1905.

NEW ZEALAND.

AUCKLAND HOSPITAL COMMISSION

(REPORT OF), TOGETHER WITH MINUTES OF EVIDENCE.

Presented to both Houses of the General Assembly by Command of His Excellency.

REPORT.

In the year 1901, prior to the appointment of Dr. Collins, the administration of the Hospital was left in the hands of Dr. Inglis and his subordinates and of the honorary staff. Owing to certain newspaper agitation, the Hospital and Charitable Aid Board determined to make a change. The honorary staff pressed strongly for the retention of Dr. Inglis, at an increased salary, and for the appointment of a junior surgeon and physician in addition, all to be resident at the Hospital (and consequently to be single men), the honorary staff continuing to perform all save the simplest operations, except in cases requiring instant assistance. This proposal the Board negatived, and an entirely new departure was taken by the appointment of Dr. Collins as Senior Medical Officer. The intention of the Board was apparently to curtail as much as possible the work and responsibility of the honorary medical staff, and to place the Senior Medical Officer in a position unique in the history of any city hospital in the colony. The effect of this has been to create friction between the honorary medical staff on the one hand and the Board and Senior Medical Officer on the other; has caused the resignation of many of the ablest men on the honorary staff; and has prevented others from applying for the position, which is usually eagerly sought after by the first men of the profession. Since the appointment of Dr. Collins as Senior Medical Officer in January, 1902, there appears to have been a steady deterioration in the surgical and medical work of the Hospital, to the manifest detriment of the patients. The generally recognised interpretation of Rule 73 has resulted in all cases of fractures and dislocations being dealt with and by the direction of the Senior Medical Officer, and instances are not infrequent where fractures have been set and attended to by the junior residents with disastrous results. As examples of these results we cite the cases of Colhoun, Allen, McLeod, and Peake (*vide* evidence; also charges 21 and 19, and 1 and 2 of "additional charges" made by Dr. Neil in respect of these cases).

Colhoun states that he arrived at the Hospital about midnight on some date in February, 1903, with a broken arm. There should have been three medical men on the premises, but none came to see him. His arm was fixed up by a nurse for the night. Next morning Dr. Collins and Dr. Williams examined him, went away, and left the two juniors, Dr. Horsfall and Dr. Bennett, to set it. They did so, and Dr. Horsfall attended to the arm until the bone had united. Then Dr. Collins examined the arm, and found it had to be broken again, and it was broken accordingly.

William Allen arrived at the Hospital with a broken arm on the 13th February, 1903, at 10.15 a.m. He endeavoured to get a doctor, but none came to examine him until 1.30. Then Dr. Collins examined the arm and sent him upstairs to bed. The arm was set by the two juniors, Drs. Horsfall and Bennett. Ten days afterwards it was "taken down" and reset by Dr. Horsfall, assisted by a nurse. This second setting was also a failure, and a photograph, hereunto appended, taken by means of the *x*-rays (Exhibit 9) shows the reason. Allen had to return to the Hospital, and then undergo another operation. His arm is not strong now.

John Donald McLeod was admitted into the Hospital on Saturday, the 20th February, 1904, suffering from a broken thigh. The accident happened at Waipu on the 18th February. The limb was temporarily dealt with by a local doctor, who ordered him to the Hospital. He was admitted between 5 and 6 o'clock on the evening of Saturday, the 20th February, and the limb was not attended to until the following Monday, when it was set by Dr. Bennett, one of the junior residents, who put on a Liston splint. The broken thigh was not examined by the senior Medical Officer until a fortnight

after the admission of the patient. From that period the fracture appears to have been properly attended to. The result of the case is that the fractured limb is crooked, and is 1½ in. shorter than its fellow.

William Peake's case: William Peake was admitted into the Hospital on the 31st January, 1903, suffering from a fracture of both legs and a fractured jaw. The case was admittedly a serious one. The broken jaw, which appears to have given much trouble, was set by a junior resident (Dr. Horsfall), the Senior Medical Officer ordering the charge nurse of the ward to tell Dr. Horsfall to put the jaw in splints. The patient was in the Hospital for six months, when, being dissatisfied with his treatment, he left and went into a private institution. He states that a short time before leaving the Hospital he was informed by the Senior Medical Officer that the fractured limb was uniting, and that he proposed to put the leg into plaster-of-paris. On his entering a private hospital it was found necessary to remove a quantity of dead bone before the fracture could possibly unite. This appears to be one of those cases where an immediate operation was absolutely necessary, and one in which every effort should have been made to procure the attendance of some member or members of the honorary staff to operate. We are by no means satisfied that such steps were taken. The operation was performed by the Senior Medical Officer, assisted by the junior residents, Drs. Bennett and Horsfall. The case should, under Rule 73, have been placed under the charge of the honorary staff. It was a case requiring serious operative interference, and as such the sole treatment and responsibility did not under that rule rest with the Senior Medical Officer. The patient complained of the food served to him, and also states that the visits of the Senior Medical Officer were irregular and infrequent. It is perfectly clear to us from the evidence that the operation for the removal of dead bone, which was performed at the private hospital, should have been performed at the public Hospital three months before the patient left it.

The Wallis A. White Case.

It is now our duty to report upon a most serious charge against the Senior Medical Officer, Dr. Collins, made respecting the treatment and subsequent death of a patient named Wallis A. White. We find the facts proved before us to be the following:—

On the 17th May last White was brought to the Hospital dangerously ill. He was put to bed, and examined by Drs. Collins and Neil. On being questioned, he indicated the left side as the seat of pain, but Dr. Collins, in spite of a remonstrance from Dr. Neil, determined to perform the operation for appendicitis, in which the incision is made on the right side. That incision was made accordingly, and the appendix was found to be normal. Dr. Collins then manipulated the large intestine adjacent to the appendix. He found the intestine distended with gas, and certain fæcal concretions were also present. He then made two incisions in the bowel; the upper incision was the smaller of the two, and was apparently made with a view of getting rid of the gas contained in the intestines; the lower incision was situated about 1½ in. above the place where the appendix leaves the bowel, and from this orifice he extracted two fæcal concretions each about the size of a walnut. He stated in his examination before Dr. MacGregor that these concretions were not sufficient to cause obstruction of the bowel. After suturing these two incisions and the incision over the appendicular region he made the median incision in order to ascertain the position of any perforation that existed, the existence of a perforation somewhere being at that stage of the proceedings apparent. He also stated in his examination before Dr. MacGregor at the departmental inquiry that he found the anterior wall of the stomach very friable and having three perforations in it, and that he had great difficulty in uniting them. The *post-mortem* examination disclosed the fact that there was only one perforated ulcer in the duodenum. After suturing that ulcer he then proceeded to put a line of stitches or sutures in a portion of the stomach-wall where no ulcer existed; this line of sutures was situated near the small curvature of the stomach, and apparently the sutures included a portion of the small omentum. The sutures were put in the stomach-wall at a point where it is clearly proved no ulcer could have existed; the *post-mortem* examination showing that the stomach was an unulcerated one, and that there was no evidence of any ulceration except the one perforated ulcer in the duodenum, which is not, strictly speaking, a portion of the stomach. The median incision was then closed, and the patient carried upstairs to bed after having been two hours on the operating-table. He died two days afterwards. We are unanimously of opinion that the reliable evidence before us shows,—

1. That the incision for appendicitis ought not to have been made. That, however, is stated to have been a mistake which even a skilful surgeon might make.

2. That the two incisions in the intestines near the appendix were both of them most dangerous and unnecessary.

3. That the sutures above referred to, put by Dr. Collins in a stomach, which was proved to be an unulcerated one, can only be characterized as wanton and uncalled-for surgery, without any justification whatever, and that the time taken up by that portion of the operation apparently lessened the patient's chances of life.

4. That, though the patient on his admission to the Hospital was in a very serious condition owing to the perforated ulcer in the duodenum, he had a chance of life which was seriously diminished by the malpractice of Dr. Collins.

5. That, in order to conceal his malpractice, he falsely stated to Dr. MacGregor at the departmental inquiry that he found the anterior wall of the stomach very friable and having three perforations in it, and that he had great difficutly in uniting them.

Dr. Craig at the same inquiry stated that Dr. Collins "explored the stomach, which presented three ruptured ulcers, one of which was 1½ in. long; the edges were of such a friable nature that it could not hold the sutures." Dr. Parkes stated at the same inquiry, "Here in the stomach I saw two

perforations (not three), the larger one opening at least 1 in. long." With statements of this nature before us, we should have felt great difficulty in arriving at any satisfactory conclusion. Fortunately, the exhumation of the body of Wallis White was ordered by the Colonial Secretary. The *post-mortem* was conducted by Drs. Savage and Bull, and the stomach and intestines were preserved and shown to us Both of these gentlemen gave us much valuable testimony, and their evidence, coupled with our own personal examination of the specimens, enabled us to judge of the value of conflicting testimony in this matter. The stomach and incised intestines have been sealed up and delivered to the Inspector of Police.

Ethel Maud McIndoe.

One of the charges made against the Senior Medical Officer was that he had performed the operation of hysterectomy upon Ethel Maud McIndoe, and that the operation was unnecessary and unjustifiable. A careful investigation of this charge showed that the operation was performed by Dr. Parkes, one of the honorary staff, assisted by Dr. Collins. The conclusion to which we are led by the expert medical evidence is that the diagnosis of the disease was, under the extraordinary circumstances surrounding the case, a reasonable one, and that the operation was justifiable.

In addition to the cases above mentioned, numerous complaints were made against the Senior Medical Officer as regards surgical practice. We do not consider it is necessary to discuss these complaints in detail. Some were apparently abandoned, as no evidence was led in respect of them, while others appeared, when investigated, to be of little or no importance. Those complaints which refer to the absence of the Senior Medical Officer from the Hospital, his perfunctory attendance in the wards, and his actions as regards the pathological laboratory will be dealt with under the head of general administration of the Hospital.

Constitution of the Board.

The Board is elected annually, and a continuous policy (so necessary to the proper management) is impossible. It is complained that the Board is not a suitable body to manage a Hospital, as its functions include dealing with questions of charitable aid. This latter complaint can be met by the creation of the Hospital into a separate institution, in accordance with sections 42 and 43 of "The Hospitals and Charitable Institutions Act, 1885."

To meet the first-mentioned difficulty, we suggest an alteration of the statute whereby the Board would be elected for three years, and thereafter a certain portion of the members (say, one-third) should retire annually in rotation. It should consist of representatives elected by the local bodies, and nominated by the Government, and provision should be made whereby there should always be at least one medical man on the Board.

Present Condition of the Hospital Buildings and Suggested Improvements.

The present condition of the Hospital buildings, as regards the buildings themselves, with the exception of the Children's Hospital and the Nurses' Home, is far from satisfactory. The main or old building consists of a basement and two upper stories. The basement is in a highly insanitary condition—cold, damp, and cheerless. It is in this portion of the building that the padded room for what may be termed semi-lunatics and delirium-tremens cases is situated. The next floor, in which the first tier of wards and the operating-room are found, is entered by a double flight of stone stairs, up which all patients have either to walk or be carried. The accident ward is on this floor. The large wards in each floor are, in their construction, entirely out of date, and are, as regards their construction, devoid of those safeguards which modern science considers of the first importance, especially as regards surgical cases. The lavatories are in a very insanitary condition, the bath-rooms small and inconveniently situated, and the arrangements as regards privacy, both in the male and female lavatories, are of the most imperfect character. The operating-room can only be regarded as a makeshift. It is a small room, lighted only from one end, possessing none of those safeguards from septic influences which modern surgical science imperatively demands. There is no separate room in which to administer anæsthetics, no withdrawing-room or dressing-room for the surgeons. A patient must be brought into the room partially clothed, in full view of the surgeons, surrounded by the instruments which are to be used upon his or her body. In short, the modern surgical requirements are conspicuous by their absence. There is no lift, and the patients have to be carried up and down flights to and from the operating-room. A large and up-to-date operating-theatre is in course of construction as an adjunct to the Children's Hospital, which has been constructed from the Costley bequest. This building with its operating-theatre is situated about 150 yards from the main Hospital, and between the hospitals is situated an old wooden building known as the fever or typhoid ward. It is proposed to remove it, and to construct on or near its site new and expensive surgical wards connected by a covered corridor with a new operating-theatre. It is absolutely necessary that either this should be done or a new and up-to-date operating-theatre should be constructed in connection with the old building. The former course we consider the best, as it would be almost impossible to render any of the wards of the old building sufficiently aseptic for surgical work; it would be out of the question to carry patients to and from the old buildings to the new operating-theatre for operation. Next to the Children's Hospital is the Nurses' Home, and beyond that is a new building intended for the residence of the Senior Medical Officer. This could, no doubt, be utilised in other directions.

In another portion of the grounds are suitable buildings intended for possible small-pox and plague outbreaks. We beg to strongly recommend that the alterations to the old main Hospital building urgently required should be immediately undertaken under the supervision of a competent architect, subject to the approval of the head of the Hospital Department.

These alterations should, in our opinion, consist of (1) a lift connecting all floors of the Hospital with the basement (we are informed that a hand-lift which could easily be manipulated could be erected for from £200 to £300); (2) the demolishing of the tower stairways and the inclusion of the space so obtained in the lavatories and bath-rooms; (3) the erection of an up-to-date operating-theatre in connection with the main building, if the new surgical wards contemplated and above referred to are not at once erected; and (4) some attempt to render more sanitary the main wards.

In this connection we consider it is of the utmost importance that all plans and proposals to improve the present building, or to erect new wards of any kind or description, should be referred to the Government Hospital Department for consideration and approval before the public money is spent upon them. We consider that the spending of large sums of money by an annually elected Board, which can in the nature of things have no continuous policy, is vicious in the extreme, and is likely to result in the waste of public funds.

Under the Harbour Boards Act and the Tramways and other Acts we find that before the expenditure of public money can take place such expenditure must receive the consideration and sanction of Government Departments, and we fail to see why the expenditure of public moneys in hospital improvements, half of which is contributed directly from the Consolidated Fund, should be excepted from this salutary check on expenditure.

Lunatics.

There appears to be great difficulty in dealing with cases of mental disease which are just on the borderland of absolute insanity. In most of such cases physicians will not certify that they are lunatics, and consequently they cannot be committed to an asylum; but their relatives or friends refuse or are unable to take charge of them, and bring them to the public Hospital, where there is no proper accommodation for patients of this class. From the evidence before us, it appears that they are usually placed in the typhoid ward, and that persons suffering from delirium tremens are sent there also. The semi-lunatics are a source of constant disquiet to the fever patients, whom they occasionally attack, and the ravings of a man in delirium tremens disturbs every one in the building. We consider the practice of placing patients of either class among sufferers from typhoid to be most reprehensible. At other central hospitals such patients are rarely admitted, and, if admitted, are sent elsewhere as early as possible.

The Relations of the Senior Medical Officer and the Honorary Staff.

It is recognised as sound hospital practice that the authority of the honorary staff should be supreme in medical and surgical as distinguished from administrative matters. The resident officers are always in such matters subject to the honorary staff. This practice obtains, so far as we can learn, in all large hospitals throughout the colonies. If, therefore, a departure is made from a practice so universal, it lies strongly on those making the change to justify it on substantial grounds. About two years ago such a departure was made: the Board by Rule 37 constituted the Senior Medical Officer the medium of communication between the staff and the Board, and by another rule (No. 74) gave him the privilege of attending meetings of the honorary staff, whilst the Senior Medical Officer, by insidious methods, such as calling the staff to useless consultations and minor operations, and appropriating to himself many of the major operations on the plea of urgency, sought to make himself, and not the honorary staff, supreme in matters medical and surgical. The advantages of placing the honorary staff in the position of responsibility in these matters are—(1) the sick poor receive the benefit of the best professional skill, and (2) the doctors in attendance have the advantage of the collective wisdom of their brethren on the staff. The advantage of placing the Senior Medical Officer in supreme control is, judging by the present inquiry, that all difficult cases have a tendency to fall under the exclusive care of the resident and such members of the honorary staff as the former may choose to call to his assistance. One result of the change has been that members of the honorary staff have not unreasonably been forced to the conclusion that they can only continue in office by sacrificing their self-respect, and the majority of them have accordingly resigned.

The reasons given by the Board for this departure from sound and recognised methods are of the flimsiest character—namely, (1) that it is improper that young and unmarried men, such as residents usually are, should have the duty cast on them of attending married women, and (2) that complaints against the honorary staff have appeared in the leading and correspondence columns of the local Press. The first of these reasons is so ludicrous that it only requires to be stated to make obvious the ground of its rejection; and, as to the second, it does not appear that proper investigations were ever made to discover that any justification existed. The Board would seem to have been satisfied with the mere making of the complaint, coupled with such imperfect knowledge as its members may have happened to possess. In all hospitals large enough to require an honorary staff it should be insisted that the authority of that staff should be supreme in the before-mentioned matters, and no departure from this policy should be possible without the concurrence of some central authority, preferably the Minister in charge of the Department.

The present system, under which the Senior Medical Officer has supreme command of the Hospital, having utterly failed, it appears to us advisable to recommend the adoption of that which is usual in most central hospitals—namely, the appointment of two junior surgeons and one physician, who should be unmarried, and should reside on the premises; and should be subject in all medical and surgical matters to the honorary staff. The latter should perform all important operations, saving only those of emergency—*i.e.*, those that require instant treatment. The cost of this, we are informed, would be less than that of the disastrous arrangement now in force; and the ablest surgeons and physicians in Auckland, relieved from the incubus imposed upon them by the present rules, would not only be willing, but anxious, to serve on the honorary staff

Alleged Irregular Attendances of the Senior Medical Officer.

The fact that no provision was made at the Hospital for the residence of a medical officer, and that in consequence Dr. Collins resided at a distance from the institution, will fully account for these irregularities.

As to Major Operations.

These operations are required to be performed by, and to be under the control of, the honorary surgeons, after consultation (see Rules 21 and 36). Where the case is an urgent one the Senior Medical Officer has a discretion to decide whether an immediate operation is necessary; but the ultimate responsibility of the operation rests with the honorary surgeon, who takes charge immediately on his arrival (see Rule 72). An exception is made in the case of fractures and dislocations (see Rule 73); but even in such cases, where the honorary surgeon expresses a wish to take charge of the case, or it is one requiring operative interference, responsibility rests solely with that official. There can be no doubt that the rules cited have been persistently misconstrued and ignored by the Senior Medical Officer, who has taken charge of cases which should have been dealt with by the honorary staff. His conduct in this respect has had the tacit consent of the Board.

Bacteriology.

There is a skilled bacteriologist at the Hospital (Dr. Frost), and it appears that her work has been considerably interfered with by the Senior Medical Officer. We are of opinion that the culture by the latter of bacilli, and specially of the anthrax bacillus, was fraught with danger to the patients whom he attended, and should have been mostly strictly prohibited.

As an example of the interference of the Senior Medical Officer, we may adduce the case of Miss Guthrie. It was suspected she was suffering from tuberculosis, and Dr. Frost was requested to examine her sputum for the bacillus of that disease. She did so on ten different occasions, and the result was negative. Dr. Collins, however, gave it as his opinion to the honorary staff that the bacillus was present, and a recommendation was consequently made with respect to the treatment of that patient which might have resulted in her being sent to the Sanatorium for Consumptives at Cambridge.

Admission of Patients.

The practice at present prevailing is not to admit any patient except in cases of accident or palpably serious illness without an order of admission obtained from some doctor. This practice, which was introduced at the request of the local contributing bodies, and is contrary to Rules 13, 140, and 141, has entailed needless suffering to patients who have presented themselves for admission. These have not infrequently been seen by a porter, and refused admission until the prescribed order was obtained. The applicant, to procure this, has been compelled to travel some considerable distance in search of the Board's dispenser or some other doctor, to whom a fee would probably be payable for examination. We fail to see why any one of the resident staff (all of whom should never be absent from the Hospital at the same time) should not determine whether the proposed patient should or should not be admitted.

Fees Payable by Patients.

By the 71st section of "The Hospitals and Charitable Institutions Act, 1885," the Board may claim from patients contributions according to their means. The primary intention of the Legislature is to make public hospitals a place for the treatment of the sick poor, whilst not absolutely excluding the well-to-do. The practice of the Board has been to charge a fixed rate of 4s. 8d. per day to rich and poor alike. This practice is in contravention of Rules 142 and 143, as well as of the statute. In the great majority of cases, however, the fixed rate has been either wholly or partially remitted. It cannot be said this is in compliance with either the Act or the rules, because once it is established a patient can afford to pay the prescribed rate, he is liable for that rate, whatever his pecuniary position may be. It must be noted that repeated demands were made for payment until the amount due is either paid or, on application to the Board, remitted. This practice has had a two-fold effect—first, it has tended to keep the deserving poor out of the Hospital, and has retarded the recovery of those who have entered by reason of the moral compulsion to pay which the fixed rate has imposed on this class; secondly, it has encouraged a not inconsiderable number of the well-to-do, who are about 20 per cent. of the total number of patients, to make use of the Hospital, to the occasional exclusion of the poor. The reason the well-to-do under present circumstances avail themselves of the Hospital is obvious: the charge made is not even an adequate return for the board, lodging, and nursing, whilst the services of the staff, resident and honorary, inclusive of operations, are obtained free. The proper course would be to let it be generally known that in deserving cases no charge whatever is made, and that when a charge is made it is in accordance with a rate fixed with reference to the means of the patient. Under such a rule the well-to-do would either be content to be treated in their own homes, or they would seek the comparative seclusion of a private hospital. It must be noted here that, whilst 20 per cent. of the patients admitted are of the well-to-do class, only 7 per cent. of the total number admitted make any compensation to the Board; it thus appears that a certain proportion of those who are able to pay are not compelled to contribute anything towards the maintenance and medical attendance they have received in the Hospital. There is thus not only a loss to the Board, but the reception of so large a proportion of the well-to-do materially adds to the capital cost and upkeep of the institution.

Dismissal of Dr. Neil.

Dr. Neil, it must be observed, was a member of the honorary staff, and the question whether his dismissal was justifiable depends upon the further question whether Dr. Collins's method of operation in the case of Wallis White was in accordance with sound surgery. We have already reported it was

not. No doubt the ground taken by the Board, after an inquiry had been held, was that Dr. Neil had approached its Chairman (Mr. Garland) about the case. It also complained that the doctor had been absent from duty for seven days without leave, in contravention of Rule 12. These grounds for dismissal were merely ostensible. There is in evidence a statement by the Chairman, made at a prior meeting of the Board, that if he were a member next year he would do his duty and move a resolution in the direction of getting rid of the honorary staff; and it would seem, from the manner in which the inquiry was conducted and from the various reasons from time to time put forth by Mr. Garland for the dismissal, that it was determined on by the Board before ever the inquiry was held. In our opinion, the dismissal, assuming the Board had power to dismiss, was without any justification. Taking the view that Dr. Neil took of Wallis White's operation—a view which the evidence has borne out—it was not only the doctor's privilege, but his duty, to at once communicate with the Chairman; and it must not be forgotten that the only justification for the Board's arriving at the conclusion that Dr. Neil was absent without leave was his omission to sign the honorary staff's attendance-book, as required by Rule 16, an omission which the doctor satisfactorily explained to the Board.

Food supplied to Patients.

A large number of the witnesses, having been patients in the Hospital, complained to us of the quality of the food supplied to them. They described the fish as frequently rotten and served with scales on, and the fowls served with feathers. Other patients, on the contrary, stated that the food was all that could be desired. We do not express any definite opinion as to the quality of the food. Its inspection is by Rule 68 cast on the Senior Medical Officer; this duty was relegated by him to the House Steward. The Matron of the Hospital should, we think, be charged with this duty; her knowledge of the requirements of the different wards would, we conceive, enable her to perform it satisfactorily; and, moreover, it appears to us to be much more the province of a woman than a man to superintend the distribution of the food to the patients.

Hypodermic Injections.

It was proved that in one ward the male nurse or wardsman was in the habit of leaving open the cupboard containing poisons during his frequent absences, and that it was a common practice for one patient to administer hypodermic injections to others. Such dangerous carelessness deserves severe reprobation.

Out-patients' Department.

One of the complaints of the Auckland Division of the New Zealand Branch of the British Medical Association is that there has been a recurring tendency to the erection of an out-patients' department, in spite of the rules against it. There is no out-patient department at the Hospital itself. Rule 163, which deals with the matter, appears to be strictly followed. There is a pharmacy, which is situated about a mile from the Hospital, where persons of straitened means can attend and receive medical advice and medicines gratis. We think this is a very satisfactory arrangement, and that no objection can possibly be taken to it.

The Maintenance of Clinical Records and other Books of Record connected with the Hospital.

We find that most of the Hospital records and other documents produced to us in evidence were incorrectly and carelessly kept. The entries in the clinical record-books were of the most perfunctory character. In many cases the result of treatment is not given, there being merely an entry of the name and disease from which the patient was suffering. If operated upon, the word "Operations" appears; the effects of the operation one is left to imagine. The best-kept books in the Hospital were those produced by the nurses. We forward as exhibits in this connection three record-books—namely, two case-books, marked respectively "1, R.B.," and "2, R.B.," and also what appears to be an admission-book, marked "3, R.B." The latter contains, on page 9, an entry of admission of Wallis White on the 18th May, 1904. Case-book 2, at page 146, under date 17th May, 1904, shows an entry—"White, disease necrosis, operation." There is no other entry in the name of White about that date.

The Auckland Hospital Operation-book, attached hereto, shows, on page 79, the description of the operation on Wallis White. The duration of the operation is there stated to be forty minutes; the actual duration of the operation was 120 minutes. In Case-book No. 1, at page 10, is the entry of the case of Maud McIndoe. The particulars are entered in two different handwritings. The description of the disease, "fibroid tumour," which appears to be in the handwriting of Dr. Collins, and must have been entered after the operation, is shown by the *post-mortem* examination of the excised uterus by Dr. Savage to be incorrect; while the entry as to the consultation on the case, inserted below Dr. Collins's entry, is in a different handwriting, and bears a date antecedent to the date of the operation. We refer to this as an instance of the careless and deplorable manner in which the clinical records of the Hospital have been kept. For this carelessness the Senior Medical Officer is responsible by the regulations to the Board (see Rule 54).

The Commission opened its sittings on the 15th October, sat on twenty days, and concluded taking evidence on the 10th November, 1904, having examined ninety-three witnesses.

C. D. R. Ward.
R. Beetham.
S. E. McCarthy.

MINUTES OF EVIDENCE.

THE Royal Commission appointed by the Government to inquire into matters connected with the management of the Auckland Hospital held its second sitting at the chamber room of the Supreme Court on the 18th October, when the taking of evidence was commenced. The Commissioners present were District Judge Ward (Chairman), Mr. Richmond Beetham, ex-S.M., and Mr. S. E. McCarthy, S.M. Mr. J. R. Reed (instructed by Messrs. Hesketh and Richmond) appeared on behalf of the Hospital and Charitable Aid Board, Mr. S. Hesketh being also present part of the day. Mr. R. McVeach (Messrs. Russell and Campbell) appeared for Dr. J. Hardie Neil, who lodged a number of complaints against the hospital management and the Senior Medical Officer. Dr. Collins (Senior Medical Officer) appeared in person, and Dr. MacGregor, Inspector-General of Hospitals, appeared on behalf of his Department. Amongst others present during the whole or part of the day were Dr. Roberton (President of the Auckland Division of the British Medical Association), Mr. G. J. Garland (Chairman of the Hospital Board), Mr. J. Stevenson (Acting-Secretary of the Board), Messrs. J. McLeod, J. R. Walters, A. Bruce (members of the Board), Drs. McDowell, Craig, King, Savage, Parkes, and Bull.

On the Commission opening at 10 o'clock, the Chairman said that the Commission had decided to first take the charges made by Dr. Neil against Dr. Collins.

Mr. Reed asked permission to cross-examine witnesses called in support of the charges against Dr. Collins. Most of the charges against Dr. Collins, he said, also involved charges against the Board.

The Chairman said the Commission would agree to what Mr. Reed asked.

Dr. Roberton asked whether, as the charges against Dr. Collins were to a certain extent connected with the charges made by the Medical Association against the management of the Hospital, he could also cross-examine witnesses called in regard to the charges against the Senior Medical Officer.

The Chairman signified that there would be no objection to this.

Mr. McVeagh said he would first proceed with the charge in relation to the operation performed on the late Wallis White.

Mr. Reed asked the Commision if he could be furnished with a copy of Dr. MacGregor's report to the Minister on his recent inquiry at the Hospital, but the Chairman said the Commission could not comply with the request.

The following list of charges made by Dr. Neil against Dr. Collins, Senior Medical Officer at the Hospital, was submitted:—

1. That Dr. James Clive Collins, Senior Medical Officer in charge of the Auckland Hospital, infringed Rule 21 of the rules and regulations for the management of the Auckland Hospital, as adopted by the District of Auckland Hospital and Charitable Aid Board in January, 1902, inasmuch as he performed a certain major surgical operation on one Wallis White on the 18th May, 1904, the said rule requiring that the honorary surgeons shall perform all the major surgical operations.

2. That the said James Clive Collins performed such last-mentioned operation without a previous consultation of at least three members of the honorary staff, and that the performing of such operation under those circumstances was a violation of the said Rule 21.

3. That the said James Clive Collins did not take sufficient care before performing the said operation to obtain correct clinical history of the case, and that in violation of Rule 51 of the said regulations he did not see that the bed-chart of the said Wallis White was filled up with full particulars and history of the case.

4. That the said James Clive Collins recognised that the case of the said Wallis White was a desperate one, and, notwithstanding that, took as his assistant in the performance of the said operation the Junior Medical Officer of the said Hospital, as to whose previous experience in assisting at abdominal operations the said James Clive Collins had no knowledge whatever, and who he was aware had charge of septic and infectious cases.

5. That the said James Clive Collins made two incisions in the large intestine of the said Wallis White, and that there was no reason or justification for so doing.

6. That the said James Clive Collins made a statement to Dr. MacGregor (the Inspector-General of Hospitals) at a formal inquiry made by him that he, the said James Clive Collins, did not make two incisions in the intestine of the said Wallis White, whereas, in fact, he did make two such incisions.

7. That the said James Clive Collins stated to the said Inspector-General at such last-mentioned inquiry that there were three ulcers in the stomach of the said Wallis White, whereas, in fact, there was only one.

8. That the act of the said James Clive Collins in making the incisions into the large intestine of the said Wallis White resulted in great loss of time during the performance of the said operation, and very seriously prejudiced the chances of the patient's recovery.

9. That the said James Clive Collins violated Rule 21 of the said rules and regulations on the 3rd August, 1904, by performing a major surgical operation upon Arthur Duke at the said Hospital, that the said operation was performed without a previous consultation of at least three members of the honorary staff.

10. That the operation that was performed upon the said Arthur Duke was entirely unnecessary and unjustifiable.

11. That the said James Clive Collins, on the 24th May, 1904, at the Auckland Hospital, performed a major surgical operation upon one Martha Gordon.

12. That in the performance of the operation upon the said Martha Gordon the said James Clive Collins negligently failed to discover that the case was one of perforation of one of the fallopian tubes, the discovery and proper treatment of which would probably have resulted in the saving of the patient's life.

13. That the said James Clive Collins, on the 9th July, 1904, at the Auckland Hospital, performed a major surgical operation on one Clarence Walters in violation of the said Rule 21, and that in the performance of such operation the said James Clive Collins negligently failed to insure the removal of pus in the abdominal cavity of the patient.

14. That the said James Clive Collins, on the 11th May, 1904, at the Auckland Hospital, in violation of the said Rule 21, performed a major surgical operation upon one Walter Freestone.

15. That the said James Clive Collins, on the 31st January, 1903, at the Auckland Hospital, in violation of Rule 73 of the said regulations, operated upon one William Peake for a fracture, the case being one requiring operative interference.

16. That the said James Clive Collins, on the 3rd July, negligently failed to acquaint himself with the condition of Florence White, a patient who had been operated upon in the said Hospital, and on that day informed Mary Ann White, her mother, that the said Florence White was dead, whereas, in fact, she was then alive in the said Hospital.

17. That on the 13th January, 1902, an anæsthetic was administered in the said Auckland Hospital to one John Burke by Dr. Teague, the junior medical officer of the said Hospital; that the said Dr. Teague requested the said James Clive Collins to be present at such administration, and the said James Clive Collins neglected to do so, and the patient collapsed while under the influence of the anæsthetic. The said James Clive Collins having permitted the said Dr. Teague to administer such an anæsthetic alone, the circumstances being a violation of Rule 48 of the said regulations.

18. That the said James Clive Collins, on the 14th July, 1904, at the Auckland Hospital, performed the operation of hysterectomy upon Ethel Maude McIndoe, aged eighteen years, and the said operation was unnecessary and unjustifiable.

19. That the said James Clive Collins, in violation of Rule 51 of the said regulations, did not see that one William Allen, a patient in the said Hospital, was attended to on admission, the fact being that the said William Allen was kept waiting at the said Hospital for a period of three hours or thereabouts before he was seen by any doctor.

20. That the said James Clive Collins, in violation of Rule 73 of the said regulations, did not solely treat the said William Allen for a broken arm, and the said William Allen was, in fact, treated therefor by a junior resident surgeon.

21. That the said James Clive Collins, in violation of Rule 73 of the said regulations, did not solely treat one Joseph Colhun, who was admitted to the said Hospital about the beginning of February, 1903, suffering from a compound fracture of his arm, and that the said case was, in fact, treated and the arm set by a junior resident medical officer of the said Hospital.

22. That the said James Clive Collins did not see that a patient named Mrs. Mooney, suffering from a fractured leg, admitted to the said Hospital for treatment, was attended to on admission, and the fracture was not set until twenty-four hours after her admission to the said Hospital.

23. That the said James Clive Collins, in violation of Rule 51 of the said regulations, did not see that a patient in the said Hospital, named Victor George Swinbourne, who was admitted thereto on the 10th August, 1904, was attended to on admission, the fact being that the said Victor George Swinbourne was not attended to until five hours after his admission, or thereabouts.

24. That the said James Clive Collins performed a major operation upon one Roy Carrington Barnes, for the purpose of exploring the mastoid antrum; that the said operation was unnecessary and unjustifiable, and caused facial paralysis and meningitis.

25. That the said James Clive Collins omitted to correctly keep a case-book for each visiting officer of the said Hospital, the same being a violation of Rule 44 of the said regulations.

26. That the said James Clive Collins has during the time that he has been the Senior Medical Officer of the said Hospital neglected to insure that a detailed account of morbid appearances should be correctly entered by the officer conducting the examination in the *post-mortem* book.

27. That the said James Clive Collins, in violation of Rule 60 of the said regulations, has failed to insure that the proper records of consultations be kept.

28. That during the time the said James Clive Collins was Senior Medical Officer of the said Hospital patients were allowed to have access to morphia, and to administer hypodermic injections thereof, particularly between the months of June and October, 1904.

29. That during the period that the said James Clive Collins was Medical Superintendent of the said Hospital certain male attendants have been habitually allowed to administer hypodermic injections of a poisonous nature in the said Hospital, and that the said practice is a very dangerous one.

30. That the said James Clive Collins, in the year 1902, while he was Medical Superintendent of the said Hospital, permitted an ex-

cessive quantity of stimulants to be used in the said Hospital, and out of all reasonable proportion to the requirements of the cases.

31. That the said James Clive Collins is required by Rule 53 of the said regulations to make an official visit to the wards of the said Hospital at 9 a.m. and 6 p.m., and that he has throughout constantly failed to comply with this rule, whereby the efficient administration and government of the said Hospital has been hampered.

32. That in point of fact the said James Clive Collins has in many instances never visited some of the wards in the said Hospital for several days at a time.

33. That the said James Clive Collins, during the time that he has been Medical Superintendent of the said Hospital, has failed to be present at the Hospital for the discharge of his duties until 10 o'clock in the morning, or thereabouts, and that during such time he has also left the Hospital for the day at 4 o'clock in the afternoon, or thereabouts.

34. That the said James Clive Collins was required by Rule 68 of the said regulations to make a daily inspection, accompanied by the head of each department, of food, kitchens, offices, and wards, and to see that all food was properly cooked and served; that he constantly failed to comply with this rule; in consequence thereof the food supplied to the patients was of an unsuitable nature and badly cooked.

35. That the said James Clive Collins was required by Rule 71 of the said regulations to superintend the training of all nurses, and that he has constantly failed to do so.

36. That during the time that the said James Clive Collins has been Senior Medical Officer of the said Hospital he has performed *post-mortem* examinations, and within a short time thereafter has also performed major abdominal operations, in violation of the accepted practice of surgery.

37. That the said James Clive Collins during the time that he was the Senior Medical Officer of the said Hospital permitted and allowed a mental case—namely, that of Mrs. Grey—to be treated in the typhoid-fever ward of the said Hospital; that the said mental case was a very noisy one; and that the action of the Medical Officer in this respect was calculated to retard the comfort and the recovery of the typhoid patients.

38. That the said James Clive Collins permitted a delirium-tremens case—namely, one Russell—to be treated in the male typhoid ward at the same time that patients suffering from typhoid fever were being treated therein, and that the said delirium-tremens case was a very noisy one, and the disturbance he created was calculated to retard the comfort and recovery of the typhoid-fever patients.

39. That the said James Clive Collins during the time that he was Senior Medical Officer of the said Hospital was engaged for long periods of time in the bacteriological laboratory, and that the said work was entirely unnecessary, and it interfered with and encroached upon his duties in relation to the government and administration of the said Hospital.

40. That the work so carried on by the said James Clive Collins in the bacteriological laboratory seriously impeded the honorary bacteriologist, Dr. Frost, in the performance of her work in that department.

41. That the said James Clive Collins encroached upon the functions of the honorary bacteriologist, Dr. Frost, by making a bacteriological examination in the clinical specimen of a patient named Miss Guthrie, and by causing it to be reported to the Health Department in Auckland that he had discovered the bacillus of tuberculosis in the said specimen, and a recommendation to be made that the patient should be sent to the sanatorium at Cambridge for the treatment of consumptives; the honorary bacteriologist having previously examined on several occasions similar clinical specimens from the said patient, and having obtained negative results.

42. That the said James Clive Collins, whilst exercising medical and surgical supervision over the said Hospital, was engaged in making anthrax-cultures and inoculating guinea-pigs therewith, such conduct being a menace to the safety of the patients in the said Hospital.

43. That the said James Clive Collins during the time that he was Senior Medical Officer of the said Hospital frequently neglected the duties of such position by failing to examine regularly the serious cases in the various wards in the said Hospital.

44. That the said James Clive Collins neglected the medical side of the said Hospital by devoting more time and attention than was necessary to surgical work.

45. That the said James Clive Collins frequently called for a number of consultations in trifling cases, where consultations were really unnecessary, with the result that the honorary staff became dissatisfied, and their attention became diverted from those serious cases in which prolonged consultations were necessary.

The following supplementary list of charges made by Dr. Neil against Dr. Collins was also put in:—

1. That one John Donald McLeod was admitted as a patient to the Auckland Hospital on or about the 20th February, 1904, suffering from a fractured thigh, and that James Clive Collins, Senior Medical Officer of the Hospital, did not see that he was attended to on admission, the fact being that the said John Donald McLeod was not seen by any doctor until about forty hours after his admission to the said Hospital.

2. That the said James Clive Collins failed to personally examine the said John Donald McLeod until about a fortnight after he was admitted to the said Hospital.

3. That the said James Clive Collins so negligently and unskilfully removed the sticking-plaster from the leg of the said John Donald McLeod that a large portion of the skin of the patient's leg was torn away in the process.

4. That the fracture of the said John Donald McLeod was so unskilfully treated that his leg is now permanently injured.

The supplementary list also included the following joint charges by Dr. Neil against Dr. Collins and the Board:—

1. That patients suffering from cancer, consumption, delirium tremens, and semi-lunacy were kept with other patients in the same ward, and that sufficient lavatory and places of convenience were not provided for the purpose of segregating such of the said cases as ought to have been kept apart and as ought to have been kept separate from the other patients.

2. That patients are refused admission to the said Hospital unless they produce at the same time as their request to be admitted a recommendation from a medical man, even though the case may be such as to require immediate attention, and that this practice is bad.

The following charges were made by Dr. Neil against the Hospital Board:—

1. That in the month of March, 1904, I was appointed by the said Board honorary ear, nose, and throat surgeon to the Auckland Hospital under the control of the said Board.

2. That on the 29th August the said Board dismissed me from my said office without any just cause or excuse.

3. That the cost of the management of the said Hospital during the time it has been under the charge of Dr. James Clive Collins, Senior Medical Officer, has been excessive.

Mr. McVeagh said he would not address the Commission, but would at once proceed to call evidence.

Samuel Maunders Hill, steward of the s.s. "Gael," said he knew Wallis White, who was employed on the same steamer as cook. He remembered White being taken ill on the 17th May last. He complained of pains in his left side, and groaned considerably. Witness applied hot fomentations over White's side and stomach. White appeared to be in great pain. Next day White was sent to the Hospital in the ambulance. William Moir, a hand employed on the steamer, accompanied him to the Hospital.

By Mr. Reed: Witness gave White a glass of hot brandy on board the steamer, but he brought it up again.

Mr. Reed: Had he complained of anything previously?—Yes, he had complained for some weeks previously. He thought it was indigestion.

Dr. Collins: What was the precise time, on the 17th May, that the patient first complained to you?—About 3 o'clock in the afternoon. He complained again about half-past 12 at night, when he woke me. The steamer was then alongside the wharf at Omaha.

What did he say to you?—He said he was in great pain, and said; "Oh, my God, I'm dying."

Did you ask him where the pain was?—Yes, I did, and he said "Here," pointing to the left side.

What did you do when you got to Auckland?—I at once had him sent to the Hospital.

What sort of food did White get?—As a rule he would eat hearty meals, his food including stewed steak and roast mutton.

Did it not strike you as strange that when he was complaining of indigestion he should eat hearty meals?—He did not always have hearty meals, but he sometimes did even after he first complained of indigestion. I was surprised when he said he was going to die.

Mr. McVeagh: Where was White the night before he complained?—He was at a dance at Omaha. He danced nearly all the evening, and also sang a song.

Walter Freestone, gum-digger, at present residing in Auckland, said he was an inmate of the Auckland Hospital during the present year. He remembered Wallis White being brought into the Hospital. Witness occupied the next bed to White. The beds were about 4 ft. apart. He saw Dr. Neil and Dr. Collins at White's bed the day he came in. He heard Dr. Neil ask White where he felt the pain.

Mr. McVeagh: What answer did White give?—He said it was in his left side.

Do you remember what the doctors did after that?—They came and stood at the foot of my bed shortly afterwards. They were talking, and seemed, so far as I understood, to be differing.

Did you hear what was said?—I heard Dr. Neil say that it could not be appendicitis, or something like that.

Did you hear what Dr. Collins said to that?—No, I could not hear what he said.

Mr. McVeagh: This witness is also a witness in another charge, and I propose to take his evidence on that now. The charge is a joint one against Dr. Collins and the Board, in regard to the method of admitting patients to the Hospital (referred to in the supplementary list of Dr. Neil's charges).

The Chairman said it would be better to take one set of charges at a time.

Mr. McVeagh said that this would mean bringing the same witnesses time after time.

The Chairman: What charge do you wish to go on with now?

Mr. McVeagh: That of admitting a patient to the Hospital without a recommendation from a medical man having been first obtained.

The Chairman said it might be inconvenient to the witnesses, but it would avoid confusion if they disposed of one set of charges at a time.

Mr. McVeagh (continuing his examination of witness): You were operated on for appendicitis in the Hospital?—Yes.

Who operated on you?—I think it was Dr. Collins.

You were then living at Kumeu?—Yes; about twenty miles from Auckland.

Was there any medical man there?—No, not so far as I know. None nearer than Henderson.

You came to the Auckland Hospital?—Yes, by train to Mount Eden Station.

What did you do when you got there?—I asked the porter whether I could see a doctor. He said No, and that I could not be admitted without an order from a doctor. I told him I was in great pain. I asked him where I could see a doctor, and he mentioned Symonds Street. I went to Dr. Neil, in Symonds Street, and got a recommendation from him for admission. I went back to the Hospital and was admitted.

When were you operated upon?—Two hours after I went in.

Do you remember saying anything to the porter about dying?—Yes; when I first got there I said to the porter, "If I go away from here to look for a doctor I might pass out."

Mr. Reed: Did you walk from the Mount Eden Railway-station to the Hospital, and up the steps, and afterwards to Symonds Street and back?—Yes.

Dr. Collins: Was there not a screen between White's bed and yours?—No; there were some screens there, but not between the two beds.

How long was it after your operation when White came in?—About a week.

What condition were you in then?—Better than when I went in.

You were then out of danger?—No.

Did you hear what I said to Dr. Neil?—No.

You cannot say exactly what Dr. Neil said to me?—No; except that I heard the word "appendicitis."

You said just now that he said, "It can't be appendicitis"?—Yes, something to that effect.

Do you remember Dr. Craig coming into the ward that night?—I cannot call it to mind.

Mr. Reed: We have a number of medical witnesses for the defence, and I do not wish to detain them unless it is necessary. I understand that the whole of the charges against Dr. Collins will be gone through before we shall be called upon to reply.

The Chairman: Yes, that is our intention.

Dr. Neil was then called. He stated that his qualifications were M.B., Ch.B. (New Zealand), M.R.C.S. (England), and L.R.C.P. (London). He detailed his professional experience in Auckand, South Africa, and England, and said that in 1903 he was appointed honorary anæsthetist at the Auckland Hospital. Last April he was appointed ear, nose, and throat surgeon at the same Hospital, and he held that position until the 10th August.

Mr. McVeagh: Do you remember the case of Wallis White?—Yes. On the 18th May I was asked by a porter to see an urgent case with Dr. Collins. I went with Dr. Collins to Ward No. 3, where White was lying. On the way to the ward Dr. Collins said the case was one of acute appendicitis, and that as the honorary surgeon for the week was absent he was going to do the case.

Did you examine the patient?—Yes; I examined his abdomen and examined him generally. I asked White to point with one finger to the locality of the pain. He pointed to the left side.

Where was Dr. Collins then?—He was on my right, towards the foot of the bed.

Was the patient in the full possession of his faculties?—He could answer my questions. He pointed to his left side. Dr. Collins then said the patient was not consistent in his statements. I asked White again, and he again pointed to the left side. I then walked towards Freestone's bed, and said, "Collins, you cannot say dogmatically that it is appendicitis. Why not operate on the middle line?" The incision for appendicitis is made on the right side.

Mr. McVeagh: Why do you suggest the middle line?—Because there was no reason to assert dogmatically that it was appendicitis.

Did Dr. Collins make any reply to your suggestion?—Yes; he said, "No, it is my case." I said, "Why have a consultation at all; you seem to have settled the matter?" He replied, "I want a consultation, but I am going to do it. The honorary staff can come and look on, but I am going to do it." I then chatted with Freestone for a little while, and as we were moving away towards the door Dr. Collins said, "Do you think it is an urgent case?" I replied, "Certainly I do, and the sooner it is operated upon the better." Dr. Collins then asked me to come and give the anæsthetic. I said I would if Dr. Inglis (the honorary anæsthetist) did not wish to come. I then went home, and returned about 8 o'clock.

The Chairman: What time did you leave the Hospital after the consultation?—Between half-past 5 and 6.

Mr. McVeagh: What happened when you returned in the evening?—The case was taken down to the theatre, and I commenced giving the chloroform. The members of the honorary and resident medical staff were present. Dr. Parkes made a cursory examination of the abdomen. When the operation commenced, Dr. Collins made the usual incision for appendicitis. On opening the peritoneum some gas escaped, and some greenish fluid with some yellowish curdy flakes showed itself. Dr. Collins quickly found the appendix, and said, "It is normal." He manipulated the large intestine near the appendix, and, feeling something hard there, said, "Fæcal concretions; I will take them out." He opened the intestine, and extracted two pieces of fæcal matter, each about the size of a walnut. After suturing up the first intestinal incision, he again cut into the intestine and took out another smaller piece

of fæcal matter. Before he cut into the intestine I said, "They are scybalæ" (pieces of hardened fæces), "there is a perforation somewhere." Dr. Collins asked me, "How is the patient getting on?" and I took that to be a hint to mind my own business. After having removed the three fæcal concretions he sewed up the incisions.

Mr. McVeagh: What time would be occupied in cutting into the intestine, removing the concretions, and suturing up the intestine?—That would be hard to say—the operation is a delicate one; but I should say from fifteen to twenty minutes. Dr. Collins asked me what time it was. I took out my watch, and it was five minutes to 9, or thereabouts.

Such an operation as that is, I take it, of paramount importance?—Yes, it is of very paramount importance, if I may use the term.

Did you, as a medical man, think there was any necessity to cut into the intestine and remove fæcal concretions?—None whatever.

