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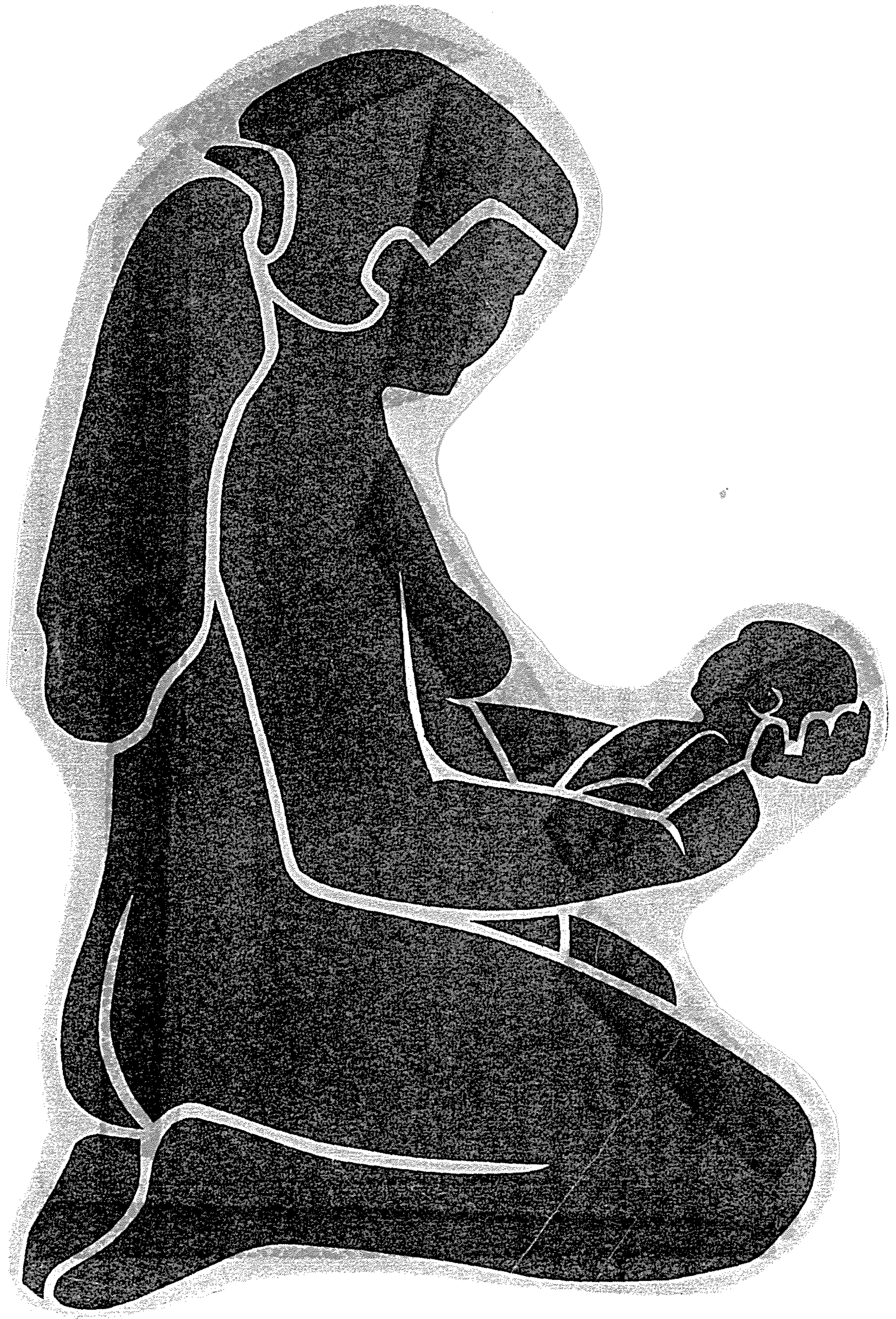

"ESSENTIALLY A WOMAN'S QUESTION"

A Study of Maternity Services
in Palmerston North 1915-1945.

A Research Exercise presented in
partial fulfillment of the
requirements for the degree of
Batchelor of Arts with Honours
in History at Massey University.

GAYNOR SMITH

1987

For Dawn

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In the course of this research exercise many people have provided much appreciated help. Firstly, I would like to thank my supervisors Dr Margaret Tennant and Dr David Thomson for their invaluable guidance, incisive comment and criticism.

The Palmerston North Hospital Board kindly allowed me access to their records. Mr John Stuart and Mr Gerry Craggs both spared me their time and knowledge of the hospital and its district. Dr Tim Smith gave me his interest and help as did Jan Rogers of Nursing Studies.

The Registrar-General (BDM) generously granted me the unique opportunity of collecting information from local birth and death registers. The staff of the Palmerston North District Court cheerfully furnished me with the relevant data.

Anne McLaughlin of The Tribune wrote "Calling all Grandmums" effectively stimulating enough interest so that I was overwhelmed by women who were willing to recount their memories of local maternity services and childbirth. To those women and the ladies of Brightwater Home I am indebted. In addition, Sisters Joyce Baker and Ruth Burrell graciously shared with me their midwifery days in Palmerston North.

The staff of National Archives in Wellington were helpful in my search for information as were staff members of the Massey University Library.

The Class of '87 provided moral support and a sense of humour. Gill and Derek Smith supplied much needed practical assistance and encouragement. Alison Olsen proved an efficient typist. Finally, Alistair deserves special mention for contributing criticism, understanding and unending aid in a what otherwise would have been a trying year.

CONTENTS

Acknowledgements		i
Contents		ii
Illustrations		iii
Abbreviations		iv
INTRODUCTION		1
CHAPTER 1:	Private Maternity Provision and the Trend to Hospitalized Birth.	11
CHAPTER 2:	A St Helens for Palmerston North ?	25
CHAPTER 3:	Growth of the Large Institution.	38
CONCLUSION		56
APPENDIX A:	Map of the Palmerston North Hospital Board District	62
APPENDIX B:	District Admittances to the District Maternity Home 1933	63
APPENDIX C:	Bookings at the District Maternity Home, 1939-40.	64
APPENDIX D:	Personalities	65
APPENDIX E:	Medical Terms	66
BIBLIOGRAPHY		67

LIST OF ILLUSTRATIONS

Mother with Child
- Courtesy of the Manawatu Home Birth Association Frontpiece

Dr Tom Paget 20
- F.S.Maclean, Challenge for Health, (Wellington, 1964) -

"Help the Mothers" 32
- H1, 75/16, WArc.

Murphy's Inhaler 45
- H.Jellett, A Short Practice of Midwifery for Nurses, 11th edition, (London, 1940).

"Rostrata" Private Nursing Home 50
- PN Public Library, Bur 97 -

ABBREVIATIONS

AJHR	<u>Appendices to the Journals of the House of Representatives</u>
BMA	British Medical Association
DDGH	Deputy Director-General of Health
DGH	Director-General of Health
Dept	Department
GP	General Practitioner
H	Health Department
KT	<u>Kai Tiaki</u>
LP	Labour Party
Min	Minister
MOH	Medical Officer of Health
NCW	National Council of Women
NZJH	<u>New Zealand Journal of History</u>
NZMJ	<u>New Zealand Medical Journal</u>
PN	Palmerston North
PNHB	Palmerston North Hospital Board
PS	Plunket Society
WArc	National Archives, Wellington
WDFU	Women's Division of the Farmers' Union
unpub.	unpublished

INTRODUCTION.

> We hear much nowadays about about national defence but we must not put our whole trust in the "reeking tube and iron shard". The safety of nations is not a question of the gun alone, but also of the man behind the gun, and he is largely the result of the grit and self sacrifice of his mother. If we lack noble mothers we lack the first element of racial success and national greatness.
>
> THE DESTINY OF THE RACE IS IN THE HANDS OF ITS MOTHERS.[1]
>
> - F. Truby King -

Truby King's articulation of eugenic anxiety at the turn of the century emphasised the importance of "noble" motherhood in the reduction of infant mortality. This was with the aim of rearing a strong Anglo-Saxon population for New Zealand and the Empire. By 1921, these eugenic fears served to magnify the gravity of maternal mortality rates and consequently attention was focused on the well-being of mothers. Without them, the "destiny of the race" was grim.

The welfare of mothers was secondary to the concern caused by infant mortality and the declining birth rate.[2] To prevent needless infant deaths the Midwives Registration Act was passed in 1904 with the hope of improving the quality of the birth environment. The Act introduced State registration and training of midwives. This was followed in 1905 with the establishment of the State funded St Helens Maternity Homes which aimed at providing inexpensive medical care for the wives of working men. This also aimed at reducing infant deaths. In 1905, two St Helens were opened, one in Wellington and the other in Dunedin. The Auckland St Helens opened in 1906.

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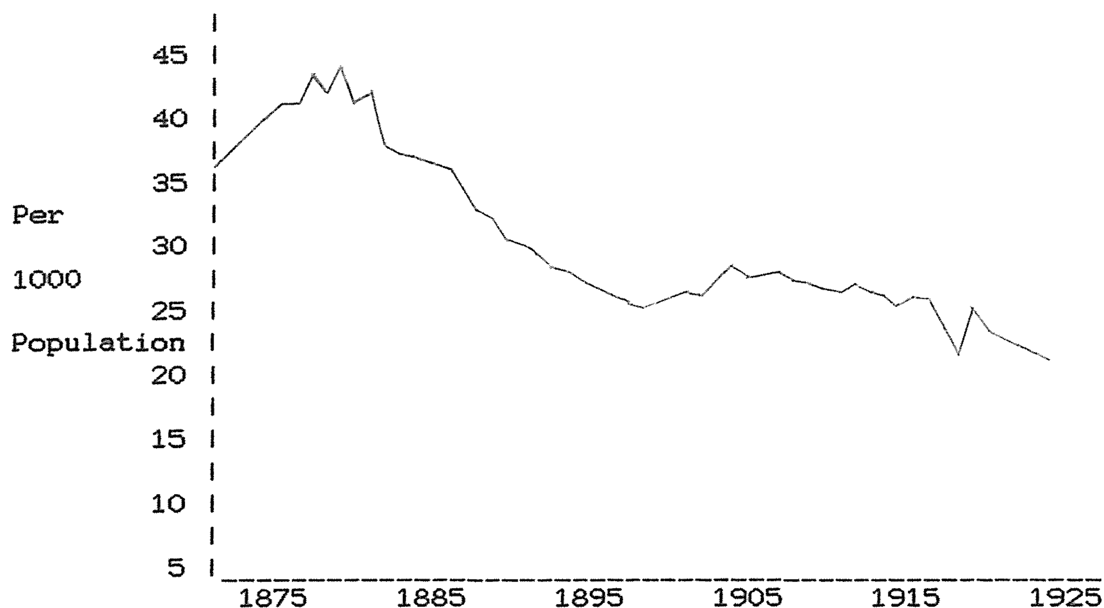
1. F.T.King, Feeding and Care of Baby, (London, 1913), p.153.
2. F.S.Maclean, Challenge for Health, (Wellington,1964), p.176, for infant mortality rates; see New Zealand Official Yearbook, 1920, p.21, for the declining birthrate.

THE NEW ZEALAND BIRTH RATE, 1872-1925



Source: P. Mein Smith, Maternity and Dispute, (Wellington, 1986).

INFANT MORTALITY RATES (European)

Deaths of Infants under One Year per 1000 Live Births.
Quinquennial Averages 1872-1921

Quinquennia	Death rate
1872-76	109.28
1877-81	93.47
1882-86	91.80
1887-91	82.65
1892-96	84.81
1897-01	78.87
1902-06	72.90
1907-11	68.46
1912-16	52.50
1917-21	48.04

Source F.S.Maclean, Challenge for Health, (Wellington, 1964).

Concern about maternal health was not surprising in an era when public health was in focus. In 1907, the Society for the Health of Women and Children was formed as part of the new age of child welfare.[3] By 1912, the Education Department had become involved in child health with the formation of the School Medical Service. Seven years later, the first Health Camp was underway near Wanganui and aimed at restoring malnourished children to health. Public anxiety produced by the influenza epidemic of 1918 and 1919 resulted in the 1920 Health Act. This Act changed the name of the Department of Public Health to the Department of Health and reorganized the existing body into new specialized areas. Three of the new divisions focussed on child health, and these were Child Welfare, School and Dental Hygiene.

The focus on child health reflected the assorted eugenic beliefs of the day with many seeking a strong, healthy population. Some like King, founder of Plunket and an ardent eugenicist, held an exaggerated fear of racial deterioration.[4] Such fears were intensified by the revelation that only 34.4 per cent of all army recruits had been classified as completely fit in World War One.[5] Eugenic fears, which had been present since the turn of the century, made New Zealand's high maternal mortality rate significant as it strengthened the belief in imperial and racial degeneration. The focus on maternity and its related services simultaneously illuminates public concern about the demise of the Empire, and the private fears of individual women.

For New Zealand women the risk of childbirth was greater than in nearly

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3. The Society, became known as the Plunket Society in recognition of the support of Lady and Lord Plunket.
4. M.Tennant, "Matrons with a Mission", MA thesis (Massey University, 1976) p 86; also see P.J.Fleming, "Eugenics in N.Z 1900-1940", MA thesis,(Massey University, 1981.)
5. P. Mein Smith, Maternity in Dispute, (Wellington, 1986), p.4.

every other Western country. In 1920, the maternal mortality rate increased to 6.48 European deaths per thousand live births in New Zealand.[6] Philippa Mein Smith in Maternity in Dispute suggests that the 1920 crisis over maternal mortality triggered the path to hospitalized birth, which by 1939 was an obstetric reality. Good results were evident by 1935, as the maternal death rate had subsided to 3.25.[7] Mein Smith's study reveals that the decline in the maternal mortality rate in the inter-war period was not directly linked to the growth of medical interventionist procedures. In reality concern over maternal mortality triggered action by the Health Department which promoted the practice of asepsis by midwives (traditionally the chief attendants at birth) to eliminate the possible introduction of septic infection after birth. In addition, the Health Department advocated formal ante-natal care to monitor the health of the mother and child at regular intervals during pregnancy. Both of these practices were integral to the reduction of the maternal mortality rate from the major killers puerperal septicaemia and eclampsia. Health Department reforms produced strict regulations governing the running and management of hospitals which eventually caused the demise of the small private maternity home as many were unable to meet the new demands for aseptic conditions. In addition, the 1925 Nurses and Midwives Registration Act raised standards of care by establishing uniformity of training. Under this Act midwifery was raised to post-graduate status and the 1904 midwifery certificate effectively became one in maternity nursing. Maternity nursing involved working under a doctor's supervision, unlike midwives who practised independently. The Health Department's reforms, particularly the practice of a standardised aseptic technique by midwives and maternity nurses, were the key to the

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6. New Zealand Official Yearbook, 1929, pp.163-164.
7. AJHR, 1938, H-31A, p.70.

decline in maternal mortality.

