1938.

NEW ZEALAND.

COMMITTEE OF INQUIRY INTO MATERNITY SERVICES

(REPORT OF).

Presented to both Houses of the General Assembly of New Zealand by Leave.

CONTENTS.

The Hon. Minister of Health.

SIR,—

The Committee of Inquiry appointed by you to inquire into and report upon the maternity services of the Dominion has the honour to submit herewith its report:—

INTRODUCTORY.

ORIGIN AND SCOPE OF INQUIRY.

As a consequence of the report of the Committee set up by the Hon. the Minister of Health to inquire into the question of the practice of abortion, concern was felt as to whether the present maternity facilities of New Zealand adequately provided for all mothers, both in the town and country. In order that the Government should have full information as to the position in all parts of the Dominion the Hon. the Minister appointed the following Committee to inquire into the question:—

D. G. McMillan, Esq., M.B., Ch.B., M.P. (Chairman).
Miss Sylvia G. de L. Chapman, M.D., D.G.O. (T.C.D.), Medical Superintendent, St. Helens Hospital, Wellington.
Mrs. Janet Fraser, J.P.
Mrs. Amy M. Hutchinson, J.P.
Mrs. N. G. Kent-Johnston.
T. F. Corkill, Esq., M.D., M.R.C.P. (Edin.), F.C.O.G.
T. L. Paget, Esq., M.R.C.S. (Eng.), L.R.C.P. (Lond.), Director of Maternal Welfare.

The function and duty laid upon the Committee was as follows:—

1. Generally to inquire into and report upon any matters affecting the maternity services of the Dominion and to put forward any relevant recommendations.

2. In particular to inquire into and report—

(*a*) Whether the maternity hospital services of the Dominion are adequate and efficient in respect of—
(1) Maternity hospitals and maternity wards established by Hospital Boards.
(2) Maternity hospitals maintained by the Government.
(3) Private maternity hospitals.

(*b*) Whether the ante-natal and post-natal services of the Dominion are adequate, and, if not, in what respects they should be extended.

(*c*) Whether the organized district nursing services which afford a maternity service are adequate and satisfactory.

(*d*) The extent to which anæsthetics are administered to women in childbirth in public maternity hospitals and whether this procedure should be extended.

(*e*) Whether the training of midwives and maternity nurses is satisfactory and adequate, and whether the number of persons who are being trained is sufficient for the needs of the Dominion.

The Minister of Health expressed his desire that the Committee should hear such evidence and representations on the above-mentioned matters, and make such inspections as might be necessary fully to inform the Committee on the questions referred to it.

To enable the Committee to meet those interested and desiring to give evidence and also to make the necessary inspections of facilities available it was found necessary

to make an extensive survey of the whole country, and the following is a list of the towns and districts which were visited :—

Places visited for Purpose of hearing Evidence and/or making Inspections.	Date.
Wellington	3rd March, 1937, and 2nd to 4th November, 1937.
Masterton, Featherston, Greytown, Carterton, Eketahuna	10th March, 1937.
Whangarei	5th April, 1937.
Dargaville	6th April, 1937.
Rawene, Kawakawa	7th April, 1937.
Whangaroa, Kaitaia	8th April, 1937.
Paparoa, Helensville	9th April, 1937.
Ngaruawahia (Maori Settlements)	12th April, 1937.
Hamilton	13th April, 1937, and 8th to 9th September, 1937.
Cambridge, Arapuni, Matamata	13th April, 1937.
Kawhia, Te Kuiti	14th April, 1937.
Rakaia, Methven, Ashburton	18th May, 1937.
Timaru, Waimate, Kurow	19th May, 1937.
Oamaru, Palmerston South	20th May, 1937.
Dunedin	21st, 22nd, and 23rd May, 1937.
Milton, Balclutha, Kaitangata, Gore	24th May, 1937.
Invercargill, Riverton	25th May, 1937.
Nightcaps, Otautau, Tuatapere	26th May, 1937.
Winton, Lumsden, Queenstown, Cromwell	27th May, 1937.
Clyde, Ranfurly	28th May, 1937.
Christchurch	22nd to 24th June, and 2nd July, 1937.
Darfield, Oxford, Rangiora	23rd June, 1937.
Hokitika	24th June, 1937.
Wataroa, Waiho	25th June, 1937.
Weheka	26th June, 1937.
Greymouth	27th and 28th June, 1937.
Runanga, Brunnerton	28th June, 1937.
Reefton	28th and 29th June, 1937.
Westport, Granity	29th and 30th June, 1937.
Millerton	29th June, 1937.
Karamea	29th and 30th June, 1937.
Denniston	30th June, 1937.
Murchison	13th July, 1937.
Motueka, Collingwood, Takaka	14th July, 1937.
Richmond, Brightwater, Nelson	15th July, 1937.
Havelock, Blenheim	16th July, 1937.
Picton	17th July, 1937.
Woodville, Dannevirke	9th August, 1937.
Waipukurau	9th and 10th August, 1937.
Waipawa, Hastings	10th August, 1937.
Napier	10th and 11th August, 1937.
Wairoa	11th August, 1937.
Gisborne	12th August, 1937.
Tokomaru Bay, Te Araroa, Tiki Tiki, Te Puia	13th August, 1937.
Waipiro Bay, Tolaga Bay	14th August, 1937.
Opotiki, Whakatane	16th August, 1937.
Rotorua	16th and 17th August, 1937.
Tauranga	17th and 18th August, 1937.
Waihi, Paeroa	18th August, 1937.
Thames	18th and 19th August, 1937.
Coromandel, Te Aroha, Morrinsville	19th August, 1937.
Mokai, Taupo, Tokaanu	20th August, 1937.
Auckland	6th to 8th September, 1937.
Warkworth	4th September, 1937.
Pukekohe	8th September, 1937.
Te Awamutu, Otorohanga, Taumarunui	9th September, 1937.
Raetihi, Taihape, Hunterville	10th September, 1937.
Hawera, Manaia, Opunake, Waitara	11th September, 1937.
New Plymouth, Inglewood, Stratford, Kaponga, Eltham	13th September, 1937.
Patea, Waverley, Wanganui	14th September, 1937.
Marton, Feilding, Palmerston North	15th September, 1937.
Foxton, Levin, Otaki	16th September, 1937.
Lower Hutt, Upper Hutt, Petone	2nd November, 1937.

The Committee would like to express its thanks to the witnesses, many of whom went to considerable trouble to collect information and prepare evidence, and in some cases travelled long distances to enable them to meet the Committee.

It is especially grateful to members of the medical profession, officers of the Health Department, Hospital Boards, and the members of their staffs, owners of private hospitals, and various women's societies who responded to the Committee's requests for information and also to those Hospital Boards and other local authorities who willingly placed their rooms at the disposal of the Committee.

The Committee wishes also to express its great appreciation of the help given by the Secretary, Mr. J. W. Buchanan, whose wide experience of committee work proved invaluable, and also to Misses K. G. Jordan and E. Watkin, who, as reporters to the Committee, gave the utmost satisfaction in the performance of their work.

PART I.—LOCAL REPORTS.

INDEX OF LOCAL REPORTS.

Column 1 shows hospital districts; column 2 the town in which is situated the principal hospital in the district:—

1. NORTH AUCKLAND DISTRICT.

The country north of Auckland is divided into six Hospital Board districts, as is indicated in the following table, which also shows population and increase in past ten years :—

Board.	County	European.	Maori.	Total Population.	Increase.
					Per Cent.
Kaipara	Otamatea	4,512	672	5,184	23·37
	Hobson	7,478	1,179	8,657	9·13
Whangarei ..	Whangarei	18,159	2,121	20,280	9·72
Bay of Islands ..	Bay of Islands ..	6,079	4,504	10,583	33·35
Hokianga	Hokianga	3,708	4,928	8,636	27·49
Whangaroa ..	Whangaroa.. ..	1,191	1,342	2,533	37·66
Mangonui	Mangonui	5,100	3,650	8,750	22·34
		46,227	18,396	64,623	..

In each of these Board districts public maternity hospital facilities are provided, and cater for both European and Maori cases. Only a small percentage of Maoris come into hospital, although the number is increasing and the educational work of the district nurses to Natives is encouraging hospitalization.

District Health Nurses.—There are nine district nurses in North Auckland.

The majority of Maori infants are born at home, delivered in Native manner. Only in emergency is the help of the district nurse sought, and the Committee heard medical evidence of the bad after-effects suffered by Maori women through the lack of skilled attendance. More hospital accommodation will be needed if Natives are to receive adequate attention.

Maori Housing is bad all through the north, some homes being no more than iron sheds full of holes, with mud floors and no sanitary conveniences, no water and no washing facilities. Members of the Committee visited some of these homes and found the women making efforts to keep these places clean and tidy. Whole families—older people, men, women, and children—are living like this in one dilapidated shed.

Under these circumstances it is no wonder that disease is rife, scabies, impetigo, and gonorrhœa being specially reported. In other parts of New Zealand, such as the thermal district, where hot water is plentiful, skin complaints are rare. It was also found that in some parts no milk is available, children depending on tinned milk.

Reports were received of excessive drinking among the Maori population in the north, and it was stated that women and children had not benefited by increased sustenance-money.

Decent housing, with water-supply, washing, and sanitary conveniences, is the chief need of the Maori people in the north. Dr. Cook, Medical Officer for the district, thinks there will be an increasing use of hospital by Natives, but that in the meantime an extension of the present system of district nursing is the only way of bringing an adequate service to the Maoris.

For the European population it is considered that at present ample maternity hospitals and beds are available. The position will require watching, as with the growing popularity of maternity hospital service more provision will have to be made. An extension of district nursing services for emergency cases and for ante-natal and post-natal attention is to be recommended.

2. MANGONUI HOSPITAL BOARD DISTRICT.

The area served by Mangonui Hospital Board includes the northernmost end of the North Island from Herekino on the West Coast to Mangonui on the east, taking in Victoria Valley and comprising the County of Mangonui. The county population is 8,750, of whom 3,650 are Maoris.

KAITAIA.

There is a public maternity annexe at Kaitaia with seven beds, in which 105 cases are attended per year, including twenty-eight Maoris. The fees are £4 4s. per week.

There is a doctor in private practice who did fifteen confinements in private homes in the past year. Apart from this, there is practically no domiciliary attendance except among Maoris.

It was stated by the medical superintendent of the hospital that Maoris are coming into hospital now in greater numbers than previously, and here, as elsewhere, there was medical evidence of injuries caused by Native methods of delivery. The main problem is gonorrhœa, which is stated to affect a large number of the population. Housing conditions are shocking, and members of the Committee visited some Maori homes which

were merely sheds made of old corrugated iron full of holes, with mud floors, no water or washing facilities, and no sanitary conveniences. In this district Maori women were using condensed milk for their children.

Mention was made of the need for education of the Maori men to treat their women with more consideration and to provide them with decent living conditions. It was stated that too much money is spent on drink, while women and children are in want.

Ante-natal Care.—The nurse to Natives assists the Native women with ante-natal advice and is called in for emergencies in confinement. More nurses are needed for this work.

Pain-relief.—Two local doctors gave personal experience of various methods of anæsthesia and stated that they now prefer ether to other methods.

HOUHORA.

Written complaints were received of the lack of medical or nursing facilities for Maoris in this district.

Recommendations.

The Committee recommends an increase of the hospital accommodation, which is barely sufficient for present needs, in order that the hospital service for Maoris may be extended.

Extension of the district nursing service to give ante-natal and post-natal care is also advised.

3. WHANGAROA HOSPITAL BOARD DISTRICT.

This is a small district on the north-east coast centering round Whangaroa Harbour, and comprising the County of Whangaroa. The county population is 2,533, of whom 1,342 are Maoris.

Facilities are provided in a small mixed hospital at Whangaroa with four maternity beds. This hospital, which is in charge of a Medical Superintendent, has also to accommodate emergency medical and surgical cases, and it is admitted by the Board that the rooms and wards are unsuitable. Proposals for a maternity annexe are now under consideration. Improvement in staff accommodation is also being considered.

The number of cases attended in the past twelve months was twenty-nine, including eight Maoris.

The fees are £3 3s. per week.

District Work.—The district nurse to Natives stated that she had attended eleven Maori confinements in two years, but sees a great number after delivery. It was stated that in this district Maori maternity patients are reluctant to enter hospital. Reference was made to the damage sustained by Maori women through Native methods of delivery. The deplorable conditions under which the Maori people are living were also described, and homes were visited by members of the Committee.

The need for educational work among the Maori men in the interests of their families was urged, it being stated that many of them kept all their money, even sustenance, and spent it on drink, to the neglect of their women and children. Housing conditions are very bad.

Pain-relief.—Pain-relief to an average degree is used in this hospital.

4. BAY OF ISLANDS HOSPITAL BOARD DISTRICT.

The district controlled by this Board extends from the Whangarei Board's boundary and includes the East Coast districts north to Takau Bay.

The population of the district is 10,583, of whom 4,504 are Maoris.

The chief centres are Kawakawa (population 1,763) and Russell (population 1,438).

KAWAKAWA.

There is a public maternity hospital of seven beds doing 120 cases per year, of which forty-three are Maoris. Twenty-eight cases were attended by the Medical Superintendent in his official capacity (European 10, Maori 18).

Pain-relief.—Pain-relief is given to an average degree.

The fees are £4 4s. per week.

Reference was made at this hospital to the prevalence of scabies, impetigo, and gonorrhœa among Maoris, also to injuries sustained by Maori women through Native methods of confinement. There are two district nurses to Natives in this area, and they are called in by the Maoris when trouble arises with a case.

Accommodation at this hospital is sufficient for the European population, but with increasing numbers of Maoris coming in more hospital beds are now required.

RUSSELL.

At Russell there are two doctors, but no hospital facilities. There is a practising midwife who takes patients in her own home.

Recommendations.

It is recommended that additional accommodation be provided at Kawakawa.

5. HOKIANGA HOSPITAL BOARD DISTRICT.

The Hokianga Hospital Board district comprises Hokianga County and extends from Kaihu on the northern boundary of the Kaipara Board's district. It takes in the west coastal area as far north as Herekino, and on the east joins the Bay of Islands boundary.

The population of the county is 8,636, of whom 4,928 are Maoris.

Rawene.

Facilities in the Hokianga district are provided at the Rawene Hospital where there are at present seven maternity beds. The fees are 9s. per day, plus £2 2s. confinement fee. The number of cases attended in the year was 108, of whom about thirty-six were Maoris.

It is stated by the Board's Secretary that Rawene Hospital also serves to some extent Kaikohe and the county surrounding in the Bay of Islands territory. The Board also states that there is insufficient accommodation to take in all Maori cases, as they would have, roughly, another one hundred cases a year, and would require seven more beds. Over half the population in this area is Maori, and their birth-rate is about two and a half times that of the European. There is no domiciliary confinement among Europeans, but in order to take in all Maori cases further equipment and staff would be necessary, although there is building accommodation available.

District Nurses.—Two district health nurses are stationed in this area, and one stated she had attended fourteen Maori confinements in seven months, but the majority are attended in their own homes either by husband, relatives, or Maori midwives. Any cases presenting difficulty are sent to hospital by the nurse. This nurse stated that after experience of hospital the Maoris prefer this method of confinement on account of more relief from pain, easy labour, and general treatment received. All cases cannot, however, be provided for as the accommodation is very limited.

Ante-natal and Post-natal Treatment.—Ante-natal advice is given as far as possible by the district nurses or by the doctor, who travels round the district weekly. There is difficulty in giving post-natal treatment on account of scattered population.

Pain-relief.—In this hospital special study has been given to the question of painless confinement, and the Medical Superintendent has submitted a detailed account of his research in this connection, tabulating results in 100 consecutive cases, comprising 34 Maoris and 66 Europeans, and giving the technique used.

Recommendations.

The Committee recommends the provision of more maternity beds, staff, and equipment in order to cater for more Maori cases.

Extension of the district nursing service for ante-natal and post-natal treatmen is also advised.

6. KAIPARA HOSPITAL BOARD DISTRICT.

The Kaipara Hospital Board district extends from the Auckland Board's boundary at Kaipara Heads, taking in the West Coast area as far north as Kaihou, to the eastern boundary of the Whangarei Board as far south as Mangawai on the East Coast. It includes Hobson County and Otamatea County.

The population of the district is 13,841, of whom 1,851 are Maoris. The chief centre is Dargaville (population 2,176).

Facilities in this district consist of two public maternity hospitals under the control of the Kaipara Board, one at Te Kopuru, and one at Paparoa. There is also a private hospital at Dargaville doing about twelve cases annually.

Te Kopuru.

This is an eight-bed maternity annexe, serving Dargaville Borough and Hobson County.

The fees are £4 4s. per week.

Of the 126 cases attended in the year, 25 per cent. were Maoris, and it was stated that Maoris are encouraged to come into hospital in an endeavour to prevent the damage which results from labour under Native conditions. Forty-four per cent. of cases are doctor-attended. The Medical Superintendent states that the efficiency of the hospital would be improved by the appointment of a house surgeon, and that the hospital is just able to give sufficient service for present numbers. Pain-relief is given to an average degree.

It was suggested that another nurse to attend Maori maternity cases would be an advantage. The present district nurse to Natives having a large area, seventy miles wide, and being responsible for the care of about one thousand people, has no time to attend at confinements.

Ante-natal Care.—All cases attending at the Te Kopuru Hospital receive ante-natal care, but country women in the district complain of difficulty in attending the clinic on account of having to travel up to thirty miles or more over bad roads. The Medical Superintendent states that facilities are there, but owing to the geographical position of Te Kopuru they are not availed of. He suggests Dargaville as more central for an ante-natal clinic.

PAPAROA.

Nurse Cavell Memorial Hospital. This is a seven-bed maternity hospital at Paparoa, serving Otamatea County.

The fees are £4 4s. per week.

Fifty per cent. of cases receive ante-natal attention.

Twenty-five per cent. are doctor-attended.

Pain-relief is given to an average degree.

Recommendations.

The Committee is of the opinion that, with the movement of population away from the Te Kopuru end of the district and towards Dargaville, some provision for ante-natal care should be made in Dargaville. It is therefore recommended that an ante-natal clinic be established by the Hospital Board in Dargaville to be worked in close co-operation with the Te Kopuru Hospital.

It is realized that duplication of the services by the provision of a public maternity hospital in Dargaville would hardly be advisable at present, but it is thought that the position arising from the present trend of population might to a certain extent be met by subsidizing a private hospital there.

The Committee also recommends an extension of the district nursing service in order that fuller ante-natal supervision can be given to country women and Maoris in their homes.

7. WHANGAREI HOSPITAL BOARD DISTRICT.

The area under control of this Board comprises Whangarei County, and is bounded on the west by the Kaipara Board's district, goes north to Hukerenui, and to Huruki on the East Coast. The county population is 20,280, of whom 2,121 are Maoris. The chief centres are Whangarei Borough (population 7,152) and Hikurangi (population 1,042).

Facilities consist of a seventeen-bed maternity annexe at Whangarei Hospital, serving 300 cases annually, of whom 12 per cent. are Maoris.

The fees are £3 3s. per week.

The annexe is an open one, and 20 per cent. of patients are attended by their own doctors. The Medical Superintendent attends 30 per cent., the balance being midwife attended.

Ante-natal Care.—Only about 40 per cent. of cases attending hospital receive ante-natal supervision, and the Medical Superintendent states that the hospital needs another doctor in order to be able to give adequate ante-natal and post-natal care.

Maoris.—The district nurse states that Maoris are being educated up to ante-natal treatment, but the majority of Maori women still have their babies at home and deliver themselves, Native fashion.

More and more are coming to the annexe, however, and they are never refused, although difficulties arise through the prevalence among them of scabies, and vaginal discharges. The morbidity rate among Maoris is higher, due to low condition of health, poor housing, and lack of bathing facilities.

Pain-relief.—In Whangarei Maternity annexe nembutal is used extensively as an analgesic, and an effort is made to give as much pain-relief as possible.

District Nurses.—District nurses do not book midwifery cases, but advise them to go to hospital, and only attend emergencies.

8. AUCKLAND HOSPITAL BOARD DISTRICT.

The area served by the Auckland Hospital Board extends from the boundary of the Waikato Board's district at Mercer out to the West Coast at Waikato Heads and northwards to the Kaipara Heads, a distance of approximately ninety miles, taking in on the north Helensville, Port Albert, and Wellsford. On the east it includes the coastal area from Mangawai in the north to Miranda on the boundary of the Thames Hospital Board's district. Total area, 1,998 square miles.

The area includes the counties of Rodney, Waitemata, Eden, Great Barrier, Manukau, and Franklin. Population and increases in the last ten-year period are shown in the following table:—

County.	European.	Maori.	Total Population.	Increase.
				Per Cent.
Rodney	5,391	242	5,633	31·67
Waitemata	42,652	449	43,101	18·12
Eden	173,941	1,517	175,458	8·92
Great Barrier	335	119	454	24·04
Manukau	20,791	498	21,289	27·30
Franklin	16,576	1,205	17,781	19·41
Totals	259,586	4,130	263,716	21·40

Thus it is seen that there is in this Board's district a population of 263,716, including 4,130 Maoris, and the number of persons has increased by over 49,000 in the last decade.

The largest centre of population is Auckland City, which with its surrounding suburbs contains 212,159 persons. This includes the boroughs on the north side of the harbour, Devonport (population 9,771), Takapuna (7,270), Northcote (2,369), and Birkenhead (3,397).

Other large suburbs are Mount Eden (18,515), Mount Albert (19,721), One Tree Hill (8,027), and Onehunga (11,082).

Statistics showing the density of population reveal the fact that Eden County, in which Auckland City is situated, contains 723·6 persons to the square mile, a number more than twice as high as any other district in New Zealand.

Outside the urban area the following are the main centres of population:—

Warkworth	630	Pukekohe	2,536
Helensville	961	Waiuku	832
Papakura	1,793		

Auckland City.

Public-hospital Facilities.—Public-hospital facilities are provided by a St. Helens Hospital under the control of the Department of Health. St. Helens Hospital contains thirty-two beds and is the largest St. Helens in the Dominion, but is now inadequate to meet the increasing demands made upon it.

Intended primarily for the training of midwives, as well as for the attendance of those whose means will not permit of reasonable comfort and skilled attention in their confinements, the position now is that this hospital provides practically the only public maternity hospital service for a population of over 212,000 persons.

Complaints which have been made that St. Helens is situated in an unsuitable place because of the noise were found to be fully justified. It is built right on a main street—Pitt Street—down which trams are running, and every variety of motor traffic passes in a constant and noisy stream almost the whole day and night.

Next door is the main fire-station, and both patients and staff complain of the noise of the siren and the loss of sleep caused by the activities of the fire-engines. In addition to this, the site is very restricted, with no space to develop recreational facilities for the nurses, who lack most of the amenities provided for them in a general hospital.

The Nurses' Home is located in the old wooden building which was the original hospital. Accommodation is overtaxed, and almost all the nurses have to share rooms.

The kitchen is in the basement of the Nurses' Home and is a primitive, old-fashioned place, with a coal range and a very low ceiling. It is extremely hot in summer and quite unsuited to modern requirements.

There is no accommodation for domestic staff, all of the maids living out, although it might be desirable for a number to live in. They have no common-room, nor is there accommodation for them when they are off duty. The only provision for their clothing is in a small locker.

There is no waiting-room for relatives or visitors of patients, who have to use the entrance lobby for this purpose. There is no sitting-room for patients when they are up. They may sit on a veranda if fine, or else in the ward or nursery.

There is no room for the medical students, who have to write their case notes, &c., in the medical staff room, size 8 ft. by 8 ft., which is used by the three Medical Officers on the staff as well.

The lecture-room is a glassed-in veranda and quite inadequate for the purpose.

There are only four single-bed wards, and more are required as waiting wards for patients in labour and also for special cases such as pre-eclamptics, or those suspected of sepsis, &c.

As with the other St. Helens Hospitals, the hospital is a "closed" one. There is a part-time Medical Superintendent and two assistants.

The nursing staff consists of the Matron, ten registered midwives, and thirty trainees. Normal cases are attended by the midwife staff, the medical staff attending abnormal cases.

All cases attending the ante-natal clinic are examined by a doctor, and at the birth, those who have been so examined and certified as fit to receive it, are given what anæsthetic and analgesic relief as is available. Cases which have not been seen by a doctor receive no anæsthetic at all, which definitely precludes the emergency normal case from pain relief.

The administration of anæsthetics by a midwife is limited in practice to the use of the Murphy inhaler for chloroform in cases which, as stated above, have been previously certified by a doctor as suitable to receive it, and when required open ether is given by one of the medical staff. Similarly, analgesics—*i.e.*, chloral hydrate, morphia, or nembutal —are given in certain cases by direction of the doctor, but not necessarily in his presence. The extent to which this is the practice seems to vary in different centres, and some complaints were received in Auckland of protracted suffering without relief.

The number of in-patients for the year ended 31st March, 1936, was 652.

This hospital is a training-school for midwives and maternity nurses.

Provision for Abnormal Cases.—St. Helens being fully occupied with booked cases, from 90 to 100 complicated and emergency cases have to be admitted every year to the public hospital in Auckland. There is no labour or special lying-in ward provided, and these cases have to be nursed in the surgical wards where there is frequently no trained maternity staff readily available. The conditions under which the nursing is carried out are most unsatisfactory and constitute a risk to the patients, causing considerable anxiety to the staff. Furthermore, there is no obstetrician appointed as such to the hospital staff.

"*Intermediate*" *Facilities.*—"Intermediate" facilities are confined to those provided by the Salvation Army in the Bethany Hospital, which, in addition to its work for unmarried mothers, admits a limited number of married women at a fee of £3 3s. per week. This type of service might with advantage be extended in Auckland.

Private Hospitals.—The private hospitals in Auckland and suburbs provide ninety-four beds.

According to the evidence tendered and inspections made it would appear that in the majority of private hospitals the facilities provided are satisfactory, but the most popular of the hospitals are overtaxed, the tendency being, as in other parts of New Zealand, for cases to go to hospital rather than be confined in the patients' own homes. The fees charged range from £4 10s. to £8 8s. per week.

According to the opinion of leading obstetricians and also of the Medical Officer of Health there is need in Auckland for the further provision of private-hospital accommodation. There is at present no private maternity hospital equipped for surgical work, and difficulties arise when operations such as Cæsarean sections are necessary. The Committee is of opinion that the provision of more private accommodation is to be encouraged.

Ante-natal Care.—Ante-natal service is provided at St. Helens and the Salvation Army maternity hospitals, but at St. Helens the ante-natal clinic is situated in a converted house adjacent to the main building and is inconvenient for patients and unsuitable for the purposes of training.

The Plunket Society also has a clinic which gives valuable assistance. In Auckland, as elsewhere, it was found that many doctors themselves prefer to supervise the ante-natal care of their patients.

District Service.—Due partly to the lack of sufficient accommodation at St. Helens, the number of district cases is comparatively high, seventy cases being attended last year. As these are all in the homes lacking the necessary facilities, the conditions are far from ideal, and if there were sufficient provision no doubt most of these cases would enter hospital.

Provision for Unmarried Mothers.—The unmarried mothers are provided for by the Salvation Army Home and St. Mary's Home.

Salvation Army Home.—Provision is made by the Salvation Army at their Bethany Hospital for unmarried mothers, who are required to stay three months to care for their babies. Normal cases are midwife-attended, an honorary doctor being available in abnormal cases. Pain-relief measures are said to be used for the single girls to the same extent as for married patients.

St. Mary's Home.—In this home also a great service is being rendered to the unmarried mother in need of a refuge and care in her confinement. About thirty cases a year are attended, all single girls, who are required to stay six months in the home; the total fee for the period is £15 15s., which is collected from the child's father if possible, but no girl is ever refused admission for financial reasons. No assistance is given this home by the Hospital Board, but it receives a grant of £200 per annum from the Government. Normal cases are attended by a midwife alone, but every girl receives ante-natal care, an honorary doctor giving his services and attending abnormal cases.

On the question of pain-relief it was stated by the home authorities that this is definitely on the increase, although complaints were received that normal cases get

little, if any, relief. Here, however, the same difficulty arises as in other hospitals where normal cases are not doctor-attended that a midwife working alone cannot give adequate relief.

Suburban Areas.

In the absence of any provision by the Hospital Board, the only facilities available to the residents of the suburban areas are those provided by St. Helens Hospital and the Salvation Army Hospital, both situated in the city. On account of the density of the population and the distances to be travelled it is evident that additional provision requires to be made in some of the larger suburbs and centres of population as follows:—

North Shore, including Devonport, Takapuna, Northcote, Birkenhead, and East Coast Bays.

There is a population in this area of about 25,000 and access is by bus and ferry. Women unable to afford private-hospital accommodation have to choose between a domiciliary confinement or St. Helens Hospital. For those going to St. Helens a serious question is the cost of transport for the regular ante-natal examination, and also when labour has begun, unless arrangements can be made to stay in Auckland. Additional provision appears to be necessary for this side of the harbour.

Onehunga.—In the Borough of Onehunga alone there is a population of 11,000, and it is the natural centre for many isolated areas difficult to reach, such as Huia, Awhitu, and other places on the Manukau Harbour reached only by launch from Onehunga. Otahuhu and Mangere residents also are within reasonable access of Onehunga, which is seven miles from Auckland. According to the evidence, there is at present only one private nursing-home and one nurse prepared to take cases in patients' own homes. For the wives of those on limited income in Onehunga a good deal of domiciliary nursing is said to be done by a visiting midwife. Complaints were received of the difficulty experienced in obtaining ante-natal attention, and the Committee considers there is a definite need for the establishment of a small maternity hospital at Onehunga.

Otahuhu is another locality which should be considered as a centre for a public or subsidized maternity hospital and ante-natal clinic facilities.

Henderson.—In addition to its own population of about 1,200, this township is the natural centre for the suburbs of Avondale, New Lynn, and Glen Eden, and for the many settlers in the Waitakere Ranges, out to the West Coast and northwards to Swanson, Huapai, Kumeu, and Waimauku, as well as Hobsonville, Riverhead, and Te Atatu. There is no nursing-home in the district, and, although there is a resident doctor, there is no midwife or maternity nurse. Women complain of the expense and inconvenience, especially in the later stages of pregnancy, of having to travel by bus or train to the nearest ante-natal clinic, which is at St. Helens Hospital in Auckland.

There is often difficulty in arranging transport, and the cost is quite beyond the means of a great many people. The taxi charge from Henderson to St. Helens is £1 1s. There is no hospital of any description between Henderson and Helensville, which is a further twenty-six miles north, through country fairly closely settled by small farmers and orchardists. The Committee therefore recommends the establishment of a maternity hospital sufficient to meet the needs of this large area.

Panmure, Mount Wellington.—Complaints were received from women in this part that there is no doctor or midwife in the district and the nearest nursing-home is two miles distant. St. Helens Hospital is about nine miles away. It is considered that an ante-natal clinic where patients could receive their routine examinations would probably meet the need in this area.

Country Districts.

The facilities provided by the Board are as follows:—

Warkworth.—At Warkworth, which is forty-one miles north of Auckland, there is a cottage hospital maintained by the Hospital Board containing five maternity beds. This serves a radius of about fourteen miles. The hospital fees are £3 3s. per week. There is a staff of matron, midwife, staff nurse, and probationer, but no medical officer in charge. A doctor in practice in the district attends cases at the hospital, patients paying the doctor's fee if they can afford it. He receives a subsidy from the Hospital Board to attend indigent cases. All cases are doctor-attended.

Maori cases are admitted, but very seldom apply. The doctor stated that he believed that the Port Albert Maoris are confined at home, but he has never been called on to attend a Maori, and is of opinion that they do not at the present time get any regular medical attention.

Waiuku.—The Franklin Memorial Hospital, maintained by the Auckland Hospital Board at Waiuku, serves the surrounding district for a radius of about ten miles, and the present accommodation is sufficient for the patients offering. The fees charged are £3 3s. per week.

Helensville.—The private hospital in Helensville conducted by the medical practitioner resident there is subsidized by the Board to the extent of £260 per annum to provide hospital accommodation for indigent cases resident in this vicinity.

Silverdale.—The Board has a district nurse stationed here, and she attends about twenty-four maternity cases a year.

The Committee is of the opinion that if it were more generally known that those unable to pay can enter free of cost more use would probably be made of both the hospital at Waiuku and that at Warkworth.

These provisions, while possibly adequate in the districts they serve, leave the major portion of the population unprovided for in the Board's area.

Reports and evidence received by the Committee show that the absence of public maternity hospital facilities in most of the outlaying parts of the Auckland district results in great hardship, inconvenience, and sometimes physical damage to mother or babe.

It was stated that there is considerable difficulty for the Waiau Pa where there are no transport facilities except private cars, no visiting doctor or nurses. Doctors charge £4 4s. for a single visit. The nearest doctor for Mangawhiri and Mangatangi is at Pukekohe, twenty-two and thirty-two miles away respectively. The charge for an ordinary visit to Mangawhiri is £4 4s. and to Pokeno Valley, £3 3s.

Representations of women resident in Makarau, Kaukapakapa, Wainui, Riverhead, Swanson, Henderson, Brown's Bay, Torbay, Takapuna, Devonport, Glenfield, and other northern boroughs, also those from southern areas, Onehunga, Otahuhu, Panmure, Mount Wellington, Huia, Onewhero, Pukekawa, Te Hohonga, Whangarata, Harrisville, Pokeno, Mercer, Mangawhiri and Mangatangi, Pukekohe, Puni, Paerata, Patumahoe, Karaka, and Drury all complained of the difficulty experienced by the mother whose means preclude any possibility of entering a private hospital.

Representatives of the Women's Division of the Farmers' Union from Clevedon and Orere spoke of the difficulties experienced by women in reaching hospital twenty-three miles away, with three unbridged streams which, if flooded, may cause serious delay or danger.

General.

If application is made before the mother enters hospital the Board sometimes grants necessitous cases £2 2s. towards the cost of confinement at a private hospital, but only where for some reason satisfactory to the Board's officers the applicant is unable to enter St. Helens. This means that the nurse who takes such a case into her nursing-home and has to attend it in confinement and board and nurse the patient for ten days or a fortnight is very often a definite loser by the contract, and is in fact relieving a public body of its duty.

Taking into consideration the loss sustained by nurses in accepting emergency indigent cases for which they receive no payment at all, it is obvious that a large part of the burden for caring for the mother needing assistance in the outer districts of Auckland is being borne by women who are conducting small private maternity hospitals.

Having regard to the distances to be covered and the expense and time involved in travelling to central clinics from the outlying places, many women are debarred altogether from the benefits of ante-natal supervision and equally so with regard to post-natal attention. The establishment of the subsidiary ante-natal clinics and hospitals as recommended would do much to remedy the position.

Summary and Recommendations.

Auckland City.

All the evidence goes to show that the present public facilities are being used to full capacity and that St. Helens Hospital is compelled at times to refuse even normal cases, whilst no provision can be made for suspect cases.

Owing to the lack of adequate provision in the general hospital for the many abnormal cases admitted it is recommended that until the main obstetrical unit advocated in the report is established the Board should appoint an experienced obstetrician to the medical staff and set aside for such cases separate wards staffed with experienced midwives.

To provide fully for the growing demands of a city of the size of Auckland, the Committee is of the opinion that there should be erected a thoroughly equipped St. Helens Hospital of fifty to sixty beds on a site sufficiently large to provide ample accommodation for present and future needs.

A visit of inspection was paid to a site in Symonds Street on which stands the old Grammar School, now occupied by the Workers' Education Association and the Elam School of Art. Adjoining and belonging to the property is a large area of unused land offering considerable scope for building purposes and the provision of tennis-courts for staff recreation. The locality is quiet though central and adjacent to trams, and the property is in a very high and sunny position. This site is recommended as a very suitable and desirable one for the purpose, though a site nearer to the general hospital might still be better.

Suburban and Country Districts.

It is obvious that much more remains to be done if the populous district for which this Board is responsible is to be adequately provided for in the matter of maternity services. At the present time, except for that portion of the city within reasonable distance of St. Helens Hospital, and the areas surrounding Warkworth and Waiuku, quite inadequate provision has been made for the remaining population.

The Committee strongly recommends that immediate action be taken to provide additional maternity facilities by the establishment or subsidizing of maternity hospitals in—

(1) (*a*) The North Shore district.
(*b*) Onehunga.
(*c*) Otahuhu.
(*d*) Henderson.

(2) In districts where the population is too small to warrant the provision of a special institution the Board should make arrangements with the existing private hospitals to take indigent cases and provide a fee sufficient to adequately remunerate the licensees and medical practitioners for their services.

(3) That the Board should accept the responsibility for emergency cases which sometimes arrive at a private hospital when in labour and have to be admitted. These at present are attended at a total loss to the licensees and are definitely a public and not a private responsibility.

(4) Here, as elsewhere, the Committee realizes the difficulty of frequent visits to ante-natal clinics by women living in suburban and country districts, but is of opinion that this could be largely overcome where no hospital facilities exist by a system of branch clinics working in conjunction with the main clinic, and recommends that action be taken to establish these where necessary.

9. WAIKATO HOSPITAL BOARD DISTRICT.

This district is situated in the South Auckland Health District and serves the counties of Waikato, Waipu, Raglan, Piako, Matamata, Rotorua, Otorohanga, Kawhia, Waitomo, and Taupo. It covers a very large area of the North Island, and included in it are many thickly populated areas.

The population is 120,705, of whom 15,647 are Maoris.

During the past ten years the population of this area has increased by 26·44 per cent. The main industries of this area are sheep and dairy farming, timber-felling, and also some mining.

It contains a number of small towns in addition to the two principal ones of Hamilton (19,337, Maoris 250) and Rotorua (9,228, Maoris 3,801). These are Huntly (2,482), Ngaruawahia (1,623), Morrinsville (3,092), Te Aroha (3, 251), Cambridge (2,694), Te Awamutu (2,688), Arapuni-Putaruru (2,194), Matamata (2,314), Otorohanga (2,160), Kawhia (2,227), Te Kuiti - Piopio (3,397), with several smaller townships in the south—Mokai (384), Taupo (523), Tokaanu (201), Awakino-Mokau (294). There is a large Maori population, the requirements of whom will be dealt with in a separate report.

There are public-hospital facilities at Hamilton, Rotorua, Huntly, Matamata, Kawhia, and Te Kuiti.

Public-hospital Facilities.

Hamilton.—The Campbell-Johnstone Ward attached to the public hospital provides nineteen beds with an average number daily occupied 11·2, and during the year 388 patients were admitted.

It is staffed by a resident obstetrician and four trained midwives and ten maternity nurse trainees. It is an " open " hospital, the local doctors attending about 20 per cent. of the cases including all abnormal cases, most of the remainder being confined by the midwife in charge. The majority of the private practitioners attend their patients in private hospitals, of which there are five, providing twenty-eight beds and admitting (in 1936) 372 patients.

Anæsthetics and analgesics are used to the average degree subject to the limitations of a " no-doctor " service.

There is an ante-natal clinic functioning, and all patients are seen by the hospital doctors, and all cases showing any signs of abnormality are seen post-natally. In addition, a Plunket Society clinic provides a limited amount of ante-natal attention, and there are two district nurses residing in Hamilton, most of whose work is among the Maori population resident outside the town.

This hospital is a training school for maternity nurses.

Rotorua.—There is a public general and maternity hospital containing thirteen maternity beds, and for the year ending 31st March, 1936, 199 patients were admitted. There is a resident medical superintendent and a registered midwife in charge of the maternity block.

The remarks in regard to the attendance of the doctor and midwife at confinements and ante-natal clinic at Hamilton apply also to Rotorua. The hospital is equipped with all facilities for maternity work.

The hospital is a training school for maternity nurses.

Private hospitals provide only five beds. There is a resident district nurse for the Maoris.

There are five doctors resident in Rotorua.

Huntly.—This town, together with Pukemiro (755), is the centre of a mining district.

There is a hospital owned by the Waikato Hospital Board, and the lessee receives an annual subsidy of £200 to cover the cost of all indigent cases.

The use of analgesics and anæsthetics is limited largely by the ability of the doctor to attend confinements, as the size of his practice is such as to preclude him from giving sufficient time to confinements to ensure adequate pain-relief. Chloroform is administered as far as possible by the midwife in charge.

The ante-natal work for hospital cases is done by the doctors so far as time will allow.

Matamata, situated forty-six miles from Hamilton, is served by a cottage hospital established by the Waikato Hospital Board and providing nine maternity beds. This hospital serves Matamata and the surrounding district and admits approximately two hundred patients per annum, the majority of whom are attended by the local practitioners.

Kawhia, situated on the West Coast, sixty-two miles from Hamilton over a hilly road, is served by a cottage hospital, established by the Waikato Hospital Board, and a medical man who receives a subsidy from the same source. The population of the surrounding district is mainly Maori. The present facilities are sufficient.

Te Kuiti, situated forty-nine miles from Hamilton, has a cottage hospital providing nine maternity beds and sixteen medical and surgical beds, and admits approximately one hundred and twenty maternity patients per annum. This hospital is under the supervision and control of the Medical Superintendent and Matron of the Waikato Hospital, Hamilton. The patients are practically all the private patients of the two medical men practising in Te Kuiti.

Ngaruawahia, situated twelve miles from Hamilton, is served by a private maternity hospital of four beds. There are three medical men in practice in this town, and the services are sufficient as the Campbell-Johnstone Ward of the Waikato Hospital is within easy reach by a good road.

Arapuni-Putaruru, situated respectively forty-six and forty-eight miles by a good road from Hamilton, and about thirty miles from Matamata, are served by a private maternity hospital of four beds situated at Arapuni. A medical man is in practice at Putaruru. Since the Committee's visit a four-bed maternity hospital has been established at Putaruru. The facilities are sufficient.

Morrinsville, which is twenty-one miles from Hamilton, has private hospital accommodation of eight beds, which is considered adequate for the needs of this district, and telephone facilities were also found to be very satisfactory. There are four doctors practising here and one district nurse who attends to the needs of the Maoris. The ante-natal supervision is given by the medical men personally.

Te Aroha, which is thirty-four miles from Hamilton, has nine maternity beds provided in private hospitals, and these were found to be adequate for the needs of the town and district. The ante-natal care of patients is supervised by the doctors themselves, of whom there are two. There appeared to be no transport difficulty in this district.

Cambridge, which is twelve miles from Hamilton, has a combined medical, surgical, and maternity hospital providing four maternity beds admitting seventy-two cases per annum. This hospital, on the surgical side, is restricted to non-septic cases.

Te Awamutu, situated on the main railway-line is seventeen miles from Hamilton. There are seven private hospital beds available and, in addition, two resident maternity nurses who do domiciliary work mainly among the Maoris.

The ante-natal work is mostly done by the medical men themselves, of whom there are four. Here again telephone and transport facilities appear satisfactory.

Otorohanga, situated thirty-seven miles from Hamilton, has four private beds with another private hospital being erected, making ample provision for the needs of this district. There are two doctors, both of whom do their own ante-natal work.

Mokai, is a small sawmilling village situated north of Lake Taupo, about forty miles from Rotorua, and is served by a district nurse employed by the sawmilling company. The births are mostly in the Maori population, most of the European mothers going to Rotorua for confinements.

Taupo.—There are no hospital facilities, but a doctor is stationed here. Evidence showed that the doctor and the district nurse stationed at Tokaanu, who is also responsible for this district, are much handicapped in their work through having no hospital to which to send cases.

Tokaanu.—The district nurse to Natives lives here, and the nearest base hospital is sixty-three miles away at Taumarunui.

The Board also pays £3 3s. per week to any of the private hospitals taking in indigent cases to be attended by the midwife in the hospital if normal. To ensure that ante-natal care is given and that the patient is able to receive that degree of anæsthesia which a midwife is entitled to give if the patient is certified by the doctor as suitable to receive it, the Board pays £1 1s. for the doctor to supervise the midwife's ante-natal care of the

case, and a further £3 3s. to the doctor for his attendance if required by the midwife during labour.

The more thickly populated areas of the district are therefore well provided with maternity facilities.

The chief complaints with regard to the provision for the Europeans in such places as Raglan (thirty-four miles), Te Uka, Te Mata, Te Akau, Ngaroma (twenty-five miles), are the lack of transport facilities and telephones. The transport facilities provided by the Board are four ambulances, one each at Hamilton and Rotorua, and subsidized St. John ambulances at Te Aroha and Cambridge, also private ambulances at Mokai and Pukemiro, the Board paying a total of £600 a year in costs and subsidies. Actually, for the most part, patients depend on their own cars or neighbours with cars for transport when in labour. There is, however, an undoubted difficulty for the country women in getting transport for ante-natal attention, and this difficulty is added to in some of the towns which they have to visit by the lack of rest-rooms or other places where they can remain between the time of their arrival and departure.

Summary and Recommendations.

(1) The Committee is of opinion that in the near future increased accommodation will have to be provided at the Campbell-Johnstone Ward.

(2) Taupo, situated sixty miles from Rotorua, and Tokaanu, sixty-three miles from Taumarunui, are particularly lacking in facilities for the European population, and undoubtedly the facilities available for the Natives are not as extensive as is desirable, though it is understood from the Medical Officer of Health that improvements will be made in this direction as soon as more district nurses to Natives are available.

The Committee recommends that a maternity hospital should be established at Taupo, as the distance to Rotorua and Hamilton for those who have to be confined is too far unless they can stay in town. The European population of this district is, however, under six hundred, and there are considerable doubts as to how the necessary facilities could best be provided. Whatever facilities were provided would undoubtedly centre on Rotorua.

The problem of providing better maternity facilities for the Maori population will be considered in a separate report.

The Maori Problem.

There are 14,710 Maoris residing within the Waikato Hospital Board's district, an increase of 3,847 in the last decennial period.

They are, except in the Rotorua district, scattered over wide areas and are chiefly occupied in farming or as labourers.

The Maori population of each county is as follows :—

Waikato	1,004	Rotorua	2,801
Raglan	2,198	Otorohanga	1,198
Waipu	1,225	Kawhia	999
Piako	731	Waitomo	1,934
Matamata	1,084	Taupo	1,536

At the public hospitals and clinics attached thereto, and at some private hospitals, the same facilities are available to Europeans and Maoris alike. For the latter a special visiting nursing service is provided by seven district nurses to Natives in the employment of the Health Department, whose work is directed and supervised by the Medical Officer of Health for the South Auckland district, resident at Hamilton.

These nurses are located as follows : Two at Hamilton, and one each at Morrinsville, Te Kuiti, Kawhia, Rotorua, and Tokaanu.

All are provided with means of transport and constantly travel throughout their district, visiting the residents in their pas and in their homes.

Their duties are not limited to maternity services. As they are largely occupied in the education of the Maoris in hygiene and attending to minor ailments, the maternity services rendered are principally ante-natal and post-natal attendance and advice. Attendance during labour is limited to cases in which the Maori "midwife" finds herself or himself (the midwife is frequently a man and is usually a relative of the husband or wife) in difficulties.

The Maoris provide most limited facilities for bathing, and the housing conditions are in the majority of cases deplorable, the whares being usually earth-floored hovels, often without windows and almost completely lacking in furniture, water-supply, and sanitary conveniences. The consequence is that in these districts the nurses are working under conditions in which it is almost impossible to maintain asepsis.

Except at Rotorua, the majority of women are delivered in their own homes.

Rotorua is an exception to this rule. Due to the instructions given them by the district nurse and the Sister in charge of the Rotorua Hospital maternity ward—both of whom are exceedingly sympathetic and understand Native psychology—the Maoris have come to realize the benefit of hospital attendance, and the majority of them now are confined in the Rotorua maternity ward to their great benefit.

The Arawa Trust Board has instituted a health-insurance scheme which provides for the admission of maternity patients to this ward at a cost of £1 to the Trust Board, which collects from the Maori where possible. The district nurse, who has been six years in the district and gained the confidence of the Native population, states that in the quinquennial period 1932–1937 there have been only four deaths among the Maoris, which would make an approximate death-rate of about 3 per 1,000. This is about half that of the general Maori maternal death-rate. She states that the Maoris attend the ante-natal clinic regularly and that they are willing to stay in hospital from ten to fourteen days. She says, "It has been hard to get them into hospital, but when they get there they don't want to leave. I think it is absolutely necessary that the nurse in charge of a hospital should be thoroughly sympathetic with them and should appreciate the psychology of the Maori."

In her opinion, the Arawa Trust Board's insurance scheme is of great benefit and she states, "owing to the insurance scheme they do not feel they are receiving charity and the Maori is very sensitive about that."

Besides the greater safety to the Maori woman when she is confined in such an institution as the Rotorua Hospital, there are distinct benefits in inducing her to breast-feed the baby, a practice which, according to the district nurse's statement, is becoming more general.

There can be no doubt that the education of the Maori in the Rotorua district as to the benefits of hospital treatment has been most successful and might with advantage be copied in other districts.

Owing to the greater popularity of the hospital it has been in the last few years necessary to quadruple the number of maternity beds in that institution.

The Committee understands that it is intended to increase the number of district nurses, and it appears that it is advisable to do so as soon as the right type of nurse is obtainable.

10. TAUMARUNUI HOSPITAL BOARD DISTRICT.

The Taumarunui Hospital Board serves the three rather remote central North Island (King-country) counties of Taumarunui, Kaitieki, and Ohura, in which all the transitional stages from bush country to pastoral land are still to be seen.

Most of the centres of population are distributed along the Main Trunk Railway, with a few along the branch line to Stratford. They include Taumarunui Borough (2,504), Ongarue (355), Okahukura (213), Owhango (504), Raurimu (278), and Ohura (453).

Ohura has shown a 60 per cent. increase in population in the past ten years, and the rest of the district has shown a moderate development.

The main roads in the counties are good, but there are still some places off these roads to which access is difficult.

Taumarunui.—Taumarunui Borough and the neighbouring areas are very well served. There is a Hospital Board maternity hospital of eight beds which, though housed in a rather old building, is well staffed and gives efficient service. It is open to the doctors of the district.