Assuming that it had been necessary to make the first incision, was there any necessity to make the second one—I mean the intestinal incision?—No; I cannot think of any reason.

Was there anything to prevent the third concretion being taken out through the first intestinal incision?—No; it could have been easily manipulated down and taken out. It was a matter of only about 2 in.

Mr. McVeagh: How was that?—Being inflated with gas, it must have got in his way. He then found the gastric ulcer.

Dr. MacGregor: Can you say which side it was on?—I have the impression that it was on the stomach side, but I am not sure.

Mr. McVeagh: What was the state of the patient?—Well, I knew he was going to die.

What effect would the intestinal incisions have upon the patient's chances of recovery?—An incision of the intestine is always a serious matter, and one must take all the facts into consideration. The incision would reduce his chances of recovery.

Did you examine White's bed-chart?—When I went into the ward first I asked Dr. Collins where the notes were, and he said, "The man has just come in."

Did the operation occasion you a great deal of thought that night?

Mr. Reed: That is hardly evidence.

Dr. Neil: I spent a sleepless night, worrying over the matter, and the useless dissipation of a 50-per-cent. chance of life.

The Chairman: We need not go into that. You can give your opinion, but we need not trouble about what worried you.

Mr. McVeagh: What did you mean by speaking of the useless dissipation of a 50-per-cent. chance of life?—It was one of those cases of gastric ulcer which, if operated on by a skilful surgeon within twenty hours of the appearance of the first symptoms, would have had about a 50-per-cent. chance of recovery.

At this stage Dr. MacGregor was asking the witness a question, when the Chairman interposed: For whom do you appear, Dr. MacGregor?

Dr. MacGregor: On behalf of the Department.

The Chairman: What has the Department to do with it?

Dr. MacGregor: The Minister instructed me to come.

The Chairman: We are very happy to see you here, Dr. MacGregor, but I do not think you can cross-examine witnesses. The Department has practically delegated all its powers in the matter to the Commission. We should be very happy to hear any evidence that you may have to bring, and no doubt your presence will be of great asistance to the Commission, but there are rules which must not be overlooked.

Dr. MacGregor: Very well, sir.

Mr. McVeagh (to Dr. Neil): In consequence of what you felt, did you communicate with the Chairman of the Board?—I first saw Dr. Scott, chairman of the honorary medical staff, and told him that I was dissatisfied with the operation, and asked his permission to call a meeting of the honorary staff to go into the question of that class of work. This was the morning after the operation. About 12 o'clock the same day I went and saw Mr. Garland, Chairman of the Board, and told him that I was very much upset over the operation.

The Chairman: We cannot go into that.

Witness (continuing): Two days after that I went to the Hospital and instructed the porter to send out notices for the meeting. The porter said Dr. Collins wished to see me. I went into his room, and he said, "Neil, is it true that you are trying to set the honorary staff against me, and are speaking outside?" I said, "I am not speaking outside, but I am upset over that operation." He said, "What operation?" I replied, "That gastric-ulcer operation the other night. Do you think I am going to stand another performance like that? You opened that man's intestines and took out fæces when he was suffering from gastric ulcer. I saw murder in South Africa, but the sight of that did not upset me as much as the sight of that operation. You ignore the opinions of the honorary staff, but you will not ignore mine. Taking a fresh junior with you in an urgent operation, as if there was no one else to get! You are inextricably mixed up with the surgical side. You had better pull out for a whole month and leave them alone. You know that everything you do in this Hospital is watched by dozens of unfriendly eyes. I have lashed out about this to the Chairman of the Board, and I am not afraid of you or any one else. Why don't you leave the surgical side alone?" Dr. Collins then said, "I will leave them alone, and you will see what will happen." I said, "The right will happen, as it did under the old regulations." Dr. Collins then said to me, "You are satisfied with your ear, nose, and throat department?" I said, "I am." "Well, then," said Dr. Collins, "why can't you leave the surgical side alone?

I am keen on surgical work." I replied, "Collins, humanity demands that some one should speak in this matter. I have spat out to you all that is in my mind; you know my opinions on the matter, and I will let it drop, as some people might construe further action on my part to be personal." Just then Dr. Pabst came in, and the conversation dropped.

Mr. McVeagh: Did you have any further conversation with Dr. Collins about this case?—I never mentioned it to him. It was on the 19th May that I had the above conversation with Dr. Collins, and on the 9th August a meeting of the honorary staff was held to consider some suggestions as to the working of the Hospital.

Was Dr. Collins present?—He was. I was instrumental in the passing of a resolution to suggest to the Board that the emergency work be done by the honorary surgeons. I was suspended next day (10th August) on a charge of having gone to the Chairman of the Board and made a damaging statement about White's operation.

Was any reason given for the suspension?—No. I next received a notice to attend a special meeting of the Board [notice produced].

Were you given any information as for what purpose the Board meeting was called?—I was given no information by the Board whatever.

Was any reason given to you?—No definite reason was given. I received a letter on the day after the meeting of the honorary staff from Mr. Garland (Chairman of the Board), suspending me, and I immediately rung him up on the telephone. I took a record of the conversation, writing it down immediately afterwards. I told him I had received his letter, and as it was a serious matter I would like to have a conversation with him. He said he was very busy, and that he had no more to say. I said, "Can't you tell me the nature of the offence with which I am charged? Is it about the honorary staff business?" He replied that it was the Sunday morning and yesterday's (Tuesday) business with the honorary staff, and remarked further, "I am sick and tired of the whole affair, and I am fit to be in the asylum. If I am on the Board next year there will be no honorary staff, if I can help it. I would not go through again what I have endured the last six months for £500." I then inquired, "You can't grant me an interview?" and he said, "No." I said, "Thank you; good afternoon," and rang off. Immediately after that I wrote a letter to the Board, stating that I had been suspended by the Chairman, protesting against his action, and asking to be heard at the Board meeting on the following Monday. I also asked that the chairman of the honorary staff be invited to attend. In reply I got a letter inviting me to attend the Board meeting.

Mr. McVeagh: You attended that meeting?

Witness: I did. Dr. Collins was also present.

What was said at the outset?—The Chairman stated the object of the meeting was to inquire into charges made against me by the Senior Medical Officer. The Chairman said the procedure would be that Dr. Collins would first read out the charges, I would reply, Dr. Collins would bring witnesses, and the Board would then go into the matter and give their decision.

Did Dr. Collins then make charges against you?—He did.

What were they?—The first one was to the effect that I was absent from the Hospital for more than seven days at a time. This I immediately denied, explaining that, although I may not have written my name in the attendance-book, my attendance at the Hospital was very regular indeed. I asked for the production of the attendance-book, but it was not forthcoming. The charge was then passed over. The second charge was that I had, from personal motives, kept Dr. Collins away from a sub-committee meeting of the honorary staff. I denied that I had intentionally kept Dr. Collins away, and that matter was dropped. The third charge brought up was that I had gone to the Chairman of the Board on the 19th May, and made certain damaging statements about the Senior Medical Officer's conduct of an operation on the previous night, and I had stated to the Chairman that the Senior Medical Officer was converting the Auckland Hospital into a "damned shambles." I admitted that I had gone to the Chairman on that date and made certain statements about an operation, which I considered I was quite privileged to do. I denied that I had stated Dr. Collins was converting the Hospital into a "damned shambles." The Chairman ruled that I was not privileged to go to him and make statements about the conduct of the medical officer. I was asked what I did say, and I replied that I detailed the operation and the conversation I had had with Dr. Collins, telling the Chairman further that a few more operations like that and people would speak of the Auckland Hospital as they would speak of a "damned shambles." I did not bring out at that meeting the way in which I used the term "damned shambles," because I was charged with having stated that the Senior Medical Officer was converting the Hospital into a "damned shambles." I denied that charge, and I deny it again. Witnesses for Dr. Collins were called, but I was not in a position to call any of those who were present at the operation—the nurses, for instance, whom I dare not call, out of consideration for them. If the matter had been gone into in an official manner I would have called half the surgeons in Auckland to discuss the operation. The Board had simply made up their minds on the matter, and communicated their finding to me on the 17th August. I was asked to resign my position as ear, nose, and throat surgeon, because of the manner in which I had spoken of the operation, and, as the Board put it, "in the interests of the Hospital."

Witness said that at the Board meeting witnesses who were called made statements which cast very serious imputations on his veracity.

What statements do you allude to?—A statement regarding the

condition of the stomach of White. I stated that Dr. Collins made two incisions, and found only one perforation, while the witnesses stated there were three ulcerations in the stomach, and therefore the patient could not have been expected to live, when the condition of the stomach was taken into consideration. I felt I had been treated very unjustly, so I went to Wellington and laid the matter before the Inspector-General of Hospitals and the Minister in charge of Hospitals, as a result of which an inquiry was held by Dr. MacGregor.

The Chairman here interposed that the matter of the inquiry was not before the Commission; it was only the specific charges made by Dr. Neil against the Senior Medical Officer and the Hospital Board.

Mr. McVeagh pointed out that it had been suggested that the statements made by Dr. Neil were incorrect, and the inquiry touched on this point.

In reply to the Chairman, Mr. McVeagh said he had not seen the evidence taken at the inquiry, nor had he seen the official result of the exhumation and examination of the body of Wallis White, made at the instigation of Dr. MacGregor by Dr. Savage. Mr. Reed, for the Board, and Dr. Collins also stated that they had not had an opportunity of perusing these documents.

The Chairman recognised the necessity of all parties concerned being given an opportunity of making themselves familiar with the contents of both documents.

Mr. McVeagh suggested an adjournment, because he desired to examine Dr. Neil as to the stand he took up at the inquiry, and also in regard to the exhumation of White's body.

A difficulty arose on account of there being only two copies of the evidence taken at the inquiry (the original of which Dr. MacGregor had temporarily handed over to the Chairman), and one copy of the report on the *post-mortem*. When the consideration of providing all parties with a copy of these documents with the least possible delay arose, the Chairman remarked, "I suppose you have no counsel here, Dr. MacGregor?"

Dr. MacGregor: I do not want any counsel here.

The Chairman: Any one to whom you could intrust the original copy of the evidence.

Dr. MacGregor: I intrust them to you.

Dr. Savage, who was present, offered to place the original draft of the report of the exhumation at the disposal of the Commission, and the offer was accepted. Matters were adjusted by adjourning the Commission till 3 o'clock in the afternoon, to enable all parties to peruse the documents for an hour each.

The Chairman, speaking to Dr. MacGregor, said: "We don't part with your documents, doctor."

Dr. MacGregor: If you part with my documents, Your Honour is responsible.

When the Commission resumed in the afternoon, Mr. McVeagh intimated that he had not quite completed the perusal of Dr. MacGregor's notes, but he had gone far enough, he thought, to continue the examination of Dr. Neil. However, he would like to be allowed possession of the notes to further peruse them. This was approved by the Chairman.

Questioned by Mr. McVeagh in regard to the inquiry held by Dr. MacGregor, *Dr. Neil* stated that in addition to Dr. MacGregor there were also present some members of the Hospital Board, honorary staff, resident staff, and witness.

Mr. McVeagh: The inquiry was directed mainly as to certain charges you had made in relation to the operation on White?—I understand Dr. MacGregor came up to inquire into my case generally, and the White episode was more the bone of contention.

Do you remember if Dr. Collins gave evidence?—I do remember that.

He gave evidence regarding White's case and the incisions he made in the intestines?—He did. He stated it was incorrect that he made two incisions in the intestines—at least, his evidence gave me to understand that.

Did any other doctor give evidence in regard to the same thing?—Yes; Dr. Craig corroborated the statement. Dr. Craig was present at the operation, as well as Drs. Parkes and King. Dr. Parkes stated at the inquiry that he was out of the room when the incisions were made, and also at the time they were closed. Dr. King was called at the latter part of the inquiry, and in a general way corroborated the evidence given by Dr. Collins.

What statement did you make?—I said Dr. Collins made two incisions.

Was there any evidence taken in regard to the perforation of the stomach?—Yes. Dr. Collins stated there was one large ulcer at least 1¼ in. in length, and two others of ordinary size.

Was anything said in regard to the condition of the stomach?—Yes. The edges of the ulcers were stated to be very friable. Dr. Parkes, in his evidence, said there were two ulcers, and that they were so friable that no sooner had one perforation been sewn up than another occurred. Dr. Craig said there were three ulcers present, one 1½ in. in length, and two others of average size, which, I understand, means ½ in. Dr. King also gave evidence, and in a general way corroborated the statements of the other doctors.

When the abdominal incision was made there was an escape of gas?—Yes.

What would be the import of that?—It would show there was a perforation.

That being so, what would a reasonably skilful surgeon do?—He would immediately search the intestines for a perforation.

Would it be a reasonable thing to delay that until incisions were made into the intestines for the purpose of removing fæcal concretions?—No, certainly not.

Was Dr. Ferguson present at the operation?—Yes; as the resident physician.

How long has he been qualified?—Since November of 1903, I believe.

What were his duties at the Hospital?—As I understand, his duties comprise looking after the medical wards and the infectious-diseases wards; and I believe on him was thrown the duty of performing the *post-mortem*, but not by the rules of the Hospital, under which Dr. Frost should have done that.

Was it a reasonable or proper thing for a doctor in charge of these cases to take part in abdominal operations?—No; he should not be allowed to take part, because, coming in contact with scarlet-fever and other contagious cases, it was likely to cause contamination. It was almost impossible for a doctor to keep so clean that he would not be a source of danger to the patient undergoing the operation. By being in contact with infectious-diseases cases a man was almost certain to have infectious matter about his clothes or person somewhere. An expert surgeon will never permit a man in attendance on infectious cases to take part in abdominal operations; in fact, they will sometimes refuse to allow him to come into the operating-room.

What was the reason for this?—It was to exclude the possibility of septic suppuration.

Mr. McVeagh mentioned here that he would proceed to other charges of which Dr. Neil had personal knowledge, while for the present some allegations would be passed over, as witnesses would be called later to prove them, and Dr. Neil would be called to give expert evidence.

As to the allegation of Dr. Collins's neglect to visit the Hospital wards at 9 a.m. and 6 p.m. daily, witness stated that it was quite a common thing for Dr. Collins not to arrive at the Hospital till 10 and half-past 10 a.m

Mr. McVeagh: In your capacity as honorary surgeon, you were frequently at the Hospital?—I was.

At what hours in the morning?—Frequently at 9 o'clock, and later.

Where does Dr. Collins live?—He has been at several places since he has been in Auckland.

From your experience of hospital work, what time of the day should administrative work be performed?—Between half-past 8 and 10 o'clock. That was before the business of the honorary staff was commenced.

Will you detail what comprises the administrative work?—Going into wards, asking after the bad cases, inquiring as to the condition of epidemics, and emergency work; also about dressing, signing requisitions for dressing, signing charge-sheets, inspecting lavatories, and making an inspection of the buildings.

Was that observed when you were resident under Dr. Baldwin?—Yes; it was the routine.

How does that compare with the routine in other hospitals which you attended?—In English hospitals—I am speaking more particularly in reference to the Netley Military Hospital—the administrative work is started at 9 o'clock and is done before 10 o'clock.

What would ordinarily and properly follow administrative work?—Professional work. The business of the honorary staff would take place, involving the resident staff accompanying the honorary staff in their inspection of the patients, and if any operative work is to be performed the resident staff is to be there to lend what assistance the honorary staff deemed necessary.

Mr. McVeagh: With regard to *post-mortem* work (referred to in clause 36 of the charges), have you had any personal knowledge of whether Dr. Collins has been doing any at the Hospital?—Yes, I have seen him doing it.

Can you convey any idea as to the frequency of it?—I have seen him, but I cannot give the exact number of times.

More than once?—Oh, certainly.

Is it, in your opinion, speaking as a surgeon, a proper thing that a Senior Medical Officer who performs abdominal operations should also perform *post-mortem* work?—No, it is not. The reason is the same as in the case of doctors in attendance in infectious cases taking part in operations—viz., septic suppuration setting in.

What is the practice of surgeons in all well-established hospitals in relation to a man performing *post-mortem* work being a short time after engaged in abdominal surgical work?—They are not welcomed in operating-theatres, and surgeons would very much object to a person who has been engaged on *post-mortem* work assisting them in an abdominal operation.

Have you, personally, any knowledge of the time that has intervened between Dr. Collins doing *post-mortem* cases and undertaking abdominal cases?—Yes, I have. I remember one afternoon I went for some material, and on returning to the Hospital found Dr. Collins in the mortuary, showing Drs. James and Stirling, of Melbourne, a case in which he had completed an operation of joining the stomach to the smaller intestine on a dead body. Dr. Collins was talking over the operation with the two doctors present. I saw him operating on the case of Martha Gordon, who died from internal hæmorrhage after the operation, about four days afterwards.

Was he working from a book?—He was referring to a book.

Where did the book belong to?—It was his own book—Coker's Surgery.

Where is the book ordinarily kept?—He keeps it in his own room.

Is that a book to which other surgeons refer?—They have access to it, and, I take it, they use it.

Where was the book on the day you saw him in the mortuary?—I could not say; but I have seen the book lying on the legs of a dead body.

It was not unlikely that a doctor would take down the book and refer to it?—No, not at all unlikely. It is a book constantly referred to, being a standard text-book.

Would there be any risk to a patient in a doctor using that book and then proceeding to perform an abdominal operation?—I should say so.

What risk?—There was a direct risk of conveying matter to the patient; it was a serious matter. In the majority of instances I saw Dr. Collins in the *post-mortem* room he was working with gloves on, but once he was not wearing gloves, on that occasion being engaged on the arteries or the limbs.

Mr. McVeagh: Do you know anything about Dr. Collins's bacteriological work?—I know that he worked in the bacteriological laboratory.

How long was he occupied there?—It was at the beginning of the year, a period centred round March last. He was pretty constantly in the laboratory. I would often find him there when I went down.

At that time was there an honorary bacteriologist attached to the staff?—Yes; Dr. Frost held the position.

Do you happen to know if Dr. Collins engaged in any cultures?—He was engaged in some experiments of an anthrax outbreak.

Do you know the nature of those experiments?—He showed me a glass which was smeared with microbes, and I understood at the time that he was operating on guinea-pigs. I never saw him so operating.

As a surgeon, would you approve of the inoculation of guinea-pigs with malignant microbes being carried on in such an institution as the Auckland Hospital?—No, I would not. I consider it a dangerous practice.

Is it one that a skilful surgeon, having regard for the patients under his care, would adopt?—No, he would not adopt it.

Mr. McVeagh: In regard to consultations held at the Hospital during the time Dr. Collins has been in charge?—The method of holding consultations has been unsatisfactory. I might say that in the time of Dr. Baldwin the consultations were attended by the honorary staff, and after conferring on a case, the junior speaking first, a decision was come to and written down, and a history made of the case. Those present—of course, some might disagree—would sign the decision immediately.

Has that practice been followed under the management of Dr. Collins?—No; it has been neglected.

Do you attach importance to the consultation being entered in the consultation-book?—I do. They are records of the opinions of the surgeons in consultation, and records to guide surgeons. The system caused definite and responsible opinions to be given, which I think is a source of safety to patients.

What were the form of the consultations held in Dr. Collins's time?—The ordinary consultations affected cases over which consultation was not necessary, and in consequence of this Dr. Gordon brought forward a motion at a meeting of the honorary staff to obviate these unnecessary consultations. It was decided that no consultation be held on a case without a previous consultation with the surgeon in charge of the case having been held.

"In charge of the case" does not mean the resident medical officer?—No; it means the surgeon under whose care the case is.

What was the upshot of the resolution?—It may have had a salutary effect for a short time, but things afterwards went back to the old level. The staff became dissatisfied, and the abdominal cases which required prolonged consultations were thereby neglected.

Mr. Reed: By the honorary staff?—The cases lost the prolonged consultations that they should have had.

Mr. McVeagh: From your attendance at the Hospital, have you come to any conclusion regarding the attention given by Dr. Collins to the medical as compared with the surgical side?—He has often said that he was not much interested in medical work, and that he was keen on surgical work.

Witness was examined by Mr. McVeagh as to what he knew of the case of Martha Gordon (charges 11 and 12). He said Dr. Collins performed an operation on the woman, assisted by a resident officer. Dr. Inglis administered the anæsthetic. Witness gave a technical description of the case, the point of the complaint being the allegation that the cause of death was a perforation of one of the fallopian tubes, which Dr. Collins did not discover. It was discovered next day at the *post-mortem*, at which witness was present.

Mr. McVeagh: Can you say why the perforation was not discovered during the operation?—He could not have made a careful search.

That operation would be classed as a major operation?—Yes.

In regard to the case of Clarence Walters, witness said he saw Dr. Collins performing the operation, assisted by a resident officer. The case was one of intestinal obstruction, and Dr. Collins had failed to insure the removal of pus from the abdominal cavity. The patient died, and the presence of pus was discovered at the *post-mortem*, at which witness was present.

Should a careful search have insured the removal of that?—Yes, it should.

Was there any difficulty in the way of removing it?—It would have required another opening on the middle line.

Do you think that should have been done?—Yes; but I do not say for an instant that it would have saved the boy's life. He was very bad.

Mr. McVeagh then questioned witness as to Hospital Rule 72, which read as follows: "He (the Senior Medical Officer) shall be responsible for the treatment of all cases of emergency, and all surgical operations connected therewith, after the visiting surgeon, under whose care the case was admitted, shall have been notified of the urgency of the case, and he shall be authorised to use his discretion as to the advisability of immediate operation prior to the arrival of the honorary surgeon."

Mr. McVeagh: What would you call "a case of emergency"?

Witness: Cases which should be operated upon without waiting for the arrival of the honorary staff—as, for instance, bleeding cases and casualty work, such as dislocations and fractures.

In other words, you would define "emergency cases" as those requiring instant action to save the patient's life?—Yes, or to prevent after-effects which delay might occasion.

How long would it be before the honorary staff could be summoned and arrive at the Hospital?—In Dr. Baldwin's time it was from a quarter to half an hour, and they were always very keen on getting there.

They are all connected with the telephone exchange?—Yes.

A certain amount of preparation is necessary in the case of these major abdominal operations?—Yes; the patient has to be put to bed and prepared for the operation, everything has to be got ready, and the friends notified.

Speaking generally, what time should the preparation take?—Fully half an hour. In Dr. Baldwin's time emergency abdominal operations were invariably performed by the honorary staff. I can recollect no case in which the patient suffered from delay in the arrival of the honorary staff.

Witness, on being examined as to the case of John Donald McLeod, said the latter would be called to give evidence. Witness saw McLeod last Sunday.

Mr. McVeagh: Was his left thigh in a normal condition?

Witness: No; it had been fractured, and there was a large thickening of bone on the side of the fracture. His left knee and ankle were also somewhat stiff.

The Chairman: Are you able to speak personally as to this case?

Witness: I cannot as to what passed in the Hospital.

Dr. Roberton: You have defined "emergency cases" as those in which immediate action is required to save life or prevent any after-effects which might arise from delays: do you consider that fractures and dislocations should be included in that definition?

Witness: I think the resident staff should treat fractures until the arrival of the honorary staff.

Dr. E. Roberton, President of the Auckland Division of the New Zealand Branch of the British Medical Association, submitted that the management of the Auckland Hospital has been, and is, unsatisfactory, and has resulted in impaired efficiency and unnecessary expense.

1. This is due in the first place to the constitution of the Board of Management being unsuitable.

2. That the management has shown itself defective in the following respects:—

(*a.*) There has been no consistent and continuous policy in regard to medical management.

(*b.*) There has been a want of proper method in arranging for increased accommodation, leading to unnecessary expense in maintenance.

(*c.*) Proper provision has not been made for the isolation of infectious diseases, including tuberculosis.

(*d.*) The expenses of the Hospital have been unduly increased by the right of admission not being restricted to the sick poor except in cases of emergency.

(*e.*) The stringent system of fee-collecting has borne hardly on the sick poor, and has led to a widespread feeling that the really poor cannot afford to go to the Hospital.

(*f.*) There has been a recurring tendency to the creation of an out-patient department, in spite of rules against it.

(*g.*) The Board has adopted the policy of appointing the honorary visiting staff from year to year only.

(*h.*) The position assigned to the Senior Medical Officer in relation to the honorary visiting staff, and the divided responsibility for the treatment of patients, has been detrimental.

(*i.*) The work of the honorary visiting physician has been hampered and its efficiency impaired by the time of the resident physician being too much occupied by work other than that in connection with medical cases.

The Commission then adjourned.

When the Commission opened at 10 o'clock on the 19th October Mr. McVeagh drew the attention of the Commission to a set of rules which he said was in force at the Hospital, and which appeared to preclude Hospital employees from making statements concerning the Hospital. The last rule on the subject read as follows:—

"Every officer, servant, or employee, therefore, resident in the Hospital, making public or being in any way the means of making public (except through the correct official method as aforesaid stated) information or statements which may be deemed of a prejudicial nature or otherwise connected with the professional or private character of any other officer or employee, or with the entire or part management of the Hospital, or regarding any possible contingencies which may arise in the judicious management of the internal affairs,

or in the professional work of the Hospital, or from any other cause not herein stated, will be regarded as having been guilty of misconduct, and will be immediately suspended by the Senior Medical Officer, pending the direct authority of the Chairman of the Board. The special attention of probationer nurses is drawn to the above rule."

Mr. McVeagh, after reading the regulations, submitted that, so far as matters within the scope of the Commission were concerned, no employee of the Hospital should be prevented from giving any information which they possessed.

Mr. Beetham: They are bound to do so.

Mr. McVeagh: I desire to interview some of the members of the staff, and I do not wish to be fettered by this rule.

The Chairman: You wish to consult them with respect to complaints already formulated?

Mr. McVeagh: That is so, Your Honour.

Mr. Reed: We desire, as far as possible, to afford all possible facilities in obtaining information, but we cannot help feeling that it would be subversive of discipline in the Hospital that any person should be allowed to go round endeavouring to get some one to give evidence on the complaints brought forward. Any witnesses from the Hospital who may be required will be produced.

The Chairman: The trouble is that it is not known what persons can give evidence. How can they know without making inquiries?

Mr. Reed: The charges should not have been made unless there were some means of substantiating them. They have already gone abroad to the world by being published in the newspapers.

The Chairman: Sufficient evidence has already been given in support of the charges to establish a *primâ facie* case, but, of course, we do not know what evidence may be given on the other side. If we have persons before us who give evidence in regard to the charges, of course they will be protected. The question now is which persons are to be summoned to give evidence.

Mr. McVeagh: I propose, Your Honour, to summon the nursing staff, and, in order to facilitate the work of the Commission, it will be necessary to have interviews with them before they are called, to ascertain what evidence they have and how it should be laid before the Commission.

The Chairman: That is the usual course to pursue in regard to witnesses.

Mr. McVeagh: That is the position I desire to be placed in; but as matters now stand these witnesses are under a restraint. I ask that that restraint should not be considered as being in force.

The Chairman: When witnesses are once summoned, I presume the usual course will be taken with respect to interviews to ascertain what information they can give. We understand that Mr. Reed objects to persons going to the Hospital before the subpœnas are issued, to see what witnesses can give evidence. The difficulty might be got over by summoning the whole of the staff, in which case, of course, the objection would be out of Court.

Mr. Reed: I submit that it is an unheard-of thing that persons affected—and all the nurses are more or less affected in the matter—should be interviewed in order practically to induce them to give evidence against themselves.

The Chairman: There are no charges against the nurses that we know of.

Mr. Reed: No, but they are part of the Hospital staff.

The Chairman: There are no charges against the Hospital staff. The inquiry is one into the manner in which the Hospital is conducted, and how the Commission can find out without calling the staff I do not know.

Mr. Reed: There are certain specific charges. I presume it is well known who were present on occasions on which operations were performed, and they could be summoned to give evidence without being interviewed beforehand.

The Chairman: Yes, but that is only one part of the inquiry, which is into the whole management of the Hospital. We are bound to grant subpœnas and summon any witnesses asked for.

Mr. Reed: Quite so. We have no objection to the whole staff being examined if necessary.

The Chairman: It is very likely they will be.

Mr. Reed: But we have an objection to outsiders being allowed to go round amongst the officials in the Hospital, and so on.

The Chairman: Before they are summoned I do not think it would be advisable for the other side to interview them; but, as I have already said, the difficulty could be overcome by summoning the whole staff.

Mr. Beetham: Without interviewing any of them first?

The Chairman: Yes.

Mr. Reed: If any of these people are wanted they will come and give evidence, but, without any disrespect to the Commission, I think we would be justified in telling them that they need not give any information before being here before the Commission.

The Chairman: It would be rather rash of you to do that. It would not be right, and would probably prejudice your case. Of course, you may tell them, but they would be exceedingly foolish to obey you.

Mr. Reed: They could be brought here to tell what they know, but I do not consider it would be right for outsiders to go amongst them first to see what they can extract from them.

The Chairman: I do not see that persons employed in the Hospital are to be bound to secrecy in regard to all that goes on inside.

Mr. McVeagh: The rules say so.

Mr. Reed: The discipline of the Hospital could not be maintained otherwise.

The Chairman: Of course, they should not be permitted to tell stories outside which have no foundation in fact, but if a patient died in the Hospital, and the relatives went to the nurses to inquire about the case, it would be strange if they could not get the information.

Mr. Reed: That is a different matter.

The Chairman: We have already ruled that these witnesses may be summoned, and that the other side may interview them after being summoned.

Mr. Reed: Of course, we accept that ruling; but, as to outsiders (apart from the business of the Commission) being justified in making inquiries as to what goes on in the Hospital, I do not think that should be permitted.

The Chairman: To enjoin upon Hospital employees strict secrecy in regard to all that goes on in the Hospital is not reasonable.

Mr. Reed: Your Honour will readily see that if it goes forth from this Commission that nurses and other Hospital employees are entitled to go outside, and to criticize operations that may be performed, all discipline in the Hospital would be gone.

The Chairman: I do not go so far as to say that they should be allowed to criticize operations.

Mr. Reed: Or express opinions regarding them?

The Chairman: I do not know that we are called upon to decide that. Any idle gossip by employees, of course, ought not to be listened to, but total silence in regard to everything that goes on in the Hospital is another matter altogether.

Mr. Reed: We are very anxious to afford every facility in regard to obtaining evidence, and every assistance will be given in regard to the interviewing of the witnesses after the subpœnas have been issued.

The Chairman: Of course, that will be necessary.

Mr. McVeagh: I understand that they will be free from any consequences so far as the rules are concerned if I wish to interview them after being subpœnaed?

The Chairman: Undoubtedly.

Mr. Beetham: It seems to me that all the rules in the world would not stop the females from talking. (Laughter.)

Dr. Collins: The rule was made upon my appointment, because there was a junior nurse in the Hospital who brought a charge of malpractice against the Superintendent. It was to avoid a junior nurse or any irresponsible person doing anything similar that the rule was made.

William Moir, a seaman on the s.s. "Gael," said he accompanied Wallis White in the ambulance to the Hospital. When he went to the Hospital he saw somebody whom he told he had brought a sick man. He could not remember whom he saw. It was some one at the head of the steps. The man asked him if he had a certificate from a doctor. The man replied that he would not take any one in, unless he had a limb broken, without a doctor's certificate. Witness then went down to the ambulance, and remained there for about half an hour. At the end of that time a man came down; he did not know whether it was a doctor. White was groaning the whole time with pain. The man asked White where his pain was. White replied that it was on his left side. White was then taken into the Hospital; witness did not go in.

Mr. McVeagh: Did any one ask you for information about the case?—No.

What was White's condition on the way from the steamer to the Hospital?—He was groaning the whole time.

Mr. Reed: Was the man who came to the ambulance the one you first saw?—Yes.

Dr. Neil, whose examination-in-chief had been taken on the previous day, was then cross-examined by Mr. Reed, as follows:—

Mr. Reed: In regard to the operation on Wallis White, you said that shortly after you went to the bedside you suggested to Dr. Collins that in your opinion the case was not one of appendicitis?

Witness: I told him that he could not say that it was appendicitis for certain.

Did you form the absolute opinion that it was not appendicitis?—No, I did not.

In your opinion the matter was one of doubt?—It was a doubtful diagnosis. Appendicitis should have been excluded from the possibilities of the case.

Do you mean that appendicitis was not to be considered?—It should have been considered, certainly.

Do you say there was very little chance of its being appendicitis?—That is so.

What did you diagnose it as?—I concluded it was something on the left side in the groin.

Had you a very fixed opinion on that point?—No.

Do you say that from a surgical point of view appendicitis was an unreasonable diagnosis?—I say that, from the clinical history of the case that Dr. Collins could have got, it was an unreasonable one.

You say that, from what Dr. Collins told you, it was an unreasonable diagnosis?—He had very little ground to go upon. He acted without the fullest consideration.

In your opinion Dr. Collins should not have operated for appendicitis?—He should have opened over the middle line. That is sometimes done for appendicitis, as well as opening over the appendix.

Do you consider that he did wrong in opening over the appendix?—Well, he might have opened over the appendix, and then closed it up, and still have been acting correctly surgically. But he did not

do so, but went further. He dealt with the case without taking the full clinical history of the case into consideration. He seemed to have "appendix" fixed in his mind before he got to the bedside.

Was Dr. Collins right or wrong in opening over the appendix instead of on the middle line?—That is a hypothetical question.

It is a direct practical question. Was he right or wrong?—He would be justified in opening over the appendix.

You say he would be justified in doing it?—Yes.

I presume you were satisfied at the time that he would be right?—No, certainly not, from what the man told me.

You said just now that he was right?—I say that, with the clinical history he could have got, he should have cut over the middle line.

Did you draw Dr. Collins's attention to the examination you made?—Yes, I did. The man pointed to his left side as the locality of the pain, and I drew Dr. Collins's attention to that. Dr. Collins said the man was not consistent, but the man, on being again asked, once more pointed to his left side. I put my hand over his appendix, and asked him if he had more pain there than on the left side, and he said "No." Dr. Collins should have asked the man whether he had had any previous attacks of appendicitis.

Mr. Reed: What was the state of the man's pulse?—I cannot say.

You were willing to give the anæsthetic?—Yes.

Who were present?—Drs. Craig, Parkes, Ferguson, and King. I do not know whether Dr. King was there all the time.

Was any consultation held?—No.

Was one held before your arrival?—I cannot say, but I do not think so, as when I arrived Dr. Parkes was tapping about the abdomen. If he had consulted in the case, why should he do this?

Did you communicate to the other members of the staff your views of the case?—No; I was not asked, and there was no consultation.

You did not think it necessary to inform the staff that you considered there were no grounds for a definite diagnosis of appendicitis?—No.

Mr. Reed: Did you examine the patient before you gave the anæsthetic?—Yes; I put my ear to his chest.

Did you feel his pulse?—I do not remember, but I usually do in such cases.

What was the man's condition? Was he dying?—I did not think he was then, but he was when he left the table.

He was very bad?—He was.

Was it not necessary for you to devote your whole attention to giving the anæsthetic?—It did not require a great deal of attention in this case.

Did not the man twice come out of the anæsthetic?—He was under the influence of it all the time.

Did he not get into such a condition that he was not under the influence of the anæsthetic all the time?—Once or twice I think he vomited, or moved on the table, but that is a common occurrence.

Do you say that you kept the man, as he should be kept, thoroughly under the anæsthetic all the time?—Well, he was kept under all the time pretty well.

Pretty well?—Yes.

These abdominal operations are very serious, are they not?—Very serious for the patient, yes.

Death or collapse in such cases is usually due to shock, I believe?—Yes.

Is not the shock considerably increased by the patient being allowed to come out from the anæsthetic?—I do not think it would be very much increased; besides, it is a good thing sometimes to allow them to come out. It has a compensating advantage. When a patient comes round and vomits it sometimes improves his pulse and condition.

Did you purposely allow him to come round?—I kept him lightly under the anæsthetic.

Would that not require constant attention, and could you give it that attention and at the same time watch the operation?—I gave all the attention necessary.

Was your allowing the man to come round done purposely or accidentally?—Well, "incidentally" would be a better term than "accidentally." It was an incident in the matter. You do not understand anæsthetics.

Possibly not, but I understand common-sense. Was it done intentionally or not?—It was not done intentionally.

It was unintentional, then?—I did not intend him to come round.

Was it due, then, to your watching the operation?—It would have made no difference if I had watched his eyes all the time. I kept him very lightly under the anæsthetic. If he made a slight move I would give him a few more drops.

If he struggled, would that not stop the operation?—Not necessarily.

Not when sharp instruments are being used?—It might, perhaps, for a few seconds.

Is not a few seconds in such a case a serious matter? Could you not have prevented him coming round?—I could have by putting him deeply under the anæsthetic; but that would not be good for him.

Could you not, even if he were only lightly under, have prevented him from coming round by watching him?—It would all depend on who was operating on him. If the operator gave a certain amount of pain the patient might move, and I would give him a few more drops.

You were standing by the head of the patient?—Yes; I was sometimes sitting and sometimes standing.

When the abdominal incision was made were the bowels distended?—Not very distended.

Do you say distinctly, and pledge your oath, that the appendix could be found without reducing the distension of the bowels?—It was seen and found.

You absolutely pledge your word?—Yes, I do.

I have medical evidence to show that it could not be seen without reducing the bowels?—Who? Are they the "three ulcer and the one incision men"?

From a surgical point of view, is there any difference between an incision and a puncture?—Well, it is simply a matter when to——

What is the difference?—An incision implies a cut, does it not?

I am asking you what is the difference. If a scalpel is inserted and strikes down into the matter, is that a puncture or a cut?—It depends upon the width of the scalpel wound. The difference between an incision and a puncture is in size.

Do you say that a surgeon in describing a case would make no distinction between the two, except as to length?—An incision is a cut with length, and a puncture is a pointed stab. These are fine points—like splitting a hair.

Were the bowels distended with gas?—Yes; there was gas in the bowels. What else do you expect?

Was any puncture made in the bowels to relieve the gas?—In the small intestines a puncture was made.

Was there a puncture made in the large intestines to remove gas?—No. There were two incisions made to remove fæcal matter.

Was any fæcal matter taken out of both incisions?—Yes, there was.

What was the length of the smaller incision, speaking on your own recollection?—I cannot give the length definitely.

Was it longer than the breadth of the scalpel?—The smaller incision in the peritoneum was larger than the width of the scalpel.

The matter of having a blackboard, on which to draw diagrams, was mentioned, and Mr. McVeagh intimated that Dr. Neil had provided a blackboard and chalk if it was required by the Commission. The Chairman received the intimation with a smile.

Mr. Reed: Did the cut, or incision, or puncture contract after death?

Witness: It was immaterial what it was like after death. I think there would be no marked difference provided the body or subject of the tissue was not put in any hardening substance.

Assuming that you could not get at the appendix without reducing the distension in the bowels, was what was done the correct thing?—No.

You understand the assumption?—To reduce the distension of the bowels by making two incisions to remove fæcal matter; certainly not the correct thing.

What ought to have been done?—The cut could be enlarged.

But if the cut was enlarged would not more of the distended bowel come out?—You would get at the appendix, would you not?

If the bowel was very distended, was not the incision the right thing to do?—If the bowel was very distended a slight puncture would be justifiable, but not to make incisions 2 in. in length.

Have you performed any abdominal operations?—Yes. One on the battlefield in South Africa; but I have never done any in New Zealand. I have assisted in a number.

In the same way as Dr. Ferguson assisted in this particular case?—I think this was his first case.

How many abdominal operations has Dr. Collins performed at the Auckland Hospital?—I do not know.

Has he done a large number?—I cannot say exactly how many he has done in breaking the Hospital rules.

Has he done a dozen?—I suppose so.

Twenty?—Yes, I dare say.

Dr. Collins has done twenty, then, in Auckland, and you have done one in South Africa?—Yes.

Dr. Parkes has also performed similar operations?—I suppose he has.

Well, when this operation was completed, did you express to the doctors present your indignation at the way it was performed?—I do not remember expressing my indignation.

Did you express any opinion adverse to the operation?—I do not remember.

After the operation you had coffee and a chat with the other doctors present?—Yes, that is so.

Why did you not mention your indignation then?—I do not know. The matron was present in the room, and I would not discuss it in her presence.

You did not discuss it with any one until after you went to the Chairman of the Board, behind Dr. Collins's back?—I discussed it with other members of the staff, and let them know my opinion about it.

Supposing these doctors gave evidence that you said nothing about it, that you had your coffee and chatted, but made no adverse criticism of the operation, would you deny it?—If the "three ulcer and the one incision men" say so, I would.

What do you mean by that? Do you mean you are prepared to deny anything these men may say?—Are their statements not to be denied? I deny there was only one incision in the large intestines, and there were three ulcers in the stomach.

If the doctors who were present at the operation and after it say that you made no adverse references to it, are you prepared to deny it?—I do not remember.

If this great indignation you speak of was in your mind, why did you not say something then?—I could not say it while the matron was there.

Did you make any statement to Dr. Collins?—No, I did not.

Any statement to the doctors who were present at the operation?—I communicated with Dr. Scott and saw Dr. Parkes.

Was Dr. Scott there?—No, but——

I am perfectly aware that you discussed the matter outside afterwards, but until it came out that you had gone to the Chairman of the Board did you make any official statement to the doctors present?—I met Dr. Parkes outside by the gate, and said to him how indignant I was, expressing my determination to bring the matter under the notice of the honorary staff. He said, "Yes, wasn't it sickening." I communicated with Dr. Scott, and met Dr. Collins in his room on the Friday afternoon.

We have Dr. Parkes here, and we will see what he says?—I make the statement that it is correct.

You went to the Board Chairman before saying anything to Dr. Collins about the operation?—That is quite so.

I am not denying your right to communicate direct with the Chairman, which was probably the proper thing to do, but is it considered professional to make complaints about another surgeon without having spoken to him first?—I went to the Chairman to tell him about the operation.

My question is, is it considered professional—I am simply asking for information, because I do not know—to go and speak about another surgeon's operations behind his back?—I was waiting to see Dr. Collins, and went to the Chairman.

Did not Dr. Collins speak to you first about your adverse remarks on the operation?—Yes, that is true.

You did not go to him voluntarily?—I received a communication from him, and then I went and saw him. He sent for me.

That was the first time you spoke to him about it?—That is quite so.

It was some days after the operation?—No, not some days; it was Friday. I went to the Hospital the following morning.

Did you speak to him then?—No; he was not there. If he had been the scene would have occurred earlier.

You say there was only one ulcer?—Yes; I said that to the Board, and I say it again.

Was the ulcer in the stomach?—Yes.

In the dudene?—No.

In addition to the ulcer in the stomach, was there one in or near the dudene?—You are trying to double it.

No, I am not. Was there one in the dudene?—There was only one ulcer; there was no second one.

Then, you say it was quite impossible there could have been two ulcers—one in the stomach and one in the dudene?—Of course. I saw the exhumation.

I know you did. But was it impossible there were two ulcers?—You are quibbling as to where the dudene and the stomach is.

No, I do not want to quibble at all.

The Chairman here asked for a diagram showing the location of the two organs, and Dr. Savage produced the requisite sketch.

Mr. Reed: Was there a possibility of two ulcers being present?—I did not see two ulcers.

Do you swear there were not two?—No, I do not.

In regard to the stitching, was silk used?—I am not very definite on that point, but I think there was silk.

Was not silk used to sew up the incisions?—He used a lot of fish-gut too.

Do you remember what was used, or is it supposition on your part?—No, it is not supposition. I saw fish-gut when the exhumation was made.

Can you say definitely what was used?—One does not pay much attention to what is being used.

Well, why do you not say that? Do you recollect silk and fish-gut being used?—Yes, I do.

How long was the patient on the table altogether?—Over two hours, I think.

What might I understand by your remark on Tuesday about 50-per-cent. chance of life?—Taking the statistics of such cases, you will find that 50 per cent. of persons operated upon within twenty-four hours are cured.

Do you say that statistics prove that 50 per cent. recover when so operated upon?—I think I have seen 50 per cent. stated; at any rate, 48 or 50. Some surgeons have even better results.

You are speaking of the chance of recovery before the operation?—No. It is the surgical treatment that is responsible for the chance of recovery. I mean, by the aid of an operation, with a skilful operator, there is a 50-per-cent. chance of life.

Is it as high as 50?—Some surgeons have had as many as five successful cases running.

But you cannot take individual instances as an average. Do you deny that the average is 75 per cent. of deaths?—I would like to know where the statistics came from first.

Reverting to the operation, and Dr. Neil's criticism thereon, Mr. Reed further inquired of the witness: You saw Mr. Garland the following day?—Yes.

You are aware that Mr. Garland says you told him that Dr. Collins was converting the operating-theatre into a "damned shambles"?—Yes, I understood that at the meeting.

You denied having said anything of the kind?—I denied having used the words in the way attributed to me.

At the Hospital Board meeting you made no explanation as to the use of the term "damned shambles"?—No, I did not.

Until yesterday, did you make any explanation of the term such as you gave the Commission, which took all the sting out of it?—Yes, I did.

Who to?—To several people.

Name one person?—To my solicitor.

Other than to your solicitor, have you made the explanation until yesterday?—I think I have.

Can you say to any one you have?—I have spoken to several persons about it.

When you had such a simple explanation, why did you not give that to the Board?—The matter was not gone into officially.

You say what Mr. Garland stated is untrue?—That is so.

Can you suggest any reason why he should make an inaccurate statement like that?—I cannot surmise what is in Mr. Garland's mind.

Can you suggest any interests he had at that time?—I cannot surmise what is in his mind.

Did you tell any members of the medical profession that Dr. Collins was converting the operating-theatre into a "septic shambles," or used words similar?—I have no recollection of doing so.

You have heard several doctors say you have?—No, not several; only one doctor, and he said I made the statement while a guest at his house.

Is it untrue?—I have no recollection of making the statement whatever.

You were at the Hospital on the Friday, and had an interview with Dr. Collins?—Yes.

He sent for you?—Yes.

And you went to his room?—Yes.

He said, "Neil, is it true that you are trying to set the staff against me," &c.?—Yes.

Then, in your own words, "you advanced towards him." What did you do that for?—I was angry, and one's impulse is in that direction when in that frame of mind.

Matters were somewhat heated?—Yes.

Did you come to blows?—I expect we should have done so.

In the same interview you told him he was being watched by dozens of unfriendly eyes. Who did you refer to?—I knew that the general opinion of the medical men in Auckland was unfavourable to the Hospital work, and Dr. Collins said to me himself, "That woman" [referring to the matron] "is trying to set the nurses against me, but I will have her out in six months."

Were your eyes unfriendly?—My eyes were not unfriendly.

You were not referring to yourself as unfriendly?—No; we were friendly at that time. I had no trouble with Dr. Collins previous to that.

Up to that time you were satisfied with him?—We were friendly. I never told him straight to his face or had a "row" with him.

Up to this time were you on friendly terms with Dr. Collins?—We had had no trouble.

On the surface you appeared to be friendly?—I do not know what you mean.

Apparently you were friendly?—I say we had had no disturbance.

Were you acting in a friendly way to him outside the Hospital prior to this "row"?—I do not remember.

Were you discussing him outside?—I have no recollection of being on unfriendly terms with him.

At the inquiry held by the Board, which you attended by invitation, there was a scene between you and Dr. Collins?—What scene do you refer to?

Did you say to Dr. Collins, "Don't point your finger like that at me"?—We had a few words.

You had some hot words?—Yes.

You gave the Chairman the lie direct about the "shambles" statement?—Yes; and I will do it again.

You still complain that you were dismissed by the Board?—Of course I do.

Can you suggest how the Hospital could be carried on with Dr. Collins as Senior Medical Officer, and you on the honorary staff, with the unfriendly feeling existing between you?—After hearing the statements made at the Board meeting I was very angry.

You charge the Board with acting wrongly in dismissing you. What should the Board have done under the circumstances? Dismissed you or Dr. Collins?—Dr. Collins had handed in his resignation, and then afterwards persuaded the Chairman to suspend me. The Chairman had no right to be dominated by the Senior Medical Officer.

How should the Board have acted, then?—The Board should not have taken the matter as hostile criticism, but should have inquired fairly and properly into it. Up to the time of the operation there was no suspicion of unpleasantness between us, although I was accredited with telling Mr. Garland, on the 19th May, that Dr. Collins was converting the theatre into a "damned shambles."

What caused the suspension?—Because I got the honorary staff to pass a resolution in regard to the emergency work.

Do you know when Dr. Collins heard of the "shambles" statement?—I believe he knew right off—that was in regard to the honorary staff, but not in reference to Mr. Garland's allegation.

What else could the Board have done but dismiss you?—They could have asked Mr. Garland what possessed him to keep the secret in his

breast from the 19th May till the 9th August, when my suspension was brought about.

Would it have been possible for you and Dr. Collins to work satisfactorily together in the Hospital?—If Dr. Collins kept in his right place it would have been.

That is, subordinate to you?—He should be subordinate to the honorary staff.

When were you first dissatisfied with Dr. Collins's surgery?—I don't remember.