In 1927, New Zealand doctors formed the Obstetrical Society in response to the Health Department's campaign. For many doctors, childbirth was a lucrative business over which they were reluctant to lose control.[8] To counter the Department's campaign the medical profession re-defined birth as a pathological condition. Ironically, hospitalized childbirth was ushered in by Health Department reforms which advocated that childbirth was a physiological rather than a pathological event. By 1939, the battle was over. Transformation had occurred with most women experiencing childbirth in hospital, not at home, attended principally by a doctor under whose supervision came the maternity nurse.

The trend to hospitalized birth was rapid in New Zealand. In 1920, approximately 35 per cent of births occurred inside hospitals; by 1935, the hospitalized birth rate had risen to 78 per cent. The greatest change in the inter-war period was the growth of public hospitals which gradually lost the stigma of charity, becoming acceptable places in which to give birth.[9] Hospitalization was replicated in other Western countries. In Australia, the pace of change was slower because the country lacked a State maternity home system and Health Department intervention that was very evident in the New Zealand process.[10] As in New Zealand, reproduction was re-defined as a medical problem which meant the growing prominence of the medical profession. In Britain, hospitalized birth also occurred at a much slower rate than in New Zealand. In 1927, 15 per cent of Britain's births occurred in hospital. By 1946, this rate had risen to 54 per cent. In Britain maternal

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8. Smith, pp.44, 47, 51.
9. ibid, p.1.
10. K.Reiger, <u>The Disenchantment of the Home</u>, (Melbourne, 1985), p.102.

mortality also became an important issue during the inter-war period.[11] New Zealand's early hospitalized birth trend is best explained by the systematic application of asepsis which enabled the country to lead the world in the "pre antibiotic conquest of puerperal sepsis".[12] Asepsis set a precedent which private hospitals and doctors were obliged to emulate. The adoption of asepsis and ante-natal care aided the doctors in the promotion of "safe" hospitalized birth.

The development of the medical model of childbirth, its techniques and consequences are under scrutiny by many modern women. Reliance upon medical knowledge is the legacy which remains into the 1980s with many women seeking "safe" births.[13] Today, feminists and other women's groups are examining the services offered them. Many women have returned to the view that birth is a physiological rather than pathological event, arguing that medicalized childbirth entails loss of control by mothers. This helps explain the rise of "active childbirth".[14] Today some women feel that their needs are not being met. In the 1980s many women are actively seeking more control over the birth experience.[15]

To state that hospitalized childbirth emerged with the doctor gaining control, denies the women of the inter-war period agency. Many studies have been written describing medicalization as a professional battle for control between midwives and doctors. Women have been portrayed as passively losing control of birth.[16] Mein Smith's focus on the debate

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11. Smith, p.118; J.Lewis, The Politics of Motherhood, (London, 1980), p.117, 220.
12. Smith, p.118.
13. J.Donley, Save the Midwife, (Auckland, 1986), p.153.
14. ibid, pp.11, 155; see A.Oakley, The Captured Womb, (Oxford, 1984), p.278.
15. J.Rakusen and N.Davidson, Out of Our Hands, (London, 1982), p.158.
16. see Lewis, pp.13-21; Reiger, p.102; Smith, p.119; B.Ehrenreich and D.English, For Her Own Good, (New York, 1979), p.98.

between the Health Department (representing bureaucrats, some doctors and midwives), and the Obstetrical Society (containing the majority of doctors), effectively excludes women. The role of women has little part in her argument, with the belief outlined in her thesis that women exerted no influence over policy at all.[17] Whilst this view has been modified in Maternity in Dispute the evolution of policy remained her primary concern, with the demands of women being discussed but as a secondary issue. Joan Donley in Save the Midwife advocated a return to homebirths in the 1980s. Donley emphasised this in an attempt to re-establish the supporting role of the midwife which she believes was eliminated with the take-over by doctors reducing the status of midwives to that of maternity nurse.[18] In Donley's historical survey, women are seen as passive. Jane Lewis in The Politics of Motherhood argues that in Britain professional rivalries limited the range of services provided for women. Whilst Lewis projected women's demands for economic aid and birth control into her study she argued that women's needs were not addressed because many accepted the traditional role of wife and mother.[19] Ehrenreich and English's American survey, For Her Own Good, also suggests a lack of agency as midwives were "eliminated" making all women fall "under the biological hegemony of the medical profession".[20]

Few studies have recognised that whilst the medical profession may have "preyed on" the fears of women, many welcomed the spread of "technological" childbirth as it offered them relief with the introduction of analgesics and anaesthetics.[21] Many women supported

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17. P. Mein Smith, "The State and Maternity in New Zealand, 1920 - 1935", MA thesis, (Canterbury, 1982), p.404.
18. Donley, p.153.
19. Lewis, pp.165-196.
20. Ehrenreich and English, p.98.
21. K.Reiger's study is one of the few which acknowledges this, see p.102.

medicalized birth as they sought improved standards of care in a health conscious era. For some, hospitalized birth provided an opportunity to leave exhausting work situations within the family home allowing concentration on childbirth alone. Shelley Griffiths asserts that women did affect policy as they desired better care, rest, shortened labour and pain relief.[22] Some women actively chose doctors' maternity care, because at that time the medical professions' offer was nearest to fulfilling women's desires.

The path to medicalized and hospitalized childbirth has been assessed on a national scale by Philippa Mein Smith in Maternity in Dispute. There is a need to complement this vision of national activity with a local study. Not all aspects of Mein Smith's study can be reproduced on a local level due to the focus on the Health Department and Obstetrical Society debate. The area that will be addressed is that of maternal mortality and the trend to hospitalization. Mein Smith identifies official concern over maternal mortality and the dangers of maternity as the factor which caused the medical profession to define childbirth as pathological. This encouraged the growth of hospitalized birth. The questions that will be addressed in this study are: at what rate did hospitalization occur in Palmerston North ? Was the trend to hospitalization affected by the issue of maternal mortality ? Were there other reasons for the trend in Palmerston North ? What effect did hospitalization have on the provision of maternity services in Palmerston North ? In what ways does this local study mirror, enhance or detract from the national one ?

The nature of the study created some problems. The local focus prompted the desire for information about private institutions which

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22. S. Griffiths, "Feminism and the Ideology of Motherhood in New Zealand, 1896-1930", MA thesis, (Otago, 1984), p.153.

closed at least thirty years ago. This made accessibility of records difficult. Many major records have been destroyed which prohibits an in depth case study of any one institution. Surviving private hospital records are chiefly from a Health Department perspective. In addition, and related to the destruction of records, was the difficulty in determining Maori experience of maternity services in Palmerston North. Thus this study focuses on European women.

It had been hoped to make considerable use of interviews with elderly women in the course of this research. This was with the aim of determining their experiences in, and desires and reactions to the Palmerston North maternity services between 1915 and 1945. Whilst oral sources were valuable in capturing women's experiences the sample was rather problematic. The representativeness of the interviewees is questionable. Collectively twenty-two women experienced fifty-six births with only four of those being pre-1935, leaving the early period somewhat barren. In addition, eleven were volunteers who had particularly bad experiences to recount. In contrast, the remaining women were either reluctant to share their accounts because they had not talked of childbirth in their lifetime and were unwilling to break the tradition or they lacked the medical jargon to discuss their actual experiences illustrating that a problem of language existed.[23]

Palmerston North was chosen as the locality under study because the Health Department launched its campaign for "safe maternity" in the town in 1924. Chapter One encompasses the local trend to hospitalized birth and private maternity provision. The period, 1915 to 1945, was chosen to include in Chapter Two the demand for maternity services,

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23. For similar problems in an Australian study see, "Mentioning the Unmentionable: The Use of Oral Sources in Investigating Women's Experiences of Childbirth 1930-1960", Oral History of Australia Journal, Oral History '85, no.7, 1985, pp.134-140.

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which injects a new and important dimension, that of local politics, into the issue of hospitalized birth. Chapter Three deals with the effects of hospitalization on the locality, chiefly the growth of the public sector and the demise of the small private institution. By 1945 Palmerston North afforded highly medicalized maternity services and there was a push to gain similar facilities for women in more rural areas of the district. Palmerston North makes an interesting case study, being a secondary centre in a rural environment, and provides a contrast to the main centres on which Mein Smith tends to focus. The trend to hospitalized childbirth in Palmerston North was affected by the inadequacy of maternity facilities in the surrounding district. It is to this trend that we shall now turn our attention.

CHAPTER ONE - Private Maternity Provision and the Trend to Hospitalized Birth.

> They must educate the mothers and stamp out the terrible curse of losing so many of them. In the interest of humanity of the glorious race to which they all belonged, they must leave no stone unturned to prevent the terrible toll of the mothers of the country.1
>
> - Sir Maui Pomare, 1924 -

By 1915, Palmerston North was a vibrant bustling town with a population of 12,206, having doubled in size since 1901.[2] The town contained a variety of general medical facilities. There were nine registered medical practitioners, four of whom worked in hospital facilities, whilst the remainder afforded general medical services.[3] The public hospital provided four wards, one of which specifically catered for women.[4] The more specialized facilities supplied by the Palmerston North Hospital and Charitable Aid Board supplemented the very limited facilities of the counties in its hospital district containing Oroua, Kiwitea, Pohangina, Kairanga and Manawatu.[5] Most counties boasted a doctor but entrusted emergency, chronically and acutely ill patients to the larger capacity of the hospital.[6]

Within the town there were a number of midwives who provided a variety of services. In 1915, there were twenty-two resident registered midwives in Palmerston North. The total number of practising

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1. Quoted in Manawatu Evening Standard, 7 June 1924, p.2.
2. New Zealand Official Yearbook, 1914, p.106; see also A.Bradfield, The Precious Years, (Levin, 1962), p.12.
3. Register of Medical Practitioners, New Zealand Gazette, 1915, no.1 pp.73-99; for PNHB medical staff, see AJHR, 1915, H-31, p.67; Wises New Zealand Post Office Directory, 1915, p.94.
4. G.Petersen, Palmerston North - A Centennial History, (Wellington, 1973) p.141.
5. Medical Directory, Wises, 1915, p.2214; PN hospital district did not contain Horowhenua county until 1919, Hospital Statistics of New Zealand, 1919, p.35.
6. New Zealand Gazette, 1915, no.1, pp.73-99; Pohangina county did not have a doctor.

registered midwives was only sixteen as three had notified the Registrar of Midwives their intention not to practise. A further four were also trained nurses, one of whom owned a general private hospital and thus delivered babies only on rare occasions, two worked at the Public Hospital and only one practised midwifery fulltime.[7] Of the practising sixteen, six were Class A midwives who under the terms of the 1904 Midwives Act had trained in a St Helens or a recognised school of nursing overseas. The remaining ten were classified as Class B midwives having satisfied the Registrar at the commencement of the Act that they had at least three years in bona-fida practice and were of good character.

Local birth registers reveal that as in the rest of New Zealand, Palmerston North contained unregistered women who practised midwifery. In 1915, thirteen unregistered women can be traced as practising in the town.[8] One unregistered woman, Annie Roby, was also a general nurse who had trained at Auckland Hospital between 1895 and 1898. Roby employed in her private hospital in Grey Street, Nurse Helen Morton, a Class A midwife, to deal with maternity cases.[9] On the basis of an unwritten agreement made with the Department of Public Health in 1905, the remaining twelve unregistered women were allowed to practise as maternity nurses under the direct supervision of a GP.[10]

The range of midwifery skills in the town meant that in 1915 women of the Palmerston North Borough had a variety of maternity services

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7. Registered nurses determined from Register of Midwives in New Zealand Gazette, 1904-1915.
8. Wises, 1915, p.732-748; Register of Births 1915-1916 for places of births; some unregistered nurses listed in Street Directory, Wises, 1915, pp.732-748.
9. Register of Nurses, New Zealand Gazette, 1910, p.422.
10. Smith, p.17.

from which to choose. Parturition and the puerperium could be experienced in one of three places: in women's own homes, in one bed lying-in-homes or in small private hospitals. Homebirths were not uncommon. In 1920 of the total births occurring in the town approximately 47 per cent occurred in the home of the expectant mother.[11] At a homebirth, women could be attended by unregistered midwives who worked under the supervision of a doctor or by a registered woman who sought a doctor's aid only in difficult circumstances. It seems likely that the type and quality of care women received was determined by what they could afford. The unregistered "handywomen" may well have been a popular choice as attendants at homebirths, chiefly because they would care for other children and the home thus affording the mother a short recovery period. However, it is impossible to determine whose attendance predominated at homebirths as birth records reveal only the place of birth, rarely providing specific information about who delivered the child.[12]

Palmerston North contained a number of lying-in-homes. For some women, these were desirable places in which to give birth as they provided a welcome break in a home-away-from-home, even though they afforded very limited medical facilities. For others they were not a practical option as they did not solve the problem of providing care for existing children.[13] One bed lying-in-homes escaped being licensed, for private hospitals were defined as "any house in which two or more patients are received and lodged at the same time".[14] Although lying-in-homes were not licensed they were required to be run by registered midwives.[15] In Palmerston North, however, eleven untrained women appear to have run one

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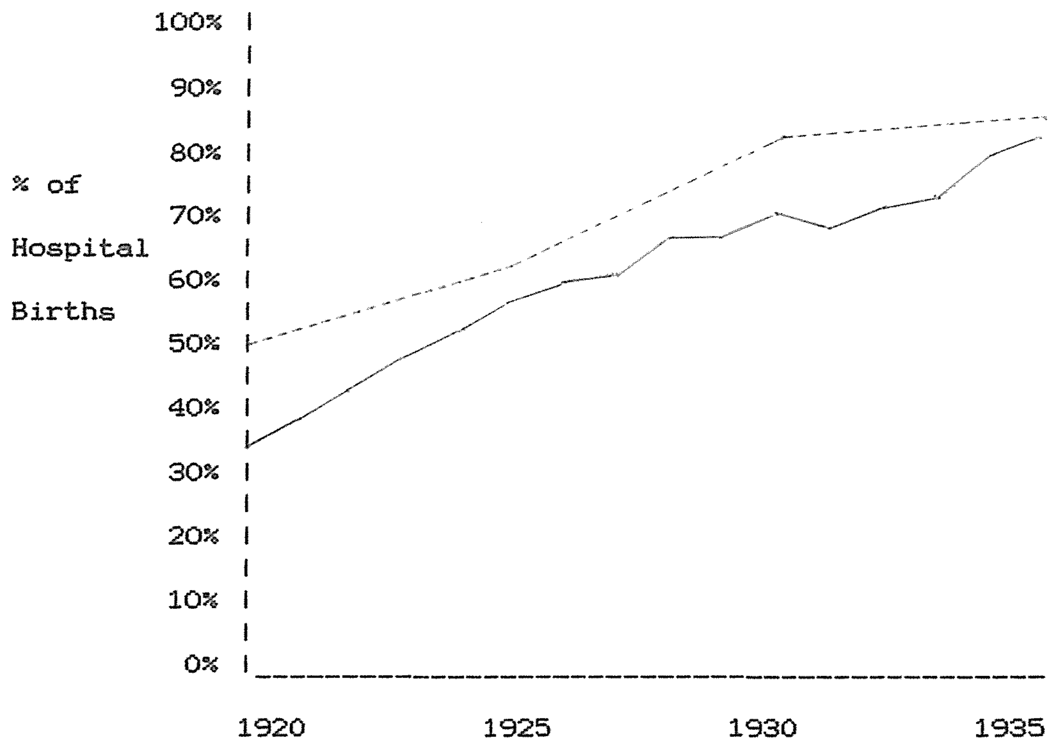
11. Register of Births, 1915-1916, PN Courthouse.
12. ibid.
13. Reiger, p.94.
14. <u>New Zealand Statutes</u>, 9 Edw VII, No.11, p.96.
15 see H1, 6 0003, WArc.

