding and Care of Baby" 1933-1938
Co-operation between Plunket nurses and District midwives
Registration of branches 1934-1940
Circulars - Dominion Council 1935-1941

AG 7 2-300 Secretary 1934-1941
Report Miss Fitzgibbons of the Johnson quadruplets 1935-1936
Report of pre-school children, Dr. W. Irwin 1934-1935
Correspondence re editorial on Plunket Diet, NZ Medical Journal 1935
Advertisements
Truby King - Harris Hospital building fund
Karitane Products Society
AG 7 2-275 Appointment of Medical Adviser 1938-1939
Advertisements, applications, particulars, rules and appointments
AG 7 2-276 Medical Advisory Board 1930-1940
Nurses Salaries
Mothers' Club
Agendas, papers and reports of council meetings 1938-1941
AG 7 2-277 Rules Revision committee 1934
Incorporated Society 1940-1941
Glaxo correspondence 1932
Advisory Board 1933-1936
Health Dept. nurse for Fiji 1935
Refresher courses 1935-1939
Karitane nurses' badges 1933-1941
Government Statistician 1931-1938
Staff changes 1931-1936
Building Subsidy 1933
Accounts 1933-1941
AG 7 2-281 Cheques from branches 1934-1941
General Medical Advisory Board - attack on Plunket methods 1938-1940
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Provincial Conference 1934-1935
Plunket Exhibit, NZ Centennial Exhibition 1939-1940
Hygeia 1933-1941
AG 7 2-292 Secretary 1932-1941
Karitane nurses, training fees, vacancies
Short courses for midwives and maternity nurses
General conference
AG 7 2-302 Karitane Products Society Advisory Board 1932-1933
Medical students 6th 1935-1941
Karitane hospitals 1934-1939
Notice of retirement 1938
Newspaper cuttings 1938
AG 7 2-304 Dominion Council 1933-1941
AG 7 2-305 Karitane Products Society Special Grant 1934-1935
Souvenir volume Mrs Joseph McGeorge 1937-1938
Resignations 1933-1941
AG 7 2-306 Expenses Sir Truby King 1931-1932
Hygeia 1934
Executive 1934-1938
Medical advisers reports 1935-1938
NZ Woman's Weekly 1933
NZ Trained Nurses Assn. 1934
Staff reduction 1932-1934
Branch levies 1934-1935
Plunket training 1934-1936

Series Three
Subseries 5: General and Subject
AG 7 3-407 Circular letters to Nurses 1920's
AG 7 3-405 Plunket Nurses Fund 1926
Lady Truby King Fellowship
AG 7 3-315 Director of Nursing - Inward Correspondence 1927
Miss Patrick and Miss Hooper, A-Z
AG 7 3-215 Plunket Nurses Association 1928-1931
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| AG 7 | 3-218 | Central Nursing Reports | 1934-1945 |
| AG 7 | 3-223 | Articles for Woman's Weekly | 1919-1937 |
| AG 7 | 3-224 | Nursing Adviser - Correspondence re complaints | 1937-1942 |
| AG 7 | 3-226 | Nursing Adviser, correspondence with Medical Adviser | 1931-1938 |
| AG 7 | 3-227 | Nursing Adviser, correspondence with Dr Tweed re examination results | 1931-1938 |
| AG 7 | 3-255 | Dept of Health, Ante-natal nursing correspondence | 1926-1929 |
| AG 7 | 3-256 | Correspondence with Health and Education Depts | 1921-1926 |
| AG 7 | 3-257 | Department of Health, General Correspondence | 1931-1938 |
| AG 7 | 3-258 | Department of Health, General Correspondence | 1938-1944 |
| AG 7 | 3-283 | Karitane Hospitals Monthly Reports | 1934-1937 |
| AG 7 | 3-284 | Karitane Hospitals Monthly Reports | 1937-1940 |