When did you join the honorary staff?—Some time in March or April, in 1903.

Can you say, then, when you first became dissatisfied with the surgery work?—I can't exactly say when. I knew he was not a brilliant surgeon. I did not think he was the best surgeon in Auckland.

When did you become dissatisfied?—I expressed dissatisfaction officially when I raised this trouble.

For twelve months as honorary surgeon you were satisfied?—I raised no complaint about his surgery.

Were you satisfied or dissatisfied?—It is very hard to think of any instance.

You haven't a clear enough recollection whether you were dissatisfied until the White case?—He did his casualty work very well.

I ask about his surgery generally?—I can't say that I saw him doing abdominal surgery, except in one case, in which Dr. Lewis stood over him.

Mr. Reed continued to press the question on Dr. Neil as to the date when he became dissatisfied, but the witness persisted in stating that he could not give a definite opinion. He admitted writing a letter, at the direction of the honorary staff, while he filled the position of secretary, transmitting recommendations to the Hospital Board, in which the following extract occurred: "The honorary staff are of opinion that the suggestion as regards the emergency surgery is an excellent one. For some time past the serious emergency work has, in the absence of the surgeon for the week, been performed by the Senior Medical Officer, to the entire satisfaction of the honorary staff." Dr. Neil said he was also a member of the honorary staff at that time, but he said it was the intention of the staff to refer to the casualty surgery work.

Mr. Reed: Do you swear that was intended as a distinction?—I took it that was the meaning I had to convey.

How is it that no such distinction was made in your letter?—Dr. Collins would not have had the emergency work in full swing by that time.

Do you say that before that letter Dr. Collins had not done abdominal work?—I saw him only on one case under the inspection and supervision of Dr. Lewis.

Do you say he only performed the one?—No, I don't say that.

You said earlier in the day that Dr. Collins had done twenty abdominal cases, and nineteen had been done before March?—I did not intend to convey that meaning.

What do you mean, then?—That letter was a reply to a letter from the Chairman of the Board, asking for the staff's opinion in regard to the appointment of assistant surgeons who would take away the casualty work from the residents.

Mr. Reed then produced a copy of the Chairman's letter, which was published in the *Herald* of the 8th March, 1904, and contained the following extract: "It has been claimed by some that the assistant surgeon should take the operations when the honorary surgeon is absent. With this I most emphatically disagree. Instead of such a procedure, I should much prefer to know that, in the absence of the honorary surgeon, the Senior Medical Officer, who is responsible to the Board, should operate, being assisted by the assistant surgeon. In other words, when the honorary surgeon for the week could not be present, then the Senior Medical Officer should take his place."

The Chairman said the copy could not be put in, except in the legal way, and providing Dr. Neil swore positively that the copy was an exact and true one of the communication received by the honorary staff from the Chairman.

Dr. Neil said he could not swear it was a correct copy, and Mr. McVeagh intimated that he would like to read the letter, and also confer with his client in regard to it during the luncheon adjournment. The matter was allowed to pass.

Mr. Reed: You were telling us yesterday the different positions you had held. Were you ever at the Dunedin Hospital?—Yes.

While there did you have a similar dispute as this?—No, I had not.

You had no dispute on leaving the Dunedin Hospital?—I don't remember.

Was not your leaving the Dunedin Hospital due to the dispute you had?—That is entirely false.

Did you have any dispute with the officials?—No, I did not. I received testimonials from members of the staff and others, and most cordially said good-bye. This is an insinuation that there was something, and you should bring it out. Make a direct charge. It is a false insinuation you are making.

I don't make an insinuation, but I have been instructed that you left in consequence of a dispute?—That is absolutely false.

Dr. Neil later on again referred to this matter, and repeated that the insinuation was an unwarrantable one. He exhibited his watch-chain, which he said was given to him when he left the Hospital at Dunedin. It was, he said, the only chain of the kind given by the Hospital staff for the past twenty-one years. To make such an insinuation, when it was absolutely false, was very wrong.

The Chairman: Mr. Reed had a right to ask the question in the course of his cross-examination, and we freely accept your denial. It is not as if the Commissioners were ordinary jurymen. With the latter the matter might carry some weight, but not so with the Commissioners.

Dr. Neil: Thank you, Your Honour.

Mr. Reed: I do not suppose ordinary jurymen would take any notice of such a question when a denial was given.

The Chairman: Jurymen are very apt to be guided more by the question than the answer in such cases.

Continuing his cross-examination, Mr. Reed asked Dr. Neil: You have taken a great deal of interest in this inquiry?—Yes.

And you started an office for the purpose of receiving charges?—I did.

Were you responsible for the insertion of an advertisement in the paper asking for people who had complaints to make?—I asked for information.

Mr. Reed produced the following advertisement, which Dr. Neil admitted he had caused to be published: "Hospital Reform: All persons having information throwing light on the management of the Auckland Hospital are invited to communicate with the Hospital Reform Office, 10, Coombes' Arcade. Hours, 10 to 12 a.m., 2 to 4 p.m."

And you engaged an office?—Yes.

And a clerk?—He came to me of his own free-will, and offered his services.

Do you know the number of patients who go through the Hospital during the year?—About two thousand.

From your experience of hospitals, I presume you would expect to find a few dissatisfied patients?—It would depend upon the management.

At all hospitals there are to be found persons with complaints?—That is human nature.

I suppose you had no difficulty in getting persons who had grievances?—No.

Were any of the persons with grievances told that there was no necessity for them to say anything further?—Who said that?

Do you know a man named Hulse?—Yes.

Did he come to see you?—He sent for me.

His was a complaint against the honorary staff?—I understood that. I went to his house at his request, and heard his complaint, which I inquired into, and informed him that it had no foundation.

Because he had no charge against Dr. Collins he was told he was of no use?—Certainly not. I said his complaint was groundless.

Did you tell him that?—I don't recollect.

In regard to the different kinds of diseases being dealt with in the same wards, did the same condition of things exist when you were senior resident at the Hospital?—There was some attempt at segregating the cancer cases more than they do now.

They were then put in available places from time to time?—Yes.

Consumptive cases?—They are being dealt with in something the same manner as then.

Delirium-tremens cases?—They are put downstairs almost invariably.

Is that done now?—They are put in the typhoid-fever ward. These cases should be isolated.

With the present accommodation, where do you suggest they should be put?—Make room for them.

Where is the room?—There was a spare room in my time. It is practically the same now as in my time.

How about the semi-lunacy cases?—They were dealt with on the same lines as the others.

The Chairman: Surely semi-lunacy cases are not put in the Hospital.

Dr. Collins explained that there were cases in connection with which doctors gave certificates of insanity, but not to commit them to asylums. In these cases the afflicted could not be attended at their homes, and consequently the Hospital was obliged to admit them.

The Chairman: If they are insane they should be in the asylum, but if not insane they should be at home.

Dr. Collins stated that in such cases friends, who have the looking-after of the sufferer, have to go to work during the day, and it was not safe to leave the semi-lunatics by themselves.

Dr. Roberton: There is a want of accommodation for this kind of cases at the Hospital.

The Chairman: One doesn't quite see where the borderland comes in. A person should be sent to an asylum, or he should not.

Dr. Roberton: This is one of the matters upon which we hope the Commission will give an opinion.

Mr. Beetham: In Christchurch the Hospital authorities won't touch lunacy cases; they won't look at them.

Dr. Neil, continuing, said, in Dr. Bedford's time at the Hospital steps were taken to remove these semi-lunacy cases, otherwise the condition was about the same.

Mr. Reed: On the whole, then, practically the same position is to be found to-day?—Yes, practically the same.

Mr. Reed then passed on to the consideration of the Hospital regulation that a patient is not admitted unless he produces at the time of making the request for admission a recommendation from a medical man, even though the case be urgent.

Mr. Reed: Was this regulation in existence in your time?—No, it was not. I have myself admitted typhoid and other urgent cases.

Dr. Roberton pointed out that the regulation had existed for a long time past, but it was left to the discretion of the authorities to enforce.

The Chairman: It is a monstrous regulation which provides the sending-away from the Hospital of cases in order to get a recommendation from a medical man. Further on, the Chairman characterized it as ridiculous and absurd.

Mr. Reed: You complain that Dr. Collins performs *post-mortem* work four days before operating in an abdominal case. Do you not know that in many cases operating surgeons in hospitals are also demonstrators of anatomy?—Well, I don't think the practice exists at present. It did some time ago, but the progress in surgery made it a rule to exclude the men. The leading surgeons of Auckland do not do *post-mortem* work.

Demonstrators of anatomy would necessarily perform *post-mortems?*—They work on bodies which are preserved in antiseptics, and specially prepared in order that septic material should be destroyed.

If that precaution is taken is there any objection?—The precautions must be very minute.

Do you know any instance of the operating surgeon being the demonstrator of anatomy?—No.

Precaution can be taken to insure safety?—It can be, but it is going to an extreme point.

Have you done *post-mortem* work and an operation afterwards?—Not abdominal work.

Have you performed other operations?—I may have done others, but not abdominal cases.

Have you not on the same day, at the Hospital, done *post-mortem* work in the morning and an operation in the afternoon?—I don't recollect, but it is not an impossibility.

Of course, there is an increased danger in abdominal cases, but is there no danger of infection in any operation?—Yes, but very nominal.

In the case of Martha Gordon you have referred to, do you know if she suffered any ill effects from Dr. Collins following this objectionable practice?—I mentioned that case as an instance of what was going on. I do not suggest that the patient died from any evil effects resulting from the practice.

Mr. Reed: In connection with the inoculation of guinea-pigs with anthrax, are you prepared to say that the statement is correct?—I cannot bring evidence to prove that. Personally, I don't know anything about it.

Did any anthrax show itself at the Hospital?—The case of the boy Brown, but he brought it in the anthrax.

Was there any other cases?—I have no recollection of any, but the practice of experimenting was a dangerous one.

Did any evil effects proceed from what Dr. Collins did?—I say it is typical of the work done, which is absolutely wrong.

Mr. Reed read an extract from a letter dated the 11th May, written by Dr. Inglis, as secretary of the honorary staff, as follows: "That, owing to advances made in the science and art of surgery, most of the more important operative work, especially on the head and abdomen, falls under the heading of emergency work." Do you agree with that?—I would like time to consider and give my suggestions later.

Mr. Reed: In one of your letters to the newspapers, written since the trouble, you state that the rule had been altered, but you did not know how the alteration had been done?—Yes, I did. When I was formerly on the staff abdominal work was being done by the honorary staff, and done well, but since my return the urgent abdominal work has been done by the resident staff.

Have you ascertained that the rules had been altered at the request of the honorary staff?—I have Dr. Collins's statement that he personally revised the rules.

Mr. Reed: In the case of Clarence Walters you say that the pus was not removed. Did you observe its presence at the time?—I suggested an examination.

Did Dr. Collins not sponge the pelvis?—He could not have done it properly.

How long did the boy live after the operation?—I think he died that night, or very shortly afterwards.

Would the pus go on forming?—It does not go on forming in the body of a dying person. Only a small portion would form whilst he was dying.

Was there a large quantity?—Yes; I drew Dr. Collins's attention to it.

You say the boy would have died in any case?—Yes, I think he would. What I object to is the resident staff taking urgent cases when lives are in absolute danger.

You have said that members of the honorary staff should be rung up. Would you wait till they were all collected?—I think it better to wait the arrival of the staff than to indulge in hasty and senseless operations.

This concluded Mr. Reed's cross-examination of Dr. Neil.

Dr. Collins then proceeded with his cross-examination of Dr. Neil, as under:—

Dr. Collins: Did you see Clarence Walters when he came into the Hospital?—I first saw him on the operating-table. I came in during the operation.

What was his condition?—He was suffering from general peritonitis and its effects.

It was an emergency operation, was it not?—An emergency abdominal operation, yes.

You were at the *post-mortem*. What made you go there? Did I ask you to?—I do not remember. I do not believe you did.

Did any one tell you the boy was dead?—I do not remember. The boy was dead all right. There was no question about that.

How many hours after did he die?—I do not know. I saw him dead next morning.

Will you swear that?—It is within the bounds of possibility that it was twenty-four hours afterwards, but my impression is that I saw him dead next morning.

You told Mr. Reed yesterday that he died some hours afterwards? —Produce the Hospital records.

The boy came in on the 17th July, and died on the 19th. How can you say it was a few hours after the operation?

Dr. Neil: What time on the 19th did he die?

Dr. Collins: About 4 o'clock.

Dr. Neil: In the afternoon?

Dr. Collins: I am not here to answer questions.

Dr. Neil: You must show the records. I cannot take your statement otherwise.

Dr. Collins: Who were there?—The porter, yourself, Dr. Ferguson, and Dr. Walsh.

What did the boy's abdomen contain?—A large quantity of pus, enough to cover the floor of the pelvis.

What did you say at the time?—I cannot remember.

Do you remember saying in front of the porter and myself that everything would be done for the boy that could be done?—I certainly do not remember saying that.

If the others present are prepared to swear that you did say this, are you prepared, on oath, to deny it?—That is a big question to ask a person.

Do you remember that there was some difficulty in finding the boy's appendix?—I have no distinct recollection of it.

Do you remember an orange-pip being taken out of the appendix? —I do not.

Do you not remember taking a knife out of your pocket and trying to cut the pip?—Why should I take a knife out of my pocket when there were other knives there?

Do you remember it?—I do not, but I may have done it. (After a pause): I believe now I do remember you saying there was an orange-pip there, and my saying that it was not a pip, but fæcal concretions, and that I cut it to show you what it was. It is a common fallacy to mistake fæcal concretions for other substances in such cases.

What methods are generally used to get rid of pus from the abdomen?—It should have been cleaned out with sponges, and the locality should have been searched to remove it all.

Are there not advantages attaching to washing the stomach out with a saline solution?—Certainly there are.

How can you say that I did not take that precaution to remove the pus?—Because the pus was there at the *post-mortem*.

In a bad case of acute appendicitis, with septic peritonitis and strangulation of the bowels, such as that boy had, do you not get adhesions in the pelvis.

Dr. Neil: Do you mean recent or chronic adhesions?

Dr. Collins (raising his finger): Answer me now.

Dr. Neil: Don't you point at me, Collins.

Dr. Collins repeated his question, and Dr. Neil again answered with the query, "Recent or chronic?"

Dr. Collins: How can they be chronic if the case is one of acute appendicitis?—In that case they would be recent.

Is it wise to break down these adhesions?—No.

You must have means of knowing what I did to get rid of the pus? —No.

A number of technical questions, relating to the details of abdominal operations, were then asked. In reply to one of these Dr. Neil said, "Do you not know that Nature herself does that, and that Nature is the best surgeon in Auckland probably to-day?"

Dr. Collins: You have accused me of doing *post-mortem* work while I was doing surgical work. Can you quote instances?—Yes; the afternoon Drs. James and Stirling were at the Hospital, the day of our interview regarding White's operation. You were doing abdominal *post-mortem* work.

Were you not working at the time yourself?—Yes, but not on the intestinal tract. I was working on the ear and part of the neck, which is not such an infected area.

What did the patient die of?—I do not know.

Was there not as much infection where you were working as where I was working?—No.

What operation did you do after that?—I have no recollection.

You said that surgeons that do *post-mortem* work are not welcomed in operating-theatres. Who administered the anæsthetics for you when you did operating work?—Drs. Walsh and Frost.

Did not Dr. Frost do *post-mortem* work?—I do not know. I think she was ignored in the matter, and that it was done by a resident.

Has she not done *post-mortem* work during the past twelve months? —She may have done some, certainly.

Dr. Collins: Has Dr. Frost not done the work day by day in the bacteriological laboratory?—She has not been doing anthrax-cultures.

Will you answer my question, Dr. Neil?—She has, yes.

Has she not done all the work in connection with the plague?—She was the one who made the diagnosis, but the newspaper report said you made it.

Has she not done all the typhoid work?—Yes.

Has she not done work on anthrax bacilli?—No, it is too dangerous.

If I produce anthrax slides made by herself will you deny it?—I am not certain about it. She may put a smear on a slide, but that is a different thing to inoculating work, which is very dangerous. She has not worked in the way you have.

Has she not made cultures?—She may have, but not in the way you have.

The Chairman: Have you seen her making them?—She may have put smears on slides, but she has never made experiments on animals as Dr. Collins has.

The Chairman: Well, we will call Dr. Frost, and see exactly what she does.

Dr. Collins (resuming his cross-examination of Dr. Neil): Were any guinea-pigs inoculated with anthrax at the Hospital?—I believe so.

Who told you so?—You will find out when the evidence is brought before the Commission.

Do you know it of your own personal knowledge?—No, I do not know.

Do you know of your own knowledge of animals having ever been inoculated with anthrax in the Hospital?—Not in my time of residence.

You have charged me with inoculating guinea-pigs?—Yes, and I will bring you evidence.

You have acknowledged that Dr. Frost has been working with anthrax, that she has been doing *post-mortem* work, and that she has given anæsthetics for you in your operating work. Is it not strange that you should bring such a charge against me when you yourself have been guilty of furthering these principles in the Hospital?—I have not been guilty of them. I have set my face against it.

How can you say that when Dr. Frost has done these things at your request?—She has not done the same as you. You were working a long time with anthrax as compared with Dr. Frost.

Has Dr. Frost done *post-mortem* work?—Not consistently.

She has worked on anthrax bacilli?—She is a skilled bacteriologist.

Dr. Collins: Do not make rude replies. It will not do you any good.

The Chairman: There was nothing in that reply. He was only speaking of Dr. Frost's qualifications.

Dr. Collins was proceeding with his question regarding Dr. Frost, when the Chairman said, "We are not called upon to examine into Dr. Frost's conduct."

Dr. Collins: I am charged with certain things, and I am trying to show that she does them.

The Chairman: That would not make it right if it were wrong.

Is it a recognised thing for surgeons of the present day to work on dead subjects?—A surgeon should have more thought for the patients under his care than to consistently perform abdominal *post-mortem* work. He must of necessity do *post-mortem* work at times, but at such times he should keep away from abdominal operative work.

Is it not customary for a surgeon to sterilise his hands?—To do that thoroughly would take a long time.

What time would it take?—Perhaps from fifteen to twenty minutes.

You have said that I did operative work four days after doing *post-mortem* work. Would that not give me time to thoroughly sterilise my hands?—Yes, but you are very perfunctory in your asepsis.

Do you consider yourself justified in saying that?—Yes, I do.

Can you specify one case in which I operated in which I got suppuration?—I have none in my mind at present, but I know of some at which you have assisted. You assisted at a number of cases in 1902, when there was a wave of suppuration in the Hospital.

Was there not then a wave of suppuration throughout Auckland?—No. I can produce records to show it.

Was not one of the private hospitals (named) closed in 1902 on account of suppuration?—Not on account of suppuration.

Was it closed on account of sepsis?—I have no knowledge of it. I would like to hear what the people connected with it have to say about it.

In answer to further questions, Dr. Neil said that a resolution had been passed by the honorary staff to the effect that surgeons doing *post-mortem* work should not do surgical work during the same week.

Dr. Collins: How do you know that I did not get to the Hospital till half-past 10 in the morning?—Every one knows it.

How many times have you been there before 9 a.m. since March, 1903?—I do not know.

You have been there twenty times. You have signed the book that number of times. Do you know that?—That is nothing. I may have been there a hundred times.

How many times have you been there between 9 and half-past 9 a.m.?—I do not know.

You have been there thirteen times.

The Chairman: How do you arrive at thirteen times?

Dr. Collins: I have taken it out of the attendance-book.

The Chairman: Do all the doctors sign that book?

Dr. Neil: Dr. Frost is there at 9 every morning, and she does not sign it.

The Chairman: That book must be produced.

Mr. Reed: It is in daily use, Your Honour.

The Chairman: Daily use or not, it must be here.

Mr. Reed said the book would be sent for at once.

Dr. Collins (to Dr. Neil): Do you consider my not being there till 10 in the day interferes with the work of the Hospital?—Yes.

Do you not think that the irregular attendance of the honorary staff also interferes with the Hospital work?—It would if they were as irregular.

From the 10th April to the 9th August, how many times did you attend the Hospital?—I attended more times than were set down for another surgeon who had more cases than I had.

You should have attended ninety-four days during that time, and you attended only on sixty days.

The Chairman: There is nothing to show how often Dr. Neil attended.

Dr. Collins: I will have the attendance-book brought here.

The Chairman: That will not necessarily show it. He says he did not always sign it.

Dr. Collins (to Dr. Neil): Is it likely that you would forget to sign the book thirty-four times?—I was very dilatory in signing the book, I admit that.

Before you were nose, ear, and throat surgeon you were honorary anæsthetist. The following resolution, I believe, had been passed: "That the honorary anæsthetist should be present and administer anæsthetics on regular operating-days, and in emergencies whenever his presence is required by the honorary surgeon notification will be received from the Senior Medical Officer"?—I have an idea that before I was appointed the honorary staff were asked to define my duties and make a recommendation, but I am not aware of such a rule being made.

Do you know that 398 anæsthetics were given during your term, and that you administered only 147?—Probably I was passed over.

If that were so, would you not have complained?—I might have been passed over without knowing it.

Is it not a fact that you would only go when certain surgeons were operating?—That is not so.

Do you know how many anæsthetics were given to March, 1904?—I cannot say.

There were 520——

The Chairman: You are giving evidence, Dr. Collins, but really we cannot take any notice of it. It can be given on oath afterwards.

Dr. Collins (to Dr. Neil): In White's case, how was the pulse and temperature?—The pulse was rapid and the temperature low.

Are those not symptoms of collapse?—The term "collapse" covers a wide range of ground.

What is meant by "collapse"?—It simply means collapse.

Did I not send for you immediately White was admitted?—You sent a message to me that you wanted to see me about an urgent case.

Did you not come at once?—No; I was doing my professional work, and I think you sent a second time.

When you saw the patient did you not try to get a clinical history of his case?—No; you should have done it as resident physician—you should have rung up his friends.

Did you ask any questions of the boy who brought him?—The boy only came to the steps for half an hour, and went away again. What a stupid question!

Could the man's friends have given a better history than the man himself?—Yes. You could have got to know where he was taken ill, where the pain was, and whether he had had any pains on the right side.

Did you offer any diagnosis?—I said that you could not dogmatically say that it was appendicitis.

Was not the boy suffering from peritonitis?—He was.

Do you not get pains all over the abdomen in peritonitis?—Yes, it is possible; but you can generally get an idea of the locality of the origin of the peritonitis.

Dr. Collins questioned Dr. Neil extensively on the question of the difficulty in diagnosing cases of peritonitis, and read authorities to prove certain points he wished to establish.

Dr. Neil objected to extracts being made without the context also being read. Dr. Collins read an extract from the *British Medical Journal*, and Dr. Neil interposed with the remark, "You are trying to prove that you were going to save the man's life by removing two pieces of fæcal matter the size of walnuts. It is insulting to the intelligence of the Commission."

Dr. Collins (to Dr. Neil): There is no advantage to be derived from being insulting, Dr. Neil.

The Chairman: There is discourtesy on both sides. I hope the profession consists entirely of gentlemen, and that everything of an insulting character will be eliminated.

Both Dr. Collins and Dr. Neil apologized to the Commission for having erred, explaining that they had not done so intentionally.

Dr. Collins continued to read extracts from the *British Medical Journal*, when the Chairman suggested that the best arrangement would be to read passages, allow the witness to read the context, and then for Dr. Collins to ask the witness whether or not he agreed with the opinions expressed in the *Journal*.

After a few more questions of a technical nature the Commission adjourned.

On the 20th October Dr. Collins continued his cross-examination of Dr. Neil, as follows:—

Dr. Collins: You said you considered a 50-per-cent. chance of life was dissipated in White's case. Do you know the percentage of mortality in perforated-gastric-ulcer cases?—It varies; it has been 100 per cent. in the Auckland Hospital this year.

Dr. Collins: I mean according to generally recognised statistical tables?

Dr. Neil: Supposing I do not recognise them. You must show them to me before I will recognise them in any way.

Dr. Collins: Mayo, Robson, and Moir say that the percentage of mortality varies, and that within twelve hours after perforation it is 28 per cent., from twelve to twenty-four hours 63 per cent., from twenty-four to thirty-six hours 87 per cent., and from thirty-six to forty-eight hours 100 per cent.?—You are only reading portions of the book. I would like to see all other portions.

Dr. Collins handed the book to Dr. Neil, who, after looking at it, said, "Why, according to these tables, I was about correct in placing White's chance at 50 per cent."

Dr. Collins: You said yesterday that a man who had perforation for twenty hours had a 50-per-cent. chance of life?—Well, I am approximately correct, according to your own showing; but it is entirely misleading to read scraps out of books which have been hunted up hill and down dale.

The Chairman: Dr. Collins has a right to read such extracts.

Dr. Collins (to Dr. Neil): Do you make out you were justified in making such a statement as to the dissipation of a 50-per-cent. chance of life?—Yes, when you considered the time (including the three hours wasted by you); your own statements bear it out. Every statement I made at the Board's inquiry has turned out to be true.

You object to me taking Dr. Ferguson, as a junior, to assist me in an operation?—Yes, when he had had no previous experience of abdominal work, and there were skilled surgeons available. His right to assist depends upon what the operation is.

Would the question of inspection be important in an operation near the brain, for instance?—Yes, it would.

Did you never ask Dr. Ferguson to assist you in an operation?—No. He asked to be allowed to assist, but he only held the flap of an ear.

If Dr. Ferguson said that you did ask him, would you deny it?—Yes; he is one of the "three ulcers and one incision" men.

Did you not assist at operations when you were house physician at the Hospital?—I do not recollect; I may have done so.

Is it not a fact that a junior goes to a hospital to get experience in physic and surgery?—Yes; but not to operate first-hand on patients. I went there to learn under experienced surgeons.

Have you not assisted at operations at the Hospital recently?—I have not been there recently; I have been chased out.

Dr. Collins: Is it not a fact that the surgeons in Auckland (with the exception of Mr. Savage) are all general practitioners?—No.

We will take Dr. Lewis (I am sorry to have to mention his name): is he not both a surgeon and a general practitioner?—Yes.

Does he not do *post-mortem* work for the Coroner?—No; he has given it up.

The Chairman: We are not required to examine into the practice of surgeons in general.

Dr. Roberton: May I ask, on behalf of the Medical Association, that no question reflecting on the reputation of any of its members be allowed to be asked in his absence?

The Chairman: We can hardly refuse it. The question is not whether certain surgeons do *post-mortem* work, but whether it is a proper practice.

Dr. Collins: I was only trying to show that certain surgeons do both. I had no desire to cast any reflection on any one.

The subject was then dropped.

Dr. Collins (to Dr. Neil): You objected to me taking a book into the operating-room because it was likely to affect other surgeons. Can you positively say that other surgeons had access to that book?—Yes; Dr. Parkes had, and any one else could. It was on the shelf.

Have you not taken a bag which you have had with you in the *post-mortem* room into the operating-room?—Yes; but that bag had not been lying on the legs of a dead subject.

Have you ever taken the trouble to disinfect that bag?—There was no necessity.

And yet it struck you as dangerous for me to take that book into the room?—Yes, after it had been lying on a dead person's legs. My bag was some distance away.

Mr. Reed: You said that when you were resident at the Hospital, in Dr. Baldwin's time, you never knew a patient to suffer through having to await the arrival of the honorary staff. Do you not remember any cases in which patients died before medical aid reached them?—I do not recollect any cases like that.

Dr. Collins next referred to the case of one Fox, who was admitted to the Hospital on the 17th August, 1899, suffering from gastric ulcer.

Did you sign up the charge?—I am not certain as to the case. Dr. Baldwin did his work. He would sign it up.

You are certain he would sign it up?—Yes; but we will have more evidence about that.

The patient died without operation?—Yes.

There was also a patient named Quinn, suffering from gastric ulcer, and was in the Hospital from the 4th to the 8th without being operated upon. How was that?—As far as I remember, it was because a friend of yours did not diagnose the case.

Was he a friend of mine in 1900?—He has been subsequently.

Fox died on the same day as he was admitted, and how was it he was not operated upon?—He was sent in as a case of poisoning, and was seen.

In that case you didn't make a correct diagnosis?—How long did he take to die?

He died the same day as admission?—Well, I wasn't in charge of the case. I never saw him.

Did you say that you were resident surgeon, and the case of perforated gastric ulcer did not come before you?—It was admitted to the medical wards.

And was never seen by you?—Why should I?

Was the case admitted to the medical wards?—It was sent in as a case of poisoning.

Would you say that any surgeon would mistake a case of perforated gastric ulcer for poisoning?—I know a person who mistook a case for peritonitis, and operated on the intestines. The work was well done in those days, Collins, and you can't throw any blame on it.

Do you remember the case of Graydon, admitted with an obstruction in the bowels?—Are they my notes?

No?—I don't remember the case. If the patient was not operated upon for three or four days without any attempt to operate, those in charge could explain.

Now, why did the Board appoint me?—Because they acted in error, and did not consult the staff.

Dr. Collins here referred to a letter which the Board received from the honorary staff on the 27th August, 1901, transmitting recommendations on the question of the appointment of a resident superintendent. The letter, which was put in, contained the following suggestions: "(1.) The senior resident shall undertake the treatment of all cases of emergency, and in cases requiring immediate operation, after the visiting surgeon, under whom the case was admitted, has been notified of the urgency of the case, he may proceed with the operation until the arrival of the honorary surgeon. (2.) The senior resident to have sole treatment of, and responsibility for, all fractures and dislocations, except (*a*) when the visiting surgeon expresses a wish to take charge of the case himself; (*b*) in any case requiring operative interference the senior resident desires he may request a consultation with the visiting surgeon in whose week the case was admitted). (3.) The senior resident to be present at, and take part in, all consultations of the honorary staff (he may also be present at any meeting of the honorary staff). (4.) He shall be responsible to the honorary staff that all treatment prescribed by them be properly carried out. (5.) He shall be responsible for the proper administration of anæsthetics, but may delegate their administration to the junior medical officer. (6.) He shall see that the clinical records are properly kept, and that they are up to date. (7.) He shall be responsible for the proper working of the pathological laboratories."

Mr. Reed: It is a letter, Your Honour, recommending the appointment of a surgeon to operate in preference to the practice in existence.

Dr. Roberton: I can't agree to that statement.

Dr. Neil also denied the correctness of the statement.

The Chairman: The letter will explain itself.

Mr. Reed pointed out that it was on this letter that the last set of rules were framed on the suggestion of the honorary staff.

Dr. Roberton: I object to that statement. It is rather an important matter.

The Chairman: There is nothing in the letter in reference to Dr. Collins's appointment. It is not necessary to the case.

Dr. Collins: You say that the Board did not consult the wishes of the staff?—They did not consult the wishes of the staff on your appointment. The staff did not want you, Collins.

Was not the letter written by the staff previous to applications being sent in?—I wasn't in Auckland when the letter was written, nor was I in Auckland when your appointment was made.

Mr. Reed explained that what was intended to be asked by Dr. Collins was as to whether this was the letter upon which applications were invited for the position of superintendent.

The Chairman: The question, then, was a misleading one.

Mr. Reed: It was not put as clearly as it might have been.

Dr. Collins: This letter was practically a basis on which the appointment was made?—I was not in Auckland at the time. The members of the staff will put a different complexion on your statements.

When was the appointment made?—I don't know.

Were you an applicant for the position?—I sent a cablegram from England to say I was an applicant, but it was only to keep my name before the Board. I had accepted engagements for twelve months ahead.

Do you say you sent an application for the position, and that you had no intention of returning to Auckland?—Not at that time.

Do you say that seriously?—I say so positively. I wanted to keep my name before the Board, because I would be eventually returning to Auckland.

Mr. Beetham: What does it matter? You are only wasting time.

In a letter you wrote to a local paper you say "that the sick of the Hospital would not have the benefit of the skill of certain surgeons if the surgeons submitted to such indignities as to be compelled to approach the Board through a subordinate officer"?—Yes; I wrote that.

Did that rule exist at the Hospital in your time?—The honorary staff were on a proper footing.

Did the rule exist?—The interpretation you put on it did not exist.

I do not put an interpretation on it?—You do. You come round and spy on the meetings of the staff. I can't tell you if the rule existed.

Dr. Collins read an extract from a letter written to the newspapers by Dr. Neil, who asked permission, and was granted it, to read the whole letter. Dr. Neil, in further evidence, said he had sent copies of the letter to all the local newspapers and to local bodies, but he could not say if his clerk had sent copies to all medical men.

Dr. Collins (referring to the letter in question): We will take one or two points?—Take every point you like, Collins.

You say the expenses have increased 40 per cent.?—Yes, I do.

Is that correct?—You wait till you give me a chance. I would prefer to have a special day for the consideration of that; I have all the documents ready.

Mr. Beetham: You are asked, Dr. Neil, if that is a true statement? —That is a true statement according to my opinion.

Mr. Reed suggested going into the question later, and Dr. Collins passed over to the next point.

You said you didn't know who these emergency rules were altered by?—Yes, I did.

You say in 1902 the rules were altered?—I don't know the reason of the alteration. You told the conference of local bodies, as well as me personally, that you had reversed the rules.

What year were the rules altered?—Information is conflicting. On the back of the rules the date is given as the 9th February, and on my copy January.

When was it first decided to alter the rules?—I wasn't there at that time.

You say you have persistently and vehemently objected?—Yes, I have.

For how long?—I can't remember.

You have stated you objected ever since you returned to Auckland?—When I found the rules with the interpretation you put on them I didn't like them

On the 14th March the honorary staff expressed in a letter to the Board satisfaction with my emergency work?—I remember the letter.

Did you vote for it?—I did.

That was voting to give me more power?—No, it was not. If there was an eye, ear, or other case, would you take it? It was subject to the rules then in force.

Didn't that give me greater power of operating than I already had?—No.

Not if I could operate in the absence of three hours' notice from the surgeon in charge of the case?—It was discretionary. You could take an emergency case; not an ear or eye case. It might have given you a little more work, but not in major abdominal operations. You had plenty of power, and you used it; you took it.

The Chairman: The rules can be read up by the Commission, Dr. Collins, and we can come to an opinion.

If you were dissatisfied with my surgical work, why did you vote? —You only started it after the strong staff left.

You stated I operated on a case with Dr. Lewis?—I did.

How many abdominal operations have I performed since I've been in the Hospital?—I can't tell you.

Then, how can you say I only started?—It was in reference to night consultations.

Was the perforated-ulcer operation, at which you say Dr. Lewis was present, a night consultation?—Dr. Lewis stood over you, and told you when to stop.

Is that the truth?—I remember it distinctly.

Are you sure you are stating the truth, Dr. Neil?—I am quite sure (witness rising from his seat); do you understand me, Collins?

What became of that patient?—She was operated upon again and died.

Was it not a fact that I was not permitted to look for the perforation?—I don't remember exactly.

Didn't I give in to your opinion and the opinion of another?—Yes; you gave in to Dr. Lewis's opinion and mine. You were under the control of Dr. Lewis, and you should give in.

Was not my work done to your approval as well as Dr. Lewis's?— Yes.

Did you not say to me afterwards that you did not think, after considering over it, that it was not the correct treatment?—I know that I sent you a journal referring to a case which verified the correctness of what had been done in this particular case.

Did you or did you not say it was not the correct treatment?—I don't remember.

Do you think it is the correct thing in a case of perforated typhoid ulcer not to look for the perforation?—I sent you a journal proving what was done was correct. It depends on the case entirely what ought to be done. You can't lay down a definite rule for every case.

So long as the perforation is allowed to exist so long is the patient's chances of recovery nil?—You might bring the perforation up to the wound.

How can you bring it up to the wound if you are not allowed to look for it?—Find it in exploring. You are getting at a lot of details now which are of no value.

In the case of Martha Gordon, did not the blood fill the whole of the abdomen?—I could not say it filled the whole of the abdomen.

Were you present when the first incisions were made?—No.

Did you see the blood come out?—No. I didn't see what came out at the first incision.

Would you deny that I found the abdomen full of blood?—I wasn't there to deny it.

How long were you at the operation?—I couldn't say.

At the operation did you see me take at least five handfuls of blood-clots out of the abdomen?—I didn't count them.

Didn't all the doctors present say it was the worst case of hæmorrhage they had ever seen?—How could everybody say that?

Have you seen a worse case?—I don't recollect one.

Wasn't the lower part of the abdomen full of blood-clots?—The pelvis was.

Do you remember the difficulty I had in getting hold of the tube?—No, I don't.

Taking out three or four handfuls of blood before I reached the womb?—Do you call that a difficult act?

Were not all the parts covered with blood-clots?—Why not remove them with a sponge?

Was it possible to remove in a few minutes all the blood from the abdomen?—Remove the surface to make a proper inspection.

Do you remember the patient had to be hurried off the table?—I left. You had made a cursory examination.

You don't know if after that I had not further examined the pelvis?—No.

Yet you can bring a charge of negligence against me?—One had only to look at the tube.

Do you not know that saline was injected into the stomach?—What does that matter? I don't know anything about that.

Well, I did?—What does that matter about finding the tube?

Does it not show that no time was wasted in looking for the tube?—You wasted time in feeling round the stomach, looking for an ulcer in the dudene.

If the tube was removed do you think she would have lived?—Why didn't you sew her up and leave her alone?

Would there have been any prospect of her living?—A slight prospect.

Didn't everybody say in your hearing there was no chance of the woman recovering?—I don't recollect. Everybody said it was a bad case.

You started a clinical society?—Yes.

And asked me to produce that specimen?—It was produced.

You asked me to write an account of the case?—Yes. You wrote several accounts of cases.

Did you then say there was negligence on my part?—Why should I?

Did you?—I don't remember. Why should I go and stand up in the society and give a lecture on your surgery?

Didn't I read and give you information you didn't get while away from the operation?—Not for me only. I didn't read the information you gave.

Didn't I see you reading it?—I don't think so.

Did I not speak on the case at the society?—I don't remember.

You charge me with negligence?—You should have made a proper examination.

Were you there till the end of the operation?—I saw the results from the *post-mortem;* and remember, Collins, you looked "sick" in the morning. You wanted to get away from the *post-mortem* in the morning.

Didn't I explain in the morning?—I don't remember.

Dr. Collins: I beg of you to try and remember.

Dr. Neil: I am not going to try and remember in that way. You are putting the questions in the wrong way.

Dr. Collins: I ask for facts?

Dr. Neil: I am giving facts, as I can remember them.

Why haven't you charged me with negligence all this time?—You never charged me with being absent from the Hospital till I was suspended; don't forget that. It cuts both ways.

Dr. Collins proceeded to question Dr. Neil about the latter's remark as to the former converting the operating-theatre into a "damned shambles," and the witness persisted in denying that he had used the term in the sense it had been attributed to him. He also denied recollection of having told members of the honorary staff that Dr. Collins was converting the theatre into a "septic shambles."

Dr. Collins: Did you say to Dr. Bedford, at his house, that I was converting the theatre into a "septic shambles"?—I have no recollection of using the words.

Didn't Dr. Bedford tax you with it after the Board's inquiry?—Yes.

Did you deny it?—I said nothing, but if he was a younger man I would have said something. I asked him if he went to the Board with an unbiassed mind, and when he said he did, and that he had no intimation of the trouble brewing, I asked him why he had told Dr. Grant that there was a strong case against me. His jaw lowered then, and we parted.

Do you deny what Dr. Bedford says?—If he comes here and makes the statement I will deny it. Previously I treated his assertion with contempt.

Then, you say Rule 72, relating to emergency work, has led to much abuse?—Yes, very much abuse.

Do you know what successful cases I have had?—I know plenty of unsuccessful ones.

How many unsuccessful cases?—There was the boy with appendicitis, he has gone the way of all flesh; Mrs. Gordon, she has gone; Wallis White, poor fellow, he has disappeared; there were also two typhoid perforations, and Mrs. Plecher, they have disappeared; and there are more which I could mention if I had the records.

Dr. Neil: I must have the statistics of the Hospital. They were ordered to be laid on the table a couple of days ago, but they are not here yet.

It was then arranged that Dr. Neil should be given permission to have access to all Hospital records at the Hospital.

Dr. Collins (continuing): At how many emergency operations were you present?—I have been at a good number.

In how many have you given chloroform for me?—I will tell you when I have seen the records.

Have you given chloroform in more than four?—I cannot say.

Would I be wrong in saying there were only three?—Very likely wrong, so far as I know.

You said that in Clarence Walters's case you demonstrated to Drs. Walsh and Ferguson at the *post-mortem* the presence of pus in the pelvis?—That is so.

Would you be surprised if both deny being present?—I would.

And if the porter denied it?—Very much surprised. But I don't think they will.

Re-examined by Mr. McVeagh: You have had considerable experience as an anæsthetist?—Yes; I have given as many as thirty (gas) in one day, and have never had a collapse.

It has been suggested that in White's case you allowed the patient to come out from under the chloroform. Was no complaint made to you about that till yesterday?—No. Dr. Collins said to me after the operation, "My word, Neil, you stuck to that chloroform like a brick."

Mr. Reed: Did you make any statement at the Board's inquiry as to the Chairman's accusation that you had said that Dr. Collins was converting the operating-theatre into a "damned shambles"?—I did. I said, "I say before God and man that I did not make the statement."

With regard to the letter from the honorary staff to the Board, in which you said that the Senior Medical Officer had been doing the emergency work satisfactorily, it was not intended by the staff, was it, that "serious emergency work" should include abdominal operations?—No.

You were questioned by Dr. Collins as to a *post-mortem* examination made by you on the day that Drs. James and Stirling were at the Hospital. Did the patient die from septicæmia?—I gathered from Dr. Collins that it was something of the kind.

Mr. Reed: Was there suppuration at the Hospital when you were resident there?—No.

You said it existed largely in 1902?—I was not there then; but it was notorious that there was then a wave of suppuration. Dr. Collins said at the local bodies' inquiry last year that every case suppurated. I think his words were "every wound became infected."

It was suggested yesterday that suppuration extended to the private hospitals?—That was absolutely untrue. In a nursing-home one case went wrong, but that is no justification for saying that suppuration ran right through the private hospitals.

What is the opinion of medical writers in regard to suppuration as affecting operations?—Dr. Christopher Martin, assistant to Dr. Lawson Tait, says that no one who has been contaminated by any septic or infectious cases should be permitted to enter the room during any operation, still less to assist. "Cleanliness," said Dr. Martin, "is the highest virtue in surgery. I would rather have my abdomen opened by a clean surgeon of moderate skill than by a dexterous dirty one."

You have said that you did not always sign the attendance-book?—No; the book was kept in the main building, and my work was often in the Costley Wards and elsewhere, apart from the main building.

Were you ever absent more than seven days at a time from the Hospital without leave?—I am almost positive I was not.

When were you charged with absence from the Hospital?—I was charged with absence in April, but the charge was not made till the 10th August, when I was suspended. In the meantime I had instigated the forwarding to the Board by the honorary staff of a resolution regarding emergency work.

What effect would the making of two intestinal incisions during an operation such as that in White's case have upon his chances of recovery?—It would have a double effect—firstly, as regards the waste of time, and, secondly, in regard to the infliction of unnecessary injury. If you did that to a healthy man it would take him all his time to recover.

How long would it take to write out the clinical history of White's case?—It could have been written up in detail in half an hour.

The honorary staff passed a resolution in regard to *post-mortem* work?—Yes; a sub-committee passed a resolution to the effect that *post-mortems* should be performed by the pathologist, and that any members of the staff manipulating corpses should not take part in operations. Drs. Scott, Craig, Parkes, and myself were present, and all took part in framing the resolution.

The witness, having obtained the loan of the minute-book of the honorary staff, who had brought it down to the Commission, took a piece of paper from it, and, glancing at it, exclaimed, "Why, here are the rough notes I made at that meeting (in July), and which I have not seen from that day till this moment. The words are: 'Emergency work: We should bring our rules into conformity with those of other hospitals in order not to speak of our Hospital as they would of shambles.' This is a reply to the charge against me."

Mr. T. Copeland Savage, who made an examination of White's exhumed body by instructions from the Government, was then called by Mr. McVeagh. He said he was a Fellow of the Royal College of Surgeons, and a gold medallist in surgery of the London University. When he made an examination of the body of White there were also present Drs. Ferguson, Craig, King, Neil, Bull (who performed the autopsy), and Mr. Gresham (the Coroner).

Mr. McVeagh: What was the state of the body when it was exhumed?—With the exception of a little destruction of the superficial structures of the limbs, the body was in an exceedingly good state of preservation. The peritoneum and contents of the abdomen were well preserved.

How many incisions were there in the abdomen?—Two.

The witness then described the examination of the specimens removed from the body, which took place on the day following the exhumation, the same persons being present as at the exhumation. The seals were broken by Mr. Gresham, who had affixed them the day before.

Mr. Savage then with the aid of an anatomical chart explained the results of his examination of the remains, which he had already reported upon to Dr. MacGregor. He said that the stomach and the first part of the bowel (duodenum) were first examined. On the surface of the stomach, close to its junction with the bowel, were a series of silk stitches. In the bowel, just beyond the end of the stomach, there was a second series of stitches. The bowel and stomach were then filled with water. The first series of stitches proved watertight, but the second series were not quite watertight. The stomach was then cut open and examined. Its surface showed no evidence of ulceration or perforation anywhere. The first series of stitches were then removed, and the surface of the stomach beneath shown to be healthy. The first part of the bowel was opened, and beneath the second series of stitches an ulcer was found. The stitches were then removed, and it was seen that this ulcer had perforated. The large intestine (cæcum) and the first part of the large bowel were found to be normal, and the appendix healthy. In the cæcum there was an incision about 1½ in. in length, closed by silk stitches. A little higher up was a second incision, closed by three stitches. This measured ½ in.

Mr. McVeagh: Were the two incisions in the colon large enough to permit of the extraction of fæcal concretions, say, as large as a walnut?—The larger one, yes.

The Chairman: There were two incisions, then?—There were.

Mr. McVeagh: Could one be described as a puncture?—I think not.

The Chairman: What would be the reason for stitching up the wall of the stomach?—The only reason I could give is that the operator thought a perforation was present when it was not.

Mr. McVeagh: You have performed a number of operations for appendicitis yourself?—Yes, a considerable number.

Did the colon in White's case show signs of distension?—A little was gas.

Mr. McVeagh: Was there anything to prevent all that scybalæ (hardened fæces) being taken out through the first incision?—No.

Do you consider that the two intestinal incisions could be justified for any purpose?

Mr. Savage (after consideration): I think not.

Mr. McVeagh: Would it be justifiable to make two incisions for the purpose of removing two pieces of fæces each about as large as a walnut?—I think not.

Would it be justifiable to make one incision for the same purpose?—In this instance I can see no reason for it.

Assuming that the colon had been distended by gas, would it have been justifiable to puncture the colon to admit of the escape of gas in order to get at the appendix?—I do not think it would have been necessary.

It being your opinion that there was no necessity for either incision, supposing the anæsthetist was urging the question of time on the operator, would the operator be doing the proper thing in making these two incisions?—That question is already answered. I have said that there was no need to make them.

In such an operation, especially when the appendix is found to be normal, time is of great importance?—Yes.

I understand you recently performed an abdominal operation on a child. How long did it take you?—Under twenty minutes.

That would be rapid?—Yes, fairly quick.

Why the rapidity?—On account of the child's condition.

Assuming that it had been necessary to puncture the ascending colon to admit of the escape of gas, could not the puncture have been made so as to admit of it being closed with one suture?—Yes.

Would the condition of the stomach justify the statement that there was more than one perforation beyond the incisions?—No.

The Chairman: There was no perforation at all in the stomach?—No.

Mr. Reed (to Mr. Savage): Have you seen the report on the exhumation furnished by Dr. Bedford to the Hospital Board? It is slightly different from yours, I think?—No, I have not seen it.

Mr. Reed handed the report to Mr. Savage, who, after reading it, said, "I entirely disagree with a great deal of it."

Mr. Reed: In what respect?

Mr. Savage: Am I supposed to answer that? I am prepared to demonstrate the correctness of my report. Dr. Bedford is not present, and I do not think I should be asked to criticize his report in his absence.

The Chairman said that it would be proper to answer the questions.

Mr. Reed: Dr. Bedford will be called, but I am putting these questions in fairness to you. In what way do you disagree with his report?—He speaks of two ulcers. That is not so.

The question has not been discussed at all between you and Dr. Bedford?—No.

You did not know his opinion and he did not know yours?—No; until the Commission sat no one had seen my report, except Dr. MacGregor. Dr. Bull, who performed the autopsy, would be able to say what took place, but it would be impossible for a man who was looking over my shoulders, at a distance of 2 yards, to speak. I am prepared to prove my statements.

Probably you could produce the specimens?—I have them here, but it might be offensive to produce them in the room. They might be examined outside in the corridor, or on the lawn.

The Chairman: An examination of the specimens would show how many ulcers there are. It is a simple question.