THE TREND TO HOSPITALIZATION IN PALMERSTON NORTH, 1920-1935.

Graph One: Percentage of Total Registered Births occurring in Hospitals in Palmerston North.



KEY: National ————
Palmerston North - - - - -

Sources: P. Mein Smith, "The State and Maternity in New Zealand, 1920-1935", MA thesis, (Canterbury, 1982), p.407.
Register of Births, 1920-1935, PN Courthouse, PN.

bed homes at their personal residences.[16] Whilst in theory this was illegal, it seems likely that the 1905 verbal agreement enabled this situation to continue. Again such work had to be conducted under a doctor's supervision. These unregistered women could not afford to fall foul of local GPs because it was these doctors who enabled them to continue midwifery.

Private hospitals were another option for expectant mothers. Palmerston North boasted at least five private hospitals providing approximately twenty four beds.[17] In theory, these hospitals afforded the most complete medical care as they were run by registered midwives who accommodated private patients of local GPs. A woman could be attended by a midwife, a doctor or both. This too was most likely determined by what the patient could afford - if a woman was attended by a doctor, the cost of childbirth increased by as much as £5 which was the GP's fee.[18] Midwifery fees are not easy to determine but undoubtedly depended upon length and intensity of care provided. Health Department reports indicate that quality of care provided in private hospitals varied greatly.[19] Private patients would normally remain in hospital for ten to fourteen days after birth.

Whilst homebirths were common, use of these hospital facilities was high. In Palmerston North the percentage of hospitalized births appears to be significantly higher than nationally. In 1920, approximately 35 per cent of New Zealand births occurred in hospital, whilst in Palmerston North, as many as 53 per cent of the births

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16. Register of Births 1915-16, PN Courthouse.
17. I am unable to provide the exact number as the List of Private Hospitals pre 1945 cannot be traced by either H or WArc.
18. Smith, p.17.
19. AJHR, 1907, H-22, p.3.

occurring in the Borough were in hospitals.[20] The reason for Palmerston North's elevated number of hospital births was rural dependence upon the town's resources. This provides a contrast to Mein Smith's study which focused chiefly on main city statistics.

Dependence upon Palmerston North by women in the surrounding hospital district served to inflate the trend to hospitalized birth, (see Graph One).[21] With five GPs affording medical services and twenty midwives of varying quality, women in the town appeared to have ample choice of places in which to give birth. In theory, these facilities seemed sufficient to fulfill the needs of the town's residents. However, the range of services was inadequate, failing to provide sufficient inexpensive facilities to meet both the town demand and that of the surrounding hospital district. Palmerston North was the centre of a largely rural community, including a number of small towns, like Sanson and Rongotea, which had inadequate facilities. Consequently many women from the district were reliant upon Palmerston North's services.

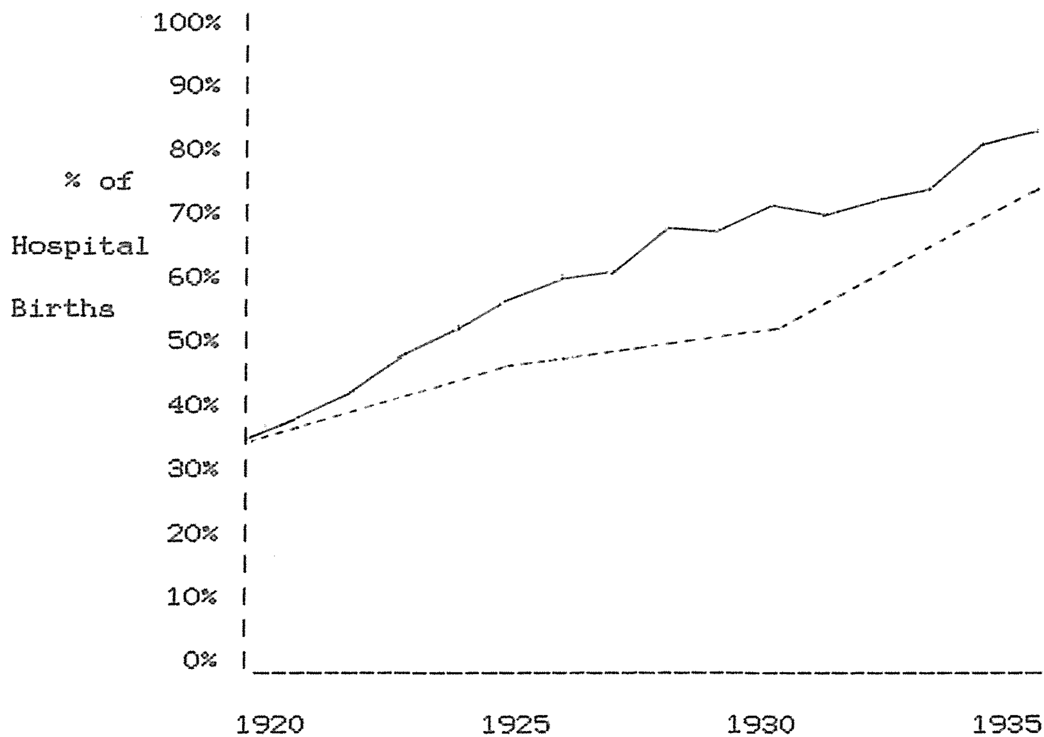
Feilding, the second largest town in the district, compared favourably in the provision of maternity services with Palmerston North but was subject to similar pressures. Feilding contained only one private nursing home which employed two midwives. In addition, there were six domiciliary midwives and six GPs. Feilding's facilities were depended upon by women in the hospital district north of the town as Kimbolton contained the only other doctor in the area.[22] With the facilities in the

---

20. Register of Births, hospitalized births do not include lying-in-home births which are classified as homebirths or other confinements, see AJHR, 1934, H-31A, p.72.
21. Surrounding district's dependence inflated PN hospitalized birth trend as rural and small town homebirths are not accounted for when the focus is on all births occurring in PN.
22. I was unable to determine if all the Feilding domiciliary midwives and doctors were practising at that time. No midwives north of Feilding could be traced.

THE TREND TO HOSPITALIZATION IN PALMERSTON NORTH, 1920-35.

Graph Two: Percentage of Total registered births occurring in Palmerston North Hospitals to residents of Palmerston North Borough.



KEY: National ————
Palmerston North ----------

Sources: P. Mein Smith,"The State and Maternity in New Zealand, 1920-1935", MA thesis, (Canterbury, 1982), p.407.
Register of Births, 1920-1935, PN Courthouse, PN.

small towns under stress, many rural women travelled to Palmerston North, gave birth, registered the new-born infant in the borough and returned to their own locality.[23] Whilst some of the district's women using Palmerston North facilities came from the small towns, the services were chiefly used by the rural community.[24] This does not mean that all rural women used the Palmerston North facilities, some may have given birth in their own homes attended by friends and neighbours and, if they were fortunate, a domicilary midwife or GP who was prepared to travel into the countryside to attend a patient.[25]

If the Palmerston North residents' usage of the town's hospital facilities is considered alone, the hospitalized birth rate followed a similar pattern to the national trend. In 1920, 34 per cent of births to residents of Palmerston North took place in a hospital.[26] This was in comparison to a 35 per cent national hospitalized birth trend. Little difference is evident in 1920, but by 1925 Palmerston North's urban trend was slower than the national one, (see Graph Two). This rate was slower because the town's women had to compete with rural women for available maternity beds. The surrounding district's dependence made the Palmerston North services deficient since they were unable to satisfy the demand of both rural and urban women.

The slower urban birth trend might also be explained by some GPs in the town promoting homebirths. This included Dr Tom Paget, who later became

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23. Register of Births illustrates this clearly as it states place of birth and normal residence of the mother or parents.
24. Register of Births shows that some Feilding women did attend PN facilities but women came mainly from rural areas like Kairanga which lacked facilities totally. This was the case into the 1930s, see PNHB file 25/2/1.
25. Sparkes, "Progress in Maternal Welfare", Kai Taiki, Nov.1932, p.264.
26. This figure was determined by using urban birth rates in Reports of Vital Statistics of New Zealand, 1921, p.60.

Inspector of Private Hospitals with the Health Department, but who acted as a GP in Palmerston North from 1919 to 1924.[27] In the 1920s, Palmerston North's expectant mothers were advised to stay at home to give birth as maternal mortality statistics revealed that puerperal septicaemia occurred most often in private hospitals. Two women interviewed in the course of this study experienced home births and were advised by their GPs to have domiciliary confinements to prevent unnecessary risk. Their doctors stressed this because the rural demand for the town's facilities increased the possibility of overcrowding which inflated the risk of infection.

Some evidence exists to suggest that the issue of maternal mortality caused concern in Palmerston North in the early 1920s. However, there is insufficient material to view maternal mortality as the major reason which triggered inter-professional rivalry and the trend to hospitalization as Mein Smith demonstrates nationally. Concern over maternal mortality is evident in 1924. Anxiety was initially generated in Auckland in 1923 by a wave of five deaths from sepsis in the Kelvin Private Maternity Hospital which triggered the formation of the Kelvin Hospital Commission. These publicised Auckland deaths were mirrored in Palmerston North by three deaths of local women in one private hospital. The establishment in question was operated by Nurse Catherine Vincent, a Class B midwife. The hospital contained six beds, a labour room and nursery but lacked a sterilizing room.[28] Paget reported the deaths to the Health Department and ascribed blame

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27. Paget remained an advocate of homebirth. He came to Palmerston North after selling his Stratford practise and hospital to Dr Doris Gordon and her husband in 1919, see Smith, p.15,31.
28. see H1, 6 0003, Warc.

DR TOM PAGET

to the hospital stating that it:

> was practically on all fours with "Kelvin" with three deaths and God knows how many more would have occurred had I not taken action when I did, and brought the matter to your personal notice. Of course I was a fool to my own interests in doing so. I always am and it makes me slow to condemn the Doctor who conceals these cases. I do condemn him [Dr Hughes, Auckland Medical Officer] and severely but I understand his reluctance to face the inevitable odium and heavy financial loss which prompt action entails.[29]

In Auckland, the publicised deaths had caused a temporary swing back to homebirths. In Palmerston North, however, the mortalities in the town did not arrest the trend to hospitalized birth but Nurse Vincent's hospital was substantially less frequented as women chose to stay away from the "at-risk" hospital.[30]

1924 was the year in which public awareness over maternal mortality appears to have peaked in Palmerston North. The public furore triggered in Auckland by the Kelvin Hospital deaths prompted the Health Department to embark on an education campaign. The "safe maternity" campaign was launched in Palmerston North in June 1924. Paget's appointment to the Health Department in May 1924 may well have contributed to Palmerston North being chosen as the centre in which to launch the campaign. Pomare (the Minister of Health), Valintine (Director-Genral of Health), King (Director of Child Welfare), Paget and Wylie (PN President of the BMA) all addressed the public at the opening. Paget urged the women of Palmerston North and New Zealand to follow the advice of the nurse because this was "invaluable" and would produce "more good than any doctor could impart, however capable he might be".[31] Despite Paget's stress

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29. Paget to Valintine, 18 March 1924, H1, 6 0003, WArc.
30. Registered births at Nurse Vincent's in 1920 were 90; in 1925 had fallen to 0 and by 1927 had risen to 38.
31. Paget quoted in Manawatu Evening Standard, 7 June 1924, p.2.

on care by the nurse, women using Palmerston North's facilities moved increasingly to the larger institutions and doctors' care. Concern triggered by the Palmerston North deaths and the "safe maternity" campaign may have prompted women to seek admission into Palmerston North hospitals due to fear caused by maternal mortality in that year.

A major difficulty emerges when dealing with the importance of maternal mortality and its relationship to the trend to hospitalized birth. Maternal mortality is problematic for the researcher at the local level because there is little certainty about how a maternal death was defined. This problem of classification makes a local comparison with national statistics impractical. District court records reveal that a number of women died in pregnancy and childbirth but for every five deaths that are clearly maternal, there is at least one that is difficult to classify.[32] This problem was recognized by the national committee established to inquire into maternal mortality in 1921. The validity of international statistics was questioned because individual countries may have defined mortality in a variety of ways. For example, a woman dying of phthisis in pregnancy might

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32. In trying to determine what constituted a maternal death I have investigated a number of sources: neither the Department of Statistics nor the National Health Statistics centre could provide me with a definition pre-1968. The 1968 Maternal Mortality Research Act requires that a women who dies during pregnancy or within 3 months of childbirth whether due to obstetric causes or not is classified as maternal death - this does not help in defining a death in my period; H.Jellett's, Midwifery for Nurses, (London,1926) provides a chapter on diseases which are associated with the puerperium, pp.335-341; Jellett's "Midwifery Notes" in NZMJ, no.153, vol 29, Oct 1930, p.301 lists Statistics of Maternal Mortality which covers the widest range of causes yet found; Smith, p.147 provides the general mortality headings that were used by the Department - whilst this is useful it does not provide solutions to particular problems; Phillipa Mein Smith, letter, 15/9/87, stated that all statistics in Maternity in Dispute are derived from official sources and was unable to direct me to a specific source to solve this problem.

be shown in mortality returns as a death from phthisis or pregnancy.[33] The problem of classification is not one that faces today's historians alone but one that haunted the medical profession at that time.

With the revelation of New Zealand's high maternal mortality in 1921 it seems likely that the questioning of international statistics aimed at undermining their validity. Despite this, the query underlines a very important issue. If national and international statistics cannot be fairly compared, then similar questions emerge about the relationship of local and national statistics. One is left wondering if the local problem of classification is also a national problem because national statistics are compiled on the basis of local returns. In reality, as classification was determined by individual practitioners national maternal mortality statistics may well have been higher than Health Department statistics reveal. This seems particularly likely because the maternal mortality statistics seemed shocking in the face of New Zealand's success in lowering infant mortality rates.[34] For a nation that was proud of its reputation as a social laboratory the statistics were a "blow to national pride".[35] This issue demonstrates the importance of the local perspective because national statistics are compiled from local sources which represent the origin of the problem.