The Board accepts responsibility for those who cannot pay. Such patients are allowed to choose their own doctor, and his fee is paid by the Board. The hospital fee is £3 3s. per week. Ninety-five cases were treated in this hospital last year, giving an average of 3·65 occupied beds.

There are also two quite satisfactory private maternity hospitals of the usual country-town type. Each has four beds, and the fee is £4 4s. per week. There is practically no domiciliary attendance. No difficulty is experienced in giving satisfactory ante-natal service.

Ohura.—The Committee considered the position of Ohura, thirty-two miles from Taumarunui on the Stratford line, where there is a growing population and where a doctor, subsidized by a medical association, is resident.

A nurse at one time had a small maternity hospital subsidized by the Board, but this is not now functioning.

Opinions of the residents differed as to the advisability of re-establishing a maternity hospital there; some considered that the expense was not warranted and that the women would still prefer the facilities available at Taumarunui, while others considered that such local provision was needed.

The Committee rather inclined to the view that a small maternity hospital would be helpful.

The residents of some of the more remote outlying settlements are naturally at considerable disadvantage. Most of them arrange to come down to Taumarunui for short period before confinement, and the Board hospital does actually take in quite a few waiting patients.

There is reason to think that the ante-natal supervision of such patients is considerably short of the ideal and that ante-natal services through the agency of a district nurse would considerably help the position.

There are a considerable number of Maoris in the district. The conditions under which they are living are not good, and most of the confinements are attended by the Natives themselves. The beginning of a service such as the Committee favours is, however, already in operation.

The hospital is prepared to take Maori patients, and they are showing a willingness to come. The district nurse is already giving a considerable amount of ante-natal advice.

The Committee commends this service and strongly advocates its development.

Summary and Recommendations.

(1) The Committee considers that the Taumarunui Borough and the neighbouring areas are very well served.

(2) It is considered that a small maternity hospital at Ohura would be helpful.

(3) The extension of the district nurse service to both Maoris and Europeans is recommended.

11. THAMES HOSPITAL BOARD DISTRICT.

This district, which includes the County of Thames, part of the Hauraki Plains, and the western half of Ohinemuri County, extends from the Firth of Thames and the Waikato Boundary on the west to the Bay of Plenty on the east. Its northern boundary divides it from the Coromandel district, and its southern from Tauranga and Waihi. Two principal towns, Thames and Paeroa, have populations of 4,268 and 2,149 respectively. The former showed a decrease of 10·26 per cent. in population, and the latter an increase of 17·24 per cent. during the last intercensal period. Apart from the Hauraki Plain, the district is in the main hilly and rugged. Some of the old-established gold-mines are still being worked, but apart from this the population is mainly occupied in small farming. The mineral springs at Puriri are well known.

Thames.

Public-hospital Facilities.—The Thames Hospital maternity annexe provides a total of ten beds and is a training school for maternity nurses. The annexe is a converted school building and, while efficiently run, is inconvenient and uncomfortable. The main lack is of proper facilities for ante-natal work. Patients are examined in the bathroom, the waiting-room being a curtained-off corridor. No dressing-rooms are provided, and this causes undue delay and waste of time.

Private-hospital Facilities.—A private hospital in the town caters for from thirty to forty cases per annum. The hospital is a mixed one, the ground floor being devoted to surgical and general, and the first floor to maternity work. No labour ward is provided, patients being confined in their rooms.

Paeroa.

Public-hospital Facilities.—A cottage hospital with five maternity beds is under the control of the Thames Hospital Board. From information received from various reliable sources in the district the Committee formed the opinion that an unsatisfactory state of affairs obtains with regard to this hospital. Though a Board hospital, it has no Medical Superintendent, nor is it under the control of the Superintendent of the Thames Hospital, cases being attended by the two local practitioners. The Sister in charge, though an employee of the Thames Hospital Board, is not under the control of the Matron of Thames Hospital. It was alleged that patients are not admitted, except on payment or guarantee of the required fee, and indigent patients are obliged to go to Thames annexe, a distance of nineteen miles. Equipment and accommodation appear to be adequate, but it was evident from a perusal of the hospital books that operations such as appendicectomy were performed at the hospital and that septic cases were by no means rigidly excluded. No provision is made for ante-natal supervision at the hospital.

Private-hospital Facilities.—A private maternity hospital takes about fifty cases a year. The licensee stated that she found it hard to make ends meet. Though charging the low fee of £4 4s. per week, bad debts are frequent, and she has from time to time taken a number of indigent cases, for which she has apparently not asked for, nor received, any assistance from the Hospital Board.

Provision for Abnormal Cases.—These are treated mainly in the Thames annexe.

Provision for Unmarried Mothers.—No special provision is made for unmarried mothers, but they are admitted to the Thames annexe on the same terms as the married.

Ante-natal Care.—Apart from private attendance, ante-natal supervision is carried out under very considerable difficulty, to which reference has already been made.

MAORI CONDITIONS.

The Maori population is concentrated mainly at Tirohia and Waitoki, between Paeroa and Te Aroha. Maoris resident in the Plains district are situated nearer Thames. It was alleged that Maori patients are not taken at Paeroa Hospital, and are obliged to travel nineteen miles to Thames, an outcome of the unsatisfactory state of affairs mentioned elsewhere. No ante-natal facilities are provided for them at Paeroa. At Thames they enjoy full maternity facilities and attend at the clinic along with other patients. The district nurse visits Maoris in their homes, and gives ante-natal instruction to many who are confined at home by Maori methods. She tries to persuade patients to go to hospital for confinement, and an increasing number follow this advice.

Summary and Recommendations.

The Committee recommends—

(1) That steps be taken at an early date to improve the accommodation of the ante-natal clinic at Thames.

(2) That the public maternity facilities, including ante-natal attention, at Paeroa should be properly developed and made known to the public.

12. WAIHI HOSPITAL BOARD DISTRICT.

This small district is an old-established mining centre. It occupies the eastern half of the County of Ohinemuri and contains only one town of any size, Waihi, with 3,916 inhabitants. Waihi showed a population increase of 2·35 per cent. during the ten-year period 1926–36, due to recent increased activity in the gold-mining industry.

WAIHI.

Hospital Facilities.—There is no maternity annexe at the public hospital, which takes in only indigent maternity cases at the rate of about three per annum. A private home deals with about thirty-five cases yearly. This home is the private residence of the owner, and its equipment does not give sufficient maternity facilities for the whole district. Consequently nearly two-thirds of the confinements in the district are conducted in the patients' own homes, which in many cases are unsuited for the purpose.

Ante-natal Care.—The large majority of confinements are attended by doctors, who also give ante-natal supervision to the patients. There are no public ante-natal facilities.

Maori Conditions.—Maoris are subject to the same difficulties as Europeans in this district. There does not seem to be any specific Maori problem.

Summary and Recommendations.

A maternity annexe of five or six beds would be a decided asset. The Committee inspected certain unused rooms at the public hospital which were suggested as suitable for such an annexe. While by no means ideal for the purpose, these rooms would, if properly equipped, constitute a distinct improvement on the existing facilities. Whether the cost of adapting these rooms would not be greater in the long-run than that of building a small and up-to-date annexe is a matter demanding consideration.

13. COROMANDEL HOSPITAL BOARD DISTRICT.

The rugged character of this district, which is coterminous with the county of the same name, precludes any great concentration of population or any extensive farming activities. Coromandel, the principal town, has 844 inhabitants, and all interests in the district are on a very small scale. The total rural population is 2,635 and increased by 24·94 per cent. during the 1926–36 intercensal period.

COROMANDEL.

Public-hospital Facilities.—The general hospital provides four maternity beds under conditions which are highly unsatisfactory to staff and patients alike. There is no labour ward, patients being confined in a bed in the corner of the maternity ward. No nursery being available, attention to infants also has to take place in the general ward. To the discomfort and inconvenience thus caused to patients is added the great difficulty of maintaining proper separation of the maternity and general services, and the consequent increased risk of infection.

There are no private facilities in Coromandel.

Recommendations.

A separate labour ward and nursery, with adequate sanitary conveniences, are urgently needed. Plans have been drawn and were shown to the Committee, it being stated that tenders would be called as soon as the plans have been approved by the Board.

14. MERCURY BAY.

This small hospital, situated twenty-two miles from Coromandel, was not visited by the Committee, but the local doctor was interviewed. The hospital is not under the control of any Board, and is supported by local efforts, subsidized pound for pound by the Government. It appears to be sufficient for the needs of the district, about twelve cases a year being attended.

15. TAURANGA HOSPITAL BOARD DISTRICT.

This district occupies a strip of coast-line sixty miles long between the Bay of Plenty and Waihi boundaries, the strip being some ten miles wide at its eastern and twenty at its northern extremity. The district also includes the islands of Motiti and Matakana, each having a population of some two hundred persons, Tauranga, the principal town (3,387 inhabitants), is in the main a popular residential and health resort, and boasts but little in the way of commercial and industrial interests. Its increase in population during the 1926–36 intercensal period was 32·88 per cent. The total rural population is 9,571, and showed an increase of 24·84 per cent. for the same period. The main industry is dairy-farming. Though roading is, on the whole, satisfactory, transport difficulties arise on account of the long distances of some localities from the hospital centre. The difficulty regarding the provision of home help is being admirably met by the efforts of the Women's Division of the Farmers' Union, who have so far been able to supply a housekeeper to every woman applying for help. Some leading women, however, are of the opinion that a residential nursery in Tauranga would be of great assistance in some cases.

Tauranga and Te Puke.

Hospital Facilities.—There is no maternity annexe at the general hospital. The facilities in the town consist of one private hospital with four beds and two midwives' homes with one bed each. According to the statement of one medical practitioner, at least twice this number of beds is required.

Patients who cannot afford the private hospital fees of £4 4s. and £5 5s. must go to the ten-bed hospital at Te Puke, eighteen miles away. Cases from Katikati, twenty-two miles north of Tauranga, are also obliged to go to Te Puke, passing through Tauranga *en route.*

Patients residing at Oropi, ten miles from Tauranga, can reach Te Puke direct, but the road is so bad that a detour through Tauranga, making a journey of twenty-two miles, is often preferred. Objections are sometimes raised by European patients regarding the large number of Maoris admitted to Te Puke Hospital. While accommodation at Te Puke is adequate for the number of cases applying, the difficulties arising from the transport situation are evident.

Provision for Abnormal Cases.—Except for any cases which may be admitted as emergencies to the general hospital, Te Puke hospital affords the only provision for abnormal cases.

Provision for Unmarried Mothers.—Unmarried mothers are admitted to Te Puke Hospital, and in a few cases have been admitted to a private hospital with the financial help of women's organizations.

Maori Conditions.—No provision for Maoris exist in Tauranga, the private hospital refusing to take them. A considerable number are confined at Te Puke, and the difficulty of isolating them from the white patients is a source of trouble there. The district nurse gives ante-natal supervision, but finds it impossible to do this adequately among a Maori population of 2,883 scattered over an area eighty miles in length by fifteen in width, and including two islands. Apart from the area in the immediate vicinity of Te Puke, the tendency is still for Maori confinements to take place at home. Many Maoris receive no ante-natal care whatever, as the district nurse cannot visit them all.

Summary and Recommendations.

It is evident from the foregoing that maternity facilities in the Town of Tauranga are inadequate, and the necessity for poorer patients to go to Te Puke for confinement involves undue travelling-expenses and consequent lack of proper ante-natal attention. The Committee favours the erection of a maternity annexe in Tauranga, which would also serve the outlying districts of Katikati and Oropi. It is thought that an annexe of six or eight beds would suffice for this purpose.

It is recommended that separate ward accommodation be made for Europeans and Maoris, both in this annexe and at Te Puke.

In the interests of Maori maternal welfare, the Committee favours the appointment of a second district nurse for Maoris.

16. BAY OF PLENTY HOSPITAL BOARD.

This district occupies the same area as the County of Whakatane. In shape it is roughly rectangular, occupying some twenty miles of coast-line on the Bay of Plenty,

and running inland for a distant of fifty miles to the boundary of the Wairoa district. It shares its eastern boundary with Opotiki and its western with the Waikato and Tauranga districts. Whakatane, on the coast, is the only town of any size, and the only centre where hospital facilities are provided. It has a population of 1,733, and showed an increase of 22·56 per cent. during the 1926–36 period. The rural population of the district is 9,667, showing an increase of 54·41 per cent. in the ten-year intercensal period. Inhabitants of scattered farming areas in the back country find the transport problem one of considerable importance. The difficulty of obtaining home help is acute in this district.

WHAKATANE.

Public-hospital Facilities.—The maternity annexe of the general hospital contains thirteen beds, of which on an average only six are occupied. It is controlled by the medical superintendent, and the two local doctors have the right of attending cases there.

Private-hospital Facilities.—There is no private hospital in the town, the facilities provided at the public hospital being sufficient.

Provision for Abnormal Cases.—These are dealt with at the public-hospital annexe.

Provision for Unmarried Mothers.—Unmarried patients are admitted to the annexe on the same terms as the married.

Ante-natal Care.—There is an ante-natal clinic at the hospital and all patients are seen by a doctor at least once during pregnancy, even if no doctor is engaged for the confinement. In addition, a doctor conducts private clinics at Edgecumbe and at Taneatua at specified times. Despite these facilities, an appreciable number of women on isolated farms find it difficult, and in some cases even impossible, to attend a clinic. The case of a woman who lives at a distance of nine miles from both Edgecumbe and Whakatane and has no means of transport but a service car to which she has to walk some distance is illustrative of this difficulty, and according to this witness not a few women find themselves in a similar case. The suggestion that one of the hospital sisters or a district nurse should visit these patients periodically and give both ante-natal service and mothercraft advice would appear to be a practical one.

Maori Conditions.—The district nurse serves an area which contains some 4,153 Maoris. The tendency is still for confinements to take place at home, though hospital treatment is increasing in popularity. Most cases are attended in Maori fashion, the nurse being summoned only in case of difficulty. Maoris are beginning to accept ante-natal services more readily. Opposition to hospital treatment comes more from the older Maoris, the younger women appreciating the pain-relief measures and other amenities afforded by the hospital. Racial superstitions regarding childbirth still persist among the Maoris, rendering proper attention difficult in certain cases.

Summary and Recommendations.

Hospital accommodation is satisfactory and more than sufficient for the needs of the district. Ante-natal services are good, but transport is a major difficulty to residents of outlying areas who do not possess cars. Much still remains to be done in educating the Maoris regarding the necessities of modern maternal welfare, and for this purpose one district nurse is insufficient.

The Committee recommends an extension of district nursing services among the Maoris and suggests that were the benefits of the system afforded to the European residents of outlying districts this would be of assistance in solving the transport problem.

17. OPOTIKI HOSPITAL BOARD DISTRICT.

This district, which is coterminous with the county of the same name, comprises a large but sparsely settled area with a coast-line extending from a point midway between Hick's Bay and Cape Runaway to Waiotahi, a distance of some seventy miles. Its eastern boundary coincides with the western boundary of Waiapu and Cook Districts, and its western boundary is formed by a line running inland due south and south-east for a distance of forty-five miles. Opotiki (1,437 inhabitants; increase in population 18·37 per cent. during the 1926–36 intercensal period) is the only township of importance and the hospital centre for the district. The total rural population of the district is 4,518 and showed an increase of 15·86 per cent. during the intercensal period. The chief industry is farming.

OPOTIKI.

Hospital Facilities.—There is no public maternity hospital, accommodation being afforded by a private hospital of four beds, and a home with one bed. The Hospital Board pays the rent of the private hospital (£1 10s. weekly), together with a subsidy of £75 per annum, making a total payment of £150 per annum. In addition, fees of from £1 10s. to £2 are paid for indigent cases. No arrangement exists for payment of medical attention to these cases, the doctors giving their services voluntarily.

Provision for Abnormal Cases.—These are dealt with mainly in the general hospital.

Ante-natal Care.—As regards the white population of the district, ante-natal services are in the main sufficient, the doctors themselves attending to this work. The main

difficulty lies in the distances which patients have to travel, in some instances fifty miles. It was suggested by several witnesses that an extension of the district nursing service would help to solve this difficulty.

Maori Conditions.—The needs of a Maori population of 2,415 are served by one district nurse, who gives ante-natal supervision and attends patients in their homes in cases of difficulty. The nurse calls a doctor when necessary, but most abnormal cases are sent to the public hospital. Maori cases are not taken at the private hospital unless sent for some special purpose by a doctor, the reason for this being the prevalence of skin-infections and the difficulty of isolation. There are no institutional facilities for normal Maori cases, the majority of whom are confined in their homes, either in Native fashion or by the district nurse.

Summary and Recommendations.

It would seem that, so far as the European population is concerned, accommodation is adequate to the needs of the district, but the licensee's difficulty in collecting fees militates against the smooth running of the hospital.

Certain additions to the hospital and its equipment are required, but are beyond the means of the licensee. Chief among these is a proper nursery and better theatre accommodation. The provision of these requirements by the Hospital Board would make for improved service, and the Committee urges that attention be given to this matter.

The Committee suggests that the Board be urged to follow the practice of other hospital boards in recognizing its responsibility for payment of a fee to doctors for emergency attendance on indigent cases.

The Commitee recommends that adequate hospital accommodation be provided for Maori patients. A four-bed annexe at the public hospital would be sufficient, and until such provision is made little can be done to improve maternity services among the Maori population.

In the interests of more effective ante-natal care for Maori women the Committee recommends an extension of the district nursing scheme, and suggests that, were the services of the district nurse made available to European as well as Maori residents of outlying districts, this would be of great assistance to patients living too far from Opotiki for regular ante-natal attendance.

18. WAIAPU HOSPITAL BOARD.

The eastern and northern boundaries of this district, which includes the counties of Waiapu and Matakaoa, are formed by the coast-line and extend from Tolaga Bay in the south to a point midway between Hick's Bay and Cape Runaway in the north. The main hospital centre is at Te Puia Springs (275 inhabitants), a popular health resort. A good road four miles in length leads to Waipiro Bay (378 inhabitants), and Tokomaru Bay (483 inhabitants), where the present maternity hospital is situated, is a distance of seven miles to the south. Te Araroa (354 inhabitants) on the north coast, and Tiki Tiki (478 inhabitants) twenty-five miles inland, are districts mainly inhabited by Maoris. Ruatoria (653 inhabitants) is the principal centre on the road between Te Puia and Te Araroa. The total rural population of the district is 8,134, a general increase having taken place during the 1926–36 intercensal period, amounting to 25·74 per cent. in Waiapu County and 22·04 per cent. in Matakaoa County. There are no railways, and communication is by roads, which in the main are good, but in parts are subject to flooding in wet weather. Telephone communication is satisfactory. An interesting feature of the district is the supply of natural inflammable gas which is collected at Te Puia and used by the residents for lighting and heating purposes. Sheep-farming is the principal industry.

Tokomaru Bay.

A four-bed hospital belonging to the Hospital Board has hitherto catered for the needs of the greater part of the district. It is proposed, however, shortly to remove to more convenient premises at Waipiro Bay. Most cases are attended by a midwife, but the doctor at Te Puia, seven miles away, is available for emergencies and also attends twice weekly for ante-natal and other consultations. The cases attended are mostly Maoris, white patients preferring to go to Gisborne for confinement, on account of the impossibility of getting a single room at Tokomaru Bay.

Te Puia and Waipiro Bay.

The general hospital and doctor's residence are situated at Te Puia, but there is no maternity annexe. The gift of a property at Waipiro Bay for conversion into a maternity hospital has recently been accepted by the Board. This house was inspected by the Committee. It is pleasantly situated and well built, and though the necessary alterations must, of necessity, be costly, the Board is of the opinion that the value of the gift outweighs any possible disadvantages. Board members pointed out that, while Ruatoria is geographically the centre of the district, Waipiro Bay is more accessible for the doctor

and consequently a more suitable site for a hospital. The doctor makes a weekly visit to Ruatoria, and monthly visits to Te Araroa and Tiki Tiki, and it is thought that, by suitable arrangements, these visits could be made to comprise ante-natal services which, together with a clinic at Waipiro Bay, would put the ante-natal work on a better footing than is at present the case.

Te Araroa.

The small hospital which formerly served the district has been closed for six years, and the Board considers that it could be reopened only at considerable loss, the preponderance of patients being Maoris. The distance to Waipiro Bay (forty-four miles) will be a drawback to patients from this district attending the new hospital, and it is thought that, when the road to Opotiki (eleven miles) is completed, the majority of patients will prefer the latter centre.

Maori Conditions.—The Maori population in this district is very large, no fewer than 5,624 residents out of a total of 8,134 being Maoris. It follows that no discussion of ante-natal and district work is possible without reference to Maori conditions, and a general survey of maternity services in the district is therefore incorporated under this heading.

The district nurses at Te Araroa and Tikitiki give ante-natal and post-natal advice and attend a considerable number of confinements. In the past they have, on occasion, had to treat abnormalities for lack of medical assistance. They are now able to get the doctor from Te Puia for emergencies, but in times of flood this may not be possible. They endeavour to persuade patients to go to hospital, and the tendency to do so is increasing among the younger Maoris. More extensive hospital accommodation is urgently needed on this account, the present four-bed hospital at Tokomaru having sometimes had to accommodate nine patients. There is no district nursing service at Tokomaru Bay nor at Waipiro Bay, and these two settlements urgently require the assistance of competent nurses. Many Maoris are still confined at home by Maori methods, and ante-natal work is rendered difficult by racial superstitions. Toxæmia is, fortunately, a rare condition among the Maoris who, on the whole, are healthy as long as they can obtain their own natural foods.

Unmarried Maori mothers are usually sent to the Salvation Army Home in Gisborne.

Summary and Recommendations.

Owing to the inadequate hospital accommodation, domiciliary midwifery among the Maoris is the rule in the Waiapu district. Apart from the small hospital at Tokomaru Bay, no provision exists for the treatment of abnormalities. Serious emergencies infrequently have to be dealt with in patients' own homes under unfavourable conditions, and in some cases where the doctor is not available by the district nurses. Extension of both hospital and district services is urgently required. The Committee endorses the intention of the Hospital Board to establish a larger hospital and has serious doubts regarding the project of converting a private house at Waipiro Bay, which is situated at a considerable distance from medical and hospital facilities. The Committee suggests that the establishment of this hospital be regarded as an emergency measure, and that the possibility of erecting a maternity hospital at Te Puia at a later date be borne in mind.

In the interests of improved ante-natal and post-natal care the Committee recommends that the Hospital Board pay an adequate salary to the doctor at Te Puia for conducting clinics at Ruatoria, Tikitiki, and Te Araroa, and also that the present excellent district services be extended by the appointment of nurses at Tokomaru Bay and Waipiro Bay. It is thought that well-trained and competent Maori nurses would be suitable for these positions.

19. COOK HOSPITAL BOARD DISTRICT.

This district extends from the northern boundary of the Wairoa district to a point on the coast a few miles north of Tolaga Bay. In shape it is a rectangle of roughly forty-five miles from north to south by thirty miles east to west. It includes the counties of Cook, Waikohu, and Uawa. Gisborne (13,587 inhabitants, 3·48 per cent. increase of population during 1926–36 period) is the commercial and shipping centre of the district, and is the situation of the general hospital. The small Township of Tolaga Bay (429 inhabitants), twenty-five miles to the north, is the only other hospital centre. The total rural population of the district is 11,987, an increase of 6·65 per cent. in Cook and 3·66 per cent. in Uawa, being offset by a decline of 6·65 per cent. in Waikohu, during the 1926–36 period. Sheep-farming is the principal industry.

Gisborne.

Public-hospital Facilities.—The former St. Helens Hospital has been replaced by a modern and up-to-date annexe of thirteen beds, situated in the grounds of Cook Hospital. It is a training school for five maternity nurses. Cases are attended by midwives, and the Superintendent of the annexe is on call for all abnormal cases. Morphia, nembutal,

and chloral are sedatives used at the discretion of the Superintendent, and all patients receive chloroform at the end of labour. A number of patients come from a distance, but means of transport do not seem to constitute a problem.

Private-hospital Facilities.—Private accommodation is to be found in two homes, one a converted medical and surgical hospital and the other a new building of six beds. The charge is £5 5s. per week. A small home of three beds serves the Kaiti suburb at charges of £3 3s. to £4 4s. per week.

Intermediate Facilities.—The Salvation Army Maternity Home affords private accommodation at a charge of £6 6s. for two weeks, £1 1s. extra being charged if no doctor is engaged. Though old, and in some respects inconvenient, the home is efficiently run, cheerful, and attractive.

Provision for Abnormal Cases.—The public hospital and its annexe provide adequate facilities for the treatment of abnormal cases.

Ante-natal Care.—Apart from private services, ante-natal care is given at the public hospital annexe, where a clinic is run by the Sister in charge. The Superintendent of the annexe attends the ante-natal clinic once a week, or oftener if necessary. Owing to its distance from town this clinic is not availed of as much as would be the case were it more centrally situated.

Provision for Unmarried Mothers.—Unmarried mothers are admitted to the hospital annexe on the same terms as married women, but special provisions are made for them at the Salvation Army Home. Girls are admitted to the latter institution some time before confinement, and adequate ante-natal care is given.

District Services.—There is only one district nurse in this area, and her work is entirely among Maoris. It was stated that, owing to the large Maori population, the services of more than one nurse would be appreciated.

Maori Conditions.—The total Maori population of the district is 2,718. There is an increasing tendency for Maori women to come in to hospital for confinement, and they are admitted without reserve to both the Cook Hospital annexe and the Tolaga Bay Hospital. Their usual stay in hospital is three to four days, and only rarely can they be persuaded to stay for more than a week. The younger women are beginning to appreciate the value of ante-natal care. A number of patients are still confined in their own homes in Native fashion. Housing conditions are excellent in some 30 per cent. of cases, but many of the poorer Maoris still live under deplorable hygienic conditions.

TOLAGA BAY.

The cottage hospital is controlled by the Cook Hospital Board and contains nine beds. Between forty and fifty cases per year are admitted, and the hospital also admits a few medical cases. The patients are mostly Maoris, European women for the most part preferring to go to Gisborne.

Maternity services in this area are on an extremely unsatisfactory footing owing to an unfortunate lack of co-operation between the one local doctor and the Hospital Board. An arrangement which previously existed to ensure medical attendance at the hospital was terminated in 1929, and it has not been found possible to renew it in any form. Though the doctor does not refuse to attend emergency cases when requested to do so by the Sister in charge, the majority of patients receive no medical attention whatever. The Sister sees patients ante-natally, and is in the habit of giving a small quantity of chloroform at the end of labour, a practice which, though prompted by kindness and sympathy, cannot be commended in view of the fact that the patients have not been medically examined. The staffing of the hospital is inadequate, as the Sister is the only trained person available. Provision for relieving her is not made, and she gets insufficient time for rest and recreation.

Summary and Recommendations.

In the opinion of the Committee public and private hospital facilities are adequate in the Town of Gisborne. In the outlying districts the facilities for an efficient hospital service to both Maori and white patients exist, but are prejudiced by certain problems of staffing, which require immediate attention. Ante-natal work among both the Maoris and Europeans would benefit greatly from an extension of the district nursing scheme.

20. WAIROA HOSPITAL BOARD DISTRICT.

This district, of which the limits coincide with those of the county of the same name, has the coast for its eastern boundary, including some sixty miles of the broad sweep of Hawke's Bay, the Mahia Peninsula, and a stretch of coast some ten miles north of the latter. The long northern boundary extends inland for a distance of eighty miles, running first north-west for a distance of twenty miles from the coast, and then due west. The southern boundary corresponds to the northern boundary of the Hawke's Bay district, and the western is formed by a line some twenty miles long adjoining the extremities of the northern and southern boundaries. The Town of Wairoa, with 2,524 inhabitants, the only centre of any size, showed an increase in population of 8·15 per cent. during the last intercensal period, and

has the only hospital in the district. The rural population of the district is 7,000. An increase of 23·38 per cent. during the 1926–36 period is probably accounted for by the activity of the Public Works Department, which has established numerous camps in connection with the power-station at Lake Waikaremoana and with the various railway and road-making enterprises.

Communication is by road, the railway between Napier and Gisborne being as yet incomplete. Roading is in the main satisfactory, excepting in the Mahia Peninsula, where isolated pas and villages can be visited only on horseback. Farming is the principal industry.

Wairoa.

Public-hospital Facilities.—There is no maternity annexe in connection with the public hospital. The erection of an annexe was contemplated some years ago, but financial difficulties consequent on the earthquake and the depression caused the matter to be dropped. The Hospital Board pays fees at the rate of £9 for two weeks to the private hospital for indigent patients, provided they have been sent in by the district midwife. The Board accepts no responsibility for patients for whom previous arrangements have not been made or who have been residents of the district for less than six months. No subsidy is paid by the Board to the private hospital.

Private-hospital Facilities.—The only hospital facilities of any kind in Wairoa are provided by a private hospital of five beds, charging £5 5s. per week, and a private home of one bed. Great difficulty is experienced in recovering fees from Maoris, who are coming to the hospital in increasing numbers. The licensee feels it an injustice that she should be forced to take in cases of skin and venereal infections, the public hospital refusing even cases of this nature. It would seem that difficulties regarding the collecting of fees and admission of patients could be largely solved by a definite agreement between the licensee and the Board. No such agreement appears to exist.

Intermediate Facilities.—No accommodation of this type is available.

Ante-natal Care.—This is given privately by the doctors, and, in indigent cases, by the district midwife. A fee of £1 1s. is paid by the Board to the doctor for each indigent patient to ensure a medical examination being given at least twice during pregnancy.

District Services.—A district midwife works under the control of the Hospital Board, this being regarded as a temporary service pending the erection of a maternity annexe. The charge for her services, which are available for all classes of the community, is £5 5s. whether or not a doctor is also employed. This charge is payable to the Board. A fee of £3 10s. or £4 4s. is paid to the doctor for emergency attendance on indigent cases. The necessary outfit for domiciliary attendance is sterilized at the public hospital.

Provision for Unmarried Mothers.—No special provision is made for the unmarried mother.

Public-works Camps.—Strong representations were made to the Committee by the Secretary of the Public Works Employees' Medical Association regarding the difficulty of providing adequate maternity facilities for the wives of public-works employees. The association covers an area from Woodville to Napier, Napier to Wairoa, Lake Waikaremoana and Kopuawhara. It also includes Wanganui, the Fordell deviation, and the National Park – Wanganui Road. It serves 2,200 men and their dependants, a total of some 5,000 people. On the Wanganui side services are satisfactory and within the means of employees, but in the Wairoa district many major difficulties exist. The camps in this area are situated at Wairoa, Kopuawhara, Tuai, Lake Waikaremoana, Nokau Falls, and Raupunga. The association has appointed a district nurse at Kopuawhara, but her time is fully occupied in giving medical attention to the four hundred men and their families, to the exclusion of maternity services.

The association undertakes to pay £4 4s. for a maternity case. In most districts this is to be paid the Hospital Board to cover nursing and medical attendance, but at Wairoa no such provision is made. The patients have to go to the private hospital, £2 2s. being paid to the hospital and £2 2s. to the doctor. In many cases patients themselves are not in a position to pay the remainder of the fees owing. Those who do not wish to be confined under these conditions are obliged to go either to the Gisborne annexe or to the McHardy Home, Napier, and the long distance to be travelled to either of these centres created serious difficulties. The Wairoa Hospital Board will accept responsibility only in cases of patients who have resided in the Board's district for six months or more, and, as public-works employees are obliged to move about a great deal, they are frequently unable to avail themselves of the Board's provision.

Maori Conditions.—The Maori population of the district is 3,541. An increasing number of patients are seeking admission to the private hospital, a fact which causes dissatisfaction to the licensee, as they often arrive in advanced labour with no warning, and seldom pay even a portion of the fee. The doctors are reluctant to attend Maoris in their homes on account of the bad sanitary conditions, but the Maori district nurses of Nuhaka and Frasertown attend a total of between thirty and forty per year. Cases developing complications are sent to the private hospital. The nurses adopt the principle of, as far as possible, allowing Maori patients to deliver themselves according to Native custom, only assisting when necessity arises. This gives the Maoris greater confidence, and so far no bad results have ensued.

Summary and Recommendations.

It will be evident from the foregoing that maternity services in the Wairoa district are on an unsatisfactory basis, and various suggestions have been made for improving the situation :—

(1) A maternity annexe under the control of the Hospital Board. The district nurses consider that greater use would be made of hospital facilities were the annexe available. The services of the Wairoa district midwife would no longer be necessary, and more adequate ante-natal care would be available for poorer patients.
(2) A temporary hospital maintained by the Public Works Department at one of the camps, possibly Kopuawhara. While this would undoubtedly be of great assistance to public-works employees, it would contribute but little to the solution of the Maori problem.
(3) Enlargement of the existing private hospital, and the payment of an adequate subsidy by the Board.

Of these suggestions the Committee recommends the erection of a maternity annexe at the public hospital and better transport facilities from the camps.

21. HAWKE'S BAY HOSPITAL BOARD DISTRICT.

The Hospital Board district of Hawke's Bay occupies virtually the same area as the county of that name. The coast, for a distance of roughly twenty miles both north and south of Cape Kidnappers, forms the eastern boundary of this district. The northern boundary, some forty miles in length, runs in a north-westerly direction to a point some five miles north of the Settlement of Tarawera ; the southern is formed by a line some fifty miles long running inland almost due west from the coast. Napier, a town of 15,302 inhabitants, is an important shipping centre, while Hastings, with 12,750 inhabitants, is the main commercial centre of the district. During the intercensal period 1926–36 Napier showed a decrease of population of 0·63 per cent. and Hastings an increase of 25·64 per cent., this discrepancy being accounted for by the much slower recovery of Napier after the earthquake in 1931 and the increased importance of Hastings as a commercial and business centre. A popular residential and educational centre is situated at Havelock North (1,050 inhabitants, increase 9·05 per cent.). The rural population of the district is 16,500, and shows an increase of 13·09 per cent. in the intercensal period. The principal industries are sheep and dairy farming and fruitgrowing ; the manufacture of wine and cider is being developed on the lower slopes of the Te Mata Range, and at Napier the fishing industry has long been a flourishing concern. The main centres are well served by the railway, and roads are satisfactory. The district suffered most severely in the earthquake of 1931, and this fact has brought about extensive activity in building, old structures which sustained extensive damage having been largely replaced by buildings of modern and up-to-date design.

Transport does not appear to be a major difficulty in Hawke's Bay, as excessive poverty is comparatively rare and cars readily obtainable. Shortage of domestic help, on the contrary, is an acute problem throughout the district. The Napier Townswomen's Guild endeavours to provide assistance in the town similar to that given by the Women's Division of the Farmers' Union in the country, but the efforts of both organizations are greatly hampered by lack of personnel.

Napier.

Public-hospital Facilities.—There is no maternity annexe at the public hospital, all Hospital Board cases being confined in the McHardy Home, an institution owned by the Board, but licensed as a private hospital. The Board guarantees the matron eight cases a month, at the rate of £6 6s. for two weeks, and pays extra for any Board cases over and above this number. The building is rent-free, the Board paying the rates and maintaining the outside of the building. Sedatives are used according to medical direction.

Private-hospital Facilities.—In addition to private accommodation available at the McHardy Home at a fee of £4 4s. to £5 5s. per week, facilities are afforded by three private hospitals, providing a total of twenty-five beds, and charging £9 10s. for two weeks. The patients are mostly attended by doctors.

Intermediate Facilities.—There are no hospitals of the intermediate type.

Hastings.

Public-hospital Facilities.—The Soldiers' Memorial Hospital maternity annexe contains fourteen beds, and is a training school for six maternity nurses. It is run on the community system, and gives special facilities for post-natal observation, three beds being available for this purpose. A considerable number of cases are attended by the matron, the medical officer of the annexe being available in case of necessity. Nembutal and chloral, with chloroform at the end of labour, are the means employed for pain-relief.

Private-hospital Facilities.—There are two private hospitals in Hastings. They are efficiently run, and charge from £4 4s. to £6 6s. per week.

Provision for Abnormal Cases.—Facilities for those cases which cannot be dealt with otherwise are available at the Memorial Hospital in Hastings and at the Napier general hospital.

The Committee was informed that febrile cases are usually transferred from the Hastings annexe to the Napier general hospital, a practice which is not to be commended.

Ante-natal Care.—In Napier adequate private service is general, and the Medical Officer of the hospital attends once a week at the McHardy Home for the benefit of cases to be confined by the matron under the authority of the Board. The Plunket Society also runs an ante-natal clinic in the town, but a certain overlapping between its work and that of the doctors and of the McHardy Home tends to reduce its usefulness, and the consensus of medical opinion is against its continuance. In Hastings ante-natal services are admirably organized, patients who do not wish to book a doctor having access to the clinic at the Memorial annexe.

Provisions for Unmarried Mothers.—The unmarried mother is admitted to both the Soldiers' Memorial annexe and the McHardy Home on the same terms as the married. She is also cared for by St. Mary's Home, a Church of England institution. Only six cases were confined in the last-named home last year, and, as this small number makes it difficult to maintain an adequate standard of service, the Committee recommends that consideration be given to maintaining this home as a rescue home only, and transferring cases to the McHardy Home for confinement.

District Services.—A district nurse is stationed at Hastings and serves an area of some hundred square miles. Her attendance is confined to Maoris.

Maori Conditions.—Maoris in the Hawke's Bay district number over two thousand, and their needs are partially served by a district nurse, who does almost all the ante-natal work among them, as it is difficult to persuade them to attend the clinic. The nurse endeavours to persuade Maori patients to come to hospital for confinement, and they are showing more willingness to do so than was formerly the case. They are admitted without question, and in increasing numbers, to the Hastings annexe, and whenever possible a ward is set aside for them. About sixty were confined in the annexe last year. The nurse confines about two cases per month in their homes, the remainder being confined in Native fashion. Increasing confidence is leading the Maori midwives to summon the nurse when difficulties arise. Birth injuries do not appear to be specially common among the Maoris.

Summary and Recommendations.

Hospital accommodation is adequate in the Hawke's Bay district, and means of transport readily available. The needs of the Maori population are fairly well provided for, and the confidence of the Maoris in European methods is growing. An extension of the district nursing service for both Maoris and Europeans in order to develop domiciliary ante-natal care is commended.

The Committee recommends that abnormal cases occurring in the maternity annexe or private hospitals in Hastings and requiring transfer to general wards of the hospital should be admitted to the general wards of the Memorial Hospital instead of being transferred to Napier.

22. WAIPAWA HOSPITAL BOARD DISTRICT.

From Cape Turnagain for some forty miles north the coast forms the eastern boundary of this district, which is roughly fan-shaped, its western boundary extending for some five miles along the foot of the Ruahine Range. The district comprises the counties of Waipawa, Waipukurau, and Patanga. The principal towns are Waipukurau (with 2,050 inhabitants; population increase 16·28 per cent. during the ten years from 1926–36) and Waipawa (1,157 inhabitants; increase of population 0·52 per cent.). These two towns, and the settlements of Takapau on the southern and Otane on the northern border, are all connected by the railway. The total rural population of the three counties is 7,000 and in the ten-year intercensal period there was a general increase of population amounting to 0·99 per cent. in Waipawa, 12·19 per cent. in Waipukurau, and 23·23 per cent. in Patanga. Roads are good throughout the district, dairy-farming being the main industry.

Waipukurau.

Public-hospital Facilities.—There is no maternity annexe at the general hospital, the Board's maternity hospital being situated at Waipawa, five miles distant. The licensee of the private hospital in Waipukurau is willing to take indigent cases on behalf of the Hospital Board should the need arise, but the Board has not hitherto made any such arrangement.

Private-hospital Facilities.—A private hospital of four beds provides satisfactory accommodation. The charges are £4 4s. to £5 5s. per week.

WAIPAWA.

Public-hospital Facilities.—The Rathbone Hospital of six beds is controlled by the Hospital Board, and is the principal maternity hospital of the district, cases coming from Waipukurau and from outlying districts. At times the hospital is overcrowded, and it is considered that a definite arrangement with the private hospital at Waipukurau would help to prevent this. Sedatives are given in cases attended by doctors.

Private-hospital Facilities.—There is no private hospital in Waipawa.

Intermediate Facilities.—These are provided by the Rathbone Hospital. Single rooms are available at a moderate fee, and attendance by private doctors is allowed.

Abnormal Cases.—Provision is made at the Rathbone Hospital for those that are suitable, other cases being admitted to the Waipukurau General Hospital. These facilities are sufficient.

Ante-natal Care.—Private patients are attended by their own doctors, who report that hitherto there has been marked unwillingness on the part of patients to avail themselves of this service. They are now, however, gradually becoming educated to the necessity of proper supervision. Apart from private attendance, facilities for ante-natal care are deficient in the district, patients who are not being confined by a doctor receiving no ante-natal care whatever. No ante-natal charts are kept at the Rathbone Hospital. The establishment of a more efficient service has been recommended by the Medical Superintendent of the Waipukurau Hospital, who is in charge of both institutions.

District Services.—No district services are at present available. A previous district nursing scheme on a partly voluntary basis collapsed owing to failure of subscriptions.

Provision for Unmarried Mothers.—Unmarried mothers are received into the Rathbone Hospital on the same terms as the married.

Maori Conditions.—The number of Maoris residing in the district is 590. No difficulty is experienced in admitting Maoris to the Rathbone Hospital, and they come in considerable numbers. Isolation facilities being adequate, any skin-conditions can be treated in the hospital, and relations between Maoris and pakehas in this district are particularly friendly. It was suggested that a district nurse, employed by the Board to keep in touch with Maori maternity cases at Porongahau and Herbertville, would be very helpful, the doctors in these areas finding that a considerable difficulty in ante-natal work arises from the fact that Maori patients often conceal their pregnancy until a late period. It is suggested that a Maori nurse of the right type might be the most suitable for this work.

Rural Districts.—Takapau is served by an efficiently run private hospital of two beds, the charges being £5 5s. per week. Ormondville and Norsewood are visited by a doctor twice weekly for ante-natal advice. Patients in outlying districts suffer considerably from neglect in this respect by reason of the distance.

Summary and Recommendations.

Hospital facilities are, on the whole, adequate in this district, though the Rathbone Hospital tends to be overcrowded at times. Ante-natal services leave much to be desired, and early attention to this matter would be of great benefit to the women of the district. The Committee, therefore, makes the following recommendations :—

(1) That the Waipawa Hospital Board be urged to enter into a definite agreement with the licensee of the private maternity hospital in Waipukurau regarding attendance of indigent cases resident in the neighbourhood. This would save patients the five-mile journey to Waipawa in cases of emergency, and would assist in preventing overcrowding at the Rathbone Hospital.

(2) That an improved system of ante-natal care be inaugurated at the Rathbone Hospital to ensure that all patients, whether doctor-attended or not, receive medical attention at least twice during their pregnancy. Owing to the difficulties created by distance, the Committee is of opinion that a branch clinic at Waipukurau would be of great assistance to many patients. The keeping of accurate records is regarded as an important part of the work of the clinic.

(3) That a district nurse be appointed and equipped with a car to give ante-natal care to patients in outlying districts. Since the ante-natal problem in rural areas is largely a Maori problem it is felt that a well-trained and sympathetic Maori nurse would be suitable for this work. The Committee is of opinion that the nurse should be maintained and controlled by the Hospital Board, and does not favour district services run on a voluntary or partly voluntary basis.

23. DANNEVIRKE HOSPITAL BOARD DISTRICT.

From Herbertville on the coast the district extends inland to the Ruahine Range. Its shape is roughly triangular, the counties of Woodville and Dannevirke forming the base of the triangle and the small County of Weber its apex. The only towns of any considerable size are Dannevirke with 4,385 inhabitants and Woodville with 1,031. The total rural population of the three counties is 7,500. During the ten-year period from 1926 to 1936 an increase of 6·37 per cent. in the population of Dannevirke County has been offset by a decrease of 0·24 per cent. in Woodville and 11·27 per cent. in

Weber. During the same period the population of the Town of Dannevirke increased by 2·91 per cent., while that of Woodville decreased by 5·33 per cent. Norsewood and Ormondville in the north are settlements largely inhabited by the descendants of Scandinavian immigrants. Dairy-farming is the main industry of the district. The towns of Woodville, Dannevirke, and Ormondville are connected by the railway, and road communications throughout the district are good.

DANNEVIRKE.

Public-hospital Facilities.—A public maternity annexe is under construction at the general hospital. It is the expressed wish of the local medical practitioners that this annexe should be open to all doctors practising in the town, and the Committee concurs in this suggestion. At present the Hospital Board pays a fee of £6 6s. for two weeks to the private hospitals for indigent patients.

Private-hospital Facilities.—There are two private hospitals of seven and four beds respectively, both of which belong to doctors, the licensees paying a monthly rental. Fees are from £4 15s. to £6 6s. per week. Equipment and accommodation are adequate. Sedatives are generally used.

Intermediate Facilities.—These are non-existent.

WOODVILLE.

No public facilities exist here, the needs of the district being adequately served by a three-bed private hospital, which is seldom overcrowded. The fees are £9 9s. for two weeks. No special arrangement exists for indigent patients. Formerly the Dannevirke Hospital Board paid £3 3s. per week for such cases, this fee being later reduced to £3 for a fortnight. Subsequently cases occurred for which no payment was made, but no claims have been made for the past eighteen months owing to the improved economic conditions. The hospital would not be a paying proposition were it not for the fact that it is the private residence of the licensee's parents, and that the produce from a farm helps to pay expenses.

Maori Conditions.—The Maori population of the district is 854. The district nurse does all ante-natal work among the Maoris, but does not possess a sphygmomanometer. She feels that the Maoris are gradually becoming educated to the necessity for this work. Most cases are confined in Maori fashion in the pas, a few going to hospital at Waipawa. In the event of medical assistance being required in a pa this is paid for by the Health Department on the nurse's recommendation. The nurse herself does very few deliveries, and considers that the erection of a public maternity annexe at Dannevirke will be a great incentive to Maoris to seek hospital treatment.

Recommendations.

(1) The Committee feels that certain of the present problems of the district will be solved by the opening of the maternity annexe, and recommends that this be run on a community basis.

(2) The Committee considers that the Hospital Board should enter into a definite arrangement with the private hospital at Woodville for the medical and nursing care of indigent cases.

24. WAIRARAPA HOSPITAL BOARD DISTRICT.

The district extends from the south coast to a line running just north of Pahiatua, from the boundary of the Palmerston North Board to the east coast, and is bounded on the west by the Rimutaka and Tararua Ranges. It includes the counties of Featherston, Wairarapa South, Castlepoint, Masterton, Mauriceville, Eketahuna, Pahiatua, and Akitio, and carries a total population of 17,863 males and 16,527 females, principally Europeans. The main town is Masterton with a population of 9,492, other centres are Carterton (2,543), Pahiatua (1,985), Featherston (1,740), Greytown (1,704), Martinborough (1,030), Eketahuna (806), and Pongaroa (422). The total population of the district is 34,390, with practically no variation during the period 1926–36.

There are no public maternity facilities other than those at the Masterton Hospital.

MASTERTON.

Attached to the public hospital is a maternity annexe containing twelve beds, which is under the control of the Matron of the general hospital. There is no resident Medical Superintendent, one of the local doctors, of which there are seven, acting in that capacity. The hospital is an " open " one, each doctor attending his own patients. The balance of the patients are delivered by the midwives attached to the staff, who call in either the resident surgeon or honorary surgeon to abnormal cases. Anæsthetics and analgesics are used to the usual degree.

It is a training school for maternity nurses.

There is an ante-natal clinic, conducted at the hospital by the Sister in charge, which gives some attention to patients booked to enter the annexe, but most of the

patients who engage a doctor receive their ante-natal treatment from their own doctors. There was an average daily occupied bed rate of six, with 157 confinements for the year.

Carterton has two private maternity hospitals providing eight beds, and is situated nine miles from Masterton. There are two doctors here.

Pahiatua has one private hospital providing seven maternity beds, and there are three doctors here. It is forty-three miles north of Masterton.

Featherston, which is twenty-two miles south of the main hospital, has a doctor resident there. A private hospital provided three maternity beds.

Greytown has a private hospital with three beds, and is fifteen miles distant from the main hospital. There is a doctor located there.

Martinborough has four maternity beds provided by a private hospital and also has a resident doctor. It is thirty-one miles from the main hospital.

Eketahuna, with a private hospital providing two beds, is twenty-five miles north from the main hospital. There is one resident doctor.

Pongaroa.—There is a medical association here, and the Hospital Board arranges for a subsidy to be paid through the association to a private hospital with three beds. Pongaroa is about seventy miles from the Masterton Hospital. There is no doctor permanently resident there.

All the above hospitals are staffed by registered obstetrical nurses.

The hospitals for the most part are small and, with one exception, are converted houses. The staffing and equipment are sufficient to enable the medical men to deal conveniently with all maternity patients except the gravest abnormalities requiring surgical intervention. At the present time these have either to be transferred to Masterton or, if they can afford to pay, are dealt with in the surgical wards of the maternity hospitals of Martinborough, Featherston, or the private surgical hospitals in Carterton and Pahiatua.

Though this district is well supplied with medical nursing and hospital facilities for maternity patients, the arrangements fall short of what is desirable, inasmuch as patients unable to pay private hospital fees have to go to the Masterton Public Hospital annexe for their confinements. This necessitates transport, generally after labour has begun, for distances of from nine to seventy miles, although in each instances, in the immediate vicinity, there is a private hospital which could admit them.

The present system has considerable disadvantages, the most obvious of which is the long journey to be undertaken after labour has begun or, alternatively, an early departure from home and a more or less lengthy sojourn in Masterton before labour begins.

Another disadvantage to those who cannot afford private-hospital fees is that while they have received throughout pregnancy ante-natal advice from their own medical man, when the critical time of labour comes they are transferred to the care of a midwife or medical man at Masterton who has had no personal knowledge of the patient's condition throughout pregnancy and in whom the patient is likely to have less confidence and therefore suffer from fear much more than she would if she were still in charge of the local medical man who has been attending her.

Minor, but real disadvantages, are the inconvenience and expense to the husband and relatives when visiting the patient at Masterton.

