Musty Records: The Story of the New Zealand Obstetrical and Gynacological Society

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The 1928 bimonthly *New Zealand Medical Journal* Report, commenting on the recently formed NZ Obstetrical Society, noted that “the obstetricians of New Zealand even by the year 1950 may find perusal of our musty records interesting and enlightening. Many present day problems should then be simplified, and adoption of surgical measures like caesarean section should by then have found their rightful place... Our children in 1950 will not benefit by perusal of the scientific records we are now compiling unless we perfect our gift to posterity and write each history up in ink”.

The first Minutes record the “Aims of the Society should be the scientific study of obstetrical work in NZ and to give the art of obstetrical practice the dignity and status it rightly deserved, but at present lacked.” Membership was open to any member of the New Zealand Branch of the British Medical Association, which was affiliated with the *New Zealand Medical Journal*. The latter proved to be one of its greatest strengths, and in 1932 a “Special Section” of the *Journal* was devoted to the Obstetrical and (later) Gynaecological Society. Not infrequently, there were 50–100 pages in the bimonthly *Journal* devoted to the Society. No other branch of medicine was treated this way. Thirteen provisional district committees were also established at the inaugural meeting.

Like many other medical societies, the Obstetrical Society has faded away, taking with it the wisdom of a former age. An age yet to have the benefits of today’s scientific advances, the benefits of our social security system and, importantly, no formally trained obstetricians. (The British College of Obstetricians and Gynaecologists was only inaugurated in 1929). The material in this paper has been taken mainly from the two almost centuries-old, very large and musty original Minute Books of the Society, written in fading ink. These extend from its inception in 1927 through to 1943. From this time, there are no known Society records. However, reports in the *New Zealand Medical Journal* continued to provide some record of the Society activities.

What have we learned from the New Zealand Obstetrical Society? The importance of strong, visionary leadership committed to a common cause—improvements in maternity care in New Zealand. In this case, the Society was well served in its long-term Honorary Secretary, Dr Doris Gordon. She knew that if she could carry through her vision of an improved maternity system for all New Zealand women, she needed a strong team to support her. To this end, in 1926, she proposed the formation of a New Zealand Obstetrical Society. Gordon also knew that to achieve her long-term goals, she needed to have firm control over the Society’s destiny. As she would later write: “The assemblage took for granted that my husband Bill would be the Honorary Treasurer and I would be the pen-driving Honorary Secretary”. Coincident with the birth of the Society, the great English gynaecologist, Victor Bonney, made a lecture tour of New Zealand. Gordon reported that since his visit, she had maintained extensive “press agitation” throughout the Dominion, keeping public opinion alive to the needs of an obstetric department in Dunedin.

While having strong support from her executive, she was fortunate to have Dr Henry Jellett, a former Master of the Rotunda Hospital in Dublin, by now Consulting Obstetrician to the New Zealand Government, and Dr Watt, Director General of the Health Department, promoting her cause. Dr Watt described obstetrics as the “Cinderella" amongst medical services, often “unwanted and neglected”. While Health Department officers, Drs Watt and Paget, were strongly in favour of the Society, there was occasional tension between them when the Department made inquiries to nurses about medical matters, without first seeking the opinion of the doctor in charge.

The recurring themes of early executive meetings were the frequent remits and deputations to the Government, Otago Hospital Board and...
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Otago University advocating a Chair of Obstetrics, together with a new maternity hospital in Dunedin. The birth of the Society also coincided with the Great Depression, providing the authorities with an excuse that they did not have sufficient money. Not only was there insufficient money, but the matter of a power imbalance between the academic departments. Lindo Ferguson, the Dean, wrote: “Some are insisting that midwifery and gynaecology should have as much time as medicine and surgery—I shall have to keep out of the clutches of the obstetricians who are anxious to reform us violently.” The executive also discussed “immersion bathing”, clinical record forms for research, and the “desirability of having a post graduate school of obstetrics in New Zealand... though the time was not yet ripe”.

At the Executive Meeting of the Society on 13 September 1929, several important issues were discussed. Despite early resistance, Ferguson finally agreed to an approach from Gordon indicating that the Society would endow a full-time Chair of Obstetrics (unlike the part-time Chairs in Medicine and Surgery which had been in existence for some time). Doris Gordon volunteered to make an “extensive personal canvas for £25,000 on behalf of the Society” on the basis of a pound-for-pound Government subsidy. At the same meeting, it was reported the Government had sanctioned the building of a new obstetric hospital in Dunedin. The National Council of Women and the Women’s Division of the Federated Farmers had each donated £50 for a New Zealand graduate to spend six months on an obstetrical scholarship in Melbourne. Thereafter, the National Council of Women established a strong and lasting relationship with the Society. This young Society had achieved much for New Zealand women in its first two years “assisted in large part by the Obstetrical Society deputations to the Minister of Health”.