Mein Smith suggests that the concern aroused by the revelation of New Zealand's high maternal mortality rate in 1921 and the Kelvin Hospital deaths in 1924 triggered an official Health Department response to the problem. The use of midwives to eliminate the

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33. see AJHR, 1924, H-31A, p.20.
34. F.S.Maclean, p.176.
35. Griffiths, p.162.

spread of sepsis made inter-professional rivalry between doctors and midwives inevitable as many GPs lacked adequate obstetrical training.[36] The ensuing battle for control of childbirth entrenched the path to hospitalized birth. This element of inter-professional rivalry is difficult to detect on the local level.

In Palmerston North, one instance of irritation by local doctors can be seen in 1926. The Palmerston North branch of the BMA were outraged by the Department's power to suspend GPs from midwifery cases if they were thought responsible for infecting patients with puerperal sepsis.[37] As elsewhere in New Zealand, Palmerston North doctors disliked being labelled "carriers of infection".[38] Doctors' annoyance in this instance was directed at the Department rather than specifically at the midwives of the town.

Instances of professional rivalry in Palmerston North are not well documented if they existed. The town contained neither a St Helens nor a public facility in these early years. These were both institutions where the midwife retained her role as chief attendant at childbirth. Consequently midwives of the town may well have lacked a strong sense of identity or autonomy in their work. This is particularly plausible in the case of the unregistered women who worked as maternity nurses in a symbiotic relationship with doctors. It is possible that women in the town actively sought more medical reassurance at the time of childbirth, encouraging midwives and doctors to work together. This is quite probable in a health conscious era and is well illustrated by the consumer demand for adequate maternity services in Palmerston North at this time.

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36. Smith, p.18.
37. BMA "Meetings of Council and Divisions", NZMJ, vol 25, No.125, Feb 1926, p.23.
38. Smith, p.61.

CHAPTER TWO - A St Helens for Palmerston North?.

> My desire is that these houses [the St Helens hospitals] will be available for all those whose means will not permit of private comfort and skilled attendance.1
>
> - Richard Seddon -

In 1915, several years prior to the national crisis over maternal mortality, citizens in Palmerston North called for some form of public maternity service for working class and poor women.[2] The desire for a public facility is significant as the decade of local politics and debate that followed reveals the town's difficulty in establishing a facility due to a transition in Government policy. This provides an important new dimension to supplement Mein Smith's national study.

Zillah Gill, a member of the Palmerston North Hospital and Charitable Aid Board, initiated the demand for a public maternity home. Gill's concern was based on the high costs associated with childbirth and parenthood.[3] The campaign that followed for a low-cost maternity service grew out of contemporary recognition that the quality of care received in childbirth was dependent upon the depth of the consumer's pocket. Yet despite this early call for public maternity care, the issue lay dormant throughout the years of the Great War. By 1918 the Hospital Board deemed such provision not to be so urgent, a view perhaps promoted by the decline in the Palmerston North urban birth rate.[4] In 1917, the rate was 28.34 per 1000 population; by 1918 this had dropped to a rate of 25.63.[5] In addition, the Board was already under

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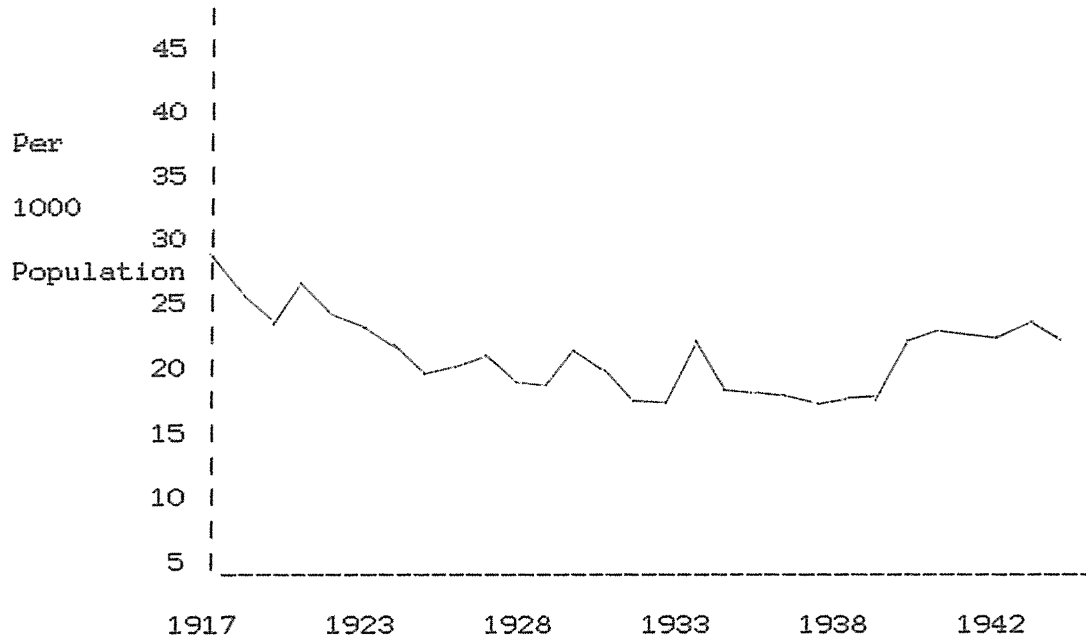
1. Richard Seddon c.1904 quoted in Donley, p.39.
2. Z.Gill to Sir Francis Bell, Minister of Hospitals, 30 March 1920, H1, 75/16, WArc.
3. ibid.
4. PNHB to Minister of Public Health, 6 Feb.1918, H1, 75/16, WArc.
5. <u>Reports on Vital Statistics of New Zealand</u>, 1921, p.60.

PALMERSTON NORTH'S URBAN BIRTH RATE 1917-1942



Source: Report on Vital Statistics of New Zealand, 1917-1947.

heavy financial commitments due to other hospital developments, including provision of a new surgical block.[6]

The citizens of Palmerston North had considerable difficulty in securing the establishment of a public maternity facility. Problems arose because, as a secondary centre, the town was caught by changing Government policy. In the early 1900s, the establishment of State funded St Helens was promoted by Seddon and the Government. The declining birthrate and high infant mortality made such provision seem vital. However, during the years of World War One this policy began to change, moving away from separate St Helens in favour of maternity wards associated with public hospitals.[7] The Minister of Public Health, Russell, articulated the new policy in 1917, wanting to see:

> a maternity ward in connection with every hospital. The lamentable wastage of life caused by the war made it imperative that the creation of population should be encouraged, and that when the children were born they should grow up to healthy men and women.[8]

Reasons prompting this policy change included recognition that maintainence and administration of St Helens was very costly for the government, as the Hospitals had often been established in unsuitable buildings.[9] In addition, there was rising emphasis on functional self-sufficiency in hospital districts to make Hospital Boards less wasteful of public money.[10] This modified policy included the Department of Public Health moving away from Grace Neill's notion of a "homely" institution run on simple lines to more elaborate institutions. This change was in keeping with other medicalized developments in hospitals

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6. PNHB Minutes, 9 Oct.1917.
7. H.Maclean, Nursing in New Zealand, (Wellington, 1932), p.61.
8. Wanganui Chronicle, 31 March 1917, H1, 54/4, WArc.
9. PNHB Minutes, 10 April 1920; see Maclean, pp.36-37.
10. AJHR, 1975, H-23, p.26.

during a health conscious era.[11] The desire for adequate maternity services was upheld by the Government throughout the 1920s.

Government policy in favour of public maternity wards had not been finalised when Palmerston North citizens called for a St Helens Home in the town. For many residents a St Helens seemed the obvious solution as such Homes were government funded and administered. It would enable the Hospital Board to proceed with its other development plans whilst the town would still gain a low-cost maternity service. The town's citizens thus sought to tranform what they mistakenly perceived to be government policy into a local reality. Consequently, in May 1918 the Manawatu Second Division League of soldiers made the first call for a St Helens urging the Government to establish such a Home "particularly for the use of Soldiers' wives".[12] The League stressed that several cases in the town proved the necessity for such a Home but failed to elucidate further.[13] Russell responded quickly announcing that the Government did not "intend to establish an institution of this kind".[14]

THe Government's emphatic refusal to establish a St Helens produced debate in Palmerston North. With the delay caused by changing government policy, local body factional fighting emerged within the town. This impeded the progress to the provision of a public maternity service. The first debate was over where a maternity home should be situated if the Hospital Board made provision. Gill and another Board member,

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11. H.Maclean, pp.56-57. Increasing emphasis was placed on good hospital management especially after the influenza epidemic had revealed the inadequacies of the public health system.
12. W.B.Cameron to Russell, 3 May 1918, H1, 75/16, WArc.
13. This may be a reference to maternal mortality. In 1917, five PN women died in childbirth, two of which had been homebirths. In total 14 children were left motherless, see Register of Deaths, PN Courthouse.
14. Russell to Cameron, 7 May 1918, H1, 75/16, WArc.

Mrs Crabb, were staunch advocates of the Home being separate from the Hospital grounds. They desired the establishment of a Home in a private property owned by William Parkes in College Street. In this they were supported by the Palmerston North Labour Representation Committee, the St John's Ambulance (PN) Nursing Division, combined Friendly Societies, the Amalgamated Society of Railway Servants, the Palmerston North branch of the Women's Christian Temperance Union and a number of women of the district.[15] The antagonism of these groups to a hospital site for a Home stemmed from the belief that women ought be confined in "cheerful surroundings".[16]

The women of the district were active in this campaign and strove to shape the type of service that would be instituted. Their participation included a deputation to meet Russell who acknowledged the importance of the issue of maternity to them as it was "essentially a woman's question".[17] In a rather paternalistic manner he noted the women's opposition to a hospital site. This did not mollify their opinion and the deputation was followed by a petition against a hospital site which contained 1137 signatures.

Local division of opinion over the site of a maternity hospital furnished the Government with a convenient excuse for prevarication. However, the constant demand for Government input by many in Palmerston North made further negotiations necessary. Neither Russell nor the Hospital Board were willing to accept financial responsibility for a maternity facility. Hospital records reveal that Board finances were already stretched for by 1919 they were committed to building new

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15. T.Reid, PNLRC to Gill, 7 May 1918; St Johns Ambulance, PN Nursing Division, to Russell, 6 May 1918; Resolution of Women of District, to Russell, 9 May 1918. See also Manawatu Evening Standard, 14 June 1918, all in H1,75/16 WArc.
16. Newsclip "A Stonewall", 10 May 1918, H1,75/16 WArc.
17. ibid.

surgical wards, x-ray and bacteriology laboratories in addition to a convalescent and administration block.[18]

In face of the Government's pro-natalist rhetoric the Department of Public Health felt obliged to offer some solution. The pragmatic attempts by the Department to remove the Palmerston North "problem" caused inconsistency in Government statements. The first solution suggested was that to fulfill the need for a cheap but safe service, Catherine Hall, a local midwife who owned a large private hospital, could provide an extra eight beds and should be approached to cater for poorer women. For the care of charitable cases the Board could make an arrangement with Hall that would suffice for years. This solution seemed to the Department to be adequate as five private hospitals containing twenty four beds were sufficient for the town, and it would exonerate the Government of responsibility especially as the birthrate had declined to 23.35 per 1000 population in Palmerston North by 1919.[19] Russell leapt at this opportunity to confirm Government policy by encouraging further provision in the district but at the Board's and not the Government's expense:

> I regard the establishment of a maternity service for the assistance of parents of limited means a clamant [sic] need in your district. It is suggested that you arrange with the matron of a private maternity hospital to take in such cases. 20

The reluctance of both the Government and the Board to accept financial responsibility generated further problems. The extension of an existing hospital was deemed unsuitable by Palmerston North citizens as a new facility was desired. By 1920, the Palmerston North campaign had

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18. PNHB Minutes, 19 July 1919.
19. Memo: Maclean to Valintine, 29 July 1919, H1, 75/16, WArc. See also Vital Statistics, 1921, p.60.
20. Russell to PNHB, 18 Aug.1919, H1, 75/16, WArc.

the inconsistency of Department policy working in its favour for the establishment of a St Helens. This was "fervently desired" by the women of the district.[21] The simultaneous granting of a St Helens in Invercargill "proved" that Palmerston North could receive similar treatment. Valintine (Director-General of Health) openly acknowledged that the Health Department was "very much in favour of St Helens Homes throughout the country" but by this time believed that existing St Helens were "unsatisfactory for the most part in that they [were] converted buildings".[22] Consequently, exorbitant expenditure, of up to £50,000, could not be recommended for a Home that would be inadequate especially as the proposed site was the Parkes' property in College St.

Aware that the Palmerston North public had recognised policy inconsistency, the Department put forward its second solution. Public tenacity needed to be substantiated by Palmerston North citizens through a £5000 donation toward a St Helens.[23] A capital contribution was required to gain the erection of a new St Helens Home which would be granted as long as it was not to be in an existing structure.[24] Official policy, however, remained in favour of Board erection of a Home.

Recognising the Department's vacillation, the citizens of Palmerston North leapt at the opportunity to secure the establishment of a St Helens and launched the "Help the Mothers" campaign to raise £10000. A Reveille ran for eight nights after promotion by the Agricultural and Pastoral Association. Local lodges held dances, plays were staged, a male choir visited and a large barometer was

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21. Nash to Bell, 24 February 1920, H1,75/16, WArc.
22. PNHB Minutes, 10 April 1920.
23. Valintine to Nash, 15 March 1920, H1,75/16, WArc.
24. Valintine to Nash, 3 February 1921, H1, 75/16, WArc. Furnished Nash with estimates of established St Helens: Townley Home, Gisborne, handed over as a going concern, land £2,000; Wanganui Home, property donated £6,000. See also Manawatu Evening Standard, 10 June 1920, H1, 75/16, WArc.

Please keep for Reference, or Post in a Conspicuous Place

"HELP THE MOTHERS"

CAMPAIGN

for £10,000

Our Hospital Districts' Noble Effort for the Establishment of ST. HELEN'S HOME.

Official Suggestions, Instructions, Rules, and Regulations of this Novelty in Competitions.

Don the Colours. Your Money or your Energy is Required. Do Something.

The Help of "EVERYMAN" and "EVERYWOMAN" and "EVERYCHILD" is wanted.

The Voluntary Contribution of ONE SHILLING will purchase ONE SQUARE FOOT OF LAND, and will entitle you to wear the Colours of the Queen of your choice.

SAVE THE BABIES, HELP THE MOTHERS, AND BENEFIT THE COMING GENERATION.