Series Five: Mary King and Truby King Miscellaneous

| 89-098-20 | Bella King, Lecture Tour, diary | 1912 |
| 89-098-22 | Bella King, Lecture Tour, diary | 1916 |
| 89-098-43 | "Sir Truby King" | 1920's-1930's |
| 89-098-48 | "Interesting but not used in Biography" | 1924-1927 |
| AG 7 | 5-27 | "Early Plunket Teachings, Aims, Ideals etc. Karitane Hospitals raison d'etre" extracts from conference papers Truby King letters, notes, and papers Clippings re early Plunket Society Maui Pomare correspondence | 1904-1912 |
| 89-098-58 | "Trouble with the BMA" (includes pages from a letterbook, ?Seacliff) | 1910 |
| 89-098-29 | "Opposition to Plunket work", notebook | 1912 |
| 89-098-33 | Truby King, notebook | ca 1915-1918 |
| AG 7 | 5-11 | "Seacliff to Wellington and Director of Child Welfare, chap. 28" Correspondence and press cuttings | 1919-1929 |
| AG 7 | 5-12 | "Director of Child Welfare" The NZ Child Welfare Dept. Objects, inception, arrangements re salary and conditions of director | 1920-1923 |
| 89-098-68 | "Child Welfare - Status" (includes Mr Skerrit's comments and correspondence with Glaxo) | 1921-1922 |
| AG 7 | 5-14 | "Maternal Mortality and Ante-natal" pt.1 Letters and cuttings re infant and maternal mortality, general Plunket and child welfare work | 1921-1924 |
| AG 7 | 5-14 | "Maternal Mortality and Ante-natal" pt.2 Letters and cuttings re infant and maternal mortality, general Plunket and child welfare work | 1921-1924 |
| AG 7 | 5-38 | Memorandum from Mr Justice Blair re Karitane "Ch 33" | ca 1927 |
| AG 7 | 5-25 | Nurse's Night Report book on Truby King | 1931-1938 |
| 89-098-35 | Report of the proceedings of the National Conferences on Maternity and Child Welfare (London) 1930 Press cuttings and photos Correspondence | 1929-1941 |
| 89-098-35 | | 1936 |
89-098-88 Miscellaneous correspondence 1928-1934
AG 7 5-18 Miscellaneous Truby King Correspondence 1931-1934
AG 7 5-23 Miscellaneous correspondence 1930
AG 7 5-36 Miscellaneous papers,
incl. The Training of Plunket Nurses
Opposition to Plunket Work, 1920

Series Six: clippings and scrapbooks
AG 7 6-36 'Our Babies' column by 'Hygeia' - clippings ca 1918-1920
AG 7 6-37 'Our Babies' column by 'Hygeia' - clippings ca 1920-1923
AG 7 6-38 'Our Babies' column by 'Hygeia' - clippings ca 1923-1936
AG 7 6-39 'Our Babies' column by 'Hygeia' - clippings ca 1936-1939
AG 7 6-50-1 Newspaper clippings 1908-1917
Incluences a list of Society organiser

Series Eight: Publications
AG 7 8-19-2 Anne Patrick: A Memoir by Miss Challis Hooper 1958
AG 7 8-20 Baby Record Books 1929
AG 7 8-22 Rules 1907-1945
AG 7 8-25 Articles on infant health and medical techniques
Infant Mortality and Preventive Work in New
Zealand U.S. Dept. of Labor Children's
Bureau, by R.M. Woodbury 1922
AG 7 8-27 The Care of Babies and Small Children: A
Guide for Young People (RNSHWC) 1920

