

# Comparative Obstetrics

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**T**he fact that New Zealand loses annually some one hundred and fifty-seven mothers as a result of childbirth has become an urgent problem, not only for our profession, but also for our country. When we contrast our unrivalled infant mortality rate with the high figure we present in international obstetrical statistics, the natural question that occurs to all is, "What makes our maternal mortality return so high?" Is it that our obstetrical service is so inferior to that of other countries? Is it that the women of New Zealand are in any way more susceptible to the dangers of maternity? Or is it that international statistics are not a true indication of the relative safety of the parturient women in the various countries

These questions were continually before us during our recent travels in Europe, and I shall briefly state our impressions of comparative obstetrics, dealing with them in sections as suggested by these questions.

SECTION I.—OUR OBSTETRICAL SERVICE.—  
Firstly, let us consider the doctors, for, in searching for a cause or causes, it is well to begin by criticising ourselves. In New Zealand the majority of maternity cases are conducted by general practitioners. Are we general practitioners working on a lower obstetrical standard, are we more indifferent in our ante-natal work, more impatient during labour, less careful of asepsis than are the doctors in the countries with lower mortality returns than ours? These charges, having already been laid at our door, must be honestly met before we seek any other cause for our high returns.

Anything that reflects adversely on the work of the general practitioners necessarily reflects on the university that trained the majority of them. According to Lord Dawson "A university is not an emporium of facts, but a place to train mind and character." We believe that, though our Medical School is a relatively small one, it is imparting to its students a training of mind and medical character that is unrivalled by any larger

school. We know that the New Zealand graduate carries a good reputation in British medical circles, frequently gets preference for residential posts, and usually does phenomenally well in post-graduate examination halls. Moreover it is a matter of common agreement, that in general all-round work, the New Zealand practitioner compares more than favourably with the English general practitioner, who is so often over-rushed with work and whose resourcefulness is tempered by the fact that there is always a specialist handy to deal with his difficulties.

We admit the presence in our ranks of a few renegades to training principles, practitioners who are careless in their general as well as midwifery work. But what country has not got a proportion of these? If we in New Zealand have an occasional instance coming to light where a derelict of our profession has applied forceps not only too early but also unsterilised, I was assured during my time in Manchester that this was an all-too-frequent occurrence in many panel practices in that area, and that, in addition, it very frequently happened that forceps were applied without any kind of anæsthesia at all. What is an isolated and censured procedure with us is accepted as a frequent occurrence with them. Dismissing the happily infrequent renegade, then, with the remark that he is found in every country, we come back to the comparative standard of the general practitioner, and I think that we can honestly say that our general medical and surgical work is as good as, perhaps better than, that of the general practitioner at Home. Can we be careful, sound in judgment and asepsis in our general work, and at the same time be "careless, impatient, and dirty" in our maternity work? Such a state of affairs is scarcely possible, for whatever powers of judgment, resourcefulness and patience we acquired in the years "that trained mind and character" must be assets which will automatically be transferred to our obstetrical work. Moreover, as will be mentioned presently, the general standard of asepsis in the New Zealand training school is,

compared with the British and Continental schools, very high indeed. Complementary to powers of deduction, judgment and endurance, our best endowment from the *Alma Mater* that moulded us is an aseptic conscience of a very high degree, and this surgical aseptic conscience must accompany us into the more difficult fields of obstetric technique, and at least must make us strive toward an ideal that may be unobtainable. In so far then, as a sound theoretical training, aseptic technique, judgment, patience and resourcefulness carry us, it may be conceded that the New Zealand general practitioner, as an obstetrician, compares more than favourably with his fellow practitioner in the Mother Country.

But there are other factors at work in this

young Dominion which may make for weakness in our obstetrical service, factors not of our own making, but one which must be considered nevertheless. Firstly, through sheer lack of clinical material our students cannot get the same practical experience as obtains in European countries, and we have as yet no resident posts for obstetrical internes, so that our young graduates are compelled to buy their experience in their first years of private practice. Secondly, present-day midwifery in New Zealand does not appeal to the budding doctor, and, in consequence, most senior students aspire to specialise in some less exacting and more spectacular form of service, and devote as little time to the study and practice of obstetrics as is compatible with getting their diploma.