Doris Gordon relished the challenge of raising the money “to enlist the help of multiple women’s committees all over the Dominion”—for an Obstetrical Endowment Fund. She enlisted the help of powerful women, including a supportive letter from the wife of the Governor General, Lady Bledisloe. Men’s groups, in particular Rotary, were supportive. She “criss-crossed the length and breadth of NZ-prospecting”. The national appeal was carefully organised, and the tour began on 25 January 1930 and concluded on 25 March 1931, raising £31,000. In May 1931, £25,000 was given to the University of Otago, with £6,000 available for a second travelling scholarship. A Recommodation Committee was appointed in Great Britain (professors from London, Belfast, Edinburgh, and Dr Victor Bonney) to make the new professorial appointment. As soon as the appointment was concluded the successful applicant, Professor J B Dawson, was instructed to travel around Great Britain, to the Continent, the US and Canada to study comparative methods of teaching Obstetrics and Gynaecology. He was specifically asked to investigate maternal mortality in these countries because this was the most pressing issue in New Zealand. The Dean noted “that for the next 10 to 20 years the production of highly trained specialists was more important than research work in obstetrics”.

In 1921, James Parr, the Minister of Health learned that more New Zealand women died in childbirth, principally from sepsis, than any other developed country apart from the United States of America. There was a public outcry when it was learned the Department had known about this for some years. Truby King, the well-known infant health crusader (and eugenicist) and Director of Child Welfare, dealt with the problem. King met the challenge of the maternal mortality scare by intensifying Plunket criticism against meddlesome midwifery, and advising women not to have doctors at their confinements and do without anaesthetics and forceps. This led to a further outcry, and fortunately, a special committee on Maternity Mortality saved the day by appointing Jellett and Gordon to deal with the problem.

Around this time, “the matter of a projected Maori Hospital was left to Dr Doris Gordon to confer with Dr Ropa and Sir Maui Pomare”. Sir Apirana Ngata stated: “the monetary grant to the Taranaki natives had not yet reached a degree of finality to progress the matter”. In 1933, the indefatigable Secretary, Doris Gordon, noted the Society was in “quiet consolidation in the face of economic depression”, although there had been only a slight fall in membership. Professor Dawson fulfilled the Society’s expectations, travelling widely and fraternising with his new colleagues, lecturing, writing for the New Zealand Medical Journal, and becoming an ex-officio member of the Society. Dawson raised the vexed issue of the place of midwives—“Doctor and Midwife, Colleagues or Rivals?” He proposed: “the ideal obstetric service for every confinement in the Dominion was a doctor and a midwife, or a doctor and maternity nurse attending.” Dawson also increased interest in research within the Society, being a prolific contributor to the New Zealand Medical Journal. He reported there were
now 20,000 maternity records collected by Society members worthy of study. Dawson bemoaned the continuing “haggle” between the Dunedin Hospital and the Government over the £50,000 for the new maternity hospital, frustrating teaching opportunities. The Society took an active role in promoting Society values—offering to be available to broadcast matters of maternal welfare, and assistance on questions related to the new National Health Insurance scheme. Interestingly, the increasing frequency of Caesarean sections over the years does not appear in the Society records.

A feature of the Society, and fulfilling its original aims, was the establishment of subcommittees, such as ‘Doctor and Midwife’, ‘Eclampsia’, ‘Maternal Mortality’, ‘Puerperal Sepsis’, ‘Toxaemia’, ‘Pain Relief in Labour’, ‘Stillbirth and Neonatal Death’, ‘Birth Control’ and ‘Criminal Abortion’. Responses from six divisions of the Society in 1932 recorded: “the increasing numbers of abortions, mainly ‘induced’ by self-administration of emmenagogues and in the later months by the intervention of a second person. Surgical curettage of a pregnant uterus occurs only where medical complications render the pregnancy inimical to the mother’s health or life and more use of tubal ligation during routine laparotomies of worn-out mothers of five or more children or for prolific mothers of the degenerate class.” Dr Watt, the Director General of Health said: “it was inconceivable that British public opinion would consent to legalised abortion”.11 Writing on the Ethics of Birth Control the same year, a Nelson doctor supported contraception “to anyone who asks for it”, praising Dr Marie Stopes, and then stating: “the sooner that the lazy, idle, drunken and incompetent of all sorts learn and practice how to avoid having families the better”.