It was stated that of 128 patients admitted to the Masterton Hospital for confinement forty-three were brought into Masterton from other towns and thus were taken out of the hands of their usual medical advisers and past private hospitals in which they could have been attended equally well, in addition to being farther away from their homes than was necessary, with the resultant inconvenience and increased expenditure to their relatives when visiting them. If arrangements were made by the Board to pay for attendance on these patients in the hospital nearest their homes, as is done in some other districts, it would be of considerable advantage.

From the evidence of some of the licensees of private hospitals it was evident that owing to their restricted capital they had been able to provide their hospital with the minimum equipment only and that the meagre returns made it a continual struggle for existence.

If arrangements are not made to assist the smaller private hospitals financially it appears that some of them will probably have to close, in which case women of the district would either have to arrange for domiciliary attendance in their own homes—many of which are unsuitable for the purpose and in which the medical men are unwilling to take the responsibility of attendance on the patient—or a transfer to Masterton, over distances varying from nine to forty miles. An alternative would be for the Hospital Board to build public maternity hospitals in most if not each of the centres named above, but the capital cost of such small hospitals to the Board would be very considerable, probably an average cost of not less than £2,000 per hospital.

This Hospital Board district has but few centres of population not provided with reasonable private maternity facilities. There are, no doubt, difficulties with regard to transport for attending ante-natal clinics for those living some distances from the townships, but the population generally is fairly well-to-do and there was no evidence of any hardship arising from this cause.

Recommendations.

To sum up, the Committee strongly recommends that the Hospital Board should make arrangements—

(1) For the respective local medical practitioners to undertake at a fixed fee the ante-natal and post-natal attention of the poorer patients living elsewhere than in Masterton.
(2) For the attention of patients during labour by a medical man.
(3) For the admission of patients to the hospital, public or private, nearest to their place of residence, the Board being responsible for the fees when necessary.

25. TARANAKI HOSPITAL BOARD DISTRICT.

The Taranaki Hospital Board serves a long coastal belt of North Taranaki from Opunake in the south to the Mokau in the north. The district is essentially a pastoral one, with New Plymouth (16,424) as its main business centre and port.

Waitara (1,806) has large freezing-works. Opunake (1,039) and Inglewood (1,254) are smaller country centres.

The roads are good, but some of the settlements at the north end of the area are rather remote from the centres.

There has been a moderate increase in the population of this area during the ten-year period 1926–36.

New Plymouth.

Public-hospital Facilities.—In New Plymouth there are no public maternity hospital beds for normal cases either under the control of the Hospital Board or under the control of the Department of Health.

The Board accepts responsibility for indigent maternity cases, after application and investigation, by subsidizing certain of the private maternity homes at the rate of £3 3s. per week.

A fee of £3 3s. is paid to the doctor when medical aid is considered necessary at the confinement. About forty cases are dealt with in this manner each year.

Most of the abnormal midwifery cases of the district are dealt with in the New Plymouth Hospital, but it is the opinion of the obstetrician in charge of these cases that the conditions of staffing and accommodation are not satisfactory.

Strong representations were made to the Committee by members of the medical profession and by representatives of women's organizations in favour of the establishment of a proper maternity annexe in association with the New Plymouth Hospital, in charge of a competent obstetrician and capable of dealing with both normal and abnormal cases. They advocate that such an annexe be an " open " one in which private practitioners could attend their own cases.

Private Maternity Hospitals.—Private maternity hospital accommodation is, on the whole, satisfactory, although none of the homes is sufficiently large to allow a night nurse to be maintained.

The number of beds is quite adequate, the wards are pleasant, and the fees are moderate.

Ante-natal Care.—There is a small Plunket ante-natal clinic, but most of the medical men of the district are strongly of the opinion that in private cases the doctor should be entirely responsible for the ante-natal care of his patients; the independent Plunket type of clinic is therefore not generally favoured.

A hospital ante-natal clinic in association with a maternity annexe is, however, considered desirable.

It was the opinion of the Committee that at the present time the community as a whole was not as adequately served in regard to ante-natal attention as many towns of a similar size in which ante-natal clinics were operating.

District Services.—There is no organized district maternity nursing amongst Europeans.

Most of the doctors use both anæsthetics and analgesics.

Waitara.

The maternity facilities at Waitara cannot be regarded as adequate. There is at present only one small private maternity hospital with three beds, working under considerable difficulty.

The district is not a wealthy one, and it is difficult for private enterprise to maintain an efficient service.

A public maternity hospital annexe at New Plymouth would afford some assistance, but the Waitara district itself is large enough to make some publicly assisted local provision desirable.

A further reason for advising this course is the necessity for making provision for the considerable number of Maoris resident in the neighbourhood; fuller reference is made to this point in discussing the Taranaki Maori position generally.

INGLEWOOD.

Inglewood has one small private maternity hospital, registered for four beds, working under the conditions usual in similar small country towns. The number of cases for the year was sixty-two and the average number of occupied beds was 2·3.

There is an arrangement with the New Plymouth Hospital Board for the treatment of indigent cases in this hospital; this works satisfactorily, but is not often called for.

OPUNAKE.

There is in Opunake a very satisfactory six-bedded maternity hospital which serves the needs of the district well. Some eighty to ninety cases are conducted there each year, the average number of occupied beds being about 3·5. There is very little domiciliary midwifery.

Originally built by the New Plymouth Hospital Board as a "mixed" cottage hospital, it was run for a number of years at a considerable loss.

It is now leased to a midwife, who receives a subsidy of £250 per year from the Board, in return for which she must accept all cases seeking admission. Private fees are charged by her to those able to pay.

The midwife is competent to take, and does take, patients on her own, but the majority of the patients are attended by either of the two local doctors.

In the case of indigent patients, if medical assistance is required, the midwife in charge of the hospital calls in one of the local doctors and is responsible for his fee (fixed by the Board under these circumstances at £3 3s.).

A small ante-natal clinic is associated with the hospital and it appears to be reasonably well attended. The doctors do most of the ante-natal supervision of their private patients at their surgeries.

Pain-relief measures appear to be used to the average extent; in the case of "no-doctor" patients chloroform is given by the Murphy inhaler method.

In general, the service works well. There is, however, one difficulty in this subsidy system—the onus of deciding who can pay and who cannot is left entirely to the midwife in charge.

In this particular instance there is another point about the administration which the Committee regards as unsatisfactory; the midwife is responsible for the doctor's fee when his assistance is called for in indigent cases.

It is stated that allowance has been made in the subsidy to cover such cases, but the Committee considers that it is unfair and objectionable to place this responsibility on the nurse, and it is recommended that in such cases the fee should be paid directly by the Board as is the usual practice elsewhere.

Summary and Recommendations.

(1) *New Plymouth.*—It is the opinion of the Committee that a very strong case can be made for the establishment of a maternity annexe at the New Plymouth Hospital on the lines already indicated.

It seems anomalous that, while in the much smaller adjacent district of Stratford good, modern maternity facilities are available at low cost, in New Plymouth there are no such advantages.

The plan of subsidizing the private hospital for attention to indigent patients serves a useful purpose under certain circumstances, but has definite disadvantages. The necessity for application beforehand for this relief is repugnant to many women. There are also in all communities a considerable number of women who, though not actually indigent, find considerable difficulty in making private-hospital provision and in meeting private doctors' fees.

In other districts the St. Helens Hospital or the public hospital annexe meets this need; adjustment of fees can be made without any hardship to private persons and without embarrassment to the patient.

The Committee therefore considers that the maternity services of the New Plymouth district would be greatly improved by the provision of a maternity annexe of ten to twelve beds, with an associated ante-natal clinic. In conformity with the general policy recommended by the Committee, it is advised that an obstetrician be appointed to this annexe for attendance on Board cases, but that the annexe be open to the medical practitioners of the town.

(2) *Waitara.*—It is recommended that a public maternity hospital with a separate ward for Maoris be erected at Waitara.

(3) *Opunake.*—An adjustment of the arrangement for medical treatment of indigent cases is considered necessary.

26. STRATFORD HOSPITAL BOARD DISTRICT.

STRATFORD.

Stratford Hospital Board serves the dairying and sheep farming district of central Taranaki, with Stratford (3,753) as the only large centre of population. Some of the back-country settlements are thirty or forty miles out.

Stratford has shown a 12·32 per cent. increase in population in the last ten years.

The maternity services of Stratford district are very complete. There is a modern maternity annexe of ten beds at the Stratford Hospital. The fee is £3 3s. per week.

Cases not desiring the services of a private doctor are under the supervision of the Medical Superintendent and are actually attended by him at confinement without further fee.

The annexe is also open to patients desiring the services of their private doctors. The hospital charge is the same, and the doctor's fee is a matter of private arrangement.

A well-equipped ante-natal clinic has been organized and appears to be functioning satisfactorily on the usual hospital clinic lines. Hospital Board patients are supervised by the Medical Superintendent, and private patients are referred from the clinic to their own doctors as necessary.

Analgesics, while not as extensively used as in some hospitals, are being gradually introduced.

The annexe is a training school for maternity nurses, but some difficulty is being experienced in getting sufficient pupil nurses—probably because they are attracted to larger training schools.

Private-hospital provision is available in the maternity wing of a "mixed" hospital owned by two local doctors. The hospital fee is £4 4s. per week, and the wards are roomy and attractive. The doctors in charge of this hospital have been pioneers in the wider use of pain-relief measures, and prefer to do all their own ante-natal supervision.

The extent to which hospitalization is practised in this district is indicated by the figures for the year ending 31st May, 1937:—

In public hospital annexe	111 cases.
In the private hospital	95 cases.
In midwives homes	23 cases.
In private homes	3 cases.

Domiciliary attendance of either public or private type does not, therefore, present any problem.

Summary.

The Committee considers that the arrangements in this district are admirable and an example to many in that a complete service within the means of all classes is available—public, intermediate, and purely private facilities of very satisfactory type are provided.

27. HAWERA HOSPITAL BOARD DISTRICT.

The area covered by this Board includes the larger part of South Taranaki dairying district and a good deal of rough back-country where the residents are engaged in sheep-farming and some timber-milling.

The larger centres of population are Hawera (4,639), Eltham (1,896), Kaponga (406), and Manaia (606).

There has been very little change in the population of this district in the past ten years.

Hawera.

Hawera is a district in which the only public maternity assistance is by way of payment by the Board to the private hospitals of the district for the treatment of indigent cases.

The payment is £5 5s. per case; a fee of £1 1s. in Hawera and £2 2s. in Eltham, Manaia, and Kaponga is paid to the doctor when his services are required in such cases.

About thirty patients per year receive this assistance.

There is no public ante-natal clinic, and the Committee was not certain that these publicly assisted cases received adequate ante-natal supervision.

There are four private maternity hospitals with a sufficient number of beds to meet present needs. Their service appears to be satisfactory, and the fees are moderate (£4 14s. 6d. to £5. 5s. per week). None of the hospitals is large enough to maintain a night nurse.

The total number of beds in these four hospitals is fifteen, and the number of admissions for the year was 216.

The doctors give ante-natal supervision personally, and anæsthetics and analgesics are used to the average extent.

Here again the Committee could not but contrast the incomplete public service given with that obtainable in towns where a maternity annexe was available.

The payment to the private hospitals for indigent cases is hardly a fair one, and the fee paid to the medical men is unsatisfactory.

The general objections to the subsidy system from the patient's point of view are also apparent.

The Committee considers that there is a definite need in a town of the size of Hawera for a public maternity hospital for the benefit both of the indigent and those of limited means. An "open" maternity annexe is recommended.

MANAIA.

Most of the maternity work of this district is conducted in a small private hospital with two maternity beds and two medical and surgical beds. The average number of confinements is sixty per year.

There is one maternity nurse, who takes an occasional single case in her own home. A few indigent cases are taken under the arrangement with the Hawera Board which has already been explained. There is only one doctor in the district, and all ante-natal supervision is given by her.

ELTHAM.

Eltham has good private-hospital accommodation, both in type and in number of available beds. Two "mixed" private hospitals under the control of private doctors have three and four maternity beds respectively. There is also a licensed maternity hospital of three beds under the control of a midwife. Fees average £4 4s. to £5 5s. per week. There are about one hundred and twenty confinements per year in the three hospitals.

Here, as at Stratford, the doctors advanced very reasonable arguments in favour of well-conducted "mixed" hospitals to meet the needs of medium sized towns.

The doctors state that they experienced no difficulty in regard to ante-natal care. Anæsthesia is used in the customary manner, and the use of analgesics varies.

Domiciliary practice is negligible.

The town is in the Hawera Hospital Board district, and that Board's arrangement for the treatment of indigent cases in the local maternity hospitals applies; this assistance is given almost entirely to registered unemployed.

KAPONGA.

There are four maternity beds available in a "mixed" private hospital, and this accommodation appears to be adequate and reasonable for a country district of this size.

About fifty cases are dealt with each year. There is practically no domiciliary attendance. The Kaponga area is divided between three Hospitals Boards—New Plymouth, Stratford, and Hawera.

The indigent cases for whom the New Plymouth Board are responsible are referred to Opunake, Stratford cases are arranged for in the Stratford annexe, and Hawera Board cases are admitted to the local hospital under the agreement with the Board.

Ante-natal care is capable of further development.

Pain-relief is practised to an average degree.

Recommendations.

(1) The chief need in this district is for proper public maternity hospital facilities in Hawera. The erection of a maternity annexe at the Hawera Hospital is recommended. It is also recommended that this annexe be "open" to the medical practitioners of the district.

(2) Meantime it is considered that some adjustment of the fees payable to private hospitals and doctors for attendance on indigent cases is desirable.

(3) It is also recommended that indigent patients resident in the Stratford district, but being nearer to and usually attended by the medical practitioner in Kaponga or Eltham, should have the right of admission to the private hospitals, the responsibility for the fees being that of the Stratford Hospital Board.

28. PATEA HOSPITAL BOARD DISTRICT.

This small Hospital Board serves a district very similar to that of Hawera, which it adjoins to the south. It includes the towns and vicinity of Patea (1,309) and Waverley (684), and a considerable area of sparsely populated back-country.

PATEA.

The Patea Hospital Board controls a maternity annexe of six beds which could serve the district adequately, but which it is not fully meeting the need on account of the system under which it operates.

The hospital fee is £5 5s. per week, reducible to £4 4s. per week if paid in advance or by 1s. per day if paid within twenty-eight days. (The rate in the general wards is £3 7s. per week, reducible by 1s. per day if paid in twenty-eight days.)

Although it was stated by the Board that women could go to the annexe and be attended without a doctor, in actual practice the Superintendent, who is the sole practitioner in the district, attends all cases.

No special provision is made by the Board for the medical attention of indigent cases; the doctor therefore has the right to charge his fee to the patient in all cases, and although there is no suggestion that the right is harshly applied and the fee is frequently never collected, yet there is always a certain sense of responsibility involved,

The Committee finds that the anomalous position appears to exist that, whereas the primary function of an annexe should be to make provision for the less well-to-do, in this district a considerable number of women are not using the annexe because of the expense involved, and are being confined at home under unsatisfactory conditions and with only partially trained nursing assistance.

Only thirty-two cases were confined in the annexe last year, approximately half of the total cases of the district. The average number of occupied beds was therefore only 1·2.

The Committee considers that the position would be much more satisfactory if the fee were reduced to that charged in the general wards and if the public maternity service were more definitely developed.

It recommends that the Board should take the responsibility for the medical attendance on the indigent.

In this case, where the Superintendent is the only medical practitioner in the area, it is suggested that the most satisfactory course might be to increase the Superintendent's salary to cover medical attendance on all maternity cases, and for the Board to collect medical fees from those patients able to pay.

Waverley.

There is no public provision for maternity cases in Waverley itself, but a small number of patients go to the Patea annexe and some, from the south end of the district, to the Jessie Hope-Gibbons Hospital at Wanganui.

There is a good private maternity hospital with six beds, in which the two doctors do most of the maternity work of the district. A few cases are attended by the nurse alone, the doctors being prepared to give assistance if necessary. The number of confinements in this hospital in the year was thirty, with an average of 1·2 occupied beds.

Very few cases are attended in private houses.

The doctors state that they do not experience any special difficulty in giving adequate ante-natal care, and the fairly extensive use of pain-relief in labour is general.

Recommendations.

The Committee considers that there are adequate maternity hospital facilities in the Patea Hospital, but that in order to serve the needs of the district alteration in fees and a more definite development of the public maternity service are required.

29. MAORI CONDITIONS—TARANAKI PROVINCE.

The population of the Taranaki Province includes nearly 4,000 Maoris.

In the North Taranaki counties of Taranaki and Clifton (including New Plymouth and Waitara) there are about 1,300 Maoris with Waitara as their centre. In the South Taranaki counties of Egmont (Opunake), Waimate West (Manaia), Hawera, and Patea there are some 2,400 Natives. Practically no Maoris are resident in the central counties of Stratford and Whangamomona.

The living conditions of the Natives generally are very poor.

At the present time most of the Maori confinements are attended in Native fashion by the Maoris themselves, the district nurse or the local doctor being called in only in complicated cases.

The district nurses do a limited amount of ante-natal work among the Maoris, but do very little actual midwifery.

The only hospital that appears to have made a real attempt to meet the needs of the Maoris is that at Opunake, where quite a number of the Natives from the vicinity are now being confined. Patea annexe is open to Maoris, but at the present time is not used by many. A few Maoris have been treated by arrangement with the Boards in the private maternity homes in New Plymouth and Hawera.

A strong plea for a special Maori maternity hospital at Waitara Pa was put forward by the Waitara and New Plymouth medical men and by representatives of the Maoris in the district.

It was suggested that such a hospital could provide proper maternity facilities and yet preserve some of the Maori customs, while at the same time it would avoid the difficulties which are sometimes experienced in hospitals open to both races.

The need for better maternity facilities was also stressed by representatives of a South Taranaki Native Association at Hawera. Suggestions were made in both places concerning the training of more Native women in this work.

Its investigation in Taranaki confirms the Committee in the view that the improvement of the maternity conditions for the Maori women necessitates provision being made for their confinement in public maternity hospitals in all districts where Maoris are resident, and their ante-natal supervision by district nurses working in close co-operation with these hospitals.

The Committee was not, however, in favour of a special Maori hospital at Waitara or elsewhere, believing that such a hospital would have a restricted sphere of usefulness, whereas the policy recommended would afford a much wider service.

It is agreed that separate wards should be provided for Maoris.

It has been shown that in quite a number of cases under proper management a maternity hospital can deal satisfactorily with both Maoris and Europeans without offending the susceptibilities of the patients of either race.

As far as Taranaki is concerned, the Committee is certainly of the opinion that Waitara, being such an important Maori centre, a public maternity hospital should be established there; it is considered that provision should also be made in the maternity annexes which have been recommended in New Plymouth and Hawera; it is recommended that if necessary the accommodation at Opunake be extended to meet the increasing needs of the Maoris; and it is thought that the Maoris of the Patea district could be encouraged to use that annexe to a greater extent than is the present practice.

30. WANGANUI HOSPITAL BOARD DISTRICT.

The Wanganui Hospital Board is responsible for a very extensive area in the north of the Wellington Province, including the closely settled pastoral districts nearer the coast and reaching back some eighty or ninety miles into the hilly central North Island country.

Wanganui urban area has a population of 25,312.

The chief inland centres of population are distributed along the line of the Main Trunk Railway and the adjacent main highway, and include Marton (2,680), Hunterville (586), Mangaweka (376), Taihape (2,131), Ohakune (1,320), and Raetihi (1,023).

There are smaller townships along the alternative highway to Raetihi.

The main roads have been greatly improved in the past ten years, but access to some of the back-country settlements is not easy.

There has been no great change in the population of this district in the last ten-year period.

Wanganui.

Public maternity-hospital facilities are provided in the Jessie Hope-Gibbons Maternity Hospital, now under the control of the Wanganui Hospital Board, though originally a St. Helens Hospital. It is conducted as a "closed" annexe to the Wanganui Hospital, and is run on St. Helens lines under the supervision of a part-time stipendiary Medical Superintendent. After a lapse of some years it is once again a training school for maternity nurses. The fees are £2 2s. per week. The number of beds is nominally eleven, but this is frequently exceeded. The number of confinements last year was 243, giving an average of 7·5 occupied beds.

The building itself is an old one, and shows many of the defects of an adapted private residence. With increasing demands for accommodation the point is being rapidly reached at which it will be necessary either to make extensive alterations or to build a new annexe—the latter course would seem to be the wiser one.

In the event of such a new hospital being built the Committee strongly recommends that "intermediate" accommodation be provided by making the hospital an "open" one.

The possibility of retaining the existing building as a rest-home under these circumstances was discussed with the Board.

The hospital ante-natal clinic is working on the usual lines. The difficulties of distance appear to interfere with full attendance in a number of cases.

The Murphy inhaler method of anæsthesia is used, but analgesics are not generally given.

There is no public domiciliary nursing service in Wanganui itself, and although certain representations for the re-establishment of such a service were made by one of the women's organizations, chiefly on the score of lesser expense, it is doubtful if the other considerations in this matter were fully realized.

There are three private maternity hospitals which, with a total of twenty-three beds, provide reasonably for the needs of the district.

The annexe being a "closed" one, there are no intermediate hospital facilities.

Public ante-natal service is also given by the Plunket Ante-natal Clinic, but most of the supervision of private patients is given by the medical practitioners themselves.

Marton.

In Marton, situated thirty-five miles from Wanganui, there are no public maternity hospital facilities, nor is there any arrangement by the Board with the private maternity home for the treatment of poorer patients.

As a result, Marton is one of the few districts in which the district nurse appointed by the Hospital Board does a considerable amount of domiciliary confinement work, partly by herself and partly in conjunction with the local doctors.

One doctor indicated that over a period of nine years rather more than one-third of his maternity cases had been conducted in private homes, mostly with the assistance of the district nurse. Although he spoke highly of her work, he did not consider this an ideal service. There were distinct disadvantages in this type of maternity work, and the opinion was expressed that some publicly assisted hospital provision was definitely to be preferred.

The arrangements for the ante-natal supervision of "no-doctor" cases cannot be regarded as complete; the district nurse is not fully equipped for such service.

The doctors do most of the supervision of their private patients, sometimes with the help of the Plunket Nurse in the less medical aspects of the work.

There is only one private maternity home of six beds, well conducted, but charging fees (£5 5s. to £6 6s.) which are beyond the means of the poorer section of the community. The average number of confinements per year is seventy-one.

The position in Marton is a somewhat difficult one, and typical of a number of medium-sized towns where there is already a private hospital service doing good work, but where there are also a considerable number of women requiring some public assistance.

One solution, of course, is to establish a public maternity hospital. The size of the town would not, however, warrant the building of a hospital of more than six beds. The result would be that neither it nor the private hospital could be developed on the most satisfactory lines; neither, for instance, could economically afford a night nurse.

If some means could be devised whereby those in need of assistance could be enabled to obtain the service of the existing private hospital in a way which would be acceptable both to the patient and to the owner of the hospital, and which would be free from the objectionable features of some of the present subsidy systems, this might prove a more satisfactory and more economical course under such circumstances.

Hunterville.

There are three maternity beds in a "mixed" private hospital, and this accommodation appears to be sufficient. There are about forty cases per year. The fees are £11 11s. for the fortnight. Practically no midwifery is done in the private houses. There is no public institution, and, although it is understood that the Wanganui Hospital Board would pay for indigent patients in the local hospital, this help has never been applied for.

A certain number of patients go to Palmerston North or Wanganui, but more for private and domestic reasons than on account of any financial difficulty associated with local attendance.

Ante-natal supervision is encouraged and patients attend reasonably well, but there are some difficulties of distance.

Taihape.

There is one private maternity hospital in Taihape, licensed for eight beds and dealing with about ninety-five cases per year. Practically all the midwifery of the district is done here, and the service given is spoken well of by the women.

There is no public maternity institution and no district nurse doing midwifery.

The Wanganui Hospital Board is prepared to pay £4 4s. per week at the private hospital for indigent cases, but this assistance has never been asked for because the circumstances were not realized until it was too late to make application.

Although general complaints were made by representatives of a women's organization regarding the cost of confinement, the position as outlined above does not suggest that any great hardship exists.

A plea was made by one of these representatives for a district midwife on the score of cheapness, but here again the Committee doubted whether the relative inadequacy of such a service was appreciated.

Some suggestions were made regarding a maternity annexe at the Taihape Hospital.

The alternative, as at Marton, would be for the Board to make a more satisfactory arrangement for the attendance of the less well-to-do at the private hospital.

Opinions regarding ante-natal care were conflicting. The doctors considered that, in spite of the considerable distances, most patients found it possible, without serious hardship, to make an adequate number of attendances for ante-natal supervision.

The women's representatives, on the other hand, stressed the fatiguing nature and the cost of such attendances.

The Committee is of the opinion that this is a district in which the assistance of a district nurse, trained in ante-natal care, could be of considerable help to the doctors.

Raetihi-Ohakune.

The only maternity-hospital facilities in this district are in the public maternity annexe at the Raetihi Hospital, where there are four beds. There are about eighty confinements per year in this hospital. Accommodation is overtaxed, and extensions are under consideration.

The Hospital Board district nurse does a considerable amount of domiciliary midwifery, partly by herself, but mainly with the doctor, and chiefly on the Ohakune side.

This is another district in which some of the women are faced with the problems of distance from doctor and hospital.

The question of improvement of the existing services is somewhat complicated by the rival claims of Ohakune for local hospital provision.

The two boroughs have much the same population, and Ohakune, being on the Main Trunk line, is more accessible to some of the outlying townships.

At the present time patients from the Ohakune side of the district have to come to Raetihi for hospital attendance, and the doctor from Ohakune has to travel to Raetihi to attend his patients.

The Committee, while sympathetic with the Board's desire to concentrate on one reasonably large unit at Raetihi for economy in working and better staffing, feels that in maternity work nearness to the patient's home and nearness to the doctor of the district are important considerations, and that in this particular case the whole district would be better served by having a maternity home of some description both at Raetihi and at Ohakune.

Although the distance between these two centres—eight miles and a half—does not seem great, public communication services are by no means frequent, and other transport is costly. Under such an arrangement the district nurse would probably be called upon to do much less midwifery in the home and might well assist in taking the ante-natal service to the outlying homes.

Maori Requirements.—There are about four thousand Maoris resident in the counties served by the Wanganui Hospital Board. At Ratana there is a population of 664 Natives and there are several other fair-sized pas in the Wanganui neighbourhood. There are also Maori communities of considerable size at Raetihi and Pipiriki.

There is the skeleton of a Maori maternity service such as the Committee recommends. Both at the Wanganui maternity annexe and at the Raetihi Hospital Maori patients are treated acceptably, and an increasing number of Maoris are seeking admission.

In both cases the only difficulty has been that of somewhat limited accommodation. At Wanganui and at Pipiriki are stationed district nurses to Natives, who visit the various pas and give a considerable amount of ante-natal supervision. There is good co-operation between these nurses and the hospitals at Wanganui and Raetihi.

Both these nurses were firm in their advocacy of hospitalization, and indicated how, by gaining the confidence of the Maoris, it was possible for them to educate the Maoris to the idea of entering hospital.

The Committee sees no great difficulties in the way of gradually extending this service to meet the full Maori needs.

Summary and Recommendations.

(1) *Wanganui.*—The accommodation in the present public maternity hospital (Jessie Hope-Gibbons Hospital) is overtaxed, and to meet future needs the Committee strongly recommends the building of a new maternity annexe rather than the extensive alteration of the existing building. In the event of a new hospital being built it is recommended that it be "open" to the medical practitioners of the city.

(2) *Marton.*—The provision for those requiring public assistance for maternity-hospital attendance is not satisfactory.

The position should be met—

(*a*) By the provision of a public maternity hospital at Marton; or

(*b*) By an arrangement, acceptable to all those interested, for the treatment of such patients in the existing private hospital.

(3) *Taihape.*—There is some lack of provision for those requiring public assistance for maternity-hospital attendance, and the Committee recommends that one or other of the courses advised for Marton be adopted here also.

(4) *Ohakune.*—After full consideration of the alternative the Committee is of the opinion that the needs of the whole district would best be served by the establishment of a small maternity hospital at Ohakune as well as at Raetihi.

(5) The Committee recommends the extension of the Maori maternity service already in evidence in this district, with hospitalization for confinement and ante-natal supervision by district nurses in the homes of the Natives.

31. PALMERSTON NORTH HOSPITAL BOARD DISTRICT.

This important and progressive district has the coast for its western boundary, the line extending from the mouth of the Rangitiki River southward for a distance of forty miles, and including the estuary of the Manawatu River. From the coast the district runs inland in a north-easterly direction, its total length being about ninety miles, and its width varying from ten to twenty miles. The neighbouring districts are Wanganui and Hawke's Bay in the north, Wellington in the south, Wairarapa, Dannevirke, and Waipawa on the east. The district contains several small but thriving towns, the chief town, Palmerston North, being a busy and flourishing centre. Sheep and dairy farming is the main industry. Roads are good throughout the district and, with the exception of Foxton, which is on a branch line, all the chief centres are connected by the main railway-line.

The district comprises the counties of Kiwitea, Pohangina, Oroua, Manawatu, Kairanga, and Horowhenua. The total rural population of the district is 25,265. Its distribution and the percentage increase in the various counties during the 1926–36 intercensal period are shown in the following table :—

County.	Population.	Increase 1926–36.
		Per Cent.
Kiwitea	2,442	2·52
Pohangina	1,350	2·97
Oroua	3,872	5·42
Manawatu	4,965	1·83
Kairanga	5,358	18·95
Horowhenua	7,278	7·46

Particulars of town population are shown in the following table :—

Town.	Population.	Increase 1926–36.
		Per Cent.
Palmerston North	22,202	23·37
Feilding	4,550	6·73
Foxton	1,605	8·81*
Levin	2,658	8·22
Otaki	1,744	12·52

* Decrease.

Palmerston North.

Public-hospital Facilities.—An up-to-date maternity annexe of eleven beds is attached to the general hospital, and is under the control of the Medical Superintendent and an honorary consulting obstetrician. The annexe caters for patients over a wide area, serving, as it does, the whole of the district north of Shannon. Patients residing south of this locality usually go to the Otaki Hospital.

Private-hospital Facilities.—Private facilities consist of four hospitals, providing in all a total of twenty-five beds. Fees are from £4 10s. to £5 5s. per week. Nursing staffs and equipment appear adequate.

Intermediate Facilities.—There are no hospitals of the intermediate type in Palmerston North.

Feilding.

Public-hospital Facilities.—There is no public maternity hospital in Feilding, patients who are unable to pay private fees going to Palmerston North annexe.

Private-hospital Facilities.—Two hospitals in the town, each having four beds and charging £4 10s. to £5 5s. respectively per week, provide the private facilities. Of these, one is an up-to-date hospital, which, on account of its attractiveness, tends to be overcrowded; the other, while less well equipped, is run with reasonable efficiency. The two together, however, would not appear adequate to the needs of the town and surrounding district.

Foxton.

Apart from three midwives who attend patients at their own or the patients' homes, facilities are totally lacking in Foxton. Many cases go to Palmerston North for confinement.

Levin.

Public-hospital Facilities.—There is no public maternity hospital in Levin, patients unable to pay private-hospital fees going to Otaki.

Private-hospital Facilities.—A mixed private hospital with three maternity beds, charging £11 11s. for two weeks, and a home licensed for two beds, provide adequate accommodation for private patients.

OTAKI.

Public-hospital Facilities.—A building which was formerly a general hospital is now used solely as a maternity hospital, and last year dealt with 116 cases. The building is old and inconvenient, but nevertheless serves a useful purpose in the district. It is under control of the sanatorium Superintendent, and the two local practitioners have the right to attend patients in the hospital and to charge their own fees. Patients come to this hospital from Shannon, where there are no hospital facilities, and from all parts of the district south of this locality.

Private-hospital Facilities.—There is no private hospital in Otaki.

Provision for Abnormal Cases.—Abnormal cases are dealt with at the Palmerston North annexe and at the Otaki Hospital. Ambulances, maintained by the Hospital Board, are always available for the conveyance of such cases.

Provision for Unmarried Mothers.—Unmarried mothers are admitted to both the Palmerston North and Otaki Hospitals on the same terms as the married, and the same provisions for ante-natal care are available for them.

District Services.—The Palmerston North Hospital Board employs district nurses, eight in number, covering the whole of its territory. Two stationed in Feilding serve the northern end of the district, and two in Palmerston North serve a radius of ten miles round the city. One nurse is stationed at Foxton, one at Levin, one at Shannon, and one at Otaki. The nurses co-operate with the matrons of the Board's maternity homes at Palmerston North and Otaki, particularly with regard to ante-natal work.

Patients wishing to enter one of these homes can do their booking through the district nurses. The nurses do not attend confinements except in cases of emergency. A charge of 2s. 6d. per visit is made for a nurse's services in medical or surgical cases, but ante-natal attendance is always free. In the event of a district nurse being compelled to attend an emergency confinement a charge of £1 1s. is payable to the Board. The nurses do the whole of the Maori work and the school work of the district in co-operation with the Health Department, the Department making the Board a special grant of £500 per annum for this purpose.

Ante-natal Care.—In no country district in New Zealand is the general public more fortunate in the provision of ante-natal services than in the Palmerston North district. Ante-natal clinics are conducted at both the Palmerston North annexe and the Otaki Hospital. Accommodation in the latter institution requires remodelling, and it is understood that the Board is taking steps in this direction. Patients who are prevented by distance from attending a clinic and who do not intend to book a doctor for confinement are attended by the district nurses, who are well equipped with all necessary articles, including sphygmomanometers. Every effort is made to get medical supervision for every patient on at least one occasion during pregnancy, and in no part of the district need any patient suffer from lack of proper ante-natal care. Ambulances are maintained by the Board and are at the service of all maternity patients should necessity arise. Ante-natal care of private patients by their own medical attendants is general.

Maori Conditions.—The total population of the district is 2,194. The district nurses are gaining the confidence of the Maori women to an ever-increasing degree. In some outlying parts Maoris are still confined at home by Native methods, but this practice is steadily decreasing, the Maoris tending more and more to go to hospital. This fact is well shown in the returns to the Otaki Maternity Hospital, Maori admission having risen from three in 1929–30 to thirty-two in 1936–37.

Summary and Recommendations.

Hospital facilities in the Town of Palmerston North are adequate and up to date, and the district service provided by the Hospital Board is second to none in New Zealand as regards completeness.

At Feilding hospital facilities are inadequate to the needs of the town, and the Committee was informed that it is the intention of the Board to erect a maternity hospital there in the near future.

Considerable discussion was heard by the Committee on the situation at Kimbolton, a farming centre seventeen miles north of Feilding, certain witnesses holding that the erection of a hospital there would be an asset to the district, which at present is devoid of maternity facilities. The opinion of Board members, however, was that the needs of this centre and surrounding districts would be better served by a hospital at Feilding, which would also considerably relieve the Palmerston North annexe. Formerly a district nurse was stationed at Kimbolton, but the work being insufficient to occupy her time she was withdrawn. Weekly visits are now made by one of the Feilding district nurses, who attends ante-natal cases as occasion arises.

The Committee endorses the Board's opinion that the erection of a hospital in Feilding is desirable and that such a hospital would serve the needs of the Kimbolton district better than a small hospital at Kimbolton.

A two- or three-bed hospital at Foxton would be a decided asset to this centre. Encouragement of private enterprise by the payment of an adequate subsidy, or the leasing of a hospital to a private licensee, would be a more satisfactory and economical scheme for this area than an annexe under direct control of the Board.

The needs of the southern portion of the district are well served by the Otaki Hospital. Work here is hampered by old and inconvenient buildings, but it is understood that the Board contemplates making alterations in the near future which will, at least in part, remedy the present defects.

32. WELLINGTON HOSPITAL BOARD DISTRICT.

The district covered by this Board includes the Wellington urban area, the Upper Hutt Borough, and two small counties, Hutt and Makara, which extend northwards to Paraparaumu, some thirty-five miles up the west coast and eastwards some fifteen miles to the Rimutaka Ranges.

The district is a very hilly one, but well roaded, with two main highways leading out of Wellington, one to the north through Johnsonville and over the Paekakariki Hill to the Manawatu, and the other north-eastwards through the Hutt Valley and over the Rimutaka Hill to the Wairarapa.

It is along these two main highways that the extra-urban centres of population are mostly situated; the chief of these are Upper Hutt (3,863), Porirua (2,257), Paekakariki (612), and Paraparaumu (1,069).

The population served and the rate of development in the different areas during the ten-year intercensal period, 1926–36, are indicated in the following table:—

Wellington Urban Area.	Population.	Increase in Ten-year Period.
		Per Cent.
Wellington City	115,368	17·00
Petone Borough	10,864	17·45
Lower Hutt Borough	15,848	100·45
Eastbourne Borough	2,255	23·52
Johnsonville Town District	1,726	33·13
Upper Hutt Borough	3,863	35·54
Hutt County	8,705	29·12
Makara County	4,305	15·76

The striking feature of the development of Wellington and its environs has been the increase in population in the Hutt Valley, particularly in the Lower Hutt Borough.

Wellington, as the seat of Government and a busy commercial and shipping centre, has a population representative of these various interests; Petone is essentially an industrial area; Lower Hutt owes its phenomenal increase partly to the fact that large industries are developing within its bounds, and partly to the fact that, more and more, it is becoming a residential suburb for Wellington.

Johnsonville and Upper Hutt are centres of small farming communities; there are a number of residential areas in the counties of Hutt and Makara, otherwise the residents are mainly engaged in small farming, mostly dairying.

Wellington City.

In Wellington City the trend towards hospitalization of all maternity cases is particularly evident, 90 per cent. to 95 per cent. of all confinements being conducted in maternity hospitals or maternity homes.

Public-hospital Facilities.—Public-hospital facilities for normal cases are provided mainly by the Government St. Helens Hospital Service. The Wellington St. Helens Hospital is administered on the usual lines as a "closed" hospital under the medical supervision of a part-time stipendiary Medical Superintendent, an Assistant Superintendent, and two clinical assistants.

The hospital is carrying out very efficiently its primary purpose as a training-school for midwives and maternity nurses, and is adequately staffed.

The building is not a modern one, but by extensive alterations and additions to equipment all reasonable requirements are met, and the records of the hospital bear witness to the fine service given.

The ante-natal service is organized on sound lines, and a post-natal clinic is being developed.

The use of anæsthetics in labour is subject to the limitations of a "no-doctor" system. Chloroform by the Murphy inhaler method has been used as a routine, but is being replaced by more satisfactory methods of anæsthesia, and other measures of pain-relief are being cautiously extended.

The institution has averaged about 550 confinements per year for the last eight years. The number of beds is twenty-eight, and the average number of occupied beds last year was 22·7.

The accommodation is barely sufficient for present needs, and it is evident that in the near future either the St. Helens Hospital will have to be extended or alternative public provision will have to be made by the Hospital Board.

With an efficient St. Helens service existing, the Wellington Hospital Board has not up to the present felt obliged to make any provision for normal maternity cases, except that, through its Social Welfare Department, financial assistance has been given to a small number of indigent cases to meet partially the costs of confinement in one of the existing maternity hospitals and that the district nurses working under the Board give occasional emergency help.

An Obstetric Department has, however, been developed at the Wellington Hospital, under an honorary obstetrician and assistant obstetrician, to deal with emergencies and complications unsuitable for treatment in the present St. Helens Hospital or in the other maternity units.

The conditions of accommodation and nursing under which the Department is at present working are not very satisfactory.

There is a very small labour ward, but there is no special ward for the nursing of these cases, most of whom are treated in the general medical and surgical wards; the babies are accommodated in the general children's ward.

There is no separate maternity-trained staff. The Committee was informed by the Board that no provision has been made in the plans of the new hospital for a Maternity Department, though some improvement may result from the release of existing wards.

"*Intermediate*" *Hospital Facilities.*—Wellington is particularly well served in regard to "intermediate" maternity beds, where the patient is able to obtain modern hospital facilities at moderate cost and where she is able to make private arrangements for attendance by her own doctor.

In this instance the provision is made by two philanthropic organizations—the Salvation Army (Bethany Hospital) and the Wellington Women's Christian Association (Alexandra Hospital)—and has been rendered possible by the fact that both these bodies were already operating maternity homes as a social service for unmarried mothers.

Both the Bethany Hospital and the Alexandra Hospital are well-equipped and well-staffed hospitals with attractive wards and fine records for careful service.

Both are training-schools for maternity nurses, and it is interesting to note that the attendance of a number of different doctors does not interfere with training.

Each hospital deals with three types of patient:—

(*a*) Unmarried mothers.
(*b*) Married women not engaging a doctor for the confinement (as at St. Helens).
(*c*) Married women attending with private doctors.

The approximate figures for the year were:—

	Alexandra Hospital.	Bethany Hospital.
(*a*) Unmarried mothers	50	50
(*b*) "No-doctor" cases	70	40
(*c*) Private cases	280	210
	400	300

Analgesics are used quite freely in both these hospitals for patients of all three types; anæsthesia in the case of "no-doctor" patients is limited to the Murphy inhaler method.

Private Hospitals.—There are in Wellington City four private maternity hospitals of eight to twelve beds each, and a few smaller hospitals. The total number of cases attended in these hospitals last year was 670. All are converted private houses, and, speaking generally, the wards are small and the accommodation for staff restricted. Herein lies a definite weakness in the hospital provision in Wellington City. The work of these hospitals is good, but the buildings are not modern in type. Private-hospital enterprise is faced with particular difficulties in Wellington; suitably situated property is difficult to acquire and exceptionally costly. It is a significant fact that while in the last ten or twelve years "intermediate" accommodation has improved markedly in extent and type, there has been practically no alteration in the private hospitals.

There is a need and an opportunity for better private-hospital facilities, but it is felt that only by a combination of interests—medical, nursing, and public—could the requirements for an up-to-date private maternity hospital be met. A satisfactory feature of the Wellington position is the almost complete absence of the ill-equipped and badly staffed one-bed maternity home, this obviously being the result of adequate low-priced modern hospital accommodation being available.

Ante-natal Care.—Very satisfactory provision has been made for ante-natal supervision in Wellington.

St. Helens Hospital, Alexandra Hospital, and Bethany Hospital all have ante-natal clinics staffed by experienced nurses working under the supervision of the medical officer, or, in the case of private patients, of the private medical attendants. No special charge is made for this attendance.

The Plunket Ante-natal Clinic, working in conjunction with the doctors, has given excellent free service, particularly to women who are to be confined in private maternity hospitals or in their own residences. The tendency is, however, apparent in Wellington, as elsewhere, for the doctor to take over the more medical aspects of the supervision to a greater extent.

In many cases the doctors prefer to undertake the full responsibility of the ante-natal supervision of their private patients; the almost universal practice is to include this service in a composite confinement fee.

Ante-natal care is therefore within the easy reach of all women in the city, and there is no excuse for failure to receive this attention. Actually the service is fully availed of, and the unsupervised case is now quite exceptional.

District Nursing.—A district (domiciliary) maternity nursing department has always been a feature of the St. Helens service; indeed, at one time it formed a considerable part of the St. Helens practice. The experience in Wellington and elsewhere is that this service is steadily diminishing, and in the year ending March, 1936, only twenty-seven cases were confined in the St. Helens district. This, of course, is a direct result of the tendency towards hospitalization.

The district service has the merit of low cost and in some respects offers a good field for practical nursing training, but on the other hand it has many disadvantages—conditions in the homes are often very unsatisfactory, it is more difficult to conform to the standards of modern maternity care, and between the visits of the nurse the patient is left with unskilled attention.

The district nursing service which remains is, of its type, quite satisfactory; it has behind it the organization of the St. Helens Hospital, and these outdoor patients have the full ante-natal service available.

The Alexandra Hospital which also, at one time, had a fairly large district practice, has now given up the work and is concentrating on indoor service.

Private domiciliary nursing, where the nurse lives in the home, is also diminishing. Being a main centre, there is naturally less difficulty in obtaining private maternity nurses for this work than is the case in smaller districts; indeed, the main difficulty is for the private maternity nurse to maintain a practice in the face of the present trend towards hospital attendance.

Provision for Unmarried Mothers.—The provision for unmarried mothers in Wellington is very satisfactory, two homes—the Salvation Army Bethany Hospital and the Alexandra Home—being available in which, in addition to receiving confinement attendance, these girls can be cared for both before and after delivery. These institutions take a considerable number of cases from outside Wellington.

The establishment of a married women's service in connection with these institutions has undoubtedly been beneficial in that a high standard of maternity care has been developed in which single women and married women share equally.

Wellington Suburban Areas.

The population of Wellington and its environs is, in the main, so concentrated that, with the exception of the Hutt Valley district, which will be discussed separately, the position of suburban residents does not present any serious problems.

All the main suburbs are within reasonable distance of the city hospitals, public and private, and there are no great difficulties, transport or financial, entailed in full attendance at ante-natal clinics. A few of the small suburbs north of Johnsonville are less favourably placed, but the number of cases in these districts does not warrant local provision.

The Hutt Valley District.

In the Hutt Valley area (including Petone, Lower Hutt, Upper Hutt, and Eastbourne), with a population of about 40,000, there are no local public maternity hospital facilities, and the Hospital Board district nurse does only a very limited amount of domiciliary midwifery.

Patients requiring the St. Helens type of service have to travel to Wellington St. Helens Hospital, a minimum distance of about ten miles. A small number of patients receive financial assistance to the extent of £2 or £3 from the Board to help with private-hospital fees.

The Plunket Society has a branch ante-natal clinic which co-operates with the city hospitals, but frequent visits to the city hospitals for ante-natal supervision are often necessary, at a cost which is a definite burden to many.

Many patients from these districts also attend the Alexandra Hospital and Bethany Hospital. This usually means that it is not practicable for the family doctor to attend, and a city doctor is engaged for the confinement.

Visits by husband and relatives to the patient in hospital must either be curtailed or else involve considerable additional expense.

There are a number of small private hospitals in the district, but the facilities which they can offer admittedly are not as adequate as those in larger and more up-to-date hospitals.

All these disadvantages of distance from modern hospital facilities which are, of course, inevitable in the case of many small communities, do not appear to be necessary or reasonable in a closely settled area like the Hutt Valley. Many of the arguments for concentration of services in one big central hospital do not apply to maternity hospital practice; in many ways it is preferable to have a number of moderate-sized, but well-equipped and well-staffed, hospitals strategically placed to meet local requirements as far as is reasonably possible.

Maori Population.

There are two hundred or three hundred Maoris scattered through the Hutt and Makara Counties, the only settlement of any size being at Porirua Pa (89). There is an increasing tendency for the Maori mothers to come into St. Helens for confinement.

Further ante-natal service through a district nurse would be helpful.

Summary and Recommendations.

(1) *Wellington City.*—In considering the question of a new maternity hospital for Christchurch, the Committee discussed in some detail certain general principles which it believes should be kept in view in the development of the main public maternity hospital in each of the four main cities and put into effect as opportunity affords.

These principles, modified to the needs of the University Medical School, are now seen applied in the Queen Mary Hospital in Dunedin, under Hospital Board administration, and they have guided the Committee in its recommendation for the new St. Helens Hospital in Christchurch, which will be under the control of the Department of Health.

The Committee is of the opinion that the aim should be to develop a similar central hospital, capable of dealing with both normal and abnormal cases, in Wellington, either under the present St. Helens administration or else as a department of the Board hospital. Owing to the very definite advantages of maintaining the present system of midwifery training the Committee favours the continuation of Department of Health control.

The separation of a small unit dealing with abnormal cases from a larger maternity hospital has disadvantages which are clearly apparent in Wellington.

The number of cases is not, and is not likely to be, large enough to warrant the provision of a separate ward with an independent maternity-trained staff.

It is recognized that even with a large combined maternity hospital a certain number of cases with complications in earlier pregnancy and a certain number of cases after confinement would still require to be admitted to the general hospital, but it should be possible to deal with all cases needing attention in labour in the central public maternity hospital of the type advocated.

(2) *Hutt Valley District.*—The Committee regards the provision of a public maternity hospital in the Hutt district as urgently required. It understands that consideration is being given by the Wellington Hospital Board to the claims of this district, and strongly recommends that a maternity hospital should be established by the Board in the Lower Hutt locality to supply the need for both public and "intermediate" service—in other words, an "open" hospital. It is suggested that a hospital of fifteen to twenty beds would cover the present requirements.

(3) The Committee is of the opinion that there is a need and an opportunity for more modern private maternity hospital facilities in Wellington.

33. MARLBOROUGH HOSPITAL BOARD DISTRICT.

The area served by the Marlborough Hospital Board practically corresponds with the Marlborough Province. The Rai Saddle divides it from the Nelson district, and the southern boundary is the Clarence River, eighty-six miles south of Blenheim.

The population of the province is 18,363, with an increase of 2·2 per cent. in the 1926–36 period. The centres included are Blenheim (5,063, increase 1·14 per cent.), Picton (1,361, increase 7·89 per cent.), Havelock (269, increase 44 per cent.), Seddon (324), and Ward (265). The inland portion is mountainous and poorly roaded; elsewhere the roads are good. There are transport difficulties in some parts of the district occasioned by the necessity for launch travel and the crossing of snow-fed rivers at some periods of the year.

The Wairau Valley is rich agricultural land growing mainly wheat and peas. The Tuamarina Valley is concerned with dairying, and the remainder of the country is occupied in sheep-raising. There are several public-works camps in the Rai Valley and towards Kaikoura, and there are a number of Maoris in the Havelock area.

BLENHEIM.

Public Maternity Hospital Facilities.—The Marlborough Hospital Board controls a maternity annexe of twelve beds in which 150 to 160 cases are attended yearly, with an average of 6·2 occupied beds.

Patients come from a radius of sixty miles. The hospital fees are 9s. per day or 12s. per day for a private ward.

The hospital is of the "open" type and is a training school for maternity nurses. The midwife in charge attends fifteen to twenty cases a year without a doctor, all other cases engaging their own doctor.

