

If we compare two sets of statistics, and then examine the factors which are responsible for the difference between them, we shall, I think, be guided towards certain definite conclusions, to which I shall later refer. These statistics are as follows :—

		Maternal Mortality.
Part of the British Empire (Great Britain, Ireland, Australia, New Zealand), six million births, approximately	4.22	per 1,000 live births.
Holland and the Scandinavian countries, two million births, approximately	2.53	per 1,000 live births.

The difference between these rates is so great that there must be some very definite causes at work to account for it, and I think a full examination of these causes will well repay any one interested in the subject. Here it is only possible to summarize them briefly. There are five essential differences between midwifery practice as carried out in Holland and the Scandinavian countries and in the British Empire.

In the first place, the education of the medical student in obstetrics is, in Holland, as full as is that in medicine or in surgery. I think I am probably correct in saying that the time devoted by students to the subject of obstetrics and gynaecology is at least four or five times longer than that devoted by them to the same subjects in Otago University, or, indeed, in most other parts of the British Empire.

In the second place, the training of the midwife is more carefully carried out in Holland and the Scandinavian countries. In the former country the period of training is three years. In the latter countries it is two years. In New Zealand the corresponding course is a year and four months; in Great Britain it is a year. The education in aseptic technique is thus far fuller in Holland, with a corresponding reduction in the incidence of sepsis.

In the third place, ante-natal diagnosis and care have been fully developed. The result of the former is that abnormal conditions have been recognized before labour begins, and either have been or can be treated under the most satisfactory conditions. The result of the latter is that the various diseases of pregnancy are either prevented or properly treated. It is impossible to overestimate the importance of these two things. Existing septic conditions are recognized and their consequences in great part or in whole prevented. Difficult labour is anticipated and loses three-fourths of its dangers. Eclampsia, a disease which is almost wholly preventable if the patient will submit to proper care, is almost wholly prevented. If all deaths preventable by ante-natal diagnosis and care were prevented, it would, I think, reduce maternal mortality by nearly 2 per 1,000. That is to say, it would bring it down to a rate comparable with that of Holland and the Scandinavian countries.

In the fourth place, all normal cases of midwifery are attended by midwives who are compelled by law to obtain medical assistance if any abnormality occurs.

In the fifth place, in most parts of the country specialists' advice is obtainable by general practitioners when it is wanted.

It is difficult to see why, in the course of time, New Zealand cannot reach the standard of obstetrical practice of Holland. Both the medical profession and the public have everything to gain from such progress, and already several steps have been taken along the road leading to the goal. Since my last report a Chair in Midwifery has been created in Otago University and the obstetrical curriculum has been revised. Practical teaching is, however, still limited by the want of a proper maternity hospital in Dunedin. Moreover, the professorship ought to be a full-time post. When these two changes are made it will be possible for obstetrical teaching in Dunedin to become truly effective, always providing that the University Council gives to obstetrics the position in the medical curriculum which its importance demands, and not the position which tradition has sanctioned for it. Unless this is done in no uncertain manner, the net result will, in my opinion, continue to be unsatisfactory.

The training of midwives has been already very much improved, and, although my inspection of the training-schools for this year is not complete, I can see that considerable progress has been made, and that in most hospitals the usual initial resistance to change is disappearing. I think that if a temporary interchange of staff nurses, or even of Matrons, could be made between the different hospitals it would lead to a still further improvement in technique. I am not so satisfied as to the training of maternity nurses in smaller hospitals, though perhaps it may be because I know little of them. Still, I have a feeling that hospitals are recognized as training-schools for maternity nurses on other grounds than suitability, and that it is possible for ill-trained maternity nurses to be thus created. I am afraid I do not regard the fact that a candidate successfully passes her examination as a proof that she is necessarily to be regarded as a reliable nurse, particularly in so far as aseptic technique is concerned.

Ante-natal care and diagnosis can only be carried out by carefully controlled ante-natal clinics which work in close touch with the Medical Officer of a hospital or with private practitioners. Such clinics have been established at the various maternity hospitals which train midwives, and I hope will soon be extended to those which train maternity nurses. Still, they have only reached a small part of the community, and a great increase in their number is essential. The Plunket Society has established clinics in the main centres. It would be of enormous benefit to pregnant women if the society could create clinics in the other towns of New Zealand, provided that such clinics were kept, as I have said, under close supervision and worked in association with local medical practitioners. I trust that it may be possible for the society to undertake this much-needed work. As I have already said, ante-natal care is, next to a sepsis, the most important factor in the reduction of maternal mortality.