Mr. Savage (reading from Dr. Bedford's report): He says, "The walls of the stomach were not watertight." That is not so. There was no leakage from the stomach, except a dripping on the outside, which might fall from any wet, smooth surface.

Mr. McVeagh: If there is going to be a contest like that, there should be other medical witnesses.

Mr. Reed: There is no contest.

Mr. Savage said that if he demonstrated the specimens to the Commissioners they would be able to observe for themselves.

Mr. Savage (again reading from Dr. Bedford's report): He says, "On raising the intestines adhesions were found to exist between the coils." There were no such adhesions. He also says, "The scrotum could not be seen," but I raised the scrotum myself, and showed it to Dr. Bull. He also says, "There were minute points through which a general leakage took place over the whole gastric sac." I do not admit that.

The Chairman: We expect that the stomach will make it plain, even to us, how many perforations there are.

Mr. Savage (once more quoting from Dr. Bedford's report): He says again, "The peritoneum was friable; it broke away readily from the stitched edges on the slightest movement." I do not admit that. He also says, "The gastric ulcer was the longer of the two ulcers," but I can say that the state of the mucous membrane of the stomach was such as to enable me to say that there had been no ulceration whatever in the stomach. Dr. Bedford speaks of the first incision in the colon being 3 in. from the root of the appendix. Its actual distance was 1¼ in. I may remark here that I think it fair to Dr. Bedford that he did not use a rule, and that he only measured with the eye. I do not suppose his measurements are intended to be minutely accurate. I was the only person present who used a measure of any kind. Dr. Bedford's description of the second incision in the colon as being of such a size as would be made by the blade of a scalpel I cannot admit. It was not less certainly than ½ in.

Mr. Reed: Can you say, from your experience, whether it is difficult to diagnose between perforated gastric ulcer and perforated appendicitis?—I would say that no expert surgeon need feel ashamed if, after opening for appendicitis, he found the case to be one of duodenal or gastric ulcer.

You have known an expert surgeon to make that mistake?—I have.

Supposing you cannot get at the appendix owing to a distension of the bowel?—That never occurs without adhesions, and in this case there were no adhesions.

What would be the percentage of mortality in cases of gastric ulcers operated upon at seventeen hours after perforation?—Up to twelve hours the average mortality is 28 or 29 per cent., twelve to twenty-four hours between 60 and 64 per cent. It increases very rapidly after twelve hours.

Could you say whether incisions such as were made in this case would get longer or shorter after death?—If the cæcum were distended with gas at the time, naturally the incisions would become shorter when the gas escaped. If you make a cut in the length of an elastic band when it is stretched, when the band is relaxed the cut becomes shorter. Therefore these incisions could not have been smaller when made.

The Chairman: How should White's case, in your opinion, have been treated?—It is difficult to definitely decide between appendicitis and gastric ulcer. I have seen exactly the same thing occur with one of the expert surgeons at Home. An incision was made over the appendix, which was found to be normal. This was sewn up and immediately an opening was made in the abdomen over the stomach, and a perforated ulcer found.

Did the patient die?—Yes.

What effect would the incisions in the intestines have on the patient? Would they militate against his chances of recovery?—They must to some extent. The question of time would be a serious matter, and every incision in the intestine or stomach conduces to grave shock, and makes more perforations in the bowel which have to heal.

Mr. McCarthy: Ought the knowledge you have detailed to be possessed by the average practitioner?—That is too difficult to answer.

The Chairman: I do not think there is any more to ask you.

Dr. Collins did not cross-examine the witness.

It was agreed that Mr. Savage should arrange for an examination of the exhibits in the presence of the Commissioners, Drs. Neil and Collins, and other doctors.

Nurse Bell, who was present at the operation on White, was called to answer one or two questions concerning the patient, but these were not of any general interest.

Dr. Gore Gillon, consulting surgeon, of Auckland, said he had been for three years Superintendent of the Wellington Hospital, and for three successive periods of three years each elected a visiting surgeon. Authorities differed, he said, as to the mortality in perforated-gastric-

ulcer cases, but the average was stated to be about 50 per cent. There was a prospect of that percentage being reduced in the near future. During the last four or five years there had been a reduction in the mortality.

Mr. McVeagh: Do you agree with the conclusions arrived at by Mr. Savage, generally upon all, or on what points do you differ?—I am not acquainted with the circumstances of the case.

After Mr. McVeagh had given the symptoms, he proceeded: Assuming it was necessary to make one incision, can you imagine the necessity of making another about 2 in. from the first?—No, never.

Assuming it was necessary, where would you make the second incision?—It would depend on circumstances. In my own experience I have never had to make an incision in the bowel.

Assuming the bowel being distended by gas, would that occasion difficulty in searching for and finding the appendix?—No, none whatever.

Would a puncture have caused the expulsion of gas?—I can't conceive a puncture being necessary. But it would expel the gas if it was.

Can you imagine any reason for the twelve stitches in the neighbourhood of the lesser curvature, as found by Mr. Savage?—No, I can't. Nor for the incision.

Dr. Gillon stated further that the proper time for doing administrative work at a hospital was between 8 o'clock and half-past 9, and that was what was done at most hospitals. He did not approve of anthrax-bacilli culture being carried on at a hospital by the Medical Superintendent, because anthrax was one of the most virulent poisons known. The Medical Superintendent should not perform *post-mortem* work as well as abdominal operative work. This was a class of work which should be confined to a very few, and witness was entirely against any medical man being appointed a Senior Medical Officer to a large hospital unless he had been a long time doing abdominal surgery work, and he should also be a well-trained abdominal specialist. There were a number of surgeons in Auckland who fulfilled these requirements.

Questioned by Mr. Reed, the witness said that in some London hospitals demonstrators of anatomy were operating surgeons, but he did not know of cases where the demonstrator of anatomy undertook serious abdominal surgery. He was limited to minor operative work. A person could keep himself sufficiently clean, and he could also perform an abdominal operation four days after holding a *post-mortem*.

Cross-examined by Dr. Collins, he said a man working with anthrax should not perform abdominal operations, because anthrax poison was infectious and virulent, but witness refused to discuss the poison on the ground that he was not a bacteriologist. Neither should a surgeon do *post-mortem* work. Personally, he had never done *post-mortem* work, and had refused it again and again.

Dr. Collins: Have you ever heard of pieces being extracted from the intestines?—I have, when there was large distension and absolute stoppage.

Isn't it done after an operation to prevent paralysis following?—I have never done it.

Isn't it recommended to open the bowel and wash it out?—Only in cases of obstruction.

Dr. Collins then read from authorities as to action taken by expert surgeons in regard to perforated-ulcer cases, but the witness declined to express an opinion, as the cases referred to where suppositions, and not parallel with the one in dispute. "I don't think you ought to have opened the bowel," said Dr. Gillon.

Mr. Beetham: Are you connected with the honorary staff?—No; when I came here I was warned against having anything to do with the Hospital, and consequently I have avoided it.

Mr. Beetham: Is the present condition of the Hospital-management such as to induce the best men in Auckland to seek positions on the medical and surgery staffs?—I don't think it is.

Mr. Beetham: What conditions would be acceptable?—Well, if you want my opinion offhand I will give it. I really believe that no hospital in a large city should be controlled by a Board as at present constituted. The proper management of a hospital requires men with knowledge and training, but this cannot be secured as Boards are at present elected. Even if there are one or two medical men on the Boards I believe confusion and trouble will be experienced for ever in New Zealand. In my opinion, hospitals should be managed by the Health Department, under the direction of the Minister, and until that is done there will be trouble. The management has to be freed from all influences, and then the best men in a city will be willing to join the honorary staff, with the result that the sick poor will have the benefit of the best skill obtainable. As at present managed, the sick suffer; that is my opinion.

Mr. Beetham: How many honorary surgeons would be required?—I don't know how many beds there are in the Auckland Hospital.

It was stated that there were 210 beds, and Dr. Gillon then said three or more would be required.

In reply to Dr. Roberton, Dr. Gillon said he did not approve of the existing mode of appointing the honorary staff. The tenure was, in his opinion, too short. They should be elected for two or three years. With the one-year tenure the surgeon did not get into the swing of things, and as the expiry of his term approached he lost interest, to the detriment of patients. It was not a proper thing for the Medical Superintendent to attend all meetings of the honorary staff. He had to attend the administrative work, and the honorary

staff's meeting should be entirely separate. It was not the practice in other hospitals. Of course, the Medical Superintendent would attend when asked to. The witness regarded him as entirely different to the honorary staff; the former's services were paid for, but the latter gave theirs gratis. Their interests were not the same. The honorary staff had no interest directly in the Hospital-management. The treatment of patients should be completely under the care of the honorary staff. The Medical Superintendent had to carry out the orders of and be subordinate to the honorary staff. As regards the definition of emergency work, Dr. Gillon said cases requiring to be operated upon within an hour of admission would, in his opinion, come under that category. It would be an easy matter to secure the attendance of one or more honorary visiting surgeons by that time, and the preparing of the patient for the operation could be carried out without detriment to the patient while the honorary surgeon was being summoned.

Dr. Roberton: The emergency operations are essentially serious?—Yes.

And the necessity for consultations is not lessened?—No. A consultation between the visiting surgeon and the Medical Superintendent should take place at once.

If possible, should other surgeons be present?—Yes; as many as can be got.

At Wellington does the Superintendent take part in emergency operations?—Dr. Ewart has been there a number of years. He does not operate without communicating with the honorary staff, but only with the permission of the staff.

Should the Senior Medical Officer be the sole communication between the staff and the Board?—No, certainly not. The secretary of the honorary staff should communicate with the Board—that is, if there is a Board at all. I am against all Boards.

Mr. Beetham: How would you man a hospital? With young surgeons?—Yes. A resident surgeon only gets a small salary, and he must necessarily be a young man.

Would there be any difficulty in getting competent young men who would carry out all instructions?—No, I don't think so. Absolute discipline is necessary.

The Chairman: In that case it would be necessary for a member of the honorary staff to be present at every operation?—Yes.

Nurse Bell stated that she was present at the operation on White. When the appendicular incision was made the appendix was found almost immediately. It was said to be normal, but who by she did not recollect. There was an intestinal incision, and she believed the object was to remove something. She did not see what was removed. There were other nurses present. It was generally after 10 o'clock when Dr. Collins arrived at the Hospital in the mornings, and it was after that hour that he visited the wards. Some days he missed visiting the wards, but this was not a common occurrence in connection with the surgical wards, where she was engaged. The Hospital rule requiring Dr. Collins to visit the wards at 6 p.m. was not always complied with. Witness stated that both Drs. Collins and Frost had been engaged in bacteriological work. Dr. Collins had been at it for about a month, but she could not say how frequently he was in the laboratory. She had been in the Hospital for eight years, and was there in Dr. Baldwin's time. The number of surgical operations she had attended she could not say. Speaking for her own ward, the general septic condition in 1901 was good, the wounds all healing. She had experienced no difficulties in the way of suppurations. In 1902 there was a good deal of suppuration, and the honorary staff appeared worried about it. This state of things would require more dressings, and the patients' detention in the Hospital was longer. She had trouble with suppurations during the present year. It had occurred in cleaning wounds, and that was not usual.

The Commission then adjourned.

Before the Commission sat in the morning of the 21st October *Mr. Copeland Savage*, who, as stated in his evidence on Thursday, made a report on the exhumation of Wallis White's body at the request of the Department, made a second examination of the stomach and intestines in the presence of members of the Commission, Drs. Bedford, Collins, Neil, Bull, and others. The specimens were opened out on the lawn, and the ulcer and the incisions which were made pointed out by Mr. Savage to those present. The specimens, which were examined with some minuteness by the Commissioners, were taken out of a sealed bottle, and afterwards placed in another bottle.

When the Commission resumed, Mr. McVeagh inquired of Mr. Savage: As a result of your second examination, do you wish in any particular to qualify the evidence you gave yesterday?—No.

Mr. Beetham: In your opinion, Mr. Savage, should operations of this character—abdominal operations—be undertaken under any circumstances by the resident Medical Superintendent of a hospital?—No. Such operations should be done by those men who have the largest experience in working practice, and the operation, under proper conditions, would be under the control of the honorary staff. I should say it was unfair to give the Medical Superintendent power to do such operations—unfair to the honorary staff, the patient, and the public. By the interpretation put upon the rules of late, however, the Senior Medical Officer is allowed to, and under certain conditions must, perform these operations.

The Chairman: The interpretation put upon the rules is one thing, but natural interpretation might be another.

The Chairman read Rule 72 (adopted in 1902), as follows: "He (the Senior Medical Officer) shall be responsible for the treatment of all cases of emergency, and all surgical operations connected therewith, after the visiting surgeon, under whose care the case was admitted, shall have been notified of the urgency of the case, and he shall be authorised to use his discretion as to the advisability of immediate operation prior to the arrival of the honorary surgeon."

Mr. Savage: Is there not a resolution that if the surgeon for the week is not present within one hour he shall proceed with the operation? Supposing the surgeon for the week was ill?

The Chairman: Another should be summoned.

Mr. Savage: That is not the rule, but it should be so.

Mr. McVeagh: I think Rule 11 provides for illness.

The Chairman (referring to the rule): Rule 11 reads, "In case of illness or other cause of absence on the part of any member of the honorary visiting staff, he must arrange with the Senior Medical Officer that the patients under his care be attended by one of his colleagues, with the consent of the Chairman of the Board"?—Yes; but I do not know what the Chairman of the Board has got to do with it.

Mr. Beetham: If the resident Medical Officer were prohibited from performing such operations, can you conceive of any abdominal case coming into the Hospital which would suffer from the interregnum of time which would elapse after the patient had been prepared for the operation before any honorary surgeon could be obtained?—Not if satisfactory rules were enforced. In the London Hospital there is a rule providing that the honorary surgeon for the week shall be within half an hour's call of the Hospital during the whole of the week. If he has engagements which will take him away beyond that distance the regulations distinctly state that he shall notify the next man in rotation on the honorary staff, and arrange with him to do the work if any such case should arise.

You do not think that any danger would arise from such a rule?—No. If the surgeon for the week could not come within, say, an hour, he ought to arrange for another man to come. It is extremely unlikely that the three or four surgeons would all be away at the same time.

Mr. Reed: You say that you consider that at present the resident Medical Officer is practically compelled under the rules to do these operations?—No. What I said was that by the interpretation lately put on the rules it had been customary for him to perform them.

Mr. Reed read the following extract from a letter dated the 11th May, written by Dr. Inglis, as secretary of the honorary staff: "Owing to advances made in the science and art of surgery, most of the more important operative work, especially on the head and abdomen, falls under the heading of emergency work." I think, continued Mr. Reed, that the most serious operations are emergency operations?—Yes; the serious emergency operations which the honorary staff should do.

Mr. Beetham: You say that no operation of any magnitude can be done within an hour, and that all emergency work should be done by the honorary staff?—Yes.

Dr. Roberton: Can you tell us where the definition of "emergency work" is the same in London as here?—I cannot exactly say, but emergency work is generally understood to be such cases as come in suddenly, needing serious operative treatment of some magnitude within a short time—that is, within two or three hours. This would include abdominal operations or compound fractured limbs, which should be attended to by the honorary staff. Generally, "emergency" cases are those which require quick surgical treatment.

Mr. Beetham: How would you deal with fractures, compound or otherwise?—Ordinary fractures should be attended to by the resident staff, and should be inspected by a member of the honorary staff next day. Compound fracture of the less serious character could be similarly dealt with. In more serious cases, such as those requiring the removal of bone, and possibly amputation, the members of the resident staff should render treatment on the principles of first aid, and a member of the honorary staff should be sent for. Apart from the interest of the patient, I do not think it fair to expect the resident staff to undertake such work, when it could be done by more responsible men, who are in constant practice. There are many unjustifiable complaints made against hospitals which would not be made if the patients were treated by more responsible men who are in working practice.

Dr. Bull, who performed the autopsy of the remains of the late Wallis White after the exhumation, said that he had been a member of the honorary staff, but had lately resigned. In describing the examination of the exhumed remains, he said there were two incisions in the cæcum, the first being about 1½ in. and the second rather less than 1½ in. in length. Apart from this, the cæcum, colon, and appendix were healthy. There were no signs of ulcerations in the stomach. An oval ulcer, measuring ¼ in. by about ⅛ in., was found in the duodenum. The rest of the duodenum was healthy.

The Chairman: There was no ulceration in the stomach itself?—No.

The Chairman: We could see this morning that there was no perforation in the stomach.

Mr. McVeagh: Did Mr. Savage show you the scrotum?—I do not remember him doing so, but I saw the scrotum.

Were there any indications of a drainage-tube having been inserted?—There were indications which went to show that a drainage-tube might have been used.

Were there any adhesions?—No.

It has been suggested that the peritoneum was friable?—Not markedly so.

Nurse Bell, whose evidence stood unfinished on the previous day, was next called. She corrected a statement she had previously made, stating that she had seen Dr. Collins arrive at the Hospital before 10 o'clock, while in regard to bad cases the doctor examined them when they came in, but not after the operation.

Cross-questioned by Mr. Reed as to White's case, the witness stated that she had no clear recollection of whether the appendix was found easily at the operation on White. It was not long before she heard some one say the appendix was normal. She remembered well seeing the first incision, but could not say if the second one was in the nature of a stab or a cut. When questioned before she felt sure there were two incisions, but she could not recollect if that was correct. It was towards the end of 1902 that suppuration was present in the Hospital, but it was general for suppuration to appear from time to time in even the best-conducted hospitals. Witness, however, stated that she had not been engaged in any other hospital. Prior to 1902 there may have been occasional cases of suppuration, but good results were always obtained. Just at the present time she did not know of any suppuration cases in the Hospital, all the cases healing by first intentions.

Nurse Jordan, who had been engaged in the Auckland Hospital nearly four years, remembered the operation performed on White. She recollected Dr. Neil saying he would give Dr. Collins a certain time, either ten or twenty minutes. It was before the abdominal incision was made. When the second incision was made Dr. Neil made some remark, from which the witness gathered that the former was surprised at the operation going further. Witness very seldom saw Dr. Collins arrive or depart from the Hospital, but it was generally some time after 10 o'clock when he made a visit to the wards. He visited the surgical wards daily, but not the medical wards. So far as witness's observation went, Dr. Collins did not visit the wards daily at 6 p.m. Witness was away during the time lectures by Dr. Collins were given. She knew Dr. Collins was at times in the bacteriological laboratory, which she had visited herself, but she could not say if the doctor had been in the laboratory frequently.

Nurse Metcalfe, who had been two years and a half on the Hospital staff, remembered taking up a basin to the operator in connection with the operation on White. There was some hard matter put in the basin, but she could not remember the appearance of the material. She did not remember what had become of it.

Nurse Butters, three years on the staff, said she was present at the operation on White. She saw the appendicular incision, and the incision on the middle line afterwards.

In reply to the Chairman, the witness stated that White was admitted to the ward between 4 and 5 o'clock in the afternoon; the time would be nearer 5 o'clock.

Nurse Margetts, who had been twelve years at the institution, said during a portion of that period she had been in charge of the typhoid ward. She remembered a patient named Russell being admitted, the ward at that time being occupied by all kinds of cases. She could not specify the complaints, as it was nearly two years ago. The patient Russell was in a state of fever and restless.

Mr. McVeagh: Were there any typhoid-fever cases?—I don't remember.

The witness went on to say that Dr. Collins did not visit the wards at any fixed period, but she did not see him every day. She also said she would require the ward-book to state what particular cases were under treatment in the ward at that time, and it was decided to secure the production of the book and the reappearance of the witness.

Dr. Thomas Hope Lewis was the next witness. He said he had had considerable experience of operating work in Auckland, and had been on the honorary staff of the Auckland Hospital at different times during the last thirty years. He had resigned.

Mr. McVeagh: You are acquainted with the terms of the emergency rule. How do you define cases of emergency?—A case requiring immediate operative interference, of which I can only think of two—viz., tracheotomy in diphtheria, and hæmorrhage from an artery or hæmorrhage generally.

Would abdominal operations be considered emergency cases?—I think abdominal cases can and must wait for an hour or an hour and a half.

That time would be taken up in preparing for the operation?—Undoubtedly; and I have had ample experience of that in the Auckland Hospital.

From your experience of the working of the Auckland Hospital, would there be any difficulty in that time in getting the attendance of the consulting surgeons?—No; not in getting one of the consulting surgeons.

The doctors don't live far from the Hospital?—No. There is one at Onehunga, but he could get in within three-quarters of an hour.

Mr. McVeagh: Was a consultation-book kept at the Hospital in your time?—At one period of my time a consultation-book was kept, and brought to the consultations, while at another period no book was at the consultations.

The Chairman: At the latter period?—Between April, 1903, and April, 1904.

In one part of the book you haven't initialled the decision?—My initials are attached to cases up to 1903, the 18th June being the last case initialled. The book was not made up at the time of the consultations, and I would take it on trust that it would be done.

Mr. Beetham: The book was not properly kept then?—No, it was not.

Mr. McVeagh: Who produced the consultation-book at the consultations?—In Dr Baldwin's time he produced it, but there was no written rule.

When were the decisions signed?—Before we left the rooms.

Do you attach importance to the consultation-book?—Yes, I do.

Mr. McVeagh then touched on the question of the operation performed on White, and, after describing the symptoms in the case, asked the witness his opinion as to what was done.

Dr. Lewis: I don't consider it good surgery.

Mr. McVeagh: Can you suggest why two incisions should be made?—No, I cannot.

Assuming the necessity of the removal of gas from the intestines, what would be the proper surgical course to pursue?—To use a trocar and canula. The incision proposition was a very crude way to let out gas.

The method you suggest would have a saving of time?—Undoubtedly; and that is a matter of great importance. If there was great distension of the intestines one would be perfectly justified to expirate it, or remove it through the instrument I have mentioned.

Can you say if it is possible for two pieces of fæcal matter the size of walnuts to cause paralysis of the bowel?—Certainly not.

Assuming there was paralysis, what would have been the condition of the patient's abdomen?—No doubt it would be considerably distended.

Would it be difficult to find the appendix with the lower end of the incision 1½ in. from the appendix?—No, I don't think so.

The Chairman: Assuming you had access to the intestine to be able to make a careful puncture, could you find the appendix without making an incision?—There would be no necessity to make an incision to find the appendix.

Mr. McVeagh: On rejoining the honorary staff last year you had a purpose in view?—Yes. I had heard there was a large amount of suppuration going on at the Hospital, and I determined to try and ascertain the cause.

During that time did you have many cases of suppuration?—No. I had two or three cases of my own which suppurated, but I cannot speak of other cases.

From your experience of hospital work, at what time, in your opinion, should the administrative work be carried out?—Between half-past 8 and 9 o'clock.

Are you familiar with Rule 73 of the Hospital, dealing with fractures and dislocations?—Yes.

Who should have charge of these cases?—I think they should be treated by the honorary staff. I may say that the rule is a new one.

Do you happen to know what classes of patients have been in No. 7 Ward?—Yes. Venereal, cancer, rectal cases, and all unfortunate cases generally.

Do you approve of all these cases being kept together?—What cases?

Consumptives, and others you have mentioned?—I didn't know about the consumptives, but they should certainly be kept separate.

Do you approve of the porters passing catheters?—No.

Who should undertake the duties?—The junior staff, undoubtedly.

Do you approve of delirium-tremens cases being put in the typhoid-fever ward?—No, certainly not. One of the essentials in the treatment of enteric or typhoid is quietness, and delirium-tremens cases are, as a rule, very noisy. That is one reason, and the most important one.

Mr. McVeagh: You know the entrance to the Hospital. Take cases of fracture, abdominal complaints, &c.: what is your opinion as to the effect of the entrance on these cases?—It could not be worse. The patients have to be carried up steps, and a fatality might result. I have seen a fatality occur through such a condition of things, but not in this particular one It is a thing that could be very well remedied.

The Chairman: To the ordinary layman such a practice is simply monstrous.

Can you suggest a better method in regard to the entrance?—There is a lift in the Hospital I don't know if it has been abandoned, but it was in use many years ago when I was on the staff.

Mr. Beetham: Is it near the entrance?—On a level with the ground. This is the invariable practice in all modern hospitals, and the lifts are of such a size that a wagon holding one patient can be wheeled on to the lift.

Mr. McVeagh: What has been your experience of consultations held in recent years?—I don't think the cases were judiciously selected for consultation. Cases have been brought up for consultation sometimes which did not need consultation. One instance was a lip-complaint, and it was a waste of time to call three surgeons together to decide if the lip should be operated upon or not. I'm voicing the opinions of the profession when I say that they are quite willing to go thoroughly into cases for consultation, but we don't think they have been judiciously selected in the past.

What has been the result of the injudicious selections made?—Well, the doctors would not turn up with the regularity they had always done, because the consultations were unnecessary and a waste of time. Consultations are one of the most interesting parts of the work, giving large experience and benefit to the surgeons participating, but when a consultation is not necessary a surgeon won't attend.

Of the two consultation-books before you, which is the one properly kept?—The one kept in Dr. Baldwin's time. The other one, the more recent, is not properly kept.

Dr. Lewis was then examined by Dr. Roberton, in answer to whom he stated that he had been a member of the honorary staff of the Hospital during various periods since 1886, totalling probably ten or twelve years. He did not consider that the management of the Hospital had been uniformly successful during this time. He thought the management was at its best in Dr. Baldwin's time. During last year, when witness was one of the honorary surgeons, cases were admitted under the Senior Medical Officer, as well as members of the honorary staff. The cases so admitted were accident cases in No. 1 Ward.

Dr. Roberton: How does one tell in the Hospital under which doctor a case is?—By the name being over the bed.

Was Dr. Collins's name placed over the bed in his cases?—No; there were blanks, and I was told that those were his cases.

Dr. Roberton: What is the position of the Senior Medical Officer in regard to meetings of the staff?—He attended the meetings according to rule.

Was his presence an advantage?—It was when the staff desired information in regard to hospital-management; but it was a disadvantage when matters affecting the relations between the staff and the Board were discussed.

Was he present when matters affecting his own position were discussed?—Yes, certainly.

What was the rule in Dr. Baldwin's time?—The Senior Medical Officer attended the meetings by request of the staff, and not as a right. I believe this worked satisfactorily.

What should be the relation of the Senior Medical Officer to the honorary staff as regards the treatment of patients?—He should certainly carry out the instructions of the honorary staff. I do not think it is fair to place all the responsibility on the Senior Medical Officer. We have had too much experience of that, and it won't work.

On such matters would his position be equal to that of the staff?—Certainly not; he should be subordinate to the staff in such matters.

What should be the tenure of office of the honorary staff?—I think the present term of one year is too short. I think three years would be better, as in such cases the surgeons would be able to do better work, knowing that they would have three years of office. The present term of one year tends to limit the choice of surgeons, as it is calculated to prevent surgeons from offering their services.

How have the Board and the staff got along together?—They have seldom got on well. The Board has generally seemed to have no confidence in the staff whatever, and as a rule would not take their advice in anything. This has been the case for the past twenty years practically. During the past ten years or so the Board has been practically dominated by one man—the Chairman. The other members of the Board have known very little about the Hospital at all.

How did you form that opinion?—From conversations with members of the Board.

In answer to further questions, the witness said that the scattered nature of the buildings make it difficult to work the Hospital. The Costley Wards were put up specially for children, as a result of general dissatisfaction as to the previous accommodation for children. One of those wards was now used for adults.

Dr. Roberton: Where was most of the operating done last year?—It was pretty equally divided between the two theatres, the better of which was that at the Costley Wards.

Will the new theatre be an improvement on the old one?—Yes, certainly.

Do you remember the Board seeking the advice of the honorary staff in regard to the theatre, and what their decision was?—I cannot remember. There are too many things connected with the management of the Hospital to remember. I think we were told that they were going to have a new theatre no matter what it cost.

Do you regard the new theatre as a luxury?—Well, I would call it a "luxurious necessity." (Laughter.) It is not a dire necessity. The old theatre was a very good one, but one could never get hot water there. It all had to be carried from the kitchen, and I have had to wait from half to three-quarters of an hour on this account.

Dr. Roberton: For what class of the community do you think the Hospital should mainly exist?—For the sick poor.

Do you object to others being treated there?—Yes; because they take the beds which should be kept for the sick poor. At present it is a weekly and sometimes a daily occurrence for poor patients to be afraid to go into the Hospital on account of being compelled to pay the fees. As a ratepayer, I also object, as the cost of maintaining the Hospital is greatly increased by taking in persons who can afford to be treated outside.

In what way does it affect the medical practitioners?—Well, it takes away patients from them. (Laughter.)

Are you sure?—Yes, absolutely sure. I have known cases in which patients who could well afford to pay for outside treatment have waited for my week in order to be treated by me in the Hospital.

Have you remonstrated against this with the Board?—Yes, but I do not remember what the answer was. This practice also unfairly affects the private nursing-homes, which are conducted for the most part by nurses who have been trained at the Hospital.

Have you ever known of a statement being made that private nursing-homes were entering into competition with the Hospital?—Yes; a member of the Board has stated to me that he does not consider it right that nurses' homes should compete with the Hospital.

Have you ever done work gratuitously in a private hospital?—Yes, I have, certainly; the patients paid the nursing-fees, which in some cases have been made the same as the Hospital fees.

Would it not be a saving to go to the Hospital?—It would, if the Board would remit the fees, as they sometimes absolutely have to do.

Dr. Roberton: Do you remember being a member of a deputation from the Medical Association which waited on the Board in March, 1903?—Yes; I went with Dr. Purchas and Dr. Inglis to point out to the Board in what respects the more economical running of the Hospital could be insured. We offered a number of suggestions as to how the expenditure could be curtailed. There had been considerable dissatisfaction, owing to an impression that the Hospital was costing too much. When we had finished speaking Dr. Collins replied to our suggestions.

He was not a member of the Board. Why did he reply?—I have no idea. It was purely a financial matter.

Dr. Lewis was then cross-examined by Mr. Reed, who handed to the witness a copy of the resolution forwarded by the honorary staff to the Board in 1901. Witness expressed dissent from some of the recommendations in the letter, but agreed with the following clauses: "He (the Senior Medical Officer) shall be responsible to the honorary staff that all treatment prescribed by them be properly carried out. He shall be responsible for the proper administration of anæsthetics, but may delegate their administration to the junior medical officer. He shall see that the clinical records are properly kept, and that they are up to date."

Mr. Reed: By whose advice do you think the Board should be guided on these points?—If the Board had carried out the advice of the honorary staff in years gone by, there would not have been so much friction as there is now.

But the Board carried out the staff's suggestions in making rules in 1902?—Yes, in some respects.

Do you think these rules would conduce to the good government of the Hospital?—I do not think the Hospital could be satisfactorily and amicably worked under such rules.

Mr. Reed: You have said that during practically the whole of the past twenty years the Board and the honorary staff have not got on well together. Can you suggest how that could be remedied?—Yes; I think it could be remedied perfectly well by separating the Hospital Board from the Charitable Aid Board, and have one distinct body for the government of the Hospital.

What would you suggest should be the constitution of that Board? It should be partly elected on the popular franchise and be partly nominated by the Government, with one medical member elected by the medical men, resident in the Hospital district.

From your knowledge of local matters, can you say that nomination by the Government has acted satisfactorily in other cases, taking the Harbour Board as an instance?—I do not know anything about the working of the Harbour Board.

Can you suggest what persons the Government should nominate? Do you mean all and sundry, or any particular class of the community?—I would leave it in the hands of the Government, which contributes a large amount of money to the upkeep of the Hospital, and should therefore be represented.

Have you any suggestion to make as to the proportion of nominated members?—No; but I am distinctly of opinion that the Hospital Board should be distinct from the Charitable Aid Board.

Can you say how a Board so constituted would be more likely to get on well with the staff than the present Board?—I think it would be more likely to keep in touch with the staff.

Can you say why?—No, I cannot.

Mr. Reed: You find fault with the Hospital-management in regard to the treatment of patients. Do you suggest that treatment in the Hospital should be absolutely free?—It is no good me making a suggestion to alter the laws of the colony.

Mr. Reed: I think the Commission has been set up to deal with matters affecting not only the management of the Auckland Hospital, but of all hospitals in the colony.

The Chairman: I think the Auckland Hospital affords quite wide enough scope, judging by what I have seen. We have to inquire into matters connected with the Auckland Hospital, and if as the result of our inquiry the Government obtain knowledge which may be of use to other hospitals, so much the better for them.

Mr. Reed (to witness): Do you think treatment in the Auckland Hospital should be free?—Yes; the sick poor having preference. I think it would be best.

You say you have known cases in which patients have been afraid to go to the Auckland Hospital on account of the fees. Do you know of any such instance, or were you speaking from hearsay?—I know a number of instances from what people have actually told me.

Those people preferred treatment in their own homes?—Not necessarily; but when they were advised to go into the Hospital they said that they could not go, as they could not afford to pay the fees.

Do you mean that they went without treatment altogether, or that they were treated in their own homes?—I have in my mind a case of this sort in which the patient was treated at home.

Could a person be treated at home for less than 4s. 8d. a day?—Certainly.

Including medical attendance?—Oh, we get nothing for attending such cases.

Do you know of any case in which hardship has been caused through the Board enforcing payment of the Hospital fees?—Well, I have known of servant-girls' wages being mortgaged for a long time to pay Hospital fees—that is, they have had to pay the fees out of their wages after recovering.

But was there any compulsion in the matter?—There is considerable compulsion implied by an authoritative body sending a bill to the patient.

But is that understood to amount to compulsion?—I do not know the inner working of the matter at all.

Do you know that a large amount of hospital fees—several thousands of pounds a year—are written off?—I have seen statistics to the effect that a large amount is written off, but I do not know how much. I understand that one of the first things that happens to a patient on going to the Hospital is a visit from the house steward, to find out what his financial position is.

Have you ever heard of any person being turned away on account of not being able to pay the fees?—No, I have not; but those who can pay the 4s. 8d. a day are more welcome.

Mr. Reed: Is it not the practice for modern hospitals to be built all on one flat?—Where would you get the land from? Hospitals are still built several stories high.

The structural state of the Hospital prevents the present lift being made available for use. Do you know that plans were prepared some time ago for a new lift?—I did not know it, but I am glad to hear it.

The Chairman: How long has the present practice of carrying patients upstairs existed?—I think it has always been the case. I do not know how long the lift has not been working.

Mr. Reed said the lift was too narrow for the conveyance of patients.

In the course of further examination, Dr. Lewis said that the custom of putting delirium-tremens cases in the wards in the basement was not at all modern, and a separate ward should be built. The Hospital Board should certainly take such cases in. There should always be a means of dealing temporarily and separately with the consumptive cases, which were not fit to take to a sanatorium or for outdoor treatment. Such cases should be dealt with separately at the Hospital, and he believed there were several spare small wards in the basement which would be suitable. At any rate, they were suitable for malignant complaints.

The witness said provision should be made for incurable cancer cases, and the cases which were not broken down could be treated in the general surgical ward. For the latter cases it was not necessary to erect a separate building, but the incurable cases, in which there was a lot of discharge, should be sent somewhere else—he thought the Costley Home was the right institution. The Hospital should receive all cases until proved to be incurable. Diphtheria should be treated in an isolated hospital. In his opinion there was no great danger in treating the diphtheria cases in the buildings on the Hospital grounds, so long as the staff took reasonable precautions. There was no necessity for a separate staff. The question of the treatment of semi-lunatics was rather a difficult one. The profession did not desire to commit to an asylum a man who was only on the borderland of lunacy, and it was those kind of cases that had to be provided for. They had to be treated somewhere, while it was seen whether or not they developed insanity.

The Chairman: The Hospital should be the last place to send them to. If their friends or relatives could not take care of them they should not be put amongst the typhoid cases at the Hospital.

Dr. Lewis: Oh, certainly not in the typhoid wards. The doctor went on to say that there should be accommodation for such cases before committal to an asylum. More room could be made at the Hospital were the patients who were well able to pay excluded from the institution. The patients were reduced last year by the Hospital authorities, but the witness was not aware of the mode of discrimination brought into effect. In reference to patients having to get a medical practitioner's certificate, the witness did not think such a rule was required. He did not favour the abolition of the honorary staff and the introduction of the system of a paid staff. It had been tried once, he said, when the honorary staff resigned in a body, but it was not a success.

Mr. Reed: As to the erection of the new operating-theatre, he did not know if it was for general surgical cases, or for the Costley Home inmates, because the theatre was 200 yards from the main building.

Mr. Beetham: Is the theatre to be used for inmates of the Costley Home, or for surgical cases generally?—In the latter case the patients will have to be carried at least 130 yards to the theatre through rain and wind.

Dr. Lewis: I think it is quite wrong.

Mr. Beetham: It is useless to erect such an expensive building for the Costley Home inmates alone.

In reply to Dr. Collins, Dr. Lewis said he saw no reason why a patient should not produce a doctor's certificate on admission, but there was no necessity for it.

Dr. Collins: Am I right in saying that before the production of the certificate was brought into force medical practitioners in town found that when his account with a patient was getting large the patient went straight to the Hospital to avoid expense?—No, I don't think so.

Does not it encourage patients to leave their own doctor and go to the Hospital to avoid expense?—Certainly not. People don't go to the Hospital for pleasure. It didn't make the slightest difference.

Do you think anybody should be admitted as soon as they come to the door?—Provided it is a fit case, and is seen and passed by the resident physician.

Without a recommendation?—Certainly, if it is a fit case.

Dr. Collins: Am I not right in saying that a great deal of the surgical work from the main Hospital has been done in the Costley theatre?—I can't say. I can only speak for when I was there. I operated more often in the main building than in the Costley theatre.

Do you know of any case being carried to the Costley theatre and back to the main Hospital?—I do remember a case.

Who planned the theatre—the Board or the honorary staff?—I don't know.

Were you on the staff at that time?—I know I was on the staff when the question of building the ward for the children was mooted.

Who planned the ward—the Board, on its own responsibility, or with the advice of the staff?—I don't know.

Did the staff approve?—I don't know what the staff did, but I did not.

Dr. Lewis then said he wanted two alterations effected—a window placed on the south side, and a new set of washing-basins and water-supply. He believed there was a convenience next to the operating-theatre, but did not think it a source of danger. He was not aware that the pipe from the convenience passed under one corner of the theatre.

Referring to the plans of the Costley Wards, Dr. Collins asked: Do you remember if the staff approved or disapproved?—I don't remember that. My own opinion is that it is a beautiful little hospital.

Do you think the Costley operating-theatre was necessary?—No, I don't think it was necessary.

Did the staff advise the Board to build one?—I don't know.

Did the staff advise the Board sending me South for the purpose of forming plans for a new theatre?—I don't know. I wasn't present at the meeting when it was discussed.

Dr. Collins: You say semi-lunatics should not be put in the typhoid ward?—I don't agree to that.

During your time at the Hospital were not several Magisterial inquiries held in the ward while typhoid cases were there?—Inquiry into what?

The mental capacity of patients?—I only remember being there once with Mr. Kettle. I think it was in one of the typhoid wards.

What cases require separate treatment at the Hospital?—There should be a ward for septic cases and delirium tremens.

Mr. Beetham: Do you take those patients into the Hospital?—Yes; at present they do.

Mr. Beetham: During my twenty-five years in Christchurch I never sent one case to the Hospital. I have never done it in my life.

Dr. Lewis: What do you do with them?

Mr. Beetham: Have them attended to at their own homes.

Dr. Collins: Are semi-lunacy, imbecile, and chronic cases sent into the Hospital on the recommendation of medical men?—I can only speak for myself. I have sent cases of that sort in.

Do you think it right to take in venereal cases?—Certainly I do.

What accommodation do your recommend?—I should recommend a ward being set aside. It is not an insuperable difficulty, and the cases would not require a large amount of accommodation.

Dr. Collins: You are aware that the Hospital washing is sent to the Costley Home?—I don't think it a right thing.

Do you advise building a laundry?—Most decidedly.

In Wellington they have a sterilising-apparatus for sterilising blankets, sheets, &c. Do you recommend something of the same sort in Auckland?—Yes. No hospital is properly equipped unless it has the means of sterilising.

Do you approve of diphtheria being treated on the Hospital grounds?—I don't see why it shouldn't be treated there.

Do you think it right we should be obliged to take in puerperal cases?—One of the main functions of the Hospital is to save life, and if you refuse these cases you are destroying valuable lives.

Would not the admission of such cases endanger valuable lives?—I don't think so, if you have them in an isolated position. The Hospital is for the treatment of various kinds of sickness, and if there is no accommodation those able to pay for outside medical treatment should be excluded.

Dr. Collins pointed out the difficulty that would be experienced in ascertaining a person's means. He went on to ask Dr. Lewis if he recommended separate wards for various kinds of contagious-diseases cases, and witness replied: I don't know how many wards you want me to say I agree to.

Dr. Collins: You say you don't agree with the present pavilion system?—No. I didn't say that.

Dr. Roberton corrected Dr. Collins in his use of the word "pavilion," and said it was not the pavilion system that existed at the Hospital.

Mr. Beetham: It is a go-as-you-please system.

Dr. Roberton: That's what I think.

In asking the witness about making provision for the various infectious-diseases cases, Dr. Collins pointed out that the padded cells in the basement were unfit for occupation, on account of their dampness and coldness, there being no means of heating the cells. Alcoholic cases should not therefore be put in the cells, as coldness was to be avoided in such cases, it being detrimental to the patient. Dr. Collins further pointed out that to erect a laundry and build separate wards would entail an increased staff, provision being made for them, and a great deal more work.

Dr. Lewis: I am not a specialist in these things. The work would be increased if you take in everybody irrespective of their ability to pay for outside medical treatment.

Dr. Collins: Doesn't the law demand that we shall take in everybody?—Yes.

And the natural sequence of events would be the rapid filling-up of the Hospital?—It would depend entirely on the attitude of the resident staff.

If a patient came to the Hospital with a recommendation from a medical man whose experience would be riper than the junior resident's, would you approve of the junior saying yea or nay?—The resident staff—I don't care if it is the junior or the senior.

Then, if a patient came without a certificate, the junior was assisting at an operation, and the senior was at a Board meeting, what is the porter to do? Leave the patient outside?—A certain hour in the morning should be fixed for the admission of patients, and admission refused in the afternoon, excepting in emergency cases.

Dr. Collins also pointed out a difficulty which he had experienced. He was operating, and the junior (the only other officer on duty) was assisting him, when a patient without a certificate was brought to the door. The operation could not be left, and the porter could not bring the case in, as he did not know what disease it might be. That Dr. Collins said, had occurred more than once.

Dr. Lewis: If the certificate is necessary you should encourage it.

Mr. Beetham: But not turn away patients without a certificate.

Dr. Collins: When you were on the staff did you hear of complaints of persons being left three or four hours without being attended to?—Yes, I heard, but not specific complaints.

Dr. Collins: Would you recommend a casualty officer being appointed to be on duty to treat only injured persons?—I don't think it is necessary.

Do you recommend the appointment of another resident?—Making three residents and a Superintendent, no.

Mr. Beetham: The duty of one to admit those who haven't got certificates from medical men?

Dr. Collins: Do you know the Melbourne Hospital, with 320 beds, has eight residents, and Auckland, with 200, has only two?—You can't compare Melbourne with Auckland. One is a teaching school, and is in no way similar.

Dr. Collins: Do you think it is fair to make the Senior Medical Officer responsible for fractures and dislocations?—No, it is quite a wrong system.

Isn't the Senior Officer much more liable to actions for damages than an honorary surgeon?—I understand that you are not liable for damages for failures at the Hospital. I say that because in Dr. Floyd Collins's time he was proceeded against twice, and only verdicts were given against him.

Before I was appointed who had charge of fractures and dislocations?—The honorary staff.

Dr. Collins: Isn't it customary in every hospital for juniors to put up fractures?—As a rule they do in simple fractures. In some cases the patients are treated with first aid till the arrival of the honorary surgeon.

A number of questions as to how fractures are dealt with, and when the bandages and splints are taken off, followed, causing Mr. Beetham to remark, "If we go on in this manner we shall soon become duly qualified medical practitioners. We don't want to be medically educated."

Dr. Collins: You think I have had too much responsibility placed on me in regard to fractures?—I do.

Dr. Collins: I agree with you.

At this stage the Commission adjourned.

When the Commission resumed on Monday, the 24th October, *Dr. Lewis*, whose cross-examination had been concluded when the Court adjourned on Friday last, was re-examined by Mr. McVeagh, as follows:—

Mr. McVeagh: Do you approve of consumptive and cancer cases using the same lavatory in common with other patients in the same ward?—No; I don't think that is at all advisable. It is against all modern ideas of the treatment of such cases that such a state of things should be permitted.

Dr. Lewis stated further that it would be detrimental to the typhoid-fever cases to put a delirium-tremens case in the same ward. He did not foresee any difficulty in a proper system of administration in the way of the resident members of the staff deciding what cases were suitable for admission. It was the duty of the resident staff to be a board of admittance. He did not think it would often occur that the Senior Medical Officer and the resident staff would be so occupied that they could not spare a few minutes to inspect a case that was brought to the door. Or, as an alternative, the patient could be taken to the out-patients' ward and made comfortable there until one of the resident staff was available. The Matron or one of the senior nurses could see the case and report to the Senior Officer the condition of the patient seeking admission.

Mr. McVeagh: What is your opinion in regard to the Senior Medical Officer having the same status as members of the honorary staff—attending all meetings of that body, and voting on all questions?—So long as such a system exists there cannot be a satisfactory state of things at the Hospital. I cannot see that the honorary staff should be subservient to a paid official of the Board.

Mr. McVeagh: Why did you resign from the honorary staff?—I was not satisfied with my position at the Hospital. I did not feel that I was happy and comfortable, and I could not take the interest in my work as I would like to have done.

How was that?—I felt that the Board had placed the Senior Medical Officer in a position superior to mine. I was even reproved by the Board for asking leave of absence for my annual holiday, because I went direct to the Board. I received a letter from the Secretary of the Board, telling me to ask for my leave of absence from the Senior Medical Officer.

The Chairman: Have you got that letter?—Yes. [The letter was handed to the Chairman.]

The Chairman, reading from the letter, said, "As expressed by Rules 11 and 37." Upon looking up the rules he remarked, "That has nothing to do with it."

Dr. Lewis: All communications from the honorary staff to the Board had to go through the Senior Medical Officer.

The Chairman: That is absurd. This is a rule that exists in no other hospital that I know of.

Mr. Reed pointed out that the letter did not say just quite what Dr. Lewis gathered from it. After granting the request for leave of absence the Board suggested that in future all such applications should be sent through the Senior Medical Officer. The application, Mr. Reed said, was only to go through the Senior Medical Officer.

Mr. McVeagh: It is a somewhat humiliating position for a member of the honorary staff to be put in.

The Chairman: Supposing a member of the honorary staff wanted to make a complaint against the Senior Medical Officer, he would have to send it to him—to the person against whom a charge was being made.

Mr. Reed mentioned that in military matters all complaints and charges went to the senior officer.

The Chairman: But these are not military matters.

Mr. McVeagh said he had to intimate that he desired to withdraw clause 17 of the list of charges, which referred to the administration of anæsthetics. Counsel mentioned that he had personally investigated the charge, and decided that the evidence then available justified him in formulating the charge, but he had since obtained further information which showed that the charge had no foundation whatever.

The Chairman: Very well.

Nurse Margetts was recalled, in order to state, from reference to the report-book, what cases were in the typhoid ward at the time a patient named Russell was there some two years ago. The witness stated there was no mention in the report of typhoid cases being under treatment at that time, but there were two consumptives and one rheumatic-fever case.

Questioned by Dr. Roberton, the witness stated that No. 8 Ward was known as the typhoid ward, restricted to male patients. She had not known the two sexes distributed in the ward. There had been several cases of tuberculosis and consumption put in the ward. She generally knew the nature of the complaints from the symptoms shown by the patients and the instructions received from the doctors, but it had always been the custom to fill in the chart at the end of the treatment. This was done, the witness explained, so as not to disclose to relatives and friends of the patient the nature of the case, in order to relieve them of unnecessary anxiety.

Mr. McVeagh then handed in several of the Hospital records. In regard to the admission-book, he pointed out that the porter seemed to have diagnosed the case of White as one of perforation.

The Chairman: The porter keeps the admission-book?

Mr. McVeagh: Yes. He seems to have been the only one of the medical men present who succeeded in getting a correct diagnosis of the case.

Mr. Reed: The diagnosis was filled up afterwards.

The Chairman: Whose writing is this (referring to the book)?

Mr. McVeagh: I understand it is in the writing of Dr. Walsh.

The Chairman: The heading of the notes is by Dr. Scott, surgeon for the week.

Mr. Beetham: He was not present?

Mr. McVeagh: No.

The operation-book was handed in, and Mr. McVeagh drew attention to the consultation in White's case. It was not in its chronological order. The duration of the operation was stated to be forty minutes, whereas it lasted for two hours.

Dr. Collins: It was really one hour and forty minutes. The entry was a mistake.