ROYAL TITLES.	COLOURS.	QUEEN'S REALMS.
The Kiwitea-Pohangina (Sappers)	Purple and White	Kiwitea and Pohangina Counties
The Manawatu (Spademen)	Green and Gold	Manawatu County with Foxton
The Oroua (Delvers)	Black and White	Oroua County
The Feilding (Tunnelers)	Red	Feilding Borough
The Kairanga (Diggers)	Red and White	Kairanga County and Rongotea Town Board
The Horowhenua (Miners)	Red and Black	Horowhenua County with Otaki, Levin, and Shannon Boroughs
The Western (Engineers)	Blue	Palmerston North
The Northern (Trenchers)	Green and White	Palmerston North
The Southern (Pickmen)	Black and Gold	Palmerston North
The Eastern (Ditchers)	Blue and White	Palmerston North

(The four Palmerston North sections: Intersected by Railway, Rangitikei Line, and Fitzherbert Street.)

For the purpose of this unique Competition, the area which it will be necessary to purchase has been sub-divided into **200,000 square feet,** giving every resident within the Hospital Districts' Boundaries the privilege of buying four or more square feet at 1/-, thus realising a sum of £10,000.

The following scale will make the matter clear, and will indicate how our loyal residents may obtain this sum for us.

One Shilling will purchase one square foot, and add one vote for the Queen of your choice.

1/-	will purchase	1 square foot	and	1	vote.
2/-	"	2 square feet	"	2	votes.
5/-	"	5 "	"	5	"
10/-	"	10 "	"	10	"
£1	"	20 "	"	20	"
£2 5s.	"	5 square yards	"	45	"
£3 3s.	"	7 "	"	63	"
£5	"	11 "	"	99	"
£10	"	22 "	"	198	"
£25	"	1 perch	"	500	"
£50	"	2 perches	"	1000	"
£100	"	1-20 of an acre	"	2000	"
£200	"	1 square chain	"	4000	"

The Hospital Board's District has been divided into Ten Sections as above. 5000 square feet of the land has been placed to the initial credit of each competing Section.

Residents of each Section unable to give their energies may assist by Honorary Contributions at the above scale.

Note this.—Each sum of 1/- donated or raised by any [illegible] one square foot and gains one vote for the contributor's Queen.

Each Section will elect a Queen and a Princess. At the close of the Competition, the Queen whose section has gained the greatest number of square feet of land will be declared the winner, and will be publicly crowned at the Grand Coronation Ceremony.

Each Queen must be represented by a Lord Chancellor, whose duty will be to allocate the money collected on her behalf as shown hereafter.

The Queen having the best Organisation and collecting the most money should be victorious; but there are great strategic possibilities, and the exact position cannot be accurately estimated, because success does not necessarily belong to the strong, but is largely determined by the best Generalship and Strategy displayed by the Lord Chancellor in allocating the money with which his Queen entrusts him. He may dispose of moneys as follows:—

(a) He may pay in the amount for the purchase of land at 1/- per square foot to be added to his own Section.

(b) Use it to dig away the same area from any opposing Queen.

(c) Divide the amount to dig away from different opposing Queens according to his own allocation.

(d) Use any part to buy more land, and the balance to dig away from opposing Queens, as set out in clause (b) and (c) above.

Provided that he shall not be entitled to dig away less than 50 square feet of any one opposing Section's area at one time.

The full area so dug away shall correspondingly reduce that held by the opposing Section or Sections concerned, in addition to which the Lord Chancellor who thus reduces other Sections will be credited with 50% of the area by which he reduces his competitors.

The record of amounts paid in to each Section, or dug away from opposing Sections shall be under the sole control of the "Secret Officer."

The first sod will be turned on Saturday, 13th August, and the Competition will commence in real earnest on Monday, the 15th August, and on the morning of Tuesday, 16th August, at 11 o'clock, the flags of the leading Queen and all other Queens will be displayed in their respective positions and hoisted in the Square, and at the same hour on all succeeding days of the great Competition.

The Queen whose flag leads each day will be credited by the Secret Officer with a bonus of 400 square feet of land, equivalent to £20 paid in. In case of two or more Queens being equal on any day, the bonus will be equally divided between them.

It is not permissible for competing Queens to hold money in reserve.

The conduct of the Competition is entirely in the hands of each Section, and is subject only to the rules and regulations herein laid down. It is in no other way directed, influenced, or controlled by the Central Executive.

All Cheques, War Bonds, Promissory Notes, etc., must be handed to the Secretary of the Central Executive at Palmerston North, who will provide a receipt and allocation form, which will be used by each Chancellor confidentially with the Secret Officer.

Note.—All Cash and Cheques collected must be paid into each Queen's local Account, and the local Treasurer must make each payment to the Central Executive by Cheque drawn on that Account.

Credit to the full assessed value will be given to each Queen for all War Bonds, Securities, approved Promissory Notes, Land, Cattle, Sheep, Pigs, Fruit, Produce, etc., or [illegible] and everything which can at the moment or subsequently be turned into cash.

Each competing Section shall control and be responsible for the payment of its own expenses in carrying [illegible]. These may be deducted by them from moneys collected, or liquidated by other means at their own discretion.

All Queens and Princesses will be expected to take their part in the Grand Final Coronation Ceremony.

Every dispute will be settled by the Central Competition Executive, whose decision shall be final.

The Central Executive shall consist of Messrs. Gibbons, Buck, Gerrand, the Chairman, and the Secretary.

J. A. NASH, M.P., Campaign Chairman.

J. R. HARDIE, Secret Officer.

J. H. STEVENS, Organising Secretary.

R. S. WATSON, Secretary.

WILLIAM LINTS, Organiser.

THE 1921 REVEILLE, a Spectacular Extravaganza, will be held in the Opera House, Palmerston North, for a Season of 8 nights, commencing 2nd September. 200 Performers.

NOTE.—Not one number of the previous Reveille will be repeated.

W. LINTS, Producer.

WATSON & EYRE PRINT.

"HELP THE MOTHERS"

erected in the Square to register the daily total of funds collected.[25] The exhaustative campaign was unsuccessful despite the emergence of national concern about maternal mortality rates triggered by Parr in 1921. "Helping the Mothers" was supposedly a national aim but with the paucity of post war finances and lack of mortality as a public issue the campaign in Palmerston North floundered.

The fundraising effort was thwarted by the controversy over the proposed site. In 1921 the Manawatu Daily Times stated "there is no division of opinion as to the necessity of a maternity hospital in Palmerston North",[26] yet in the array of related issues, there was considerable disagreement. Desire for a Government funded St Helens was unanimous. Those who opposed a hospital site wanted the purchase of the College Street residence whilst the Department of Health were reluctant to be encumbered with another "unsuitable institution".[27] In addition, three local GPs were vocal. Doctors Miller, Will and Paget were also against the Parke property as it was wooden and not germ or sound proof and was in an unsuitable locality.[28] Paget argued that safety was essential as the national sepsis death rate was "deplorable and disgraceful" and proved the necessity for aseptic safety.[29] He promoted the erection of a brick building to ensure asepsis. Paget, a man very conscious of the problem of maternal mortality, injected the issue into the local campaign exploiting it to strengthen the local case. This mention of maternal mortality was one of the few documented references in the Palmerston North campaign in the years after it had emerged

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25. Manawatu Evening Standard, 29 June 1921, H1, 75/16, WArc.
26. Manawatu Daily Times, 5 July 1921, H1, 75/16, WArc.
27. ibid.
28. ibid, 19 July 1921.
29. Manawatu Daily Times, 27 July 1921, H1, 75/16, WArc.

as a national issue.

Another issue was brought into the local debate by the town's GPs. They raised the question of whether an "open" or "closed" hospital system would be instituted in a public facility. A "closed" system meant that a resident obstetrician would attend difficult cases with midwives in the main delivering uncomplicated births. This was the system used in the St Helens Homes. In contrast, an "open" system meant that a woman could be attended by her own GP. The GP's expression of support was subject to an important qualification which was that women should be attended by whomever they chose in an "open" hospital system.[30] Their support for an "open" system was insurance that they would not be "pounds out of pocket" which New Zealand doctors had feared on the establishment of the St Helens Homes.[31]

Amid an atmosphere of varying aspirations, less than one-third of the desired amount was raised in the "Help the Mothers" campaign. This meagre contribution enabled the Government and the Department to default on their apparent concern for maternity. The public pressure that had been exerted in Palmerston North did however have a decisive effect in shaping national policy regarding the provision of maternity homes. The Director of the Hospitals Division, Dr David Wylie, believed that it was the duty of the Hospital Boards to build and erect Maternity Homes, the Department's only responsibility being administration of existing homes.[32] Valintine prevailed upon Parr, who had become Minister of Health in 1920, to introduce this as the Department's future policy.

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30. PN's GPs to PN Public, undated, H1, 75/16, WArc.
31. M.Tennant, "Grace Neill in the Department of Asylums, Hospitals and Charitable Institutions", NZJH, vol.12, No.1, April 1978, p.13.
32. Memo: Wylie to Valintine, undated. Outlined Boards' effectively running maternity homes including: Napier, Masterton, Blenheim, Picton and Dunedin, H1, 75/16, WArc.

Such a policy decision did not solve what had become the Health Department's problem of Palmerston North. The varying political statements that had been made needed to be clarified. In 1922, Parr attempted to do this and outlined to the Palmerston North St Helens Home Committee and Paget three alternatives :

1. Erection of St Helens Home.

Entail Government expenditure of:	£10,000
Less Palmerston North contribution of:	£ 2,800
Government provision of	£ 7,200

   Plus £2,000 maintenance per annum.

2. St Helens Home Committee grant £2,800 to Palmerston North Hospital Board. Board application for 24/- in £1 subsidy to erect a Hospital maternity ward.

3. Use existing building for a St Helens Home: cost £ 7,000. Not a satisfactory solution.[33]

By 23 March 1922, Cabinet rejected Palmerston North's application for a St Helens Home. The reason was simple, "It will be impossible until public finances materially improve for the Government to find a large sum of money for building a new St Helens in Palmerston North".[34]

Finance proved the pivotal question in the establishment of a public facility in Palmerston North. In 1924, the new Minister of Health, Maui Pomare, recognised some form of Government responsibility. Pomare's action reflected the Health Department's concern over maternal mortality which had been produced by the Kelvin Hospital deaths in Auckland. Good medical care, he believed, was an urgent need for expectant mothers. Consequently he pledged that if Palmerston North made a more "substantial contribution" of £5,000 the Government would erect a St Helens Home to be taken over, free of cost, by the local Hospital Board.[35] Pomare's pledge represents a new policy decision

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33. PNHB Minutes, St Helens Home Committee, undated. See also Manawatu Evening Standard, 16 March 1922, H1, 75/16, WArc.
34. Parr to Nash, 23 March 1922, H1, 75/16, WArc.
35. Pomare to Nash, 1 February 1924, H1, 75/16, WArc.

made by Valintine and himself, triggered by the Kelvin Hospital Commission, to secure the disappearance of private hospitals and promote the erection of public maternity annexes.[36]

Political manoeuvrings and public dissension culminated in a failure to raise the necessary £5000. Public weariness after a decade of debate and procrastination ended finally when the Hospital Board assumed responsibility for provision of a public maternity service. This decision was conditional on the St Helens fund being donated to the Board.[37] The Board resolved to secure the 24/- in the £1 subsidy that Parr had suggested toward the total cost of erecting a Home. A new scheme for special grants had been implemented which meant the Board was entitled only to a subsidy on the amount of voluntary contribution. If the public fund had been granted to the Board in 1922, the subsidy would have been payable on the amount estimated to be raised by levy.[38] The old subsidy had been pledged by Parr and as a result the Board received a special grant of £773. Treasury was terse about the extra expenditure fearing that a financial precedent might be set. In 1926 the new Minister of Health, J.A.Young, justified the grant in economic terms as:

> A matter of good faith with certain undertakings given during the term of the Massey Government and releasing the Government from a definite promise to establish a St Helens Home in Palmerston North. The course now agreed upon between the Government and the Palmerston North Hospital Board is an easy way out of what otherwise would involve a costly annual charge upon Treasury through the Health Department.39

In September 1927, after twelve years of policy vacillation, factional

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36. Smith, p.32.
37. PNHB Executive Committee Meeting Minutes, 13 May 1926.
38. Memo: W.Downie Stewart to Young, 17 July 1926, H1, 75/16, WArc.
39. Young to Stewart, 26 July 1926, H1, 75/16, WArc.

fighting and parsimony, the foundation stone for the new District Maternity Home was laid in Palmerston North.

The importance of this local case study lies in its revelation that a active public demand finally produced a low cost public maternity facility. The service that emerged in Palmerston North was shaped by this public demand and can be seen more clearly than Mein Smith's national study would allow. The difficulty in gaining the establishment originally arose because of a changing government policy, but also revealed that Palmerston North shaped national policy as policymakers wished to relieve themselves of financial responsibility. The delay this caused was exacerbated by local debate over what type of institution would be established, where it would be situated and whether an "open" or "closed" system would be instituted. Local dissension enabled both the Board and the Government to deny financial responsibility, which is ironic in an era when maternal mortality had emerged as a national issue.

This Palmerston North study reveals that developments in maternity were not simply a result of inter-professional rivalries, but of local and central government conflicts over responsibility which bedevilled the establishment of a maternity service in the town. Thus the local case study provides a new dimension to the national picture. Just as Mein Smith's Health Department sources produced an argument based on concern over mortality, the local perspective represented here reflects the concerns most prevalent in the Palmerston North community because of the reliance upon local records.

CHAPTER THREE: Growth of the Large Institution.

> The private maternity hospital system in New Zealand is unsatisfactory at present from almost every standpoint ....While it must recognised that the system now in operation has been of much service to the community, its defects cannot [sic] longer be endured, and a complete and drastic change is called for.1
>
> - Kelvin Hospital Commission, 1924 -

The District Maternity Home opened in 1928 and provided Palmerston North the long awaited low cost facility. With women in the district actively seeking hospital births and increased Health Department regulation governing maternity practice the end of domiciliary and lying-in-homes was to follow.[2] In reality, with the demise of the private sector, the new public Home did not provide the district with more maternity beds but simply replaced the declining number of domiciliary midwives.[3] Consequently, women's increased demand for maternity beds placed a strain on Palmerston North services, especially the low cost district facility. The public maternity service in Palmerston North was eventually shaped by consumer demands following the introduction of maternity benefits.