Series Eleven: Plunket Miscellaneous
AG 7 11-1 Karitane Home reports 1908
AG 7 11-2 District Nurse's reports 1908
AG 7 11-5 Letters from the Otago B.M.A. 1910
AG 7 11-8 Letters on a case indicating opposition to the
Plunket Society, inc. FTK telegrams 1925
AG 7 11-9 Letters of complaint from Dr G. Bruton Sweet 1928
AG 7 11-10 Correspondence re resignation of Dr Ludbrook
Hon. Medical Staff - Karitane, Auckland 1931
AG 7 11-11 Correspondence re the resignation of Miss
Patrick, Director of Nursing. 1933-1934
AG 7 11-12 Resignation of Dr Tweed, Plunket Medical
Adviser 1938
AG 7 11-15 Reliance Baby Booklet and related
correspondence 1924-1926
AG 7 11-16 Karitane Hospitals Medical Officers and
Medical Advisory Board Meetings 1933-1958
AG 7 11-21 Correspondence relating to new editions of
Feeding and Care of Baby 1936-1941
AG 7 11-24 Nutrition
includes correspondence with Dr. Spencer
re opposition to Plunket dietary methods 1938, 1948
AG 7 11-26 Memo from Mr Justice Blair re Truby King's
change re charging for Plunket services 1932
AG 7 11-27 Miscellaneous correspondence
Address by Sir Truby King to annual meeting
of the Christchurch branch 1931
Reprint from NZ Medical Journal 1930
Misc. correspondence 1925-1938
| AG 7 11-28 | Miscellaneous correspondence                                          | 1916 |
| AG 7 11-28 | Sir Truby King giving advice on feeding                               |
| AG 7 11-28 | Sir Truby King attending conference                                  |
| AG 7 11-28 | Draft regulations for Lady King Scholarship                           |
| AG 7 11-28 | Copies of the rules of the Society 1907, 1921, 1931, 1942              |
| AG 7 11-32 | Mrs James Begg Notes on the early history and development of the Plunket Society with a covering letter from M.C. Begg | 1960 |
| AG 7 11-39 | Miscellaneous items                                                  | 1922-1930 |
| AG 7 11-39 | Misc. letters and circular letters, Truby King                       |
| AG 7 11-39 | Address of Dr Martin Tweed to Wellington Conference                   | 1937   |
| AG 7 11-49 | Report of a Meeting of the Medical Advisory Committee to Examine Plunket Feeding Practices (evidence given by Drs Spencer, Pettit, Cronin and others) | June 1938 |

**Royal New Zealand Plunket Society Truby King-Harris (Karitane) Hospital, Dunedin.**

AG 38 69 Challis Hooper's Research on Anne Pattrick

**Royal New Zealand Plunket Society Wellington Branch.**

89-098-3 Wellington branch minute book 1925-1930
89-098-4 Wellington branch minute book 1930-1935

**Royal New Zealand Plunket Society Christchurch Branch.**

AG 63 6 Plunket Nurses' Reports 1933-1936
AG 63 6 Plunket Nurses' Reports 1936-1840
AG 63 6 General Committee minutes 1932-1936
AG 63 36 Plunket Nurses Association minutes 1926-1946

**Books**


**Articles and Editorials**

'Miss Pattrick's Resignation', *New Zealand Nursing Journal*, (March 1934).
King, F. T, 'Physiological Economy in the Nutrition of Infants', *New Zealand Medical Journal*, 6, 24 (1907).
King, F.T., 'Application of Science, Simplicity and Economy to the Everyday Practice of Artificial Feeding during Infancy', *New Zealand Medical Journal*, 20, 95 (1921).
'Retirement of Miss Pattrick, Director of Plunket Nursing', *New Zealand Nursing Journal*, (September 1934).
Obituaries

'Sir Frederic Truby King', *New Zealand Medical Journal*, 37, 200 (1938).

SECONDARY SOURCES

Books


Snowden, Rita, *From the Pen of F. Truby King*, Auckland, 1951.


**Articles and Chapters in Books**


Davies, Celia, 'The Health Visitor as Mother's Friend: A Woman's Place in Public Health, 1900-14', *Social History of Medicine*, 1, 1 (1988)


Howe, Renate, 'Gender and the Welfare State: Comparative Perspectives', *Gender and History*, 8, 1 (1996).


Levenstein, Harvey, "'Best for babies' or 'Preventable Infanticide'? The Controversy over Artificial Feeding of Infants in America, 1880-1920", *Journal of American History*, 70, 1 (June 1983).

Lewis, Jane, 'Gender, the Family and Women's Agency in the Building of "Welfare States": the British Case', *Social History*, 19, 1 (1994).
Mechling, Jay E., 'Advice to Historians on Advice to Mothers', *Journal of Social History*, 9, 1 (1975).

Unpublished Theses and Research Essays

Brewster, D.P., 'A Decade of the Woman's Weekly, 1932-1942', BA(Hons) essay, University of Otago, 1980
Mattheus, Louise, "This Leakage of Life" Richard Seddon's Memorandum on child-life preservation' BA(Hons) essay, Massey University, 1988.