Mr. McVeagh also pointed out the appearance of page 144, the entries looking as if they were written up *in globo*.

The case-book was referred to in connection with the White case, and Dr. Collins remarked that the particulars were written up after the case had ended.

The Chairman: After the man died?

Dr. Collins: Yes.

The Chairman: Who was it written up by?—The house surgeon, Dr. Walsh.

The Chairman: He wasn't at the Hospital. Where did he get the particulars?—From the other doctors and myself.

Nurse Brouin was then called by Mr. McVeagh in regard to the charge made by Dr. Neil against Dr. Collins to the effect that the latter had negligently failed to acquaint himself with the condition of Florence White, a patient who had been operated upon, and that he had informed the patient's mother that she was dead, whereas she was still alive. Witness said she was a charge nurse in No. 4 Ward. Witness remembered Florence White coming from the operating-theatre on the 3rd July, 1904, in a low state, and with the breathing rather

shallow. The patient was ordered to be given stimulants, amongst which was oxygen, which was administered in desperate cases. She died at half-past 9 the same evening. Witness did not send word to any one about death having occurred. It was usually after 10 o'clock when the Medical Officer visited her wards, while she could not say as to him visiting the wards at 6 o'clock in the evening. Witness was aware that experiments were being conducted by the Senior Officer in the bacteriological laboratories, and she had two or three times to go there for him.

Replying to Dr. Collins, the witness said she knew the doctor gave demonstrations to the nurses in the bacteriological laboratories. He was often in her ward after 5 o'clock, and she could not recollect any serious case being neglected. In the case of the patient White, witness did not remember what explanation was given by Dr. Collins to Mrs. White when she got to the Hospital, after having been erroneously informed that the patient had died.

To Dr. Roberton: It was usual for the nurses to administer oxygen under instructions from the doctors.

John Donald McLeod, contractor, of Waipu, said he fractured his thigh on the 18th February, and the injured limb was set by a local doctor. He arrived at the Auckland Hospital on Saturday, the 20th February, but was not attended to till the following Monday, about 11 o'clock, by Dr. Bennett. The splint on his leg was replaced by another one. Sticking-plaster was put on both sides of the leg above the knee down to about the ankle. No side splints were used. There was a nasty wound below the knee after the removal of the bandages, which witness thought was caused by tight bandaging, as it was not there when he entered the Hospital. Six weeks later Dr. Bennett examined the leg again, removing the splint and replacing it. Dr. Collins saw him a fortnight later, when he removed the splint and put it back again. He also pulled the sticking-plaster off, tearing away a lot of skin. In all, he was at the Hospital for fourteen weeks. His leg was now weak, and he could scarcely bend the knee.

An *x*-ray radiograph of the injured thigh, taken by Dr. Purchas, was produced, together with a normal thigh-bone, the difference between the two being considerable.

Cross-examined by Mr. Reed, witness said he was not prepared for chloroform on the Saturday night he was admitted. He did not remember seeing Dr. Bennett on the Sunday morning; his leg was not examined that day. The leg was set without chloroform. He had had rheumatism whilst he was at the Hospital, but he had not had it previously. His thigh was not so stiff now as when he left the Hospital.

In cross-examination by Dr. Collins, witness said he did not remember his leg being seen by him (Dr. Collins) on the morning after his admission. He remembered being treated for about a week for rheumatism whilst in the Hospital, when his leg was swollen.

Dr. Collins: Do you remember me being very anxious about you, and coming to see you two or three times a day?—Yes.

In reply to further questions, witness said that his knee did not swell till after the sticking-plaster was taken off. He thought the plaster was taken off very quickly. He could see the skin coming off with it. The skin came off nearly the whole length of the leg. He remembered Mr. J. McLeod (a member of the Hospital Board) going to see him, and telling him that he had heard that he (witness) was not being properly treated. Witness replied that he had nothing to complain of. He said this because he thought that anybody with a broken leg had to go through the same performance as he had gone through, he never having had a broken limb before.

James Frederick Fisher said he was a patient in the Hospital from the 25th June to the 22nd August. He was affected with a throat trouble. He was first in No. 3 Ward. He was seen by Dr. Collins on admission (on a Saturday). He saw no other medical man till Monday, when he saw Dr. Neil. He was afterwards transferred to No. 7 Ward.

Mr. McVeagh: Do you know anything about the habits of Dr. Collins in regard to visiting patients in the wards?—He was most irregular. I never saw him to speak to, except on my admission. He sometimes never went near patients for two days at a time.

Witness said he did not see a member of the resident medical staff for some time. One day, however, he saw one, and suggested that he should leave. He was advised to stay another week. He remained another week, but nobody went near him.

Was Dr. Collins in the habit of visiting the wards at 9 in the morning or 6 o'clock in the evening?—No.

Mr. McVeagh: What was the quality of the food supplied?—It was not good. One morning, in No. 3 Ward, there was fish for breakfast, and it was that rotten that no one could touch it. It stank. The same thing frequently happened in No. 7 Ward. Nobody would touch it. I myself have made a breakfast from porridge and bread-and-butter.

What was the porridge like?—Very often it was lumpy and not sufficiently cooked.

Anything as to sugar?—There was no porridge for sugar in No. 7 Ward. (Laughter.)

No porridge for sugar?—No. (After a pause): I mean there was no sugar for porridge.

What did you do for sugar when you wanted it?—Bought it. I bought it on two or three occasions, and I have known other patients do the same.

What was the condition of the eggs?—The quality was good, but there was not enough in No. 3 Ward. There was enough in No. 7. I frequently went without.

What about cabbage?—I never saw a piece of white cabbage all the time I was there. It seemed to be all outside leaves, and not well cooked at that.

What about meat?—It was of good quality, but it was spoilt in the cooking. Very often the joints had the appearance of having been cooked and cut on the previous day, and then warmed up and rung in on to us. The meat was first of all steamed in a steamer, put in the oven to brown, and then covered with gravy. Very often it was steamed to rags.

What about soup?—It was generally of one kind, and frequently so greasy that I could not touch it.

Have you had experience in cooking?—Yes; I have been cooking on sea and shore for ten years. At present I am on the Union Company's steamer "Herald." I have been with the Union Company for six or seven years.

Mr. McVeagh: Did you see any one administer hypodermic injections in No. 7 Ward?—Yes; I saw Cook, the wardsman, doing it. I also saw another wardsman, known as "Dick," doing it. I have also seen a patient named Robert Halifax do it to himself and others.

How did this patient get hold of it?—He got it from the cupboard in the absence of the wardsman.

Was the cupboard locked?—I could not say. I caught Halifax one night injecting morphia into himself, and I advised him to leave it alone. The effect was to make him and others to whom he gave it very stupid.

Have you also seen him apportioning medicine to patients?—Yes, I have. He offered me mine once, but I refused to take mine from him.

Mr. Reed: Do you suggest that Halifax obtained the morphia with the connivance of the staff?—He obtained it without their knowledge.

Was he the only person you saw doing it?—Outside the staff, yes.

Did you think it necessary to call the attention of the staff to it?—It was on the tip of my tongue to do it several times, but I did not, as I did not wish to create ill-feeling between Halifax and myself, especially as I had had one or two rows with him already.

Did Halifax give out the medicine unknown to the staff?—Yes, as far as I know. The wardsman was off duty at the time.

Mr. Beetham: Was there no female nurse in the ward?—No; there was only the male nurse.

Mr. Reed: Do you suggest that Halifax gave out the medicine at the request of the staff?—I should imagine so, as the medicine was given out at the proper time.

Did you make any complaint about it to the wardsman?—No.

Did you make any complaint about the food?—Yes, to the wardsman. Every time there was anything wrong I complained, but I saw no result.

What did the wardsman say?—He said he would report it.

How often was the fish bad?—I should say about twice a week.

Did any one eat it?—No; it may have been picked over by one or two, but it was rotten.

You say the meat was too overdone?—Yes; it was done to rags.

Dr. Collins: You say that you have seen Halifax administer morphia to other patients?—Yes; to two other patients. I advised him, from a friendly point of view, to give it up, but he took no notice.

Did you take any other steps to stop him?—No. I had already had one row with him, and did not want another.

How could you advise him in a friendly way when you had had a row?—I thought it was a wrong act, and I looked upon it as a friendly act and my duty to advise him to give up the practice.

Do you not also think that it would have been your duty to report the matter?—I have thought the matter over very seriously since, and I am sorry that I did not report it.

Dr. Collins: You have complained of the food. Are you a judge of cooking?—Yes, certainly.

You consider yourself as good a cook as there is in Auckland?—I know bad fish from good fish.

It does not need a cook to tell bad fish. Every one has a nose. Is there any jealousy in your profession?—There may be a little.

Do you think that there may have been a little jealousy between you and the Hospital cook?—I should be very sorry to be jealous of that cooking. (Laughter.)

Did you have any words with the Hospital cook?—No; I never spoke to him.

Did you ever go out whilst you were at the Hospital?—Yes; I went down to see my old shipmates on the "Mararoa," but I did not go out for any other purpose.

Was it not necessary to go out to buy sugar?—I used to buy at a little shop across the road near the Hospital gate.

When you were out on the verandah during the day, would you have known if I went into the wards whilst you were there?—No.

Were you left long without seeing a doctor?—After Dr. Neil's suspension I was left without seeing anybody.

Did Dr. Neil see you every day?—No.

Did you think you were well treated in the Hospital?—By Dr. Neil I was, certainly.

Did you complain of the food to Dr. Neil?—No; I thought it was sufficient to tell the wardsman.

If the food disagreed with you, did you not think it necessary to tell the doctor?—I did not give the food a chance to disagree with me, as I would not touch it.

Will you swear that the fish was in a rotten condition two days a week?—Yes, I will swear it. It was so pretty well all the time I was there.

Did the Hospital manager ever come into the ward to inspect the food?—No.

Did you ever see him in the ward?—If he wanted any one to go down town with a message for him he would come.

Dr. Roberton: Are you aware that there is a rule in the Hospital prohibiting patients taking food into the Hospital?—Yes.

Was the wardsman aware that you were bringing it in?—He was; but I do not know whether the other members of the staff were aware of it or not.

Carl Brown, a comedian, of Auckland, said he was in the Hospital from the 18th July to the 5th September. He was in Ward No. 1, and knew a patient named Bob Halifax. He had injected morphia into himself and other patients, obtaining the morphia from a chest while the wardsman was absent. Halifax said he slept beautifully after the administration of the morphia. This was done nearly every night when Mr. Cook, wardsman, went to his tea. The other patients seemed anxious to have the injections. Witness saw no money changing hands. He had remonstrated with Halifax, and the latter only replied, "They'll never find out." The patients participating were Harding, Taylor, and others. Medicine was administered in the ward always by some one on the Hospital staff. There were delirium-tremens cases in the ward. One case had to be strapped down, but the cases generally kept the other patients awake. In the bathroom there was only one piece of soap, one bath, three basins, and one convenience. All patients who could get out of bed used those same conveniences. One patient, whose skin was peeling off, had a bath every morning. When convalescent he had given a hand in the pantry in serving out the meals, and it occurred sometimes that there was not sufficient to go round. Sometimes the fish was good, but other times dry and stale. The porridge was sometimes very lumpy. It was very seldom that they had sugar, and the patients used to send out for it. On one occasion witness saw all the chops returned; they were not cooked, only warmed. The soup (barley) and eggs were good.

Questioned by Mr. Reed, witness stated that a certain quantity of sugar was supplied to the ward daily, and if some patients had more than their due others had to go without, or send out for it. Halifax obtained possession of the morphia unknown to the attendant. One or two patients had soap specially for their own use. On more than one occasion fish was sent into the ward unfit for food. It occurred on two occasions to his recollection. Complaint was made to the attendant.

Joseph Colquhoun, cab-driver, of Remuera, said he was admitted to the Hospital with a fractured arm at the beginning of February, 1903, about midnight, when the nurses attended to his injuries. The following morning Drs. Collins and Williams examined it, and a little later Drs. Horsfall and Bennett set it. When the splints were removed Dr. Collins looked at his arm, and after asking witness his occupation he crossed the room and spoke with Dr. Bennett. Dr. Collins returned to him and said he would have to go under chloroform. This was done, and when witness came out of the operation he found his arm had been rebroken, and it was giving him great pain. Some weeks later Dr. Collins looked at it again, and shook his head, and ordered Dr. Frost to massage it. She followed this out daily for a week. The arm appeared to improve, and Dr. Frost asked permission to continue the massage treatment. Shortly after Dr. Collins was called over by Dr. Frost, and he said the arm had united.

Witness, replying to Mr. Reed, said some of the fish was good, but sometimes flounders were rank. Eggs were sometimes rotten, and had to be thrown away. Cabbage was poor, meat was sometimes overcooked, and the soup was occasionally greasy.

Replying further to Mr. Reed, the witness said his arm was not straight, and would not stand heavy lifting. The limb had united. He was about six months as a patient of the Hospital, four months of which he was actually residing on the premises. Complaint was made several times about the fish, amongst the patients, and also to the nurse.

Mr. Reed: Did you complain?—No. Several of the others spoke about it.

Dr. Collins: Did you have any complaint to make against me at the Hospital?—No.

Did you not tell me that you were satisfied with the way I treated you?—With the way the nurses treated me. I didn't like your action in allowing the juniors to operate on me.

You have expressed gratification at the results of the treatment?—Yes.

You have got good use of your arm?—Yes, fair use of it. I can follow the occupation of cab-driver, but don't expect to be always at that.

The witness, on being reminded of the dates on which he was an inmate of the Hospital, admitted that his term there had been only two months and two weeks. The rest of the time he was an out-patient.

Mrs. Wootten, who was Matron of the Hospital for some years, and lady superintendent since 1900, stated that she had also held the position of Matron of the Melbourne Orphan Asylum for five years. Witness said Dr. Baldwin's usual time of seeing her in the mornings was between half-past 8 and half-past 9 o'clock, and sometimes earlier, while she had rarely seen Dr. Collins in reference to administrative work unless she went to him. His time for arrival at the institution was very irregular. She had seen him at a quarter to 9 when he went for operations, but on other occasions it was 10 o'clock or later, 10 o'clock being the usual time. Witness did not know the usual time at which he left the Hospital, but she had seen him leaving at 5

o'clock, or, when operating, 6 o'clock and later. During the interval between Dr. Baldwin's resignation and Dr. Collins's appointment witness had full control of the nurses, and no friction whatever occurred. She had a testimonial from the Board in regard to the satisfactory working of the system. There had never been any friction between witness and the nurses.

Mr. McVeagh: Has it come under your observation the attention Dr. Collins has given to the surgical side in preference to the medical side?—He has appeared interested in the surgical work. I am not in the wards, so cannot give evidence definitely on the point.

Has Dr. Collins carried out his duties in regard to giving lectures to the nurses?—The lectures have not been as regular during the past two years as formerly by the honorary staff, Dr. Collins, and myself. A few have been given by Dr. Collins. In 1902 he lectured, in 1903 not so many were given, and in 1904 he has given six. The nurses had been given more lectures than the State demanded.

Are you prepared to state if the lady superintendent should have full control over the nursing staff?—I certainly think she should.

Who appoints the probationers?—Application is first made to the Secretary, and the names are submitted to me in their turn on the list, and on my recommendation they are taken on trial for three months.

Do you know the cost in the separate wards?—No; I don't know anything about the accounts.

Are you prepared to make a comparison of the cost between now and Dr. Baldwin's time?—No; I don't go into figures.

Will you tell the Commission about the restrictions it was attempted to make on the nursing staff?—Prior to Dr. Collins's appointment a nurse wishing to be out later than 8 o'clock at night obtained verbal permission from me. Dr. Collins insisted on a written pass being given. I objected at the time, but when I was told it was the wish of the Board I agreed to it.

How was it received by the nurses?—I was away on my holidays when it was brought into effect, but there was rebellion amongst the nurses. The former method was reverted to in a month's time on the authority of the Chairman of the Board.

Mr. Reed: At the time you had complete control of the nurses there was no Medical Superintendent?—No; there was no Superintendent, but the honorary staff attended daily.

Mr. Reed: It is the duty of the house steward (Mr. Schofield) to visit wards during meal-times?—Yes.

And that is the time to make complaints about the food?—Yes, if there are any complaints.

Do you know if he attends to his duties?—Yes; he attends to them most regularly.

Mr. Reed: What have you to say about the food?—I am only responsible for the food at the home, and not at the Hospital. The food generally is good compared with that given in other hospitals. I have never had complaints made to me. Now and again it might happen that the fish would be unsuitable, or other food not of the best quality, but that was to be expected at every similar institution.

Replying to Dr. Collins, witness stated the reason for not giving so many lectures in 1903 was that he was engaged with the Costley Home Commission for about three weeks, he having informed her that he would have to give up the lectures in consequence. Witness said she could not speak as to the cooking of the food in the Hospital, as she had never had meals there.

The witness, questioned by Dr. Roberton, said there were sixty nurses in the institution. This included six sisters, three charge nurses, five staff nurses, and the remainder probationers. She thought the proportion of probationers was rather large, with an approximate number of two hundred patients annually. If the buildings were better arranged it would be easier to control the nurses. First-year probationers had been in the fever wards just as assistants, but they had always had lectures from witness as to cleanliness, which was the chief point to be observed.

Mr. McVeagh: Do you know if the resident staff gave nurses clinical demonstrations at the bedside of patients?—I have never been present.

In your opinion, is it a proper course to pursue in the training of nurses?—It is done in other hospitals, and I myself have derived much benefit from it.

Can you classify the cases kept in Ward 7?—No, I can't. I only go there at intervals to inquire if there are any bad cases.

The Chairman: In the case of the patient being admitted to the Hospital at midnight with a compound fracture, who, under Rule 73, should be treated by the Senior Medical Officer, can you tell us why Dr. Collins was not there to attend the case?—He does not live on the premises.

But surely you must send for him when a serious case is brought in?—I do not know anything about the practice of attendance at night.

But the Senior Medical Officer is not only paid to be at the Hospital during the day?—I think the practice has been for the resident surgeon to attend to the patients until morning.

Until the morning, instead of sending for the Senior Medical Officer, who, according to the rules, should take charge of the case?—He is sent for in a serious case.

Isn't a compound fracture a serious case, where the man's arm was not united, and had to be set a second time?—I do not remember the case at all.

Is it usual to send for him—I am only asking for information as to the knowledge you have on the subject?—I don't think it is usual to send for him unless the case is serious, where an operation is necessary.

Mr. Reed: Has it ever been the practice to send for the Senior Medical Officer?—Yes, in Dr. Baldwin's time. He lived close to the Hospital.

The Chairman: Under the rules he should attend; it is his duty to be there.

Sister Margetts, recalled, said Dr. King was at present honorary visiting physician.

Dr. Roberton: Does the resident physician always accompany him on his visits to the ward?—No. He is sometimes engaged on operations.

How often is he engaged on operations?—I don't know how often, but he is more frequently than not when the honorary visiting physician make his visits.

Well, to whom does the visiting physician give his instructions in the absence of the resident physician?—To the charge nurse or the others in charge of a case.

Has any difficulty through doubt arisen in connection with issuing instructions in that way?—Not to my knowledge. I don't know of any disadvantage accruing through the resident physician being absent.

Dr. Collins: How many operating-days have we in the week?—I don't know.

Dr. Collins: Well, there are Wednesday, Thursday, Friday, and Saturday.

At what hour does the visiting physician make his visits?—At no fixed hour.

What time do operations take place in the mornings?—They start about a quarter to 9.

As a rule the physician gives the anæsthetics?—I don't know.

Do the honorary physicians often go round in the afternoon?—Dr. King sometimes goes round in the afternoon and evening—sometimes by himself and sometimes with Dr. Walsh.

Are the visits of the honorary physician regular?—No, they are irregular.

If the visits of the honorary physician in charge of the ward are not regular, does it not throw a lot of responsibility on the charge nurses and resident staff?—I suppose so.

When the bad pneumonia cases with the troopers were in, didn't I visit the ward frequently, about eight times a day?—At that time the honorary physician's visits were more regular. I know you came in frequently when bad cases had to be looked after.

William Peake, carpenter and joiner, of Grey Lynn, said on the 31st January, 1903, he met with an accident, sustaining two broken legs and a broken jaw. He was sent to the Hospital on the same day and placed in No. 1 Ward. Drs. Collins, Horsfall, and Bennett operated on him. It was about half-past 2 when he was put under chloroform, and he came out about 5 o'clock. Soon after he complained to a nurse that his jaw was broken, and it was then bandaged up. A great deal of calico bandaging was used, making it very uncomfortable. The bandages would not keep the jaw in position, and on witness complaining to the nurses he was told that the doctors knew their business. Eight or nine days subsequently he told Dr. Collins that his jaw was not right. Dr. Collins put his hand inside the mouth and found the fracture, as also did Dr. Bennett. A splint was ordered, and Dr. Horsfall set the fracture. Later an abscess set in, and had to be lanced. While in the Hospital Dr. Collins examined the legs occasionally, the splints being removed only once or twice. Each time he examined it he replied, in answer to witness's inquiries, that the leg was uniting. Witness thought otherwise, as he could feel the bones moving, so he told some friends that he would like to get another doctor's opinion. Dr. Lewis was seen, and, after getting permission from Dr. Collins to examine the leg, he saw it. Just after that it was arranged for witness to leave the Hospital, and on the day he gave notice Dr. Collins examined the leg and said it was uniting. That afternoon Dr. Collins came to witness and remarked upon witness's decision to leave the institution. In the evening Drs. Lewis and Collins came to him, and the former refused to have anything to do with the case, because he was under Dr. Scott at the Hospital. Eventually his friends took him from the Hospital, after being there for six months. He was treated in a private hospital for eight weeks. It was eight or nine days before it was discovered at the Hospital that his jaw was broken. His leg had never united while in the Hospital.

Witness, asked about the diet, said there was a sameness about it which spoilt his appetite. There was no seasoning put in the food. At times the fish had to be removed from the table, it being bad. There was also some of the inside left, and also scales on flounders.

"On flounders"? asked the Chairman.

The witness replied in the affirmative, but afterwards said he would not be positive, as they might have been fins.

Continuing, he said delirium-tremens cases were admitted to the ward he occupied, and made things very uncomfortable. He was sorry for the nurses on account of the language used. He saw the juniors setting the fractures in the cases of two other patients, William Adams and Colquhoun.

Mr. McVeagh: Can you say if the Senior Medical Officer visited the wards at 9 o'clock in the mornings and 6 o'clock at night?—There were some mornings I never saw Dr. Collins at all.

Reverting to the question of diet, witness stated he complained to the nurse that the food was unsuitable, and upon that Dr. Collins came to him. Witness told the doctor that he believed the reason of his blood being out of order was because of the sameness of the food. Dr. Collins said if anything was sent along he would see that witness got it. It was left at that. Food was carried in an open basket from the Hospital to the plague hospital, a distance of 200 to 300 yards. At the time of the scarlatina outbreak the Hospital was closed to visitors for a fortnight. A case occurred in No. 1 Ward, and the patient was removed to the fever hospital. Out-patients were in and out of No. 1 Ward as usual while the Hospital was closed. Porters carried fever patients from the main Hospital to the fever wards, and afterwards returned, going somewhere under the Hospital.

Mr. Reed: Your case was considered a serious one?—Yes, I believe it was.

You made your will out?—Yes; because I didn't know whether or not I would come out safely from the chloroform.

Your leg has now united?—Yes. It is much smaller than the other one. The bone was decayed, and a piece had to be cut off at each end to make them join.

Dr. Collins: Were you conscious on the operating-table?—Yes. I gave instructions for my will.

Were you not in such a condition that you were almost unable to write your name?—My hand was shaky. It was my right hand that was injured.

Did I not hold your hand?—I don't remember.

Did I not tell you the serious position you were in, and that it was probable you would not get over the operation?—I don't remember.

Further examined, witness said he recovered consciousness in his ward, after the operation, but did not know the time. He did not refuse to lay on his back. He did not remove the bandages from his jaw, but tried to shift the bandage one night, because the jaw had shifted out of position, and the teeth were jammed against the roof of his mouth. The abscess formation was not due to a cut, inflicted while shaving, becoming infected. Suppuration occurred in connection with the leg, but witness did not know that it could not be operated on until the suppuration had been conquered. There was a lapse of at least four months during which Dr. Scott had not seen witness's leg.

Dr. Collins: Did I not order a special diet for you?—I don't know.

Do you remember me asking a nurse to get a special pie for you? —I didn't get it, if you did.

How many delirium-tremens cases were in the ward at the time?— —Two through drink, and one injured in the head.

Do you know if all the patients with delirium tremens had fractures?—I believe they had.

Sister Woods, a nurse of nearly six years' service at the Auckland Hospital, said she was in charge of the children's ward. Dr. Neil did not neglect the ward. He visited the children two or three times a week.

The Commission then adjourned.

The sittings of the Commission were continued on Tuesday, the 25th October.

Dr. Lewis was called as a witness in regard to the case of William Peake, whom the witness operated upon after leaving the Hospital. Peake was suffering from a discharging sinus running down through the jaw at the side of the face There was an ununited fracture of the tibia, which the witness operated upon. The bones were split up into fragments, and these were removed from both ends of the bone. In order to secure a proper surface, portions of the fragments were sawn off at both ends, together with 1½ in. of sound bone. The two ends were wired together, and the injured limb set in splints.

Mr. McVeagh: Was the operation successful?—A sound union has now been secured after long delay.

What was the proper surgical course to pursue in the first instance in regard to the broken fragments in the leg?—I can hardly offer an opinion on that, as I didn't see the case at that time. As a rule the loose fragments are removed.

Did you keep the fragments?—Yes.

Dr. Lewis here produced the fragments in a corked bottle, and submitted the specimens for the inspection of the members of the Commission.

Mr. McVeagh: What was the proper surgical course to pursue in the removal of the fragments in the first instance?—I cannot give an opinion, as I do not know the state of the leg at that time.

The evidence shows that the fracture was not discovered for eight or nine days after admission. Is there any reason why it should not have been discovered earlier?—I think it depends very much on what kind of fracture it is. I don't know what the fracture was. I only saw Peake two or three days prior to him leaving the Hospital.

To what do you attribute the sinus-formation?—To an injury to the jaw.

Was there any reasonable method adopted in treating the jaw?— Undoubtedly there was.

How long after the sinus appeared did the patient come to you?— As far as I remember, six weeks.

We have it in evidence that when the patient was admitted to the Hospital he was operated upon by the Senior Medical Officer, assisted by two juniors. Do you approve of such a case as this being dealt with by the resident staff?—I think the case should have been dealt with by the honorary surgeon.

Do you consider such a case was an emergency case?—Yes; I think Peake's case should have been attended to as soon as convenient—say, within two hours.

The Chairman: And there would have been ample time then to summon the honorary surgeons?—I think so.

Mr. McVeagh: There was some friction between you and the Board over this case?—There was.

Did it result in correspondence?—Yes.

The members of the Commission then perused the correspondence. Mr. Reed asked permission to hand in a letter relative to Peake's case, written by Dr. Bennett, at one time a resident at the Hospital, but the Chairman ruled that it was not permissible.

Dr. Lewis went on to explain that he was entreated by Peake's friends to attend him at the Hospital, and he told them he could not, as it was against the rules of the Hospital. They then asked witness if he would attend Peake if he left the Hospital, and the doctor said, "If the patient is brought to me outside the Hospital I can't refuse to treat him."

Quoting from the Board's correspondence with Dr. Lewis, the Chairman remarked it appeared to him that the Board set up the position that the Senior Medical Officer was a member of the honorary staff in regard to fractures.

Mr. Reed: I think that is the position taken up.

Dr. Lewis: I understand that was the contention of the Board.

The Chairman: Under what rule is the position assumed that the Medical Officer is on the same footing as members of the honorary staff?—I cannot say under what rule.

Mr. Reed: Was that not the position the honorary staff assumed in regard to Dr. Collins?—I think we were given to understand that that was what the Board wished.

The Chairman: What the Board wished and what Dr. Collins did are different.

Dr. Lewis: Dr. Collins attended all meetings of the honorary staff, and, according to the rules, he had a right to.

The Chairman: Yes; he is to be the medium of communication between the honorary staff and the Board.

Mr. Reed again urged that Dr. Bennett's letter should be received, for the reasons that it was written by Dr. Bennett in his official capacity at a time when it was his duty to report to the Board.

The Chairman: Under what rule was it his duty to report?

Mr. Reed: Dr. Bennett was asked by the Board to report on the case not in view of an inquiry like this arising, but in the ordinary course of his duty. He was now absent from the colony, and the letter contained a statement from his point of view. Statements had been admitted on the other side, while Dr. Bennett's letter gave an explanation of the case from his position as one of the surgeons present.

The Chairman: You have the evidence of Drs. Collins and Walsh; what more do you want?

Mr. Reed: Dr. Bennett was present at the operation, and did certain things in connection with it. His letter explained the circumstances, and should be received by the Court as evidence. Even if the letter admitted were confined strictly to legal evidential documents the letter should be admissible.

Dr. Lewis: The letter was written eight months after the operation, when Dr. Bennett had left the Hospital.

Mr. Reed: That makes the admissibility of the letter stronger. There was no chance of trouble at the time, and Dr. Bennett was not interested in any way.

The Chairman: We cannot accept his evidence. It is a letter written to the Board by a doctor formerly in the Board's employ. Under the circumstances we must decline to accept it as evidence.

Mr. Reed (continuing the examination of Dr. Lewis): In regard to anything being said to you relative to a second operation, I understand you said you were not told a second operation was thought of?—I cannot swear that. I was told there would be an operation, but I can swear that Peake said there would not be an operation, because he would not consent to another operation in the Hospital.

You knew Dr. Scott was honorary surgeon in charge of the case?—No, I did not. Dr. Scott's name was taken down six weeks after Peake was admitted to the Hospital, and there was no name over his bed.

Mr. Reed: Is it not good surgery to set a fracture and leave it in splints for observation purposes?—Yes; that is good surgery. It would not be a wise thing to operate at once in compound fractures.

The way you were compelled to operate eventually?—The same operation was performed on both occasions except for the removal of bone.

It doesn't necessarily imply that it was bad surgery originally because you had to operate afterwards?—Certainly not.

The explanation in regard to the sinus is that Peake received a slight cut just under the fracture while shaving, which became infected, and the abscess formation set in: is that a satisfactory explanation?—I don't think it is. A slightly infected cut would not cause a deep-seated sinus such as was present.

Does not the sinus deepen?—I should say not. The sinus was due to the injury to the jaw, of that I feel certain.

The sinus does not necessarily show that there was bad surgery in the treatment of the jaw?—No, certainly not. It had to be borne in mind that a fracture of the jaw was not a simple fracture as a rule. It was usually connected with the mouth or internally, so that it was always liable to sinus-formation occurring as in compound fractures.

With regard to putting the legs in splints for observation purposes, should the observations be made in less than six months?—Certainly. That is the only point in connection with the case that I have to comment upon. Peake, too, got tired of being kept in the Hospital, and he had made up his mind to leave, while his friends begged of me to attend the case after he left the institution. The operation that I performed should have been done at the end of three months.

Would the patient have been in as good a condition?—He would be in a better condition for operating upon in three months than he would after lying in the Hospital for six months.

Dr. Roberton: Who first assumed the position of the Senior Medical Officer being the same as a member of the honorary staff?—The Senior Medical Officer.

Did the Board assume it?—Certainly.

Was it with the consent of the honorary staff?—I can't answer that question. I don't know the history of the honorary staff at that particular time.

Are you aware that when you joined the honorary staff there was dissatisfaction with the status?—I was told there was dissatisfaction.

Were you satisfied?—No; I was not satisfied with that position.

Mr. McVeagh then proceeded to call evidence relating to clause 1 of the charges made jointly against the Hospital Board and Dr. Collins in that patients suffering from cancer, consumption, delirium tremens, and semi-lunacy were kept with other patients in the same ward, and that sufficient lavatory and places of convenience were not provided for the purpose of segregating such of the said cases as ought to have been kept apart and as ought to have been kept separate from the other patients.

Miss Winifred Gertrude Smith, a nurse, at one time in the service of the Auckland Hospital, said she was in charge of Ward No. 8. She remembered a patient named Tudehope, but did not recollect the exact complaint. It was a mental case. There were all kinds of cases in the ward at that time, including typhoid, consumption, and others she could not remember. Referring to the Hospital reports, witness said, On the 30th February, 1903, Tudehope was very noisy, and disturbed the other patients. On another occasion he had to be put under a restraining-sheet. The patient was removed to the asylum on the 1st November. During the time he was under treatment in the ward a typhoid-fever patient named Russell was there, and this patient subsequently died. The witness did not think it advisable that noisy cases should be placed in wards with typhoid cases.

Mr. Reed: Where should such cases be put in the Hospital?—I don't know.

Dr. Collins: Do you remember that Tudehope had been examined by two doctors in town, and they reported he was not insane?—Yes.

The same night his straps were removed because of complaint?—Yes.

And that night he got a poker and very nearly injured a nurse?—I don't know if it was that night, but the incident occurred.

We sent again for two medical men, and the patient was found to be a lunatic?—Yes.

We had great difficulty in getting any one to state the man was a lunatic?—Yes.

Why was he put in straps and the retaining-sheet?—Because he tried to get out of bed, and was violent altogether.

Miss Jean Dalton Foote, a nurse, said she was admitted as a patient in the Auckland Hospital on Christmas Eve, 1902, and remained for ten or eleven weeks, suffering from typhoid fever. She was first in No. 2 Medical Ward, and then removed to No. 9 Ward, which joined No. 8 Ward. While in that ward she was disturbed at times, both day and night, by shouting and general noise originating in the male ward. It was going on for a week or longer. At that time she did not know the patient making the noise, but she concluded he was very delirious.

Mr. McVeagh: What is the effect of such noises on typhoid cases?—I don't think it is good for them.

Is not absolute quietness insisted upon?—We try to insure it.

The charge of negligence as embodied in charge 16, relative to the death of a girl named Florence White, was next taken.

Mrs. Mary Ann White, mother of the girl, said her daughter was admitted to the Hospital on the 3rd July, 1904.

Mr. McVeagh: Did you wait for the operation?—Yes.

You made inquiries after the operation?—Yes.

And subsequently saw her taken to the Costley buildings?—No. I was waiting for them to return to the same ward in the Costley building, but they put her in a ward at the general Hospital. My husband, who was waiting outside the ward, came to me and said a porter had told him our daughter was dead.

Did you see Dr. Collins?—Yes. I was taken to a room, where I met him. I said, "Is she gone?" and the doctor replied, "Half an hour ago. She was really dead when she was sent in." I asked him why the child had been sent in, and he remarked, "While there is life there is hope." He went on to say he didn't know what mothers were thinking about to let their children die like they did. He insisted that in this case the child must have complained, and must have been sick, and I don't know what he didn't say. I had enough of it at last, and said, "There are lots of us who don't do what we should do," and protested that the child had not complained. When I inquired what was wrong with the child, he said, "We have taken an ulcer out of her that long" (indicating the length with her hands). I went to the ward where my child was in bed, and I was accompanied by my daughter and a friend, Mr. Lynch.

Did you see the child?—I went up to the ward for that purpose. The child turned her head round and recognised us. My daughter said, "They told us you were dead," and the child remarked, "What have they been telling you?" She continued to talk quite sensibly till a few minutes before her death, two hours later, and, in fact, I didn't expect her to die so quickly as she did.

Did you have a conversation with Dr. Collins?—Yes. I asked him about the statement that the child was dead. He turned to the nurse and said, "Who sent word down that this child was dead?" The nurse shook her head and made no reply. The doctor, turning to me, said, "Who told you the child was dead?" and I replied, "You did." He then asked my husband who told him, but he made no reply.

When you went up to the ward was the nurse doing anything?—Yes; she was holding a glass tube to the child's mouth.

Robert Lynch, a packer, of Auckland, said, as an acquaintance of the White family he accompanied Catherine White to the Hospital on the day the operation was performed. When there Dr. Collins came to a room where Mrs. White was seated, and told her that the girl had passed away. He spoke to Mrs. White about the neglect of mothers, and also made some mention of ulcers. Later they saw the child, and it was a surprise and a shock to them to find the girl alive.

Miss Catherine White, a sister of Florence White, said she was at the Hospital on the afternoon her sister was operated upon. On going to the ward witness found the girl alive, and a nurse giving her something out of a tube. She did not hear the conversation between Dr. Collins and her mother. Witness's sister was quite sensible from about ten minutes to 7 till a few minutes after 9 o'clock. Dr. Collins was at the side of the bed only for a few minutes.

Mr. McVeagh then handed in particulars recorded in the operating-book relative to the operation.

Evidence was next taken in regard to No. 9 of Dr. Neil's charges against Dr. Collins—viz., that he (Dr. Collins) "violated Rule 21 on the 3rd August, 1904, by performing a major surgical operation upon Arthur Duke at the Hospital, and that the said operation was performed without previous consultation of at least three members of the honorary staff."

Arthur Duke, residing in Cobden Street, said that in August last he was admitted to the Hospital suffering from stricture. When he went to the Hospital he was taken (after a hot bath) to the operating-theatre, where he saw Dr. Collins and Dr. Walsh. He was not aware of any consultation with the honorary staff. Dr. Collins said it was a bad case of stricture. An attempt was made to pass a catheter, but this failed, and the next thing that he knew was the placing of a cap on his face. He presumed he was being chloroformed, but he was not informed that this was to be done. He became unconscious. When he came to he found he had been operated upon. About a week after the operation Dr. Collins wanted him to go under another operation. Witness refused point-blank to allow Dr. Collins to operate upon him again on any account. He was still suffering slightly from his complaint.

Mr. McVeagh: Was there a bed-chart over your bed?—Yes. It had Dr. Parkes's name on it.

Did Dr. Parkes see you?—He did when I was convalescent.

Did he not see you when you were in bed?—Not to my knowledge.

Are you prepared to return to the Auckland Hospital for treatment?—Not under the present staff.

Witness said that in his earlier days he had been a second-class cook. He complained of the food which was served out at the Hospital, and said that the rice was boiled to such an extent that frequently there was no nutriment left in it. No proper distinction was made in the food of the different patients. The porridge was fair, but the vegetables were not of good quality. The sugar given was not sufficient.

Mr. McVeagh: What about the eggs?—They were unfit for human consumption.

Did you consume them?—Yes. (Laughter.)

What about the beef-tea?—I would not like to give it the name of beef-tea. It was a disgrace to beef-tea.

What about the tea?—It was fair, but it might have been better. It was not fit for patients.

Mr. Reed: Did you complain of the food?—Yes: I mentioned the sugar and tea. The fish was bad two or three times during the seven weeks I was there.

Did you take the fish?—I took one lot, but I had to take medicine afterwards.

Did you not tell the manager of the Hospital that you had been well treated?—No. He asked me when I was going out whether I was going to give evidence before the Commission, and I said I supposed so. That is all that was said.

Dr. Collins: Before you went to the Hospital did you see any other doctor?—Yes: I saw Dr. King.

Did you not see Dr. Neil before you saw Dr. King?—No, I did not. I will swear I did not.

Dr. Neil: So will I.

Dr. Collins: Did you not tell Dr. King that Dr. Neil had advised you that an operation was necessary, and that you had left him on that account?—No. If Dr. King said that, I should simply say that he was speaking—well, I will not use too strong a term in public.

If Dr. King and Dr. Ferguson, the porter, and myself were to swear that you had a lump from here to here (indicating portions of the body), what would you say?—I should say it was false. I am the one who ought to know, as I was the sufferer.

What doctor attended you in the Hospital?—Well, you were conspicuous by your absence. Dr. Walsh attended me.

Did Dr. Parkes never attend you when you were in bed?—Not to my knowledge. If he did he must have come when I was asleep.

If Dr. Parkes said he attended you from the time you were operated upon until you left, would you say that he was saying what was not correct?—Certainly I would.

Did you make any complaint to me about the food?—Certainly I did not. I left it to your discretion. Whilst I was in bed I had very little food, and I was that ravenous that I often ate food which I should not have eaten.

And do you expect a man who gets three meals a day to be ravenous? Do you get better meals outside than in the Hospital?

Witness: Better meals! Why, I would not eat such stuff if it were put before me.

Dr. Collins: Then, why eat it in the Hospital?—I had nothing else.

In answer to a further question, witness repeated his former statement as to the observation made by the manager of the Hospital regarding the question of giving evidence before the Commission. He naturally thought that he was being asked to give evidence in favour of the Hospital. His answer to the question was "Probably."

Dr. Collins: What induced you to change your mind?—Why, to tell the truth.

Mr. McVeagh: Did you suggest to the manager that you were going to give evidence in favour of the Hospital, or did he suggest that you should do so?—No, certainly not.

Dr. Gore Gillon was examined as to the different operations for cases of stricture. Duke was now being treated by him. It was difficult, he said, to offer an opinion as to the correctness or otherwise of the operation performed by Dr. Collins without knowing the surgical state of the patient at the time he was operated upon.

Dr. Collins: Why did you not, when you first knew you were to be called, come to me and get my statement of the case?—I thought I would hear it from you before I gave my evidence.

All the evidence on one side is given before the other side opens its case. Do you not know the procedure of a Court of law?—I am not particularly well up in the law-courts.

In the course of further cross-examination by Dr. Collins, the witness said that, after hearing the circumstances of the case, he could say that the operation performed by Dr. Collins might possibly have been justifiable and necessary.

The Chairman made a statement to the effect that in intricate surgical cases in which there might be a great conflict of professional testimony (as seemed to be implied by the cross-examination of Dr. Gore Gillon) the Commissioners would not consider themselves competent to give an opinion, and would probably say, "We can't decide where doctors disagree." Of course, the case of a palpable mistake was a different matter. In respect to Duke's case, the question was whether the operation was performed by Dr. Collins in accordance with the rules of the Hospital. That the Commissioners might judge.

Mr. McVeagh: The question is whether the rules of the Hospital permit that, and, if so, whether it is a wise policy.

Mr. Reed: This is probably a matter on which I shall have to address the Commissioners.

Dr. Constance Helen Frost, bachelor of medicine and surgery (New Zealand University), stated that she was the honorary bacteriologist and pathologist on the honorary medical staff. She had given special attention to the study of bacteriology. She was for three years on the resident staff of the Adelaide Hospital, where she had charge of the bacteriological laboratory for about eighteen months. She had occupied a similar position at the Auckland Hospital for the past eighteen months. The Hospital was then poorly equipped, but it had since been well equipped with the necessary instruments. She was engaged in the laboratory generally from about 9 till 11 a.m.

Did Dr. Collins come into the laboratory often when you were there?—Not lately; but when I was first there he came very often, and he seemed very enthusiastic in regard to the work. He asked me how to make culture-media. I showed him how it was done.

How long was Dr. Collins in the laboratory?—When he was making culture-media, which was for only a short period, I hardly ever went to the laboratory without his being there.

Was the work he was doing necessary for any purposes in the Hospital?—No: it could not have been.

Did his presence there affect you in any case?—Yes; it interfered with my work. After a time there seemed to be a tacit understanding between us, by which I had the laboratory to myself in the mornings, and he had it in the afternoons.

I suppose if the work was required for the Hospital it would be your duty to do it?—That is my opinion.

You would not regard Dr. Collins as a skilled bacteriologist?—I do not suppose he would think that himself.

In your opinion, is it desirable for one, who was practically an apprentice, to engage in bacteriological work at a hospital, bearing in mind that he is Senior Medical Officer at the Hospital?—It depends upon the cultures.

Do you know what cultures Dr. Collins was engaged upon?—Well, he made some anthrax-cultures.

Do you consider it a proper thing for the Senior Medical Officer of a hospital, having charge of surgical and medical cases, to be concerned in making anthrax-cultures?—I have never seen it done before.

Mr. McVeagh: Do you remember having some specimens from a girl named Guthrie sent to you for bacteriological examination?—Yes; I examined them on several occasions for tubercle bacillus, but I only got negative results.

Do you know whether Dr. Collins undertook an examination of the same specimens?—Yes; I heard that he had made an examination, and had found what was, in his opinion, tubercle bacillus, and that he had given that opinion to the honorary physician in charge of the case. As a consequence I understood that Dr. Makgill received an application for the admission of the patient to the sanatorium.

The particular specimens which you were asked to examine require to be very carefully taken from the patient?—Yes, very carefully; and a certain other bacillus, similar to the tubercle bacillus, is very often present in such cases, but it may be excluded if the specimen is taken in a certain way.

Mr. McVeagh: Who controlled the administration of anæsthetics in the Adelaide Hospital?—The Superintendent, who was a skilled anæsthetist.

At what time did the resident medical staff visit the wards there?—As a rule the morning visits were commenced about half-past 8, and those in the evening were made about half-past 6 or 7. The visits were made before the honorary staff made theirs.

Was not the Superintendent of that Hospital mainly concerned in the administration of the internal economy of the Hospital?—Yes.

Did he ever undertake major operations, such as those of an abdominal nature?—I never saw him undertake one. There was no trouble in getting the honorary staff to attend them.

Could you express an opinion as to whether the most skilled physicians and surgeons in Auckland are on the honorary staff at the present time?—I have not been long enough here to give an opinion about that.

You were administering anæsthetics in the Adelaide Hospital. Was your administration controlled in any way?—It was for the first few months; and even after five or six months, if there was a bad case, the Superintendent undertook it. After that time I was allowed a free hand.

Do you think that junior resident doctors, of the age of those now in the Auckland Hospital, should be permitted to administer anæsthetics without any guidance?—No, I do not.

In reply to questions concerning the admission of patients, the witness said she saw no difficulty in the way of a member of the resident staff examining and admitting a patient who went to the Hospital without a doctor's recommendation.

Mr. McVeagh: Do you know whether any animals were inoculated by Dr. Collins in the laboratory?—He said he inoculated some frogs with anthrax.

Do you consider that judicious on the part of the Senior Medical Officer of the Hospital?—Well, I did not inoculate anything with anthrax myself at the time, because I considered it would be dangerous in the Hospital.

You have been present at meetings of the honorary staff?—Latterly I have.

Do you remember any discussion since Dr. Neil's suspension in relation to emergency work?—At the meeting before Dr. Neil was suspended it was suggested that the emergency work should be done by the honorary staff, if possible. I do not remember whether any direct discussion took place on the subject of Dr. Neil's suspension.

Do you remember any observation by Dr. Collins as to the position he would take up if he did not have the emergency work?—Yes; I understood him to say that under the conditions of his appointment he was permitted to do emergency work, and that he would resign if not permitted to continue it.

You are aware of the rule requiring members of the honorary staff to sign the attendance-book?—I am aware of it now; but I did not know of it until this bother arose. I never signed the book. The laboratory is in the basement, and I did not always see the book.

Was any complaint ever made of your not signing it?—No.

There was no talk about suspending you for non-attendance?—No.

Mr. Reed: Did any ill effects follow the anthrax-cultures made by Dr. Collins?—Not to me. I took care not to go there whilst he was fixing them up.

Did you have any difficulty in obtaining instruments from the Board for the laboratory?—No; they were most liberal. Anything that I suggested was done.

Did you complain to the Board or Dr. Collins that he was interfering with your bacteriological work?—It was rather awkward to tell him to go out. I could not possibly do my work when he was always there.

You are cramped for room in the laboratory, then?—It is big enough for two or three people if each one knew their own work.

You say there was a tacit arrangement that you would be there in the mornings, and that Dr. Collins would have the laboratory in the afternoons?—I suppose so. Some one told me that Dr. Collins had been asking why I avoided him as if he were the plague.

Has Dr. Collins been in the laboratory much lately?—I have not seen him there for the past six months.

Did you directly request him not to go there?—No, I did not; but I think I told him I could work much better if I had it to myself. He seemed to agree to that at last.

Questioned on the point of the production by patients of doctors' certificates before admission, Dr. Frost said it would, no doubt, act very well for the convenience of the Hospital, and there was no reason

why it should be done away with. In connection with the Adelaide Hospital she had admitted patients if there was room and the case was suitable. There had never been any difficulty in her experience. The production of a certificate should not be essential.

Mr. Reed: Here we have a case of a man walking from Mount Eden Railway-station presenting himself at the Hospital door after climbing up the steps. The porter sees him, and tells him to go and get a doctor's certificate. The man complains of pain. Do you think the porter justified in asking him to go and get a certificate?—Some of these cases are very delusive, and men will walk to the last step sometimes. If you were taken in once or twice you would know.

In the case of Miss Guthrie, the consumptive, do you know that Dr. Collins was away on a three-weeks vacation at the time one of the juniors communicated the fact that he (Dr. Collins) discovered tubercle bacilli?—I don't dispute that, because I know nothing to the contrary.

Dr. Roberton: In regard to the administration of anæsthetics, what is your objection to junior residents acting?—I think the giving of it requires experience, even in the simplest cases.