Public hospitals had originally been provided in New Zealand to care for the destitute and in cases of maternity were associated with the

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1. AJHR, 1924, H-31A, pp.15-16.
2. Health Dept regulations included inspection, practise of asepsis, and use of sterilizing equipment.
3. Register of Births: in 1915, eleven lying-in-homes; by 1925 only three remained and by 1945 only one domiciliary midwife is traceable.

charitable needs of unmarried mothers.[4] The St Helens Homes had lessened this "taint of charity" gradually by stressing over many years that such institutions were provided for wives of working men who paid for care. Hospitalized maternity care for respectable married women was stressed in the interests of safe birth.[5]

Throughout New Zealand in the 1920s public hospitals were in a state of transition, moving away from the belief in self-support to a social service which was increasingly used by all citizens. In theory, public facilities were provided for those unable to pay for private medical care but in practice were used by all classes, with those able being expected to pay.[6] The District Maternity Home is an example of an institution where fees were determined by a patient's ability to pay, ranging from £2/9/- to £5/5/- per week.[7] Despite this change a legacy of charity remained hanging over those using public maternity care into the 1930s. Twenty one of the women interviewed spoke of the stigma associated with confinement in a public hospital many still viewing it as a place for poor and immoral women.[8]

Despite the ambivalent feeling toward the new Home from some members of the community, it functioned to capacity until 1938. Hospital records reveal that in 1931 the Palmerston North Home treated more patients annually than any other home run by a Hospital Board in New Zealand.[9]

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4. AJHR, 1975, H-23, p.37.
5. M.Tennant, "Indigence and Charitable Aid in New Zealand 1885-1920", unpub. PhD thesis, (Massey University, 1981). p.356.
6. see the Bryce case, "Honorary Staff and Public Hospital Patients, PNHB Inquiry", NZMJ, no.118, Dec 1924, p.519.
7. PNHB Minutes, 6 March 1933.
8. Four of the sample gave birth in the Home and each experienced hostility from friends,neighbours and family as they had publically acknowledged their inability to meet the cost of childbirth in a more "repectable"private institution.
9. PNHB Minutes, 17 April 1931, showed PNHB treating 221 patients; Batchelor Maternity Home 212; McHardy Home, Napier 209; and Hastings Home 174.

Being a district facility, the maximum twelve bed Home often experienced overcrowding and on occasions catered for up to eighteen patients at a time. The dependence of the surrounding district is revealed in a breakdown of counties from which patients were admitted over a six month period in 1933. Patients from surrounding counties constituted 46 per cent of total births occurring in the Home, and Kairanga provided 11 per cent of all total births occurring in the annexe because it lacked alternative services. Heavy rural use of the facility was corroborated by the Committee of Inquiry into Maternity Services in 1938. Evidence to the Committee showed that in 1935, 39 per cent of total confinements had come from within the Hospital Board district. The proportion rose to 41 per cent in 1936.[11]

The Committee of Inquiry into Maternity Services, which had been established to determine whether New Zealand's maternity services were adequate, concluded that the facilities in Palmerston North were sufficient and modern.[12] This did not reflect the evidence provided by the district's women. Rural women contended that little provision was made for them. In a submission to the Committee of Inquiry representatives of the Palmerston North branch of the Women's Division of the Farmers' Union stressed that the District Maternity Home was almost inaccessible to them as it was "nearly always full".[13] These women appealed for more extensive public provision and emphasized the difficulty in gaining domestic help to care for the family whilst

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10. Percentages calculated from statistics showing from which county patients were admitted, PNHB file 25/2/1.
11. Percentages calculated from evidence of Phillips, Managing Secretary, PNHB to Committee of Inquiry, PN, 15 Sept 1937, see H3, 3/7, WArc. It should be noted that this was calculated from total confinements, less urban confinements thus the rural percentage may include some births of non-residents of the Hospital district, however, this would be minimal.
12. AJHR, 1938, H-31A, p.40.
13. Feild, WDFU, PN, 15 September 1937, H-3, 3/7, WArc.

confined in the Home.

Urban women corroborated the rural women's submission, affirming that maternity facilities were overstretched. The proprietor of the "Ellora" Nursing Home, told the Committee that she refused a minimum of six bookings a month always, being heavily prebooked.[14] Overcrowded facilities in the town, some women testified, put great pressure on all the Homes, resulting in indifferent care particularly in the private hospitals.[15] The official definition of adequate services was contrary to the perception of those services held by the women of the district.

In theory, the Committee's verdict was correct, especially as it acknowledged that if Feilding, the second largest town in the district, had adequate facilities the Palmerston North annexe would be considerably relieved. However, women's perception of inadequacy reflected a reality that the Committee failed to appreciate. Poor distribution of low-cost maternity beds caused the district to experience difficulty. Patients north of Shannon were dependent upon Palmerston North's services. Feilding lacked a public facility and supplied only eight private maternity beds which were always under heavy demand.[16] Women in the Kiwitea and Pohangina counties, north of Feilding were compelled to seek services in Palmerston North if the Feilding home was full. Foxton lacked any form of hospital provision which meant that women in that area had little option but to seek admission into Palmerston North facilities if they desired hospital births.

The County of Horowhenua, although in the hospital district, contained a total maternity provision of fifteen beds in Otaki and Levin to serve a

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14. Thomas, ibid.
15. ibid.
16. AJHR, 1938, H-31A, p.39. Population of Feilding was 4560 whilst Foxton was 1605.

population of 11,680.[17] Poor distribution of low cost maternity beds produced the demand for the District Maternity Homes services. Total public and private provision in Palmerston North equalled 61 per cent of all services to serve a rural and urban population north of Horowhenua. The Horowhenua county had a total bed provision of 1.3 per 1000 head of population whilst Palmerston North had only 0.8 per 1000. In addition to this uneven distribution of all beds, Palmerston North's low cost public provision was only 0.2 per 1000 population in contrast to 1.03 in Horowhenua.[18] In theory and in terms of total population, the Palmerston North Hospital Board district had adequate services but the geographical distribution of low cost maternity beds was unfortunate in the face of rural demand.

The Committee's failure to differentiate between the range and cost of available services is significant. This is illustrated by the effect of the Social Security Act on its introduction in 1938. The effect of the Act supports the Committee's verdict of sufficiency but also illustrates their lack of insight in failing to recognise the cost factor as an important aspect of maternity in Palmerston North. Prior to the introduction of maternity benefits the cost of childbirth was high. The minimum Public Hospital charge was 7/- per day whilst private hospital fees reached 18/- per day. Other services including circumcision, medical and surgical inductions were additional costs. Private hospital patients also paid an extra five guineas to be attended by their GP.[19] By 1939, this had changed as New Zealand women increasingly sought

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17. ibid.
18. Rates calculated from AJHR, 1938, H-31A, p.39; PN public facilities had an average bed occupancy 9.8 per diem in 10 beds, whilst Otaki with 12 beds had only 5.1 occupancy.
19. "Rostrata" charged up to £2 for circumcision; "Wiltshire" charged £1/10/-; medical and surgical induction ranged in cost from 10/- to £1/10/-; see AJHR, 1938, H-31A, p.39; also H1, 210/4 for fees; for doctors fees see Dr Williams, PN, 15 Sept.1937, H3,3/7.

the introduction of some form of economic aid in childbirth. In 1938, politicians reinforced the trend to medicalization by emphasising that all women had an equal right to care by a doctor.[20] Consequently by 1939, childbirth was free, paid for by the taxpayer.

In 1939, the Maternity Benefit section of the Social Security Act provided free treatment to all patients in Public and private maternity hospitals.[21] The effect of this upon the District Home was to increase hospital bookings, as public provision included all medical attention in contrast with private treatment where doctors' fees were outside the scheme.[22] By October 1939, the Government concluded an arrangement with all doctors practising obstetrics for free treatment of maternity cases.[23] This meant patients could be confined in private hospitals with their own GP entirely without cost to themselves. The effect of the amended Act upon the District Home was dramatic because it operated as a "closed" hospital. The "closed" system denied patients attendance by their own GP with all cases being attended by midwives and trainee nurses and in cases of complication by the Board's Medical Officer.

Bookings increased at the District Maternity Home in 1939 after the enactment of free Hospital care. By November a rapid decline was evident when full Maternity Benefits, with full medical and nursing treatment, came into force. The Board's concern was produced by the dramatic drop in bookings and was aggravated by the fear that if women sought their own GPs' attendance a permanent reduction of bookings at the District Home would result.[24] Additionally the Home had lost

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20. Smith, p.120.
21. Social Security Act, NZ Gazette, 1938, No7, 2 Geo VI, pp.120-121
22. see Appendix B.
23. Social Security Amendment Act, NZ Gazette, 1939, No.31, 3 Geo VI, P.427.
24. North Report, 14 February 1940, PNHB, File No. 25/2/1.

patients of poorer circumstances, previously referred by their GP. Doctor referrals ceased to be a source of patients for the Home as poorer women could now avail themselves of the private hospitals, attended by their own GP who was paid by the Government irrespective of the financial circumstances of the patient. Paget, now Director of Maternity Services, assured the Board that similar developments had occurred in public hospitals nationwide.[25]

Women of the Palmerston North hospital district effectively prompted a policy change. By denying the Home its consumers, women demonstrated to the Board that its services were not competitive or what they desired. By March 1940, the Board decided to partly "open" the Maternity Home, allowing approved medical practitioners to be appointed as visiting staff. Doctors were able to admit patients and received the Government fee for maternity work under the Social Security Act. Patients attended by their own doctor were required to attend the ante-natal clinic at the Hospital at least three times during the ante-natal period, with the aim of providing adequate patients for the teaching of trainee nurses. Visiting GPs were required to allow nurses to deliver patients under their supervision.[26]

Commencement of maternity benefits revealed that Palmerston North maternity services had been shaped where possible by the consumer. Removal of the cost encumberance liberated women's choice, enabling them to use services in the town where they could be attended by their own GP. The Board as a result was compelled to operate the Home on a new basis, re-thinking its services to fulfill the aspirations of the women of the district. The remodelling of services to promote bookings offered women of the district a greater chance to gain the confinements

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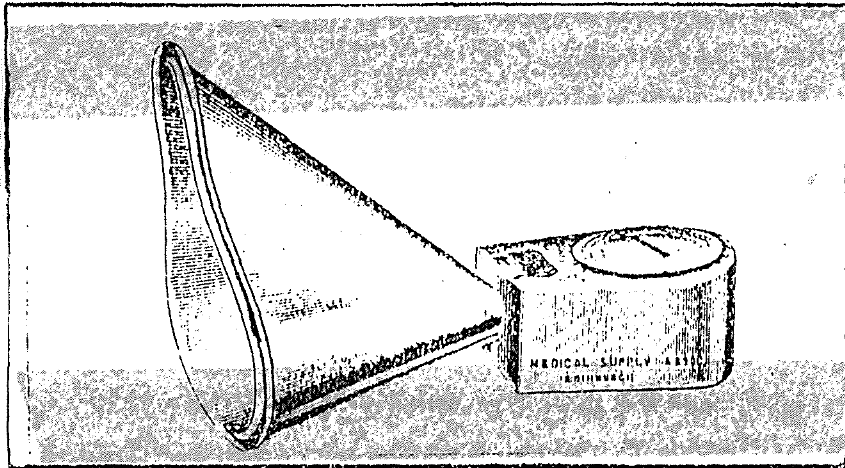
25. Paget quoted in North Report, ibid.
26. PNHB Minutes, 18 March 1940.



MURPHY'S INHALER

they desired.

Another issue that was important to women in the district was pain relief. During the sittings of the Committee of Inquiry into Maternity Services concern was expressed by the Palmerston North Branch of the Labour Party and the Women's Division of the Farmers' Union at the inadequate administration of pain relief in private hospitals.[27] Unfortunately private hospital records containing information about pain relief have been destroyed but the evidence of Palmerston North women's groups to the Committee was reinforced by my oral sources. Fourteen of the interviewees spoke of the lack of adequate pain relief and only one felt that sufficient relief had been administered, as she remembered only snippets of the eighteen hour labour.[28] Of that fourteen, nine women received a "whiff of chloroform" at the actual moment of birth. Chloroform, an inhalational analgesic, was administered by a specially designed inhaler, known as Murphy's Inhaler. This was advocated by the Department of Health because it was cheap and safe and could be administered by midwives from 1926.[29] On the basis of the oral sources it would seem that in Palmerston North Murphy's inhaler was a common method of anaesthesia, making the patient drowsy and less conscious of pain.

The Committee of Inquiry had urged the adoption of the policy favouring administration of "the fullest degree of pain relief consistent with the safety of the mother and child".[30] With the private hospital reputation for inconsistent administration of pain relief the District Maternity Home can have only gained from continual provision of pain relief. In a six month period in 1944, 97.4 per cent of women giving

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27. PNLP and WDFU, PN, 15 Sept.1937, H3, 3/7, WArc.
28. Interview: Mrs F., 23 April 1987.
29. Smith, p.83.
30. AJHR, 1938, H-31A, pp.89-90.

birth in the District Maternity Home received pain relief, 92 per cent of them receiving Nembutal and Seconal.[31] Nembutal and Seconal were anxiolytics which induced sleep - that is, they had an anaesthetic rather than analgesic effect. Of the remaining women, 5.4 per cent received chloroform because they entered the Home in an advanced stage of labour, whilst the remainder, 2.6 per cent, received no relief due to endangering circumstances, most notably prematurity.[32] Pain relief was administered at the Home in every possible circumstance, which increasingly made it a desirable institution in which to be confined. By 1945, the District Maternity Home bore fruit from its new "open" hospital policy and the administration of pain relief as it experienced record bookings for the financial year.[33]

Mein Smith suggests that pain relief was used by the medical profession to entrench their control of childbirth. Whilst she succeeds in proving this, it is equally important to note that the Palmerston North example reveals that women actively sought pain relief at that time. Women, like the doctors, helped shape the maternity service. For Palmerston North women in this period pain relief was an important issue which illustrates that one must be wary of viewing women simply as dupes of doctors. The medical profession may have created fears which generated the calls but simultaneously many women ignored the alternatives they were offered. In Palmerston North pain management was promoted as a technique with the use of breathing exercises as a means of coping with pain. These ideas were disseminated through the ante-natal clinic and midwives. Many of the women interviewed believed that the alternatives were insufficient and eight women desired labours that

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31. Percentages calculated from 6 month sample, 1943 to 1944, PNHB Maternity Casebook.
32. ibid.
33. Bookings at the Home increased with admissions in 1945 being in the region of 300.

could be forgotton.[34]

The temporary rejection of the public sector in the early 1940s placed even greater pressure upon the already popular private maternity hospitals in the town. Overcrowding was exaggerated because by 1945, only three private institutions remained, these were: "Rostrata", "Wiltshire" and "Whare-Ana". Collectively these institutions provided thirty three beds with each fulfilling Health Department regulations by providing separate labour and sterilizing rooms as well as nurseries.[35] Overcrowding was a common problem in these hospitals and this contravened Health Department rules.

