

The universal management of normal labour by midwives is one of those considerable changes which can only come gradually. When it does come, as I believe it will, it will mean that the medical profession must become to a greater degree responsible for the management of every pregnant woman during pregnancy, both in order that the care of pregnancy may be effective and that it may be as certain as is possible that labour will be normal. It will also mean that the medical attendant must continue to be, as at present, responsible for the treatment of all abnormal cases. Lastly, it will mean that he must be responsible for the "post-natal care" of the patient—that is to say, for the diagnosis and treatment of all injuries, complications, and ill health resulting from labour. The importance of "post-natal care" is well recognized, but it has not yet become a matter of general adoption.

It is not difficult to see how great a benefit it would be to the medical profession to be freed from the irksome demands of normal labour. The advantages to the patient are also obvious. Medical attendance on normal labours brings two inevitable disadvantages in its train. The first is the element of haste, which under present conditions is almost unavoidable even by those who most clearly recognize its dangers; the second is the additional risk of sepsis which the attendance of a second attendant imply. If this second attendant—i.e., the medical practitioner, whose profession necessarily brings him into contact with many sources of septic infection—can be eliminated, it seems obvious that the septic death-rate will fall. The disadvantages which I have mentioned are inevitable; but the blame for them must not be thrown on the medical profession: they are the result of the wrong system which has grown up and which is due at least as much to the insistence of the general public as to the wish of the medical profession. Once such wrong system is established, then the disadvantages I have mentioned are inevitable. Until the example of Holland is universally followed, it is well to remember that the essential part of a medical practitioner's duty is ante-natal care and diagnosis, and that his presence during the final stages of a normal labour, while often gratifying to the patient, is not essential to her welfare.

The results of the association of effective ante-natal care and of the management of normal cases by midwives can be seen from the statistics of the Queen Victoria Jubilee Institute. Amongst 317,758 patients confined under the care of the Institute's nurses, with medical assistance in abnormal cases, the total mortality, including deaths from associated disease which are not included in official statistics, was at the rate of 1·64 per 1,000 deliveries; while if this rate is adjusted by excluding associated deaths, and on a basis of live births instead of on a basis of deliveries, it falls to approximately 1·41 per 1,000 live births. Such a rate is not only a considerable improvement on that of Holland and the Scandinavian countries, but also clearly shows that the low mortality-rate of these countries is not due to any special qualities of its women, but can be also obtained in British countries. In this connection the following statistics may be of interest:—

Table C.—Comparative Causes and Rates of Maternity Mortality.

Cause of Death.	Rate per 1,000 Live Births.			Rate per 1,000 Deliveries, Queen Victoria Jubilee Institute.*
	England and Wales.*	New Zealand.*	Holland.†	
Puerperal sepsis	1·46	1·82	0·92	0·33
Puerperal albuminuria and convulsions	0·72	1·16	0·45	0·16
Puerperal hæmorrhage	0·52	0·69	0·51	..
Accidents of pregnancy	0·45	0·49	0·35	..
Accidents of labour	0·44	0·29	0·21	0·33‡
Puerperal embolism, sudden death, and phlegmasia dolem	0·33	0·37	0·38	0·18
Other causes	0·30	0·05	0·30	0·16
Diseases independent of childbirth ..	..	..	..	0·48§
Total death-rate	3·96	4·87	2·59	{ 1·64 1·41

* Six years' statistics. † One year's statistics. ‡ Including hæmorrhages. § Such cases are not included in official statistics. || Adjusted rate comparable with official statistics.

To show what can be done in New Zealand under most favourable conditions, I append a mortality table similar to the above compiled from the collected statistics of the St. Helens Hospitals of this country. It must be noted that the number of patients admitted to the St. Helens suffering from the diseases of pregnancy is below the normal rate, and that the death-rate may not be strictly comparable with that of the country generally for this reason. On the other hand, all deaths, whether they occurred in these institutions or, in the case of transferred patients, in other hospitals, are included.

Table D.—St. Helens Hospitals, 1923.

Hospital.	Total Deliveries.	Total Deaths.
Auckland	670	0
Christchurch	356	1
Dunedin	157	1
Gisborne	176	0
Invercargill	265	2
Wanganui	155	0
Wellington	599	1

Mortality-rate per 1,000 deliveries, 2·1.