The Medical Superintendent of the general hospital lectures to the maternity nurse trainees, but does no practical obstetrical work. If an emergency arises in a "no-doctor" case, the Sister in charge calls one of the local medical practitioners, who attend gratuitously. No sedatives or anæsthetics are administered in "no-doctor" cases, and sedatives are used sparingly in other cases.

Ante-natal Care.—An ante-natal clinic is conducted at the hospital. The Sister in charge does all the supervision of the midwife cases and co-operates with the doctors in the care of their patients. The Plunket nurse also does a little ante-natal work, but refers most cases to the hospital clinic.

There are two district nurses attached to the Marlborough Hospital Board; one with headquarters at Picton and the other at Seddon. Representations were made to the Committee that the district nurse stationed at Seddon should be provided with a car, in order that she could give ante-natal care to women in the area between Awatere and the Clarence River, and that similar arrangements should be made for the district nurse stationed at Picton to give ante-natal supervision to the women in her country district.

The need for a waiting home and convalescent home at Blenheim was expressed, and it was also stated that home help was exceedingly difficult to obtain. The suggestion was made that the establishment of training centres for home help in different areas was desirable.

Private-hospital Accommodation in Blenheim.—There is one private maternity hospital in Blenheim with six beds. Ninety-six cases were attended in the hospital last year. The fees are £4 4s. per week. All cases are "doctor-attended" and sedatives and anæsthetics are used. In the opinion of the medical practitioners of the town the private maternity hospital's facilities are sufficient.

Havelock.—There is a cottage hospital at Havelock with four maternity beds. The number of cases for the year was forty-two, giving an average of 1·4 occupied beds. The fees are £4 4s. per week. There is one doctor resident in the district, and his midwifery is practically all done in the hospital.

In cases attended by the midwife alone no anæsthetic is given; in cases attended by the doctor chloroform anæsthesia is used. Some criticism of the conditions of staffing was made to the Committee by representatives of the Women's Division of the Farmers' Union. The Sister in charge has no trained nursing assistance, and therefore, apart from five weeks' holiday in the year, has almost continuous responsibility. There has also been some difficulty in obtaining assistance on occasions when the number of patients exceeded four. The district is widely scattered, and patients have frequently to come by launch from the Sounds, involving considerable expense as well as transport difficulty.

Largely owing to these reasons, very little ante-natal work is done in this area. There are a number of Maoris in the district, but only a few of them are confined in the hospital each year. Maori housing conditions are poor, and to many of the houses there is no water-supply.

The medical practitioner receives a salary for attendance at the hospital and a subsidy from the Health Department for attendance on sick Maoris, but this does not include payment for attendance on maternity cases.

There is also a district nurse to Natives who does general preventive and educational work, but no maternity work.

PICTON.

Practically all the midwifery cases of the district are attended in a five-bed maternity annexe controlled by the Marlborough Hospital Board. The hospital is open to the local doctors, who attend all cases. Sedatives are used sparingly, but chloroform anæsthesia is given in all cases.

Quite a number of Maori patients now seek admission, although they usually stay in hospital only a few days.

The hospital fees are £4 4s. per week. Patients frequently come long distances by launch, involving transport difficulties and considerable expense.

The need for accommodation for waiting mothers was stressed.

Recommendations.

(1) The Committee is of the opinion that the maternity facilities in the Marlborough district are on the whole adequate, but considers that some adjustment of the staffing arrangements should be made at the outlying hospitals, particularly at Havelock, to relieve the Sisters in charge at reasonable intervals and to ensure assistance when the number of patients exceeds the normal.

(2) It is advised that consideration be given to the possibility of utilizing the district nurses to a greater degree in ante-natal work amongst country mothers and that some provision be made for waiting mothers.

(3) It is recommended that definite financial arrangements be made for medical attendance on indigent maternity patients both European and Maori.

34. NELSON HOSPITAL BOARD DISTRICT.

The area served by the Nelson Hospital Board includes the City of Nelson and extends north-west through the Motueka Valley, over the high range of the Takaka hills to the Takaka Valley, and along the coast to Collingwood; the southern boundary is beyond Murchison, eighty miles from Nelson through hilly country.

Nelson is the principal centre. Its population is 11,188, with an increase of 10·5 per cent. in the period 1926–36. The surrounding districts with small towns are Motueka (2,118), Takaka (1,528), Collingwood (1,517), Brightwater (600), and Richmond (1,136).

A rich, closely settled agricultural plain extends twenty miles west of Nelson, and settlement is also close in the Motueka and Riwaka districts, where the rich farming land is mainly used in the growing of fruit, hops, and tobacco. Elsewhere in the country districts the population is scattered.

The country in the vicinity of Murchison suffered very severely in the 1929 earthquake, and the settlers are only now recovering from their losses.

Roading.—Although many of the roads are over very hilly country, access to all parts of the district appears to be reasonably satisfactory. The distance of some of the outlying farming areas from the centre does, however, introduce considerable transport difficulty for those without motor-cars.

Nelson.

Public-hospital Facilities.—The Nelson Hospital Board has provided a maternity annexe with accommodation for fourteen patients. The number of patients attended last year was 198, with an average of 7·6 occupied beds. It is bright, fairly modern in construction, and up-to-date in equipment.

The fees are £4 4s. per week.

Extensions will probably be required in the near future, particularly if the hospital is conducted as is advised on the "open" system. The question of making this hospital an "open" one was discussed with the Medical Superintendent, who can see no serious difficulty other than the necessity for the additional accommodation.

All first confinements and abnormal cases are attended by the Medical Superintendent or the Assistant Medical Superintendent, other cases being attended by the Sister in charge.

Nembutal, and chloroform by the Murphy inhaler, are administered in cases attended by the Sister. Where a doctor is in attendance analgesics and anæsthetics are used to a greater degree.

An ante-natal clinic is conducted at this hospital.

Private-hospital Facilities.—There is one "mixed" hospital taking an average of seven to eight maternity cases a month. The staff on the maternity side of the hospital consists of the lessee, who is a trained midwife, another midwife, and a probationer with experience. The night nurse in the medical side attends to the babies at night.

A new private maternity hospital is contemplated.

Ante-natal supervision is given to private patients by their own doctors.

Brightwater.

There is a small private hospital with three beds in Brightwater doing about twenty cases a year. There is no doctor resident in the township, but doctors attend from the neighbouring towns of Richmond or Wakefield. The fees are £4 14s. 6d. per week.

Richmond.

There is a mixed medical, surgical, and maternity hospital in this township. The lower floor is reserved for the maternity cases, and accommodation is provided for four patients. The two local doctors do practically all their maternity work in hospital. The fees are £5 5s. per week.

Motueka.

Motueka has no public maternity hospital accommodation, but a subsidy of £200 is paid by the Nelson Hospital Board to the larger of the two private maternity hospitals, which is owned by the Board, for the treatment of indigent cases. As is frequently the case under such an arrangement, the classification of indigent cases is indefinite, and the position is not altogether satisfactory either for the nurse or for the patients.

The Board makes no provision for indigent cases to be attended by a doctor if difficulties arise. The hospital has three beds and takes about eighty cases per year.

The fees are £4 4s. per week or £5 5s. per week for a single room.

There is a small Maori population in the district, and four or five Maori confinements take place in this hospital each year.

There is also a small private hospital with three beds, in which all cases are attended by the doctors. The fee is £4 4s.

There is practically no domiciliary midwifery. Patients in the town attend the doctors regularly for ante-natal advice, but full supervision is difficult in the case of women living in the outlying localities.

Takaka-Collingwood District.

The Committee has already reported on the particular difficulties of the Takaka-Collingwood area. The position may be more briefly restated.

Takaka and Collingwood are the two natural centres in a scattered and relatively isolated district whose communication with Nelson is impeded by the steep and difficult road over the Takaka hill.

Collingwood.

District served.—The district surrounding Collingwood branches out in four directions. To the *south* it goes to Onekaka; to the *south-west* to Bainham and the surrounding districts, a distance of fifteen to twenty miles; to the *north* it goes to Puponga, a mining village about seventeen miles away; and to the *west* there are settlements extending down the West Coast as far as fifty miles from Collingwood.

Present Facilities.—The only maternity facilities in Collingwood are provided in the home of an elderly nurse. Though she has rendered excellent service in the past, she is now seventy-five years of age and is not physically able to carry on such onerous work. The patients are required to care for their babies during the night, as the nurse feels herself unable to get up at night.

For the past eighteen months the Nelson Hospital Board has subsidized this nurse at the rate of £50 per year, but it is obvious that, with many of the residents in poor circumstances, no private nurse could earn reasonable wages in such a hospital unless a subsidy of a substantially larger amount were given. About thirty infants are born each year in the district, and a considerable number of women go to other centres for confinement owing to the inadequacy of the existing facilities.

There are no trained maternity nurses or midwives available in the district for domiciliary attendance. A district nurse, subsidized by the Hospital Board, was resident in the district for a time, but she was unable to maintain a practice and left some years ago.

Moreover, even if skilled assistance were always readily available, a large number of the houses in the district, as in all districts, are not suitable for domiciliary maternity attention. The scattered district over which the medical practitioner has to travel also makes attention in the homes extremely difficult.

From all points of view it is clear that the needs of this district cannot be met by any system of domiciliary attention.

The Committee received a number of deputations from representative organizations who stressed their need for adequate maternity institutional facilities in Collingwood.

Recommendations.

The Committee is satisfied that a maternity hospital is urgently needed at Collingwood, and recommends that steps should be taken by the Board to ensure its construction without delay.

The Committee recommends that the hospital be a three-bed one, with one single-bed ward to provide for the temporary admission of an accident case.

The hospital should be of a design and construction and situated on a site approved by the Health Department's technical advisers.

Takaka.

Takaka is also the centre of a fairly extensive district, the maternity needs of which can only be met by the provision of a maternity hospital at Takaka. Unfortunately, the position is complicated by a local dispute between medical practitioners and sections of the public.

The number of confinements at Takaka and district is between thirty and forty per annum.

Existing Institutional Facilities.—The only facility available at present is the home of a maternity nurse, who takes one patient. Previously there was a maternity hospital with four beds, but owing to the local dispute the hospital has been closed and the midwife in charge has given up the license.

The Committee was informed that the Nelson Hospital Board had placed the sum of £2,500 on their estimates for the construction of a maternity hospital at Takaka, but that no further action had been taken in the matter. It was also ascertained that the Nelson Hospital Board has in hand a bequest of approximately £1,200 for the erection of a hospital at Takaka.

Domiciliary Services.—What has been said of the Collingwood district applies equally to the Takaka district; the needs cannot be met by any system of domiciliary attention.

Recommendations.

The Committee is convinced that a public maternity hospital is urgently needed at Takaka, and recommends that steps should be taken by the Nelson Hospital Board to ensure its speedy provision.

Owing to the position existing in Takaka the Committee is convinced that satisfactory public provision can only be made in this way. It is therefore recommended that the bequest of £1,200 should be used, and that a new three-bedded maternity hospital, with provision for the temporary admission of an accident case, be erected at Takaka on a site approved by the Department.

An alternative proposal put forward by members of the Hospital Board for the establishment of a maternity hospital at Onekaka to serve both Takaka and Collingwood districts was regarded by the Committee as entirely impracticable. Whatever the future of Onekaka, it is at present in no way a suitable centre for either area and there is no doctor resident in the locality.

Murchison.

There is a suitable private maternity and general hospital in Murchison with four maternity beds and taking about thirty-five cases a year. The nurse in charge has maintained this service for many years, at times under circumstances of exceptional difficulty.

A subsidy of £250 per year is granted by the Nelson Hospital Board, in return for which all cases must be admitted. The fees are £4 4s. per week.

When there is a doctor resident in the district practically all cases are doctor-attended, but when there is no resident doctor, which is occasionally the case, the nurse conducts the cases on her own and uses ether on the mask for anæsthesia. Sedatives are used when the doctor is attending.

Summary.

As indicated above, the Committee is of the opinion:—

(1) That the Nelson Maternity Annexe should be conducted on the "open" principle and that it should be enlarged to meet the increased requirements, consequent upon that change of policy.
(2) That arrangements should be made by the Board by which any maternity patients for whom the Board is responsible shall have the right to be attended by their own medical attendant in the hospitals at Brightwater or Richmond, the Board being responsible for a reasonable amount of the fees.
(3) That the Board should without further delay provide maternity hospital accommodation at Collingwood and Takaka.
(4) That the subsidy to the medical practitioner at Murchison and the provision of proper housing accommodation should be definitely regarded as the responsibility of the Board and the control removed from the Murchison County Council.
(5) That the subsidies to the Motueka Hospital should be increased and the position regarding those patients unable to pay the fees should be more clearly defined.

35. BULLER HOSPITAL BOARD.

The Buller Hospital Board district is that of the county of the same name and covers an area of 1,951 miles with a population of 10,380. It extends to the boundary of the Nelson Hospital Board district in the north; on the west is bounded by the sea; on the south by a line running from Perpendicular Point round the Paparoa Range to the boundary of the Inangahua County; on the east by the Inangahua and Nelson Hospital Board districts.

The capital of the county is Westport (4,241), and there are also Denniston (717), Granity (558), Millerton (552), and Karamea (780).

The principal industry is mining, with a certain amount of sawmilling.

Westport.

The Kawatiri Maternity Hospital, which is owned and conducted by the Buller Hospital Board, provides twelve beds. The present building was purchased some years ago and has been remodelled. The number of cases confined last year was 145, and the average number of daily occupied beds 5·9. The hospital is staffed by a Matron and three trained obstetrical nurses.

The hospital is open to the doctors of the district, of whom there are three. About half of the confinements are conducted by the Matron, who calls in the Medical Superintendent in the case of abnormalities. The Matron, under instruction of the Medical Superintendent, gives nembutal.

For women who do not engage a doctor the Matron conducts a regular ante-natal clinic, when necessary referring any case to the Medical Superintendent. Cases entering from the surrounding district are generally attended ante-natally by their own doctors, who, in the case of abnormalities, send in reports to the hospital. The fees are £3 3s. a week and £4 4s. for a single room. If a patient's husband is a member of the Buller Medical Association, the contribution of £1 1s. per annum to that association entitles her to free hospital treatment at Kawatiri.

Unmarried women are admitted to and treated in this hospital under exactly the same conditions as married ones.

Evidence went to show that there was need for improved accommodation.

Denniston.

With the Township of Burnett's Face this district has a population of over a thousand people. Denniston is situated on the brow of Mount Rochfort plateau, 2,000 ft. above sea-level. Access is obtained by a steep and winding though good road. Burnett's Face is about a mile farther along the summit of the hill. Practically the whole of the male population is engaged in the coal-mines.

There is a hospital here containing four maternity beds which is conducted and financed by the Medical Association, who receive a subsidy of £250 per annum from the Buller Hospital Board and £100 from the Westport Coal Company.

The resident doctor is Medical Superintendent, and there is a staff of Matron and trained obstetrical nurse.

The ante-natal work is conducted at the hospital by the Medical Superintendent, who is also present at all confinements. Chloroform and ether are given in the final stages of all confinements. No confinements are conducted in the homes.

The fees charged are £3 3s. for the confinement and the doctor's fee is £2 2s.

In the opinion of the Committee the whole formed a satisfactory unit and made good provision for the requirements of the two places. The medical fee was considered inadequate.

Granity, Ngakawau, Millerton, and Stockton.

These four settlements form a group of townships with no hospital accommodation. There is a doctor stationed at Millerton and one at Ngakawau, but only one qualified nurse in the district.

At the present time, since the homes in the townships are unsuitable, practically all the women have to go to Westport for their confinements, and it is admitted that the maternity hospital service available there is good and superior to anything which could be provided locally.

There are, however, distinct disadvantages in this service in that the distance to hospital is considerable, there is added expense to the husband and other relatives when visiting the patient in hospital, and, perhaps most important of all, it is impossible for the patient's own doctor to attend her at confinement.

Karamea.

The Committee was impressed with the urgent need of more adequate facilities for maternity care in Karamea, north Westland. At the end of the road, sixty-five miles north of Westport, the nearest town of any size, with an approach over a long hill, and situated in an area which is liable to be cut off by flooding, this is indeed one of the most isolated districts of its size in New Zealand.

The population is about eight hundred, concentrated mainly around the Township of Karamea.

For many years the residents, largely through the contributions of a local Medical Association, subsidized by the Buller Hospital Board, have maintained a doctor in the district. There are two qualified maternity nurses and one nurse registered under the Act living in the district, but none of these women is practising nursing as a whole-time occupation.

With a doctor available, the maternity needs were reasonably well covered, and the majority of women were confined locally. It was recognized, however, that the private homes were not really suitable and that a maternity home was desirable.

For a time one of these nurses maintained a small maternity home, but for various reasons, including insufficient financial support, she was forced to close it.

During the last two years there has been considerable difficulty in retaining a doctor, and for some time there has been no medical practitioner in the district.

With no doctor, no maternity home, and no midwife in Karamea the women have been forced to go to Westport for their confinements. In some cases this has entailed a long and costly period of waiting in Westport before confinement: in other cases it has meant a sudden journey under trying circumstances.

The main need, as the residents themselves state, is a competent doctor in the district. They also urge, however, the great need of a small maternity home where the mothers could be confined under more satisfactory conditions and saved the expense, anxiety, and discomfort of travelling to Westport. Such a maternity home would undoubtedly be an inducement for a doctor to take up the practice.

Summary and Recommendations.

It was clear from the evidence taken and inspections made that many parts of this district are unprovided for in regard to maternity facilities. Whilst in some of the country townships the resident doctors carried out the ante-natal supervision of pregnant mothers, the distance of the Kawatiri Hospital precluded them from attending the confinements, and the Committee is definitely of opinion that the position calls for early action.

WESTPORT.

As stated previously, Kawatiri Hospital is a house converted into a hospital and is definitely unsuitable to enlarge or improve, and the Committee is of opinion that the time has arrived when a new hospital should be built adjacent to the public hospital. The evidence showed that if additional beds were available more mothers would enter Kawatiri. The sale of the hospital and the section on which it stands would provide money towards the erection of the new hospital.

GRANITY, NGAKAWAU, MILLERTON, AND STOCKTON.

The Committee believes that with a population of three thousand concentrated in these four nearby townships and served by two doctors there is a legitimate place for a small maternity home.

It is recommended that a maternity home of three or four beds be built and maintained by the Buller Hospital Board at Granity, to be staffed by a nurse with both midwifery and general qualifications.

KARAMEA.

The Committee considers that the claims of this community are most justifiable. It is clear that the economic circumstances of the residents and the comparatively small number of maternity cases in the year would not allow of any private provision of the necessary facilities.

It is therefore strongly recommended that a small maternity home be built and maintained by the Buller Hospital Board at Karamea, under the charge of a nurse with midwifery and general nursing qualifications.

36. INANGAHUA HOSPITAL BOARD.

This Board serves the Inangahua County, whose area is 949 square miles and contains the townships of Reefton (1,441) and Waiuta (601), also a number of smaller settlements. It is bounded on the north by the Nelson and Buller Hospital districts and on the south by the Grey Hospital district. On the east is the central range of mountains.

The principal industry in this district is mining.

The public facilities are seven beds in the maternity hospital attached to the public hospital and under the control of the Medical Superintendent, who is the only doctor resident in Reefton. For the year 1936–37 there were eighty-one patients confined, nearly all of whom were attended by the doctor. The fee is £4 4s., but indigent cases are attended free.

Nembutal is used to a limited degree, chloroform being more generally used.

An ante-natal clinic is run by the Sister under the supervision of the Medical Superintendent, who sees every patient. There are no regular days for the clinic, nor are ante-natal records kept.

At Waiuta, which is twenty-six miles distant, there is a resident doctor employed by the Medical Association, and also a Class C midwife, but no hospital.

The doctor attends on the average twelve maternity cases a year. Half of these go to the hospital at Reefton and the other half are confined in their homes on the score of economy. They receive £3 from the Medical Association and £6 from the National Provident Fund. The doctor is financed by the Medical Association at Waiuta and receives £2 2s. for maternity cases. This fee includes all ante-natal work. This basis of payment is laid down by the Medical Association, but the association does not guarantee the £2 2s.

The Committee consider that the needs of this district are satisfactorily met, but regards the fee paid to the medical attendant as unsatisfactory.

37. GREY HOSPITAL BOARD.

The area of the Grey Hospital District is that of the Grey County, 1,594 square miles, containing Greymouth (8,115), Brunner (998), Runanga (1,647), and a further population of 5,698 in the various smaller settlements in the district. The population shows an increase of 19·28 per cent. over the last ten years, most of which has been

in Greymouth. The main industry is that of coal-mining, and a large percentage of the population, outside the Town of Greymouth, is engaged on this work.

GREYMOUTH.

The only maternity hospital facilities in the district are those provided by the "Rewa" Hospital in Greymouth, which is owned and conducted by the Board. It is a ten-bedded hospital, but is not sufficiently large for the requirements of the district, and is often overcrowded. There is, however, a new maternity ward under course of erection at the public hospital, and this will replace the "Rewa" Hospital. Twenty beds are being provided.

The present hospital is open to the medical practitioners of the district, but whereas at the present time there is no Medical Superintendent at "Rewa," when the new annexe is built the Board intends appointing a resident Medical Officer to supervise the maternity work.

The fees charged are £4 4s. per week, in addition to a doctor's fee of £4 4s. when he attends the confinement. A local doctor is called in if a "no-doctor" case presents any abnormality, and if the patient is indigent the doctor receives no fee.

The domiciliary work is done by a fully trained midwife and two Class C midwives.

There are no private hospitals in the district.

There is no ante-natal clinic conducted at the present hospital, and all the medical men supervise the ante-natal treatment of their own patients.

RUNANGA.

This is a mining village eight miles from Greymouth. There is a Medical Association with a membership of six hundred, the members of which are entitled to a maternity benefit of £6 paid from the National Provident Fund to members of all friendly societies. Half the maternity fees are also paid by the association. There are two elderly untrained women who take in patients. About 50 per cent. of the women go to Rewa Maternity Home, and it is probable that when the new hospital is built the majority of women will prefer to go into Greymouth rather than have domiciliary confinements at Runanga.

There are several families at Rewanui, where the Liverpool Mine is situated. Access to the township is difficult, and it cannot be reached by vehicles. The Medical Association pays £5 towards the transport of patients to hospital at Greymouth.

BRUNNERTON-BLACKBALL.

Brunnerton is another mining village eight miles from Greymouth. The present position in this district is that there is a resident doctor subsidized by a Medical Association, but no maternity hospital or registered midwife, and the homes are unsuitable for confinements. The majority of the women are confined in Rewa Hospital at Greymouth.

Recommendations.

The Committee is of the opinion that with a modern maternity annexe at Greymouth the district will be well served. The decision to have the maternity hospital under the charge of a responsible Medical Officer with maternity experience is endorsed, and it is recommended that the annexe be open to the medical practitioners of the town as at present.

The question of providing local facilities at Runanga and Brunnerton is rather a difficult one to decide, but the Committee considers that, with a fully equipped hospital at Greymouth, the tendency will in any case be for that institution to be preferred. It is therefore not regarded as necessary to make local provision in these instances.

38. WESTLAND HOSPITAL BOARD.

The area served by this Board includes the town of Hokitika and a long, narrow stretch of country between the Southern Alps and the west coast approximately twenty miles wide and two hundred miles in length. A good road runs down from Hokitika as far as Weheka, the settlement at the foot of the Fox Glacier, whilst there is much public-works activity south of this point, building roads and bridges, which will finally connect up with the road from Otago.

The population is sparse, being 9,194 for the whole district, 2,689 of whom live in Hokitika, situated towards the northern boundary of the district. This popuation shows an increase of 20·74 per cent. over that of 1926.

The main industry is that of timber-felling and sawmilling, whilst some gold-dredging is also carried on.

In addition to Hokitika, the main settlements are Kumara (500), Ross (400), and Wataroa (350), whilst south of Weheka is a large public-works camp at Bruce Bay, to which frequently the only access is by air or sea.

Hokitika.

The only public-hospital facility is a six-bedded hospital provided by the Board at Hokitika. This hospital is a converted house and is leased to a registered midwife, who receives a subsidy of £150 per annum, which is intended to recoup her for admitting patients who are unable to pay any or only part of the fees, which are £4 11s. per week.

The provision made by this hospital is, however, quite inadequate to meet the requirements of the district, in addition to which the building itself is quite unsuitable for the purpose of a maternity hospital. The hospital is frequently overcrowded, and patients have occasionally to be discharged on the tenth day of their puerperium to make room for those whom it is necessary to admit.

Furthermore, the Committee is satisfied that the subsidy paid the licensee is in no way adequate to meet the purpose for which it is paid. There is no arrangement for the medical attention of patients who are unable to pay, and if the midwife, after engaging to attend a patient by herself, finds it necessary to call in medical assistance she has to depend on the gratuitous service of the doctors. There is no other hospital accommodation either in the town or in the district.

Ante-natal Care.—For the women living out of Hokitika very little ante-natal care is available owing to the lack of transport and the distances to be travelled.

Ross.

There are no facilities whatever in this district, the nearest doctor being at Hokitika, and the cost of a visit of a doctor to Ross is £6 6s. Most of the mothers from here are confined in the maternity home at Hokitika, which is fifteen miles distant.

Wataroa.

This township is seventy miles south of Hokitika, on the main road to the Franz Josef and Fox Glaciers. A doctor is resident here and is paid partly by the South Westland Medical Association and partly by the Hospital Board. There is no midwife in practice, although a retired nurse has been assisting the doctor when available. The distances between settlements are long and, with few exceptions, the houses are unsuitable for confinements, there being no electric light and few other conveniences.

It is considered that a small maternity hospital is urgently needed to serve the district as far south as Waiho (Franz Josef Glacier) and Weheka (Fox Glacier).

Bruce Bay.

Thirty-five miles south of Weheka is the timber-milling settlement of Bruce Bay, the population of which is at present augmented by a large public-works roading-camp. Owing to the fact that some of the bridges are not completed the locality is at times entirely isolated except for aeroplane transport.

The Committee is informed that arrangements have been made by the Public Works Department with the Health Department to build a casualty station. It is considered that provision should be made in this little unit for the treatment of maternity cases.

Summary and Recommendations.

(1) The existing facilities in Hokitika are considered inadequate. It is therefore recommended that a maternity hospital be built in Hokitika, preferably in close proximity to the public hospital. It should either be staffed and managed by the Board itself, or leased to the licensee of the present hospital with a more adequate subsidy than is at present given.

(2) Owing to the fact that the population is so scattered and that the settlements in the south of the district are so far from Hokitika, additional provision is required, and it is recommended that a cottage hospital should be built at Wataroa and that it should be staffed by a registered nurse who is also a midwife, with the necessary domestic assistance. It is advised that it should consist of a two-bedded ward and a single ward, and that it should be used principally as a maternity hospital, but should be able to admit as a temporary measure urgent medical and surgical cases, including accidents, until they can be transported to the main hospital at Hokitika.

(3) The Bruce Bay settlement being so entirely isolated, it is recommended that maternity accommodation be added to the proposed casualty station. It is advised that this should comprise, on the patients' side, casualty and dressing room, waiting-room, two single bedrooms, bathroom, closet, and sluice-room, and, on the staff side, a combined dining-room and sitting-room, kitchen, two bedrooms, bath, W.C., scullery, and combined washhouse and fuel-store.

It is recommended that this small hospital should be staffed by a person registered both as a nurse and as a midwife, together with the necessary domestic assistance.

This should provide all the accommodation necessary for maternity patients who, in normal cases, would be attended by the midwife, and any abnormal case would have to depend on the doctor from Wataroa, whose access at present is by aeroplane.

(4) Regarding transport, it is apparent to the Committee that, owing to the high cost of transport by aeroplane—£12 for the return trip—and the lack of room in the

maternity hospital at Hokitika, or elsewhere, for patients awaiting their confinement, considerable hardship was imposed on those earning moderate salaries or wages. The cost in some cases would be £12 for transport and £12 for attendance in a maternity home, with possibly waiting-time in addition. If the hospital facilities at Wataroa and Bruce Bay mentioned above are provided, the necessity for this expenditure will seldom occur, but when it does, in exceptional cases, the Committee considers that the Hospital Board should be ready, in the cases of those who cannot afford it, to meet these expenses itself.

39. NORTH CANTERBURY HOSPITAL BOARD DISTRICT.

The area served by this Board includes the City of Christchurch, Port Lyttelton, the Banks Peninsula, and a wide belt of mainly level country extending about fifty miles inland from the coast towards the foothills of the Southern Alps, about thirty-five miles south to the Rakaia River, and about 130 miles north to the Clarence River, beyond Kaikoura. The total area is 8,767 square miles. The whole district is well roaded and there are no difficulties of access. Christchurch urban area has a population of 132,282 (including New Brighton Borough, 5,233, and Lyttleton Borough, 3,188). In the ten-year period 1926–36 there has been an increase of 10·66 per cent. in the population of Christchurch City, an increase of 16·62 per cent. in that of New Brighton, and a decrease of 12 per cent. in Lyttelton.

The city population is representative of the business and professional interests associated with the centre of a big farming community, in addition to which there is a large industrial element.

The population of Lyttelton is largely engaged in the activities associated with the shipping of the port.

The area outside Christchurch urban district includes some sixteen small counties with a total population of 32,000. There are no large towns, the main centres of population being Kaikoura (1,338), Cheviot (342), Rotherham (324), Hanmer (542), Waikari (397), Amberley (542), Rangiora (2,621), and Kaiapoi (1,578) to the north; Darfield (492), Oxford (959), and Springfield (372) to the west; Akaroa (670) and Little River (442) on Banks Peninsula; and Leeston (879) and Lincoln (644) to the south.

There has been comparatively little increase in the population of this area in the ten-year period, some slight gains in the northern counties being offset by losses in the southern counties.

The population is essentially a farming one. There are woollen-mills at Kaiapoi and freezing-works at Belfast, and at the present time a considerable number of men are engaged on public works, notably on the railway towards Kaikoura and on the Lewis Pass Road.

Christchurch City.

Public-hospital Facilities.—Public-hospital facilities are at present provided by a St. Helens Hospital under the direction of the Department of Health, and by the Essex Home, an auxiliary hospital controlled by the North Canterbury Hospital Board.

St. Helens Hospital.—The St. Helens service is in great demand, but the present hospital of fifteen beds, inadequately housed in a most inconvenient, old, converted building, is unable to meet the needs. The method of administration is similar to that of the other St. Helens Hospitals. The hospital is a "closed" one, and is under the medical care of a part-time stipendiary Medical Superintendent, who is an obstetric specialist, and three assistant obstetricians, under whom the standard of work, in spite of all difficulties, has been raised to a very high level.

Normal cases are attended by the midwife staff, and the members of the medical staff are called to abnormal cases. Cæsarean sections are performed by the medical staff at the hospital.

The use of sedatives has been considerably extended in the last few years. Syrup of chloral, seconal, and chloroform by the Murphy inhaler method are used in "no-doctor" cases, and other methods of anæsthesia are used when a doctor is present.

The hospital is a training school for both maternity nurses and midwives.

A well-organized ante-natal clinic is attached to the hospital, and there is an extern department doing district work. There were seventy-seven district cases last year, the largest district practice of the four St. Helens Hospitals.

An average of 330 cases has been attended as in-patients in the last five years, with 376 cases last year.

The average number of occupied beds was 13·9.

Essex Home.—The Essex Home has seventeen beds and cares for about 280 cases per year, of whom about thirty are unmarried mothers and the remainder women of limited means. The average number of occupied beds for the past year was 10·8. It was originally opened as a home for single girls, but, with the establishment of other institutions doing work of a similar nature, there was accommodation to spare, and the North Canterbury Hospital Board therefore decided to make provision for destitute women. The need for this branch of work has gradually lessened, and the Board has added a separate brick building designed as a maternity hospital. In this there

is provision made for married women of limited means. The service has been considerably developed during the last few years largely on account of the inadequacy of St. Helens Hospital to deal with all such cases.

The fee is £5 10s. for the two weeks, but this is subject to adjustment.

The hospital is a closed one, and is conducted in much the same manner as St. Helens in that there is a part-time Medical Superintendent who exercises general supervision of the hospital and ante-natal clinic and attends all abnormal cases, while normal cases are attended by the midwife staff.

There is this difference, however, that at the present time the Essex Home is not a training-school, and is therefore staffed entirely by registered midwives and maternity nurses.

The hospital has its own ante-natal clinic. The unmarried mothers are accommodated in the home for some months before confinement and for varying periods afterwards.

Sedatives are not extensively used, and chloroform is given by the Murphy inhaler in "no-doctor" cases.

The buildings are old and in an unattractive environment, and, although excellent work is done there, the accommodation, as at St. Helens, falls considerably short of what is now considered satisfactory maternity provision.

The institution receives an income of about £500 per annum from the Twigger endowments.

Provision for Abnormal Cases.—On account of the absence of facilities elsewhere for dealing with them, a number of complicated and emergency midwifery cases have to be admitted to the Christchurch Public Hospital. No labour ward is provided, and, apart from the Sister in charge of the gynæcological ward in which these cases are nursed, there is frequently no trained maternity staff. The babies have to be accommodated in the children's ward. The conditions under which these abnormal cases have to be treated are therefore far from satisfactory. They constitute a risk to the patients and are a cause of great anxiety to the medical and nursing staff.

"Intermediate" Facilities.—It cannot be said that any modern "intermediate" facilities exist in Christchurch. The Grace Home, conducted by the Salvation Army, in addition to its service to unmarried mothers, does help to a certain extent by admitting at a moderate fee women who desire the services of a private doctor, but this side of the work in Christchurch has not been developed to the same extent as in Wellington.

The Committee understands that some consideration is being given to such an extension.

The home at present deals with about forty unmarried women per year and gives accommodation before and after confinement in such cases. The hospital fee is £6 6s. for the confinement and the lying-in period of two weeks.

Ante-natal supervision is given to the unmarried women by the nursing staff, and these cases are seen by the honorary medical officer at least once and are referred to him more frequently if necessary.

Sedatives are used only occasionally, and chloroform is given by the Murphy inhaler method in "no-doctor" cases.

That there is a definite need for intermediate provision in Christchurch is quite clear; the absence of it is unquestionably the reason why so many small, poorly-equipped maternity homes have persisted in this city, while in some other centres they have been superseded. There are about twenty one-bed maternity homes in Christchurch.

Private Hospitals.—Christchurch has one private maternity hospital of sixteen beds and several smaller hospitals taking from two to eight patients.

In all, eighty-three beds are available in these private hospitals.

The general opinion, with which the Committee agrees, is that this accommodation is not sufficient and that, speaking generally, there is a big need for more modern private hospital facilities.

Ante-natal Care.—Through various channels a very complete ante-natal service is available in Christchurch. St. Helens Hospital and the Essex Home both provide ante-natal care for their patients. The Plunket Society has a large clinic which gives excellent assistance to those patients and those doctors who desire its co-operation.

A considerable number of doctors, especially those who are developing midwifery as a specialty, prefer to take the full personal responsibility of the ante-natal supervision of their private patients.

A certain number of patients with limited means in the outlying suburbs find the cost of making frequent visits to the clinic a burden. The Committee is of the opinion that a system of branch clinics might be of assistance.

District Service.—The St. Helens domiciliary service is still the largest in the Dominion, but even here the number of cases attended in the district has fallen from 156 in 1931 to 77 in 1936. It is quite probable that this relatively large number is due to the inadequacy of the in-patient accommodation.

Any other domiciliary service is of very small proportions.

Provision for Unmarried Mothers.—With two maternity homes—the Essex Home and the Grace Home—taking unmarried women and caring for them both before and after

confinement, their needs are very satisfactorily met. As in other hospitals where a married women's section has been added, the unmarried women have benefited by improvements in technique.

The Committee was inclined to think that the use of sedatives had not been developed as much as in similar institutions in some of the centres.

Christchurch Suburban Area.

The residents of the Christchurch suburbs are served, as far as public-hospital facilities are concerned, by the two central hospitals—St. Helens and Essex Home. The new St. Helens Hospital will serve in a similar but more adequate manner.

Representations were made to the Committee that the position in the New Brighton Borough, which is about six miles from Christchurch, was unsatisfactory. The population is over five thousand, with an increase of 16·61 per cent. in the last ten years, and many of the residents have but limited means. It was urged that there was considerable hardship involved in attendance at St. Helens or Essex Home, and some local facilities were asked for.

The Committee, however, is of the opinion that a public maternity hospital established at New Brighton would necessarily be small and the facilities which it could offer would be so inferior by comparison with those of the nearby large hospital that almost certainly a considerable number of the residents would still come to the city. In Lyttelton, a borough somewhat similarly placed which does have a maternity hospital of five beds, this tendency is already apparent.

The Committee realizes the difficulties associated with frequent attendances at ante-natal clinics, and is of the opinion that they might be overcome by a system of branch clinics in the suburbs working in close co-operation with the main clinic. The provision of a car for the full-time use of the Ante-natal Sister and the extern department would assist this work. Assistance might also be given to these suburban residents for transport to hospital for confinement.

Lyttelton.

Although in the Christchurch urban area, Lyttelton, owing to the fact that it is separated from the city by the barrier of the hills, is situated somewhat differently from the other outlying districts. The Hospital Board has recognized this position by establishing a small hospital at Lyttelton, where there are five maternity beds. That this provision is adequate is indicated by the fact that the average number of occupied beds for the last year was 1·24.

North Canterbury Rural Districts.

An admirable feature of the North Canterbury Hospital Board's policy has been the provision of a large number of small country hospitals to serve the needs of the numerous small counties in its very extensive district. In all of these the maternity requirements have received first consideration.

Rangiora is purely a maternity hospital; the others do varying amounts of medical and surgical work in addition.

The local doctors have the right of private practice in these hospitals, and attend practically all patients. The fees are 12s. per day and 6s. per day waiting-time, subject to adjustment according to the circumstances.

There are eleven of these hospitals maintained by the Board in the rural area of North Canterbury. Their distribution, size, and adequacy to meet the needs of their districts are shown in the following table:—

——	Number of Maternity Beds.	Average Number Occupied Beds.	Number of Cases in Year.
Akaroa	4	0·83	23
Amuri	3	0·66	17
Cheviot	2	1·03	31
Darfield	4	1·18	36
Kaikoura	5	1·75	50
Leeston	6	2·36	76
Lincoln	4	1·57	45
Little River	2	0·28	11
Oxford	3	0·80	22
Rangiora	10	5·12	157
Waikari	6	0·59	18

At Kaiapoi there is a private hospital, mainly maternity, owned by the local doctor, but leased to a nurse. The Hospital Board pays a subsidy of £150 for attention to indigent cases. Of this, £75 is paid to the nurse and £75 is reserved for hospital maintenance. The nurse pays no rent, charges and collects her own fees (£9 9s. for two weeks), but in return for the subsidy must take indigent cases without fee. The doctor attends all cases. A number of Maoris from the neighbouring settlement are admitted, most of whom are indigent cases.

There are no other private maternity hospitals in the district and, owing to the generous provision of public hospitals, there is practically no domiciliary midwifery attendance. Ante-natal care is mostly given by the local doctors, but in some cases as at Kaikoura and Rangiora a number of patients attend the hospital clinics. Sedatives and anæsthetics appear to be used to an average degree.

Maori Conditions.

There are a few hundred Maoris living within a radius of twenty-five miles from Christchurch, the largest settlements being at Tuahiwi (148), Little River, Wainui, and Kaikoura.

The conditions in the Maori homes are fairly satisfactory and compare very favourably with those in the North, the majority of the Natives living in European fashion. There is a growing tendency for these Maoris to come into hospital at Little River and Kaiapoi. The Committee considers that this should be encouraged. At one time there was a special District Nurse for Natives, but during the depression this service was discontinued some years ago. The Committee is of opinion that if it were recommenced the development of ante-natal work among the Maoris would improve the Maori maternity service considerably.

Chatham Islands.

The North Canterbury Hospital Board is also responsible for the hospital service in the outlying Chatham Islands. Four maternity beds are provided in the small hospital there, and ten cases were attended last year. There is one medical practitioner, who supervises these cases.

Summary and Recommendations.

(1) Christchurch City Area.

The position in Christchurch is that although the St. Helens service in itself is excellent and although the Hospital Board has given commendable assistance in dealing with the maternity needs of those with small means, the maternity hospital facilities for both normal and abnormal cases are quite inadequate both in type and in number of available beds.

By instruction, the Committee gave very full consideration to the site and scope of a proposed new St. Helens Hospital, and its opinions and recommendations were incorporated in an interim report which has already been submitted.

It is considered that, since some of these views have a general as well as a local application, it is advisable to quote a considerable portion of that interim report.

The Committee stated :—

> Of the urgent necessity for the improvement of the public maternity hospital provision in Christchurch there can be no argument.
>
> The need has been realized for many years, but for various reasons it has not been found possible to proceed with the erection of a new hospital.
>
> It having been decided to take this work in hand, the Committee was asked to investigate and to advise on various aspects of the project.

I. *The Site.*

The first question investigated was the most suitable site for the proposed hospital. Evidence has been taken from representatives of all those interested in the matter, and various sites examined.

It is clear that the considerations which must weigh in the selection of a suitable position for a maternity hospital are :—

(1) Area.
(2) Environment.
(3) Convenience of access for patients from all parts of the district, particularly for ante-natal and post-natal visits.
(4) Convenience of access to the facilities of the general hospital.
(5) Cost.

It is agreed that, as far as possible, the hospital should be pleasantly situated, but, on the other hand, many sites quite suitable from this point of view alone are definitely unsuitable in other respects.

The site chosen must not only be adequate for immediate needs, but sufficiently large to allow of reasonable extension of the hospital in the future.

In emphasizing the importance of convenient access to the hospital the thought is not so much of the transference of the patients to the hospital at the time of lying-in as of the much more frequent attendances at the hospital clinic which modern maternity care now demands.

The convenience of visitors has also to be considered.

A site reasonably accessible by tram, and at the least possible cost, is obviously desirable.

While not desiring to overstress the value of close proximity to the general hospital, the Committee agrees that in many ways such proximity tends to economy, efficiency, and safety. Although in many respects a well-equipped maternity hospital is a self-contained unit, yet there are occasions on which close contact with the facilities of the general hospital is most desirable. For purposes of X-ray examination, for the fullest utilization of the laboratory services, for full co-operation with the other out-patients departments and for convenience in consultation with physicians and surgeons, there are undoubtedly great advantages in the two hospitals being close together.

Finally, while fully realizing the necessity for studying most closely the cost of any proposed site, the Committee believes that in embarking on a major work of this kind it would be a serious mistake to lose the best site because of a somewhat increased initial cost.

Examining the various proposed sites in the light of these considerations, certain locations on the outskirts of the city were at once ruled out and the choice appeared to rest between :—

(*a*) A site at Addington, owned by the Department of Health.
(*b*) The present St. Helens site, increased by the buying of certain properties at present belonging to the Salvation Army and other owners.
(*c*) The site at present occupied by the St. Andrew's Manse.

All three sites are believed to be adequate in size for present needs.

The St. Helens site and the St. Andrew's site are both quite well situated for access ; the Addington site is less favourably placed.

As to the locality the great majority of witnesses strongly disapproved of the Addington site, situated as it is in a definitely industrial area. The present St. Helens site is open to somewhat similar criticism.

The Committee agrees with the majority of the witnesses who consider that the St. Andrew's site is much the most pleasantly situated.

Finally, the St. Andrew's site presents all the advantages of nearness to the main hospital which have already been discussed.

From every point of view, then, except cost, the Committee considers the St. Andrews site to be the most suitable one.

The question of comparative cost was then discussed in detail and the Committee expressed the opinion that although the cost of the St. Andrew's site was somewhat greater than that of the other properties, this factor did not outweigh the other advantages.

On the question of site the Committee therefore concluded :—

Taking everything into consideration, in the opinion of the Committee the St. Andrew's site is certainly the best one, and the selection of the property is strongly recommended.

The Committee then continued :—

II. *The Scope of the New Hospital's Activities.*

The Committee is of the opinion that the present time affords a valuable opportunity not only for the discussion of the continuation and improvement of the type of maternity service hitherto provided by the St. Helens Hospital, but also for the consideration of a much wider development of the maternity services for Christchurch City. Certain of these matters will be more fully dealt with in the general report, but, in so far as they may have a direct bearing on the type of hospital to be constructed, they are here dealt with in relation to the local position.

(1) *Provision for the Improvement and Extension of the present St. Helens Service.*—This, of course, is the first essential. With sixteen beds the present St. Helens has been totally inadequate to meet the demand. It is evident that, with a modern well-equipped hospital, the demand for beds will be still further greatly increased.

From the evidence presented, the Committee is of the opinion that, for this purpose alone, forty beds should be provided.

(2) *Provision for Obstetrical Emergencies.*—Although comparatively few confinements are now conducted in private houses, and although any reasonably well-equipped maternity home is able to deal with the great majority of its own "booked" cases, there is always a small number of cases which require to be

transferred to a hospital provided with facilities for dealing with special complications. Such cases are at present dealt with in the Christchurch Hospital, but medical witnesses have made it clear that the provision made is quite inadequate.

Two courses are open:—

(*a*) To develop a fully equipped unit for complicated obstetrical emergencies in connection with the general hospital; or

(*b*) To develop this department in association with the proposed new maternity hospital.

As far as Christchurch is concerned, the medical witnesses generally favoured the latter plan.

It is generally agreed that the establishment of one centre in which the main obstetrical activities of the community are concentrated has great advantages.

The Committee, therefore, strongly recommends that provision should be made for the treatment of obstetrical emergencies, other than septic cases, in the new hospital.

For this purpose an additional five to ten beds would be required.

(3) *Provision for the Training of Medical Students.*—The investigation of the Committee makes it clear that the general tendency in New Zealand is towards a system in which every woman will be attended by a doctor as well as a midwife or maternity nurse during pregnancy and labour. That being so, the adequate training of the future medical practitioners of the country is a matter of urgent importance and a responsibility which the community itself must accept.

The problem of providing sufficient clinical experience for medical students in this important subject is a world-wide difficulty, and is an acute one in New Zealand. It is with the greatest difficulty that the very reasonable requirements of the General Medical Council are even approached. Even with the new Queen Mary Obstetrical Hospital in Dunedin the number of cases available will be quite inadequate to meet the needs of all the students.

It is obviously desirable that assistance should be given in this matter in other centres where the hospital facilities, the clinical material, and the special experience of the staff are conducive to efficient training.

It is generally agreed that efficiency in training is greatly promoted where resident facilities are provided in the obstetrical hospital, so that the students can be in the closest touch with all phases of the work.

The Committee considers that this should be a definite function of the main Christchurch Obstetrical Hospital, and recommends that provision should be made for the training of medical students with resident facilities for two students at a time.

(4) *Provision for a Resident House Surgeon.*—The view is widely held that a stage has now been reached in the development of the larger obstetrical hospitals in the Dominion when the provision of a resident house surgeon is necessary to give the fullest service. It is advocated that in such cases a resident doctor with at least one year's experience in a general hospital should be appointed. It is urged that such a house surgeon would be of the greatest assistance to the Superintendent and the other members of the staff in much of the routine work of the hospital, and that there are many directions in which he could be of assistance to the patients—for instance, in the giving of more adequate pain relief than is now possible.

It is also urged that such appointments would be in the interests of the maternity service generally in that they would afford opportunities for the more special training in obstetrics, under experienced supervision, of a number of the best New Zealand graduates.

The Committee is impressed with these recommendations and believes that the contemplated obstetrical hospital in Christchurch will be of such a size as to make the appointment of a resident house surgeon definitely advisable, especially if obstetrical emergencies, requiring close medical supervision, are to be admitted as suggested.

To summarize the recommendations of the Committee:—

(*a*) It is recommended that the St. Andrew's site be selected.

(*b*) It is recommended that forty beds be provided for the extension of the present St. Helens service.

(*c*) It is recommended that the new hospital be developed as the obstetrical centre for the treatment of obstetrical emergencies and that for this purpose at least five to ten additional beds be provided.

(*d*) It is recommended that resident quarters be provided for two medical students.

(*e*) It is recommended that provision be made for a resident house surgeon.

Regarding the old St. Helens site and buildings, the Committee is not in a position to suggest any definite use, but there is a suggestion that the new Nurses' Home on the old site could well be used as a waiting home and creche for children whose mothers are in hospital.

In the above report one very important aspect of the maternity services of Christchurch has, however, not been discussed—the need for modern "intermediate" hospital facilities for people of moderate means who wish to have their own doctor. The possible ways in which this need might be met will be discussed in the general section of this report.

It is contemplated that the new obstetric hospital will supersede the married women's section, at least, of the Essex Home as well as the present St. Helens Hospital. The future of the Essex Home and its work amongst the unmarried mothers will then come under consideration.

If the Essex Home continues to fulfil the functions of both home and hospital for unmarried women only, it is feared that, with the smaller numbers, it would be difficult to maintain the same standard of hospital efficiency.

One alternative is to maintain the Essex Home as a home only, and to transfer the women to the new hospital for the confinement period. It has occurred to the Committee that it might be possible as a second alternative, to arrange with the Salvation Army to take over the whole of this work in Christchurch and at the same time assist them to build a modern maternity hospital in which their married women's section could be considerably extended.

(2) North Canterbury Rural District.

The Committee was very favourably impressed with the maternity hospital service in the North Canterbury rural district. It recommends, however, that the Rangiora Hospital be reopened as a training school for maternity nurses.

It is also of opinion that the reappointment of a district nurse to Natives to give ante-natal service as well as general supervision to the Maoris, is advisable.

40. ASHBURTON HOSPITAL BOARD DISTRICT.

The area served by this Board extends north to the Rakaia River, south to the Rangitata River, twenty miles westwards to the mountain-ranges and eastwards to the sea. The population is approximately 13,000. Ashburton (5,683), Rakaia (1,015), and Methven (1,228) are the principal towns. The whole area has shown a population increase of 7·66 per cent. in the 1926–36 period, and Ashburton itself has developed to the extent of 11·89 per cent. Wheatgrowing is fairly extensive on the flat land and sheep-raising on the higher levels. The district is well roaded, and there appear to be no transport or telephone difficulties.

