775. Was there anything in the condition of this patient from which you could reasonably anticipate that septic trouble would follow the operation?—No, I think not.

776. Was there anything in this patient's condition which would lead you reasonably to expect septic trouble would follow—that any misadventure would arise?—No, I think not. There is one point which I afterwards drew attention to and made a note of. This woman had been confined thirty-seven days previously. I thought at the time that the operation had possibly been undertaken too soon after delivery.

777. What happened to the patient after the operation?—Three hours after the operation she had a severe rigour, and her temperature ran up. She complained of symptoms that made me diagnose endometritis.

778. That is inflammation of the inner walls of the womb, is it not?—Yes—of the inner coating of the womb.

779. *The Chairman.*] What I understand is this: This case was operated on, the operation being simple and successful, yet three hours afterwards septic poisoning set in?—Yes, and it is the septic symptoms which I regard as important.

780. *Mr. Solomon.*] Did you take any steps to cope with that septic poisoning?—I did.

781. Were you successful or unsuccessful?—I was in a measure successful. I opened up the womb, washed it out– a very unusual proceeding after an abdominal section; but I recognised the complication.

782. *The Chairman.*] Then a second operation was required?—I dilated the mouth of the womb, as I was frightened of mischief extending to the peritoneum.

783. The septic poisoning had increased, had it not?—It had increased.

784. Rapidly or gradually?—She seemed somewhat improved after that dilatation, but peritonitis soon set in. I really do not know whether there was a real improvement or not—there may have been—but on the next day she got very much worse.

785. That was on the sixth day?—No, on the next day. The septic mischief had extended from the uterus along the tube into the peritoneal cavity. That appears by my clinical notes made at the time.

786. When did peritonitis set in?—On the Saturday.

787. *Mr. Solomon.*] And the patient ultimately died of septic peritonitis, did she not?—She died on the Sunday of septic peritonitis.

788. Which is inflammation of the peritoneum?—Yes.

789. I am not leading you in saying that the unfavourable cause in her case was that the septic trouble spread along the fallopian tube into the peritoneum?—No. There was a very grave difficulty in her case, and was a thing that I never could account for.

790. What is your theory now?—My theory now is that she died from septic peritonitis, from an extension along the fallopian tube.

791. May I put it in this way: that the septic trouble, which arose in the uterus, spread into the fallopian tube, and extended to the peritoneum?—That is quite right, but that was not the theory I held before.

792. We need not trouble any more about that in the meantime, but that is your idea of the matter now?—Yes.

793. And would that result, in your opinion, be surprising, if we are to assume that the conditions under which that woman was treated were favourable?—It would be very surprising, if the conditions were favourable.

794. In all your experience in practice in Dunedin outside of the Hospital have you ever had such a result arising?—Never.

795. Are such unhealthy atmospheric conditions as you have described as being existent in the Hospital apt to produce results such as you have spoken of here?—They are.

796. Is the result you found surprising under the conditions which you know to exist in the Dunedin Hospital?—No; it is not. She died in No. 4 ward.

797. *The Chairman.*] Was she never taken back to No. 7 ward?—No. She was first put in the downstairs ward—No. 4, I think it was; there was another abdominal case in there at the time, and was doing well—but when my patient began to develop septic symptoms I had her removed to a wooden shed at the back.

798. Where there were chronic cases?—Yes.

799. Then she died in a chronic ward?—Yes; but the ward was empty at the time. A point in connection with this case I should like to say a few words about now. At the consultation some days before operation, several medical men made an examination of my patient. One gentleman seemed to be doubtful of the diagnosis, thinking it possibly a fibroid tumour. He passed the sound, as I thought, clumsily, and bleeding ensued. I think this proceeding was unwise, dangerous, and quite unjustifiable, and I complained afterwards about it. I do not think that he recognised the risk.

Mr. Chapman submitted that this was not evidence.

The Chairman: Not unless Dr. Batchelor is prepared to say that any mischief resulted from the passing of this sound. But then it contradicts his previous statement that the patient was in a good condition.

Witness: I think that the passage of a sound—especially when accompanied by blood—indicates that there has been abrasion of the surface.

800. *The Chairman.*] Was this operation conducted in the new operating-room?—No; but it was performed with strict antiseptic precautions, with the spray going continually.

801. *Mr. Solomon.*] The next case to which I wish to draw your attention is that of Mrs. T——. You have already told us that you wrote a letter to the Trustees about her?—I did.

802. It is not necessary to go into lengthy details, but will you give us shortly the circumstances of her case?—They are expressed very concisely in that letter.