

are to hand too late for an exhaustive summary in this report, but it should be mentioned that returns giving the proportion of instrumental deliveries show how greatly at variance is the practice of different medical men in their attitude towards this important matter. St. Helens Hospital returns show that out of 1,999 women attended in these seven institutions, where all confinements are conducted by midwives unless an abnormality exists, only 3.80 per cent. of deliveries were artificial. The returns of instrumental deliveries in the 13,055 births that took place in others show an average of 15.28 per cent. of instrumental deliveries, varying in hospitals of fifty deliveries and over from 2.61 per cent. to as high as 56.8 per cent. Of the other hospitals where the number of confinements justify a comparison, one public hospital with over 150 deliveries shows a percentage of 2.61 instrumental, while two others with 113 and 165 deliveries show a percentage of 42.81 and 42.48 respectively, and two private hospitals show percentages of 55.7 and 56.8 out of between fifty and sixty cases each.

I am unable at the present to make comparisons of still-births, deaths of infants in the first fortnight of life, maternal morbidity, sepsis, and deaths in connection with the above figures. As time permits these will be carefully taken out, and it is to be hoped will give statistical results from which sound conclusions can be drawn.

I here draw attention to some facts published in the *New Zealand Medical Journal* from a most interesting and instructive article by Dr. Doris Gordon, "Comparative Obstetrics." Reporting upon the methods used in Holland, Dr. Gordon says:—

"We were amazed when, in reply to a question *re* the incidence and treatment of R.O.P. cases, they said, 'We do not get that presentation at all.' When we pressed for more information on this point Professor Van der Hoeven looked up his records and reported that his percentage was 1 per 1,000 births. Every hospital we visited gave us this same low ratio of R.O.P. presentations. Why Dutch women should be so physiological in labour and our women so unphysiological is another field of obstetric research. This is not the place to theorize on the etiology of R.O.P. positions, but every one doing obstetrics in New Zealand knows how very frequently we encounter this complication. What percentage of our cases come into labour with the foetus in the posterior position, what percentage of these fail to rotate and deliver themselves naturally with the occiput still posterior, or what percentage have to be manually rotated after a trial labour of, say, thirty to thirty-six hours, are facts that could only be accurately determined if those practitioners that are genuinely interested in obstetrics banded together to keep accurate records on a standard form. Our country may be too young yet to have an obstetrical society, but perhaps the nucleus of such an association could be formed by the voluntary agreement of fifty or a hundred doctors willing to keep full and faithful records of their obstetric cases. There is no need to point out how useful such voluntary and scientifically accurate records would be for purposes of comparison in future years."

Statistics for the last ten years covering 13,488 cases conducted in the seven St. Helens Hospitals definitely support Dr. Gordon's statement that R.O.P. presentations are much more numerous among our New Zealand women. The following are the figures: 50.01 per cent. L.O.A., 25.46 per cent. R.O.A., 10.85 per cent. R.O.P., 7.30 per cent. L.O.P., 2.92 per cent. breach.

The variation in the proportion of 0.10 per cent. R.O.P. cases for Holland to 10.83 per cent. for New Zealand suggests some great difference in the method of diagnosis and designation. I suggest that possibly Professor Van der Hoeven may have been referring to persistent occipito-posterior cases. Whatever the explanation may be, this fact stands out most prominently: that an average of 18.14 per cent. for both R.O.P. and L.O.P. presentations among the 13,488 cases quoted emphasizes the need of the most careful and skilful ante-natal supervision and treatment during the latter week of pregnancy, since in many cases it is possible to convert these posterior presentations into occipito-anterior presentations, thereby shortening and easing labour and considerably reducing risks of injury to both mother and child. The whole matter suggests a field of useful and interesting inquiry; and if, as Dr. Gordon suggests, an obstetrical society were formed it should go a long way towards improving maternity work in New Zealand.

Dr. Gordon, in that portion of the report dealing with statistics of Holland and Great Britain, quotes an "eminent British doctor" as follows:—

"Our [maternal] mortality statistics are only approximately correct; and our morbidity statistics are not worth the paper they are written on."

Again, Dr. Jitta, Chief Health Officer at The Hague, says that it is a question if the position in Holland is indeed as favourable as official figures might lead one to infer. He states that it is possible that a number of cases of mortality directly due to labour may not have been admitted as such in the official statistics, and that therefore care is necessary in comparing the official figures of the Netherlands with those of other countries.

And Dr. Turberg, Chief Health Inspector of the Netherlands:—

"Furthermore, Dr. Turberg, Chief Health Inspector of the Netherlands, told us that puerperal fever was not a notifiable disease with them, that they knew nothing of a maternity case going wrong until they got the death certificate, and that on receipt of that they instituted no inquiries; and that none of the many maternity hospitals were subject to supervision or inspection by his department. These interesting sidelights on Dutch methods are sufficiently eloquent to speak for themselves, and the only possible conclusion is that, though both Holland and New Zealand use the same Bertillon system of compiling their statistics, once these figures reach the central offices there are such profound differences underlying the methods by which the initial figures are collected that the final returns, as standards of comparison, are utterly useless."

Though I cannot agree that comparison of statistics are "utterly useless," there is no doubt that the very complete returns, checked by inspections of our hospitals and very close inquiries into our maternal deaths, while of the greatest use to ourselves, tend by comparison with other countries to show New Zealand in a more unfavourable position than is correct. This opinion has always been held,