Ashburton.

The maternity facilities consist of the Malvern Maternity Hospital, an auxiliary of the Ashburton Hospital, and two private hospitals. The Malvern Hospital has ten beds; the average number of occupied beds last year was 5·1, and the total number of patients confined was 136. Until a year ago this hospital was a training school for maternity nurses. The staff now comprises a Matron, two maternity nurses, a hospital aid, a maid, and a cook. Patients come from distances as far as thirty miles both north and south.

The hospital is of the "open" type, and practically all patients are attended by their own doctors. During the last year only two patients were attended by a midwife alone. The Medical Superintendent of the Ashburton Hospital does not attend indigent patients; any patient who has not engaged a doctor must nominate one to be called on in case of complications, but the Hospital Board takes no responsibility for medical fees in such cases.

The hospital fees are £4 4s. per week. Sedatives are generally used, and in "mid wife" cases chloroform is given by medium of the Murphy inhaler.

A few abnormal cases are sent to the public hospital to be attended by the Medical Superintendent. The Sister in charge of the women's ward has her midwifery certificate.

Both the building and facilities at Malvern Hospital are much below the requirements of modern standards.

Ante-natal Care.—The doctors in Ashburton prefer to do their own ante-natal work. The few patients who have not engaged a doctor receive ante-natal supervision at Malvern Hospital, and the Plunket nurse resident in Ashburton gives some assistance mainly in the direction of mother-craft instruction. It was the opinion of several witnesses that the benefits of ante-natal care were not fully appreciated by the women of the district and that some education on these matters would be helpful.

Home Help.—Shortage of home helps was stressed by representatives of the Women's Division of the Farmers' Union.

Methven.

There is a fairly modern cottage hospital at Methven, owned by the Ashburton Hospital Board and leased to a registered midwife. This hospital has four maternity beds and two beds for medical and non-septic surgical cases. A subsidy of £250 per

annum is given by the Board; the lessee is responsible for the upkeep of the whole of the hospital except the building itself, and all indigent maternity cases must be admitted.

The staff consists of the midwife in charge and one maid.

The local medical practitioner sends practically all his maternity cases to this hospital and also attends indigent cases therein free of charge.

The hospital fee is £4 4s. per week.

Representations were made to the Committee that the subsidy was not sufficient.

Rakaia.

Rakaia also has a cottage hospital, owned by the Ashburton Hospital Board and leased to a registered midwife. There are four maternity beds and two beds for emergency general (non-septic) cases. A subsidy of £250 per annum is given by the Board, and all indigent cases must be admitted. The number of maternity cases averages thirty a year. The hospital fees are £4 4s. per week. The staff consists of the midwife in charge, a trained nurse, and two domestics. There is one medical practitioner in the district, who attends all indigent cases free of charge.

The doctor does all his own ante-natal work. Sedatives are generally used.

Recommendations.

The Malvern Hospital, in so far as the building and equipment is concerned, does not by any means comply with modern requirements, and the Committee strongly recommends the building of a modern maternity annexe, near the Ashburton Hospital, to take its place. It is suggested that the hospital should be open to all doctors as at present, but that one of the local medical practitioners should be appointed as medical officer to the annexe for attendance on indigent cases.

It is recommended that consideration should be given to the opening of this hospital as a training school for maternity nurses, instruction being given by the medical officer.

The Committee understands that consideration is being given to the possibility of using the bequest of the late Miss Chalmers for this purpose.

The Committee considers that the salary of the Staff Sister at Malvern Hospital might be raised, and that the subsidies paid to the lessees of the hospitals at Methven and Rakaia should be increased.

When these hospitals were administered by the Board the annual cost was between £600 and £700. In view of this fact the present subsidy does not appear to be an adequate one to meet the costs of maintenance and to give a reasonable remuneration for the services rendered.

41. SOUTH CANTERBURY HOSPITAL BOARD DISTRICT.

The boundaries of this district are the Rangitata River about thirty miles north of Timaru, the Waitaki River about fifty miles south, the sea-coast on the east, and the ranges to the west.

Timaru, the principal centre, has a population of 18,800 and has increased by 12·16 per cent. in the period 1926–36. Other centres are Temuka (1,896), Winchester (479), Geraldine (957), Fairlie (1,041), Waimate (2,314).

The population of Timaru is representative of business and professional interests, associated with a substantial population of retired farmers. The town is also a very popular summer holiday resort. The eastern portion of the district is rich agricultural country and the higher levels are devoted to sheep-raising. The district is very well roaded, and there appears to be no transport or telephone difficulties.

Timaru.

Public-hospital Facilities.—Public maternity hospital facilities are provided by the South Canterbury Hospital Board in a fifteen-bed maternity block. Last year 169 maternity cases were attended, giving an average of 7·7 occupied beds. This block is shortly to be replaced by a new maternity wing.

The hospital is of the "closed" type, under the administrative control of the Medical Superintendent of the Timaru Hospital, with a visiting obstetrician in charge and a resident house surgeon acting under him. A doctor is present at all confinements. In normal cases the house surgeon attends, but in abnormal cases the visiting obstetrician is called or, in his absence, the Medical Superintendent.

Sedatives are used according to medical instruction, and since a doctor is always in attendance a satisfactory degree of anæsthesia can be given in all cases.

The hospital is a training school for maternity nurses.

During the last twelve months it has been possible to have a medical student in residence and to give him the opportunity of delivering a number of maternity cases under supervision.

The hospital fee is £4 4s. per week. Provision is made for unmarried mothers who apply for help, and the Board appears to have an excellent social service committee which makes recommendations regarding indigent cases.

The question of opening the hospital to the local medical practitioners was discussed, but the Medical Superintendent and the visiting obstetricians were not in favour of this course, considering that it would interfere with the training of nurses and introduce different standards of maternity care.

Private Hospitals.—There are three private maternity hospitals—one of eleven beds, one of three beds, and one of two beds. The medical practitioners of Timaru were apparently satisfied that the private facilities available were adequate.

Ante-natal Care.—An ante-natal clinic is conducted by the Sister in charge of the maternity block, supervised by the visiting obstetrician, who sees all patients on one or more occasions. In private cases the doctors prefer to do their own ante-natal supe rvisionand, although the Plunket Nurse gives some advice, there appears to be little co-operation between the nurse and the doctors in this branch of the work.

Country Districts.

An excellent feature of the South Canterbury Board's policy is the provision of small hospitals to serve the needs of the outlying areas. The details concerning these hospitals are given in the accompanying table.

Township.	Number of Maternity Beds.	Average Number of Occupied Beds.	Number of Cases per Year.
Fairlie	4	1·2	39
Geraldine	6	1·9	54
Temuka	6	2·7	83

Every case in these hospitals is attended by a doctor, and the fees are £4 4s. per week, plus medical fees.

Fairlie has one medical practitioner, Geraldine has two medical practitioners and a district nurse who does general work, Temuka has two medical practitioners, and in addition to the public hospital there is one private maternity hospital.

Maoris.—There are about three hundred Maoris living in the Temuka district, some of whom enter the Temuka Hospital for confinement. The Committee had no opportunity of inspecting Maori living-conditions, but evidence was given that many Maoris were confined in their own homes under unsatisfactory conditions. In order to encourage hospitalization, the Committee is of the opinion that a district nurse should be made available to carry on educational work, to give ante-natal care, and to arrange for admission to hospital.

Waimate.

There is no public maternity hospital in Waimate, but the Board subsidizes the lessee of the Waimate private maternity hospital to the extent of £3 3s. per week for all indigent cases. Board patients have averaged eighteen per year during the last three years.

All cases are attended by the local doctors, but no medical fees are paid by the Board for attendance on indigent cases. This hospital appears to be adequate for the needs of the district.

Kurow.

The South Canterbury Board pays one-sixth of the annual cost of maintaining the Kurow Hospital, which is controlled by the Waitaki Hospital Board, but which admits South Canterbury patients from the Hakataramea district.

Summary and Recommendations.

The Committee was impressed with the very satisfactory maternity services provided by the South Canterbury Hospital Board, and is of the opinion that, with the new maternity annexe, the local requirements will be very adequately met.

The Committee endorses the principle of appointing an obstetrician to the Timaru Hospital.

In conformity with its general policy, however, the Committee recommends that the maternity ward be open to the medical practitioners for the treatment of private patients.

42. WAITAKI HOSPITAL BOARD DISTRICT.

The Waitaki Hospital Board area is irregularly triangular in shape with its apex in the Alps at the back of Lake Ohau, about seventy miles from the sea. Its northern boundary is the Waitaki River, and its southern boundary is at Shag Point, forty-five miles distant.

Along the coast the area is gently rolling, well roaded, and the people are engaged in mixed farming, poultry-keeping, and cropping. Inland the country is mountainous, sparsely settled, and satisfactorily roaded, the people being engaged in sheep-farming.

The population inland consists largely of runholders, their employees and those engaged in village occupations.

The population of 17,000 has shown an increase over the last decade of 7·61 per cent., while Oamaru, the largest town and the seat of Hospital Board control, has a population of 7,487, an increase of 6·91 per cent. over the past ten years.

Other centres of population are Hampden, twenty-one miles south of Oamaru (308), and Kurow, forty-four miles inland from Oamaru.

There are eleven medical practitioners in the area—nine in Oamaru, one at Herbert, and one at Kurow.

The only public maternity hospital in the district is at Kurow, which is about half-way between the coast and the Alps. It is a seven-bed hospital (six maternity and one emergency), and is an "open" one. The fees payable to the Board are 9s. a day, the patient being responsible for her own doctor's fees.

Theoretically indigent cases are attended free of charge, but as the local residents are not aware of this, the doctor is left to collect from the patient whatever sum is considered equitable.

The average number of occupied beds last year was 2·1, and the number of cases confined during the year sixty-two.

In Oamaru itself there are four private maternity hospitals supplying twenty-five beds. Indigent patients are sent to a private hospital at the Hospital Board's expense.

A most undesirable practice has been inaugurated by the Waitaki Hospital Board, which lets the provision of maternity care for indigent cases by tender. The contract price, which is £5 12s. 6d. per case, is below cost. The practice of providing such services by tender is most undesirable, for obvious reasons.

Uncomplicated indigent cases are attended by the nurse alone, who can obtain medical assistance from the hospital staff if she considers she needs it.

Ante-natal care for indigent cases is at a minimum, no records are kept and post-natal examination is rare.

In the year 1936–37, twenty-three indigent cases were provided with services.

Pain-relief.—In the Kurow Maternity Hospital, all the cases being doctor-attended, pain-relief approximates that in ordinary private practice. Indigent cases in Oamaru receive pain-relief, which is limited to that possible under nurse-attendance conditions.

Transport facilities are as good as in other well-roaded country districts.

Recommendations.

In the opinion of the Committee the time has come when the Waitaki Board should provide a public maternity annexe in association with the public hospital in Oamaru.

43. OTAGO HOSPITAL BOARD DISTRICT.

This area includes the counties of Waihemo, Tuapeka, Waikouaiti, Peninsula, Taieri, and the City of Dunedin.

It extends from Shag Point in the north-east to the Taieri River in the south, a distance of fifty-six miles, and inland it extends about the same distance.

In the rural area the occupation is, in the coastal area, mixed farming with relatively close settlement, grading into the larger holdings of sheep-farmers inland.

The area is well roaded, but between Palmerston and Dunedin there are two large hills.

The road between Middlemarch and Dunedin, a distance of fifty-two miles, is also hilly and slow travelling.

The population is about 103,000, and changes of population in the several counties over the past ten years have been—Waihemo, decrease of 7·89 per cent.; Tuapeka, increase of 0·86 per cent.; Waikouaiti, decrease of 4·26 per cent.; Peninsula, an increase of 12·81 per cent.; and Taieri, a decrease of 0·43 per cent. Allowing for the influx of visitors to the exhibition in 1926, the population of Dunedin has remained stationary during the same period.

The largest centre of population in the area is Dunedin, with a population of 81,961, including the urban area.

Other centres are—Mosgiel, ten miles south-west of Dunedin (2,105), showing an increase of 12·32 per cent. during the past ten years; Outram, seventeen miles south of Dunedin (372), an increase of 8·5 per cent; Waikouaiti, twenty-four miles north of Dunedin (597); Palmerston South, thirty-six miles north of Dunedin (799), decrease 0·62 per cent.; Lawrence (676), increase 1·65 per cent.; Roxburgh (479), increase 18·27 per cent.; Tapanui (316); Port Chalmers (2,165) shows a decline of population of 15·73 per cent.; Middlemarch (143). The area is served by forty-nine doctors, of whom thirty-eight are in Dunedin, two in Palmerston, two in Port Chalmers, two in Mosgiel, one in Outram, one in Middlemarch, one in Roxburgh, one in Lawrence, and one in Tapanui. The Hospital Board maternity hospitals in the country districts are:—

Palmerston South.—Here there is a five-bedded maternity hospital with an average occupied bed rate of 1·6, and forty-two patients were confined therein last year. The hospital is an "open" one, and all cases, including indigent cases, are "doctor attended."

Middlemarch.—The Louisa Roberts Maternity Hospital at Middlemarch is a four-bedded one, with an average occupied bed rate of 0·84, and twenty-two patients were confined therein last year. There is no doubt that the hospital is rendering valuable service, which must be continued, but there is much to be said for the desire of the Otago Hospital Board to replace it with a smaller institution if an alternative use for the existing one can be found.

Lawrence.—The Tuapeka Hospital has four beds, an average occupied bed rate of 0·99, and the number of confinements therein last year was twenty-six.

Tapanui.—The Tapanui Hospital has three beds, an average occupied bed rate of 1·7, and forty-six patients were confined last year.

Roxburgh.—The Roxburgh Hospital has two beds, its average occupied bed rate is 1·45, and the number of patients confined last year was thirty-eight.

Port Chalmers.—The Port Chalmers Hospital has six beds, an average occupied bed rate of 1·6, and the number of patients confined therein last year was thirty-five. Though the Board owns this hospital, it leases it to a nurse, guaranteeing her a minimum wage of £100 a year.

Indigent cases at Port Chalmers are required to enter the Hospital Board's Maternity Home in Dunedin.

Hospital Fees.—The fees payable in all the country hospitals administered by the Hospital Board are 9s. per day, and the hospitals are administered on the "open" principle. Indigent cases are admitted and arrangements for payment made after discharge. No provision is made for indigent cases other than in Board institutions. There is, however, no smoothly working method of determining indigency.

Dunedin City.

Public Facilities.—Public facilities formerly consisted of the St. Helens and Batchelor Hospitals, but early in the year these were superseded by the Queen Mary Hospital of thirty beds, established and controlled by the Hospital Board. This modern building incorporates features which might with advantage be studied when the erection of other maternity hospitals is under consideration. It adjoins the general hospital, rendering the transport of patients from one institution to the other an easy matter; food is brought from the main hospital kitchen in special containers, and laboratory, X-ray, and other hospital facilities are close at hand. Though at present capable of accommodating thirty patients, the hospital is so designed that accommodation for a larger number could be added at any time, the present theatre, nursery, and clinic facilities allowing for this.

The ground floor of the hospital is occupied by the offices, ante-natal clinic, theatre, and residential quarters for house surgeon and six students, the lying-in wards and nursery being on the first floor, and the quarters for the nursing staff on the top floor.

The ante-natal clinic comprises interview and record rooms and examination cubicles so arranged that teaching can be carried out with the least possible disturbance of the patient's comfort and privacy. The theatre block contains two up-to-date theatres, three single first-stage wards, sterilizing, and sink rooms. It is so situated in relation to the lying-in wards that patients are not disturbed by noises from the theatre. The benefit to students of having comfortable quarters in the hospital building is evident.

The nursery, which faces north and west, is airy and pleasant. Adjoining it is a small, sunny room, the temperature of which can be easily regulated, and which makes an excellent ward for premature babies.

The lying-in wards, containing from one to four beds each, are cheerful and bright. No special provision is made for prolonged isolation, febrile cases being removed immediately to the gynæcological wards of the general hospital.

The hospital forms a compact unit admirably adapted to the purposes of modern obstetric practice and teaching.

Private Hospitals.—There are five private hospitals in Dunedin, supplying fifty beds. They are of varying size and meet reasonably well the needs of those who can afford such services, but the Committee is of the opinion that here, as in other centres, the interests of patients and the practice of obstetrics would be advanced by the provision of more modern private hospital facilities.

Intermediate Hospitals.—A limited amount of intermediate accommodation is provided at "Red Roofs" Salvation Army Maternity Hospital.

Ante-natal Care.—In the country districts ante-natal care is limited to some extent by the distances patients require to travel, and by the fact that in some areas there is not as yet a general recognition by the women of the great value of regular ante-natal supervision. In Dunedin an up-to-date clinic is in operation at the Queen Mary Hospital. Mother-craft instruction is given by the Plunket Society, while ante-natal care is given to a varying extent by the medical practitioners.

Unmarried Mothers.—The Salvation Army Maternity Hospital, "Red Roofs," provides the same good rescue and hospital service as their similar institutions in other towns. The hospital is pleasantly situated and well equipped. Unmarried mothers will also be admitted, if necessary, to the Queen Mary Hospital.

Summary and Recommendations.

(1) The Committee is of the opinion that the public maternity facilities in Dunedin are of a very high order. In the Queen Mary Maternity Hospital are embodied the principles which the Committee has recommended for adoption in the development of a main obstetric centre in each of the large cities.

(2) In Dunedin, as in some other large centres of population, there is a marked deficiency in intermediate facilities for those women who desire to be attended by the doctor of their choice. The development of such a service is most desirable.

(3) The Committee is of the opinion that there is an opportunity for the development of more modern private hospital facilities in Dunedin, as in other large cities.

44. SOUTH OTAGO HOSPITAL BOARD DISTRICT.

The Board's district comprises the Bruce and Clutha Counties, extending from the Taieri River in the north to Chasseland's Mistake in the south, a distance of about seventy miles. The population is approximately 17,000, and is engaged in mixed farming, mining, fishing, and timber-milling. The population of the Bruce County has decreased 4·66 per cent. during the past decade, while that of Clutha County has increased 2·41 per cent. during the same period. The centres of population are Milton (1,423), which shows a decrease of 5·39 per cent. over the past ten years; Balclutha (1,546), an increase of 0·65 per cent.; and Kaitangata (1,375), a decrease of 11·12 per cent.; Clinton (440), an increase of 14·52 per cent.; and Owaka (475).

The number of doctors in the district is six—two at Milton, two at Balclutha, one at Kaitangata, and one at Owaka.

The only public maternity hospital in the district is at Kaitangata, where there is a six-bedded hospital. The average number of occupied beds per day is 2·3, and last year forty-six patients were confined therein, eighteen of them being indigent.

The South Otago Hospital Board endeavours to persuade all its indigent cases to go to Kaitangata, but because of the distances such patients must of necessity travel, and because of transport difficulties this is obviously not satisfactory.

Kaitangata, being a mining town, has an uncertain future, and the present facilities thereat are adequate for Kaitangata and its environs. Analgesics should be used at the Kaitangata Hospital.

The time has now come when public maternity facilities should be provided by the addition of a maternity block to the cottage hospital at Milton. Until such is done the Hospital Board should make provision for ante-natal care and lying-in accommodation for indigent cases at Milton.

Balclutha.

At Balclutha there are two private hospitals supplying nine beds. These are adequate for the needs of the district, but some provision should be made for indigent cases at Balclutha as is suggested for Milton.

Owaka.

At Owaka there is a four-bedded private hospital. It is desirable that the Hospital Board should pay the fees of indigent cases confined in this hospital.

Recommendations.

It is recommended that the Hospital Board should erect a maternity block in connection with the Milton Cottage Hospital and that better provision should be made for those unable to pay private fees at Balclutha and Owaka.

45. VINCENT HOSPITAL BOARD DISTRICT.

This Hospital Board area corresponds with the county of the same name. It extends to the Alps at the back of lakes Hawea and Wanaka and borders on the Waitaki, Maniototo, Tuapeka, Southland, and Lake Counties. Its population of 6,500 is engaged in mixed farming, fruit-farming, mining, and public works. Its centres of community interest are Cromwell (737), which shows an increase of population of 21·22 per cent. over the past decade; Clyde (293); Alexandra (871), with a population increase of 42·79 per cent; Lauder (285); Omakau (382). The area as a whole has shown a population increase of 32·61 per cent. over the same period. The number of doctors in the area is four—one each in Cromwell, Clyde, Alexandra, and Lauder. The only public facility is a public hospital at Cromwell. The bed space is ten, the average number of occupied beds is three, and the number of patients confined therein last year was seventy-two. The fees are £4 4s. per week, no fees being payable to the doctor if he attends at the confinement, but patients pay consultation fees for ante-natal consultations. This is a most undesirable practice, as it discourages adequate ante-natal care. The remuneration paid to the doctor by the Board should cover the cost of ante-natal care and attendance at the confinement by the doctor.

Modern opinion on maternity services recognizes that the best service is obtained and optimum pain-relief can only be given when the doctor gives close supervision to all cases. This is incompatible with a position where the doctor attends only those cases which develop abnormalities in the mechanism of labour. No provision is made for indigent cases outside the Cromwell annexe. Admission there entails long journeys for those resident far from Cromwell, and though the Plunket nurse gives some ante-natal care the amount received is insufficient.

Recommendations.

(1) Arrangements should be made to permit of the admission to Ranfurly Hospital (Maniototo Hospital Board district) of those patients for whom it is more convenient.

NOTE.—This is an instance where closer co-operation between adjoining Hospital Boards is advisable in the interests of the patients.

(2) Improved facilities in the form either of a public annexe or a subsidized hospital should be provided at Alexandra where indigent and other patients could receive attention closer to their homes.

46. MANIOTOTO HOSPITAL BOARD DISTRICT.

This is a sparsely settled farming area bounded by the Waitaki, Waihemo, Taieri, Tuapeka, and Vincent Counties. Its population of 3,000 has increased by 15·19 per cent. during the past ten years. Its centres of community interest are Ranfurly (449), and Naseby, a dying mining town (219). There are two doctors in the district, and both reside in Ranfurly, where there is a public maternity ward of eight beds. The average number of occupied beds is 2·4; the number of patients confined therein last year was sixty-two. The fees are £4 4s. per week wards, and £5 5s. per week single rooms, inclusive of all services. The doctor informed the Committee that he attends all confinements. The patients have free choice of doctor, but as no fees are charged by the doctor and only one of them is paid by the Board for the service the free choice of doctor is theoretical rather than real.

The maternity ward is adequate for the needs of the district. It is well equipped and adequately staffed. Ante-natal work is carried out at the hospital, and although some patients have upwards of forty miles to travel the Superintendent says that they attend regularly for ante-natal care, but not for post-natal examination. The difficulty in obtaining sufficient confinements for the nursing trainees is likely to be accentuated rather than improved as time goes by. Transport and telephone facilities are as good as in other South Island east coast country districts.

Recommendations.

The Committee is of the opinion that the maternity hospital provision in this district is very satisfactory, but recommends that the local doctors be granted the right to attend private patients in the maternity ward and to charge the customary medical fees.

47. SOUTHLAND HOSPITAL BOARD DISTRICT.

This is a very big district, including a large area of sparsely settled country.

It consists of the Stewart Island, Southland, and Lake Counties, extending from Lake Wanaka over to the West Coast, and extending down to the sea in the form of a wedge whose base extends along the coast from the Invercargill side of Riverton to Chasseland's Mistake.

The population of this large district is approximately 64,000, and the people are engaged in gold-mining, timber-milling, mixed farming, and fishing. During the past decade the population has shown the following increases: Southland County, 9 per cent.; and the Lake County, 56·72 per cent.

The centres of community interest and their population changes are:—

Invercargill, 25,772; increase 15·97 per cent.
Bluff, 2,058; increase 26·9 per cent.
Wyndham, 574.
Mataura, 1,500; increase 21·36 per cent.
Gore, 4,635; increase 18·39 per cent.
Winton, 888; increase 2·2 per cent.
Lumsden, 543; increase 1·69 per cent.
Queenstown, 931; increase 15·8 per cent.
Arrowtown, 279.
Pembroke, 292.

The number of doctors in the area is twenty-eight—three at Gore, two at Mataura, one at Wyndham, fourteen at Invercargill, one at Bluff, two at Winton, one at Lumsden, two at Queenstown, one at Arrowtown, and two at Pembroke.

Gore.

There are three private maternity hospitals at Gore—one of six beds and two of four beds each.

Two of them are subsidized £30 each to pay for the admittance of indigent cases. A local committee holds the sum of £765 16s. 7d. which was subscribed by the local citizens twenty years ago for the construction of a maternity annexe at Gore.

A local resident also left £900–£1,000 some years ago to defray the cost of construction of maternity and children's wards.

This money, along with Government subsidy, is held by the Southland Hospital Board and now amounts to about £3,000. These funds should be used to help defray the construction cost of a public maternity annexe at Gore.

Mataura.

Mataura is the seat of the New Zealand Paper Mill's plant, and its population is destined to show steady and gradual expansion. There is a private hospital of three private beds, which meet the present needs fairly adequately.

Wyndham.

The four private beds at Wyndham are all that are required.

Bluff.

At Bluff there is a three-bedded private hospital which receives a subsidy of £50 per annum from the Hospital Board.

Stewart Island.

On the Island there is a district nurse who is a qualified midwife and who attends about six mothers per annum in their own homes.

Winton.

At Winton there is a private hospital of three beds which receives a subsidy of £50 per annum to compensate for caring for indigent cases.

Lumsden.

Here the Board has provided a converted-house hospital, along with a subsidy of £150 per annum. The efficacy or otherwise of this arrangement remains to be proved.

Queenstown.

At Queenstown a private hospital of four beds receives a Board subsidy of £100 a year and is meeting the needs of the district.

Glenorchy.

Glenorchy is an isolated area inland from Queenstown. The residents are engaged in mining and farming. The population is not sufficient to warrant the appointment of a nurse, and it appears that the solution of their problem lies in the construction of a road from Queenstown to Glenorchy.

Pembroke.

The area of the Southland Hospital Board district which lies around Lake Wanaka has but little community of interest with the remainder of the area; indeed, during the portion of the year when snow renders the Crown Range Road impassable, the route to Queenstown from Pembroke lies over the Cromwell Flat, and maternity cases for that area go chiefly to Cromwell.

Invercargill.

Public-hospital Facilities.—In Invercargill there is a twelve-bedded St. Helens' Hospital, which is at times grossly overcrowded.

Structurally it is not capable of providing accommodation for the number of patients which are being admitted. The average occupied bed rate is 10·4, and 285 patients were confined therein last year. It is recommended that a new St. Helens Hospital be erected at Invercargill at the earliest opportunity.

There is no public provision for abnormal cases, and provision for such cases should be made in the new St. Helens block or in a Hospital Board institution.

There is no public provision in Invercargill for those mothers who desire to be attended by the doctor of their choice.

Private Hospitals.—There are four private hospitals in Invercargill, providing nineteen beds. Ante-natal care is provided to a varying extent by St. Helens, the Plunket Society, and medical practitioners.

Unmarried Mothers.—The Victoria Home, which is controlled by a Ladies Committee, meets the needs of unmarried mothers. The institution was commenced forty-two years ago, and since 1906 has provided a maternity ward. The institution is hampered by want of funds. Experience in other centres shows that benefits are conferred on both the unmarried mothers and the controlling organization by combining the functions of an ordinary maternity hospital for married women with the maternity facilities for unmarried mothers. The rescue work, of course, is of necessity kept separate. Victoria Home might well be maintained as a rescue-home, admitting the patients to St. Helens or other hospital for their actual maternity service.

Recommendations.

(1) The present St. Helens Hospital building at Invercargill is regarded as inadequate and it is recommended that a new St. Helens Hospital be erected at the earliest opportunity.

(2) It is recommended that public provision for abnormal cases be made, either in a new St. Helens Hospital or in a ward of the Hospital Board institution.

The need for intermediate hospital services is discussed.

48. WALLACE AND FIORD DISTRICT.

Since the visit of the Committee this large sparsely scattered Hospital Board district has been amalgamated with the Southland Hospital Board area. The population of 12,166 is engaged in mixed farming, timber-milling, and farming, and includes about one hundred Maoris. The Fiord County, which has a population of nineteen, has decreased by 13·64 per cent. in the last ten years, while that of Wallace has increased by 7·68 per cent. in the same period.

The centres of community interest are :—

Riverton, population 908 ; increase 4·13 per cent.
Otautau, population 592 ; decrease 10·17 per cent.
Nightcaps, population 612 ; decrease 5·41 per cent.
Tuatapere, population 550.

Public Facilities.—At Riverton there is a six-bedded Board hospital leased to a nurse. The average number of occupied beds was 1·29 last year, and the number of patients confined therein was forty-one.

No provision is made for indigent cases to receive medical attention, and in the event of abnormal labour these patients are dependent upon the generosity of medical practitioners.

Nightcaps.

At Nightcaps there is another Board hospital leased to a nurse with a small subsidy. The Board's provision of maternity facilities at Nightcaps has been most unsatisfactory, and steps will need to be taken to ensure adequate provision under the new Board. The hospital has three beds and admits twenty-five to thirty cases a year. This hospital serves the needs of the mining township of Ohai, which has a population of 847.

Tuatapere.

At Tuatapere is another Board-owned hospital, leased to a nurse. The Board's management here has been as unsatisfactory as at Nightcaps, and improved provision must be ensured under the new Board. No provision has been made for indigent cases, nor has the lessee been paid a subsidy sufficient to enable her to earn a living wage. The hospital has four beds, and thirty-six patients are confined therein per annum.

Private Facilities.—There is a four-bedded private hospital at Riverton.

Otautau.

At Otautau there are two residences in which maternity services are provided. One is a licensed maternity hospital of four beds.

District Nurse.—There is a district nurse stationed at Otautau. She is an employee of the Riverton Board. She attends the thirty to forty Maori families, which are resident in the district, for general conditions, but she has attended no maternity cases amongst the Maoris.

Recommendations.

(1) That adequate provision should be made for the payment of the medical and nursing services rendered to indigent patients.

(2) That the subsidies to the lessees of the maternity hospitals at Nightcaps, Riverton, and Tuatapere should be increased, and that the equipment in those hospitals should be brought up to accepted standards.

PART II.

1. BRIEF HISTORY OF THE DEVELOPMENT OF MATERNITY SERVICES IN NEW ZEALAND FROM 1882 TO 1937.

The earliest official references to the provision of public maternity services are those appearing in the annual reports of the Inspector of Hospitals, George Wallington Grabham, M.D., to the Hon. the Colonial Secretary. In his first report of 1882 he states:—

"*Dunedin Hospital.*—A small wooden annexe on the north side contains the lying-in department, which consists of two wards, a small kitchen, and a room for the midwife."

Again, in 1883 we read with reference to the same hospital:—

"There are to-day 130 beds occupied—82 by males and 48 by females. Twelve of the latter are inmates of the lying-in wards, where I also saw four infants."

In 1886 he reports, with reference to this ward:—

"I may again point out that the 'lying-in ward' is not well placed for this use. I strongly object to the existence of a lying-in ward as a portion of a general hospital. If needed at all, which I doubt, it should be erected elsewhere in the city."

Ten years later, in 1896, Dr. D. MacGregor, M.A., M.B., Inspector of Hospitals, in his report on Hospitals and Charitable Institutions of the Colony states:—

"The practice of granting midwifery certificates based on mere theoretical instruction ought to be discontinued."

From 1896 to 1901 official records make no reference to any public maternity services. In the latter year a definite step was taken towards organizing nursing services by the passing of the Nurses Registration Act, 1901, and in 1904 this was followed by the Midwives Act. In moving the second reading of this Act the Right Hon. R. J. Seddon said:—

"I claim that the reproduction and preservation of life is one of the first duties of mankind, and if I am able to prove that this Bill goes in the direction of the preservation of life I feel sure that I shall have the support of honourable members. As I have said, reproduction is essential for the continuance of the human race. The risks attached thereto we all realize, and if we can minimize these risks and, as is provided in this Bill, ensure that those who are called in at that interesting and anxious time to which I have alluded are efficient, then I say we have so far done our duty. Have we in the colony up to the present time devoted our attention to this matter, and have we made provision for that skill which is essential to the preservation of life at such an anxious time as that of maternity? Sir, the deaths at maternity are alarming, and I say without hesitation that if these proposals are given effect to, the number of deaths will be decreased.

"I may say that up to the present time we have made no provision for the training of midwives. The midwife is generally a woman of advanced years, and in the country districts and on the diggings if you asked them the question how they became qualified, how they obtained their requisite knowledge, they would say, 'Oh, I picked it up.' Philanthropists and religious bodies do not provide, nor do they in the slightest, attempt to provide for that which is provided for in the Bill. . . . I may be told that we have a large number of nurses at present training in our hospitals, but we must keep in mind, in connection with this phase of the question, the nurses trained in our hospitals know very little indeed in respect to the matter which is being dealt with specifically in this Bill."

One clause in this Bill provided for the establishment of State maternity hospitals where pupil nurses could be instructed in all duties required for the welfare of the expectant mother and her infant.

Dr. MacGregor writes in his report of 1906:—

"With the passing of the Midwives Registration Act, 1904, the day of the dirty, ignorant, careless woman who has brought death or ill health to many mothers and infants will soon end. After 1907 every woman who undertakes the responsibilities of a midwife will have to show that she is competent to do so. This will necessarily limit the number of women who can be found in a district to attend a case of labour at a low charge. To meet this difficulty St. Helens Hospitals have been established in each of the four centres where the wives of working-men can obtain, at a fixed charge, care and attendance during childbirth. The success already met with in these hospitals testifies to the need for them. There has hitherto been no hospital in New Zealand devoted to maternity work where nurses could be trained, and St. Helens hospitals provide careful training for maternity nurses."

Lavina Dock, in her "History of Nursing Study," writes—

> "Of all the great work which this man (Mr. Seddon), so gifted with the genius of statesmanship, accomplished for his adopted country, perhaps none will have such lasting effect and do so much for the coming race of New Zealand as this of founding the four State maternity hospitals. They are a more enduring monument of his memory than any statue or tombstone can be."

It is therefore from 1904 that we may now consider the evolution of the present maternity services in New Zealand.

From 1904 only registered midwives might attend a woman in her confinement, except in case of emergency. As, however, midwives who had received no special training but had "just picked up their knowledge" had to be placed on the register by virtue of having been in practice, it is not surprising that little improvement in the maternity mortality returns was shown.

In 1913 an outbreak of puerperal sepsis occurring in St. Helens Hospital, Auckland, was inquired into by a Royal Commission.

In 1921, in consequence of considerable publicity being given to the fact that New Zealand's maternal death-rate was placed second in a list of nations issued by the Labour Bureau of the United States of America, a special committee of the Board of Health was set up "to consider and report on the deaths of mothers in connection with childbirth." The report states that from 1877 to 1881 the death-rate was comparatively low, with a minimum of 3·93 per thousand live-births in 1880, and that from 1882 to 1890 there was "a somewhat extraordinary increase," the rate reaching 7·31 in 1885. From 1890 to 1913 there was a progressive decline from 5·42 to 3·58, while from 1913 to 1920 there was an abnormal rise to a rate of 6·48. The principal cause of this rise was puerperal septicæmia.

The next public inquiry was into an outbreak of sepsis in a private maternity hospital in Auckland in 1923. In this outbreak between July and October of that year six were infected, of whom five died. The inquiry showed that, whatever efforts had been made to improve maternal welfare, they had been ineffective as far as sepsis was concerned, and in 1924 the Health Department's personnel was strengthened by the appointment of an Inspector of Maternity Hospitals in May, a Consulting Obstetrician to the Department in July, and somewhat later a Medical Officer to be in charge of public ante-natal clinics.

The Inspector of Maternity Hospitals was instructed to draw up a scheme for the reduction of maternal mortality in New Zealand, and the following are some of the recommendations taken from that report. Briefly, the report advised :—

(1) The establishment of free ante-natal clinics in conjunction with maternity hospitals and the Plunket Society.
(2) The establishment of public maternity hospitals efficiently equipped for dealing with obstetrical abnormalities and emergencies, and the closer inspection by the Inspector of Maternity Hospitals of all private maternity hospitals.
(3) The introduction of "an aseptic technique for midwifery that would be recognized and accepted as standard by the medical profession generally."

The report goes on to recommend—

The training of midwives and maternity nurses in the preparation and use of sterilized outfits and in ante-natal care ;

The provision of sterilized outfits available to all maternity nurses and midwives ; and

The training of maternity nurses as distinct from midwives in order that the cases attended by doctors shall be efficiently nursed and the application of the aseptic technique ensured.

In 1925 the Nurses and Midwives Registration Act was passed, which provided for the training and registration of maternity nurses and made it unlawful, except in cases of emergency, for any person to act as a maternity nurse unless she was registered or received a certificate from the medical practitioner engaged to attend the case "that under the circumstances of the case, having regard to the welfare of the respective mother and child, he was willing to accept her" as the maternity nurse for that case. This Act immediately put out of court the "handy woman" whose lack of knowledge of asepsis and the correct use of antiseptics constituted a menace to the health and life of patients attended by her.

The course of training for midwives and maternity nurses was drastically overhauled by the Consulting Obstetrician. The Nurses and Midwives Registration Board, which had been established in 1926, was given the responsibility of deciding from time to time what that training should be and of appointing suitable hospitals to carry on the training.

The regulations governing the training, conduct, and requirements of practice for midwives and maternity nurses were overhauled and a pamphlet issued entitled "The General Principles of Maternity Nursing and the Management and Aseptic Technique of Labour and the Puerperium." The aseptic technique of labour was designed to apply to obstetrics the well-established principles of surgical asepsis.

The regulations governing the conduct of maternity hospitals were reviewed and brought up to date, and a general survey of all these hospitals was made by the Inspector of Maternity Hospitals and improvements instituted.

The Midwives Regulations were also drastically revised, and for the first time midwives were permitted to "administer chloroform or any other anæsthetic or sedative drug" *by the direction of a medical practitioner*. This regulation was designed to relieve a busy doctor from being called in personally to give the necessary alleviation from pain, a practice which had undoubtedly led to much inadvisable interference with the natural course of labour, particularly by the use of forceps.

The publicity given by these successive steps undoubtedly led to a much greater interest in obstetrics on the part of the medical profession, and a further impetus was given to this interest by the formation of the Obstetrical Society (N.Z. Branch B.M.A.). So great was the interest taken that, due largely to the efforts and energy of the honorary secretary of this society, a fund of £31,700 was raised by the women of New Zealand to endow a Chair of Obstetrics at the Otago University, while the surplus of the fund was put on one side to provide travelling scholarships in obstetrics for medical graduates.

Private maternity hospitals were greatly improved, more public maternity hospitals were built, public ante-natal clinics in connection with St. Helens, public maternity hospitals, and the Royal New Zealand Society for the Health of Women and Children (Plunket Society), were established and have for many years done a valuable educational work among the women of New Zealand on the advantages of ante-natal care.

Until 1932 Hospital Boards were not legally responsible for maternity services for the indigent, though many of the Boards did make limited provision. In that year, by amendment of the Act, it was made the duty of Hospital Boards to provide these services.

By 1927 the scheme outlined in 1924 was well under way and has resulted in a marked diminution in deaths from puerperal sepsis and a slight reduction in those from shock, hæmorrhage, and other "accidents of labour." The eclampsia rate, however, was not influenced by the extended facilities for ante-natal care.

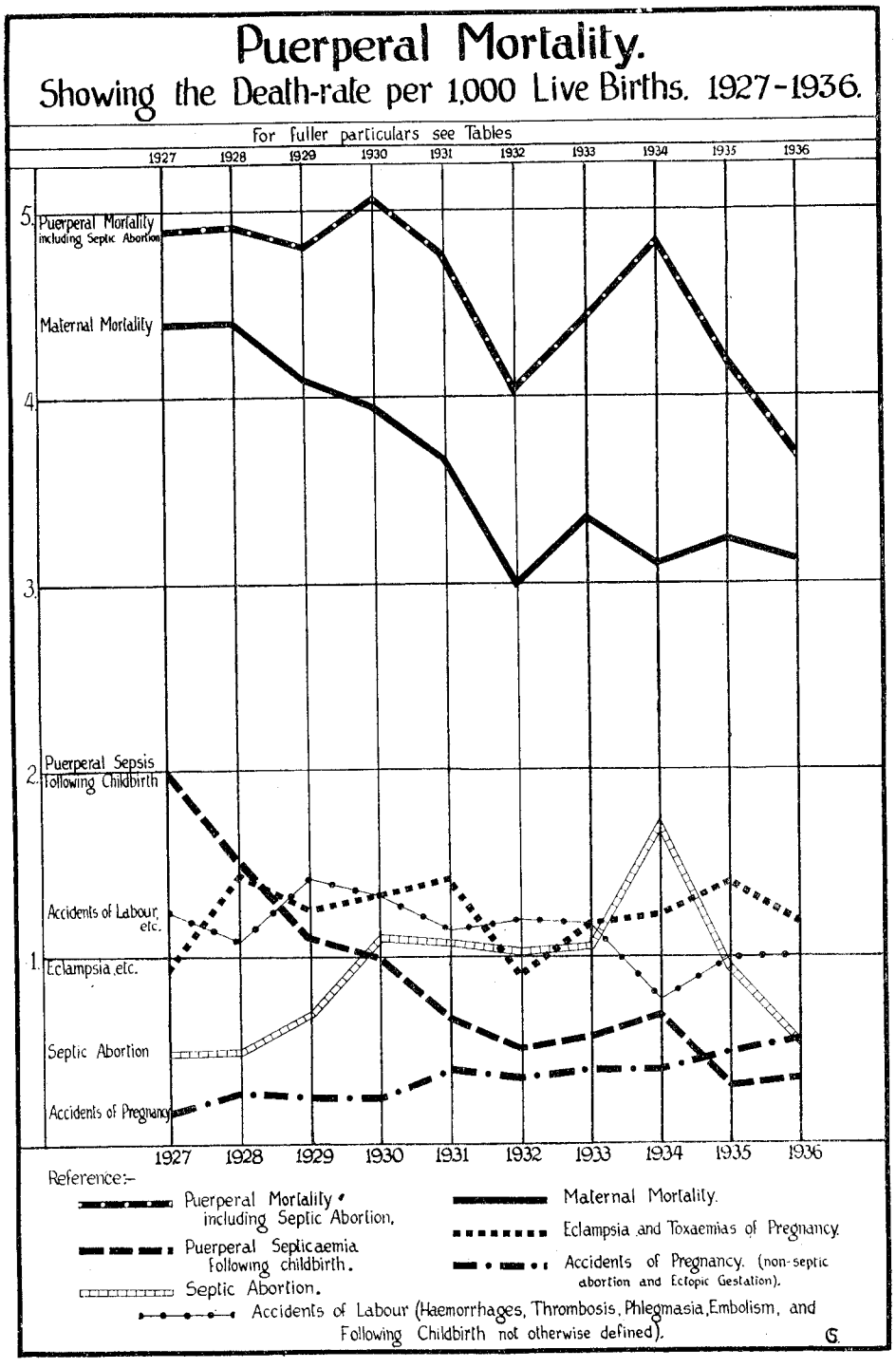
Table 1, with its accompanying graph (see page 71), shows the results obtained up to the end of 1936. The education of the public in the necessity for foresight and for making better arrangements for attendance in labour, and the great improvement in the facilities and conduct of the 270 public and private maternity hospitals, led to the greatly increased hospitalization of patients. Graph 2 (see page 72) shows that during the ten-year period 1927–36 the percentage of patients attended in hospitals increased from 58·59 per cent. to 81·75 per cent., and that, coinciding with this increase in hospitalization, the death-rate from sepsis fell from 2·01 per 1,000 live-births to 0·36. This rate represents 53 per cent. of that of Holland in 1935, the last year for which returns are available, and 29 per cent. of that of England and Wales for the year 1936.

The above gives an outline of the development of the maternity services provided for the mothers of New Zealand, and the effect of those services to date.

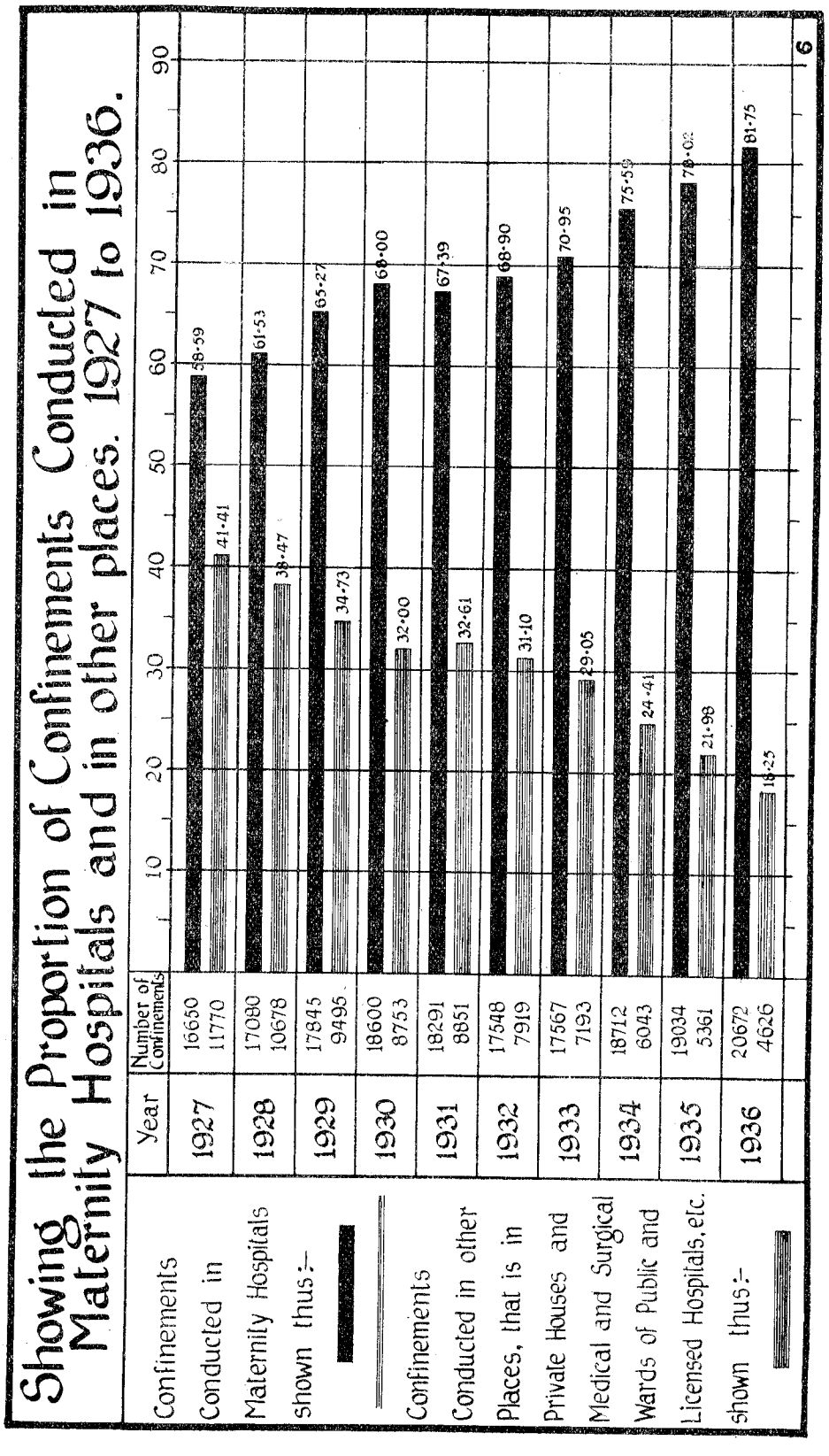
Table 1.—Showing the Number of Puerperal Deaths and the Death-rate per 1,000 Live Births, 1927–1936.

		1927.	1928.	1929.	1930.	1931.	1932.	1933.	1934.	1935.	1936.
Puerperal sepsis following childbirth	No.	56	42	30	27	18	13	14	17	8	9
	Rate	2·01	1·54	1·12	1·01	0·68	0·52	0·58	0·70	0·33	0·36
Hæmorrhage, accidents of labour, thrombosis, phlegmasia, and following childbirth not otherwise defined	No.	35	30	39	36	31	30	29	19	24	25
	Rate	1·26	1·10	1·46	1·34	1·16	1·21	1·19	0·78	1·00	1·01
Toxæmia, albuminuria, and eclampsia	No.	27	40	34	36	38	23	29	30	34	30
	Rate	0·97	1·47	1·27	1·34	1·43	0·92	1·19	1·24	1·42	1·20
Accidents of pregnancy, non-septic abortion, and ectopic gestation	No.	5	8	7	7	11	9	10	10	12	14
	Rate	0·18	0·29	0·26	0·26	0·41	0·36	0·41	0·41	0·50	0·56
Total maternal deaths (excluding septic abortion)	No.	123	120	110	106	98	75	82	76	78	78
	Rate	4·41	4·42	4·11	3·96	3·68	3·02	3·37	3·12	3·25	3·14
Septic abortion—											
Married women	No.	14	14	19	26	26	24	16	29	17	13
Single women	No.				4	3	2	10	13	6	1
Totals		14	14	19	30	29	26	26	42	23	14
Rate		0·50	0·51	0·71	1·12	1·09	1·04	1·07	1·73	0·96	0·56

Graph 1.


Puerperal Mortality.
Showing the Death-rate per 1,000 Live Births. 1927-1936.
for fuller particulars see Tables
1927 1928 1929 1930 1931 1932 1933 1934 1935 1936
5
4
3
2
1
Puerperal Mortality including Septic Abortion
Maternal Mortality
Puerperal Sepsis Following Childbirth
Accidents of Labour, etc.
Eclampsia, etc.
Septic Abortion
Accidents of Pregnancy
Reference:-
Puerperal Mortality including Septic Abortion.
Puerperal Septicaemia following childbirth.
Septic Abortion.
Accidents of Labour (Haemorrhages, Thrombosis, Phlegmasia, Embolism, and Following Childbirth not otherwise defined).
Maternal Mortality.
Eclampsia and Toxaemias of Pregnancy.
Accidents of Pregnancy. (non-septic abortion and Ectopic Gestation).
G.