Health Department regulations hoped to secure the disappearance of private maternity hospitals as they inflated the risk of sepsis.[36] However, the Department did recognize that private hospitals filled "a necessary role".[37] In order to govern the management of private hospitals the Department drafted regulations in 1924 and 1927 which enabled departmental inspection of all hospitals, the adoption of a standard aseptic procedure for labour and the puerperium, and the use of sterilizing equipment which by the 1930s was part of normal obstetric practice in New Zealand. For some Homes, the array of new directives were economically unviable and precipitated the closure of many of the smaller institutions as the returns from such hospitals was insufficient to attract the "capitalist".[38]

The exhaustive barrage of Health Department reforms had reduced the

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34. Interviewees: twelve desired medical pain relief and only one tried birth management.
35. Private hospital facilities as in HMT4, 1945, in H1, 13/17, WArc.
36. This had been illustrated by the Kelvin Hospital deaths in 1924.
37. Smith, p.32 cites NZ Official Yearbook, 1927, p.219 which shows private/public hospital ratio of five to one.
38. AJHR, 1924, H-31A, p.15.

private maternity sector to three. "Rostrata", the largest private hospital in the district had opened in 1919 and by 1940 took more than half the total confinements that occurred in the town.[39] Many women gave birth in "Rostrata" not only because it had the greatest capacity but also because the hospital enjoyed the best reputation. It was perceived as the "fashionable" place in which to be confined.[40] "Rostrata" was the town's most desirable birth place and its fees ranged up to 19/- per day with women remaining in the Home for up to ten days after birth.[41]

"Rostrata" experienced overcrowding before the public Home's services were rejected. In 1938, a woman gave birth on a board placed over a bathtub as both labour rooms were occupied.[42] By 1942, this problem had become out of hand and the Nurse Inspector reported to the Department that three unregistered beds were in use at the hospital.[43] In the early 1940s "Wiltshire" also took more patients than registered beds in order to meet the demand.[44] Overcrowding not only illustrates continual dependence by the surrounding district but also shows that the granting of financial equality amongst women enabled selection of the service that came nearest to fulfilling their desires. Rejection of the public sector in favour of the "open" private homes may have been promoted by the public hospital's historical association with charitable aid.

The incidence of overcrowding in the private sector whilst the public hospital re-structured reveals that some unexpected and undesirable

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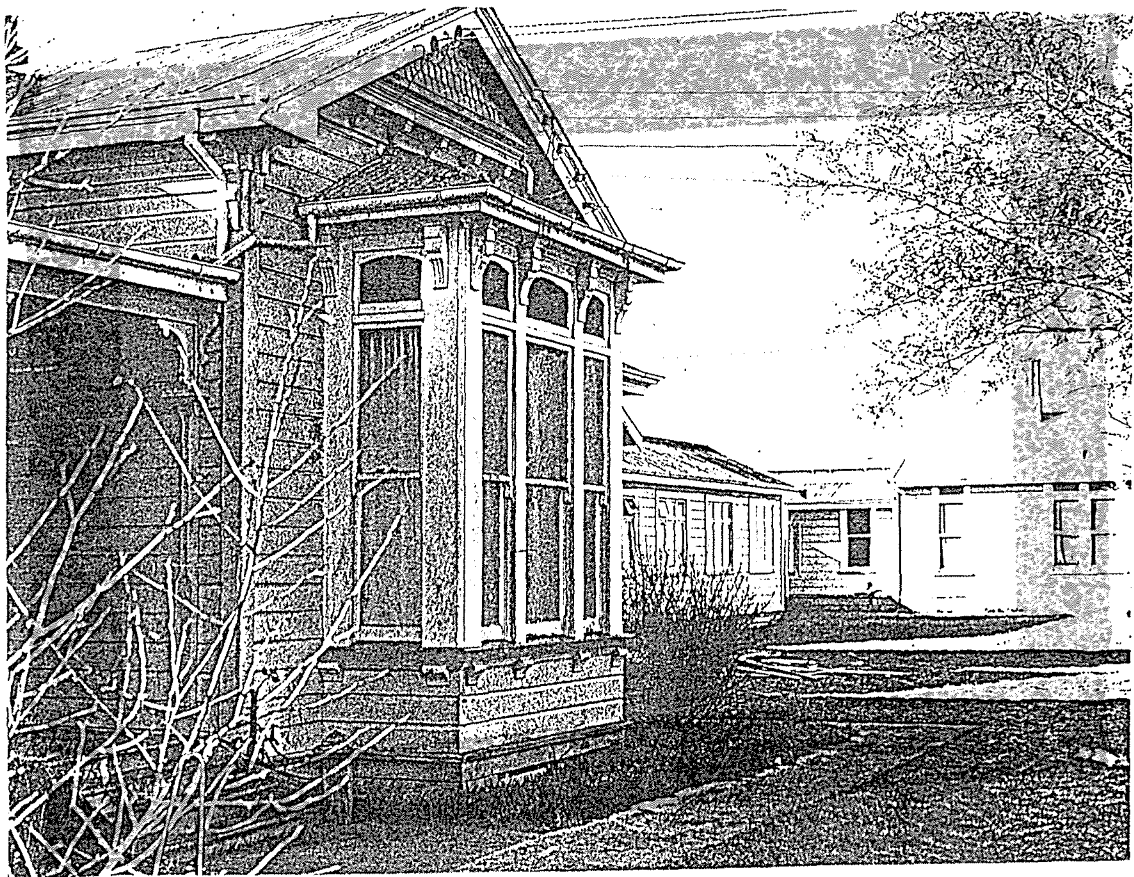
39. HMT4 returns shows "Rostrata" 425 births; District Maternity Home 282; "Wiltshire" 220; "Whare Ana" 73, from 31/3/44 to 31/3/45 in H1,13/17, WArc.
40. Interviews:Mrs M, 15 Apr.1987; Mrs S, Mrs R, Mrs Si, 11 May 1987.
41. H1, 210/4 for fees; interviews, ibid.
42. Mrs M's room mate, Mrs K was the woman this happened in 1938, interview, 15 April 1987.
43. Memo: Cook to Dujany, 17 February 1942, H1,6/6/236, WArc.
44. Interview, Miss B, 22 April 1987.



"Rostrata" Private Nursing Home

results were produced by Health Department regulations. Aseptic practice had reduced mortality from puerperal septicaemia in the hospital district to one between 1940 and 1945.[45] However, regulations that prohibited admission of more women than registered beds caused problems. Overcrowding placed patients in potentially harmful situations as shortcuts in care were made. Private hospitals strove to meet the demand for beds and attempted to outwit the bureaucratic system but did not always escape the Department's investigations.

The possiblity of shortcuts in care seems likely in the face of the staffing problems that "Rostrata", for example, experienced in the early 1940s. In 1943, E.Dujany, the Matron, left the hospital without a midwife while she holidayed. Her rather casual attitude was attributed by the Department to her Australian training which made her resent the system of hospital control in New Zealand. In 1945, staffing problems remained unsolved and Dujany threatened closure of "Rostrata". This would have left the district seriously short of maternity beds.[46] The Hospital Board did not prevaricate, recognised that responsibility ultimately fell on them and provided staff.[47] The Board eventually assumed control in 1949 as "Rostrata's" beds were needed, especially with the effect of the post-war baby boom being felt in the town.[48]

The difficulties that Palmerston North experienced was again used in an effort to change national policy. Lambie, the Director of the Division of Nursing used the "Rostrata" staffing problem to argue for the training of more midwives. Her investigation revealed a

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45. Vital Statistics, 1940-1945; Register of Deaths, 1940-1945.
46. Jewiss to Lambie, 30 October 1944, H1,6/6/236, WArc.
47. Hospital and Charitable Institution Amendment Act 1932, made maternity service Hospital Board responsibility, NZ Statutes, 1932, no.22, 23 Geo.V, p.186.
48. DGH to PNHB, 31 Dec.1948, H1, 6/6/236, WArc. See also D.Gordon, Doctor Down Under, (London, 1958), p.109 for national shortage of maternity beds.

national shortage of midwives in 1945. Putting aside the draining effect on nursing caused by the war, she attributed the shortage to poor salary and the lack of promotional opportunities and superannuation schemes in private hospitals.[49]

The transition from home and lying-in-home births to the larger institution meant theoretically that women received more efficient medical care with the benefits offered them by sterilized equipment, labour rooms, nurseries and isolation wards. For "Whare Ana" and "Wiltshire", the smaller surviving private hospitals in Palmerston North, it was increasingly difficult to meet the Health Department's demands for better standards. They fell victim to the hospital policy in 1946 and 1950 respectively.[50] The demise of domiciliary childbirth highlights the changing conception of "hospital". In 1915, for many women a hospital was home-away-from-home providing rest and, if they were lucky, professional aid; by the 1940s a hospital was a complex institution where sterile facilities attempted to ensure "safe" delivery with a medical practitioner close at hand.

The growth of the large public and private institution marks the major change in the shift from informal to formal maternity services in New Zealand. Formal ante-natal care emerged as part of this new institutionalized service. The necessity of ante-natal work had been recognized by those in the Health Department as a way of reducing maternal mortality - notably eclampsia, which by 1935 was the greatest maternal killer.[51] The aim was preventative hoping to secure and

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49. Lambie to DGH, 10 October 1945, H1,6/6/236, WArc.
50. "Whare Ana" closure see Lists of Private Hospitals in N.Z, 1945-61, H1, 6/9, WArc; for "Wiltshire" see H1, 6/9, interview Miss B, 22 April 1987.
51. T.L.Paget and I.B.Ewart, "Ante-Natal Care in New Zealand", NZMJ, vol.34, no.180, April 1935, p.13: see Smith, p.92.

maintain expectant mothers' health, to instruct women in bodily hygiene during pregnancy, to preserve pregnancy to a full term and to secure a normal labour and lying-in period. The end result, it was hoped, would be a breastfed baby and undamaged mother.[52]

Mein Smith's study reveals that the campaign by the Health Department to establish ante-natal care resulted in the erection of twenty clinics, only two of them were outside the four main centres.[53] Consequently, little provision was made for the secondary centres like Palmerston North. The initial thrust for ante-natal care by the Department had been in conjunction with the Plunket Society, with the use of Plunket rooms in the chain of State clinics. The Society, however, was reluctant to cooperate in expansion of this ante-natal clinic system beyond the four main centres. It seems unlikely, therefore, that the Palmerston North branch of the Plunket Society played a significant role in the provision of ante-natal services in the town.[54]

The lack of Department input regarding ante-natal care meant that Palmerston North women, especially those confined in private hospitals which did not provide ante-natal care, were reliant upon their GP for the service. Women interviewed were most commonly attended from the seventh month of pregnancy. In line with the national pattern, these women were not fond of the treatment because it involved uncomfortable physical examinations and prior to the introduction of maternity benefits was an additional expense.[55]

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52. E.Gurr, "Ante-natal Work", KT, 2 July 1928, p.123.
53. Smith, p.26, 93.
54. I am unable to be more precise as the PN PS records date back only to the late 1940s and were unable to help me; files H1, 127 B.81 and H1, 127 9251, WArc were equally uninformative.
55. 16 Of the sample received some form of ante-natal check.

The Palmerston North Hospital provided the largest ante-natal institution in the district.[56] The clinic functioned between 10am and 1pm on Friday mornings under the supervision of the medical officer, Dr Ward. Prior to the introduction of maternity benefits ante-natal care was charged for in accordance with a patient's capacity to pay.[57] This service included the use of a sphygmomanometer to test blood pressure which, if high, was important in early detection of pre eclamptic toxaemia. Hospital policy stated that all booked expectant mothers had to attend the clinic.

Rural women were unhappy about the restricted hours and compulsory attendance for the Home's patients. Lambie recognized the problem in 1936 and stated that a district service was necessary. Consequently, the district nurse was provided with a sphygmomanometer.[58] Despite the changes the country branches of the Women's Division of the Farmers' Union felt that it was impossible for mothers to come into town to the ante-natal clinic as some had to travel many miles for a short check.[59]

The Committee of Inquiry's verdict was that "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".[60] The official definition of "fortune" was considerably different from the perception of the service held by rural women. In giving evidence to the Committee the district nurse stated clearly that she did not undertake any ante-natal work for European women in the district,

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56. Otaki's Hospital also provided ante-natal care but the accommodation was unsuitable.
57. Memo: Managing Secretary to Sister in Charge, Maternity Home, 11 March 1933, file 25/2/1, PNHB.
58. Managing Secretary to Chairman, PNHB, 1 Oct. 1936, PNHB Minutes.
59. Thomas, WDFU, PN, 15 Sept.1937, H3, 3/7.
60. AJHR, 1938, H-31A, p.40.

unless asked by the Sister at the annexe to do so in cases of difficulty.[61] However, the Board was trying to provide rural women with adequate ante-natal care and in 1936 11 per cent of the district nurses' attendances were maternity cases.[62]

Rural women's concern about the service failed to produce change because the Board believed that its ante-natal service was sufficient in outlying districts as well as in the town.[63] Even though the women of the Palmerston North district had secured some changes in their maternity system the situation can be equated with the one that remains into the 1980s. Dr. Tom Corkill, Vice Chairman of the Committee of Inquiry, summarized this when he so aptly stated that "it is possible to have a maternity service that is safe but which yet is not altogether acceptable to the mothers".[64]

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61. Spenceley, PN, 15 September 1937, H3, 3/7.
62. Calculated from Hospital Statistics of NZ, 1936, p.49.
63. PNHB Minutes, 18 July 1938.
64. Corkill, PN, 15 Sept. 1937, H3, 3/7.

CONCLUSION

In Maternity in Dispute Philippa Mein Smith provides a national study tracing the transformation of New Zealand's maternity services in the inter-war period. Her focus on the evolution of policy reveals that concern over high maternal mortality rates in New Zealand precipitated a battle for control of childbirth between midwives and doctors. The medical profession is portrayed as the victor with the move to hospitalized birth the consequence of the battle. Despite the growth of medical intervention Mein Smith reveals that the decline in maternal mortality for puerperal septicaemia was due to the practice of aseptic methods by midwives. When pursued on a local level an exploration of the shift from informal domiciliary to formal medicalized childbirth in Palmerston North demonstrates the ways in which a local perspective can effectively confirm, query or modify the national pattern.

Many aspects of Mein Smith's study cannot be reproduced on the local level. Despite this, three areas emerge in the Palmerston North study that reinforce the national picture. In Palmerston North there was a move to hospitalized birth as had occurred nationally. The percentage of hospitalized birth by town residents was identical to the national one in 1920, but moved at a slower rate throughout the period. By 1935, 70 per cent of births to Palmerston North residents were in hospital. Nationally the figure was 78 per cent.[1]

Secondly, the campaign against maternal mortality produced

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1. Register of Births, 1935, PN Courthouse; Smith, p.1.

reforms and regulations imposed on hospitals by the Health Department. Consequently, many small private maternity businesses fell victim to Health Department regulation because the new demands required a capital input that many could not meet. The local case corroborates Mein Smith's national study as small maternity homes disappeared to be replaced by the large medicalized hospital.