In reference to doctors' certificates being presented on admission, the witness said she had always found such certificates of help when she was a resident of Adelaide Hospital, because the patients were brought in in the mornings, when the staff was in full work, and there was no one available to see the cases so brought in. The production of the certificate prevented any delay in the patients being admitted and put in a ward. It did not give much help in the treatment of cases, as frequently the certificates were bare of details.

Dr. Roberton: In the case of a man coming up the steps and complaining to the porter, is he the proper person to decide as to the man being admitted?—I don't think he can decide. A doctor should see the patient before he was sent away.

Are the residents, who are qualified practitioners, capable to give a certificate?—Yes, I should think so.

Dr. Collins: Do you consider working on plague bacilli infectious?—Not to the person working if proper precautions are taken.

You don't think it a dangerous thing to work with?—Not if the person is careful. It is carelessness that makes it dangerous.

In Japan, where there are the most skilled bacteriologists of the times, four or five men have died, and would you say that their death was due to carelessness?—They carried on investigation at plague-time, when the plague was actually about. That is a different thing to doing culture-work. I did not consider I was in any danger. A person was not open to danger when taking proper precautions. I could say absolutely that I would be safe in working with plague bacilli.

Asked as to the practice followed in Adelaide Hospital as to the selection of patients for different wards, Dr. Frost said no doubt care would be exercised. She knew a plague patient was one time admitted and taken to a ward, and next day a neighbouring patient died from plague.

Dr. Collins: Do you think such cases should be admitted?—That was an exceptional case, and exceptions prove the rule, don't they?

The witness explained that the case was admitted by a resident who had worked in Hongkong, and she believed no person in the city could have determined better than he could that it was a case of plague. In reply to questions, she said she did not know if a resident was always on duty at the Auckland Hospital.

Mr. Beetham here interceded, and told Dr. Collins that the point at issue was that a man had been turned away from the Auckland Hospital by a porter without being seen by a member of the resident staff. It was a clear case that should have been admitted.

The witness said she knew of no case which should have been admitted to the Adelaide Hospital and was refused, but she had an impression that something occurred in connection with a London hospital, where a patient, after being examined by a resident, was turned away as an unfit case and died within twelve hours.

Dr. Collins: Do you think that similar accidents could happen in a hospital where patients are allowed to come and the question of their fitness is left to the junior to decide?—I consider that if a patient comes to the Hospital it would be very much better for the junior to admit him than send him away.

The Chairman: There is no harm in having a certificate, but if a patient has not got one he should not be excluded.

Dr. Collins: Do you know of any case sent away to seek a doctor's certificate?—No.

Have you done many *post-mortems* at the Hospital?—Virtually none. They have been practically discontinued since there was a row about one. The mortuary porter used to generally do them under my supervision.

And you have worked in the laboratory on organisms of a very dangerous nature?—Yes.

Do you think it is safe for a person, even with the greatest care, who is working on dangerous organisms to frequent the operating-theatre?—I think you can take cultures and sub-cultures. I don't think there is any danger to me; I don't know about any one else.

In regard to the letter sent to the Health Department for an order to admit Miss Guthrie to the sanatorium?—I know it was written, but do not know who sent it.

Who made the diagnosis?—I know who made the diagnosis, and I consider it disgraceful. I ought to have resigned my position at that time.

Mr. McVeagh: Do you remember the *post-mortem* on a patient named Mrs. Woods, over which there was a good deal of discussion?—Yes.

Who performed the *post-mortem?*—Dr. Ferguson.

Under the Hospital rules you should have done it?—Yes; but I was not consulted.

Did I understand you to say that there was no risk involved in skilled bacteriologists taking cultures and frequenting the operating-theatre?—That is so. No danger to those who know the precautions to take.

Miss Mary Gertrude Williams, a nurse, formerly of the Auckland Hospital, said she was in the service for nearly six years, leaving last May. She was in charge of the operating-theatre for a short time, and also had charge of the female typhoid ward. When in charge of the operating-theatre one accident case came into the Hospital, and it had to wait. It was a case of a cut wrist, and the artery appeared to be severed. She complained of the hours being too long, the number of operations affecting her work. Witness thought the nurse in charge was responsible for getting ready the instruments, &c., preparatory to operations. Witness prepared the instruments for operations when she was in the theatre.

Mr. McVeagh: Do you remember any cases of suppuration?—There were a great many cases at that time, and the honorary staff appeared annoyed. I cannot account for it. I was the only nurse there, and there was no difference in my methods.

How did you know what instruments to get ready?—I could refer to a book, and also my experience.

Were the nurses ever blamed for the suppuration cases?—It was generally attributed to the nurses.

Mr. McVeagh: I suppose they were fair scapegoats. Was it the practice of the resident physician to go round the wards with the honorary physicians?—If there were no operations it was.

What time did Dr. Collins arrive at the Hospital?—I have seen him at times at 9 o'clock and after, and also at 10 o'clock and half-past 10. I have no idea what time he left the institution.

Have you ever seen Dr. Collins going round the wards and examining the food?—I can't say that I have.

Did he make any difference in his attention between the surgical and medical side?—I was in the medical ward, and cannot say. He would come round there about once a day.

Mr. McVeagh: Were there any mental cases put in the typhoid ward?—I remember one or two. There was a woman who at times was very noisy. She eventually died in the ward. I complained to Dr. Walsh about putting mental cases in the typhoid ward, and the woman was removed, but only for one night.

The witness, on being further examined, stated that to put noisy cases in the typhoid wards retarded the recovery of the latter cases. She resigned because the work was too heavy.

Replying to Mr. Reed, the witness said the house steward (Mr. Schofield) regularly visited the wards twice daily. Dr. Collins visited the physical wards at least once daily, and the cases were also attended by honorary physicians, who made daily visits in bad cases, and averaged at least four visits a week in other cases.

Cross-examined by Dr. Collins, witness denied that she left the Hospital with two other nurses to start a private hospital. She never had any difficulty in the operating-theatre in regard to preparing the instruments. She had had a month's experience in the theatre before being appointed charge nurse there. The suppuration cases occurred at the time she was in the theatre.

Further examined by Mr. McVeagh, Nurse Williams stated that there were only occasional cases of suppuration at the time Dr. Inglis was in charge.

In regard to first-year probation nurses, Mrs. Wootten, lady superintendent of the Hospital, explained that they are not employed in the fever wards as assistants, but merely as probationers in the pantry.

The Commission then adjourned.

On resuming business on Wednesday, the 26th October, the first witness was *Dr. Gordon*, who was for some time attached to the honorary staff of the Auckland Hospital. He said he had heard the evidence in the theatre case, and thought that the non-union of the bone should have been discovered within three months. At the end of that time the proper course to pursue would have been an operation to remove the dead bone and join the bones.

Mr. McVeagh: Do you approve of the junior residents putting up fractures—simple fractures—under the supervision of the Senior Officer and the honorary staff?

The witness said emergency cases would include ordinary cuts, scalp-wounds, and hæmorrhage. An urgent case would be one requiring attention within two, three, or four hours.

Mr. McVeagh: Do you consider it proper that such cases as these should be treated by the Senior Medical Officer?—Not major cases.

Within what time would it be possible for honorary surgeons to be at the Hospital after being telephoned for?—Between a quarter to three-quarters of an hour. The time occupied in the preparation of patients for operations would depend upon the nature of the particular case. In a serious abdominal operation from half an hour to an hour would be necessary.

Dr. Gordon, referring to consultations, said many cases had been brought up for consultation which did not require it. They should

save the time of the visiting honoraries so that they could devote more attention to serious cases.

Do you approve of the Senior Medical Officer doing *post-mortem* and surgical work at about the same time?—I don't think it is wise to do so.

Do you approve of the Medical Officer engaging in anthrax-culture, and at the same time doing surgical work?— No, I do not.

The witness said he attended a patient named William Allen at the Auckland Hospital for a ununited fracture. It was a fracture which witness would not approve of juniors putting up.

Replying to Dr. Roberton, the witness said he was a member of the staff for a year and a half, finishing up in April, 1904. His position was that of honorary visiting surgeon.

Did you consider the condition of the Hospital satisfactory?—Not when I went on the staff. There was a great deal of suppuration.

Dr. Gordon went on to say that steps were taken to suppress the suppuration cases. A meeting of the honorary staff was called, and a number of resolutions were framed, some of which were not carried out. Personally, the witness said he redoubled his own exertions, spoke to the theatre nurse, made his own preparations, and spoke to the assistant. Dr. Collins, he said, rarely assisted him at operations. Matters gradually improved in regard to the suppuration cases.

Witness did not think the rule permitting the Senior Medical Officer to attend meetings of the honorary staff a good one. His presence at the meetings was sometimes of advantge—for instance, in cases such as suppuration—while his presence would be a disadvantage when the duties of the Senior Medical Officer came up for consideration. He should not be regarded as a member of the honorary staff. At the meetings of the staff the Medical Officer would represent himself, and also, witness presumed, the Board.

Dr. Roberton: Rule 37 says that the Senior Medical Officer is to be the sole medium between the honorary staff and the Board.

The Chairman: One would think the Board controlled the post-office.

Dr. Roberton: There are various interpretations to be put on it.

Dr. Gordon said it was so interpreted that all communications between the staff and the Board had to go through Dr. Collins, and all communications to the staff from the Board, he believed, went through the same channel. That was not a good rule, because it asked the honorary staff to communicate through one who should be in a subordinate position. Dr. Collins gave a few anæsthetics while witness was on the staff. The nurses on the surgical side should, he thought, be partly trained by the honorary surgeons, because the surgeons had to rely on the nurses to carry out instructions given.

On the question of the tenure of the appointment of the honorary staff, Dr. Gordon considered a year too short. If the tenure was longer the doctor could carry on the work better and with more interest, and it would insure greater experience. The Costley Wards were not, in his opinion, satisfactory, it being awkward to carry cases for operation from the main building to the operating-theatre in the Costley Wards. The distance of the Costley Wards from the main building entailed more work, involving extra nurses and additional expense.

The Chairman: That system is most monstrous. Carrying the patients up and down the steps, through bad weather and the rest of it, was monstrous.

Mr. Reed: It is the intention of the Board, when the new operating-theatre is completed, to use the Costley Wards as surgical wards.

Dr. Roberton: That is an extremely important admission to make, and I would like the Commission to make a note of it.

Dr. Gordon said when he spoke to patients about going to the Hospital he was told by some that they were too poor, but they were exceptional cases. In joining the staff he expected to give his services to the poor, and objected to attend to patients who were able to afford to pay for attendance outside the institution. The persons who could afford to pay being in the Hospital would keep the poorer patients out.

The responsibility for the professional treatment of patients should, in witness's opinion, fall on the honorary staff, who should also attend emergency cases when possible. It was not desirable that the Senior Medical Officer should perform major operations, but witness thought it would very rarely occur that an urgent major case would arise requiring the Senior Medical Officer to perform the operation. Dr. Gordon favoured the appointment of assistant surgeons, which would enable the younger surgeons to gain an experience of the serious part of surgical work before being appointed full surgeons.

Questioned by Mr. Reed, Dr. Gordon said the honorary surgeons were generally available at all times of the day to go to the Hospital if required. If engaged, they left word where they would be found at stated intervals. It had been the practice for the Senior Medical Officer to perform operations when requested to do so by the honorary surgeon for the week. He always understood that if the surgeon for the week was not available the Senior Medical Officer had a right to do the operation.

The Chairman: Under what rule?

Mr. Reed pointed out that Rule 72 had something applicable to the position. It placed the responsibility on the Senior Medical Officer after the honorary surgeon had been notified.

The Chairman: Was that acquiesced in by the honorary staff, because it is a direct violation of the rule?

Dr. Gordon: Dr. Collins was a member of the honorary staff.

Mr. Reed: Yes; that was the position.

Dr. Roberton asked that a note be made of the admission.

Mr. Beetham: He can't be a member of the honorary staff unless he has been made one by the rules. What is the rule?

The Chairman: He must obey the orders of the honorary staff.

Mr. Beetham: The rule says he can attend meetings, and that differentiates him from a member of the honorary staff.

The Chairman: He is to be under the control of the honorary staff. He cannot control himself.

Proceeding with the cross-examination of Dr. Gordon, Mr. Reed elicited that some recommendations as to the washing of patients and aseptic precautions by assistants, which were made by the honorary staff in their endeavour to combat suppuration, were not carried out. He favoured the honorary staff having a representative on the Hospital Board, through whom, or else through the secretary, communications could be received either from or to the Board. The management of hospital and charitable-aid affairs should be distinct. It would be better to set aside the Costley Wards for surgical cases.

Mr. Beetham: If these wards were set apart for the purpose would they cope with the cases?

Dr. Collins said there were four wards capable of holding twelve beds each, and four single wards holding one bed each, making a total of fifty-two beds.

In connection with improving the premises, Dr. Gordon said the best thing to do was a difficult question. It would be hardly advisable to add to an old building, while if separate buildings were erected it would be best to connect them with corridors. How to discriminate between patients able to pay for outside attendance and those not able to pay was a question full of difficulties. He thought it would depend a good deal on the doctor who sent the cases in. The production of a doctor's certificate should not be made essential to a patient's admission to the Hospital.

Mr. Reed: In your opinion, should the Hospital authorities refuse to admit a patient if it is perfectly clear to them that the person is capable of paying for attendance outside?—I think they should, if the person could obtain proper treatment outside.

The Chairman: In a case of urgency? That is the point.

Mr. Reed: I understand that the rule requiring the certificate was made in order to prevent persons capable of paying being admitted to the Hospital. Is that so?—The rule was made after a conference of local bodies was held about a year ago, and I believe it was for that purpose.

The Chairman: It is monstrous that a patient should be sent away to get a certificate.

Mr. Reed: The particular case that has been referred to was an unfortunate accident. The porter asked the man to go and get a certificate

The Chairman: Well, it is monstrous.

Mr. Reed: You mention an exceptional case, where a person said he was too poor to go to the Hospital. The first thing that struck me on coming to the colony was a person saying he was too poor to go to the Hospital.

Do you suggest that the Hospital should be free?—I haven't gone into that question.

Do you know of any cases in which the Board has unduly pressed patients for payment of fees?—No.

The Chairman: What do you mean by "unduly"?

Mr. Reed: Issuing a distress warrant, or something of that sort. We admit we have summoned patients for payment.

Mr. Reed (to the witness): Have you any suggestion to make as to whether the fees should or should not be collected, or whether the fees charged are too high?—I am not sufficiently conversant with the subject to say. At Home the hospitals, which are supported by voluntary contributions, make no charge.

In order to avoid misconception in regard to Dr. Collins's position on the honorary staff, did the honorary staff look upon it more that it should be for the purpose of discussing matters with the members?—Yes.

Mr. Beetham: He attended meetings of the staff and entered into the discussions.

Mr. Reed: Being a paid officer he could not be a member of the honorary staff.

The Chairman: And being under the control of the honorary staff he could not be one of them.

Dr. Collins: Have you asked me to do major abdominal operations?—I have asked you to do an appendicitis case.

Do you approve of the Senior Medical Officer doing major operations?—Not as a rule.

Speaking further, Dr. Gordon said he had no objection to the resident staff doing small operations. He had not known septic cases left to the residents by honorary surgeons because the latter had outside cases and did not wish to run the risk of contamination. The honorary staff were not regular in attendance at consultations, and this would, witness presumed, throw a great deal of responsibility on the Senior Officer.

You have heard complaints made as to the classification of cases for consultation?—I don't know what the classification was.

Witness said that he would class such operations as those for appendicitis and gastric ulcers, of from seventeen to twenty hours' standing, as emergency operations. In answer to Dr. Collins, he said that it was a fact that there was no other class of operations more liable to cause dissatisfaction than fractures. He thought that the treatment of fractures and dislocations must necessarily be left to the resident staff, especially cases of simple fractures.

In re-examination by Mr. McVeagh, witness said that he did not experience the same difficulty in his private practice in regard to suppuration as in the Hospital. The honorary staff did all the serious operations in witness's time. In respect to the operation performed on Peake in the Hospital, he said that it was proper surgery not to remove the loose pieces of bone, and it was also proper to wire them to the main bone, as had been done, as otherwise the effect (owing to the greatness of the separation between the two ends) would have been to make the leg so much shorter.

Dr. Roberton: Would not the chairman of the honorary staff be a proper means of communication between the staff and the Board?—Yes, certainly.

Elizabeth Susannah Rowles, Matron of the Northern Wairoa Hospital, and formerly a nurse in the Auckland Hospital, stated that she left the latter Hospital last November, after having been there nineteen years and a half. She remembered the case of William Peake. Dr. Scott's name was at first over Peake's bed, but it was afterwards turned in by the instructions of Dr. Collins, who said that all the names had to be turned in. She remembered Peake having hæmorrhage from a broken jaw, and also having an abscess in the jaw, which was ascribed to Peake cutting himself whilst shaving. Dr. Bennett said it was due to the broken jaw. Prior to Dr. Collins's time the honorary staff had charge of witness's ward. They did not have the same degree of charge after Dr. Collins was appointed. There were good results under both systems. She considered that the food was fairly satisfactory on the whole. Sometimes the fish was not very good. The eggs were not very good during the winter. Witness suggested that something might be substituted for eggs, but the suggestion was not adopted. Dr. Collins usually went to the Hospital in the mornings between 9 and 10, and earlier in cases of operations.

By Mr. Reed: The house steward used to visit the wards at mealtimes. So far as she knew, all complaints regarding the food were attended to.

By Dr. Collins: She could prepare a patient's leg for operation in half an hour. There would be a further preparation necessary on the operating-table, occupying from twenty minutes to half an hour. In all, it would take over an hour from the time a patient came in until the operation commenced. Peake's was a very bad case, and the operation was done as quickly as possible on account of the man's serious condition.

Have we not had satisfactory results from fractures whilst I have been at the Hospital?—Yes, fairly satisfactory.

What time did you first go to the Hospital?—In 1883.

Who was the resident Medical Officer then?—Dr. Mackellar. Dr. Bond afterwards took it.

Did Dr. Bond leave the Hospital on account of any unpleasantness?—I do not remember. When he was afterwards an honorary surgeon some charge was brought against him in regard to an operation, and he resigned.

Was a charge laid against Dr. Floyd Collins when he was in charge of the Hospital?—Yes; a charge was brought against him by a nurse. As a result he resigned.

Was a Royal Commission appointed?—I do not remember; but there was an inquiry. Witness said that after that they got the honorary staff back again, and then Dr. Baldwin was appointed Senior Medical Officer.

Do you know whether Dr. Baldwin left on account of some trouble in regard to his opinion regarding a supposed plague case?—I do not remember.

Did he not have his salary reduced during his term?—I believe so.

Is it not strange that this should be so, if things were so satisfactory during his term as we have been told?—It does seem strange.

Was there any unpleasantness between members of the staff and Dr. Baldwin?—Yes, I suppose so.

Was not Dr. Baldwin exceedingly glad to leave the Hospital on that account?—I do not know.

What happened when Dr. Baldwin left?—Dr. Inglis took charge, and Dr. Bedford, as medical adviser to the Board, acted as supervisor.

Was that satisfactory?—Yes.

Then, why was it changed?—I do not know.

William Allen was then examined in relation to the charge against Dr. Collins of allowing junior surgeons to attend to him when he was suffering from a broken arm, and also of failing to attend to him immediately on admission. Witness said he met with an accident through falling amongst some machinery, and broke his arm. He went to the Hospital, where, after some time, Drs. Horsfall and Bennett put the arm in splints. Some days afterwards it was taken out and reset. He afterwards became an out-patient, and his arm not feeling right he underwent another operation in the Hospital by Dr. Gordon. There was then a consultation. He owed the sum of £19 16s. 8d. for the Hospital treatment. His wages was £2 2s. a week, and he had a delicate wife and child to keep.

Mr. McVeagh: Have you received any demand for payment?—Yes; I have received two letters demanding payment.

Mr. McVeagh read the two letters. The first, dated May, 1903, demanded payment, and the second, dated January, 1904, repeated the demand, and stated that if it was not paid legal proceedings would be taken to enforce payment.

Did you make any application to the Board for a reduction?—No.

By Dr. Roberton: Did it occur to you that the members of the Hospital Board were a kindly lot of gentlemen, who would have let you off if you had asked them?—I do not think they would have done so.

Edmund Burke, bricklayer, of Seafield View Road, was called in support of the charge as to the refusal to admit patients without a doctor's recommendation. He said that at the end of 1903 he went into the Hospital suffering from hernia. When he went to the Hospital he saw the porter, and told him he wished to see Dr. Collins. The porter said, "Have you got a doctor's recommendation?" He replied, "No." "Well," said the porter, "you can't see no doctor here." Witness, who was very weak, went away, and a couple of days afterwards he got a recommendation from Dr. Gordon, and went into the Hospital, where Dr. Gordon attended him. On leaving the Hospital in February he was handed a bill for £8 11s. He said he was unable to pay it, and the house steward advised him to see the Board. Witness went to the Hospital on the following Monday, and saw Mr. J. R. Walters, a member of the Board, who said he would have to pay the amount. Witness said he was not able to pay it then, but Mr. Walters said, "I see your father's place has been sold, and there ought to be something coming from that." Witness said he had nothing to do with that. Mr. Walters said, "Well, you will have to pay it." Witness had been told by Dr. Gordon that he should do no heavy work for six or nine months, but he went to work earlier, in order to earn money to pay the account. He paid £4, and then was informed that if he paid another £2 within three months it would be accepted in full payment.

Mr. McVeagh: What was the food like at the Hospital?—The bread was about the only thing fit to eat. The eggs were absolutely rotten—not merely stale, but perfectly rotten. I had fish with scales on them, and it was not very fresh either.

The Chairman: I suppose you will probably have some evidence from the contractors as to the food.

Mr. Reed: We shall have to call the contractors, I suppose, to explain. The contractor for the supply of fish is one of the largest merchants here.

The Chairman: I do not know how they can explain how the fish came to be rotten.

Witness said he was in No. 3 Ward. There were consumptive and cancer patients in the same ward.

Where did the patients have their meals?—All at the same table. One man had a cancer on his lip, and when he was at the table he used to put the spoon into the salt and into his mouth and then back into the salt again.

Did you observe whether Dr. Collins visited the ward regularly?—I never saw him there.

Do you remember a man named Wilson coming in for an operation for appendicitis?—Yes. One day before the operation he got up to go down town. He was asked where he was going, and he replied that he was going to get the remainder of his money.

Mr. Reed said this would probably be a serious charge, and he objected to hearsay evidence being taken. If Wilson could be produced, of course it would be all right.

Witness said that the man got up to go down town. He returned later on in the day. No further questions were asked on the matter.

Was anything said further between Mr. Walters and you as to wiping the whole thing off?—I did not ask them to wipe the whole thing off. I said I was not in a position to pay the account.

Did he tax you with spending your money on drink?—He said I asked him one day if he would have a drink. When he declined he said I remarked, "Perhaps you think I haven't enough money to pay," and then produced some one-pound notes.

Mr. Reed: Did you ever make complaint in the Hospital about the food?—No. I found it was the best policy to be civil. The nurses knew perfectly well that the eggs were rotten.

Mr. Reed: It is quite possible for eggs to be rotten on occasions; the internal part cannot be seen.

Why did you not make a complaint?—I did not want to make a complaint, but to get well as soon as I could, and get out as soon as I could.

Did you see Mr. Schofield, the house steward, go round the wards at meal-times?—I never saw him: and he could not have gone round without me seeing him.

Did you make any complaint to Mr. Walters about the food when you were speaking to him?—No; I was worrying about the money.

How often do you say the eggs were bad?—Very often.

Was anything else ever substituted?—No. We all sat round the table in the convalescent ward. There was plenty of bread to eat.

Did you ask for anything else?—When you smelt one of those eggs you would not be inclined to ask for anything else.

What did you say to the porter when you first applied for admission?—I said to him I had a note from Dr. McLaughlin, of Rotorua, and the porter said, "You must get a note from a local doctor."

The note was produced, and it certified to Burke being unfit for manual labour.

The Chairman: You say that note was refused?—Yes.

The Chairman: Did you show it?—I had no time. He said it was no use; I must get a note from a local doctor.

Dr. Collins: When did you see Dr. McLaughlin at Rotorua?—Two or three days before Christmas.

How long were you at Rotorua?—Two months. Prior to that I was at Atiamuri.

Why didn't you go to Hamilton? Dr. McLaughlin gave you that note to go there?—No; it was not for Hamilton Hospital.

Do you think Dr. McLaughlin would give you a note for any other than the district hospital?—The note was intended to show to my wife, who had a maintenance order against me.

The Chairman: Who is the note addressed to?

Dr. Collins: To no one, Your Honour.

Dr. Collins: Did you show the porter that note?—No. He took my breath away by the manner he spoke to me.

Did not Dr. McLaughlin mention the Hamilton Hospital to you?—He said I must go to a hospital at once.

Did he mention the Hamilton Hospital to you?—He said, "If you like, I'll give you a note for the Hamilton Hospital." I remarked that I had friends in Auckland, and he replied that I must go there at once.

Is it not the recognised thing in Rotorua that all sick persons go to the Hamilton Hospital?—I don't know.

Are you prepared to swear Dr. McLaughlin sent you down to Auckland?—Yes, I'm prepared to swear that.

Dr. Collins: Did you walk from the station to the Hospital?—I went to Hobson Street first. The pain made me sick.

Did you ask for me at the Hospital?—I said I wanted to see the doctor.

At this stage Dr. Roberton rose to correct the suggestion that Rotorua was in the Hamilton Hospital District. He said Rotorua was no more in that district than in the Auckland Hospital District.

Dr. Collins stated it was a recognised thing that Rotorua patients were sent to the Hamilton Hospital, because it was not right to admit them to the Auckland Hospital unless a guarantee as to payment of fees was received either from the patient or the Board at Hamilton. Only emergency cases were admitted, and in other cases the Hamilton Board had to be informed and then permission obtained.

The Chairman: Who is that recognised by?

Dr. Collins: I have received instructions from my Board, because it has been arranged by the different District Hospital Boards that we should not admit patients from their district, and *vice versâ*. These patients are not to be admitted if they can be sent back by rail.

The Chairman: How has that come about?

Dr. Collins: The District Hospital Boards have come to the arrangement.

Mr. Reed: The arrangement was made because if a patient comes from one district the charge for his treatment has to be paid by the Board in the district from which he originally came.

The Chairman: When seriously ill a person has a right to be admitted.

Dr. Roberton stated that the Rotorua Township was not in any hospital district. Patients from Rotorua went to other districts, and the charge was sent to Rotorua. The Hamilton Board had had trouble with the Rotorua Town Board over the question. Hamilton was nearest to Rotorua, and therefore the most convenient.

Burke pointed out that he belonged to Auckland, and he was in Rotorua only for two months working.

The Chairman: The Hospital is open to receive patients when they come to the gates.

Mr. Beetham considered an up-to-date hospital in a city was far more suitable for serious cases than a country hospital, where the necessary appliances would probably not be at hand. Because a man was poor he should not be prohibited from taking the best chances he could for recovery.

Mr. Reed: The other districts won't allow it. They will not pay for the treatment of persons from their districts unless they first give their consent, or it is a case of emergency, which are never refused.

The Chairman: If a man is seriously ill it is a case of emergency. To refuse to admit a man who is seriously ill because he belongs to another district is wrong.

Dr. Collins again rose to explain, but the Chairman remarked, "We will have an opportunity of hearing you later on, doctor."

The witness was questioned as to seeing Dr. Collins in the Hospital while he was a patient, and Dr. Collins pointed out to him that he (the doctor) was on leave at that particular time.

Dr. Collins: How long did the cancer patient put the spoon he was using in the salt and then in his mouth?—In eating eggs he put the spoon in the salt and then in his mouth.

For how many days did you notice it?—One or two days I noticed him.

Did you make any remark to him?—Another patient named Bell threw the salt out.

Victor George Swinbourne, railway storeman, living at Remuera, said that about six weeks ago he went to the Hospital suffering from the effects of an overdose of chlorodyne. He was shown into the waiting-room on arrival, about 10 a.m. He waited there for about an hour without any doctor seeing him. He was then shown into No. 7 Ward, where he waited until about 3 o'clock, when Dr. Ferguson came to see him. This was the first time that he saw a doctor. He remembered a patient named Bob Halifax.

Mr. McVeagh: What was his behaviour towards you?—It was very rough. He put me into straps, and on one occasion he came and jumped on my chest.

Mr. Beetham: What was he supposed to be?—I believe he was an ex-patient, but at the time I did not know what he was.

Mr. McVeagh: Did you see him doing anything else?—Yes; I saw him injecting morphia into the other patients, and he told me he also used it upon himself. He asked me if I would take a dose, but I refused.

Where did he get it from?—From a cupboard near my bed. It was not locked.

Mr. McVeagh: What was the food like?—It was very poor—in fact, bad. The meat appeared to have been warmed up. I was only there a week, and during that time I never had a warm meal. It was always lukewarm.

What about the soup?—It was beastly. The porridge was served up in a mug without any sugar. The sugar we bought ourselves. On one occasion when the food was bad we had to have a tarpaulin muster to get something for tea.

Mr. Beetham: A tarpaulin muster! What is that?

Mr. McVeagh: It is a subscription amongst the patients.

What about the fish?—It was often overcooked.

Mr. Reed: Did you ever see the house steward visiting the wards at meal-times?—No.

Did you complain of the food?—Yes; I complained to Halifax. He was in charge, and did the cooking and washing-up.

Did not all the convalescent patients help in the same way?—Yes; but not so much as Halifax.

Was there not a wardsman named Cook in charge?—Yes; but when he was absent Halifax was left in charge.

Was it known that Halifax was administering morphia to patients?—Yes; it was common talk among the patients.

Do you suggest that it was done with the knowledge of the officials?—I would not like to suggest that. I spoke to Halifax about the ill effects of morphia, but he said the feeling was glorious.

Did you speak to Cook about it?—No. I may say that I left the Hospital sooner than I would otherwise have done but for that. I had to go to another doctor after I left the Hospital.

Dr. Collins: Why were you strapped down shortly after you went to the Hospital?—I think it was simply because Halifax did not want to be bothered with me.

Were you a quiet unassuming person at that time?—I was at that time.

Were you so all the time?—No; I was delirious some of the time, when the chlorodyne had taken effect.

Why did you take chlorodyne?—I did not take it. I was ill in bed, and it was given to me in mistake for medicine. I did not inquire what it was. I had been suffering from the after-effects of influenza.

Did you take liquor for it?—No.

If two doctors said that you were suffering from delirium tremens, would you say that they were wrong?—Most decidedly I would.

Do you remember whether you were violent?—I was not violent.

You know that chlorodyne is practically opium, and is it not strange that it should have affected you in the way you say?—I had had a lot of mental trouble at that time.

Will you swear that you had not taken liquor, and that you did not have delirium tremens?—I will swear that I did not have delirium tremens, and that I had not tasted liquor for a considerable time before that.

Mr. McVeagh: How long was it before you went to the Hospital that you had any drink?—I had a glass about three weeks or a month before I went there. I was in bed for a week before I went to the Hospital, and I had no liquor in the house.

Mr. McVeagh said that, as it had been suggested that the witness was suffering from delirium tremens, he would like the bed-chart to be produced. Mr. Reed said this would be done.

Mrs. Emma Rose Mooney, of Pitt Street, said she broke her leg on the Hospital steps when leaving the Hospital on a visiting-day last November. She was taken to the Costley Wards on the same afternoon, and the leg was set about noon the next day by Dr. Collins.

Have you any remarks to make on the food?—If I had depended on the Hospital food I should have starved.

What was the condition of the fish?—I could smell it before it came into the ward.

What of the eggs?—They were boiled hard, like cricket-balls. Not fit for patients.

What was the state of the cabbage?—You wanted glasses to look at it. It was full of snails. The soup was coloured with vegetables.

How did you get on?—I could not eat the food. My friends and children brought me food.

How was the porridge?—It was so lumpy and raw that I refused it.

Did you complain?—I told one of the porters that it was very hard that we had to pay and get food that we could not eat. He replied that he could not help it; he was carrying out his orders.

Mr. Reed: Did you complain to the doctors?—I did not see any doctors to complain to.

Did you complain to the nurses?—No.

Did you send the food back?—I left it. I used to have bread-and-butter and a cup of tea sometimes.

Why didn't you complain?—It was no good complaining. It was best to keep it to yourself. So long as I could get it from my home I didn't want it from the Hospital. When porridge was brought to me half-cooked and lumpy I said, "I can't eat it; it is not cooked."

You did speak to the nurse, then?—Yes; but I don't remember her name.

Dr. Collins: When you broke your leg didn't I examine it?—Yes.

Did I not have you sent to the ward?—Yes.

Were you not prepared for chloroform that night?—I don't remember anything; I was in great pain.

I said I would put up your leg?—I don't remember.

Do you remember asking me if I would do your leg, and I said I would?—One of the nurses told me Dr. Collins was coming in the morning, and I asked to have him sent along early.

You said the cabbage was full of snails: did they have shells on?—I didn't have my glasses on, doctor.

You would have seen them had you had your glasses?—Certainly I should.

Mrs. Elizabeth Harper, Edinburgh Street, Newton, said she was a patient for fourteen days in August, 1904. She was first in Ward No. 9, and then removed to No. 4 Ward. No. 9 was a fever ward, but witness was suffering from blood-poisoning. There were two noisy patients in the ward at that time, keeping witness awake all night. The patients were delirious, and one had to be strapped down. In No. 4 Ward one patient became very bad, and was for two days delirious, causing great excitement in the ward. All the patients were upset. It was a delirium-tremens case, and she was taken away. She was continually talking, screaming, and singing out, and it took the nurses all their time in looking after her.

What was the quality of the food?—The food was very bad.

In what respects?—It was that bad that some of the patients could not eat it. The fish was not good. The potatoes were bad, and the beef-tea was given without salt. The bread also was very bad. At times I could not eat it at all. The eggs we got at times were also very bad.

Mr. Reed: You say the bread was bad?—Yes.

The tea?—It was more like water. The fish was bad and insipid. There was no salt with it, and it had no taste. Sometimes it was cooked on the one side and not on the other.

What do I understand—was it unfit for food?—It was rank, and not fit to bring to any patient.

Did you make any complaint?—That was the only complaint, in addition to insufficient attendance by doctors.

Did you say anything to any one?—I said I did not like it. I complained to Sister Wood, and she didn't seem to think anything about it. She said the other patients could eat it.

Dr. Inglis, who was next called, said he was a resident of the Auckland Hospital for two years, and for a time was Senior Medical Officer, completing the latter engagement in 1901. While there he did not have cases of suppuration. He was on the honorary staff at present as honorary anæsthetist. When there were scarlet-fever cases at the Hospital under his *régime* there was no increase in cases of suppuration. In his opinion, the administrative work of the Hospital should be done first thing in the morning. When he was in charge he started on the wards at half-past 8. He lived at the Hospital at that time. To leave the administrative work till 10 or half-past 10 o'clock would interfere with the visits of the honoraries who arrived any time after 9 o'clock.

Mr. McVeagh: From your experience of hospital administration, do you think a hospital could be well looked after when the Senior Medical Officer lived away from the institution and came to the Hospital about 10 o'clock, leaving about 4 or 5 or 6 o'clock?—I don't think that would answer.

Mr. Beetham: Should he live at the Hospital?—At any rate, close to it.

Dr. Inglis considered the production of certificates acted very well, but in a case of emergency should not be insisted upon. He had admitted patients without certificates.

Mr. Beetham: You never allowed the porter to deal with cases?—No.

The witness did not think it a good practice to put delirium-tremens cases in the same ward as typhoid-fever cases, as they would irritate the latter. When in charge he had carried out his duties in regard to giving lectures to nurses, and in addition to the lectures gave clinical demonstrations in the wards. The proper training of the nurses was important to the administrator, as well as important from the point of view of the public.

Mr. McVeagh: Who did the major operations during your time?—The honorary staff.

Did the Senior Medical Officer do any serious abdominal operations?—I don't think so. I did one while I was there.

Do you approve of the system of the Senior Medical Officer doing these operations?—No, I don't.

Had you ever any difficulty in getting surgeons in cases?—No.

Any difficulty in getting them to attend consultations?—No. I think we always had a quorum.

In what classes of cases have consultations been called lately?—Consultations have been called in cases where they were unnecessary, with the result that members of the honorary staff have got rather tired of it and won't attend, because it takes up a lot of time.

Were you present at a meeting of the honorary staff just prior to Dr. Neil's suspension?—Yes.

Was there some discussion about emergency operations?—Yes.

Was Dr. Collins present?—Yes.

What was the trend of the discussion?—On the subject of emergency work generally.

Did Dr. Collins make any observation?—He objected to the rule relating to emergency work being altered. The proposal under consideration was that the honorary staff should be called on to perform major emergency operations. I understood Dr. Collins objected.

Was a statement made as to the Board changing the rule?—Dr. Collins said it could not be changed without affecting the status under which he was appointed. I further understood him to say that it would mean his resignation if it was altered.

It has been suggested that Dr. Collins was overworked, and had all these things thrust on him?—I can't say.

Dr. Inglis said when he was in charge he always produced the consultation-book and had it signed at each consultation. Lately the book was written up and signed some time after the consultations had been held. Since the inquiry held at the Hospital by Dr. MacGregor he had been asked to sign the book to a consultation held before the inquiry. It was far better to sign the book at the time of the consultation.

Mr. Reed: Do you approve of the method adopted in some of the English hospitals of having a highly paid manager, without any medical training, to act as administrator?—I think that would work better.

In one of the leading London hospitals they have a non-medical manager at £1,000 a year, who was formerly manager of a soapworks. What do you think of such an arrangement?—It would depend on what the duties were.

Do you think the honorary staff could manage the Hospital with the assistance of juniors?—Yes; a secretary at the Hospital and two, or possibly three, juniors would do.

Continuing, witness said that in his time he did most of the administrative work. The medical adviser did not interfere much. He understood that the arrangement was satisfactory. He did not know of any particular complaints as to there being no one on the premises with sufficient experience to perform major operations, but on returning from a holiday he found that the system had fallen into disrepute. On being questioned as to the honorary staff's recommendations (as embodied in Dr. Pentreath's letter), witness said he thought the staff was coerced into that position. If the Board said practically that the Senior Medical Officer must be on the staff, of course they would carry it through. With regard to delirium-tremens and consumptive cases, he always tried to isolate them, but it was difficult to do this in entirety, especially in regard to female patients, owing to the lack of accommodation. The septicæmia cases were usually kept separate.

The Commission then adjourned.

Dr. Inglis, who had been called the previous day, continued his evidence under cross-examination by Dr. Collins on Thursday, the 27th October. He considered he was in charge of the Hospital when Senior Medical Officer, but his position was never defined. Dr. Bedford was medical adviser, and attended the Board meetings. At the time witness was recommended to fill the position now occupied by Dr. Collins he did not think Rule 72, relating to emergency work, was in force. Routine work of the Hospital had been interfered with by the irregularity of visits of the staff. He put up fractures while he was in charge, and attended them afterwards under the honorary staff. The house physician assisted at operations, attended fever patients, and carried out *post-mortems,* but the work was so arranged as to minimise any risk of infection. When a bad case came to the Hospital and the two residents were engaged on an operation, one of the residents left the operation, either at once or at a convenient time.

In reply to Dr. Roberton, witness said the Hospital Board had too many institutions to look after at present; they had no medical knowledge, and the members were elected for too short a period. The effect of annual elections of the Board prevented members from taking a proper interest in the work, and also tended to make a continuity of policy impossible. When witness was in charge all the members of the Board did not frequent the Hospital sufficiently to gain a thorough knowledge of the working of the institution. Mr. Bruce and Mr. Stichbury, as successive Chairmen, were often there, and showed a real interest in the institution. Mr. Gordon also attended pretty often. The Fees Committee were also often there. There had been a difficulty with two resident surgeons in taking in patients, but he did not think there should be any difficulty with three residents. He objected to persons able to pay for outside treatment being admitted to the Hospital, as it took away beds for the sick poor, and was unfair to ratepayers and taxpayers. It was also unfair to the honorary staff to ask them to treat patients in the Hospital who were in a position to pay for outside treatment. It was also unfair to the nursing-homes. He had frequently heard it stated by patients that they were too poor to go to the Hospital. He had told them in some cases that the Board would probably remit the fees, but they had replied that they would not care to make a request for remission.

Were they Scotch folk?—Some of them. (Laughter.)

Witness, continuing, said that in many cases patients, after going to the Hospital, had their recovery retarded by worrying over the fees, and in many cases they left before they were really fit to do so. He thought the tenure of office of the honorary staff should be for a longer term, and he approved of the idea of assistant surgeons. With proper precautions there should be no danger in the physician who attended to ordinary infectious cases giving anæsthetics. He did not approve of the Senior Medical Officer being present at all the meetings of the honorary staff. He should be there by invitation. His presence at all meetings tended to restrain discussion, and also placed himself in an invidious position. He did not approve of the Senior Medical Officer, as a subordinate, being the only means of communication between the staff and the Board. He did not think the Senior Medical Officer should do any operations. Casualty work should be done by the junior residents under the supervision of the Senior Medical Officer, who should be really a Medical Superintendent. There were more medical than surgical emergencies, and there was no reason at all why the

Senior Medical Officer should be more of a surgeon than a physician. There was not sufficient accommodation in the Hospital for women. He did not approve of such cases as those of consumption being put into the typhoid ward.

Witness stated that the present constitution of the Board, even with medical representation, was not satisfactory. The Board should be elected for a period of years, with representation of ratepayers, medical profession, and the Government. It should be distinct from charitable aid.

Mr. Reed here pointed out that tenders were invited by the Board in 1901 for the erection of a new lift for the Hospital, and the price tendered was £1,095. It was a question of finance at that time.

The witness said he was not in favour of the Senior Medical Officer doing any operation under the present conditions. His idea was that a resident secretary could look after the administration work, with three resident medical men.

Mr. Reed: That is another system. We have tried many systems.

Mr. Beetham: That is the system that obtains at the Christchurch Hospital.

Dr. Inglis, re-examined by Mr. McVeagh, said when he was in charge admission was never refused unless the Hospital was full.

The Chairman: When a man is turned away in the fashion described and told to go and get an order from a medical man, if he goes to a medical man and was examined as to his fitness for admission, I presume a fee is payable?—It is payable, but is not always got.

The Chairman: I don't say it is, but is there always a fee to be paid by the patient?—Yes.

Mr. Beetham: With a properly organized honorary staff, with honorary assistants, and if the patients who are able to pay are excluded from the Hospital, do you think that a resident surgeon and physician, with the resident secretary, would be able to carry on the work satisfactorily?—They would have a surgeon, a physician, and a man to attend special departments.

Mr. Beetham: At all events, there should be three men. Should they be young men?—Yes.

With the Costley Wards away from the main building, with imperfect sanitary arrangements and obsolete lift, what would you recommend to put the building in proper working-order, so that all concerned could work to the best advantage?—It would be almost impossible to make the present building suitable. It would be the best plan to convert the Costley Wards into surgical wards.

Would you suggest the building of any other to make the operating-theatre in the centre?—It is quite possible it would be necessary to do that.

Should the residents be resident in the new building?—I think so.

The Chairman: What about the new house?

Mr. McVeagh said it was nearly completed. It was intended for the Senior Medical Officer.

Dr. Inglis expressed the opinion that the resident secretary and the resident medical staff could live in that building. There was very small accommodation in the Hospital for the resident men.

The Chairman: What is the cost of the new house?

Mr. McVeagh: I understand about £16,000.

The Chairman: The Board can afford £16,000 for the Medical Officer, yet they cannot afford £1,000 for a lift to save the lives of patients.

Mr. Reed: One of the complaints was that the Medical Officer lives too far away.

The Chairman: He should not live too far away.

Mr. McVeagh: Dr. Baldwin lived close by.

Mr. Reed: But there are no houses to be had there now.

Mr. Reed (after turning to the Chairman of the Board) said the private house being erected was costing £1,290, and comprised ten rooms.

Mr. Reed (to Dr. Inglis): Of course, there is no accommodation in the Hospital for a married man?—No.

The Chairman: Well, then, he should not be married. If the junior residents, on applying, were married they would not be appointed.

Dr. Inglis: In Sydney a man when he got married had to resign.

The Chairman: Just so.

Matron Rowles was recalled by Mr. McVeagh in reference to some correspondence concerning the case of William Peake. Dr. Collins had written to her for some information on the subject, and his letter and the reply were read. The witness, in her letter, stated that her memory was not very clear in regard to the details of the case.

Dr. MacGregor, who was called by Mr. McVeagh, produced the copy of the evidence taken by him at his inquiry at the Hospital last month, and his report to the Government on the subject.

Dr. Roberton said he did not consider it advisable to cross-examine Dr. MacGregor, he being a Government servant, but Dr. MacGregor expressed his willingness to answer any questions.

The Chairman: Probably Dr. MacGregor may offer some opinions. Of course, when we consider our report we shall take his report into careful consideration.

In reply to Mr. Reed, Dr. MacGregor said that the Auckland Hospital in its time had been a very fine Hospital as hospitals went, but it now possessed several defects, owing to the recent advance in specialisation in medical science. The Hospital was not now up to date, and to make it so certain new buildings should be erected. This would mean a large expenditure of money. He considered the position in which the new operating-theatre had been placed required that the

whole of the block there should be devoted to surgical cases. Every penny that the Board could scrape together for years to come ought to be devoted to the pulling-down of the wooden building (Nos. 8 and 9) and the erection of new wards on the same site. With the present accommodation very little improvement could be made, with the exception of the lift and sanitary improvements, beyond what had been done. Generally the Board, with the existing accommodation, were doing as well as could be expected. The back steps were only a survival of some mediæval manor-house. He had stated this long ago, but he had no power to compel anything to be done.

Mr. Reed: Do you think the old building should be pulled down?—No; it would be a pity to do that, as for certain classes of cases it could not be beaten in the world.

In reply to a question by Mr. Reed as to the Board being able to afford to effect improvements, Dr. MacGregor remarked, "I have known the Auckland Board to pretend they were poor when they were not." (Laughter.)

Mr. Reed: Should patients be admitted free?—No; excepting those not able to pay, the Hospital being largely for the poor.

Would you propose to exclude persons from the Hospital able to pay for outside assistance?—The members of the Board and the medical staff must not be afraid to do their duty, no matter how the Press or public may clamour.

Do you say the Board has been influenced by the public?—I am not prepared to make any such general statement. I won't be caught like that. (Laughter.) In vain is the net spread in the sight of any bird. (Renewed laughter.)

Mr. Reed: What should be the constitution of the Board?—Well, we are living in a democratic country of an advanced kind, and in asking me that question you want me to discuss the political and social position of the country.

What improvement do you suggest?—There would be an improvement if the public exercised a little common-sense. For instance, the alteration of the suffrage upon which the members of the Board are elected, which has been spoken of and contemplated, to that on which members of Parliament are elected.

Would the same result be obtained under the present elective system?—Practically the only result obtained under the existing state of things is confusion.

What is your opinion as to the constitution of the Board to secure better results?—I have thought the Government should be represented as finding more than half the money. The Government is not at all represented. No *locus standi*. I do not know if the Government has really even the power to elect a Royal Commission to see how you are getting on. (Laughter.)

Without Government representation, is the Board likely to be better constituted from a patient's point of view?—Is there a patient's point of view? It is a figure of speech, and we are now dealing with accurate expressions.

None of the doctors have given a clear reason why a Board with nominated members would be in a better position to satisfy patients than an elective Board. What is the reason?—If it is a case of patients perpetually demanding things without paying for them—a Board likely to give them things for nothing out of the pocket of the ratepayer—then I admit it certainly would not be so advantageous to the patients.

I am afraid I can't get anything more definite than that?—You can try. (Laughter.) I think perhaps it is a little too definite, and not indefinite. I don't wish to be charged with giving indefinite answers, not even by implication.

Would the medical profession having representation on the Board be of advantage?—Judging of the wisdom of the medical profession of Auckland by the representations made by them, I say it would not be good. (Laughter.)

You don't agree with the representations made?—Certainly not.

Where are the members of the Board to get guidance from?—They want to listen to me. (Laughter.)

But you are not always on the premises?—I am always accessible, and I give straight answers.

Has the Board made errors through following the advice of the medical profession?—Certainly. I don't think with a Board of Solomons you would have got the medical profession to pursue the path of common-sense with regard to the Auckland Hospital, even during the time I have seen it.

In reply to Mr. Reed, witness said he thought that the present annual elections of members of the Board were a disadvantage. He would favour a system under which, say, three members would retire every year, as it would insure continuity of administration except in regard to the secretary, unless the members were re-elected. As a consequence they spent most of their term in learning their duties. As to whether the Hospital Board should be distinct from the Charitable Aid Board was a big question. There was no possibility of curing the hospital evils in the colony, both here and elsewhere, without local government reform. Supposing, say, nine-tenths of the existing local bodies were abolished, and they had a few large organizations, hospitals, perhaps, would be placed in charge of one committee, and so on. He certainly thought that the lady superintendent should attend to the inspection of the food, and he had been astonished and staggered to hear her say that she did not do it now.