Graph 2.


Showing the Proportion of Confinements Conducted in Maternity Hospitals and in other places. 1927 to 1936.
Confinements Conducted in Maternity Hospitals shown thus:-
Confinements Conducted in other Places, that is in Private Houses and Medical and Surgical Wards of Public and Licensed Hospitals, etc. shown thus:-
Year
Number of Confinements
10
20
30
40
50
60
70
80
90
1927
16650
11770
38·59
41·41
1928
17080
10678
61·53
38·47
1929
17845
9495
65·27
34·73
1930
18600
8753
68·00
32·00
1931
18291
8851
67·39
32·61
1932
17548
7919
68·90
31·10
1933
17567
7193
70·95
29·05
1934
18712
6043
75·59
24·41
1935
19034
5361
78·02
21·98
1936
20672
4626
81·75
18·25
6

2. METHOD OF ATTENDANCE.

The Committee found quite early in its investigation that there were two big primary considerations which would require to be discussed and decided before any general scheme for a maternity service could be outlined—

(1) The role of the doctor, the midwife, and the maternity nurse in the proposed scheme.
(2) The extent to which hospitalization or domiciliary attendance was to be recommended.

The attitude of the Committee towards these two issues obviously had a very definite bearing on its method of dealing with other questions set out in the order of reference.

Already a definite tendency regarding both these points is apparent in New Zealand, but, nevertheless, since the national maternity services which are being recommended for England and for some other countries are based on an entirely different system, it was considered necessary to bring these matters fully under review.

One important consideration in the development of a national service is the *method of attendance* which is to be recommended.

As regards the nursing side of the service, there are no arguments; it is universally agreed that the lying-in patient should have the help of a fully-trained maternity nurse or midwife, either in hospital or in her home. Actually in New Zealand this practice is now almost universal; it is illegal for an unregistered woman to attend a lying-in woman (except in emergency), and very few untrained women, registered by virtue of previous maternity experience, now remain in active employment.

The role of the doctor, the midwife, and the maternity nurse in the ideal scheme of attendance at actual confinement is, however, a matter on which there is considerable difference of opinion, and in examining the development of the maternity services in the various countries of the world it will be recognized that there are, broadly, two different tendencies.

(1) The Case for Midwife-attendance.

In a number of countries the trend is towars a service in which the bulk of the normal midwifery is conducted by highly traineddmidwives. A medical practitioner of experience in obstetrics decides during the ante-natal period whether or not the patient is likely to have a normal confinement. If the examination reveals no abnormality, arrangements are made for a midwife to carry out the routine ante-natal care and to attend the patient alone at the actual confinement. A doctor sees the patient on two or more occasions during the ante-natal period and is available if any unsuspected complications occur either then or during labour; he makes a complete examination of the patient in the post-natal period, but in normal cases, *he is not present at the confinement.*

If, on the other hand, abnormalities are evident or suspected, arrangements are made for supervision by a doctor throughout. A small proportion of women, even though normal, are attended by obstetric specialists at what must necessarily be high fees.

It will be seen that in such a scheme the general practitioner is excluded from all normal midwifery practice. This system is seen at its best in Holland and the Scandinavian countries, where it has been in operation for very many years, and where the maternity services are recognized to be of a very high order. The practising midwives are very highly trained, the course for previously untrained women being three years in Holland and two years in most of the other countries. These midwives do not continue the after-confinement nursing, but are followed by maternity nurses, who have had a shorter period of training.

The recommendations for a national maternity service for England and Wales put forward by the departmental Committee set up by the Ministry of Health in England, by the special committee of the British Medical Association (England), and by the British College of Obstetricians and Gynæcologists, are all based on the principle of midwife attendance in normal labour; undoubtedly they have been largely influenced by the success of the method in Holland and the Scandinavian countries.

Already there are some excellent examples of this type of service both in hospitals and in district practice in Great Britain, but it is admitted that the general standard of midwife-attendance does not, as yet, compare with that of Holland.

In New Zealand the midwife system is seen in operation in the St. Helens Hospitals, in many of the maternity annexes attached to public hospitals, and, to a comparatively small extent now, in the practice of district nurses. The service rendered under these circumstances has been proved to be safe and efficient.

The case for the midwife system has been fully considered by Dr. H. Jellett, previously Master of the Rotunda Hospital, Dublin, and more recently Consultant Obstetrician to the Department of Health in New Zealand, in his book "Maternal Mortality" (pp. 7–28).

In giving evidence before the Committee Dr. Jellett put the position as seen by those who advocate the midwife system as follows :—

"The first thing I would like to say is that I have always been interested in the question of attendance on maternity patients during pregnancy, labour, and puerperium. I am interested from three points of view—the point of view of the patient, the point of view of the medical practitioner attending, and the point of view of the finance of the whole affair—because money enters into the question. If the amount is limited, as it necessarily has to be, to a comparatively small sum, it seems to me to be a matter of looking for what are the essentials of the service wanted, and paying for those essentials and not for unwanted services.

"The point of view that I advocate is that the medical practitioner is absolutely essential in the care of the pregnant woman and the woman in labour. He is essential from the point of view of supervising the entire course of events. He must make a diagnosis as to whether the woman is a normal woman, healthy in every respect. He must be satisfied as to the prospects of her normal confinement, and must be available should any complication arise.

"After that, I am of opinion that the rest of the management of the case is more satisfactorily entrusted to a competent midwife—that is to say, I think that every woman during pregnancy should first come to the doctor who is primarily responsible for everything, right through, but who, once he is determined that the patient is normal and that there are no complications likely to develop, plays what we may call a 'waiting hand,' while the midwife looks after the woman under his directions. She confines her in his absence, but again under his directions. He is not there unless complications arise. The same thing happens during the puerperium.

"That, roughly, is the course of practice adopted in most of the Scandinavian countries, and just to show that it is not an idea of my own I may say that in 1929 I brought this matter up in Sydney when I was giving an address to the Australasian Medical Association and my book was published at the same time. A review of the book in the *British Medical Journal* said that 'Dr. Jellett's book has practically followed the recommendations of the Committee of the British Medical Association's Report.'

"My reason for recommending this system is that I think it is beneficial for the patient. Statistics tend to show that mortality is lower among women attended under the system I recommend than among those attended by a general practitioner. I think there are obvious reasons for that. This is no reflection on the general practitioner. He has been asked to take the entire care of the woman during pregnancy, labour, and the puerperium, to be at her beck and call at any time, to be responsible for anything that may go wrong, and he is supposed to do that at a fee that is wholly and absolutely out of proportion to the services he has to render. My own idea is that a busy medical practitioner would have to be more or less superhuman to give the services which are called for and at the same time to carry out all the necessary aseptic technique and management that is necessary in modern midwifery. He has necessarily to treat all kinds of cases—septic and infectious, &c.—and he is not to my mind a suitable person to attend cases in normal labour where his services are not required. If he is required, that is another matter. That is a matter of balancing risks. If the case is abnormal, it is the lesser risk that he should go rather than that he should refrain from going. Where, however, the case is normal, then I think it is a mistake to bring in the complication of the medical man who has to attend all kinds of disease; statistics and history having proved over a period of years in other countries, and also at Home, that these cases can be attended more satisfactorily by midwives.

"As regards the practitioner himself, there has been a suggestion made at various times that I was trying to act unfairly to the general medical practitioner. Nothing could be further from my mind. I am recommending what I, if I had been a general practitioner, would have welcomed. I can conceive no greater advantage for the general practitioner, as far as obstetrical matters are concerned, than to be relieved of the routine care of normal labour. If he is a busy man it turns his life into a form of modified slavery.

"From the financial point of view the money which is ordinarily available for a confinement might be considered as sufficient to pay for the duties that I would recommend, namely: Examination during pregnancy, and attention should abnormalities arise; the diagnosis that everything is going to be right during labour; the care during labour if anything goes wrong. A small fee should be sufficient to pay for this service, but in my opinion it is not sufficient otherwise. As far as the whole thing is concerned, if you cannot pay the medical man some commensurate sum for the full duties, pay him for the essentials and relieve him of the non-essentials."

(2) The Case for Doctor-attendance.

There are, however, many who consider that the ideal system is one in which the service of a practitioner, well qualified in obstetrics (though not necessarily limited to it as a speciality) are available for every mother during labour as well as in the ante-natal and post-natal periods.

They also can point to large groups of cases in which, under this system, an excellent and a safe service has been given.

It is true that certain disadvantages associated with general practice have been suggested. The objection has been raised that the danger of contact with infection is greater in the case of the general practitioner than in the case of the midwife. This danger must not be overlooked; but the extremely low incidence of sepsis in large groups of doctor-attended cases which have been recorded is clear evidence that, with proper care, the difference as between midwife and doctor in this respect is negligible.

The charge is frequently made that owing to the exigencies of general practice there is much hurried midwifery; whatever the justification for this suggestion may be in certain instances, as a statement of general application it is an unwarranted reflection on the work of a very large body of conscientious practitioners. On the other hand, the personal control of the case by a competent doctor clearly has many advantages.

Granted that the well-trained midwife can be trusted to conduct a normal case safely, yet there is an additional safeguard when the doctor himself assesses progress from time to time during the course of labour and is present at the delivery. This does not mean that the doctor must be prepared to spend hours of waiting in the first and second stages of labour performing a duty which a midwife or maternity nurse is quite competent to undertake; the co-operation between nurse and doctor advocated by the exponents of this system definitely aims at avoiding non-essentials while ensuring that the doctor exercises general supervision of the first and second stages and is present at the delivery.

A very important feature of modern maternity care is the great development of the use of sedatives and anæsthetics in labour; such being the case, there can be no question that they can be used more safely and more effectively when controlled by the doctor.

It is a very significant fact that, largely owing to this demand for pain-relief, an increasing number of women are seeking the services of a medical attendant even in Holland, where it is stated that only 60 per cent. of patients are now attended by midwives alone.

The third stage of labour (immediately following the birth of the infant) is also a period of possible danger, and the presence of a competent doctor is undoubtedly a further security.

The child's interests, too, are better served, since from time to time sudden emergencies in connection with the child arise in which the wider knowledge of a doctor may mean the difference between life and death. Finally, there is the important point that to be prepared for abnormal midwifery the practitioner must have a wide experience of normal practice.

In New Zealand, as has already been indicated, the tendency is very definitely in the direction of combined attendance by doctor and nurse wherever the financial circumstances of the patient will allow it. Approximately 75 per cent. of the total confinements are attended by doctors, and there is a general consensus of opinion that the additional sense of security to be gained by a doctor's personal supervision is greatly to be desired.

In framing a general policy for New Zealand, is this tendency to be encouraged or restricted?

The Committee is not impressed with the arguments of those who contrast the midwife system at its best with the doctor service at its worst. It is more concerned to decide which system *at its best* offers the fullest advantages from all points of view to the lying-in mother.

If there have been in some instances in the past unsatisfactory features about doctor attendance, as can be freely agreed, the same can be equally definitely stated in regard to some types of midwife-attendance; if it is possible to correct the faults of the midwife system of the past, surely it is not impossible to do the same in the case of a doctor service.

The question of real importance is the standard of training and practice of the attendants, whether they be midwives acting alone, or doctors and nurses acting together. Throughout this discussion emphasis has been laid on the necessity for *competent* obstetric help; that being so, the implications regarding the training of medical students in midwifery are obvious, and every endeavour should be made to facilitate their training in the hospitals throughout the country.

There are, and always will be, small and isolated communities where the doctor must work without other medical assistance; it is therefore necessary that all medical practitioners likely to be engaging in such practice shall have reasonable experience in midwifery.

It is not, however, suggested that all general practitioners should be encouraged to practise midwifery, but there should be no difficulty in every community of any size in making available a number of well-trained practitioners who, without going to the length of full specialization in obstetrics and gynæcology have given special study to maternal and infant care, who are competent to give up-to-date service, and into whose hands the midwifery will naturally pass. Without any regulation or restriction of the rights of practice, this tendency is very definitely developing in New Zealand. In the larger towns, in addition to a group of practitioners of this type, there should be opportunity for certain practitioners to practise full specialization in obstetrics and gynæcology, thus developing the consulting and teaching sides of the service.

The Committee is completely in accord with this tendency to partial and full specialization and believes that it is along these lines that the best maternity service will be developed in New Zealand, provided that it can be put within the reach of all.

It is the opinion of the Committee, after full investigation, that, although the midwife system as it operates in this country is giving a safe and efficient service, the combined system of doctor and nurse attendance can give a still more efficient and a more satisfying service. Already, as has been indicated, some 75 per cent. of all cases are attended by both doctor and nurse.

Is it possible to bring this combined service within the reach of all?

The Committee is of the opinion that this could be assisted in several ways:—

(1) In communities with a sufficiently dense population the development of the larger public maternity hospitals to a size which would allow of the maintenance of a resident house surgeon would help materially. While not expert obstetricians, these house surgeons, if selected in the way advised, would be thoroughly qualified to supervise or administer fuller pain-relief and to act promptly in the emergencies which have been referred to, while they would act in close co-operation with the senior staff in all complicated cases.

In a similar way the house surgeons in the larger public hospitals with maternity annexes could be used to give this service in close co-operation with the Superintendent or visiting staff; this course is already adopted in some hospitals. Such a system would also be of the greatest benefit to the maternity service as a whole by giving opportunities for post-graduate training in midwifery, under supervision, to a number of doctors preparing to enter the wider field of practice.

(2) In smaller hospitals provision could be made for the doctor-attendance of indigent cases by the Superintendent or by members of the visiting staff; this plan is also in operation in some hospitals.

(3) In the event of provision being made for doctor and midwife attendance under a health-insurance plan, many of the difficulties would be solved, with the additional advantage that many women, now unable to afford it, would be in a position to have the services of the doctor of their own choice.

See reservations by Doctors S. G. de L. Chapman and T. L. Paget.

3. HOSPITALIZATION OR DOMICILIARY ATTENDANCE.

A second primary consideration is the extent to which hospitalization or domiciliary attendance is to be recommended.

It is found that the proportion of cases confined in hospitals or maternity homes varies greatly in different countries. Whereas in England and Wales only 15 per cent. to 25 per cent. of the total confinements take place in hospitals, in New Zealand 81·75 per cent. are so conducted at the present time.

It will thus be seen that while in England and Wales hospitalization is largely restricted to abnormal cases, in New Zealand the greater proportion of normal midwifery, as well as the abnormal, takes place in hospitals.

On this matter there is a good deal of difference of opinion. Those advocating the policy of domiciliary attendance for normal cases in Great Britain assert that the results where hospitalization is practised have been less satisfactory than under the system of attendance in the homes. The serious danger in hospitalization is the risk of transference of septic infection, and there can be no doubt that the inefficient hospital is a menace.

If, therefore, the general maternity hospital standard is not a high one, it can be conceded that domiciliary practice will probably be safer.

On the other hand, there are those who maintain that if adequate steps are taken to safeguard the patient through attention to equipment and staffing, the introduction of a standard aseptic and antiseptic technique, rigid inspection, and the insistence on accurate record-keeping and notification of abnormal cases, then the hospital system is safer than a domiciliary one.

It is their opinion that it is a simpler matter to introduce completely satisfactory methods of maternity care into hospitals than it is into the average home. Once assured of the safety from the point of view of sepsis, the advantages of the hospital from the medical point of view are many, especially in the case of first births. This is not disputed

when complications are apparent or suspected ; but even where ante-natal examination is reassuring as to the improbability of the more obvious difficulties, there are not a few cases in which quite unanticipated trouble arises. There are many details in the management of labour which can be more satisfactorily and safely dealt with in hospital where fuller and additional help is available.

The Committee has given careful consideration to the above question, and in its conclusions is guided very much by the results obtained. The fact that during the decennial period 1927–36 the proportion of women confined in public or licensed private hospitals (not including one-bed maternity homes) increased from 58·69 per cent. to 81·75 per cent., and that during the same period the maternal mortality rate, excluding septic abortion, fell from 4·41 to 3·14 per 1,000 live births and the death-rate from puerperal sepsis following childbirth fell from 2·01 to 0·36 per 1,000, is a strong argument in favour of attendance in hospital (see graphs, pages 71, 72).

Practically all the medical witnesses were of opinion that where confinements were conducted in hospital, with the much better facilities available there, they were enabled to deal with complications more adequately and be more certain in maintaining asepsis.

A very few women stressed the desirability of the woman remaining at home for her confinement, their point of view being that the environment of the home was pleasanter and it enabled her to supervise the running of the house during the lying-in period.

On the other hand, the more general opinion expressed was that a woman was better in hospital, where she could get a greater rest.

Thus the different points of view were obviously influenced by the question of the ability to obtain help in the home when the wife and mother was away in hospital, a matter which has been dealt with in a separate portion of the report.

In considering the pros and cons of hospitalization versus domiciliary attendance the economic factor must be given due weight, and there can be no doubt that, apart from the capital cost, if the same quality of nursing is to be given under each system the hospital is far more economical.

An efficient midwife with domestic and semi-skilled nursing help can give adequate attendance to three patients at a time in a hospital, while if the woman is in her own home, and the same quality of nursing is to be given and reasonable working-hours observed by the nurses, the same two nursing attendants in addition to domestic help would be required for the one woman.

It is also easier in the case of a hospital for a nurse to carry on when the patients are " out in their dates " as is quite frequently the case.

On the other hand, when that occurs in a domiciliary case, the nurse may have been called to another patient and is not available.

Furthermore, unless she has a thoroughly competent assistant, a nurse attending a patient at home is on duty or call for the whole twenty-four hours. In a well-conducted hospital the hours on duty need not exceed more than eight to ten per day, and if there are more than two midwives or maternity nurses on the staff days off during the slack periods are easily arranged without sacrificing the interests of the patients in the hospital during that time.

It must be understood that in England and Wales a very considerable part of the domiciliary attendance which is being recommended is carried out by district midwives who attend daily and do not live in the homes. This, of course, is a much cheaper service, but the Committee is of the opinion that it has many disadvantages and is satisfied that it is not efficient nor is it generally acceptable in New Zealand.

The Committee therefore considers that the aim of the Government should be to promote the hospitalization of all maternity patients, both pakeha and Maori. The benefit to the latter was shown in the different results obtainable in Rotorua, where hospitalization has become very general as compared with other districts.

At the present time New Zealand has seventy-one public maternity hospitals or maternity wards attached to public hospitals, and 191 private maternity hospitals.

The small private hospital in country towns is providing a very valuable and, in the opinion of the Committee, an essential maternity service.

The majority of these hospitals, of which 154 admit less than 100 cases per annum, are ordinary houses slightly altered to meet their purpose and only equipped with the essentials to maintain asepsis and give comfort to mother and infant and moderate convenience to the nurse. Many of them are owned by elderly nurses who have always had a struggle to make ends meet, and as these nurses give up there can be no question that many of these hospitals will cease to function unless they receive some financial assistance by way of an annual subsidy or by the subsidizing of the fees paid by those patients requiring admission, but unable to pay the full cost of hospital service.

It appears to the Committee that some system of subsidy is thoroughly justified, as, if the private hospitals are given up by the licensees, the Boards will be faced with heavy capital expenditure to replace them.

This under any circumstances will take place in a limited number of cases, but to replace the 154 small private hospitals at present licensed will cost not less than approximately £2,500 per hospital, making a total of £385,000.

On the other hand, if domiciliary attendance were adopted as a policy as against hospitalization, a larger number of midwives and maternity nurses would be required, and the majority of these would have to be subsidized and pensions provided.

The Committee is of opinion that the maintenance of the present system of maternity hospitals is the best that can be adopted, though it is advisable that they should be supplemented by providing rest and convalescent homes for women before they enter hospital, and after they leave it, or by a system of domestic assistance for the same periods.

4. SUMMARY OF EXISTING HOSPITAL FACILITIES.

(1) Maternity Hospital Facilities provided by Hospital Boards.

The Committee found very great variations in the provision made by different Hospital Boards to meet the maternity needs in their districts. The facilities available were of three types—

(*a*) *Maternity Annexes and Hospitals.*—In a number of the cities and in many of the larger towns maternity annexes or hospitals have been established in connection with the general hospitals. In some cases these annexes are of the "closed" type and all the attendance is given by the stipendiary staff. Usually the system of attendance is similar to that in operation in the St. Helens hospitals—midwife-attendance in normal cases, with the medical staff exercising general control, supervising ante-natal care, attending difficult cases, and lecturing to the nurses in training. In a few instances the medical staff, either the Superintendent or a house surgeon, attends all confinements.

In some of these annexes a medical practitioner of special experience in obstetrics has been appointed to the medical charge of the hospital.

The majority are training schools for maternity nurses.

A number of the annexes are open to the medical practitioners of the district, who are able to attend their own patients in these hospitals, the medical fee being a matter of private arrangement between patient and doctor.

The hospital fees, with few exceptions, are £3 3s. to £4 4s. per week, usually corresponding with the rate charged in the general hospital to which the annexe is attached. These fees are subject to adjustment as is customary in the public hospitals.

Maternity hospitals and annexes of this type are established in the following places:—

Whangaroa.	Whakatane.	Blenheim.
Kaitaia.	Taumarunui.	Christchurch (Essex).
Kawakawa.	Raetihi.	Ashburton.
Rawene.	Stratford.	Timaru.
Whangarei.	Patea.	Dunedin (Queen Mary).
Te Kopuru.	Wanganui.	Ranfurly.
Waiuku.	Palmerston North.	Cromwell.
Hamilton.	Gisborne.	Westport.
Coromandel.	Hastings.	Reefton.
Thames.	Waipawa.	Greymouth.
Rotorua.	Masterton.	
Te Puke.	Nelson.	

The Committee found that, in general, the accommodation, equipment, and standard of attention in these annexes was exceedingly good; some of them are the most modern maternity hospitals in the Dominion.

As is natural, in some of the older ones the accommodation is being taxed, and extentions or replacements are becoming necessary.

These hospitals, both "closed" and "open," are meeting the great need for efficient maternity care at moderate cost in a very satisfactory manner, and their services are in great demand.

In addition, they are taking an important part in the training of maternity nurses and might be used to assist in the practical training of medical students.

The Committee is of the opinion that their place in the maternity service is an essential one, and their further development is definitely to be encouraged.

(*b*) *Cottage Hospitals.*—In a considerable number of smaller towns a very similar provision, suited to the smaller populations, has been made by Hospital Boards through the establishment of small maternity hospitals (in some cases associated with certain facilities for general medical and surgical work). In some instances local medical practitioners have been appointed to the charge of these little units, while in other cases they are open to the local practitioners on a private hospital basis and arrangements have been made for the treatment of indigent cases.

An outstanding example of this service is given in the chain of small maternity hospitals established by the North Canterbury Board through its country district.

Public maternity hospitals of this type have been established in the following localities :—

Paparoa.	Picton.	Leeston.
Warkworth.	Kaikoura.	Geraldine.
Kawhia.	Cheviot.	Fairlie.
Te Kuiti.	Waikari.	Temuka.
Matamata.	Rotherham.	Kurow.
Mercury Bay.	Rangiora.	Palmerston.
Paeroa.	Oxford.	Middlemarch.
Otaki.	Darfield.	Roxburgh.
Tokomaru Bay.	Lyttelton.	Lawrence.
Tolaga Bay.	Akaroa.	Tapanui.
Havelock.	Little River.	Kaitangata.

The hospital fees are similar to those charged in the larger annexes—£3 3s. to £4 4s. per week, subject to adjustment.

While there are certain limitations in the service which can be given in these smaller units, and some difficulties in their staffing, they give the essentials of safe maternity care to the residents of many districts in a way which would hardly be possible otherwise.

Wherever such a service exists it is found that the call for untrained midwives and the necessity for attending patients in ill-equipped houses disappears, and even domiciliary attendance by trained maternity nurses or midwives is largely superseded.

The Committee regards this provision as most valuable and necessary, especially in districts where no satisfactory private institution exists which could be made available to meet public needs by subsidy or other method of financial assistance.

(*c*) *Subsidized Private Hospitals.*—In some districts the Hospital Boards are making provision for the maternity needs of the patients needing assistance by the payment of subsidies to midwives maintaining private maternity hospitals. In some instances (as at Methven, Rakaia, Opunake, and Riverton) the hospital has been built by the Board and then leased to the midwife, with a subsidy, for private management; in other cases the hospital itself is privately-owned. In return for this subsidy the midwife must take all cases applying.

While this system has certain very definite advantages, there are some difficulties in its present working. There is frequently no clear indication to the nurse as to which patients are to be received at reduced fee or at no fee, and as a result the responsibility for deciding the point rests with the nurse, a position which is sometimes unsatisfactory both to her and to the patient.

In some cases the subsidy allowed by the Board is not adequate for the service rendered.

Another method of utilizing the services of existing private hospitals to give treatment to indigent cases is by the granting of a payment for each case for which the Board accepts responsibility. The sum allowed varies from the very inadequate amount of £2 per case, which is given presumably as part payment, up to a full fee of £3 3s. per week, or, in a very few instances, £4 4s. per week.

Here again, while in some respects the system is a good one provided that the fee is reasonable, there are certain disadvantages. The requirement of many Boards that application shall be made beforehand to an officer of the Board for this assistance is distasteful to many people, and in some cases where the nurse has taken an indigent patient in emergency she has found it difficult to obtain a fee from the Board.

There are a number of small districts which already have quite satisfactory private maternity hospitals, but which would be unable to support two reasonably staffed and properly equipped hospitals—one private and the other public.

The Committee is of the opinion that it would be both advantageous and economical if in these cases the Boards would make arrangements by which the existing private hospitals could be used for all patients in a way that was completely acceptable to both nurses and patients.

It is considered that, under a health-insurance system which provided maternity hospital benefit to those insured by direct payment of a reasonable fee to the hospital, the difficulties would be solved.

In the meantime, even with its disadvantages, the Committee believes that the system of subsidizing private hospitals is serving a need and might well be extended, as, for instance, in the Wairarapa district, where patients who need assistance are passing small private maternity hospitals in their own localities and travelling many miles to the nearest public maternity hospital.

Subsidized hospitals are operating at the following localities :—

Helensville.	Murchison.	Riverton.
Huntly.	Denniston.	Tuatapere.
Opotiki.	Hokitika.	Nightcaps.
Napier.	Methven.	Winton.
Opunake.	Rakaia.	Lumsden.
Pongaroa.	Port Chalmers.	Queenstown.
Motueka.	Gore.	Kaiapoi.
Collingwood.	Bluff.	

Although from the description of the facilities of various types already given it will be realized that in some districts the Hospital Boards have made satisfactory provision for the needs of indigent maternity patients, there are exceptions.

An outstanding instance is the Auckland Hospital Board district, where, apart from the Franklin Memorial Hospital at Waiuku and a cottage hospital at Warkworth, the Board has provided no institution for normal maternity cases and gives assistance by subsidy to a very inadequate extent. The Committee regards the facilities in this district as entirely insufficient and has made full recommendation in the local report for the improvement of these conditions.

In the Wellington Hospital Board district practically no provision has been made by the Board, and although in the city there is at present no serious deficiency owing to the presence of alternative facilities, the maternity services in the Hutt Valley area are very inadequate, and a public maternity hospital in that district is considered necessary. The Committee is of the opinion that in the Taranaki and Hawera Hospital Board districts the assistance at present given by way of subsidy to private hospitals does not meet the public needs in an adequate manner, and the establishment of maternity annexes at New Plymouth and Hawera, and of a small maternity hospital at Waitara, has been recommended.

The Committee also found that in the isolated districts of South Westland and North Westland, and in the Takaka-Collingwood portion of the Nelson district, there was an urgent need for more satisfactory public provision. Recommendations regarding these areas have been made in an interim report and in the local section of this report.

(2) Maternity Hospitals maintained by the Government.

The Government, through the Department of Health, at present controls St. Helens Maternity Hospitals in Auckland, Wellington, Christchurch, and Invercargill. (The Dunedin St. Helens has merged with the new Queen Mary Hospital and the Wanganui and Gisborne St. Helens Hospitals have been taken over by the Boards.)

These hospitals continue to serve the double purpose for which they were established. They are the chief training schools in the Dominion for nurses entering the maternity service and the only hospitals in which the higher—midwifery—course is now given. They also provide safe maternity care for a large number of women of small means. These hospitals are all conducted on the system of midwife-attendance on normal cases, with a part-time stipendiary staff of medical practitioners, largely specializing in obstetrics, who are responsible for the general supervision of the hospitals, attendance on all difficult cases, and the medical aspects of the nursing training.

The fees are £2 10s. per week in the hospital (subject to adjustment), a charge which by no means covers the cost of the service. This fee is sometimes criticized by comparison with that charged when the St. Helens Hospitals were first founded, but it is not realized how vastly more complex and expensive modern maternity care now is compared with the simpler service then given.

Although with the growth of Board hospitals giving service of a somewhat similar nature and affording facilities for training the St. Helens Hospitals are no longer the only public maternity institutions, yet they still hold a particular and very important position in the maternity service. Through their particularly intimate association with the Department of Health these hospitals are able to set a standard of treatment and maintain a uniformity of training which gives a lead to the service as a whole. It has been suggested at times that these St. Helens Hospitals should be taken over by the Boards, but the Committee agrees that there are very definite advantages in maintaining the present system of control.

If this is to be the policy, extensive additions or replacements will be required in all the St. Helens Hospitals in the near future.

The Committee finds that these hospitals have developed in a highly satisfactory manner in staffing, equipment, and standard of service, but all the hospital buildings are showing deficiencies of greater or less degree.

The position regarding the Christchurch St. Helens Hospital is particularly urgent, and the Committee has made full recommendations regarding a new hospital to take its place.

The Committee similarly recommends, as the future policy, the development of the St. Helens Hospitals in Auckland and Wellington as the main obstetrical centres for both normal and abnormal midwifery, with resident house surgeons and provision for the clinical training of medical students.

(3) Private Maternity Hospitals.

Throughout the Dominion there are 191 private maternity hospitals. It will be seen, therefore, that, in the total, they play an important part in the maternity hospital organization. The majority of these hospitals are owned or leased by the midwives who control them. In a certain number of cases they are owned and conducted by doctors.

The fees in the country towns are usually £4 4s. to £5 5s. per week; in the cities, owing to higher capital costs, the average fees are a little higher, and in a few instances where the hospitals are more expensively equipped and staffed the charges for single rooms are up to £8 8s. per week.

Since the reorganization of the private maternity hospital system under the direction of the Inspector of Maternity Hospitals the equipment essential for safe maternity care has been insisted on and the standard of nursing has been greatly improved. The results have been very satisfactory, and the Committee is satisfied that, in general, the work of these private hospitals is very creditable.

With very few exceptions, however, these private hospitals are converted private houses and, as hospitals, show many structural defects. The impression gained by the Committee was that individual private enterprise was finding it increasingly difficult to provide hospital accommodation of the standard which a modern maternity service demands, and it was felt that the future of the private maternity hospital lay in a combination of interests financially strong enough to provide up-to-date facilities. The Committee is of the opinion that the private maternity hospital has a very valuable place in the maternity service and that every encouragement should be given to its development on modern lines.

It is considered that in determining maternity benefits under any health-insurance scheme provision should be made so that average payments will ensure a reasonable remuneration for the services rendered; also that the payments should be safeguarded so that they are definitely applied to improving conditions and payment for those who actually render the service.

The Committee was most favourably impressed with the "intermediate" private-hospital facilities which were being provided by certain organizations such as the Salvation Army and the Alexandra Hospital Committee, and is of the opinion that the extension of this type of service would meet the need of those who, while unable to pay full private-hospital fees, desire the services of their own doctor.

5. DISTRICT NURSING SERVICES.

In the cities, as a result of the trend towards hospitalization, attendance at confinement in the home has steadily diminished. Whereas formerly the district work formed a very considerable part of the St. Helens practice, it has now dropped to quite a small proportion, and some other district services, such as that of the Alexandra Hospital in Wellington, have lapsed altogether.

This question of domiciliary treatment has been fully discussed in another section, and the opinion of the Committee was that although the system has the merit of low cost and in some respects offers a good field for practical nursing training, the standard of attendance which can be given under it is inferior, and the advantages of hospitalization are so definite that it would be inadvisable to develop the district services any further for actual confinement work.

The district maternity service which remains in the cities is, of its type, quite satisfactory with the St. Helens Hospital organization behind it. In some country districts the district nurses appointed by the Health Department and by some Hospital Boards are still doing a certain amount of confinement work in the homes, but it is significant that where maternity hospital facilities are available this service has disappeared. Here, again, the Committee is in favour of the provision of maternity hospitals in those districts where they are lacking rather than the extension of the domiciliary service given by midwives.

There is, however, one direction in which it is believed that organized district nursing services could with great advantage be developed both in the cities and in the country districts. The Committee is of the opinion that district nurses with midwifery training could give great assistance in the ante-natal supervision of women residing in localities situated at long distances from the hospitals they intend to enter or from the doctors who are to attend them.

In this way the physical and financial burdens which stand in the way of full ante-natal supervision for these women would be lightened.

The suggestion is that this work should be done in close co-operation with the hospital clinic and doctor, by whom the patient would be seen on one or more occasions, while the intermediate attention would be given by the district nurse. Similarly, midwives from the St. Helens Hospitals might be used to conduct branch clinics in the more distant suburbs of the larger cities.

This service has also been recommended for the Maori population. Work of this type is already being carried out to some extent, and with very great benefit, by a few district nurses, as for instance, those attached to the Palmerston North Hospital Board, and also by a number of the district nurses to Natives. Its extension would call for additions to the district nurse staff.

6. CONCLUSIONS AND RECOMMENDATIONS REGARDING FUTURE HOSPITAL POLICY.

The Committee finds that there is an overwhelming preference for the treatment of maternity cases in hospitals and is satisfied that, as far as New Zealand conditions are concerned, that preference is justified and to be encouraged.

After a full survey of existing hospital facilities the Committee is satisfied that, in general, there has been a very real and progressive improvement in the maternity hospital services of all types both in respect of the accommodation provided and of their efficiency and safety.

The investigation, however, revealed a certain lack of uniformity in this development, especially in respect of the public provision made by different Hospital Boards. It is therefore recommended that a definite and uniform hospital policy be adopted for the whole Dominion incorporating the best features of the present system as follows :—

(1) *In all country districts* it should be the general policy to provide maternity hospital facilities as close to the homes of the mothers as is reasonably possible. Such provision makes it possible for the mother to be attended by her own doctor both in the ante-natal period and for confinement, relieves her of the physical and financial burdens associated with frequent visits to clinics and hospital in a distant centre, and keeps her in closer touch with her family. Admittedly these smaller units cannot be of the ideal maternity hospital standard, but they can give the essentials of safe maternity care. It is considered that the advantages of nearness to the homes of the patients outweigh the benefits to be gained by centralization in bigger units at long distances from the homes. It should be recognized as the responsibility of the Hospital Boards to make this provision for those unable to make private arrangements, and, since in most of these districts it is not possible to develop satisfactorily both a public maternity hospital and a private maternity hospital, it will, as a rule, be better to concentrate on one institution—

(*a*) Where no satisfactory private hospital is available which would be capable of development to meet the full needs of the district it is recommended that a public maternity hospital be established and controlled by the Board and that, in addition to making provision for the nursing treatment of all indigent cases, the Board should accept responsibility for the medical attention of such cases both ante-natally or at confinement when necessary. It is also recommended that such hospitals be made available to the local doctors for the treatment of their private patients. The Committee believes that by satisfactory health-insurance provisions it would be possible to attain the ideal of doctor-attendance for all cases in these hospitals.

(*b*) Where an efficient private maternity hospital is already functioning in the district it is considered that the most advantageous and economical course is to make use of this hospital to serve the public needs by some method of financial assistance which is satisfactory to all those interested. The Committee believes that the most satisfactory method would be by hospital benefit under a health-insurance system. The alternative in the meantime is to arrange for a uniform and acceptable system of subsidy by Hospital Boards.

Although some very well managed "mixed" hospitals taking both maternity and medical and surgical cases were inspected and strong arguments were brought forward in some country districts in support of such combined hospitals when strictly controlled, the Committee is convinced that as far as possible the principle of the purely maternity hospital should be developed.

(2) *In all the larger towns and small cities* the policy should be to develop maternity hospitals of a larger and more modern type. It is recognized that the converted private house rarely fulfils all the requirements, and, as far as possible, all new maternity hospitals should be specially constructed for the purpose.

The ideal moderate-sized hospital should be large enough to allow of the maintenance of a night nurse and a staff sufficiently large to make possible reasonable hours of duty; proper staff quarters should be provided; it should have labour-ward block and nursery so placed as to be well removed from the lying-in wards; and it should have sanitary arrangements and equipment which conform to accepted standards. These provisions are hardly possible if the hospital has less than ten beds. In such communities the number of people requiring some public assistance is so large that the only really satisfactory way to serve their needs is by the establishment of a maternity annexe or hospital in association with the general hospital. This should be regarded as a definite duty of all Hospital Boards, and due publicity should be given to the facilities available. In addition to making this hospital provision the Boards should also be responsible for the medical attention of indigent maternity cases.

Having seen how very well the "open" maternity annexe meets the needs of those who desire modern maternity hospital facilities at moderate cost and who wish at the same time to be attended by their own doctors, the Committee is definitely of the opinion that this community-hospital principle should be adopted in all maternity hospitals and annexes of this group. It is also recommended that each of these annexes be placed in the charge of a medical practitioner with special experience in

obstetrics to be responsible for the treatment of Board cases, for the training of maternity nurses, and for the general supervision of the hospital.

It is considered that the establishment of a number of such positions would be an inducement for practitioners with this special experience to take up practice in these towns and that such a policy would be very beneficial to the maternity service of the whole country.

In such towns there will also be a place for private maternity hospitals. Recognizing the good service that many small private hospitals have given in the past nothing should be done to injure them, but, nevertheless, when the present licensees retire the perpetuation of such small hospitals should be discouraged and every endeavour made by a combination of interests to establish more efficient hospitals of the type indicated.

(3) *In each of the four main cities* (Auckland, Wellington, Christchurch, and Dunedin) the general policy should be to develop maternity hospitals along three lines:—

A. A MAIN OBSTETRIC CENTRE.

It is recommended that very careful consideration should be given to the development of one main public maternity hospital in each of these cities to act as the centre for the obstetrical activities of the area.

The principles which should be kept in view are already seen applied in the Queen Mary Hospital in Dunedin, and have guided the Committee in its full recommendations regarding the proposed new St. Helens Hospital in Christchurch.

I. *The Site.*

The site should be in a pleasant environment and sufficiently large to allow of future expansion.

Convenience of access for patients from all parts of the district should be studied, the thought being not so much of the transference of the patients to the hospital at the time of lying-in, as of the much more frequent attendances at the ante-natal clinic which modern maternity care now demands. A site reasonably accessible by tram or bus is obviously desirable. Consideration should be given to the value of close proximity to the general hospital, which in many ways tends to economy, efficiency, and safety.

Although in many respects a well-equipped maternity hospital is a self-contained unit, yet there are occasions on which close contact with the facilities of the general hospital is most desirable. For purposes of X-ray examination, for the fullest use of the laboratory services, for full co-operation with the other out-patients' departments, and for convenience in consultation with physicians and surgeons there are undoubtedly great advantages in the two hospitals being close together.

II. *The Scope of the Hospital Activities.*

(*a*) *Provision of a Full Maternity Service for Mothers in Poorer Circumstances.*—This is simply an extension of the present St. Helens service.

(*b*) *Provision for Emergency and Complicated Cases.*—In addition to being the main public maternity hospital for normal cases it is recommended that each of these hospitals should be the centre for the treatment of obstetric emergencies. Although any reasonably equipped maternity hospital is able to deal with the great majority of its own "booked" cases, there are always a few cases which require special facilities for their treatment. Such cases have hitherto been dealt with in the general hospitals under conditions which have not been fully satisfactory. The position could be improved either by developing a fully-equipped and properly-staffed unit for complicated cases in connection with the general hospital or by combining this department with the main maternity hospital. The Committee is satisfied that the latter course is preferable.

(*c*) *Provision for the Training of Midwives.*—The main hospitals in Auckland, Wellington, and Christchurch would continue, as at present, to be the chief training schools in the Dominion for midwives and maternity nurses.

Owing to the special circumstances obtaining in Dunedin with its Medical School, the Queen Mary Hospital has been given over to the training of medical students.

(*d*) *Provision for the Training of Medical Students.*—The investigation of the Committee makes it clear that the general tendency is towards a system in which every woman will be attended by a doctor, as well as a midwife or maternity nurse, during pregnancy and labour. That being so, the adequate training of the future medical practitioners of the country is a matter of urgent importance and a responsibility which the community itself must accept. The problem of providing sufficient clinical experience for medical students in this important subject is a world-wide difficulty and is an acute one in New Zealand. It is with the greatest difficulty that the very reasonable requirements of the General Medical Council are even approached. Even with the special facilities which have been referred to in the Queen Mary Hospital in Dunedin the number of cases available will be quite inadequate to meet the needs of all the students. It is obviously desirable

that assistance should be given in this matter in other centres where the hospital facilities, the clinical material, and the special experience of the staff are conducive to efficient training.

It is generally agreed that efficient training is greatly promoted where resident facilities are provided in the obstetric hospital, so that the students can be in the closest touch with all phases of the work.

The Committee recommends that, as each of these hospitals is developed, resident facilities for medical students be provided.

(*e*) *Provision for a Resident House Surgeon.*—The view is widely held that a stage has now been reached in the development of the larger obstetric hospitals in the Dominion when the provision of a resident house surgeon is necessary to give the fullest service. It is advocated that in such cases a resident doctor with at least one year's experience as a house surgeon would be of the greatest assistance to the Superintendent and the other members of the staff in much of the routine work of the hospital, and that there are many directions in which he could be of assistance to the patients, as, for instance, in the giving of more adequate pain-relief than is now possible.

It is also urged that such appointments would be in the interests of the maternity service generally in that they would afford opportunities for the more special training in obstetrics, under experienced supervision, of a number of the best New Zealand graduates.

The Committee is impressed with these arguments and recommends that, in each of the new main hospitals suggested, provision be made for a resident house surgeon.

III. *Medical Staffing.*

All those associated with the administration of these teaching hospitals for midwives are definite in their opinion that they should be of a "closed" type with a staff of Superintendent and assistant obstetricians possessing special qualifications.

Dr. McMillan dissents from this view and is of opinion that all doctors who possess approved post-graduate qualifications and who are prepared to comply with regulations should have the right to attend patients in St. Helens Hospitals and that the patients should have free choice of these approved doctors.

He is of opinion that such a system will encourage medical men to undertake post-graduate study on the one hand, while on the other the free choice of these approved doctors will ensure that the wishes of the patients receive more consideration.

The majority of the Committee are sympathetic towards Dr. McMillan's suggestion, but, in view of the overwhelming nature of the evidence to the contrary, are convinced that they are impracticable at the present time.

Supervision of Obstetric Cases in Obstetric Hospitals.—Until the policy suggested above is so far implemented that maternity patients need not be admitted to general hospitals, all such hospitals should have on their medical staff an experienced obstetrician who would be responsible for the treatment of all obstetrical emergencies and abnormalities admitted to the hospital. This would avoid the undesirable practice at present existing in some general hospitals of patients sent in for cæsarean section or other obstetrical operations being referred to surgeons who may have only a limited obstetrical experience.

IV. *Administration.*

On account of the special relationship between the Otago Medical School and the Dunedin Hospital, it has been considered advisable, in the case of Dunedin, to develop the main obstetric hospital under the administration of the Hospital Board.

In the other main cities, owing to the particular interest of the Department of Health in the uniform training of midwives, it is recommended that the hospitals continue as St. Helens Hospitals under the control of the Health Department.

Dr. McMillan is not in entire agreement with this recommendation, and points out that for quite a number of years the St. Helens Hospitals in Auckland, Wellington, Christchurch, and Invercargill have been in a deplorable condition structurally and that facilities have been improved very reluctantly and very grudgingly, with the result that they compare most unfavourably with the maternity annexes provided by the more progressive Hospital Boards.

While recognizing that the Minister of Health has expressed his intention of bringing these hospitals up to modern requirements, Dr. McMillan argues that as in the past there has been, so in the future there can be no guarantee that there will not again be, in office a Government which will refuse to keep these hospitals up to date, and is of the opinion that in the long-run the best conditions would be obtained by placing their administration in the hands of the respective Hospital Boards. Dr. McMillan does not admit that either the modified "open" system or Hospital Board administration of St. Helens Hospitals would militate against the efficiency of the midwife trainee, and instances the high standard of efficiency that is obtained in the training of general nurses in Board institutions.

B. COMMUNITY HOSPITAL SERVICE.

The need for modern "intermediate" hospital accommodation is just as pressing in the cities as it is in the towns.

The Committee has agreed with those responsible for the administration of the main teaching hospitals that it would not be satisfactory to conduct them on the "open" principle. Nevertheless it is felt that all other interests cannot be made subservient to the requirements of the teaching hospital and that some hospital accommodation should be provided where patients of moderate means who so desire it can be attended by their own doctors. It seems entirely illogical that because a patient is living in a city in which the public hospital is a training school for midwives or students she must be denied a valuable privilege which is available in smaller centres. Where such institutions as the Salvation Army hospitals and the Alexandra Hospital are operating they meet this need well, and the development of such services is to be encouraged.

The alternative course would appear to be the establishment of an independent community hospital wing in connection with the main public maternity hospitals, staffed by trained nurses and not used for teaching.

This suggestion, however, does not receive the unanimous support of the Committee, some of whom hold that the State is not called upon to provide two types of service in its main maternity hospitals.

C. PRIVATE HOSPITALS.

The same policy is recommended for the development of the private hospitals in the cities as in the towns—a combination of interests to establish hospitals of modern design and large enough to allow of fully efficient staffing.

D. ONE-BED HOMES.

Throughout the country there still remain a number of unregistered homes in which a midwife is allowed to take one case at a time and which are not subject to inspection as hospitals.

The Committee is of the opinion that all such homes should be subject to definite regulations as are the private maternity hospitals.

The Committee, though recognizing the useful part which many of these homes have played in the past, considers that they lack many of the advantages of larger hospitals and are not a really satisfactory feature of a modern maternity service.

7. ANTE-NATAL AND POST-NATAL CARE.

ANTE-NATAL CARE.

Prior to 1925 no system for providing ante-natal care existed in New Zealand. Advice on general lines was given to patients by the Matrons of public maternity hospitals, and a few medical practitioners recognized the need for proper supervision of pregnant women, but in the absence of organized facilities many women went through their entire pregnancy without supervision of any kind.

In 1925 the Department of Health appointed an officer to organize ante-natal clinics in connection with the St. Helens Hospitals, under the supervision of the Inspector of Maternity Hospitals. The task was by no means an easy one. In most of the hospitals no room could be set aside for the purpose and examination of patients often had to take place under most trying and inconvenient conditions. In addition to this, a certain amount of opposition was encountered on the part of both medical and nursing staffs on the grounds of interference with hospital routine and the extra work entailed. Patients, also, not understanding the purpose of ante-natal supervision, resented being asked to come to hospital for examination, and some years of education were necessary before they began to realize the benefits of ante-natal care.

The good results obtained in reduction of the number of abnormalities of pregnancy and labour have long since silenced such opposition, and a fully equipped ante-natal clinic is now regarded as an essential in any well-conducted maternity hospital. This has had repercussions on general medical practice, and there are now very few doctors who do not regard regular ante-natal attendance as a necessary part of their service to pregnant women.

The following are the principal benefits of ante-natal care :—

(1) Supervision of the patient's general health, and early detection of any pathological condition such as tuberculosis, heart-disease, nephritis, dental caries, &c., which may be adversely affected by the pregnancy.
(2) Recognition and correction of malpresentations.
(3) Detection at an early stage of the symptons of toxæmia of pregnancy, with resulting prevention of the more serious manifestations such as convulsions and hæmorrhage.
(4) Instruction of the patient regarding diet, exercise, and general hygiene.
(5) The opportunity for midwives and doctors to gain the patient's confidence, and so banish the unnecessary fears and apprehensions associated with pregnancy and labour in the minds of many women.

Present Facilities for Ante-natal Care.

(1) *Private Practice.*—Most doctors practising obstetrics recognize the need for efficient ante-natal supervision, and an increasing number prefer to be personally responsible for carrying it out.

(2) *St. Helens Hospitals.*—Each hospital has its ante-natal clinic, and all patients, whether hospital or district cases, are encouraged to attend it. When abnormalities are detected in the clinic, patients are admitted to hospital for their correction. As all the hospitals were built before the establishment of ante-natal clinics these have had to be improvised, and in every case the work is carried out under considerable difficulties. That the clinics run efficiently and smoothly under existing conditions is a tribute to the work of the hospital staffs.

(3) *Public Hospital Annexes.*—Where the hospital is of recent construction the requirements of the ante-natal clinic have been given due consideration in the design. In older hospitals difficulties exist similar to those encountered in the St. Helens Hospitals.

(4) *District Nursing Services.*—In country districts having a scattered population most of the ante-natal work among Maoris, and in some cases also among the European population, is carried out by visiting district nurses who are trained midwives. The importance of this service cannot be overestimated; it is the only means by which patients living at a long distance from a clinic can be given the benefits of ante-natal care. In some districts this service is adequate to the needs of the population, but in others, particularly those with a large Maori population, it could be extended with great benefit to residents.

(5) *Plunket Society Ante-natal Clinics.*—In some centres the Plunket Society has included ante-natal attendance in its schedule of services to expectant mothers. Patients are attended free of charge, and any abnormalities arising during pregnancy are reported to the doctor or hospital responsible for the confinement. While these clinics have, in the past, done very valuable work, their usefulness has decreased somewhat in view of the increased number of public clinics connected with hospitals. Their work suffers from the serious drawback that those responsible for ante-natal care are not in charge of the confinement, and continuity of observation and treatment is thus impaired.

