The smaller private hospitals having one hundred or less confinements annually are in some instances less conveniently planned and equipped, and on the average the quality of their nursing service is probably not as high as that in the larger private and public hospitals. The main difference however in the classes of hospitals lies between the maternity hospital which takes labour patients only and the mixed maternity and medical and surgical hospital, and that difference is markedly shown by the inferior results shown in mixed hospitals. In my opinion this is not in any way due to an inferiority in the knowledge or training of the staffs of these hospitals. In most instances they have the same degree of knowledge and skill as elsewhere. There can, I think, be no doubt that the inferior results are due to the influence of environment and to surgical cases being nursed, at any rate occasionally, by the same nursing staff as the maternity cases. All private mixed hospitals are classed as such since the conditions under which they are licensed are the same. The decision as to which public hospitals to class as mixed hospitals is more difficult, and I have adopted the principle of classifying all hospitals as mixed in which the maternity side of the hospital was not conducted as an entirely separate unit. I have not taken into consideration the fact as to whether or not the maternity block or ward formed part of the same building as a general hospital, as, in my opinion, it has very little influence on the welfare of the patient. With regard to the medical staff of these hospitals, I do not consider that they are any more liable to convey infection from their patients than the general practitioner is, and in all instances maternity hospitals in New Zealand are staffed by medical men who are not solely obstetricians, but are engaged in other branches of practice besides that of obstetrics.

The table showing the maternal mortality-rate in the different groups of maternity hospitals also shows that the best rate is to be found in the seven St. Helens Hospitals, at which 2,402 confinements were attended with five deaths, giving a maternal-mortality rate of 2.08.

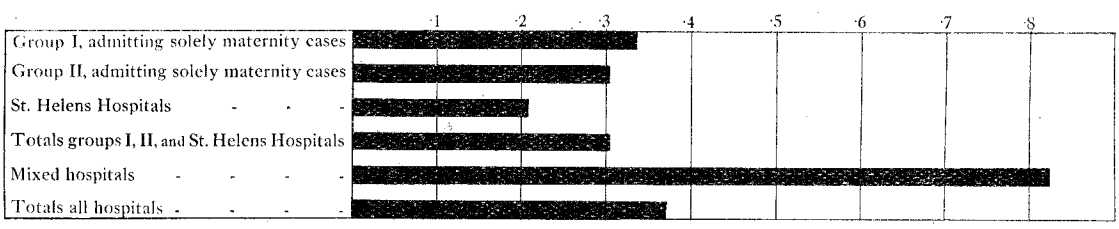
Next in order of merit is Group II, consisting of forty-two hospitals, having 101 cases or more annually, but not including St. Helens Hospitals. This group with 6,263 cases and nineteen deaths has a maternal-mortality rate of 3.03.

Following close on Group II comes Group I, consisting of 149 hospitals, each hospital having one hundred cases or less per annum and being responsible for 6,869 confinements with twenty-three deaths, giving a maternal-mortality rate of 3·35.

Last on the list comes the result of forty private and thirty-one public mixed hospitals. In these seventy-one mixed hospitals, there were 2,310 confinements, with a maternal mortality rate of 8·23 per 1,000. While the small variations in the mortality-rate for Groups I and II cannot be taken as throwing any light on the influence of these hospitals on maternal welfare, it cannot be disputed that the great increase in the mortality rate for mixed hospitals must be regarded as condemning such hospitals under present conditions as being an undesirable part of our hospital system. The more exact knowledge afforded me by the figures drawn from this investigation confirms the opinion which I have formed on less exact data. It also will afford me a very welcome and a necessary support in advocating and instituting certain reforms in the management of this class of hospital that, lacking the exact knowledge I now have, I found it impossible to carry out as completely as I should have wished.

The problem of how to deal with these mixed hospitals is an urgent and very difficult one. It is certain that fairly drastic alterations will be required in most instances to remove the risks they cause to maternity patients. I am of opinion that it will be necessary to exclude from many of these hospitals either the maternity cases or the surgical cases. Further, I consider that hospitals in which the maternity nurse also attends to surgical out-patients, should not be allowed to take maternity cases at all. In some instances this may produce an economic condition that will entail either closing the hospital or materially increasing the expenses of keeping it open if it is to be used for both classes of patient. It will be necessary to consider each hospital separately and decide what should be done with it, always regarding as essential that, whatever action is taken, the special risks to maternity patients revealed by the above figures must be removed. While the interests of patients requiring surgical treatment and the interests of doctors and nurses who may be licensees of these hospitals will be considered, it cannot for a moment be conceded that these interests can be allowed to jeopardize the safety of maternity patients who may enter the hospital for attention. Their safety must be considered of paramount importance, and must be the determining factor in deciding the conditions under which these hospitals can be permitted to continue. Investigation of the conditions present in certain mixed hospitals has shown that the danger to the maternity patient is very real, and suitable curtailment of their surgical activities has already been effected.

MATERNAL MORTALITY IN MATERNITY HOSPITALS BY GROUPS FOR 1929.



ANTE-NATAL CLINICS.

The returns of 1929 show that two public clinics have been opened during the year, making a total of twenty-four altogether established in New Zealand. The appended table shows the number of cases receiving attention in these clinics during the past year, and also shows the gradual increase in the work since 1925, which is satisfactory, and indicates that these clinics are providing a service that was previously wanting and is now appreciated by the expectant mother.