Mr. Reed: Should not the house steward see to that?—Yes, he could go also, but it should certainly be done also by the lady superintendent.

You mean they should go together?—Yes, if they were sufficiently good friends. (Laughter.)

Mr. Reed: Have you any other suggestions?—I think the present relations between the resident and honorary staffs in the Auckland Hospitals are preposterous. I object to the position either thrust upon or arrogated by the Senior Medical Officer. His contention is that the honorary staff have thrust upon him certain duties which he should not be called upon to perform. It appears to be arguable on the other side, and it seems with more likelihood of success, that he has arrogated these functions to himself, and that the Board has connived at it, the result being the present mess in which we find ourselves.

But, according to the letter sent to the Board in 1901 by the honorary staff, they seem to have acquiesced in that position?—Yes, apparently; but what they were thinking of I am unable to understand.

You think that in that case the profession wrongly advised the Board?—Yes, not only wrongly, but, what is worse, stupidly. (Laughter.)

What should be the duties of the junior residents?—They should undertake the whole work of the institution under the supervision of the honorary staff.

Do you think there should be no Medical Superintendent at all?

Dr. MacGregor (with emphasis): No. The Hospital is not large enough to justify anything of the kind.

Mr. Reed: Do you agree with Dr. Inglis that a business-man or secretary should be the really responsible man in the Hospital?—No, I do not, because a layman would be absolutely helpless in directing any department.

Mr. Reed: Do you think there should be a senior medical man in charge?—Yes; if you have three residents—I cannot myself agree that more than two are necessary—and one of them proved capable, you could give him extended powers in regard to supervision. I think he could do with one assistant. Dr. Inglis said it was hard work, but I would like to know exactly what he calls hard work. People can make work for themselves, you know.

Would you allow the man in charge to perform operations?—Yes.

Could he attend to fractures?—That word "fractures" is a most dangerous one in the hands of a lawyer when he is trying to trip up a witness, but I am not going to be tripped up. (Laughter.)

Could he set fractures?—That term also is old-fashioned. He could set some fractures.

Should he be responsible for fractures?—Responsible to whom?

To his employers—the Board?—How could he be responsible to the Board for setting fractures?

Could he do major operations?—That is another out-of-date term, and I object to it. Persons who have allowed themselves to be tripped into the use of it have placed themselves in a false position.

Supposing the senior resident was performing an operation, and his only assistant was administering the anæsthetic, who would attend to patients seeking admission?—In such case the duty should be delegated to some other capable officer. It only requires a little commonsense. It would be a very unusual thing for both doctors to be occupied as you say. I have performed operations and given the anæsthetics at the same time, with no one to help me except some old woman. "Operation" is a very indefinite term, and some can easily be postponed or interrupted when there are more important matters to be attended to.

Dr. Roberton: Do you think it would be an advantage if the members of the Board had a medical education?—That is a double-barrelled question. Fire one barrel at a time. (Laughter.)

Matters may come before the Board of a technical nature. Could a Board with no medical knowledge deal with it satisfactorily?—It would depend on the expounder or the writer of the letter, if it were in the form of a letter.

Would it not be an advantage if a member of the Board could explain the medical terms?—That is the other barrel. Are you going to fire it now. (Laughter.)

You were formerly a professor of mental science at the Otago University?—Yes.

Do you find that knowledge of advantage?—Well, yes. Most of the time that I held that position I was in charge of the largest asylum in the colony. I am now the oldest official in connection with asylum work in the colony.

You have, I suppose, found it advisable sometimes, even when dealing with an insane person, to give a straight answer?—Well. Socrates once asked whether a man was justified in telling a lie. I think a medical man sometimes is in speaking to a patient.

Still, you would condemn a medical man who did tell lies?—Yes, if done unnecessarily.

Let us return to the point if we can?—If you can, you mean. (Laughter.)

Witness, in answer to further questions, said that members of the medical profession did not always make good members of local bodies, but he thought that the chairman of the honorary staff should be in communication with the Board.

Mr. Reed: You have said that the Board has got into trouble through listening to the medical profession. Have they not also got into trouble through not listening?—Very likely.

Mr. Reed: Do you think hospitals should be restricted to the sick poor?—That is what hospitals are supposed to be for; but in defining "sick" and "poor" there has always been a difficulty. I have seen people driving up to the outdoor department of a hospital in their own buggy and pair. I think that if people say they cannot afford to pay it should insure instant admission into any hospital.

Dr. Roberton read a letter sent by the Board to the staff in July, 1901, suggesting the appointment of a Senior Medical Officer, and asking the Board's opinion. The Board, in reply, suggested that the then senior resident should be advanced to that position, with an increase of salary, that he should be assisted by two residents, that he should administer the out-patient department, give primary treatment to cases upon admission, and supervise the administration of anæsthetics.

Replying to a question regarding this letter, Dr. MacGregor said he objected to the position which the Senior Medical Officer had appeared to desire to conquer for himself, either through the supineness or connivance of the staff. He had never previously heard of any other man in Dr. Collins's position performing such operations as he (Dr. Collins) had been called upon to perform. The staff's advice, if sternly insisted upon, might have obviated the position. The Board had apparently, in its rules, conferred upon the Senior Medical Officer power which he should not have had.

On resuming after the luncheon adjournment, Mr. McVeagh intimated that he had examined all the witnesses he intended to call, and then handed in various documents relating to the charges made by Dr. Neil against Dr. Collins and the Board.

Mr. McVeagh stated that he had asked for the bed-chart of the patient Victor George Swinbourne because it had been suggested that he was a delirium-tremens case, while the patient contended he was suffering from an overdose of chlorodyne. A chart had been produced, but it was so obvious that it was recently written out that he objected, and inquired for the original, which he was told had been destroyed.

The Chairman: The original been destroyed?

Mr. McVeagh: I understand so.

Mr. Reed pointed out that the original copies were only kept for a short time. The chart of this particular patient had been destroyed along with others.

Mr. McVeagh (continuing) said he objected, because it was stated in the chart that the patient was suffering from delirium tremens. In the discharge-book the case was stated to be one of chlorodyne-poisoning, so a chart to that effect was insisted on and granted. In justice to Swinbourne, he had the chart produced.

Mr. McVeagh stated that Dr. Williams, of Avondale, who was too ill to attend the Court, desired to give evidence to the Commission. The doctor had for sixteen years been in charge of the Thames Hospital, and could give valuable information in regard to hospital-management.

The Chairman intimated that the Commission would like something more definite as to what information Dr. Williams could supply before consenting to spend a day in going to his house.

Mr. McVeagh stated that the doctor had also been on the honorary staff of the Auckland Hospital for two years.

Dr. Roberton said he did not know in what direction the evidence of Dr. Williams would be, but recommended that it should be obtained. He was prepared to say the evidence of a man of the skill of Dr. Williams would be accepted by the Medical Association as of great value.

The Committee decided to take the evidence of Dr. Williams at his residence on Saturday.

Dr. Roberton then proceeded with the allegations brought forward by the Medical Association against the management of hospital affairs by the Hospital Board. He pointed out that the allegations were quite distinct from the charges made by Dr. Neil, and he would like to have been able to bring his evidence in a systematic way, instead of being required to examine witnesses in the order called by counsel for Dr. Neil.

The first witness called was *Mr. George Joseph Garland*, who said he had been a member of the Board for four years, and represented the Manukau County. This was his second term of Chairmanship. Previously he had been Chairman of Road Boards, a member of School Committees and Licensing Committees, acting as Chairman of the latter on one or two occasions. He had no actual experience of hospital administration prior to being appointed on the Auckland Board, but had visited the large institutions of New South Wales. The Manukau County was a portion of the Auckland Hospital District, and he was elected by the local bodies, numbering twenty-nine or thirty. The election was held annually.

Dr. Roberton: Who notified you of your election?—I saw it in the Auckland papers.

Not officially?—There was a Returning Officer elected.

Mr. Garland said candidates were elected by the local bodies, who had one vote each, excepting one Borough Council, which had four votes. His election had been annual for four years, and it had been contested. The interest the districts had in hospital affairs was that underlying the broad principles of democracy—viz., where there was taxation there must be representation. The local bodies were not the only contributors. The expenses of the Hospital annually were £12,000, roughly, of which sum the Government contributed half, and the local ratepayers the other half.

Dr. Roberton: Do the honorary staff contribute towards the maintenance of the Hospital?—No.

Are their services not of monetary value?—I don't think so. If the staff was unreasonable in their requests they would cost the Board money.

Witness went on to say that if there was no honorary staff the work they were doing would be carried out by the Board retaining medical men at a cost of £600 to £700 more than was now being paid.

Two more medical officials, a junior and a senior, would be required, and witness thought they could do all the work at present being done by the honorary staff. They possibly might not do it as well. It would depend on the cases coming in as to the cost of consultations, which would require to be done outside. An honorary staff would save £700, or even double that, if they were not unreasonable in their requests, but witness would not admit without consideration that the staff contributed that amount to the Hospital maintenance. If they did it would be right, on the broad principle of democracy, that they should have representation on the Board.

Dr. Roberton questioned the witness as to the law relating to the appointment of representatives to the Board, and the Chairman remonstrated, remarking: You may give us credit for having some knowledge of it. I must confess we are intelligent, and quite willing to listen, though.

The witness said the Board managed the Hospital and Costley Home, and the general business pertaining to these institutions. In arranging finances the Board had been hampered through pressure brought to bear through the Press. The non-payment of contributions up to date by local bodies had been inconvenient, resulting in the Board being short of funds at times. A Board should always have its finances in a sound state. In giving particulars of the time members of the Board ordinarily devoted to their duties, Mr. Garland said members would give up a full day a week, and a Chairman three days a week.

Dr. Roberton: Are there many members of the community who could afford that time?—I suppose there are.

Are many prepared to do it?—I don't know. I won't be prepared to do it after this year. (Laughter.)

Witness said he could not say if members of the Board had had previous experience of hospital administration, but he did not think the members of the present Board had had a medical education, which would be an advantage. He did not remember if necessary improvements at the Hospital or a change of policy had been deferred on account of the election of a new Board approaching.

Dr. Roberton: What led up to the appointment of Dr. Collins to the Hospital? Was it a public agitation against the Hospital being "run by two boys"?—Witness said the Board had to acknowledge this, and communicated with the honorary staff, asking their advice on the matter. A reply was received, partly affirming the appointment of a Senior Medical Officer, at a salary of £500 a year. Witness subsequently admitted that the honorary staff favoured the appointment of three medical men, and that he regarded the alternative suggested by the honorary staff, that Dr. Inglis be promoted to Superintendent, with an increased salary, as an affirmative reply. As the staff would terminate their appointments in nine months from that time, the Board did not give much consideration to the recommendation of the staff. A letter was written to the staff in reply, and Dr. Pentreath (secretary of the staff at that time) wrote about four months later. Prior to Dr. Collins's appointment the Board had it strongly impressed on them that the man appointed should have had some experience in surgical work, and the members of the Board had that in their mind in making the appointment they did. They realised it was necessary to have a man able to assume responsibility for operations in the absence of the honorary surgeons. Probably the best and legitimate course to adopt would be to take the advice of the honorary staff, but he further admitted that the advice given by the staff in regard to the appointment of Dr. Inglis was disregarded.

The letter written to Dr. Pentreath, as secretary of the honorary staff, remitting recommendations, was referred to by Dr. Roberton. Mr. Garland stated that Dr. Collins attended Board meetings, but did not vote.

Did you intend that he should vote at the meetings of the honorary staff?—I did not look at it in that way.

The rule regarding the Senior Medical Officer being the medium of communication between the honorary staff and the Board had, the witness said, been honoured more in the breach than the observance. He did not distinctly remember a recent case in which he objected to a communication because it did not go through the Senior Medical Officer. Witness said the Senior Medical Officer was made responsible for the giving of anæsthetics, because there were some deaths under chloroform, but the responsibility had been removed since the appointment of an honorary anæsthetist.

Dr. Roberton: Are Rules 56 and 75 compatible? One says the Senior Officer shall assist at operations, and the other that he may delegate the administration of anæsthetics, but shall be responsible to the Board in case of doubt as to proper administration?—Yes, I think so.

Is it fair to put such duties on the Senior Officer—assisting at operations and making him responsible for the giving of anæsthetics, which he could not control?—It does not seem fair.

What was the object of the Board in wishing the Senior Officer to attend meetings of the staff?—I don't know. What effect it had I cannot tell, not being present.

Are you in favour of continuing the rule?—I cannot tell. I will tell in a month's time.

Mr. Garland said the Senior Medical Officer was often consulted in hospital work. Personally, he had not consulted him in the appointment of the honorary staff, but he believed they consulted in regard to the appointment of Dr. Neil to the honorary staff.

Dr. Roberton: Do you think it wise to consult on such a matter?—Of course I do.

Does it not put a dangerous power in the hands of the Senior Officer?—I don't think so, if you trust him.

Had the medical side any consideration when the Board was determined to appoint a man of ripe surgical experience as Superintendent?—I thought a man who was a good surgeon would also have good qualifications as a medical man. I know eminent surgeons who are good medical men.

Will you name one?—I will, if I'm pressed to.

Dr. Roberton: May I press the question, Your Honour?

Witness: I am not afraid to mention it.

Dr. Roberton: I won't press it, Your Honour.

Continuing, the witness said the Senior Medical Officer was consulted sometimes in regard to finances, but he was not allowed to reply to a deputation from the honorary staff, which waited on the Board in March, 1903, in regard to the Board's finances. Some technical questions arose, and the Senior Medical Officer was asked to explain them. Witness himself replied to the deputation.

Dr. Roberton: Has the Senior Officer kept all the Hospital rules?

Witness: You and I are not able to keep the ten commandments, so I don't know how you expect the Senior Officer to keep forty-seven of them.

The Chairman: You are not paid for keeping the ten commandments. (Laughter.)

At this juncture the Commission adjourned.

On the Commission resuming on Friday, the 28th October, *Mr. G. J. Garland*, Chairman of the Hospital Board, continuing his evidence under examination by Dr. Roberton, detailed the various measures adopted during the past two or three years in regard to the treatment of infectious diseases. In reply to Dr. Collins, witness said that very few infectious cases were treated at the Hospital prior to his (Dr. Collins's) appointment. Beyond what was known as the "plague" hospital, they only had the cottage, capable of accommodating about six patients. He believed that there were over a hundred cases between January, 1902 (when Dr .Collins took charge), and October of the same year. In order to cope with the infectious cases in that year, the Board took charge of the "plague" building, drained it, and used it for infectious cases.

Dr. Collins read a report which he furnished to the Board in October, 1902, dealing with the question of infectious diseases. He pointed out the extra expense (about £1,155) already incurred in that year in treating infectious diseases, and warned the Board that it would have to make provision for the treatment of such cases.

Dr. Roberton read a provision in the Hospitals and Charitable Institutions Act, which provided that any person seeking relief "shall be liable to contribute a reasonable sum, according to his means."

The witness said he considered a "reasonable sum" was the average daily cost of maintenance in the Hospital, and that was the basis adopted by the Board. The fees, however, were written off when the Fees Committee considered there was reason for it. Some patients cost more than others, and these patients frequently did not pay anything. A suggestion had been made that a record should be kept of the cost of each patient, and that every patient, if his means permitted, should be compelled to pay such cost. The Board considered that such a system would entail too much book-keeping. The amount spent on the Hospital buildings was, he thought, over £50,000. No provision was made for depreciation and interest on the cost of these buildings in calculating the average cost of patients. He recollected a deputation waiting on the Board in reference to the introduction of a graduated scale of charges arranged according to the financial position of the patients. His idea of the scheme was to exclude people who could pay, so they would have to go to a private hospital. That was the impression he gained, although it was not so stated. Under certain circumstances he favoured patients being charged according to their means, but the law would, in his opinion, have to be changed.

Dr. Roberton: If a millionaire was treated, should he only pay the same as the person who could barely pay the 4s. 8d. per day now charged?—If a man who is opulent contributes towards the upkeep of the Hospital through the local authority, and has to go to the Hospital for treatment, or a member of his family is sent, it would be very unreasonable to expect him to pay more than another ratepayer who is not so wealthy.

Dr. Roberton: But the Act provides for the payment of a "reasonable sum according to his means."

Questioned about the method adopted by the Board for recovering fees from patients, the witness said it was dealt with by a Fees Committee. The first notice sent out asked for settlement, the second for immediate payment, and this was followed up, if no reply was received, by a man making inquiries as to the position of the defaulter. If thought expedient, legal proceedings were then taken. No hardship was intended by the Board. He remembered, since he had been Chairman, that an order had been given to cease the out-patient department, because it was growing to such proportions as to become uncontrollable. The out-patient department had now been arranged so that it should be carried on by the Charitable Aid Committee.

Dr. Roberton handed the notices sent out by the Board to patients to Mr. Garland, who, on looking them over, stated that four notices were sent out before legal proceedings were taken.

Dr. Roberton: Legal proceedings are mentioned on the second notice. How is that?—I suppose some people are thick-skinned.

The Chairman inquired the reason of the sudden change of the Board in deciding to convert the Costley Wards into surgical wards.

He pointed out that the advantages of the Costley Wards for the children, for whom they were originally built, had been expatiated upon by Mr. Garland when they (the members of the Commission) visited the Hospital, but since the absurdity of erecting an expensive operating-theatre close to the wards had been pointed out the Board had made a sudden change.

Mr. Garland said it was hoped at no distant date to sweep away the typhoid-fever buildings and erect in their place wards suitable for the children. That, he said, was in the mind of the Board.

The Chairman: I hope so.

The Chairman also inquired under what authority members of the Board gave notes to persons for admission.

Mr. Garland said that only the Chairman ever gave such notes, and he had only given four or five in cases where he was certain that the persons were in pain.

The Chairman thought the practice was open to abuse.

Mr. Garland remarked that he could positively say there had been no abuse of the practice since he was Chairman.

Mr. Reed said he would call Mr. Garland again later.

Alexander Bruce said he had been a member of the Hospital Board for ten years. He was Chairman of the Board in Dr. Baldwin's time. He represented the Borough of Devonport and the Counties of Waitemata and Rodney. He had been a member of the Waitemata County Council for sixteen years. He agreed that the services of the honorary staff had a considerable money value.

Dr. Roberton: Do you think £2,000 a year too high an estimate to place on the services of the ten memers of the honorary staff?—I do not suppose we could get the talent for the money.

Do you think it could be equalled by the work of two men paid £700 a year each?—No.

Witness spoke of the time given by members of the Board. He thought a medical man would be useful on the Board in connection with the purchase of drugs, the choice of resident officers, &c. He did not think it would be an advantage to separate the Hospital Board from the Charitable Aid Board. He did not think a medical man of experience would be able to give his time as a member of the Board. He thought that the Board derived some advantage from having a medical adviser when he was Chairman, but he thought the best advice could be got from the combined honorary staff. Dr. Baldwin left the Hospital in order to take up a Government position. Witness was opposed to the change to the present position of medical management, which was brought forward by Mr. Stichbury. He was fully aware that the staff was opposed to the change. Witness did not know how the rule was introduced making the Senior Medical Officer the medium of communication between the honorary staff and the Board. He did not remember how the latest code of rules was drawn up. The rules were one of the most important parts of the Hospital, and should be drawn up by the Board, with the assistance of the honorary staff. It could not possibly be done by laymen at a Board meeting in a satisfactory manner.

Witness said that in giving the Senior Medical Officer power to attend the honorary staff meetings it was his belief that the Senior Officer would attend only to give information, and not to take part in the business. He thought it would be a similar position to that held by the chairman of the honorary staff ten years ago, when he had a seat at the Board meetings, but did not take a part in the business.

Dr. Roberton: Has Dr. Collins acted as financial adviser to the Board?—I could not say definitely if he has, but he has pretty well controlled the Board.

In reply to Mr. Reed, witness said he never considered the honorary staff as being under the Senior Medical Officer. There could not be any suggestion that the change in the system of medical management was instigated by Dr. Collins, who had not arrived in the country at the time. He believed that the majority of the members of the Board were influenced by public opinion as expressed in the Press. It was not wise to take much notice of every letter that appeared in the newspapers. He gave an instance in which a complaint had been made as to the treatment of a patient at the Hospital by Dr. Collins. On investigating it he found there was no foundation for the statement.

Witness did not know anything about the food-supplies beyond that tenders were invited annually for the supplies in different sections. Meat was one class, bread another, groceries another, the latter including nearly everything that grocers sold.

The Chairman: Is there anything that a grocer does not sell at times? (Laughter.)

Witness said that the vegetables generally came from the Costley Home.

Mr. Beetham said that, if he remembered rightly, the Costley Home complained that all the best of the cabbages went to the Hospital, and that they (the Costley Home people) got only the outside leaves. (Laughter.)

Examined by Mr. McVeagh, witness stated that he understood that all major operations would be performed by the honorary staff, as stated by Rule 22.

The Chairman: It is the grossest distortion to say that under the rule the Senior Officer has a right to perform any major operations that went into the Hospital.

Mr. Bruce: The rule is most emphatic.

Mr. McVeagh: But that is not the construction that has been placed on the rule.

The Chairman: The construction put on it is a direct violation of the ordinary rules of the English language.

Witness said that he was present at the ordinary meeting of the Board on the afternoon prior to the evening of the special meeting at which Dr. Neil was called upon to resign. At the afternoon meeting Dr. Neil's suspension (which had taken place a few days previously) was referred to, and witness asked for the reason of it. The Chairman of the Board said, "You will know to-night." Witness said he had a right to know then, and the Chairman said the reason was that Dr. Neil had been absent from duty for nine days. At the special meeting in the evening the whole stress of the proceedings was laid upon the subject of White's operation. After statements had been made by several medical men, Dr. Bedford and Dr. Mackellar (the two consulting surgeons) were called in.

What statements did they make?—Dr. Bedford pronounced distinctly in favour of the Medical Superintendent. Dr. Mackellar said the matter should never have come before the public, and that it should have been sent back either to the honorary staff or to the Medical Association—I forget which.

A resolution was then proposed?—Yes; that Dr. Neil be called upon to resign. There was no discussion, and it was carried. I voted against it, because I felt that we should have heard both sides. At the following meeting of the Board a letter was received from Dr. Neil, declining to resign, and it was resolved that he be dismissed. Some one said that it would be impossible to retain both Dr. Collins and Dr. Neil in the Hospital. I admitted this; but I always considered that Dr. Neil should not have been subjected to the indignity of being called upon to resign without being first proved guilty.

Dr. McDowell, the next witness, stated that he joined the honorary staff in March, 1901, when the resident staff consisted of a surgeon, a physician, and a medical adviser. That arrangement was very satisfactory, and remarkably good results were obtained. The only objection he had, however, was that there was too much work for the two residents. He remembered outside dissatisfaction expressed on account of a fatality under an anæsthetic during the absence of the senior, Dr. Inglis. There was no foundation for general charges of want of care, as he considered Dr. Inglis, as senior surgeon, quite competent to carry out the administration of all anæsthetics and the treatment of cases. In regard to a proposal, originating in consequence of the dissatisfaction, to appoint a Medical Superintendent, the honorary staff, of which witness was secretary at the time, considered that Dr. Inglis should be advanced to the position and another junior appointed. From an economical standpoint the honorary staff recommended this course in preference to the proposal of the Board to appoint a senior Superintendent at £500 a year.

The Chairman: Besides the absurdity of building a house at a cost of £1,500 for him when the Board's funds were in a chronic state of impecuniosity.

Witness said the proposal of the Board to assign distinct surgical work to the Medical Superintendent was a novel one, and the staff felt so strongly on the subject that a deputation was appointed to wait on the Board. The deputation was not successful. The members of the honorary staff were opposed to active work being delegated to the Superintendent, and wanted to reserve to themselves the right of putting up fractures and doing major operative work. He was surprised to find the rule making the Senior Medical Officer the medium of communication between the staff and the Board tacked on to one of the other rules. The staff also objected, and caused a letter to be sent to the Board asking for a definition of the position. A reply was received stating that all communications had to go through the Senior Medical Officer, but if the Board wished to keep a communication private it would be handed to the Senior Officer in a sealed letter. This was derogatory to the staff and an absurd condition of things.

Dr. McDowell said he retired from the honorary staff in March, 1903, and did not make application for reappointment, because he was not satisfied with the condition of management. He felt that the honorary staff was in a way subordinate to the Senior Medical Officer, and that too much responsibility was put on the honorary staff without any control of the management. That was especially in reference to the epidemic of infectious diseases some time back, when the buildings were unsuitable, and the resident staff was too busy at operations to go round the wards with the honorary staff.

Dr. Roberton: If satisfactory arrangements were made, would you be prepared to rejoin the honorary staff?—Yes. I can say on behalf of the profession that it is a position we prize very much.

Dr. McDowell said the present constitution of the Board was unsuitable. He believed better men would be found if the Hospital and charitable aid were separated. The Government should nominate suitable men, such as appointed visitors to the asylum, Mr. Justice Cooper, Mr. Ewington, and others. The medical profession should have representation on the Board. The tenure of office of the Board was too short. Going on to the question of the Hospital buildings, the witness stated it was inconvenient to the honorary resident and nursing staffs to have the buildings located some distance away, and it also added to the expense of running the institution.

Cross-examined by Mr. Reed, Dr. McDowell said he had no record in the minutes of the honorary staff while witness was secretary of the question of the Senior Medical Officer performing abdominal operations having been discussed. Witness had addressed letters direct to the Board, because he felt it was derogatory to have to communicate with the Board through the Senior Medical Officer.

Witness was cross-examined by Dr. Collins as to what might be termed emergency operations. He had remembered Dr. Collins performing an operation on one of witness's cases in a case of urgency.

Gastric ulcers could also be termed emergency cases under certain conditions. Peake's case was an emergency operation. Certain classes of cases which Dr. Collins specified would be considered major operations.

Dr. Collins: There was a surgeon on the honorary staff, was there not, who systematically cut his telephone off at night?—I do not know.

Has the staff not tacitly agreed until the last few days with the interpretation put upon the term "emergency"?—I have always thought that when death was threatening the operation should be performed.

Then, I was not contravening Rule 21 in performing these operations?—If life was in danger, you were not.

Witness said he considered more buildings for infectious diseases should have been erected in years past. He had formerly thought that for minor infectious diseases the building could have been erected in the Hospital grounds. Now that the number of infectious cases had increased so much he thought it would be better to have the Hospital farther away.

Dr. Scott stated that he was an honorary surgeon on the Hospital staff. He had occupied the position of chairman of the honorary staff for some time. He pointed out some defects in the Hospital buildings and the old operating-theatre. "There was," he said, "really no operating-theatre in the Hospital at present." The staff had expressed the opinion that better facilities should be provided, and the Board had followed out this advice by erecting the new operating-theatre. The modern trend was in the direction of having separate theatres for septic and aseptic cases. He considered that there should be two, if not three, theatres at the Auckland Hospital. As honorary surgeon, he considered he should treat only the poor.

Have you found any difficulty in getting people to go into the Hospital?—Yes. There are two classes who do not mind going in—the very poor and the fairly rich. The former know that they cannot possibly lose any money, and the latter did not mind when they knew they could get fifty pounds' worth of operation for £5 or £10. Those who fear to go in—and their fear is very bitter—are the comparatively poor, who by being provident have got a roof of their own over their heads. I have known cases of people of sixty years of age say, "I will have to mortgage my property if I go into the Hospital, and if I do that I shall never have a chance of lifting the mortgage." Then, when these people do go into the Hospital, they often have a terrible dread of remaining there owing to the expense.

Witness considered members of the honorary staff should be appointed for a longer period. When the question of the appointment of the Senior Medical Officer came up the intention of the Board, he believed, was that they should get a man specially qualified for emergency work. He had been very much surprised to hear the view expressed that the Senior Medical Officer should not perform major surgical work. He did not think the Senior Medical Officer had performed any operations not in conformity with the rule. The honorary staff had discussed the question as to who was to use the discretion as to the advisability of performing operations, and they decided on the person on the premises.

The Chairman: The question is whether the rule authorises him to do it.

Dr. Scott: The rule does authorise him.

The Chairman: We will form our own opinion of the rules.

Continuing, Dr. Scott said it would be advisable to have a uniform system of hospital-management throughout the colony, arranged according to the size of the institutions. It would give an opportunity for the promotion of deserving residents to higher posts, and would avoid trouble between Board and staffs. He favoured the appointment of assistant surgeons to the honorary surgeons. As an ex-Mayor of Onehunga, he could say that the representative of that district on the Hospital Board was elected from a financial standpoint—one who would see that as little levy as possible would be made on the local authority in the upkeep of the Hospital. He estimated that the monetary value of the services rendered by the honorary staff to the Hospital at £3,600 a year, reckoning on two guineas a visit, with four visits a week. The honorary staff were thus, *ipso facto*, contributors to the maintenance of the Hospital.

Mr. Reed cross-examined the witness as to the White operation. He said he was visiting surgeon that week, and was communicated with by Dr. Collins. Witness was in bed, suffering from influenza, and could not attend, so requested Dr. Collins to operate, as he had the fullest confidence in his capabilities. He said he was conversant with the particulars of the case and the operation, and stated he had known in a similar case it was necessary to evacuate the bowels.

Mr. Reed: It has been suggested that the shock of the opening of the bowels is likely to accelerate the death of the patient?—That is half of the truth. The other half is that a surgeon who feared shock was perfunctory about the cleansing of the bowels, and he would have a larger proportion of deaths than one who disregards shock and thoroughly cleanses the peritoneal cavity. It was more surgical to risk deaths by shock than to have certain deaths following peritonitis. It would cause delay, but the results were much superior.

Opening the bowels takes time and causes shock, but it is safer than closing up the wound without relieving the bowels?—In many instances that would be the case.

In reply to Dr. Collins, the witness said he did not think Dr. Collins had arrogated his position, but had not overstepped the position granted him by the Board.

Dr. Collins: You have known me to do very difficult and trying work?—Yes.

Have you always had confidence in my work?—Undoubtedly.

You have heard it said that Wallis White had a 50-per-cent. chance of his life dissipated?—Yes.

White was suffering from a duodenal ulcer. Would you take Sir Frederick Treves's word on such a case as an authority?—Undoubtedly.

He says very few such cases are operated upon successfully: do you know if that is so?—I presume he is right.

Would that contradict the assertion of a 50-per-cent. chance of life being lost?—Yes.

Mr. McVeagh: If the mortality were more than 50 per cent., you will agree that it shows the necessity of the surgeon losing no time and using every care and skill in the operation?—All other things being equal, time is of great importance, but what was of more primary importance was the proper cleansing of the peritoneum.

If the mortality is 80 per cent.?—My contention still holds good. It was no good getting the patient off the table simply to die of secondary peritonitis.

You say you have made incisions in the intestines similar to those made in this case?—I have made incisions in the intestines, but I have not seen the incisions in this case.

In this case two incisions were made in the colon, within 2 in. of each other. Have you ever done that?—I don't know that I have.

If you found the appendix normal, have you in such a case opened the intestine in two places within 2 in. to remove scybalæ?—I don't know if that has been done. It would be a legitimate course to pursue with the object of exploring the abdominal cavity. I could quite imagine some one opening the intestine within 2 in.

Could you suggest why it was done?—I would suggest that possibly it was done because there was urging by some one else of the operation, who would perhaps do it because he was pushed for time and hadn't time to consider.

Do you suggest any other reason?—While doing a thing it is difficult to find out exactly where you are and what you are doing.

Witness, replying to another question, said that the apex of the appendix was often difficult to find.

Dr. A. C. Purchas stated that he was formerly a member of the honorary staff. When he first went on the staff there was only one resident. After some time the Board appointed a second resident. The Board next decided to appoint a Medical Superintendent. The staff opposed this, and as the Board held to its decision and appointed a Superintendent (Dr. Floyd Collins) the staff resigned in a body. The Medical Association supported the staff on being called upon to fall into line with the staff.

Mr. Reed: That was to boycott the Hospital?

Dr. Roberton: May I object to Mr. Reed suggesting that the medical profession had decided to boycott anybody?

The Chairman: It would be as well not to do so.

Witness, proceeding with his evidence, gave a short history of the subsequent changes. In Dr. Baldwin's time, if the surgeon for the week was not available for an operation, the next in rotation was sent for. Witness did not remember any case in which the Superintendent failed to get one of the honorary surgeons for an emergency operation. He considered all urgent surgical cases should be treated by the honorary staff. He did not regard a Medical Superintendent as desirable. The Hospital should be worked by junior residents under the honorary staff. He objected to annual appointments of the staff, and did not think the Board should have power to alter rules in this respect without reference to some higher authority, such as the Inspector-General. When he was on the staff they had a very varied collection of members on the Board—undertakers, and all sorts.

The Chairman: Undertakers!

Witness thought that men who might be looking after little trade pickings out of the Hospital should not be on the Board.

Dr. Roberton: Are you serious in what you say?—I am afraid I am.

Mr. Reed (laughing): Do you suggest that in regard to undertakers?

Witness complained of the position of the Costley Wards. He said that when the plans were prepared they were submitted to the honorary staff. The members of the staff, after spending a great deal of time in considering them, advised that the wards should be erected at the eastern end of the main building. They understood that the Board's architect agreed with them, but, to their surprise, the Board placed the wards in the present position. Witness after that left the staff in disgust.

The Commission then adjourned.

On Saturday, the 29th October, the Commission proceeded to the residence of Dr. Williams, at Mount Albert.

Dr. Williams, examined by Mr. McVeagh, said he was three years on the honorary staff of the Auckland Hospital, and was formerly in charge of Thames Hospital. He was on the staff of the Auckland Hospital in 1902, when the suppuration occurred.

What is the general medical opinion with regard to those cases of suppuration?—Some one generally has to shoulder the blame.

Does it infer any want of care or skill?—Well, it practically means that there is a weak link in the chain.

Do you experience the same thing with your cases outside?—Not to the same extent. I have had suppuration outside. I cannot claim to be perfect. It will occur from time to time.

Do you approve of the Senior Medical Officer being engaged in making anthrax-cultures in the institution?—I objected to Dr. Baldwin making plague-cultures in the basement of the main Hospital, and the honorary staff at that time recommended the Board to have a pathological and bacteriological laboratory outside the building altogether.

Dr. Williams, further examined, said he saw no objection to a surgeon doing *post-mortem* work, and being engaged in an abdominal operation four days afterwards. Any surgeon could get clean in four days. Personally, if he did a septic case he would not do a clean one for two or three days afterwards. With regard to consultations, he said these were frequently called for minor cases, and then members of the honorary staff had to hurry off to attend their own patients, and could not look at the more serious cases.

It has been suggested that the Costley Ward could be converted into a surgical ward. Do you think it suitable?—It would not do at all. It is structurally defective. It was designed for children, and the wards are not wide enough for surgical cases.

With regard to the admission of patients, Dr. Williams thought members of the resident staff should, when patients presented themselves, determine whether the cases were suitable for admission to the Hospital.

You have strong views regarding the training of nurses?—Yes; I think the portals through which women come to be nurses are too narrow. Applicants are at the whim of the Matron of the Hospital, who may turn them away on account of their religion, or on account of something in their manner, without giving any reason. My idea is that every large hospital should have a nursing-school, and that the honorary staff should have a longer tenure of office, and give lectures to the nurses.

Dr. Roberton: Do you think the Hospital Board as constituted is capable of deciding what is a suitable hospital building?—No. I go further. It requires some knowledge of the actual medical work of the Hospital, and it requires a man to be up to date as far as reading and experience goes. If an architect was acquainted with modern materials a surgeon or physician could tell him what was wanted, and he could fill in the details.

Would it be an advantage if hospital plans were submitted to a central authority before the buildings were proceeded with?—In theory it is all right, but in practice it does not work out. An hospital was built at the Thames; the Government passed the plans without comment, and after the hospital was built they said it was defective. I was not in Auckland when the operating theatre in the Hospital was built, but it is a triumph of bad management. They could not have conceived anything worse. There was no ventilation—not a window in it that would open; and I don't suppose the atmosphere was changed from one year to another.

Mr. Beetham: Do you think such a mess would have occurred if there had been any central authority? Is not that an instance in which a central authority would be useful?—Yes; to submit plans to an expert.

You are to have a first-rate operating-room in the Costley Ward, and the wards in that building are absolutely useless, you say, for surgical cases. What do you suggest should be done to remedy that, and to avoid carrying patients up and down those brutal steps in all sorts of weather from the big building to the operating-room?—It will have to go on until the time is ripe for building more surgical wards, where the wooden buildings used for typhoid-fever patients are.

Then, they should be connected by a corridor with the operating-theatre?—Yes.

Could you use the present operating-theatre if proper surgical wards were built there?—Undoubtedly.

Would you recommend building a new operating-theatre in connection with the main building?—I should not think it is required.

You would not put surgical cases in the big building?—No; I would keep it entirely for medical cases.

And if they wanted to be transferred to the surgical wards it could be done?—Yes. I think the only way to do any good with the big building would be to pull it down.

You cannot utilise the new operating-theatre for surgical work until proper surgical wards are built in that building?—No; not with comfort to the patients.

Dr. Collins: I have been informed that I was more or less responsible for the building of the Costley operating-theatre. Do you agree with that?—No; you have documents to prove that the honorary staff wanted the place altered, and brought up to date.

The plans of the new Costley theatre were, I think, left in your hands and mine?—Yes; we drew them up.

Did you ever know a case in which you could find fault with my work?—Never in my time.

You cannot say I have ever usurped any work from the honorary staff?—No: I can safely say that. I can say that whatever Dr. Collins was doing he asked the honorary staff would they do it, or would he do it. In cases of my own I have even allowed Dr. Collins to operate, and have assisted him.

Judge Ward: Was it in your power to allow that according to the rules, which say major operations shall be performed by the honorary staff?—That is the interpretation; but if a man does the operation and you are there you are responsible that he does the work to your satisfaction.

On resuming proceedings on Monday, the 31st October, Dr. Roberton called further evidence in support of the allegations brought forward by the Medical Association.

Dr. Mackellar, after detailing his experience in hospital work in Glasgow, Europe, and New Zealand, said he had been a member of the honorary staff of the Auckland Hospital between the years 1885 and 1895, and was at present consulting surgeon at the Hospital.

Dr. Roberton: Do you consider the Board suitable for hospital-management?—I think the members individually have shown interest in their work, and, considering the method of election, they have done their duty very well. However, they have suffered from the method of election in vogue.

Has the management been good?—Members of the Board have shown want of experience and continuity of plan. There has not been a regular thought-out system of management, but, to put it in other words, it has been essentially experimental.

The witness (proceeding) said the elections being annual the members hardly got accustomed to their duties when they had to quit their posts. It was desirable that the medical profession should be represented on the Board in order that the Board could have the advantage, as far as may be, of the advice of an unbiassed medical man. Since witness had been associated with the Hospital half a dozen or so different systems had been tried, and the most satisfactory, in his mind, was the system of residents, with a visiting staff. In joining the honorary staff he expected to treat patients who were unable to pay for outside attendance, and those who were in a position to pay should be excluded as patients from the institution. The establishment of an out-patient department was an unnecessary expense to the Hospital, when it was considered there was a public dispensary in the town for such cases, and the honorary staff had advocated the abolition of the former. The annual election of members of the honorary staff was an undignified arrangement, and with the tenure of office so short it tended to make the staff less frank and candid in their criticism of the management.

Referring to emergency work, Dr. Mackellar said the practice when he was at the Hospital was for the visiting surgeon for the week to be notified at once, and in the event of his inability to attend the next doctor on the list would be called in. It would very seldom occur that the resident staff would have to perform a major emergency operation. He objected to Rule 73, giving the Senior Medical Officer sole treatment and responsibility in cases of fracture and dislocation, and cases requiring operative interference, unless the honorary surgeon specifically intimated his desire to look after the case himself. A Senior Medical Officer should be a well-qualified surgeon and physician, with an aptitude for organization. The Hospital regulations were so badly arranged that even an ideal body of men doing their very best would not obtain satisfactory results; the nature of the regulations amounted to an entanglement.

Dr. Roberton proceeded to question the witness as to the training of nurses and other details, which provoked the Chairman to remark, "Let us get out of the nursery if we can."

Further questioned, Dr. Mackellar said he could only remember one occasion on which his advice had been asked by the Board, as provided by the rules, and his advice was at once followed. Replying to Mr. McVeagh, witness said the advice sought was on the contention between Drs. Collins and Neil.

Cross-examined by Mr. Reed, the witness said the positions on the honorary staff were eagerly sought after. The medical and surgical staff of the Hospital should be subservient to the honorary staff so far as professional duties were concerned only.

Regarding the advice given the Board relating to the contention between Drs. Collins and Neil, witness said he recommended that the Board was not the right tribunal to try the case first. A member of the honorary staff was doing wrong in going to the Chairman of the Board with a complaint against a colleague, and the Chairman of the Board was equally wrong in lending an ear to the complaint. The proper thing was to refer the matter to the medical staff, with instructions to report to the Board; and if the report was considered satisfactory by the Board, to adopt it, but if not satisfactory in all points, to take it as a basis for procedure. His final advice to the Board was to have nothing to do with the matter, but to refer it back to the honorary staff.

Replying to Dr. Collins, the witness said he considered the nursing staff at the Hospital was sufficient for the average number of patients. The Senior Medical Officer should not have power to do major emergency operations. He considered that the public hospital was in competition with private hospitals, and this could be, in a measure, remedied by the charges at the former institution to patients able to pay being increased to the fees levied at the latter. Even then the patient at the public institution would have the direct advantage of free medical attendance. There was, in his opinion, no reason for animosity between the paid staff of the Hospital and the medical profession while the competition existed.

Dr. Purchas was called to complete his evidence, which was commenced on Friday afternoon. Questioned on the White operation by Mr. McVeagh, the witness said a doctor would not be justified in making two incisions in the intestines to remove two pieces of scybala of the size of walnuts. The gas could be removed by the first incision by the natural force, and the scybala could be easily removed from the first incision by manipulation.

Will you state, as a surgeon, what is the effect on a patient in making intestinal incisions?—It tends to produce shock.

Then, the dealing with any portion of the abdominal cavity would have the same effect?—It would be contributory.

Is it your opinion that the making of two intestinal incisions would have a greater tendency to create paresis than the relieving of the scybala in the ascending colon?—The removing of the scybala would

tend to set up paresis. The division of the intestines tends to disturb their normal functions. On the assumption that the condition of the stomach was normal at the *post-mortem*, it was not an indication that the intestines were friable, nor that there were three or even two ulcers.

Quoting from Sir Frederick Treves on gastric-ulcer operations, Mr. McVeagh asked: Do you agree with this authority, "The less the delay the greater the chance of recovery"?—Yes.

Also that when the operation is undertaken within twelve hours of the perforation three out of four cases recover; from twelve to twenty-four hours after, one out of three live; and from twenty-four to thirty-six hours there is 100 per cent. of deaths?—That is so.

What, then, would be the chance of recovery of a patient operated upon eighteen hours after perforation?—I must have a little more information before answering that question, as cases differ. Was the stomach full or empty? Was there food in the peritoneal cavity when opened?

Mr. McVeagh: We have it in evidence that there was an escape of gas.

Dr. Purchas: If a patient is operated upon eighteen hours after perforation he only has a second best chance of recovery. He has the best chance when operated upon within the first twelve hours, and after that time up to eighteen hours gives only a second best chance, other things being equal.

Mr. McVeagh: The operation on this patient, White, lasted from 8 till 10 o'clock, and he lived till half-past 7 the following evening. What inference do you derive from that?—He must have had a good deal of tenacity of life to live that time.

Mr. Reed: In giving these statistics as to chances of recovery you are dealing with gastric ulcer?—Yes.

Do you know that there is a greater mortality in cases of duodenal ulcer than in gastric-ulcer cases?—Yes. I know that.

You agree with Sir Frederick Treves that few such cases are operated upon successfully?—Quite so.

Mr. Reed: This was a case of duodenal ulcer. The statistics you give, then, do not refer to duodenal-ulcer cases?—In forming a basis for statistics one would have to allow for the difference of mortality between the two.

Mr. Reed proceeded to question the witness as to the *personnel* of the Hospital Board. Witness said he knew some of the members only, but denied that a statement he previously made was a suggestion that the members went on the Board for the purpose of getting trade pickings.

Mr. Reed: You referred to an undertaker. Do you suggest that he would gain any advantage by being a member of the Board?—I never mentioned any name, and we can leave the undertaker alone.

Do you know that the *personnel* of the Hospital Board is not surpassed by any local body in the district?—Well, I say, God help the local bodies.

Mr. Reed picked out the name of Mr. Bagnall, and read off the numerous positions he held, insisting on an opinion from Dr. Purchas as to the competency of such a man occupying a seat on the Hospital Board.

The witness said he was not prepared to discuss the individual members of the Board.

Mr. Reed was pressing for an answer, in justice to the members of the Board, whom he said he was present to defend, when the Chairman interceded, remarking, "I don't see where the justice comes in."

Mr. Reed said it had been complained that the members of the Board were not fit for the position, and he wanted to show that they were.

The Chairman: If the member was president of all the bodies in the colony, it did not matter. That will not help you.

Mr. Reed contended that if the member could fill these other positions he was competent to hold a seat on the Hospital Board. The members' qualifications should, as a matter of justice, be read.

The Chairman: I'm quite willing to accept the status of the Board, but we don't want to go into the fact as to whether Thomas Jones was baptized, christened, and confirmed.

Mr. Reed protested he was not doing that, but was showing that the qualifications of the members entitled them to hold a position on the Hospital Board. It was, he said, complained that the prevailing franchise did not make eligible the best men in the community.

The Chairman: We are not considering the franchise nor the qualifications of the members of the Board, which would be of value if there was a distinct and certain charge made against the individuals.

Mr. Reed (to witness): Do you suggest that members of the Board are capable of taking advantage of their position to make a profit out of the Hospital?—No.

Do you think better persons would be obtained on the Board if the franchise was altered?—I do. I would prefer the Board to be composed of men like Mr. Bagnall, who has been successful in business.

Dr. Pabst said he had been a resident at the Hospital for three years and a half, and had, since 1894, been associated with the management of the institution as visiting surgeon. The witness gave evidence to the effect that the advice of the honorary staff had not always been taken, and the frequent change of the system of management indicated a want of appreciation of hospital work. His experience of the sick poor was that they were adverse to entering the Hospital, because they said they were unable to pay. While witness was resident at the Hospital patients worried about leaving the institution, as they recognised that their bill of expenses was mounting up. Those able to pay should be excluded,

The Chairman: The Board should not pay the slightest regard to the ability of a person to pay according to his means. If the Hospital authorities did we should hear nothing of the competition with the private hospitals.

Dr. Pabst said he was a ratepayer, but did not favour every ratepayer receiving treatment at the Hospital at the same charge. The ratepayer able to pay for outside attendance should be charged the same rates as levied at private hospitals, and in that way the patients would in a measure pay according to their means. He estimated that 20 per cent. of the patients were in a position to pay. He knew of a blind man, who was poor, unable to gain admission to the Hospital last week, and his recovery depended on proper treatment. If there were patients in the Hospital able to pay, then they kept him out.

The witness, continuing, said the position of the Senior Officer was not satisfactory. The honorary staff should have the treatment of cases. The emergency work resolved itself into two classes—namely, an emergency case requiring no special skill and admitting of no alternative in treatment, which the Senior Officer should undertake, and cases which admitted of no delay in treatment, requiring the highest medical skill and experience, which the honorary staff should undertake. The Senior Officer should not perform major emergency cases. The honorary staff could easily be summoned, and quite as easily as the Senior Officer, who was not actually a resident, as he did not live on the premises.

Dr. Bull said he was acquainted with the management of London hospitals, and had also been associated with the Auckland institution. As a member of the honorary staff, he expected to give his services to the sick poor, as he considered the Hospital was primarily for that purpose. His relations with the Senior Medical Officer had been, on the whole, very good. In attending the meetings of the honorary staff, witness thought the Senior Medical Officer represented the Board as well as his own interests. Instead of being always present at the staff meetings, and thus restraining free discussion of subjects, Dr. Bull considered the Senior Officer should only attend when requested to by the honorary staff. The accommodation at the Hospital for female patients was not adequate for proper classification. There were frequently delirium-tremens, typhoid-fever, and consumptive cases in with other medical cases, being scattered throughout the medical wards. It was a grave risk to have the cases mixed together. He protested against the practice of a staff meeting, but nothing definite resulted.

The junior physician was supposed to accompany witness round the wards and look after the cases in his absence. The junior was rarely able to do this, as he was practically the "fag" of the surgical staff. The same junior had to look after all infectious diseases, conducted most of the *post-mortems*, administered anæsthetics, and, in fact, his medical duties were subordinated to other work he was called upon to carry out on the surgical side. The duties of the junior physician should primarily be on the medical side, and any extra work ought to be subordinated to his legitimate duties. The practice that had prevailed had affected the efficiency of the medical department of the Hospital work, and the patients suffered accordingly.