Post-natal Care.

Only comparatively recently has it come to be recognized that the supervision of patients for some weeks after confinement is equal in importance to ante-natal supervision. As yet this service is fully developed only in a minority of hospitals and in the private practice of doctors who take a special interest in obstetrics. Post-natal clinics are established in all St. Helens Hospitals, and are found to be a valuable means of observing the results of treatment. Patients are asked to report at the clinic one month after discharge from the hospital. If examination reveals a satisfactory condition, they are finally discharged at this visit; if treatment is found to be necessary, further visits are arranged accordingly. Patients are beginning to appreciate the value of this service, and the majority are willing to attend at the clinic.

A striking fact noted by those with experience of post-natal work is the rarity of serious injury resulting from childbirth, and it is thought that this pleasing result is in large part due to the intensive ante-natal supervision and close attention during labour given to patients as a routine in the clinics and hospitals of this country.

The principal advantages of post-natal attendance are as follows:—

(1) Observation of the patient's general health, especially as regards aggravation or amelioration of any pre-existing pathological condition.

(2) Examination of previously toxæmic patients with a view to estimating the degree of damage, if any, inflicted on the patient's system by the toxæmic condition.

(3) Examination of the pelvic organs, with correction of displacements, and treatment of subinvolution and erosions which if neglected might lead to chronic ill health.

(4) The opportunity to advise the patient about her health, particularly with regard to the desirability or otherwise of further pregnancies.

(5) Instruction in birth-control methods, where this is necessary for health reasons, is a function of the post-natal clinic which it is hoped to develop in due course.

Further Considerations in regard to Ante-natal and Post-natal Care.

The following statement was made to the Committee by the Medical Officer of the St. Helens Hospital, Wellington:—

> "While it has long been recognized that good health during pregnancy, and a normal delivery are largely dependent on proper ante-natal hygiene, recent research has established incontrovertibly the supreme importance of emotional states in influencing the activity of the reproductive organs, especially during delivery. It has been convincingly demonstrated that emotions such as fear and anxiety cause spasm of the muscles during labour, affecting both the involuntary muscle of the orifice of the uterus, and the voluntary muscle of the pelvic floor.

This spasm causes marked slowness and, in extreme cases, even failure of dilatation, and results in a prolonged and painful labour. Further, it has been shown that deliberate relaxation of the voluntary muscles produces corresponding dilatation to proceed normally without excessive pain. To quote Dr. Dick Read, an eminent exponent of physiological labour: 'Fear, therefore, produces tension, tension pain, pain, increased fear. . . . Confidence is the arch enemy of fear; the two cannot exist at the same time in the one mind, and there is no better way of obtaining confidence than by teaching progressive relaxation during the last three or four months of pregnancy. . . . And, further, this method allows of the birth of the child without any deep anæsthesia; in fact, in many cases, the woman herself will prefer to go on fully conscious so that she may appreciate the mysteries of natural child-birth.'

"Two important considerations arise out of the foregoing quotation. Firstly, fear arising from a mistaken view of pregnancy and labour produces an actual obstruction to the progress of labour, and must at all costs be replaced by a mental attitude of calmness and confidence; secondly, the psychological relationship between mother and child is in every way as close and as real as the physical relationship, and to deprive a woman of consciousness, or of memory of the birth of her child, is to inflict on that relationship a loss which, while difficult to estimate, is none the less actual.

"It is clear that some system which will induce relaxation, and at the same time improve the tone and efficiency of the voluntary muscles, will be of great benefit to the patient. An attempt in this direction is being made at St. Helens Hospital, Wellington, where the system of exercises designed by Margaret Morris has been in regular use for six months. While it is too early as yet to express any opinion of value, it is thought that these exercises are having a definitely beneficial result in improving the general health of patients and in shortening labour and rendering it less painful, thus diminishing the need for sedative drugs. The voluntary statement of many patients who, on getting up for the first time exclaim: 'I have never felt so well after a confinement,' has been a pleasing feature, and in the post-natal clinic it is thought that uterine displacements are definitely less frequent than was formerly the case."

No less important is the question of diet in pregnancy, and attendance at the ante-natal clinic gives the medical attendant valuable opportunities for instructing patients on this matter. It is now generally accepted that a correct diet is necessary not only to the health of the mother during pregnancy, but to the development and future health of the child. Further, certain workers in England have suggested that the susceptibility to puerperal sepsis is undoubtedly influenced by diet, and, while the effect of unsuitable diet in the production of the toxæmias of pregnancy is disputed, there can be little doubt that diet plays an important role in connection with these diseases.

Many women are ignorant of the essentials of a properly balanced diet, and ill-informed articles in popular magazines serve to intensify rather than dispel this ignorance. The growing practice of prescribing certain mineral and vitamin substances in highly concentrated form, while necessary in cases of true deficiency, is less desirable than supplying these elements in the form of fresh, wholesome food, and it is desirable that patients should have a working knowledge of what these constituents are and in what foodstuffs they are present.

It should be emphasized that a wholesome and sufficient diet is not necessarily an expensive diet. Further, all who visit the homes of the people know that all too often good food is ruined by bad cooking. Instruction on these points should form an important part of mothercraft training.

The Present Position of Ante-natal Care in New Zealand.

The Committee finds that ante-natal supervision is very generally practised throughout New Zealand and that there is very general appreciation of its value both by the members of the medical profession and by the women of the country.

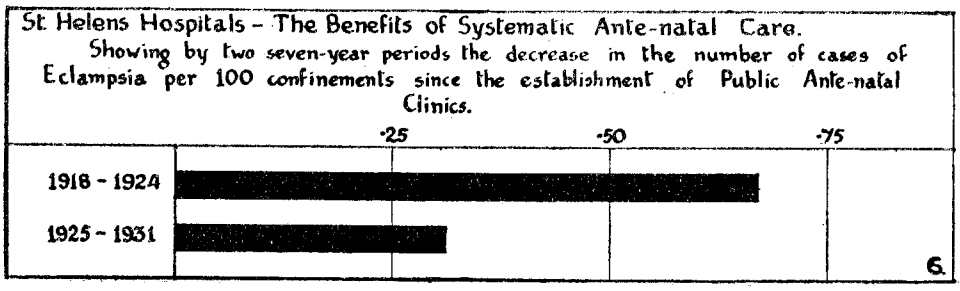
It is obvious to the Committee, however, that there are wide variations in the standard of service given, partly due to difference in keenness and efficiency on the part of those giving the service, and partly owing to difficulties of access.

This is also manifest from the fact that, as in Great Britain, while in certain hospitals and practices the influence of ante-natal care is clearly apparent in improved results, the general statistics for the whole country have not improved in the manner which was expected, especially in regard to the toxæmias of pregnancy.

The death-rate from eclampsia and other manifestations of the toxæmias of pregnancy has remained at practically the same level from 1927 to 1936 in spite of the efforts begun in 1924 and continued since to reduce it, through the application of more scientific and up-to-date methods of ante-natal investigation and treatment both by the general body of obstetricians and through hospital clinics (see graph and Table No. 1, pages 70, 71).

Nevertheless the following table and graph shows that in the group of St. Helens Hospitals beneficial results have been obtained; the incidence of eclampsia per one hundred confinements has been reduced by 56 per cent. in the first seven years and by 50 per cent. over the period of twelve years:—

Period.	Total Confinements.	Eclampsia.	
		Number.	Rate per 100 Confinements.
1918–1924	10,264	70	0·68
1925–1931	16,020	49	0·31
1932–1936	10,266	40	0·39



It is not to be doubted that if records over the same period could be obtained from other obstetric hospitals in which equal care and attention is given to this branch of obstetrics similar good results could be shown.

These results clearly demonstrate that though the causes of eclampsia remain hidden, its incidence can be materially diminished by careful and skilful ante-natal attention and treatment, and it can be expected that as further knowledge is gained of the causes of this condition, further improvements will follow.

The important lesson which has been learnt by experience is that ante-natal supervision, to be really efficient, requires very frequent examinations by well-qualified observers especially in the later stages of pregnancy. Certain dangerous complications arise so insidiously that occasional and incomplete examinations at long intervals are entirely insufficient. Admittedly these troubles occur in only a small proportion of cases, but the detection of the few requires the frequent examination of the many. Cumbersome as this system may possibly seem, and exacting as it certainly is, there is no adequate alternative.

Recommendations.

The Committee is satisfied from the medical evidence that those aspects of ante-natal supervision which are essentially medical should as far as possible be the duty of the doctor engaged to attend the case, and that in private practice the best service is given where the doctor himself undertakes the sole responsibility for this work. In endorsing this principle the Committee would point out the great responsibility which rests on all those undertaking midwifery practice to see that the very full service which experience has shown to be essential is given in all cases.

It seems clear that, although much good work has been done by them in the past, the functions of those ante-natal clinics not attached to hospitals will, in the future, be best limited to the less medical aspects of ante-natal supervision such as mothercraft instruction.

In all public maternity hospitals the ante-natal clinic has proved to be an essential department, and it is recognized that the work of many of the New Zealand clinics is admirable. It is recommended that the standard of practice in such clinics should be followed generally. Here again, while certain duties can quite satisfactorily be delegated to the nursing staff, the more medical features of the ante-natal supervision should be the direct responsibility of the medical officers.

The Committee is impressed with the value of the ante-natal service rendered by district nurses, and recommends that such service be further developed and extended in districts where the size and scattered nature of the population require it.

While in no way belittling the importance of pain-relieving drugs in labour, a subject which is dealt with in another section of the report, the Committee would urge on all who have the care of pregnant and parturient women the even greater importance of wider study into the physiology of pregnancy and labour with a view to achieving painless labour by more natural methods.

Recognizing the value and importance of post-natal examination and treatment the Committee recommends more extensive and complete development of this service by the medical profession.

8. THE RELIEF OF PAIN IN LABOUR.

The knowledge of the fact that certain new drugs and methods of anæsthesia are being extensively used for the greater relief of pain in labour has led to a very natural desire on the part of many people that such help shall be made available to all women. It must be realized, however, that there are considerations involved in this matter regarding which the medical profession is still by no means unanimous.

The conservatism shown in some quarters towards these newer methods of pain-relief has not been due to any lack of sympathy with suffering, but to a very genuine doubt as to their safety from the point of view of both mother and child, and also to a feeling that, where pain-relief was widely used, the necessity for artificial assistance in labour was increased, with certain possible risks.

In the Scandinavian countries, where, in many respects, the maternity service is regarded as a model to the world, anæsthetics and analgesics are rarely used in normal labour, and the percentage of instrumental deliveries is extremely low. Similarly in the practice of the big public maternity institutions in Europe and in Great Britain, and in the district midwife services, where the use of methods of pain-relief in normal labour has in the past been very limited, the percentage of assisted labours has been equally low. Amongst Native races the same position obtains.

On the other hand, it is undoubtedly the case, generally speaking, that, in those countries where pain-relief is largely used, the need for assistance in labour is more frequent.

Furthermore, as regards the safety of the various anæsthetics and analgesics which have been advocated and used there is the widest difference of opinion even among obstetricians of repute.

It is therefore not surprising that there has been considerable hesitancy on the part of some medical authorities in recommending a general use of these methods.

There are others, however, who look upon the position differently. Agreeing that a more extensive use of anæsthetics and analgesics and a more frequent need for assistance in labour do often coincide, they do not regard this as necessarily cause and effect; rather do they consider them both indications of the same tendency amongst the modern more sensitive women of these countries.

They consider that the changed reactions on the part of many modern women towards labour must be met, and can be met safely under certain conditions.

They insist that anæsthetics can only be used to full effect by a doctor or in his presence; that the use of analgesics requires close supervision by the doctor on account of the differing reactions of different individuals; and that these measures of pain-relief are much more satisfactorily applied in hospitals.

Many convincing illustrations are available of the beneficial routine use of pain-relief under such conditions. It will be realized that the chief difficulty occurs in cases conducted under a midwife system with no doctor present at the confinement.

The measures of pain-relief now used in midwifery practice are of two types:—

(1) *Anæsthetics* given mainly in the final stages of labour.
(2) *Analgesics and amnesics*, which are given either by injection or by the mouth, and which are administered at intervals during the more painful stages of the whole labour and sometimes over a period of many hours.

Medical opinion generally has been very definitely against the use of anæsthetics, as hitherto available, by midwives alone on account of the dangers associated with their administration. Efforts have been made to develop some method by which a midwife alone could, with safety, give a light anæsthesia suitable for the purpose.

Actually New Zealand has led the way in this step by allowing the midwife alone to administer a small quantity of chloroform by an apparatus known as the Murphy inhaler, provided that a doctor has previously certified the patient as suitable for such anæsthetic. This method as used in New Zealand, whilst not proving entirely satisfactory in relief from pain in all cases, has been used to advantage in many thousands of cases over a period of fourteen years without any fatalities.

This course has not, however, been deemed advisable in other countries, though the use of glass capsules containing a limited amount of chloroform has been tried to a certain extent in England.

More recently attempts have been made in Great Britain to provide a simple and portable gas and air apparatus (a modification of the gas and oxygen machine) which could be used by midwives. Considerable success has been reported with the use of this apparatus in hospital, but it has not been so successful, practically, in district work. An ether-vapour apparatus suitable for use by well-trained midwives is now being tested. On the whole, however, there is still considerable doubt as to the wisdom of entrusting anæsthetics to midwives alone.

As regards the use of analgesics and amnesics by midwives there is considerable difference of opinion. The unsupervised use of such potent drugs as morphia and scopolamine or the newer barbiturates would unquestionably be very dangerous, but there are those who believe that, under instruction, midwives could quite safely give these sedatives to a limited, but still quite helpful, degree in any particular case.

The Present Position in New Zealand.

The Committee has reason to believe that there are few countries where the use of some measure of pain-relief, both in the form of anæsthetics and analgesics, is more general than in New Zealand, and this largely for the reasons that so many women are attended by doctors and that such a high percentage of cases is confined in hospitals.

In private practice it was found that an anæsthetic was generally given to a degree that was said to be satisfactory to the patient. Chloroform is still the anæsthetic most generally used, though ether, and gas and oxygen were used by a number of doctors.

The evidence given before the Committee showed that while morphia and scopolamine (the drugs used in what has been popularly known as "twilight sleep") have been used in varying degrees for many years by a number of doctors, with the introduction of newer analgesics during the last few years there has been a very great increase in the use of sedative measures in the earlier stages of labour.

There were, however, the widest differences of opinion amongst the doctors who gave evidence regarding the dosage, the effects, and the safety of the various drugs.

The experience of the Committee in taking this evidence made it clear how difficult and dangerous it would be to attempt to make any dogmatic statement regarding methods.

Certain complaints were made of the inadequacy of the pain-relief in some of the public maternity hospitals which are conducted on the midwife system. It is admitted quite readily that the amount of pain-relief which can be given with safety varies greatly in individual cases. In the case, however, of those women whose financial status necessitates their being confined in certain hospitals, both public and private, where the patients are "nurse-attended" in the absence of abnormalities in the mechanism of labour, it cannot be denied the amount of pain-relief given does not approach that which is generally given by modern obstetricians in their private practice.

It is true that the amount of anæsthetic given is definitely less than in the average case in which a doctor is present, but, this has been an inevitable limitation of the midwife system.

Although, as has already been indicated, New Zealand has gone further than most countries in allowing the use of chloroform in the Murphy inhaler by midwives, many witnesses stated that this method was not satisfactory.

It was understood that in the Wellington St. Helens Hospital an ether-vapour apparatus was now being tested.

The use of analgesics in these hospitals varied greatly. In some no sedatives were given except in special cases; in others there had been a gradual development in their use, under the direction of the doctor concerned, until at the present time in quite a number of instances they were used almost as freely in no-doctor cases as in doctor-attended cases.

A commendable point was that in the majority of hospitals taking both married and unmarried mothers the same methods of pain-relief were used in the two groups.

Conclusions and Recommendations.

The Committee considered that it was its function to inquire into the general aspects of pain-relief and not to make any recommendations regarding actual methods.

It is of the opinion that the effort to extend to all patients in labour the fullest degree of pain-relief consistent with safety to mother and child is entirely right and proper.

The Committee is convinced that, although there are differences of opinion regarding methods, under suitable conditions adequate pain-relief can be given, and is being given very extensively in private practice in New Zealand, with entirely satisfactory results.

The Committee is of the opinion, however, that, mainly owing to lack of sufficient medical supervision, pain-relief, to the fullest possible degree consistent with safety, as generally provided for the private patients of those specializing in obstetrics, is rarely given to patients in public hospitals.

The majority of the Committee is of the opinion that to ensure this maximum relief with safety attendance by a doctor at intervals during labour and at delivery is necessary, and that provision for this should be made in all public hospitals.

This has already been referred to as one of the reasons for advocating the principle of doctor-attendance in all cases, and various suggestions have been made for the furtherance of this aim in New Zealand as, for instance, by appointing house surgeons to the larger public maternity hospitals. The Committee is of the opinion that even under existing circumstances the practice adopted in a number of the public maternity hospitals where the midwife system operates, whereby sedatives are given under the direction of, though not necessarily in the presence of, a responsible medical officer, could quite safely be made general, thus very considerably supplementing the limited amount of anæsthetic which the midwife is able to administer.

Finally, the Committee realizes that, owing to the closer supervision required, these methods of pain-relief can be much more satisfactorily carried out in hospitals.

See reservation by Dr. S. G. de L. Chapman and Dr. T. L. Paget.

9. TRAINING AND CONTROL OF MIDWIVES AND MATERNITY NURSES.

The early history of obstetrical training for nurses in New Zealand is referred to in another section of the report, and we are here concerned with the position obtaining since the year 1925, when the Nurses and Midwives Registration Act was passed.

The Act provides for the training and registration of two types of obstetrical nurses—maternity nurses whose training fits them to attend confinements under the supervision of a medical practitioner, and midwives whose more detailed training enables them to conduct normal cases on their own responsibility.

Present Requirements for the Training of Midwives.

A registered nurse who wishes to qualify as a midwife must first complete six months' training as a maternity nurse, and then undergo a further six months' training before sitting for the State examination. An untrained woman must take the prescribed eighteen months' maternity training and must then undergo training for an additional period of six months in order to be eligible to sit for the State examination. The course includes theoretical and practical training in all subjects relating to pregnancy, childbirth, and the care of infants. In particular the applicant for registration as a midwife must show evidence of having personally delivered twenty cases, of having assisted at thirty labours, and of having examined a total of sixty patients ante-natally. The administration of sedative and anæsthetic drugs to the obstetrical degree is also an important factor in the training of a midwife.

Facilities for Training Midwives.

Only four training schools are available for the training of midwives—the St. Helens Hospitals at Auckland, Wellington, Christchurch, and Invercargill—a total of about sixty midwives qualifying yearly from these institutions. These hospitals are maintained on the "closed" system—*i.e.*, the medical staff, all of whom are specially qualified in obstetrics, consists of the Medical Superintendent and a number of assistants which varies according to the size of the hospital. Private practice is not allowed in the hospital, but consultation with practitioners who are not members of the staff is permitted. This method ensures a uniform system being taught in each of the four schools. All normal cases are available for delivery by trainees, and material for ante-natal instruction, while not as plentiful as could be desired, is reasonably adequate. The Matron and senior members of the nursing staff are, in every case, midwives with special qualifications for teaching.

Need for Trained Midwives.

During the past five years 295 midwives have qualified from the training schools, of whom only 56 are not generally trained nurses. Of this number, 222 are, or have recently been, practising obstetrics, 21 are members of the Plunket Society's staff, and 32 have taken positions in general hospitals. In only 20 cases are the present activities of the midwife not known to the Nurses and Midwives Registration Board, and of these it is probable that some have gone abroad to acquire further experience, and some have married.

It will be clear from these figures that the number of midwives qualifying yearly is not by any means too large to meet the present and future needs of the country. In many districts the Committee heard complaints from the licensees of maternity hospitals as to the difficulty of obtaining reliable midwives for their staffs. It is very desirable that charge positions in private obstetric hospitals and all staff positions in teaching hospitals should be held by fully qualified midwives. The admirable service rendered by district nurses in many parts of the country might with advantage be greatly extended in certain districts. It is essential that these nurses should be trained midwives, as ante-natal advice to Maori and European inhabitants of scattered country districts forms an important part of their duties. Further, though district nurses are only occasionally called upon to conduct a confinement alone, circumstances may easily arise in which a nurse finds it impossible to summon medical assistance in time, and may be faced with the necessity of dealing with a serious emergency unaided. A sound training in the fundamentals of obstetrics is an obvious necessity in such cases.

In addition to the requirements of New Zealand, nurses must be supplied to staff the services in the dependencies of Samoa, Cook and Fiji Islands, and also for service in the mission fields. In the majority of instances nurses going out to these positions must be midwives.

Training of Maternity Nurses.

The length of training for a maternity nurse is six months for a general trained nurse and eighteen months for an untrained woman. The general outline of the course is similar to that for the midwife, but less detailed, and involves a more limited experience in the personal conduct of labour.

During the last five years 933 women have qualified as maternity nurses, of whom 768 were registered nurses. Many general trained nurses rightly consider that their training is incomplete until they have gained their maternity certificate. The shorter period of training and the smaller number of deliveries required make it possible for

maternity training to be given in a number of suitable charitable institutions and public-hospital annexes, and only untrained women are accepted as maternity trainees in hospitals which are also training schools for midwives.

For purposes of staffing in a general hospital, and for private work, maternity training is sufficient, but this does not apply to responsible positions in obstetric hospitals or to district work, where the full midwifery training is indispensable.

Objections to the Present System of Training Midwives.

Certain objections to the present system of training midwives have been advanced, of which the following are the principal:—

(1) That the course of training is unnecessarily full and detailed for women who, in the majority of cases, will attend patients only in conjunction with a doctor. A review of the work of district nurses alone will make it clear that this contention is fallacious. A district nurse who, under ordinary circumstances, would not attend actual confinements may at any time be called upon to deal with an obstetrical emergency in the absence of medical assistance. The prescribed attendance on 50 cases of labour 20 deliveries and 30 witnesses) is the minimum which will confer the requisite manual skill, and the number of ante-natal attendances required is barely sufficient to provide the necessary experience and judgment. For a midwife working under a doctor a thorough knowledge of analgesic methods is essential if pain-relief is to be adequate. The lower maternal mortality rate in New Zealand as compared with Canada and the United States of America, where a much briefer and less practical course is given, is sufficient argument for the maintenance and further improvement of the system followed in New Zealand. A suggestion that tutor midwives should be appointed to the training schools would seem worthy of consideration.

(2) That the large number of cases required for pupil midwives interferes with the training of medical students.

It is true that the problem of providing students with sufficient case material is, and always has been, a major difficulty. With the opening of the Queen Mary Hospital in Dunedin, however, all cases in this institution will be available for student attendance, and arrangements exist whereby cases are available in many public-hospital annexes and charitable institutions. Where it is possible to do so without interfering with the midwives' training, the officers of St. Helens Hospitals are always willing to provide students with cases, and abnormalities of labour which are unsuitable for delivery by midwives are not infrequently attended by students under the supervision of the Medical Officer. It would seem that a further development of present arrangements would be preferable to any enroachment on the training material of midwives. As regards the standard of obstetrics in New Zealand, any advance in the teaching of students, important though it may be, will be entirely defeated in its object if accompanied by a lowering of efficiency in the work of midwives.

(3) That the "closed" hospital system observed in training schools for midwives is detrimental to the interests of patients who are denied the right of engaging their own doctor.

It is argued by some that training schools should be conducted on the "open" system—*i.e.*, that any practitioners desiring to do so should have the right of attending patients in the hospital. This course is thought by many to be undesirable in many respects. Under the present system difficulty is experienced in providing the requisite number of cases for pupil midwives, and it is suggested that if any patient who so desired were to be attended by her own doctor the supply of cases would be still more inadequate. There are some, however, who do not consider this difficulty insuperable. Furthermore, as most doctors prefer to do their own ante-natal work, material in this field would be insufficient to enable pupils to form a sound judgment. The multiplicity of methods which would result from the "open" system, while instructive to the graduate nurse, would be confusing to the inexperienced pupil. Uniformity of method in asepsis, treatment, and technique is essential for sound teaching.

(4) That the number of trained midwives is excessive for the needs of the community.

A glance at the figures for the past five years will serve to refute this statement, and the further development of district services which will, in all probability, take place in the near future, will make even greater demands on the number of midwives in training.

(5) That the complicated methods of sterilization and general technique used in the training schools and the large personnel available do not tend to develop resourcefulness and self-reliance in the pupil, who tends to become careless and indifferent to essentials when the appliances to which she is accustomed are not available.

While there is undoubtedly some justification for this objection, every effort is made to help the pupil to distinguish between fundamental necessities and mere amenities, and to develop good judgment and resourcefulness. The suggestion that short refresher courses in hospital should be made compulsory for practising midwives and maternity nurses would appear to be a practical one. Already the number of trained women who take voluntary refresher courses is an indication of their interest in modern obstetrical developments.

Emoluments and Superannuation.

Maternity nursing undoubtedly taxes both the time and the strength of a nurse more than any other branch of the nursing profession. Where employment is regular, as on a hospital staff, the wage she commands may be sufficient to maintain the nurse in modest comfort, though allowing but a small margin for saving. On the other hand, in private nursing or in small country hospital practice periods of unemployment caused by the irregular character of the work may so encroach on the nurse's earnings as to leave her with quite inadequate means of livelihood and little or no more possibility of putting anything by.

While under existing economic conditions it might not be practicable to increase the nurse's fee to a figure more commensurate with the services given, it is clear that some form of superannuation is highly desirable. At present no such provision exists.

Disciplinary Measures.

It was pointed out by a representative of the Nurses and Midwives Registration Board that at present no legislation exists to enable the Board to discipline midwives and maternity nurses who have been guilty of breaches of the Nurses and Midwives Registration Act. While a midwife or maternity nurse who is guilty of a major offence may be struck off the register, no penalty can be enforced for minor offences.

Recommendations.

After detailed consideration of the present position regarding the training and control of midwives and maternity nurses the Committee advances the following recommendations :—

(1) That in the interests of efficient training the present "closed" system be adhered to in training schools for midwives, and that in these schools the appointment of tutor midwives be given consideration.
(2) That short compulsory refresher courses be held for practising midwives and maternity nurses. Such courses should be free of cost.
(3) That no measures be taken which might have the effect of reducing the efficiency of midwives' training.
(4) That an adequate system of superannuation for midwives and maternity nurses be introduced.
(5) That legislation be enacted conferring on the Nurses and Midwives Registration Board powers for imposing adequate discipline on the midwives and maternity nurses under its jurisdiction.

10. TRAINING OF MEDICAL STUDENTS IN MIDWIFERY.

The first specific directions regarding the course in midwifery at the Otago University Medical School are found in the University statutes published in the New Zealand University Calendar for 1882, wherein it is laid down that no student shall be admitted to the final examination for the degree of M.B., Ch.B. until he has shown evidence of having attended a course of not less than sixty lectures in midwifery and the diseases of women, and of having attended six confinements. This regulation remained in force until 1911, when the number of compulsory attendances at confinement was increased to twelve, "of which at least four shall have been attended under proper supervision at a maternity hospital." In 1923 the number of compulsory attendances was raised to twenty, and in 1936 it was laid down that at least eight of these were to take place in the University Maternity Hospital.

Prior to 1931 the subject of obstetrics was taught by a lecturer assisted by two tutors, who attended abnormal cases and gave instruction in ante-natal examination. This latter consisted of the palpation and auscultation of at most six cases. In normal cases students conducted deliveries under the supervision of the Matron or Sister in charge; they were usually summoned when the birth of the child was imminent, and were given no opportunity of observing the different stages of labour or of making internal examinations. The difficulty of providing case material for students was in some degree eased by their admission to St. Helens Hospital, Dunedin, and by the courtesy of the Salvation Army authorities arrangements were made for a limited number of cases to be attended at Redroofs Hospital.

In 1931 a Chair of Obstetrics and Gynæcology was established by public subscription, and a whole-time Professor appointed. The Professor's activities have hitherto been seriously hampered by the limited and inconvenient conditions under which teaching has had to be carried out at the Batchelor and St. Helens Hospitals, both of which are converted residences and lacking in modern equipment.

At the present time, however, a far-reaching change is being effected in the training of students in midwifery by reason of the fact that a modern obstetric teaching hospital of twenty-six beds has been opened, superseding the two small hospitals—the Batchelor and St. Helens. It is equipped with facilities for conducting every type of case, and all case material is used for the benefit of students, no nurses being in training in the

hospital. Arrangements are made for students to reside in the hospital during part of their course, thus eliminating the uncertainty and waste of time which the previous system entailed. While the available case material will still be insufficient for the requirements, further development of the extra-mural teaching system should assist in this respect. The constant attendance at the hospital of the Professor and the obstetric tutors ensures that every student receives a thorough training in all matters pertaining to pregnancy, labour, and the puerperium.

In the past midwifery has, not without reason, been named "the Cinderella of the medical sciences." Teaching was scant and perfunctory, and it was quite possible for a student to become fully qualified without ever having witnessed an obstetrical abnormality or observed a normal labour throughout its entire course. The newly qualified practitioner was sent out to pick up experience as best he might. Post-graduate students who wished to make a special study of the subject were obliged to undertake a costly journey to Europe or America in order to obtain the experience which their own school had failed to give them.

In recent years, however, a complete change of attitude has taken place. It is recognized that if he is to serve the public adequately a practitioner must have a thorough knowledge of both normal and abnormal midwifery, and that this knowledge can be gained only by observation of numerous cases. Every effort is now being made to provide the student with adequate case material, but the small population of the country renders this a difficult task.

The paramount importance to the community of a sufficiency of medical practitioners thoroughly trained in obstetrics cannot be too strongly emphasized. It is a most unfortunate fact that from time to time propaganda of an uninformed character has sought to exclude the medical student from the practice of lying-in hospitals, and it should be clearly understood that such a policy could result only in ultimate disaster to the community. Successful midwifery is not the prerogative of the obstetrical specialist—it is a field in which the general practitioner may, and frequently does, excel; and it is on the men and women who have devoted time and means to the development of obstetrics as a branch of general practice that the safety, health, and happiness of the child-bearing woman must, in the long-run, depend.

While a survey of the history of obstetrical training for students discloses very great improvements in recent years it is evident that much remains to be done in regard to the teaching of this important subject. The two chief difficulties are the provision of case material and the length of time necessary for the proper observation of cases. The first of these can be solved only by increasing the number of extra-mural available cases, the second will in part be remedied by the suggested plan of giving each student one month during the sixth year to be devoted entirely to obstetrics to the exclusion of other clinical duties. The advances of modern obstetrics make heavy demands on the time of both teachers and pupils. A concrete example of this is the use of analgesia in labour, a development the importance of which is universally admitted and which can be learned only by observation of numerous cases from the beginning of labour to its termination. An appreciation of the importance of physiological, as distinct from pathological, labour is another factor which only prolonged bedside experience can teach.

Important as is the training of under-graduate students in obstetric practice, the more specialized training of post-graduates is no less essential. Hitherto no facilities for post-graduate instruction have been available in New Zealand, graduates wishing to practice obstetrics being obliged to go abroad for further training, or else to enter practice with a very deficient knowledge of the subject. The appointment of resident house surgeons to the public maternity hospitals would go some way towards remedying this lack, and the establishment of short post-graduate refresher courses in some of the larger hospitals would be of great assistance to the general practitioner.

The establishment in 1931 of a travelling scholarship to enable medical graduates to gain overseas experience in obstetrics has so far been disappointing in its results, a number of able graduates having left New Zealand under this scheme, and only one holder of the scholarship having returned to the country.

Recommendations.

After a comprehensive study of the needs and conditions of obstetric training in New Zealand, the Committee advances the following recommendations:—

(1) That in view of the paramount importance of sound and practical training of medical students in obstetric practice, the Government, Hospital Boards, and charitable institutions having the care of parturient women be urged to do all in their power to assist the University in the matter of increasing the case material available for instruction of students.

(2) That the appointment of resident house surgeons to the St. Helens and larger public maternity hospitals be considered.

(3) That post-graduate vacation courses in midwifery be inaugurated at the Otago Medical School on lines similar to those followed in the English and Scottish universities.

11. RESEARCH.

No maternity service for a country can be regarded as complete that does not provide for research into the special problems affecting the country for which it is designed.

At the present time no such organization exists, and the Committee advocates its inauguration.

New Zealand women, for some reason which is not known, suffer from eclampsia to a greater extent than those of England, Holland, and some other countries for which the statistical returns are comparable.

One of the first duties of a research service should be to make systematic inquiry into the reason for this position in order to attempt to solve that problem which particularly affects New Zealand, Australia, and Canada.

There is a large mass of information already possessed by the Health Department, the Obstetrical Society, and the Otago Medical School that would be of immense use in this research and possibly might succeed in revealing the causes and replacing assumption and theories with definite knowledge.

Another problem that has lately exercised the minds of those interested in obstetrics is the relief of pain. As has been indicated in another portion of the report, new drugs and new methods of using old ones for the relief of pain during labour have in recent years come into use, and others no doubt will be introduced from time to time.

The necessity for research into this particular subject was made very evident to the Committee by the very varied opinion as to the value and safety of different methods adopted by different practitioners, but in only one instance was any evidence based on a systematic record placed before the Committee, and on no point was there more contradictory evidence given than with regard to the value and safety of the many methods now in use.

The Committee feels that the establishment of an obstetrical research committee under a competent officer who would collect and collate information derived from the many practitioners and workers interested in obstetrics in New Zealand and elsewhere is a duty that is owed to the women of New Zealand, to the practising obstetricians, and even to other parts of the world.

The work of this Committee would, of course, be co-ordinated with that of the Medical Research Committee.

The Committee is of opinion that if a competent research officer were appointed at a reasonable salary there are a large number of medical men interested in obstetrics who would willingly co-operate, and that such an officer would be able to gain and distribute valuable information and make it available for the benefit of New Zealand's future mothers and infants.

12. MAORI MATERNITY SERVICES.

The Risks of Maternity amongst the Maoris.

Contrary to what is widely believed to be the case, childbirth amongst the Maoris is associated with considerable risks; the death-rate is nearly twice as great as amongst the European population, and disabilities following confinement are far from uncommon.

Investigation shows that, whatever may have been the position when the Maoris lived under their truly Native conditions, septic infection is at the present time the most common cause of death.

While pelvic contraction is almost unknown amongst the Maoris, obstructed labour due to malpositions of the child has been one of the dangers in Maori midwifery, and even to-day, when the Native attendants send for help more speedily, deaths from this cause are not uncommon. Experienced observers also suggest that, now that the Native women are performing less laborious manual work, the tendency is for the size of their infants to increase.

Hæmorrhages, both ante-partum and post-partum, constitute another serious menace, and it does not appear that the Native attendants have any adequate method for dealing with these grave, and often very sudden, emergencies. An arresting illustration of the danger came under the notice of the Committee where, within three months of the year, four deaths from hæmorrhage had occurred in Maori homes in one area of the North Island.

To one group of complications, however—the toxæmias of pregnancy—the Maoris appear to be relatively immune. Careful investigation has confirmed the impression held by those interested in midwifery that these conditions, and especially eclampsia, are extremely rare. There is every reason to believe that this is due to the different temperament, habits of life, and diet, particularly of the Natives. It is suggested that a more complete study of these points might yield some important evidence in the investigation of the problem of the toxæmias of pregnancy generally.

Opinions varied as to the frequency of injuries following childbirth. Some doctors stated that evidence of such damage was common in hospital gynæcological wards, but the general experience of the district nurses did not suggest any striking incidence of these complications.

From this brief survey of the risks of maternity amongst the Maoris it will be seen that any preconceived idea that childbirth is easy and safe and that the Natives can well be left to themselves is not supported by the facts.

The Present Methods of Attendance.

The Committee was informed by those engaged in work amongst the Maoris that the conditions under which the women are confined vary considerably.

(*a*) A large number of Maori women are still confined in the Native fashion with the assistance of their own folk—their relations, or Native "midwives," who are usually men of the tribe with special experience in this work. Crude as the methods may appear when compared with modern European standards, the general opinion amongst the district nurses and doctors was that, in the absence of complications, they were effective and, as a rule, applied with reasonable skill and restraint. It was thought, however, that there were some cases in which gross force was used, and some cases in which the use of forceful methods was mistimed, leading to fatigue and resultant complications. It was stated that a commendable feature was that no examinations of the patient were made and that this, under the circumstances, lessened the risk of infection.

The main criticism of the Native method appeared to be in respect of the very unhygienic environment in which it was now so frequently practised. The impression was given that methods quite suitable under truly Native conditions in a more or less temporary raupo whare, in a clean bush clearing, and near a fresh-running stream were much less satisfactory when used under quasi-European conditions in a dilapidated, often overcrowded, and probably germ-infested wooden house, in an insanitary Native village.

The increase in dental and throat sepsis and in septic skin conditions—all previously rare among the Maoris—has introduced new dangers. To the Committee another serious disadvantage of the method is the inability of the Native attendants to deal with certain grave and sudden emergencies which cannot be predicted by ante-natal supervision. A striking example of this risk has already been recorded. The Committee has also reason to believe that the Native attendants of the present day are less skilled than those of a previous generation.

(*b*) Attendance by the Health Department district nurses to Maoris at the actual confinement in the home is, with few exceptions, limited to assistance in cases where some difficulty has arisen. The limited number of nurses, their large districts, and their manifold duties makes any other course impossible at the present time even were it desirable.

Even when called to these cases it is often the practice of the nurse to allow the Natives to follow their own method under her supervision, and the introduction of the European technique is only attempted in cases where it is considered definitely necessary. The practical difficulties of applying this technique under Native conditions were stressed by all the nurses.

Attendance by doctors is similarly limited almost entirely to abnormal cases. It was stated that the Maori attendants were more ready to-day to call in timely assistance, and that grossly neglected cases were much less frequent than formerly.

(*c*) An increasing number of Maori women are now entering maternity hospitals for their confinements. This is due largely to the advice of the nurses, but in many cases it is the result of their own appreciation of the advantages.

It was found that in certain hospital districts the knowledge of the fact that pain-relief measures were used was proving a strong attraction to the younger generation.

The Committee found that the demand for, and the provision of, hospital facilities varied greatly in different districts.

In North Auckland and Rotorua, for instance, the available accommodation was found to be sufficient for present requirements, but would need to be considerably extended to meet the increasing demands.

In the Bay of Plenty and Taranaki districts, on the other hand, the hospital provision was not considered adequate. It was suggested that disinclination to enter hospital was often due to a conflict with Maori customs which occurred under these circumstances, but the Committee was convinced, from the experience elsewhere, that, where sympathetic consideration, which is essential, was given to the feelings of the Natives, little difficulty was experienced.

It was the general opinion that, in the interests of both Maori and European patients, there were great advantages in having separate wards.

In some hospitals the prevalence of septic-skin conditions amongst the Maoris was regarded as a potential danger to other patients and was certainly a reason why they were less welcome than would otherwise have been the case.

Ante-natal Care.

The Committee was informed by the district nurses that Maori women of the present generation appreciate the value of ante-natal care and are very willing to receive the help even though it is their intention to be confined in Native fashion in their homes.

At the present time the district nurses to Natives, who are provided with motor-cars, endeavour to combine as much of this ante-natal advice as possible with their

general work, and a considerable number of Maori expectant mothers are seen at least a few times pre-natally.

Advice is given concerning diet and hygiene—where the confinement is to be conducted by the Native method attempts are made to give instruction in the elements of cleanliness, and in some cases simple sterile equipment is provided; some attempt is made to treat skin conditions and similar complaints, and where abnormalities are detected entrance into hospital is urged. All this is of considerable value. It cannot, however, be said that any organized supervision of the kind which is now considered to be necessary has been achieved. As with the European women living in more sparsely populated districts, it seems quite impossible to arrange regular attendance at ante-natal clinics associated with the local maternity hospitals. The solution of the problem would seem to be an increase in the number of the district nurses to Natives sufficient to allow of frequent visits to these Maori women in their own homes. The Committee believes that such a system, worked in close co-operation with the maternity hospital of the district, could give an adequate service.

Recommendations.

(1) The Committee considers that the logical conclusion is that the same general policy of hospitalization of maternity cases should be developed for the Maoris as for the European mothers; indeed, the arguments in favour of this course might be regarded as even more cogent owing to the inability of the Native domiciliary method to meet serious emergencies.

It is accordingly recommended that in all Maori districts provision should be made in the local public maternity institutions for the admission of Native patients and that sympathetic consideration be given to their customs.

It is suggested that, as far as possible, separate wards should be provided.

(2) It is considered that a more thorough system of ante-natal supervision could be organized by the local maternity hospitals working in conjunction with, and largely through the agency of, an increased staff of district nurses to Natives. With this service further post-natal supervision could also be given.

(3) The Committee believes that an important factor in the improvement of midwifery conditions among the Maoris lies in a betterment of their housing and general hygiene. The menace of skin and other infections can only be combated by such measures.

It is considered that an extended district nursing service such as has been advocated could do much valuable preventive work in this direction.

13. FACILITIES FOR THE CARE OF THE UNMARRIED MOTHER.

(1) *Public Facilities.*—Unmarried patients are admitted to all Government and Hospital Board maternity hospitals on the same terms as the married. This is a sufficient provision in cases where the patient has a home of her own to return to and where the means for caring for the child are satisfactory.

(2) *Private Facilities.*—Where financial resources permit, private hospital or private domiciliary attendance is arranged for.

(3) *Charitable Institutions.*—Certain religious and charitable institutions provide not only for the confinement and puerperium, but also for the care of the mother for a period before and after delivery. The Alexandra Home, Wellington, the Essex Home, Christchurch, the various Salvation Army Homes, and the St. Mary's Home, Auckland, are examples of this type of institution, the advantages of which are that a girl is able to enter a home, perhaps in a distant town, before her acquaintances have become aware of her condition, and that she is kept in the home for some months after delivery, being thus enabled to nurse her child and give it a better start in life. During her stay in the home the girl is given careful ante-natal and post-natal attention, and is taught domestic work and handwork, those in charge endeavouring to inculcate better ideals of parenthood and citizenship. That such provision is beneficial is seen from a consideration of the statistics. It is well known that the rate of both maternal and infant mortality is distinctly higher among unmarried than among married women, this being easily accounted for by the fact that in the unmarried pregnancy is often concealed until a late period, so that no ante-natal care is given, and the birth not infrequently takes place in unsuitable surroundings with inadequate attendance. Where, on the other hand, unmarried patients are admitted to suitable institutions where they receive proper care and attention, statistics of morbidity and mortality campare favourably with the figures relating to the total birth-rate. It is worthy of note that the opinion formerly held that endurance of pain during labour is an essential part of the discipline to be meted out to girls who have transgressed the moral code is now rapidly losing ground. With few exceptions it was found that in homes for unmarried girls pain-relieving measures are being used to an increasing extent. This tendency is especially noticeable in homes having a department for married women in addition to that for rescue work, the high standard of technique in the private wards being reflected in the care given to the unmarried patients.

Recommendations.

The Committee is impressed with the valuable work in assisting the unmarried mother which is being done by the various charitable institutions visited, and recommends that every possible support and encouragement be given to this work.

Recognizing that the separation of mother and child is detrimental to the interests of both, the Committee appeals to the public at large to give every assistance to the unmarried mother who determines to keep and support her child to rehabilitate herself in the community.

14. SOCIAL ASPECTS.

A. TRANSPORT.

In urban areas difficulties of transport seldom arise, private or hired cars being easily available, and ambulance services being at hand for emergency cases. In Christchurch an excellent system of voluntary private transport has been developed in connection with St. Helens Hospital for the benefit of those patients who cannot afford taxi fares and are unable for any reason to make use of tram or bus services. A similar system would be appreciated in many other localities.

In country districts conditions vary very widely regarding transport facilities as will be seen from the section of the report regarding local conditions. An example of this variation is seen in a comparison between the districts of Hawke's Bay and Bay of Plenty. In the former district little difficulty is experienced in the matter of transport, as the majority of residents own motor-vehicles, and those who do not are for the most part able to rely on the good will of neighbours for assistance in an emergency. In the Bay of Plenty, on the other hand, transport difficulties form a serious bar to patients attending hospital or clinic, in many cases the only means of transport being a service car passing at rare intervals and often at a considerable distance from the homestead. No ambulance service is maintained by the Hospital Board.

In other districts, though transport facilities are available and the roads are good, the length of the journey which must be made in order to reach the nearest hospital involves great expense, as well as discomfort and inconvenience to patients. Such conditions are exemplified in North Westland, where residents of Karamea have to travel sixty-three miles to reach the hospital at Westport.

In the Palmerston North district difficulties of transport are to a great extent overcome by maintaining a number of district nurses provided with cars, who visit patients in outlying districts, thus obviating the necessity for frequent visits by the patients to a clinic. The Hospital Board's ambulances are at the service of patients in emergencies. This method of dealing with the transport problem is a very effective one.

Bruce Bay, in South Westland, is an example of a district which may become completely isolated during unfavourable weather, at which times the only means of transport is by air. Such conditions are rare in New Zealand.

The recommendations of the Committee regarding transport difficulties are fully set out in the section of the report which deals with local conditions. Briefly these recommendations fall into the following categories :—

(1) Where difficulty arises from lack of transport facilities, the development of a visiting service similar to that in the Palmerston North district is advocated.
(2) Where distance is the cause of the difficulty the erection of small local hospitals is recommended.
(3) The establishment of waiting-homes for expectant mothers is advocated in certain localities in order to do away with any necessity for patients travelling when at or near the onset of labour.
(4) In certain districts where communication between an outlying area and a main centre is difficult, improvement in road communication is recommended as a more economical alternative to the erection of a local hospital.

B. TELEPHONES.

The Committee found that telephonic communication throughout the country is in the main satisfactory, even the most isolated areas being reasonably well served in this respect. In some instances complaints regarding the telephone service were heard, but on investigation these proved to have but little foundation. The suggestion received in one locality that all residents of outlying areas should be supplied with telephones free of charge is a manifest impossibility, since the cost of such a service would be prohibitive and its uses very restricted.

A more genuine cause for complaint was the closing of country exchanges on Sundays and holidays, which is alleged to be a source of hardship in some instances. In most cases, however, it is possible to have the exchange opened for emergency purposes on payment of a small fee.

The Committee recommends that in cases where no telephone is available in isolated areas, public telephones be installed, if necessary in private residences, and so situated that no resident of a district is at a distance of more than five miles from a telephone.

It is also urged that Postmasters or others having charge of small country exchanges be requested to make adequate provision whereby the exchange may be made available on holidays and during the night in case of necessity.

C. DOMESTIC ASSISTANCE.

In every part of the country visited by the Committee the problem of domestic assistance was found to be of paramount importance. Lack of adequate help in the home is a difficulty which affects all classes of the community in both town and country, and there can be no doubt that in many cases it acts as a powerful deterrent to child-bearing. Further, the incessant round of domestic work and anxiety regarding household affairs play havoc with the physical and mental health of many women. Frequently the lack of domestic assistance causes much greater distress to the overburdened housewife than actual financial stringency, and it is evident that this problem is an urgent one.

Reasons for the Shortage of Domestic Help.

Domestic work as practised in many homes in this country is little more than a round of endless and uninteresting drudgery. Work must begin at an early hour in the morning and continue until late in the evening, with often not more than one half-day, and perhaps two evenings, of freedom during the week. There is no free time at the week-end, with the exception of the afternoon and evening on alternate Sundays, and restrictions on personal liberty are harrassing to many women who adopt this means of livelihood. Lack of consideration and sympathetic understanding on the part of householders towards their domestic assistants is not infrequently a cause of the latter refusing to remain in domestic service.

Young women and girls, therefore, are scarcely to be blamed if they turn from so unattractive a prospect to one of the many other avenues of employment which are now open to them. Work in a factory, shop, or office may be hard and exacting, but the compensations of personal liberty, shorter hours, and complete freedom during week-ends and evenings lead many women to prefer this life to a subordinate position in the home of strangers.

For some reason, which is difficult to assess, the domestic worker is often looked down upon and made to feel that her position is an inferior one, instead of being accorded the respect and consideration which are due to every *bona fide* worker from the community in which he or she works.

The manageress of a well-known and justly popular domestic registry office recently volunteered the information that the opening of a large new store in the city had almost completely depleted the personnel from which her supply of domestic workers had previously been drawn.

It is thus evident that the whole question of domestic assistance demands immediate and thorough investigation.

Attempts to meet the Shortage of Domestic Help.

It would be difficult to praise too highly the efforts of certain women's organizations to deal with this grave problem, at the same time placing the matter of domestic service on a better footing. In country districts the Women's Division of the Farmers' Union, by means of an admirable voluntary organization, endeavours to send working housekeepers to families where, by reason of illness, the mother is compelled, for the time being, to relinquish household duties. Preference is given to expectant mothers and those about to enter hospital for confinement. The women employed are responsible and experienced individuals capable of taking entire charge of a household in an emergency. A reasonable salary is paid and the housekeepers find no lack of employment. Every effort is made to meet all requests for help, but lack of personnel is a serious drawback. This excellent service is an example of genuine mutual aid, and a very real asset to the domestic life of this country.

The more recently formed Townswomen's Guilds are endeavouring to perform a similar service for women in the towns, and labour under difficulties similar to those experienced by the country women's organizations.

Smaller organizations, such as Mothers' Help Societies, operate in certain localities with great benefit to the community. They also, however, encounter almost insuperable difficulties in obtaining sufficient helpers.

Certain religious and charitable institutions having the care of orphaned girls give them excellent training in domestic work. On reaching a certain age the girls enter domestic service, though still remaining under the care of the institution. While in many instances this is a most valuable form of service, the numbers provided are too small materially to affect the problem as a whole.

SUGGESTED REMEDIES.

In the report of the Committee of Inquiry into the Abortion Problem reference was made to this matter, and it will not be out of place here to quote verbatim from the section of that report dealing with the question of domestic assistance :—

"Many admirable efforts are being made to give assistance in this direction—in the country by the housekeeper plans of the Women's Division of the Farmers' Union and other organizations, in the cities by the Mothers' Help Society and similar agencies. Extension of such systems is highly desirable, and the possibility of their organization on a much larger scale with a subsidy from the Government well deserves consideration.