The growth of public facilities was described by Mein Smith as a major change in this period. The establishment of the District Maternity Home mirrors this development. An example of the growing institutionalization of maternity care is the the emergence of formal ante-natal care which developed in Palmerston North. Following the national pattern, Palmerston North women disliked the service and were reluctant to attend clinics. The provision of ante-natal care also illustrates the importance of district nursing services in a rural environment.

Whilst Palmerston North followed these general national patterns there are three main areas in which the Palmerston North study suggests differences and thus modifies Mein Smith's conclusions. Firstly, Palmerston North birth registers reveal that the trend to hospitalized birth was inflated by the dependence of the surrounding hospital district. The poor geographical distribution of low-cost maternity beds within the hospital district meant that Palmerston North's maternity services were used by women from the surrounding rural communities. This inflated local trend underlines a consistent theme of rural dependence in the Palmerston North study and provides an additional perspective to supplement Mein Smith's focus on main centres.

Concern about maternal mortality played only a minor part in the move to hospitalized births in Palmerston North. In 1924 public awareness of maternal mortality was evident in the town following the launch of the "safe maternity" campaign. However, there is little to suggest that maternal mortality became a public issue on any other occasion in Palmerston North. The only recorded expressions of concern were made by members of the medical profession. In addition, the validity of maternal mortality statistics was found to be questionable because it is uncertain exactly what constituted a maternal death.

Inter-professional rivalry is difficult to detect on the local level. Whilst there was some antagonism toward the Health Department in 1926, there is little evidence of strong rivalry between midwives and doctors. This apparent lack of rivalry might be explained by the deficiency of a public facility until 1928. In St Helens Homes or public maternity wards, midwives worked independently which produced a strong sense of professional identity. In Palmerston North a spirit of co-operation appears to have pervaded, with doctors and midwives often working together.

There are a number of areas in which the Palmerston North material provides new insights or focuses on areas not fully developed by Mein Smith. In particular, a new dimension, that of local pressure became evident. With a general concern emerging about public health from the turn of the century it is not surprising that a public maternity facility was sought from 1915. The institution that emerged was a response to a practical need in the town for an inexpensive birthing place. This new element represents a shift from Mein Smith's emphasis on maternal mortality with the revelation that immense local pressure for adequate facilities existed in a health conscious era.

The difficulty experienced in the establishment of a public maternity home resulted from the fact that the Palmerston North district was caught in changing Government policy. By 1917, the Government was moving away from the establishment of costly St Helens Homes in favour of maternity wards associated with public hospitals.

The Palmerston North study shows that local debate over the provision of a public maternity service diverted attention from the basic need for a low-cost facility. Delay resulted from central and local government tensions - most notably the reluctance by both the Government and the Hospital Board to accept financial responsibility. In addition, local body pressures produced debate over what kind of institution was desired, where it would be situated and what hospital system would be employed. Finally, the local dimension reveals the presence of inter-district rivalries. Palmerston North citizens expressed concern when they were passed over for Government provision whilst Invercargill was granted a St Helens.

The Palmerston North study suggests that as a locality it influenced national policy. The continual demand for adequate inexpensive facilities by Palmerston North citizens was not unreasonable when viewed in the context of the pro-natalist statements of the day. The Palmerston North locality was instrumental in producing a final policy statement in favour of public maternity wards by the Government as a way of freeing itself from the Palmerston North "problem". Local input, although minor, is evident into the 1940s when staff shortages experienced in Palmerston North hospital were used to argue for the training of more midwives nationally. Mein Smith's focus on the evolution of policy remained on the central body's role in policy making. The local dimension adds to this perspective.

Mein Smith's study outlines the demands of women's organizations regarding maternity services on the national level, revealing that women were active on the issue. The establishment of a public maternity ward in Palmerston North develops more fully the role of women in the provision of maternity services. Here three elements become clear with consumer preference ultimately producing a user-shaped service. Cost provides the first example of women's "agency", because women's groups actively campaigned for an affordable facility. Secondly, with the eventual granting of maternity benefits women in the district expressed their dislike of the existing "closed" public service. Although not explored by Mein Smith, this was a national trend according to Paget, Director of Maternal Welfare. Palmerston North women actively moved to the "open" services with their GP providing reassuring aid in a "safe" birth environment. The decline in bookings resulted in the Board re-thinking its services at the District Maternity Home in Palmerston North.

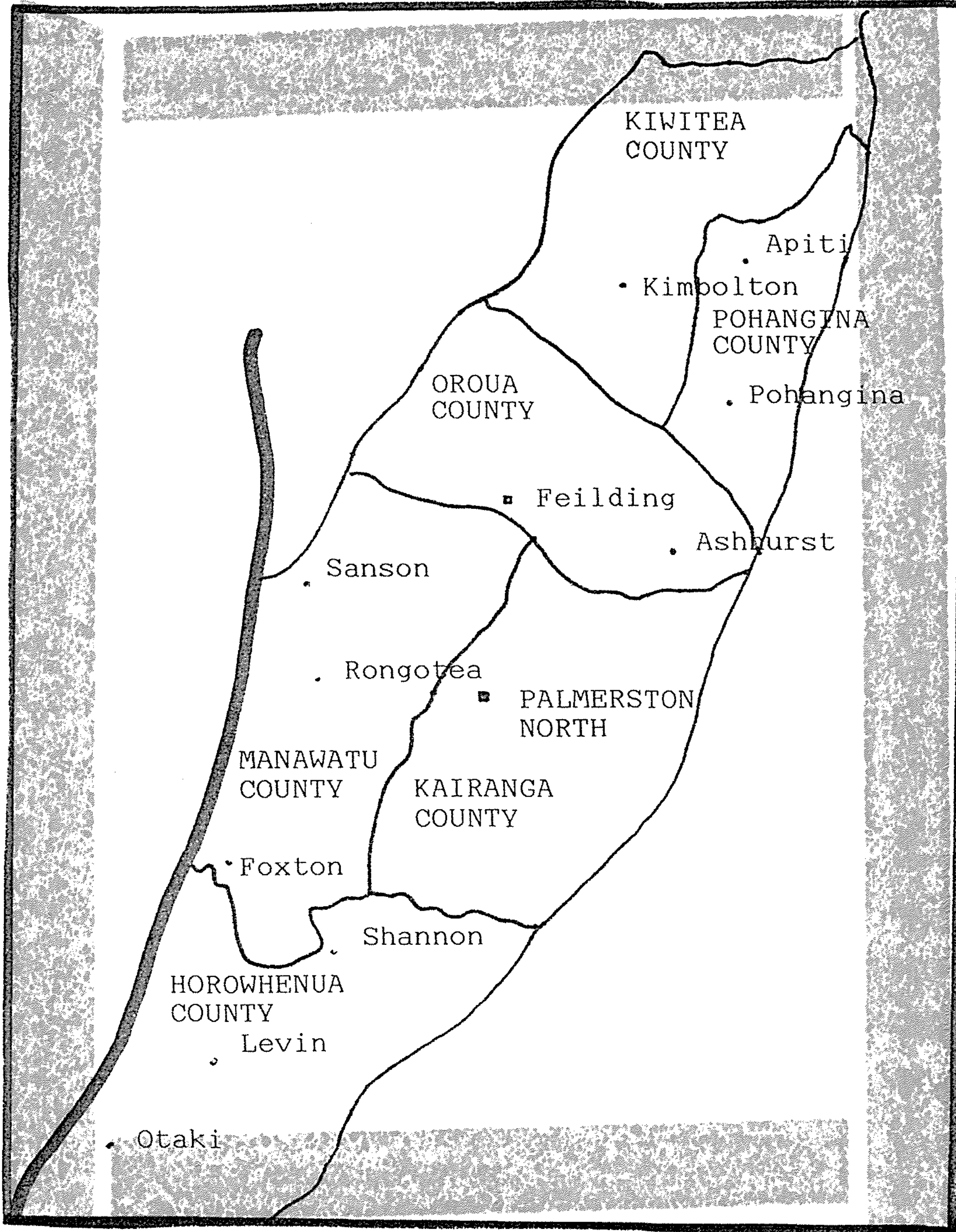
Pain relief is the final area in which women in Palmerston North can be seen as actively shaping the service they received. The District Maternity Home consistently administered pain relief from the 1940s and consequently women returned to the service. Mein Smith maintains that doctors "preyed on" the fears of women. Whilst this cannot be dismissed it must be acknowledged that <u>in the context of their time</u> women sought medicalized pain relief, displaying a reluctance to learn about alternative forms of pain management. The Palmerston North study reveals that services were not simply doctor imposed but equally, were consumer shaped.

Women in the 1980s are re-evaluating this emphasis on pain relief arguing that medical intervention is now routine and denies women options in childbirth. Many practices that women are now resisting

are the changes that women actively sought in the 1930s. Today further change is desired because it is believed that medicalization has gone too far.

In 1915 Palmerston North had a variety of maternity services of varying quality. The thirty years that followed witnessed a dramatic transformation with a move away from small lying-in-homes and domiciliary births to large formal institutions which were governed by strict regulations demanding uniformity. In the 1980s the desires of women's groups reveal that for many the repercussions of the change have been too dramatic. Today, in Palmerston North the Home Birth Association stresses the need for women to have a choice in the range of maternity facilities, as they seek greater access to domiciliary birthing services. In the search for a service that women define as fulfilling their needs and in the hope of achieving balance, the pendulum swings back.

APPENDIX A: The Palmerston North Hospital Board District.



Source: PNHB file, 25/2/1

APPENDIX B

DISTRICTS FROM WHICH PATIENTS WERE ADMITTED TO PALMERSTON NORTH MATERNITY HOME, FOR THE PERIOD 1 APRIL 1933 to 30 SEPTEMBER 1933.

District	Patients
Palmerston North City	82 patients
Kairanga County	16 patients
Oroua County	14 patients
Manawatu County	8 patients
Horowhenua County	4 patients
Pohangina County	4 patients
Kiwitea County	7 patients
Feilding Borough	10 patients
Foxton Borough	2 patients
Shannon Borough	2 patients
Otaki Borough	1 patient
Rongotea Borough	1 patient
	151 patients

SOURCE: PNHB file, 25/2/1.

APPENDIX C

TABLE 1: PALMERSTON NORTH DISTRICT MATERNITY HOME

Number of cases booking each month for an 18 month period

	Bookings Made	Unbooked
1938		
September	29	6
October	17	1
November	22	2
December	22	2
1939		
January	15	2
February	18	3
March	17	1
April	13	2
May	41	2
June	18	2
July	15	4
August	24	4
September	18	6
October	15	4
November	7	5
December	9	2
1940		
January	16	2
February (2 weeks)	6	-

TABLE II

Bookings made by the 13 February compared in the years 1939 & 1940.

For the month of:	1939	1940
February	23	10
March	15	8
April	13	11
May	9	10
June	5	7
July	2	2

SOURCE: PNHB file, 25/2/1.

APPENDIX D: PERSONALITIES

CORKILL, Dr. Thomas Frederick (1893-1965)
Chairman of Council, New Zealand Branch BMA. 1934-5
Vice-chairman, Committee of Inquiry into Maternity Services 1937-8.

JELLETT, Dr. Henry (1872-1948)
Consulting obstretician , Department of Health 1924-31.

KING, Sir Frederic Truby (1858-1938)
Medical Superintendent, Wellington Public Hospital 1888-9
Seacliff Mental Asylum 1889-1920; founder of Society for the Protection of Women and Children 1907; Director of Child Welfare, Department of Health 1920-27.

LAMBIE, Mary Isabel (1890-1971)
Director, Division of Nursing, Department of Health, 1931-50.

MACLEAN, Hester (1863-1932)
Assistant Inspector of Hospitals, New Zealand, 1906-23.
Director, Division of Nursing, Department of Health 1920-31.

NASH, Sir James Alfred (1871-1952)
Mayor of Palmerston North 1908-1923.
Member of Parliament for Palmerston North 1918-1935.

PAGET, Dr. Tom (1868-1947)
Private practice in Palmerston North 1919-24; Inspector of Private Hospitals, Department of Health 1924 until he became Director of Maternal Welfare 1937.

PARR, Sir C. James
Minister of Health, 1920-24.

POMARE, Sir Maui
Minister of Health, 1924-26.

RUSSELL, G.W.
Minister of Public Health, 1915-19.

VALINTINE, Dr. Thomas Harcourt Ambrose (1865-1945)
Inspector General of Hospitals 1907; Chief Officer of Health 1909-20; Director-General of Health 1920-1930.

WATT, Dr. Micheal Herbert (1887-1967)
Deputy Director-General of Health 1925-31; Director-General, 1931-47.

WYLIE, Dr. David Storer (1876-1965)
Director. Division of Hospitals, Department of Health 1920-2;
In practice Palmerston North 1923 - ; Palmerston North President of B.M.A.

YOUNG, J.A.
Minister of Health, 1926-28.

SOURCES; F.S. Maclean, Challenge for Health, (Wellington 1964).
P. Mein Smith, Maternity in Dispute, (Wellington 1986).

APPENDIX E: MEDICAL TERMS.

ALBUMINURIA - condition in which albumin is present in the urine. It is most correctly described as proteinuria, because other blood proteins are present in the urine as well as albumin.

ANAESTHESIA - loss of the power of feeling. Local anaesthesia means loss over a limited area whereas total anaesthesia is a total loss of feeling.

ANALGESIA - loss of the sense of pain without loss of consciousness.

ASEPSIS - freedom from infection, or prevention of contact with micro-organisms.

ECLAMPSIA - convulsions arising in pregnancy, associated with pre-eclampsia, i.e. with hypertension, oedema and proteinuria.

PROTEINURIA - condition in which proteins are found in urine.

PUERPERAL FEVER - also called childbed-fever, puerperal sepsis and septicaemia.
Septicaemia accompanied by fever due to weakened state following childbirth with injuries incidental to childbirth producing raw surfaces in the genital tract, from which absorption occurs with great facility. The organism most commonly involved is streptococcus haemolyticus.

PUERPERIUM - is the term applied to the period during which the woman is recovering from the effects of pregnancy and childbirth.

TWILIGHT SLEEP - condition of analgesia and amnesia produced by injection of morphine and scopolamine. Formerly widely used.

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6 8084	General 1928-40
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6/3 8087	Regulations 1926-36
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6/6/263	"Northcote" Sisters R.E McKenzie and L.Mudford, P.N.
6/6/697	Mrs Forlong...P.N
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6/21 11268	Licensing of Private Hospitals

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13/5	Ante-natal clinics
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13/6/2 8427	Maternal mortality in Private Hospitals and St Helens
13/6/5 8428	Maternal mortality other than puerperal septicaemia 1926-32
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131/66/8 9345	Eclampsia Returns 1927
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