In 1935, 42 women died from septic abortion, leaving 338 children motherless with “the bulk of evidence suggesting that it was the married women with relatively large families on the bread line” and “while the Society had endorsed the principle of birth control for certain types of people” (married couples), septic abortion deaths had risen markedly. The Society could not at present advocate birth control knowledge to the adolescent and younger section of the community: “It would alienate valuable public support of our Society by antagonising the Roman Catholic Church and that section of the community now seriously concerned at our alarmingly low birth rate”. Nonetheless, the Society “viewed with alarm the grave increase in maternal deaths due to abortion”. Professor Dawson advised setting up a Commission to investigate the matter.12 Pressure by the Society and Women’s groups led to a commission of Inquiry into Abortion in 1936.

Gordon was planning an overseas sabbatical to attend a meeting of the British College of Obstetricians and Gynaecologists in 1939. The Executive of the New Zealand Society asked her to investigate why the “overseas” scholars, who had benefitted from the Society’s scholarships, were not returning to New Zealand. At that time, only one of nine scholars had returned. Never afraid to approach “big names”, she asked the College President Professor (later Sir) William Fletcher Shaw to chair a small committee. The committee included Professor Lowry from Belfast, a former scholar, John (later Sir) Stallworthy, and Dr (later Sir) Robert Macintosh, a New Zealand born anaesthetist at Oxford, to resolve why scholars were not returning. Fletcher Shaw was blunt. It was the attitude of the New Zealand hospital boards—“controlled by laymen”.14 Late in 1940, the Society convened a meeting which unanimously approved the idea of establishing a postgraduate school and hospital in Auckland.15,16

Gordon visited Auckland and addressed meetings of professionals and laypeople interested in the project. This led to a group of businessmen launching an appeal which resulted three years later in the investment of £100,000, the interest enabling a Post Graduate Chair in Obstetrics and Gynaecology in the University of Auckland. Sadly, Doris Gordon died in 1956, a few years before the new National Women’s Hospital opened.

Maternal deaths were always a concern for the Society. While many factors contribute to the overall measures of feto-maternal outcome, the advent of the Society played an important role in addressing preventable factors. Maternal mortality fell from 5 per thousand when the Society was established, to 0.5 per thousand at the time of Doris Gordon’s death 20 years later. Over the same period, the stillbirth rate halved and deaths from puerperal sepsis from 2 per thousand to 0.1 per thousand (reflecting the advent of antibiotics). Eclampsia deaths, always a measure of obstetric performance, fell from 0.61 to 0.03 per thousand births.17

With the establishment of National Women’s Hospital, the bulk of postgraduate teaching moved from the Society to the Postgraduate School of Obstetrics and Gynaecology. The Society devolved with a national executive rotating through local branches around New Zealand. The city hosting...
the national executive would typically have large 2–3 day meetings, often with international speakers and much evening revelry.

In 1932, the Royal College of Obstetricians and Gynaecologists established a New Zealand Reference Committee and, after the war, a New Zealand Regional Committee. When Australia formed its own College, New Zealand felt obliged to follow suit, forming its own College in 1982, eventually amalgamating with the Royal Australian College in 1998. A combination of legislative changes, social and economic factors, and a now autonomous midwifery service brought general practitioner obstetrics—and the Obstetric and Gynaecological Society—to an end by the mid-1990s.

The Doris Gordon Trust, which was established following her death, was re-established to allow and that funds are now used for public lectures on aspects of women’s health. While the scientific advances promoted by the Society were abreast of the times, social attitudes of the largely male membership sometimes remained Victorian. For example, when in 1935 a member promoted the addition of “Gynaecological” to the Society title, and “the necessity for an obstetrician to be ‘gynaecologically minded’... as otherwise, not only might a woman’s happiness be wrecked by disturbances such as septic cervix, relaxed uterine supports, parametritis, etc., but a husband’s success in life might be retarded and children cheated of their rights to a happy childhood, as no patient with the above gynaecological disorders could give of her best to her husband.”

What did the Society achieve? First and foremost, both academic Chairs in Obstetrics and Gynaecology in New Zealand, together with two travelling scholarships. Second, it established a national organisation to pursue continuing education and a forum on medico-political maternity-related issues. As noted above, the Society can also take some credit for the dramatic improvements in maternity statistics, one of the Society’s aims.
COMPETING INTERESTS
Nil

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