"In many cases these efforts are limited as much by lack of personnel as by lack of funds.

"Alternatively, we suggest—

"(1) That the Government should inaugurate and recruit a National Domestic Service Corps of young women agreeable to enter the domestic service profession.

"(2) That the recruits be guaranteed continuity of employment and remuneration as long as their service was satisfactory.

"(3) That they undergo whatever training is considered desirable at technical school or otherwise.

"(4) That they agree to perform service wherever required by the Domestic Service Department, which Department will ensure that the living and working conditions are up to standard.

"(5) That the service be made available to all women and that first consideration be given to expectant mothers, mothers convalescent after childbirth, and mothers who have young families, and that the service be either free or charged for according to the circumstances of each case.

"Again realizing the fact that many of the considerations involved in this question of domestic help are beyond the scope of this Committee, we recommend that a full investigation of the matter should be made."

The Committee fully endorses the suggestion of the Committee of Inquiry into the Abortion Problem, but realizes that certain factors other than those mentioned merit consideration, some of which are briefly indicated here :—

(1) Domestic work should never be allowed to fall to the level of dull and monotonous routine. Personal interest in the home life should be encouraged in the domestic staff by the development of activities, such as gardening, handwork, &c.

(2) The accommodation of the domestic staff should be not merely hygienic, but as pleasant and attractive as possible. This can be achieved at very little extra cost to the householder.

(3) There should be facilities for a reasonable degree of privacy.

(4) Hours of work should be reasonable, and the worker's time when off duty should be entirely her own. The pursuit of outdoor activities should be encouraged.

(5) The relationship between the employer and the domestic worker is of first importance. An attitude of sympathy and interest on the part of the employer will often gain the loyalty and co-operation of a worker where indifference or intolerance will have the opposite effect.

The Committee is confident of the good will of all sections of the community in an endeavour to solve this major problem of modern life, and urges that no effort should be spared to place the service of the home on the footing which it merits.

15. ECONOMIC CONSIDERATIONS.

Modern maternity care of the standard rightly regarded as necessary in New Zealand cannot be cheap. Whether it be hospital service or full-time domiciliary nursing attention, the expenses are necessarily considerable. The only cheap service is a no-doctor district midwife system with the nurse attending daily and not living in the home ; this, the Committee is convinced, is not generally acceptable in New Zealand.

The Committee gave close attention to the question of costs throughout its investigation.

It is satisfied that the fees charged in the public maternity hospitals are by no means high for the service given ; this is clearly proved by the fact that they rarely cover the cost per patient in these hospitals.

The provision of even the minimum facilities and equipment necessary for carrying out the recognized aseptic and antiseptic technique ; the addition of an ante-natal service requiring extra facilities and extra staff ; the payment of nurses in training who previously received no remuneration ; the increase in staffing necessitated by shorter hours ; a much-developed teaching syllabus and a standard of care which calls for closer supervision of the patients—all these factors have added greatly to the hospital costs.

Similarly, the private maternity hospital fees are not high when the costs of maintenance and the work involved are taken into consideration. Maternity nursing is exceedingly arduous and responsible, and the administration of a maternity hospital is associated with particular difficulties owing to the uncertainty of the dates on which patients will be admitted to hospital; no maternity hospital is able to book patients up to its full-bed capacity.

Few maternity hospitals, regarded as investments, would be found to be giving an adequate return for the capital involved. In the majority of cases they are merely providing a home and a moderate living for the nurses who own them, or, in the case of doctor-owners, a satisfactory environment in which their midwifery work can be conducted.

The Committee is also satisfied that, taking into consideration the range of service involved, the responsibility and the exacting nature of the work, and the great additional demands of modern ante-natal and post-natal care, the medical fees in midwifery practice are moderate and in some cases quite inadequate. Thus, while the total costs when paid by the individual may seem considerable, the charges for the various items of the service are by no means excessive.

The fact must also be faced that certain of the improvements recommended in this report—the further development of doctor-attendance, the extension of the ante-natal and post-natal services, and the more general administration of pain-relief—would add somewhat to these costs.

The economic problem, therefore, appears to be not how the services can be cheapened, but how the individual in need can be assisted to meet these necessary costs.

It is quite clear that the expenses of the service are beyond the means of a large section of the community and a definite burden to others.

Already the care of the indigent in maternity has for some years been the statutory responsibility of all Hospital Boards, and satisfactory provision has been made in most Hospital Board districts. The Committee has recommended the development of the maternity hospital system in such a way that the deficiencies in this respect shall be remedied and assistance to the indigent shall be available in all cases.

The position of those who, while not indigent, find difficulty in meeting the expenses of confinement has also been very considerably helped by the provision of public maternity hospitals—either St. Helens Hospitals or maternity annexes to general hospitals—in which very adequate facilities are available at a moderate fee which is further subject to adjustment according to the circumstances of the patient.

In a number of instances a very valuable assistance has been given to still another section of the public by making the public maternity hospital facilities available for those who desire the services of their own doctors. It will thus be seen that at the present time a very great deal of public assistance is being given both by providing modern hospital facilities and by giving service to the recipient either free of cost or at reduced fees.

In the majority of cases this public assistance is based on the midwife system, with a doctor available in cases of difficulty.

It will be understood that, under existing conditions, the development of the maternity services in certain directions which have been considered desirable would necessarily call for further public assistance.

An alternative method of meeting the relatively high costs of this complete maternity service is by a system of health insurance. In many countries this principle is being largely developed, and the Committee was impressed with the possibilities of maternity benefit, covering both hospital service and medical attention, in New Zealand.

At the present time those contributing directly, or indirectly through friendly societies, to the National Provident Fund receive a maternity benefit of £6. The Committee had ample evidence of the great value of this type of insurance in helping individuals to meet hospital and medical fees.

The Committee does not, however, regard a cash benefit, helpful though it undoubtedly is, as the most satisfactory form of insurance assistance, and recommends that in the investigation of a national health insurance scheme for New Zealand full consideration be given to a maternity benefit which will cover both hospital and medical expenses by direct payment to those giving the service.

SUMMARY.

PART 1.—REPORT ON LOCAL CONDITIONS.

In Part 1 of the report the Committee has given a detailed review of the conditions existing and the facilities available in all the Hospital Board districts throughout the Dominion. Recommendations arising out of the needs of each particular locality have been made.

PART 2.—GENERAL SURVEY AND RECOMMENDATIONS.

Methods of Attendance.

Turning to the general considerations based on this complete survey, the Committee has first discussed the relative position of the doctor, the midwife, and the maternity nurse in the maternity service. The Committee found that the preference in New Zealand is for attendance by both doctor and midwife, or doctor and maternity nurse, in all cases, normal or abnormal, rather than for attendance by midwives in normal cases with the doctor acting in a supervisory capacity and available in abnormal cases.

The former system is advocated by the majority of doctors in New Zealand for reasons which have been fully explained, and is favoured by the majority of women, although, at present, mainly owing to financial circumstances, a considerable proportion of women are attended on the midwife system, especially in the St. Helens Hospitals and the annexes to public hospitals.

Full consideration was given to this matter because it is recognized that in some countries with very efficient maternity services the midwife system operates. It is the opinion of the Committee, however, that, while the midwife system can give a safe and efficient service, the combined system of doctor and nurse attendance can give a still more efficient and a more satisfying service.

The extension of this principle is therefore advised, and certain recommendations have been made whereby such a combined service might be brought within the reach of all by the appointment of house surgeons to act in conjunction with the senior staff in all the main public maternity hospitals and in the larger maternity annexes, by Hospital Boards making provision for the doctor-attendance of indigent cases in smaller hospitals, and by the incorporation of provisions for doctor-attendance in any national health insurance system which may be developed. The Committee fully recognizes the importance of thoroughly competent medical attention, and is in complete sympathy with all steps which will lead to the most efficient practical training of medical students in this work and to the encouragement of the special practice of midwifery by those to whom it appeals. While in isolated districts all general practitioners must of necessity engage in obstetric practice, the Committee is in accord with the tendency in larger communities for the midwifery to be undertaken by those who, through partial or full specialization in this branch of medicine, are best fitted to give the service.

See reservations by Doctors Sylvia G. de L. Chapman and T. L. Paget..

Hospitalization or Domiciliary Attendance.

The Committee next examined a second important matter of policy regarding which there are differences of opinion—the extent to which hospitalization should be encouraged. It was found that the tendency in New Zealand was overwhelmingly in the direction of hospitalization of all maternity cases, both normal and abnormal; at the present time 81·75 per cent. of all cases are conducted in hospitals.

The Committee is satisfied from the evidence presented that the advantages of hospitalization, as far as New Zealand conditions are concerned, have been clearly proved, and has no hesitation in recommending that any national maternity service shall be based, in the main, on hospital attendance.

District Nursing Services.

As a natural corollary to this increase in institutional treatment there has been a corresponding decrease in domiciliary attendance which has affected both the public district nursing services and private maternity nursing practice. Although provision must still be made for a certain amount of this type of attendance, both in the cities in association with the St. Helens Hospitals and in the country through the agency of district nurses, the Committee is satisfied that the existing facilities of this nature are sufficient and that there is no object to be gained in attempting to extend such services in the face of the present trend of practice.

The Committee has, however, recommended that the services of the district nurses could be further developed, more particularly in the country districts, to assist the hospital ante-natal clinics and the doctors by the nurses making supplementary visits to the patients' own homes, thus overcoming some of the difficulties which at present interfere with the complete ante-natal supervision of these women.

Conclusions and Recommendations regarding Future Hospital Policy.

In the light of this tendency towards hospitalization, the development of the maternity hospital system becomes a matter of first importance. The Committee made an extensive survey of the existing hospital facilities, both public and private, and is satisfied that already the hospital system is developing on sound lines, although there was found to be a certain lack of uniformity in this development, especially in respect of the public provision made by different Hospital Boards. The effects of the policy of the Health Department in insisting on essential equipment and a uniform standard of maternity care were also clearly evident in a high level of general efficiency and safety even in the small hospitals which were by no means elaborate in their accommodation.

The Committee has made certain recommendations whereby, building on the existing structure, a complete and uniform system may be developed suited to the varying needs of country districts, larger towns, and main cities.

These recommendations are regarded as so important as to require restatement in full. The Committee has advised as follows:—

"1. *In all country districts* it should be the general policy to provide maternity hospital facilities as close to the homes of the mothers as is reasonably possible. Such provision makes it possible for the mother to be attended by her own doctor both in the ante-natal period and for confinement, relieves her of the physical and financial burdens associated with frequent visits to clinic and hospital in a distant centre, and keeps her in closer touch with her family. Admittedly these smaller units cannot be of the ideal maternity hospital standard, but they can give the essentials of safe maternity care. It is considered that the advantages of nearness to the homes of the patients outweigh the benefits to be gained by centralization in bigger units at long distances from the homes. It should be recognized as the responsibility of the Hospital Boards to make this provision for those unable to make private arrangements, and, since in most of these districts it is not possible to develop satisfactorily both a public maternity hospital and a private maternity hospital, it will, as a rule, be better to concentrate on one institution.

"(*a*) Where no satisfactory private hospital is available which would be capable of development to meet the full needs of the district it is recommended that a public maternity hospital be established and controlled by the Board, and that, in addition to making provision for the nursing treatment of all indigent cases, the Board should accept responsibility for the medical attention of such cases both ante-natally and at confinement when necessary. It is also recommended that such hospitals be made available to the local doctors for the treatment of their private patients. The Committee believes that by satisfactory health-insurance provisions it would be possible to attain the ideal of doctor-attendance for all cases in these hospitals.

"(*b*) Where an efficient private maternity hospital is already functioning in the district it is considered that the most advantageous and economical course is to make use of this hospital to serve the public needs by some method of financial assistance which is satisfactory to all those interested. The Committee believes that the most satisfactory method would be by hospital benefit under a health-insurance system. The alternative in the neantime is to arrange for a uniform and acceptable system of subsidy by Hospital Boards.

"Although some very well managed 'mixed' hospitals taking both maternity and medical and surgical cases were inspected and strong arguments were brought forward in some country districts in support of such combined hospitals when strictly controlled, the Committee is convinced that as far as possible the principle of the purely maternity hospital should be developed.

"2. *In all the larger towns and small cities* the policy should be to develop maternity hospitals of a larger and more modern type. It is recognized that the converted private house rarely fulfils all the requirements, and, as far as possible, all new maternity hospitals should be specially constructed for the purpose.

"The ideal moderate-sized hospital should be large enough to allow of the maintenance of a night nurse and a staff sufficiently large to make possible reasonable hours of duty; proper staff quarters should be provided; it should have labour ward block and nursery so placed as to be well removed from the lying-in wards; and it should have sanitary arrangements and equipment which conform to accepted standards. These provisions are hardly possible if the hospital has less than ten beds. In such communities the number of people requiring some public assistance is so large that the only really satisfactory way to serve their needs is by the establishment of a maternity annexe or hospital in association with the general hospital. This should be regarded as a definite duty of all Hospital Boards, and due publicity should be given to the facilities available. In addition to making this hospital provision the Boards should also be responsible for the medical attention of indigent maternity cases.

"Having seen how very well the 'open' maternity annexe meets the needs of those who desire modern maternity hospital facilities at moderate cost and who wish at the same time to be attended by their own doctors, the Committee is definitely of the opinion that this community-hospital principle should be adopted in all maternity hospitals and annexes of this group. It is also recommended that each of these annexes be placed in the charge of a medical practitioner with special experience in obstetrics to be responsible for the treatment of Board cases, for the training of maternity nurses, and for the general supervision of the hospital.

"It is considered that the establishment of a number of such positions would be an inducement for practitioners with this special experience to take up practice in these towns and that such a policy would be very beneficial to the maternity service of the whole country.

"In such towns there will also be a place for private maternity hospitals. Recognizing the good service that many small private hospitals have given in the past nothing should be done to injure them, but, nevertheless, when the present licensees retire the perpetuation of such small hospitals should be discouraged and every endeavour made by a combination of interests to establish more efficient hospitals of the type indicated.

"3. *In each of the four main cities* (Auckland, Wellington, Christchurch, and Dunedin) the general policy should be to develop maternity hospitals along three lines:—

"A. A MAIN OBSTETRIC CENTRE.

"It is recommended that very careful consideration should be given to the development of one main public maternity hospital in each of these cities to act as the centre for the obstetrical activities of the area.

"The principles which should be kept in view are already seen applied in the Queen Mary Hospital in Dunedin, and have guided the Committee in its full recommendations regarding the proposed new St. Helens Hospital in Christchurch.

"I. *The Site.*

"The site should be in a pleasant environment and sufficiently large to allow of future expansion.

"Convenience of access for patients from all parts of the district should be studied, the thought being not so much of the transference of the patients to the hospital at the time of lying-in as of the much more frequent attendances at the ante-natal clinic which modern maternity care now demands. A site reasonably accessible by tram or bus is obviously desirable. Consideration should be given to the value of close proximity to the general hospital, which, in many ways, tends to economy, efficiency, and safety.

"Although in many respects a well-equipped maternity hospital is a self-contained unit, yet there are occasions on which close contact with the facilities of the general hospital is most desirable. For purposes of X-ray examination, for the fullest use of the laboratory services, for full co-operation with the other out-patients' departments, and for convenience in consultation with physicians and surgeons there are undoubtedly great advantages in the two hospitals being close together.

"II. *The Scope of the Hospital Activities.*

"(*a*) *Provision of a Full Maternity Service for Mothers in Poorer Circumstances.*—This is simply an extension of the present St. Helens service.

"(*b*) *Provision for Emergency and Complicated Cases.*—In addition to being the main public maternity hospital for normal cases it is recommended that each of these hospitals should be the centre for the treatment of obstetric emergencies. Although any reasonably equipped maternity hospital is able to deal with the great majority of its own 'booked' cases, there are always a few cases which require special facilities for their treatment. Such cases have hitherto been dealt with in the general hospitals under conditions which have not been fully satisfactory. The position could be improved either by developing a fully-equipped and properly staffed unit for complicated cases in connection with the general hospital or by combining this department with the main maternity hospital. The Committee is satisfied that the latter course is preferable.

"(*c*) *Provision for the Training of Midwives.*—The main hospitals in Auckland, Wellington, and Christchurch would continue, as at present, to be the chief training schools in the Dominion for midwives and maternity nurses.

"Owing to the special circumstances obtaining in Dunedin with its Medical School, the Queen Mary Hospital has been given over to the training of medical students.

"(*d*) *Provision for the Training of Medical Students.*—The investigation of the Committee makes it clear that the general tendency is towards a system in which every woman will be attended by a doctor, as well as a midwife or maternity nurse, during pregnancy and labour. That being so, the adequate training of the future medical practitioners of the country is a matter of urgent importance and a responsibility which the community itself must accept. The problem of providing sufficient clinical

experience for medical students in this important subject is a world-wide difficulty and is an acute one in New Zealand. It is with the greatest difficulty that the very reasonable requirements of the General Medical Council are even approached. Even with the special facilities which have been referred to in the Queen Mary Hospital in Dunedin the number of cases available will be quite inadequate to meet the needs of all the students. It is obviously desirable that assistance should be given in this matter in other centres where the hospital facilities, the clinical material, and the special experience of the staff are conducive to efficient training.

"It is generally agreed that efficient training is greatly promoted where resident facilities are provided in the obstetric hospital so that the students can be in the closest touch with all phases of the work.

"The Committee recommends that, as each of these hospitals is developed, resident facilities for medical students be provided.

"(*e*) *Provision for a Resident House Surgeon.*—The view is widely held that a stage has now been reached in the development of the larger obstetric hospitals in the Dominion when the provision of a resident house surgeon is necessary to give the fullest service. It is advocated that in such cases a resident doctor with at least one year's experience as a house surgeon would be of the greatest assistance to the Superintendent and the other members of the staff in much of the routine work of the hospital, and that there are many directions in which he could be of assistance to the patients, as, for instance, in the giving of more adequate pain-relief than is now possible.

"It is also urged that such appointments would be in the interests of the maternity service generally in that they would afford opportunities for the more special training in obstetrics, under experienced supervision, of a number of the best New Zealand graduates.

"The Committee is impressed with these arguments and recommends that, in each of the new main hospitals suggested, provision be made for a resident house surgeon.

"*III. Medical Staffing.*

"All those associated with the administration of these teaching hospitals for midwives are definite in their opinion that they should be of a 'closed type' with a staff of Superintendent and assistant obstetricians possessing special qualifications.

"Dr. McMillan dissents from this view and is of opinion that all doctors who possess approved post-graduate qualifications and who are prepared to comply with regulations should have the right to attend patients in St. Helens Hospitals and that the patients should have free choice of these approved doctors.

"He is of opinion that such a system will encourage medical men to undertake post-graduate study on the one hand, while on the other the free choice of these approved doctors will ensure that the wishes of the patients receive more consideration.

"The majority of the Committee are sympathetic towards Dr. McMillan's suggestions, but in view of the overwhelming nature of the evidence to the contrary, are convinced that they are impracticable at the present time.

"*Supervision of Obstetric Cases in General Hospitals.*—Until the policy suggested above is so far implemented that maternity patients need not be admitted to general hospitals, all such hospitals should have on their medical staff an experienced obstetrician who would be responsible for the treatment of all obstetrical emergencies and abnormalities admitted to the hospital. This would avoid the undesirable practice at present existing in some general hospitals of patients sent in for cæsarean section or other obstetrical operations being referred to surgeons who may have only a limited obstetrical experience.

"*IV. Administration.*

"On account of the special relationship between the Otago Medical School and the Dunedin Hospital it has been considered advisable, in the case of Dunedin, to develop the main obstetric hospital under the administration of the Hospital Board.

"In the other main cities, owing to the particular interests of the Department of Health in the uniform training of midwives, it is recommended that the hospitals continue as St. Helens Hospitals under the control of the Health Department.

"Dr. McMillan is not in entire agreement with this recommendation, and points out that for quite a number of years the St. Helens Hospitals in Auckland, Wellington, Christchurch, and Invercargill have been in a deplorable condition structurally and that facilities have been improved very reluctantly and very grudgingly, with the result that they compare most unfavourably with the maternity annexes provided by the more progressive Hospital Boards.

"While recognizing that the Minister of Health has expressed his intention of bringing these hospitals up to modern requirements, Dr. McMillan argues that as in the past there has been, so in the future there can be no guarantee that there will not again be, in office a Government which will refuse to keep these hospitals up to date, and is of the opinion that in the long-run the best conditions would be obtained by placing their administration in the hands of the respective Hospital Boards. Dr. McMillan does not admit that either the modified 'open' system or Hospital Board administration of St. Helens Hospitals would militate against the efficiency of the midwife trainee, and instances the high standard of efficiency that is obtained in the training of general nurses in Board institutions.

"B. COMMUNITY HOSPITAL SERVICE.

"The need for modern 'intermediate' hospital accommodation is just as pressing in the cities as it is in the towns.

"The Committee has agreed with those responsible for the administration of the main teaching hospitals that it would not be satisfactory to conduct them on the 'open' principle. Nevertheless, it is felt that all other interests cannot be made subservient to the requirements of the teaching hospital and that some hospital accommodation should be provided where patients of moderate means who so desire it can be attended by their own doctors. It seems entirely illogical that because a patient is living in a city in which the public maternity hospital is a training school for midwives or students she must be denied a valuable privilege which is available in smaller centres. Where such institutions as the Salvation Army hospitals and the Alexandra Hospital are operating they meet this need well, and the development of such services is to be encouraged.

"The alternative course would appear to be the establishment of an independent community hospital wing in connection with the main public maternity hospitals, staffed by trained nurses and not used for teaching.

"This suggestion, however, does not receive the unanimous support of the Committee, some of whom hold that the State is not called upon to provide two types of service in its main maternity hospitals.

"C. PRIVATE HOSPITALS.

"The same policy is recommended for the development of the private hospitals in the cities as in the towns—a combination of interests to establish hospitals of modern design and large enough to allow of fully efficient staffing.

"D. ONE-BED HOMES.

"Throughout the country there still remain a number of unregistered homes in which a midwife is allowed to take one case at a time and which are not subject to inspection as hospitals.

"The Committee is of the opinion that all such homes should be subject to definite regulations as are the private maternity hospitals.

"The Committee, though recognizing the useful part which many of these homes have played in the past, consider that they lack many of the advantages of larger hospitals and are not a really satisfactory feature of a modern maternity service."

ANTE-NATAL CARE.

In reviewing the ante-natal services of the Dominion the Committee formed the conclusion that, although there is a very general appreciation of the value of ante-natal care both by the members of the medical profession and by the women of the country, its full benefits have not yet been generally experienced owing to variations in the standard of service given especially in some country districts where the physical and financial difficulties of distance from doctor or clinic interfere with a full service.

The Committee would emphasize the fact that ante-natal supervision to be really efficient requires very frequent examinations by well-qualified observers, especially in the later stages of pregnancy.

Extensive experience of the practical application of ante-natal care has convinced those most closely concerned with the subject that this should be considered as an integral part of a maternity case and that there should as far as possible be a continuity of service by the same attendant through all phases.

For this reason those independent clinics not associated with the hospitals in which the patients are to be confined are not regarded as completely satisfactory, in that they are divorced from the other aspects of the maternity service.

It is also realized that, since the most important aspects of ante-natal supervision are essentially medical in character, advice on these matters should be given directly by doctors. The Committee is therefore of the opinion that ante-natal service is best given either personally by the doctor responsible for the case or through the agency of ante-natal clinics associated with the maternity hospitals and closely supervised by the medical staff or doctors attending.

To meet the peculiar difficulties of the country mother, however, the Committee has recommended the development of a system whereby district nurses with midwifery training might assist the hospital clinics, and those country doctors who desire it, by paying supplementary visits to such patients in their own homes.

While fully appreciative of the very great potential value of efficient ante-natal care, the Committee would warn against an extravagant estimate of its possibilities; obstetric skill in labour and a rigid aseptic and antiseptic technique remain equally important.

The Relief of Pain in Labour.

In New Zealand, perhaps more generally than in most countries, the demand for the more extensive use of the measures of pain-relief which are known to be available is being made by some women's organizations and by individual women. The Committee, sympathizing with the effort to extend to all patients in labour the fullest degree of pain-relief consistent with safety, examined this question very thoroughly.

The Committee has reason to believe that there are few countries where the use of some measures of pain-relief is more general than New Zealand, but found that there were very considerable differences of practice amongst doctors and hospitals both regarding methods and the extent to which these agencies were used.

The investigation was mostly concerned with the practice in the public maternity hospitals, and it was found that, speaking generally, the amount of pain-relief hitherto given in such institutions has certainly been less than in the average case where a doctor is present; this has been an inevitable limitation of the midwife system.

The Committee is satisfied that any conservatism in the introduction of these measures has not been due to any lack of sympathy with suffering, but mainly to genuine doubts as to their safety from the point of view of both mother and child, and also to a feeling that where such measures were extensively used the necessity for artificial assistance in labour was increased, with certain possible risks.

The Committee is, however, convinced that there are now various methods whereby under suitable conditions a satisfactory degree of pain-relief can be very generally used with complete safety.

The majority of the Committee is of the opinion that pain-relief can only be developed to the most satisfactory degree if the doctor, in addition to directing the details of the use of sedatives during the earlier stages of labour, is also present to give, or to supervise the giving of, the anæsthetic in the final stages. This has already been referred to as one of the reasons for advocating the principle of doctor-attendance in all cases.

Nevertheless the Committee is of the opinion that, pending this development, the practice now adopted in a number of the public maternity hospitals operating under the midwife system where sedatives are given under the direction of, though not necessarily in the presence of, a responsible medical officer could quite safely be made more general, thus very considerably supplementing the limited amount of anæsthetic which the midwife is able to administer.

There is general agreement that these measures are much more satisfactorily controlled in the hospitals.

See reservations by Doctors Chapman and Paget.

Training of Midwives and Maternity Nurses.

Certain considerations regarding the training and supply of midwives and maternity nurses came under the survey of the Committee. Largely arising out of a certain conflict between the interests of midwives and medical students in obtaining the necessary amount of all-important practical training in the maternity hospitals, the question has arisen whether an excessive number of nurses was being trained as midwives. There was a strong feeling in some quarters that many of these nurses were taking the midwifery diploma simply for the purpose of higher qualification, and without any intention of continuing in active midwifery practice; were this so it is obvious that there would be a serious wastage of clinical material which would be much better utilized in the practical training of medical students, who are finding the greatest difficulty in obtaining the necessary number of cases. After full investigation the Committee finds that this is not actually the case; during the past five years 295 midwives have qualified from the training schools, of whom 222 are, or have recently been, practising obstetrics, 21 are members of the Plunket Society's staff, and 32 have taken positions in general hospitals. In only 20 cases are the present activities of the midwife not known to the Nurses and Midwives Registration Board, and of these it is probable that some have gone abroad for further experience and some have married.

Under these circumstances the Committee is not prepared to recommend the introduction of certain restrictions which have been suggested limiting the midwifery course to those nurses who, after taking the maternity nurse certificate, have had actual practical experience in obstetrical work over a period of one or two years.

It has also been suggested that since the tendency is so definitely in the direction of doctor-attendance in the majority of cases there will no longer be the necessity to train all midwives as though they were to practice independently, and that therefore the number of cases which the midwife is required to conduct personally might be reduced.

There is considerable force in this argument, and the matter might be considered fully by the Nurses and Midwives Registration Board. At the same time the Committee realizes that, since there will always be occasions in the practice of a midwife on which her skill will be taxed to the utmost, no measures should be taken which might in any way reduce the efficiency of the midwife's training.

It should be made perfectly clear to Hospital Boards and those responsible for the appointment of nurses that, for general purposes, the maternity certificate is fully sufficient, and that only in cases where the duties definitely require midwifery experience should the higher certificate be demanded.

In the case of maternity nurses (as distinct from midwives) it is clear that a very considerable number of general trained nurses do take the course merely as an aid to advancement in their professional careers and with no intention of continuing in midwifery practice proper; nevertheless the nurse in her general work, especially if she happens to be posted to the women's ward of a hospital, has so many indirect contacts with maternity work that there is a very general feeling among those directing nursing education that this additional course of study is highly desirable for nurses.

Since the number of cases which each maternity nurse is required to conduct personally during training is only five this does not, however, use up the same amount of clinical material as does the training of midwives.

Quite apart from any wastage of clinical material, there is another aspect of this failure of nurses who have taken their maternity training to continue in active midwifery practice—a very great difficulty is being experienced by many maternity hospitals in obtaining the necessary staff.

There is no doubt that the majority of doubly-certificated nurses, who are in a position to choose, elect to engage in some other branch of nursing than pure midwifery. The Committee examined the reasons for this position closely and finds that it is due to the fact that the work is regarded as more anxious, that the hours are more irregular and more onerous, that the salaries offered are frequently less than those obtainable elsewhere, that the opportunities for professional advancement are limited, and that superannuation facilities are frequently not offered.

It is clear that the nurse with general training can only be attracted to continue in midwifery work if the terms of service are comparable with those obtainable in other branches of the nursing service and take into consideration the particularly responsible and exacting nature of this work. In justice to those in charge of maternity hospitals it must be stated that the majority are doing their utmost to adjust their hospital management to meet new conditions.

In considering the place of maternity hospitals, especially private hospitals, in any national maternity scheme the financial considerations involved by these necessary adjustments in terms of service must be sympathetically met.

The need for a superannuation scheme to cover midwives and maternity nurses in all classes of practice is very evident.

It has been suggested that to maintain the supply of maternity nurses it may be necessary to recruit more maternity nurses from the ranks of those who have not already taken general training. In many ways this would be unfortunate, for, other things being equal, the maternity nurse with double qualification is undoubtedly the superior assistant. In quite a number of cases, too, such nurses decide subsequently to proceed with general training.

The Training of Medical Students.

The attention of the Committee was drawn on many occasions to the great difficulty which medical students have in obtaining the number of midwifery cases which is required by the regulations of the General Medical Council and which is so essential for their efficient training. The difficulty is not peculiar to New Zealand, but is the experience in most countries.

In part, as already indicated, it is due to the conflicting interests of midwives, maternity nurses, and medical students, all of whom require cases.

Although the Committee is not prepared to recommend certain suggested regulations which might restrict the position of nurses desiring to take this training, it is nevertheless felt that by mutual arrangement between those responsible for the training of medical students and nurses, adjustments might be made whereby the clinical material available could be shared in such a way as to meet the requirements of both.

Difficulty has also been caused by a prejudice against the entry of medical students into some hospitals where the facilities for training are available; such an attitude is exceedingly unfortunate and dangerous for the maternity service as a whole. It is urged that every facility be given by Hospital Boards and other organizations responsible for maternity hospital management for medical students to obtain this all-important practical instruction under experienced supervision. The Committee has made recommendations regarding the provision of resident facilities for medical students in the main public maternity hospitals in each of the four chief centres when these hospitals are developed and extended. Such resident training is regarded in medical teaching circles as essential to the best instruction.

The closely allied question of post-graduate facilities in obstetrics has also been discussed, and, in addition to the establishment of post-graduate courses at the University Medical School, it has been advised that all larger maternity annexes be placed under the supervisory control of medical practitioners with special qualifications in obstetrics, thus encouraging specialization in this branch of medicine.

Research.

The Committee has drawn attention to the possibilities of research into the special obstetric problems of the Dominion and has recommended the establishment of an obstetric research committee whose work would be correlated with that of the recently appointed Medical Research Committee.

The Maori Problem.

The Committee had the opportunity of discussing the special problems of Maori maternity attendance with those most closely associated with this work in the various parts of the Dominion. A very prevalent idea that confinement amongst Native women is safe and easy is not borne out by the facts; on the contrary, the risks of maternity amongst the Maori women at the present time are twice as great as amongst white women, and the incidence of sepsis is particularly high.

The various factors involved have been considered, and the Committee is of the opinion that the unsatisfactory position of the Maoris is due partly to an inability on the part of the Native attendants to deal with urgent complications, such as hæmorrhage, but mainly to unhygienic living conditions and a departure from the simpler but more wholesome diet of the past leading to dental, throat, skin, and general infections which are a menace to safe maternity. The Committee considers that much good could be done by an augmented staff of district nurses to Natives giving ante-natal supervision to the Maori women in their homes (in co-operation with the hospital clinics).

Through the same agency general hygienic instruction could be given to all those living in the Native settlements.

The urgent need for improving the housing conditions in many of these settlements is fully recognized by those in touch with Maori life; the Committee can only emphasize it.

The Committee does not believe that the position can be met by an attempt to introduce European methods of confinement attendance into the Maori homes, but strongly recommends the provision of hospital accommodation for Maori women in the public maternity hospitals in all districts where Maoris are resident.

The Committee does not favour special Maori hospitals, but agrees that the establishment of separate wards is desirable.

Social Aspects.

Several difficulties of a social nature which added to the burden of maternity were brought very prominently before the Committee. The chief of these was undoubtedly *the lack of domestic assistance*—a problem of town and country alike. This matter has been fully discussed in the report of the Abortion Committee, and the remarks and suggestions therein made are fully endorsed. The Committee can only emphasize the seriousness of the position and commend all efforts to make domestic service more congenial, and all organized efforts, such as those of the Women's Division of the Farmers' Union, the Women's National Reserve, and the residential and day nurseries to assist those in greatest need.

Difficulties of transport to and from clinic and hospital were found to constitute a hardship in a number of the more isolated country districts. To assist the position the Committee has recommended the establishment of small maternity hospitals in some districts which are not at present provided with such facilities, the greater use of district nurses to assist the doctors and clinics by giving ante-natal supervision in the homes of country mothers, and, in some cases, the provision of suitable waiting accommodation near the maternity hospitals to obviate the necessity for difficult last-minute journeys.

Some complaints of *inadequate telephone facilities* were made. The Committee found that, on the whole, the telephone service was very complete. In a few instances public telephones are needed to bring the residents within reasonable distance of this channel of communication, and the difficulties occasioned by the night and holiday closing of certain rural exchanges might be met by better arrangements for emergency calls.

The Committee investigated *the facilities available for the care of unmarried mothers*, and considers that very satisfactory provision is made throughout the Dominion. The work is mainly in the hands of the Salvation Army and certain other charitable organizations whose institutions, in addition to caring for these women at confinement, provide accommodation for a period before and after. There can be no doubt that in the majority of cases arrangements of this type are highly desirable. A hospital for married women has also been developed in connection with a number of these homes, and a very high standard of maternity attention is shared by married and unmarried mothers alike. A commendable feature is that in the majority of these hospitals the same measures of pain-relief are also used.

Where it is possible to make satisfactory arrangements elsewhere for the mother beforehand, and for mother and baby subsequently, the St. Helens Hospitals can take the unmarried mothers for the actual confinement period. This also applies to the majority of Hospital Board annexes, and, of course, similar arrangements can be made with private maternity hospitals.

Economic Considerations.

Finally, the Committee has discussed the economic considerations involved as follows:—

"Modern maternity care of the standard rightly regarded as necessary in New Zealand cannot be cheap. Whether it be hospital service or full-time domiciliary nursing attention, the expenses are necessarily considerable. The only cheap service is a no-doctor district midwife system with the nurse attending daily and not living in the home; this, the Committee is convinced, is not generally acceptable in New Zealand.

"The Committee gave close attention to the question of costs throughout its investigation.

"It is satisfied that the fees charged in the public maternity hospitals are by no means high for the service given; this is clearly proved by the fact that they rarely cover the cost per patient in these hospitals.

"The provision of even the minimum facilities and equipment necessary for carrying out the recognized aseptic and antiseptic technique; the addition of an ante-natal service requiring extra facilities and extra staff; the payment of nurses in training who previously received no remuneration; the increase in staffing necessitated by shorter hours; a much developed teaching syllabus and a standard of care which calls for closer supervision of the patient—all these factors have added greatly to the hospital costs.

"Similarly, the private maternity hospital fees are not high when the costs of maintenance and the work involved are taken into consideration. Maternity nursing is exceedingly arduous and responsible, and the administration of a maternity hospital is associated with particular difficulties owing to the uncertainty of the dates on which patients will be admitted to hospital; no maternity hospital is able to book patients up to its full capacity.

"Few maternity hospitals, regarded as investments, would be found to be giving an adequate return for the capital involved. In the majority of cases they are merely providing a home and a moderate living for the nurses who own them, or, in the case of doctor owners, a satisfactory environment in which their midwifery work can be conducted.

"The Committee is also satisfied that, taking into consideration the range of service involved, the responsibility and the exacting nature of the work, the medical fees in midwifery practice are moderate and in some cases quite inadequate. Thus, while the total costs when paid by the individual may seem considerable, the charges for the various items of the service are by no means excessive.

"The fact must also be faced that certain of the improvements recommended in this report—the further development of doctor attendance, the extension of the ante-natal and post-natal services, and the more general administration of pain-relief—would add somewhat to these costs.

"The economic problem, therefore, appears to be not how the services can be cheapened, but how the individual in need can be assisted to meet these necessary costs.

"It is quite clear that the expenses of the service are beyond the means of a large section of the community and a definite burden to others.

"Already the care of the indigent in maternity has for some years been the statutory responsibility of all Hospital Boards, and satisfactory provision has been made in most Hospital Board districts. The Committee has recommended the development of the maternity hospital system in such a way that the deficiencies in this respect shall be remedied and assistance to the indigent shall be available in all cases.

"The position of those who, while not indigent, find difficulty in meeting the expenses of confinement, has also been very considerably helped by the provision of public maternity hospitals—either St. Helens hospitals or maternity annexes to general hospitals—in which very adequate facilities are available at a moderate fee which is further subject to adjustment according to the circumstances of the patient.

"In a number of instances a very valuable assistance has been given to still another section of the public by making the public maternity hospital facilities available for those who desire the services of their own doctors. It will thus be seen that at the present time a very great deal of public assistance is being given both by providing modern hospital facilities and by giving service to the recipient either free of cost or at reduced fees.

"In the majority of cases this public assistance is based on the midwife system, with a doctor available in cases of difficulty.

"It will be understood that, under existing conditions, the development of the maternity services in certain directions which have been considered desirable would necessarily call for further public assistance.

"An alternative method of meeting the relatively high costs of this complete maternity service is by a system of health insurance.

"In many countries this principle is being largely developed, and the Committee was impressed with the possibilities of maternity benefit, covering both hospital service and medical attention, in New Zealand.

"At the present time those contributing directly, or indirectly through friendly societies, to the National Provident Fund receive a maternity benefit of £6. The Committee had ample evidence of the great value of this type of insurance in helping individuals to meet hospital and medical fees.

"The Committee does not, however, regard a cash benefit, helpful though it undoubtedly is, as the most satisfactory form of insurance assistance, and recommends that in the investigation of a national health insurance scheme for New Zealand full consideration be given to a maternity benefit which will cover both hospital and medical expenses by direct payment to those giving the service."

D. G. McMillan, Chairman.
Sylvia G. Chapman.*
Janet Fraser.
Amy M. Hutchinson.
Nan. G. Kent Johnston.
T. F. Corkill.
T. L. Paget.*

J. W. Buchanan, Secretary.

* Signatures subject to reservation, which is appended.

RESERVATION BY DOCTORS SYLVIA G. de L. CHAPMAN AND T. L. PAGET IN RELATION TO SECTIONS OF REPORT ON "METHOD OF ATTENDANCE" AND "RELIEF OF PAIN IN LABOUR."

There can be no doubt that, under the conditions of an ideal maternity service, the doctor responsible for the ante-natal and post-natal care of the patient would also attend at the confinement in order to supervise both the conduct of labour and the administration of the optimum degree of analgesia. This ideal is, in fact, attained by many obstetricians in town practice.

In many parts of New Zealand, however, this ideal is impossible of attainment. We are of opinion that it is quite impracticable for the majority of general practitioners in country districts to hold themselves in readiness for repeated visits during the twelve to twenty-four hours during which a normal labour may last, and that to try to force this upon the medical practitioner would inevitably result in his being placed in the position of having either to neglect other patients, who have an equal, or perhaps superior, claim to his attention, or to hasten delivery by the use of instruments.

It is conceded by all that every woman should have the benefit of attendance by both a doctor and a nurse during her confinement. Opinion differs only regarding the degree to which attendance by the doctor is necessary. We maintain that, given the necessary ante-natal attention, the doctor having seen the patient early in labour, and being satisfied that the course of labour is likely to be normal, the conduct of the remainder of labour may safely be left to the midwife, provided the doctor is available in case of emergency. We consider that the competent and specially trained midwife is capable of administering sedatives and analgesics safely and effectively when acting on the instructions of a responsible medical practitioner.

Admitting that at present, in the absence of a medical practitioner *thoroughly versed in modern methods of pain-relief*, such relief is not as complete as it might be, we are of opinion that this is due not to the inability of the midwife to be trained in these methods, but rather to the fact that the medical profession has as yet had insufficient evidence on which to base a definite opinion as to the best and safest methods of using the newer drugs such as nembutal and its allies, and modern methods of administering the older drugs. Evidence which, to us, was convincing, was placed before the Committee that a competent and specially trained midwife, acting under a doctor's instructions, could be trusted to use her judgment in the administration of these drugs, and that the results so obtained were excellent.

In our opinion, therefore, the implication that every woman should be attended at intervals during labour and at delivery by a doctor postulates a system which, in isolated districts in New Zealand, is impracticable. We believe that, with further research into the use of sedatives and analgesics, and with particular care in training the midwife in their use, a midwife service with a doctor on call for emergencies would give results equal in every respect to the service advocated by the Committee. Furthermore, such a service would be practicable in the very great majority of cases, whereas that advocated by the Committee is possible of realization only in the larger centres where facilities for attendance are close at hand.

We submit, further, that the usual fee of £4 4s. to £5 5s. is only sufficient to remunerate the doctor for full ante-natal and post-natal attendance and for the limited attendance at normal labour specified above, and that to impose upon the medical attendant duties which in normal cases can be carried out equally well by the midwives would, since these duties must be paid for, have the effect of burdening the service with an unnecessary cost.

SYLVIA G. CHAPMAN.
T. L. PAGET.

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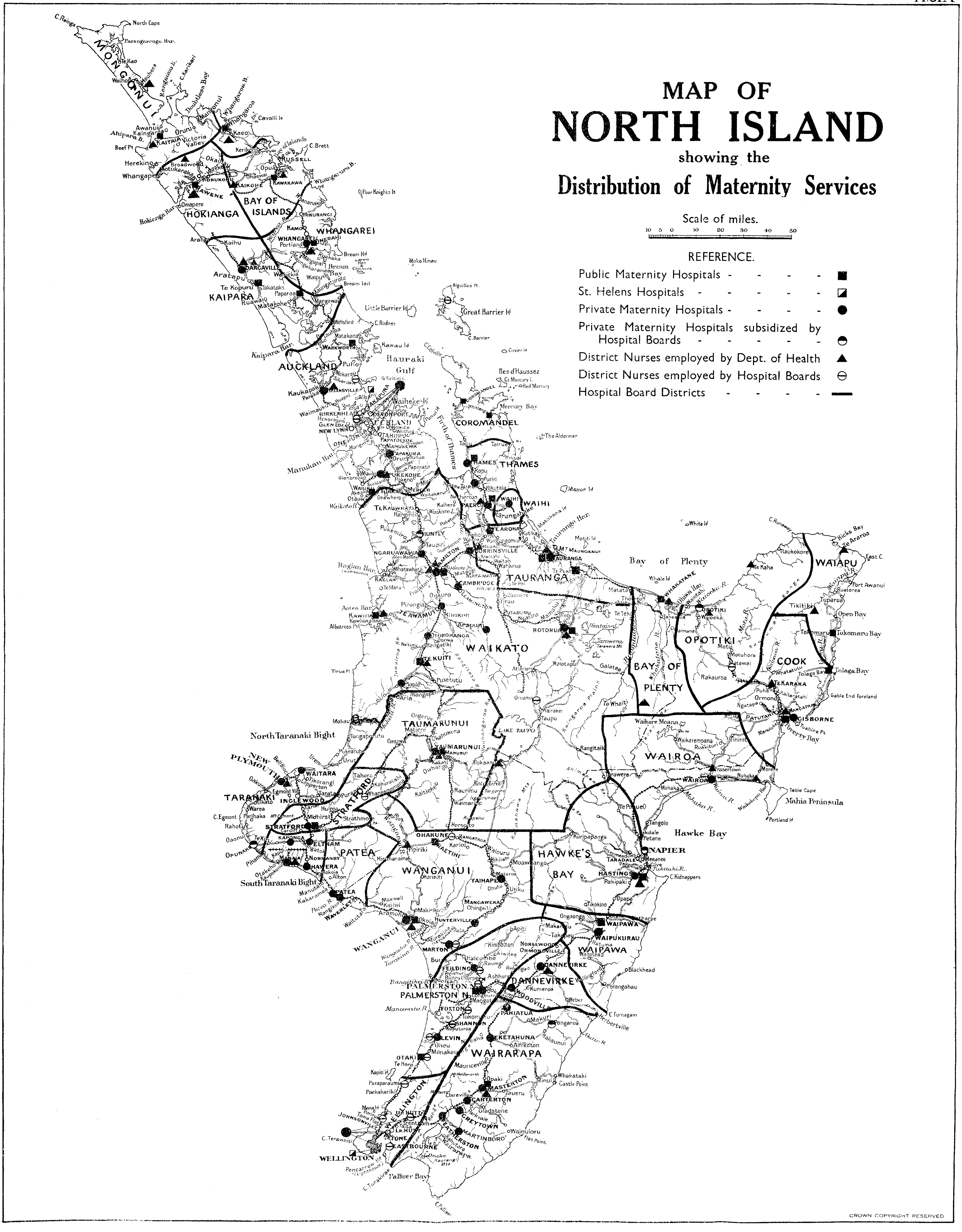
MAP OF
NORTH ISLAND
showing the
Distribution of Maternity Services
Scale of miles.
10 5 0 10 20 30 40 50
REFERENCE.
Public Maternity Hospitals
St. Helens Hospitals
Private Maternity Hospitals
Private Maternity Hospitals subsidized by Hospital Boards
District Nurses employed by Dept. of Health
District Nurses employed by Hospital Boards
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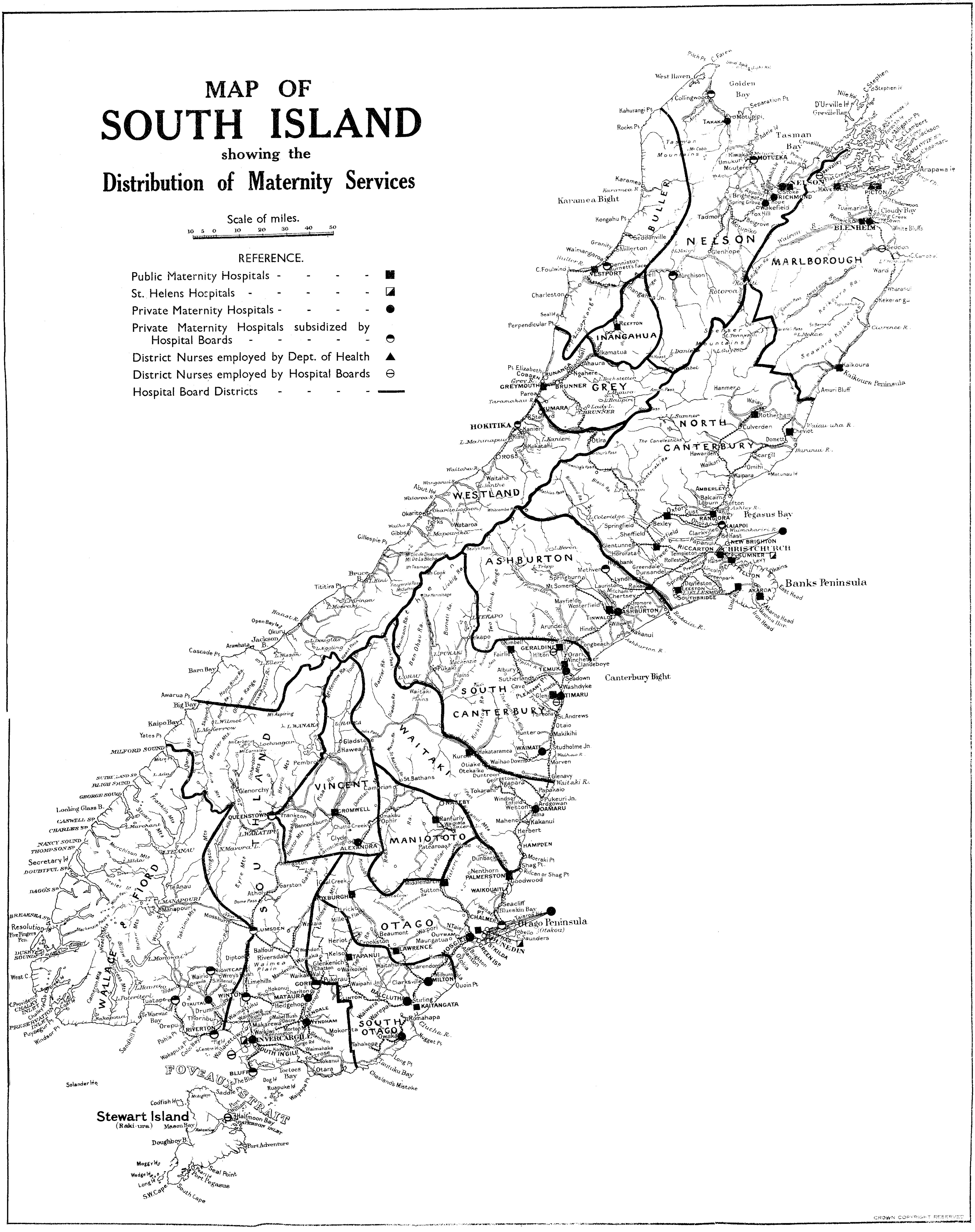
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MARLBOROUGH
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