Referring to the Hospital Board, witness thought it could be improved upon. The annual election was not a good arrangement: the tenure of office should be longer. Medical representation on the Board would be in conformity with the system in London, and would enable the Board to obtain impartial advice, which was now obtained from the Medical Superintendent. The medical profession should amongst them nominate their representative on the Board.

Witness said he resigned in August of the present year. He had spoken to the Chairman of the Board, when the latter said he did not approve of the honorary staff tendering their advice to the Board, and the best method of running a hospital was by means of a good Superintendent alone. He said, further, that if he remained at the head of the Hospital he would ask the honorary staff to resign, and would be prepared to pay a Medical Superintendent £1,000 a year if necessary, or secure outside help. If alterations took place in the constitution of the resident staff, witness would be prepared to apply again for the position of honorary physician. He did not think one honorary physician was enough.

Mr. Reed: What duties do you think the resident physician should be relieved of?—He should be relieved of infectious diseases and *post-mortem* examinations, and the number of anæsthetics administered by him should be limited to certain hours. Either another resident should be appointed to look after infectious diseases or an outside practitioner should be appointed to take charge of them. In London hospitals of practically equal size there are usually at least five junior officers.

Do you consider the wards in the big building suitable for medical cases?—They want structural alterations to make them suitable. They could be made suitable for certain classes of medical cases. A lift ought to be provided: more bath accommodation would be necessary. It was an absolute necessity that semi-lunatics and similar cases should be kept out of the general wards. Room might be found for them in the eastern building. The treatment of such cases was a difficulty all over the world.

Judge Ward: Are they treated in hospitals at Home?—They are frequently brought in, but they are not kept. In Auckland at present there was no other place for them, and they had to be allowed to stay in the Hospital.

I never heard of semi-lunatics in any other hospital in the colony?—They are not kept for a length of time; but the matter is a very difficult one, especially when the relatives say they cannot control them.

Judge Ward: If that is so, the sooner they go to the asylum the better.

Dr. Bull: They have made attacks on other patients.

Mr. McCarthy: Do many well-to-do patients pass through the Hospital?—A good proportion who are able to pay go through the Hospital.

Judge Ward: If they knew that, according to the statute, they have to pay compensation according to their means, they would probably go to a private hospital.

By Dr. Roberton: If the resident physician did all the medical work, and did nothing else, he would have quite enough to do.

Mr. Beetham: If there were two resident junior physicians and two surgeons, there would be no difficulty, would there?—I do not think so.

And that could be done for the same expenditure as the two juniors and one resident officer at present?—Yes.

You could quite easily get four men for the same money as you now get three?—Yes, especially if the Hospital Board would take the New Zealand qualification, and I see no reason why they should not.

This closed the case for the Medical Association, and Mr. Reed intimated that he would open the Hospital Board's case the next day.

A new charge was lodged by Charles Theodore Emil Guiseler, of Auckland, against the Hospital Board, on the ground that they refused to admit him to the Hospital about the month of June, 1903, when he was suffering from an internal complaint. He said he was informed that there was no doctor at the institution, and in consequence he had to obtain outside medical attention. The Chairman intimated that the Commission would hear the complaint next day.

During the day's proceedings Mrs. Wootten, lady superintendent of the Hospital, asked permission to explain her position in regard to the selection of the probationer nurses, as referred to by Dr. Williams in his evidence on Saturday. Mrs. Wootten protested that she never allowed her whim or religious convictions, as suggested, to actuate her in the selection of nurses. In the instance specified by Dr. Williams the applicant was of the same denomination, and Mrs. Wootten said she was supported in her refusal to accept the applicant by four charge nurses.

The Chairman remarked that the Commission did not dispute the correctness of her action, while they also thought Dr. Williams did not wish to make any imputation against Mrs. Wootten.

[In the report of Dr. Williams's evidence on Saturday the answer to a question by Dr. Collins was misplaced. The witness was asked whether he had ever known a case in which he could find fault with Dr. Collins's work, to which he replied that he did not consider the question a fair one, but he could say that Dr. Collins always looked up to the honorary staff, and he could safely say that Dr. Collins never usurped any work of the honorary staff.]

On the Commission resuming on Tuesday, the 1st November, the evidence of *Charles Guiseler* was taken in respect to the charge lodged on the previous day to the effect that when he applied for admission at the Hospital he was not admitted on account of there not being a doctor there.

Guiseler stated that he was advised by Dr. Bakewell, whom he consulted for stricture, to go to the Hospital, and on applying at the Hospital for admission he was told there was no doctor there, and he went away.

The Chairman: Who told you that?—A young chap who was sitting in the hall.

Mr. Reed: How did you come to give evidence here?—Dr. Neil asked me to come.

In answer to Dr. Collins, witness said he went to the Hospital about 4 o'clock in the afternoon.

What was the man like that you saw?—I do not remember.

Mr. Reed: Have you any relatives in the Hospital?—No.

At a later stage of the inquiry Mr. Reed again referred to the matter, and said that Guiseler's wife and child were now in the Hospital.

Dr. Neil: They are separated.

Mr. Reed: That does not matter; she is still his wife, and therefore his relative.

The Chairman: The fact that his wife is now in the Hospital does not prove that he was not ill.

Mr. Reed, before opening the case for the defence, informed the Commission that he had a list of seventy-five witnesses, but that he did not wish to call these unless it was necessary. He would like the Commissioners to indicate, if possible, the charges in respect to which they considered it would be necessary to call evidence.

The Chairman said that perhaps Mr. Reed had better proceed with his evidence, and then, if at any stage no further evidence were required in regard to any specific charge, it might be indicated.

Mr. Reed also drew attention to a section of the Commissioners Act, which, he said, did not appear to give the Commissioners the wide powers conferred upon it by the Commission.

The Chairman said that the Commission would have to hear considerable argument before they would recognise that the powers referred to were not conferred upon them by the Act. The Commissioners would exercise all the powers conferred by the Commission.

Mr. Reed said he would not address the Commission at present, but later on he might have to direct the Commissioners' attention to different portions of the evidence.

The Chairman: We shall be guided by the evidence, and not by the comments. We have all had a certain amount of experience, you know.

Samuel Charles Schofield, manager and house steward of the Hospital, said he had occupied the position for nineteen years and eight months. He was usually at the Hospital at 7 o'clock in the mornings. After opening the office he visited the lower parts of the building, and returned from breakfast at a quarter to 8. He then went to the kitchen and inspected the food, which was supposed to be delivered in the wards at a quarter to 8. He regularly looked at the food, inspected the lavatories, bathrooms, and offices of the several wards, and inquired if there were any complaints. The isolation ward and No. 7 Ward were seldom visited, because by the time the others were visited breakfast was over. When any complaint was lodged he made it his business to go to the kitchen to put it right and to prevent a recurrence. The cook received the meat, and witness inspected it a few minutes after arrival. In the summer fish was taken to the Hospital before 7 o'clock in the morning, while sometimes it was secured overnight in order to have it prepared up to time in the morning. In that case the fish was placed in the ice-chest. Only on one occasion had a complaint been made in regard to the fish. That time witness investigated the complaint, and found that the fish was bad only in the one ward, and the occurrence was put down to a mistake by the cook in placing in the pot a piece of fish left over from the previous day. The matter was reported to the doctor, and subsequently satisfactorily explained. Witness said he saw the vegetables every day when sent from the Costley Home. The vegetables were as good as the Home could send along. Sometimes complaints had been made about the eggs, but this occurred at a time when eggs were scarce. The contractor had been interviewed, and explained that, owing to eggs being scarce, he had to purchase from other than his usual customers. The shortage was always made up. Complaints had not been frequent. Porridge had also been complained of as being lumpy, but only on rare occasions, and witness had always had it remedied. A coarse kind of meal was being used at one time, but when patients objected to it a finer meal was promptly substituted.

In regard to the sugar-allowance, the witness explained that in Dr. Baldwin's time complaint was made as to the insufficient supply, and the allowance to patients was increased from 1 oz. to 1½ oz. per diem. Patients who had sop and other soft food required more sugar than others, and requisition had only to be made to the charge nurse to secure the additional quantity. This rule had all along been in force.

Mr. Reed: You have made up a packet of 1½ oz., so that an accurate idea of the quantity can be obtained?—Yes.

The witness produced the packet, which was handed to the Chairman, who, after looking at it curiously for a minute, remarked, "I don't wonder that the patients went out to buy their own."

Mr. Reed: Personally, I don't use a quarter of that amount myself, but I don't know what other people take.

Continuing, witness said the sugar was issued in bulk to the separate wards according to the number of patients. The same quality of food as given to the patients was given to the doctors and nurses. For the Nurses' Home smaller joints were secured, but the quality was the same.

Witness was questioned by Mr. Reed as to interrogating patients relative to their ability to pay the fees levied. He replied that when patients were admitted they were brought into his office if they were fit to see him, and they were then asked about their trade and means to pay for treatment in the Hospital. When not fit to be seen on admission the patients were interviewed in the convalescent ward, or when they were obtaining their certificate of discharge from the Hospital.

Mr. Reed: You invariably ask the patients as to what their means are?—Yes, if they are in a fit condition.

The Chairman: You ask the patients on admission?—If they are able to come to my office.

The Chairman: Worrying a man who is almost dying with a whole series of questions like that is a rather curious proceeding.

The witness: It is not the rule.

The Chairman: It isn't the rule! I asked you if you made these inquiries of the patients when they first came in.

Witness: Some patients are not fit to see me. I exercise my discretion. I have never worried a man who was in pain or suffering. I judge when to ask him.

Mr. Reed: What do you do when you have made these inquiries? —When I find the patient is not able to pay the fees I advise him to apply to the committee.

The Chairman: You say when the patient can't pay the fees! What fees?—The Hospital fees, 4s. 8d. per diem, charged to patients.

The Chairman: On what authority?—I act on the authority of the Board.

The Chairman: The Board has no authority in the matter. The Board has power to charge fees according to the means of the patient, and not to levy a fixed fee.

Mr. Reed: It is a matter of book-keeping.

The Chairman: Not at all, and you would find that out if you went to Court about it.

Proceeding with his evidence, the witness said after three notices were sent out to defaulting patients the arrears were put in the hands of a collector, who made inquiries, and his advice was invariably followed by the Fees Committee.

Mr. Reed: In some cases you have sued for recovery of the money?—Yes.

Have you sued without the committee being satisfied that the patient was able to pay the fees?—No.

The Chairman: And you say that in all cases you plied the patient on admission with the question as to his ability to pay the fees?—No, sir.

Let us understand this. Are these inquiries made before the patient is attended to, either surgically or medically?—When the person is brought to my office he is brought as a patient, but I don't know anything about the treatment.

I can't make it out. We wish to know what is the routine. You say if the patient can walk he is brought to your office?—The patient generally brings an order from a doctor, and is taken by the hall porter to one of the resident doctors. After that the patient is brought to my office, when I ask him as to his means, his trade, or anything else.

Supposing a patient comes and has not got an order from a doctor, and is seen by you, what happens?—The porter generally brings the man in and says, "A man to see a doctor; he has no order." I ask the man how long he has been bad. A patient who is not very ill and has no order is advised to go and get an order from an outside doctor, or if he is unable to pay he is advised to go and see the Charitable Aid Board to get an order to receive attention from the public dispensary.

The Chairman: It is a most monstrous regulation for a man who goes to the Hospital dying to be packed off to see an outside doctor.

Witness: It does not apply to persons seriously ill; only those who can walk and are not in pain.

And you then send them off instead of the resident staff seeing them?—I send them off according to instructions.

The Chairman: If that is the instructions of the Hospital, no more monstrous thing have I ever heard of.

Mr. Reed pointed out that the instructions were the result of recommendations made by a conference of local distributing authorities.

The Chairman: I don't care sixpence about that.

Mr. Reed: The local bodies have to contribute the money, and insisted on this instruction.

The Chairman: The local bodies are not above the law.

Further, the witness said he had only been carrying out his instructions in sending a patient to get an order from an outside doctor when the patient did not appear to be seriously ill.

The Chairman: Are you a doctor, Mr. Schofield?—No. I am telling you I am carrying out my duties.

You use your judgment on medical or surgical points, and if the patient does not seem to require urgent treatment you send him off about an order or fees. Do the patients have to pay a fee for examination for an order?

Mr. Reed stated that there was a public dispensary, and a patient had only to go to the Charitable Aid Board to get an order to go to that institution, where he would be examined free.

Witness: The patient was told that in the Hospital when he said he could not pay.

Mr. Beetham: The weak point is that the man is not seen by one of the resident staff.

Mr. Reed: There is a difficulty about admission.

The Chairman: We are not blaming Mr. Schofield; he is simply carrying out the instructions given him.

Mr. Reed: Have you known of cases of hardship of men being sent away to get a doctor's certificate?—I don't quite understand.

Have you known of any case of a man suffering through having to go and get a certificate.

Mr. Beetham: We have the case of Guiseler this morning. Unless this man is lying, it is a clear case. He was suffering from stricture, and went to the Hospital, but was sent away in pain.

Mr. Reed: Have you known any one suffering through being required to get a doctor's certificate?—A case has never been brought under my notice.

Do you ascertain from all cases as to whether he is well before telling him to go and see a doctor?—I do the best I can. I don't send a man away if he is unable to walk. If in my judgment the man was in pain and was suffering, I would arrange for him to see a member of the resident staff.

Cross-examined by Mr. McVeagh, the witness said he had Saturday afternoon off, and one Monday morning a month, but was generally at the Hospital on Sundays, consequently there were many admissions of which he was not aware.

With regard to the instructions from the Board, when did you first receive them?—A short time after the local bodies' conference; not directly from the Board, but through the Senior Medical Officer.

Some time prior to the issuing of these instructions, witness said, his office was not in the main building, so he did not know the procedure of admitting patients. He could not say if patients were admitted without a certificate.

Do you remember a man named Wilson, who was in the Hospital, and who got out of bed and went down town for money to pay his fees before he was operated upon for appendicitis?—I do not remember him, but I would have his chart.

What are done with the bed-charts?—They are kept.

Mr. McVeagh: Have you got the chart of Swinbourne?—No; it was destroyed.

Who destroyed it?—Dr. Ferguson, the resident physician. He asked me for it, and I gave it to him.

When was this?—Within the last fortnight.

Since this inquiry commenced?—Yes.

Have any other charts been destroyed since the inquiry commenced?—Not that I know of.

The Chairman: Did Dr. Ferguson give any reason for its destruction?—Yes; he said it was a wrong diagnosis.

The Chairman: And therefore he destroyed the record! We shall require Dr. Ferguson to be here.

Mr. Reed: He will be called in any case, Your Honour.

Mr. McVeagh: Did you prepare another chart relative to the same man?—No; Dr. Ferguson prepared it.

What diagnosis was marked upon it?—Delirium tremens.

Do you remember what diagnosis was on the original chart?—Yes, chlorodyne poisoning by accident.

In answer to questions regarding the nurses' food, witness said he ordered it for them. He got the lists from the Matron and sent them to the contractor. Patients had fruit taken to them in the Hospital, but he did not know of other food being taken there to patients by their friends. When eggs were scarce they were supplied with some pickled eggs, but these were not sent to the patients; they were used in the cooking. Witness had a great deal of work to do, and sometimes did not finish until 10 o'clock at night. He never spoke to the patients when visiting the wards, as he was not required to do so.

In reply to Dr. Roberton, witness said the fees charged were 4s. 8d. per day, which was based on the cost of maintenance, the actual cost being 4s. 7¾d. The charge was formerly 4s. a day, and the fees had been raised in acordance with the recommendation of the Local Bodies' Commission last year.

Sydney Nash, assistant cook at the Hospital, said he mixed the eggs for the puddings.

The Chairman: We have had no complaint about the puddings.

Mr. Reed: No, but we have had complaints about the eggs supplied to patients, and I want to show that the same class of eggs is used for the puddings.

Witness said that in winter there were about four bad eggs out of the six dozen used daily. Since he had been there he had known two occasions on which the eggs were reported to be bad. The fish was frozen about three times a week in the winter, and in summer it was fresh.

Francis King, hall porter at the Hospital, said that when a patient presented himself for admission he took the order (if he had one) to one of the doctors. If he had no order he took him to the house steward. If the latter were not there, he found a resident as soon as possible. In some cases, when patients came without orders, and they had means, he advised them to get an order from an outside doctor, and if without means he advised them to go to the charitable aid relieving officer and get an order for treatment at the dispensary. He was not on duty when the patient Freestone presented himself for admission.

What hours did Dr. Collins usually attend in the mornings?—Recently he has been a little later, but during the first two years he generally arrived at about 9 or a quarter past. When late he always rang up to say that he would be a little late. Dr. Collins often had other duties to perform in the mornings, such as meeting the Chairman of the Board.

Mr. Reed: Do you remember Swinbourne coming to the Hospital?—Yes; he came with a letter from a doctor, stating that he was suffering from delirium tremens.

Mr. Reed said the doctor's letter would show that an error had been made in the diagnosis in preparing the original bed-chart.

The Chairman: That would not justify Dr. Ferguson in destroying a record of the Hospital after the inquiry commenced.

On the admittance-book being produced, witness found the following entry in it, made by himself, in reference to Swinbourne: "Mental or d.t.'s." The doctor's letter, he said, specified "delirium tremens."

Mr. Beetham: Why did you put in the word "mental"?—Because I had some doubt about it.

Did you differ from the medical man's diagnosis?—I beg pardon, I never diagnose anything. That was only my own private note.

The Chairman: It is part of the Hospital records, is it not?—Yes, it belongs to the Hospital.

On the doctor's letter being asked for, it was not available, whereupon the Chairman remarked, "What with the disappearance of the doctor's letter, the diagnosis of the porter, and the destruction of the bed-chart, things seem to be rather confused."

Witness, replying to other questions, said he remembered Edmund Burke going to the Hospital without a doctor's certificate, but he was not very bad. Witness advised him to get a doctor's certificate. He had never turned away any man who was in pain. In cases of urgency and emergency he was usually instructed to ring up the honorary staff.

Mr. McVeagh: Do you have any instructions from the Hospital Board or the Senior Medical Officer as to the present regulation affecting the admission of patients?—No; I saw the Board's resolution in the newspapers, and I acted upon it. When a man was very ill he got a doctor to attend to him at once.

The Chairman: And you were the judge of whether it was a bad case?—Well, if a man was lying in an ambulance, and could not move, I could tell that it was a bad case.

The Chairman: If he could not move he could not get to the Hospital?—He was taken there.

Mr. McVeagh: Supposing a man were suffering from appendicitis, would you call a doctor to see him?—If a man were suffering from severe abdominal pains I would get a doctor for him.

In answer to Dr. Roberton, witness said that he had always rung up the honorary staff when instructed in cases of emergency. He could not say whether he was instructed in all cases. He had no knowledge of patients complaining of being sent away for outside doctor's orders. He had no recollection of a man named Wrigby applying for admission in February last.

Mr. Reed: Did you in any form receive instructions from Mr. Schofield to carry out the Board's resolution?—Yes, casually.

In the course of further remarks, Mr. Reed said that if the officials strictly carried out the Board's rule it would have meant refusing admission to a dying man. Of course, they would not do that.

The Chairman: If they had, the Board might have been liable to a charge of manslaughter.

Mr. Reed: Rightly or wrongly, the rule exists.

The Chairman: But it was not consonant with humanity for the porter and steward to be left to be the judges, when there were three doctors at the Hospital.

Joseph Williams, fishmonger, said he had the contract for supplying fish to the Hospital. He could not explain the complaints as to fish supplied to the Hospital being bad. It was always delivered in good condition, and signed for as such. The fish was cleaned before delivery. He had only had one complaint about the fish. That was when he sent frozen fish, and Mr. Schofield told him not to send it again. The fish, however, was not bad on that occasion. Either he or one of his employees saw the fish before it was sent to the Hospital.

George Rowland Hutchinson, contractor for supplying groceries to the Hospital, said that for about two months in the year there was a difficulty in obtaining fresh eggs. There had been occasional complaints, but he did not think they averaged more than four a year. Special eggs, for which more was paid by witness, were supplied to the Hospital. The yearly consumption of eggs at the Hospital was about 83,000 lb. per year. About eight eggs went to the pound.

Mr. Reed said he had also got the bread contractor (Mr. Teasdale) to attend, but the Commission said there was no need to examine him, as there had been only one complaint of the bread being bad, and it was generally admitted to be good.

Edward Wolstenholme, laboratory and *post-mortem* attendant at the Hospital, said that he did the *post-mortem* upon the body of Clarence Walters, under the supervision of Dr. Collins. Dr. Neil came in whilst the *post-mortem* was going on, but neither Dr. Walsh nor Dr. Ferguson were there. Under Dr. Collins's instruction witness took out the appendix and found an orange-pippin in it. Dr. Neil came in after that, and said to Dr. Collins, "What have you found?" Dr. Collins replied, "An orange-pippin in the appendix." Dr. Neil said, "Are you sure it is not fæces?" Dr. Neil picked up a scalpel and satisfied himself that it was an orange-pippin. Witness produced the appendix and pippin, which had been preserved in formalin. Dr. Neil made no remark about pus in the pelvis, and none was found there. Dr. Collins remarked that it was a pity that such a sturdy little fellow should be carried off like that. Dr. Neil said, "Well, you have done all that was possible."

Mr. Beetham: Did Dr. Neil look in the pelvic cavity?—Yes.

Charles Richard Devon, formerly assistant male nurse in No. 7 Ward, said that the hypodermics were kept in the press, which was in constant use nearly all day. He did not know of any patient administering hypodermics in that ward. He remembered Bob Halifax being there. There would have been nothing to prevent a patient getting at the hypodermics when the wardsman on duty was out of the ward.

In answer to Dr. Roberton, witness stated that poisonous medicines and liniments, as well as the hypodermics, were kept in the press, which was not kept locked on account of it being constantly in use.

Sister Syms said she recollected the case of William Peake, who was admitted to the Hospital in a serious condition. Witness was a charge nurse for a time, and said the patient was a bad one as a patient. When a patient was not willing to be satisfied the nurse said his whole condition suffered. He insisted on sitting up instead of lying on his back, and, although he had a broken jaw, continued to speak, remarking that "he could keep his jaw steady while he was talking."

Questioned as to the visits paid to the wards by Dr. Collins, the witness said his visits were regular, and no patient suffered from neglect. He was always available when she wanted him.

Mr. Reed: What time does he make his visits to the wards?—He has been in my ward at half-past 8 a.m., to my sorrow.

Witness said the Senior Officer had been at the Hospital till after midnight, and as early as 4 o'clock in the morning.

Referring to the food, witness said, with the exception of the fish, it was good on the whole. In April and May she had several times to complain of bad fish, and Mr. Schofield had, on her application, substituted chops for the patients.

Cross-examined by Mr. McVeagh, witness said Dr. Scott was visiting surgeon for the week when Peake was admitted, and the doctor's name was not taken down while she was in charge of the ward. She was not in the ward when it was not visited by honorary surgeons at all.

Mr. McVeagh: Did the Senior Medical Officer visit the wards daily at 9 o'clock, accompanied by the house physician?—Not regularly.

Is it a fact that he is not in the Hospital till considerably after 9 o'clock?—He might be in the Hospital. I would not dispute statements made that the Senior Officer was not at the Hospital till 10 o'clock and after.

Sister Maxwell said she had been ten years in the Auckland Hospital. Dr. Collins had regularly visited the wards she had been in,

and none of the patients of these wards suffered from the inattention of Dr. Collins or the staff. With regard to the food supplied to the patients, it was good, but one day the fish was bad, and she got jam in the place of the fish.

Did they ask for jam?—I don't remember.

In connection with the allowance of sugar, witness said there was never any difficulty in getting any extra quantity required.

Mr. McVeagh: Did not the food get cold carrying it from the Hospital to the Costley Wards?—That has not been my experience.

Did you not have complaints from the patients that the food was cold?—No.

You have a distance of from 200 to 300 yards to go. Wouldn't it get cold in going that far, say, in the winter?—Not necessarily. It is brought across in a closed tin, warm from the kitchen.

You say Dr. Collins's visits to the ward were regular?—He has been in my ward at 8 o'clock.

Did he have a fixed hour?—He has been in at 8 o'clock.

Has he always been there at 6 p.m.?—I am not always on duty at that hour.

The witness said the wave of suppuration in 1892 was the largest she had known. She did not know that the nurses were blamed for it.

Sister Wheeler said she had been a nurse at the Hospital for over five years, and was at present in charge of the operating-theatre. When an operation was about to take place the ordinary custom was for Dr. Collins to inform her to hold herself in readiness for an operation, and then the honorary surgeon was communicated with. At times she had had the theatre prepared for hours awaiting the attendance of the honoraries.

Mr. Reed: Can you say you know of any patient suffering through the neglect of Dr. Collins?—No, never.

Has he been attentive to patients as came within your view?—He has paid them every attention.

Did Dr. Collins visit the wards regularly?—When I was in ward-work a year ago he visited the wards twice a day.

Have you known Dr. Collins to be detained in the Hospital late at night?—Very often.

Do you know of him having been rung up for late at night?—Yes: I've know him to come to the Hospital at 12 o'clock for an operation, and I got up to assist.

Have you noticed any difference in the attention given by Dr. Collins to the patients?—The only difference was that in the cases under the charge of honoraries they gave their instructions, and in his own cases he would personally give the necessary instructions.

To Mr. McVeagh: Sometimes when she was waiting with the theatre prepared she had gone to Dr. Collins, and he had said he was waiting the arrival of the honorary.

Witness said she had visited the mortuary once, at the request of Dr. Collins, when an operation took place on a dead body. She did not know if Dr. Collins's object was to make her acquainted with the technique of the operation in view of a similar one being performed on Mrs. Tracey the following day. Witness did not think the operation on the dead body was performed the day before the operation on Mrs. Tracey.

Mr. McVeagh: What became of the patient?—I don't know anything about her after the operation.

Is it not a fact she suppurated?—I don't know.

And died a month afterwards?—I don't know.

Questioned by Dr. Roberton, the witness said she had waited with the operating-theatre prepared from 10 a.m. to 4 p.m. She did not know the honorary was absent from town. The instruments, being sterilised, became rusty through having to wait.

Dr. Roberton: Is that the only one occasion you've been in the mortuary at a *post-mortem*?—Only on one other occasion.

Do you know if any of the nurses have been there?—There were others when I was there.

Were you aware of the danger of going into *post-mortem* rooms while in charge of the operating-theatre?—I have been warned all through my training.

Were you there with Mrs. Wootten's consent?—I could not have gone there without. She gave permission to the Senior Medical Officer for me to go.

Did you offer any objection?—Not on a technical point. Only on account of one's natural repugnance to the work.

Do you think you could conscientiously go to a *post-mortem* room while in charge of an operating-theatre, knowing that you were liable to be called on to assist at an operation in a day or two?—I took every precaution. I did not touch anything. I did not wear the same clothes, and I had a lysol bath.

Replying to Dr. Collins, the witness stated that when the doctor gave two lessons on the use of the different-coloured silk in rotation on lint, the witness had a difficulty in following what was required, so the doctor carried out the operation on the dead body, in order to more clearly demonstrate the proper order of events.

James Bagley said he was chief cook at the Auckland Hospital, a position he had held for a little over ten years. His previous experience was chiefly in large hotels. His first duty in the morning was to allocate provisions for the different wards, such as bread, butter, eggs, and lemons. It was distributed at half-past 6 o'clock, according to the lists handed in by the nurses of the separate wards. He then personally prepared the meal for porridge. The milk was checked in quantity and quality, and also tested every day. The supply of fish arrived about the same time, and it was weighed, and the quality noticed.

Witness said he knew complaints had been made once or twice in regard to bad fish, but he had never noticed it when serving it out. The explanation was that flounder was usually the cause of the trouble. This fish was probably sent from the Thames district, and in sending it to Auckland the fish was packed on top of each other; a "sweat" was produced, which made it a little tainted. This could not be discovered, however, on arrival. Flounder generally was susceptible to a taint, mainly through congealed blood accumulating over the neck, and unless this was thoroughly cleansed with salt water the taint was developed in the cooking. The house steward, Mr. Schofield, regularly inspected the food. Beef-tea was made from the top side of the joint, which was the very best for that purpose. No complaint had been made personally to him in regard to the beef-tea, which witness was confident was of good quality. Complaint had never been made to witness as to his work, and he took every precaution to provide good and wholesome food suitable for the sick.

To Mr. McVeagh: I say that very probably most of the flounder would be caught in the Thames district, and delivered in Auckland. I cannot say how long after the fish was caught it was served out to the patients.

Questioned further, the witness stated that the Senior Medical Officer frequently visited the kitchen; at least six times a month.

Ernest William Bates, dispenser at the Hospital, stated that hypodermics were issued to the wards on requisition from the Senior Medical Officer, and also signed by the charge nurse.

The Chairman: There is no charge on this score.

Mr. Reed: It is complained there was negligence in allowing patients to get morphia and other drugs.

The Chairman: It is different to leaving persons in the ward in a position to get across to hypodermics and other drugs.

The witness said the dispensary was left open, but no one was allowed to remove anything without his knowledge. In witness's department there was no waste; in fact, a saving of £400 had been effected this year in comparison with last year. The dispensary faced the Hospital main entrance, and witness saw Dr. Collins nearly every morning arrive between 9 and a quarter past 9, except when he had been at an operation late at night.

Questioned by Dr. Roberton, the witness said there was a saving all round, but chiefly in oxygen, wool, tow, and patent foods. Outpatients were not being treated this year, and there would be a saving in that direction.

To Mr. McVeagh: I don't say I saw Dr. Collins arrive every morning, but when I saw him it was at the time mentioned.

James Quinn said he was a patient at the Hospital about a year ago, and he received every care and attention from the medical staff, and all the patients were treated similarly to him. The food was excellent, and no one could complain about the quality of it.

The Chairman: Are you going to call all ex-patients?

Mr. Reed: I don't propose to call them all, Your Honour, as there are an average of two thousand a year. But I intend to call some of the former patients to throw doubt on the statements of those who had complained of the treatment in the Hospital.

Miss Maggie Gibbons said she was a typhoid-fever patient of the Hospital, and while in the institution had received every attention, and was supplied with excellent food.

The Chairman: The question is not whether a large number of patients were well treated, but whether there were some who were not well treated.

Mr. Reed: I am quite aware of that, Your Honour. I am also aware of the position that if I can produce several former patients who, by their own experience and observation, can speak of the treatment and the food, it is material. Witnesses have complained of the food and the treatment, and I want to call witnesses, covering the same time, who can give contrary evidence.

The Chairman: It is not complained that the food is always bad. If you prove that sometimes the food was good it is not material, unless it refers to the same time as when it was stated to be bad.

Mr. Reed: Surely it is competent for me to give some evidence as to the general condition of the food.

The Chairman: You have it from members of the Hospital staff.

Mrs. Saunders, mother of the previous witness, said she frequently visited her daughter while a patient at the Hospital, and was quite satisfied with the treatment she received and the food supplied.

The Chairman: This witness was only a visitor.

Mr. Reed: That is so, but she can speak of her observation.

The Chairman: Would she have an opportunity of seeing all? Oh, dear, Mr. Reed, this is rubbish. She visited the Hospital once a week, and you expect her to testify to the treatment and food. It is too absurd.

Mr. Reed: My clients consider they have a more important duty to perform than actually laying evidence before this Commission. We have to satisfy the general public.

The Chairman: We are not here to satisfy the general public, and we decline to satisfy the public. We have to carry out the duties of the Commission as imposed upon us by the Government.

Mr. Reed: The Board looks to the public in the matter.

The Chairman: The food has been stated to be bad at times, and evidence should be restricted to that. If at other times the food was good it was an entirely different matter.

Mr. Reed: There may be bad food on occasions, and we cannot help that.

The Chairman: This witness was only a visitor, and knows nothing about the matter.

Mr. Reed said he had not finished with the witness. He wanted to question her about the payment of fees.

The Chairman: That is a different matter. You can ask her about that.

Mr. Reed: I can't ask her all the questions at once, Your Honour.

The Chairman: You commence with the other thing.

Mr. Reed reminded His Honour that he had suggested in the morning that the Commission should give an indication as to what were the charges that had to be answered.

The Chairman: If there was an opinion that bad food was given at certain times, that could not be contravened by calling witnesses to show it was good on other occasions.

Mr. Reed: The fish was bad at times, but that was an accident. Still, I ought to be able to show over an extended period of time that the food was good.

The Chairman: We do not infer from the evidence that the food was always bad.

Mr. Reed: If I left the case for the prosecution where it was it would have been reasonable for the Commission to conclude that the food was not properly attended to, and was bad. Now, I wish to call evidence to show that food was good over an extended period.

The Chairman: During the time the food was not complained of it was good. That is the conclusion we will come to.

The witness said she was not harassed in regard to payment of fees, and was asked to pay any reasonable amount she could afford.

To Dr. Roberton: It was a month before she saw her daughter. By that time she was enabled to go out on to the verandah, and after that witness visited her daughter in the typhoid wards.

How many times did you go in the wards?—My daughter was there two months, and I visited her once every week.

Went in the wards once a week?—Yes.

Did other people go and see their friends in the wards?—I could not say.

Dr. Craig, a surgeon on the honorary staff, who was the next witness, said he had considerable experience as surgeon to mail and troop ships, and also had had charge of the Ross, Mercury Bay, and Gisborne Hospitals. He was Superintendent of the last-named hospital for six years. He performed all operations at these three hospitals. He was present at the operation on Wallis White in the Auckland Hospital, and consulted on the case with Dr. Collins and afterwards with Dr. Parkes. Witness did not come to any definite diagnosis at the time. Dr. Collins's diagnosis of appendicitis was a reasonable one. As the operation was commencing he was called out of the room to attend to the telephone, and when he returned the first incision had been made. He saw Dr. Collins make an incision in the cæcum and remove two pieces of fæcal concretions rather larger than a walnut. The small intestines were distended and inflamed, and there were flakes of yellowish fluid in the abdominal cavity. On the stomach being explored, what appeared to be a gastric ulcer was found, with stomach-contents oozing out of it. There were also some interruptions in the continuity of the external walls of the stomach. At the time he thoroughly believed that there were three perforated gastric ulcers. Dr. Collins would not be able, owing to the want of time, to make a minute examination. There were extensive signs of general peritonitis. Under such circumstances a surgeon would not be justified in leaving fæcal concretions in the intestine; in fact, authorities did not consider that it was absolutely necessary that there should be a fæcal obstruction to make incisions in the intestines justifiable.

Mr. Reed: Can you refer to any cases similar to that of White?

Witness quoted from a number of authorities, one of which spoke of six cases nearly parallel with that of White. The treatment adopted was similar, one patient of the six recovering. The witness continued to quote medical opinions, and proceeded to read one in which reference was made to the supposed case of a patient with a weak heart.

The Chairman: But the patient in this case was not supposed to have a weak heart. He had quite enough the matter with him without that.

Dr. Craig: A patient's heart might be all right at starting, but it might get weak towards the end of an operation.

The Chairman: Probably it would if the operation lasted an hour and forty minutes.

Dr. Craig was continuing to quote from authorities, when the Chairman said the Commission did not want any more.

Mr. Reed said he thought that the opinions of surgical experts would be of value to the Commissioners in deciding between the contrary opinions of the surgical witnesses.

The Chairman said the Commission would be glad to hear Mr Reed's witnesses, but they did not require lengthy quotations.

Mr. Reed: Very well, Your Honour; it will simply be living witnesses against living witnesses.

Mr. Beethar[illegible]ad as to facts.

Witness (continuing) said he was present at the exhumation of White's body. The coffin was put on a sleigh, and taken up and down declivities in such a manner as to shake the body considerably. There was considerable saponification of the body. Evidences of inflammation would disappear quickly after death.

When did you first hear any criticism upon the correctness of the operation?—Not till the Board's inquiry in August—three months after.

Did Dr. Neil say nothing to you on the subject during those three months?—No.

Has Dr. Collins always referred your cases to you before dealing with them?—Yes; and in the case of White he specially sent for me, in order to have a consultation.

Mr. McVeagh: When did the consultation take place?—At about half-past 7. I examined the patient.

Did not Dr. Neil first suggest an incision in the middle line?—I do not remember. I cannot remember all the details of a case which happened so long ago.

The Chairman: You seem to recollect a great deal about this case, but you cannot remember this point very well.

Witness said he deferred to Dr. Collins's judgment in the matter. When the patient was on the operating-table witness had some conversation on the case.

Mr. McVeagh: Does that not show that it was intended to go on with the operation if Dr. Parkes had not been there?—I could not say; it might have been necessary to do so.

Did Dr. Parkes make an examination after his arrival?—Yes, I believe so; but I do not remember what his opinion was.

Was not Dr. Parkes's diagnosis indefinite, like yours?—I cannot say.

Would you consider, if the opinions of two doctors out of three were indefinite, that a medical incision for exploration purposes would have been the proper thing?—Yes, it would.

Where did you get your clinical history from?—From Dr. Collins, and also from the patient.

How was it that you could form no definite opinion?—I could not detect sufficient signs to lead me to a definite opinion.

Did you say anything at the Board's inquiry about the fæcal concretions?—I said that there were two pieces rather larger than a walnut.

On the report of the Board's inquiry being referred to by Mr. McCarthy it was shown that Dr. Craig had said that there were "large concretions in the intestines."

Dr. Craig: I may have said that, but I also used the term "rather larger than a walnut."

Mr. McVeagh: Did you not say at Dr. MacGregor's inquiry, firstly, that they were "round and as large as a walnut," and, secondly, that they were each "as large as a walnut"?—Yes; but what is the difference?

Would two pieces of concretions of the size you refer to create an obstruction?—In my opinion, they would.

What clinical history did Dr. Collins give you?—I forget.

Mr. McCarthy: What did the patient say?—I forget.

Mr. McVeagh: Apart from general peritonitis, the cæcum and colon were normal?—Yes.

Can you suggest why the two pieces of concretions should create an obstruction?—They would just about fill the cæcum, and for all I know there may have been more than two pieces.

Can you suggest why one incision in the intestines would not have been sufficient for both the release of gas and the removal of the fæces?—The fæces might not be noticeable till after the gas had been released, and it might then be found they could not be removed through that incision.

In answer to another question, the witness said that it was not the practice to remove fæcal concretions in cases in which there was no peritonitis or no excess of concretions, but when such conditions existed it was the duty of the surgeon to make an incision and remove the accumulations.

Mr. McVeagh: You spoke at the Board's inquiry of the condition of the anterior wall of the stomach. What did you say?—There were large pieces of diseased area, around what I imagined to be the perforated ulcers, and I believed them to be from 2 in. to 2½ in. in extent.

Did you say there were large pieces of eroded and softened tissue?—Very likely.

Did you hear Mr. Savage say the membrane and the anterior of the wall was healthy, except at the site of the ruptured ulcer?—I heard him say that.

Well, how about the erosion and softened tissue you refer to?—The *post-mortem* changes had taken place.

Would the *post-mortem* changes have the effect of removing the erosions and the softened tissue and making that less friable which was not friable?

Mr. Beetham: And closing up two ulcers?

Mr. McVeagh: Do you suggest that was so?—I suggest that the actual appearance of the stomach during life could not be reproduced three and a half months after death.

Make it so much worse?—It would not improve it.

If the stomach was friable at the time of operation it would be much more so at the time of exhumation?—Certainly; it ought to be.

Mr. McVeagh: Well, what about the three ruptured ulcers you spoke of?—I have told you all about them. They appeared to be perforated gastric ulcers, but with the stomach partly covered up and getting glimpses in between other people's shoulders I was unable to see the stomach properly. I did not have a very good view.

You were assisting at the operation?—Yes; but I can't remember clearly what I did. I held a retractor or something.

Then, you have no confidence in your former statement that there were three ruptured ulcers?—There were no complete perforations, but there was a loss of continuity of what I call the external surface.

Mr. Savage said the peritoneum was intact?—I must say I am doubtful. His report is not infallible.

I want to point out to you the position. You said there were three ruptured ulcers?—That was my impression at the time.

That would make it appear the patient's condition was hopeless?—Well, a surgeon is seldom in a position to know if there is no chance whatever of life.

Assuming there were three ruptured ulcers, what is the chance of recovery?—Infinitesimal.

With one ulcer the chance would be much better?—Yes; better.

Mr. Beetham: Did you observe the perforations very closely at the operation?—I observed them for a few minutes.

Mr. Beetham: I wanted to know what chance you had of observation, because you proceed to describe an ulcer, including its length. Your observation must have been close?—In judging the distance my description is fairly correct.

The Chairman: You say the edges were so friable that they would not hold a stitch?—I saw a stitch put in, and it pulled out.

Mr. McVeagh: At the time of the operation was it the omentum flap on the lesser curvature of the stomach that was friable?—I saw sutures put in and give way. I derive the inference that the stomach was friable.

I would suggest that the stitches were carried away through the omental fat. Is that correct?—I would not say that was not so.

That would be consistent with Mr. Savage's statement that the peritoneum was perfectly healthy?—I won't say it was not.

Mr. Beetham: You say there were three ulcers. Where have they gone to?—There was the undoubted one in the duodena, which at the time of the operation appeared to be in the stomach, the second one in the centre of the stomach, while the third one has not been discovered. I saw stitches put in there, six or seven, and I believe the anterior of the stomach has thinned away.

Mr. Reed: Was there any loose suturing found at the exhumation?—Yes.

That would probably pull out from the place where, in your opinion, the third ulcer was located?—No.

Mr. Beetham: I say, what has become of the third ulcer? Where is it? Who knows anything about it? The ulcer seems to have been lost altogether?—I believe there has been decomposition of that portion of the stomach.

Would decomposition eliminate an ulcer?—I don't say so.

Mr. McCarthy pointed out to the witness that at the Hospital inquiry he stated that there were large patches of the stomach, from 2 in. to 2 1-7 in. in diameter, of softened tissue of a yellowish-green colour, which would be liable to be ruptured on the slightest pressure. This state of things had not been borne out by Mr. Savage's report.

Dr. Craig: My description was the appearance in life.

Mr. Beetham: Would this appearance be rendered less by decomposition?—I do not see how Mr. Savage could demonstrate the peritoneum at all. I have described the appearance of the stomach as it was to me at the time of the operation.

Dr. Collins: Do you agree that the peritoneum does not saponify?—No. The peritoneum is lined with a pavement containing certain chemical elements that will saponify.

Can you tell me the effect of formalin on a stomach?—It would harden it.

Could you possibly compare the appearance of a stomach put in formalin in any degree of similarity to what it would present before the operation?—No, I don't believe you could.

Do you remember me putting three stitches in the anterior wall of the stomach?—I do

What was the condition of the patient prior to the operation?—He was in a low condition.

How did he take the anæsthetic?—He took it all right, so far as I can remember.

Was he deeply or lightly under it?—He came partly to on one or two occasions.

You have seen the report on the exhumation: do you agree with it?—No. There is no mention that the body was saponified, or that the peritoneum was saponified, and there is no mention of extensive inflammation in the peritoneum with roughened patches.

Anything else?—The small bowel was reported to be absolutely normal. The small bowel is 25 ft. long and 3½ in. wide all along the surface of the peritoneum, and that this escaped the action of the microbe organism I don't understand. There was also the omental fat. I do not think it was a stitch placed in the upper curvature of the stomach, but in the process of decomposition the stitches letting go their hold pulled upwards, and was made to appear a part of the lesser omental pulled down.

In examining the stomach where did you see it?—In Mr. Savage's stables in the gaslight.

Did you see light through any part of it?—I did. The stomach had been in formalin some hours from the time of the exhumation till the examination.

Would it present the shrivelled-up appearance it does now?—No; it was a slimy mass.

Could you see light through it when held up?—Yes. I could see light better in some portions than in others. There was an appearance of more light in the centre than the side.

After the exhumation was there an ulcer in the stomach as well as in the duodena?—I don't think there was.

Was any one else of that opinion?—Dr. Bedford thought so.

Mr. McVeagh pointed out that there was no evidence before the Commission as to whether the stomach had been in formalin before examination by Mr. Savage.

Mr. T. Copeland Savage (recalled) stated that when the stomach of White was taken from the cemetery it was not placed in any preservatives. It was sealed by the Coroner at the cemetery in a bottle containing no preservatives, and was reopened at witness's house thirty hours later by the Coroner.

Replying to Dr. Collins, Mr. Savage stated that when he held the stomach up to the light it was not more visible in some places than in others. There was no indication that one portion of the stomach had suffered in any way more than another.

The Commission then adjourned.

Wednesday, the 2nd November, was occupied in the examination of further witnesses called on behalf of the Board and Dr. Collins.

William Conway said he was in the Hospital from the 8th May to the 6th October of the present year, suffering from a broken thigh. He was seen immediately on admission, and received good attention. The food was all that could be desired. Witness had not been unduly pressed for the payment of fees.

Edward John Quigley said he was in the Hospital recently with a broken leg, and was entirely satisfied with the nursing and medical attention he received. He had no complaint to make regarding the food. Mr. Schofield regularly visited the wards twice a day—breakfast and dinner time. He had not been worried for the payment of his account.

Frank Foss Tarry, who was in the Hospital from the end of April to the beginning of June, 1903, said he was seen on admission by Dr. Walsh, and was subsequently operated upon by Drs. Collins and Craig. He was satisfied with the treatment he received, and had not been pressed for the payment of the whole of the fees.

The Chairman: What are these witnesses called for, Mr. Reed?

Mr. Reed said they were being called to prove that during the period of their treatment in the Hospital the attention and food was good, and, further, that the Board had not unduly pressed patients for the payment of fees.

The Chairman: The fees are illegal.

Mr. Reed: It is a legal question, which I am prepared to argue if necessary.

The Chairman: You will have to argue it. The fees are illegal unless charged in proportion to the means of the patient.

Mr. Reed: If the patient was charged 4s. 8d. per day, and it was shown that he could pay that amount, no Court would nonsuit the plaintiff, as it would obviously be in proportion to the means of the patient.

The Chairman: I must again point out that the question is not whether a large number of patients were well treated, but whether a certain number were not. We are quite prepared to assume that proper treatment was meted out to those who had made no complaint.

Mr. Reed: The suggestion is that from beginning to end the Hospital had been run with a total disregard to the interests of the patients.

The Chairman: I don't think so. Well, go on, Mr. Reed, and your witnesses, if that is your object. You can call every man who was in the Hospital.

Mr. Reed said that if 4,900 patients were called and testified to the good treatment received, and a few made complaints, there was some explanation as to the complaints by the few.

Dr. Bedford said he had been on the staff of three naval hospitals at Home, and had been on the staff of the Auckland Hospital for about six years. For about eighteen months he was medical adviser to the Board. During his attendance at the Hospital he had seen Dr. Collins perform one major operation, which was the only one he had seen him do.

Mr. Reed: Do you know the general results of Dr. Collins's operative work?—I have seen some successful cases after recovery.

The delirium-tremens cases, the witness said, were divisible into two groups, those who were mild and manageable, and those who were not. The former were put in the enteric wards, while the others were, the witness was ashamed to say, put in the padded rooms, which were not habitable. That had been the custom since witness had been at the Hospital.

Witness said he represented the Board at the exhumation and the examination of the body of Wallis White. The examination of the stomach was made in Mr. Savage's stable. The light used was a gas-jet, and was not a good light for witness.

Witness then detailed how the coffin was carried on a sleigh, a distance of a quarter of a mile, to a compartment in a shed, just permitting one person to stand at the side of the coffin, the others having to peer round the door. There were 4 in. or so of water in the coffin when opened, and water also fell freely from it when removed from the grave-edge. When the body was so arranged that they could obtain a good view of the operative area—the abdomen, and the lower part of the chest—it was seen that there was an incision in the appendicular area, about 3½ in. or a little more in length. In the middle line there was an incision that began a little above what was known as the crest of the pupil, and carried up to near the pit of the stomach. A triangular incision was made in the abdominal wall, and the whole of the surface of the operative area was turned down, enabling them to see the under-surface of the lines of the incisions. Under the appendicular incision—that was the one on the right—there lay on the surface of the intestines a small piece of what witness believed to be gut suture. This gut suture had apparently come from the peritoneum-edges that had been sutured beneath this wound. In the middle line the peritoneum-edges were separable and frayed-looking, as if it had been drawn out of the stitch-holes. The small intestines were carefully scrutinised through their entire length, inch by inch, and the same was repeated with the large intestines. Those doing the ex-

amination found, and we saw, two lines of stitching, one in front of the stomach and another on the front of the duodenum. These two were close together, probably 2 in. or a little more apart. In the small intestines, in the part known as the duodenum, one stitch was found as if holding together the lips of a puncture. Lower down in the cæcum, the commencement of the great bowel, an incision was found about 1½ in. in length, and this was closely sutured. A little higher was another opening, sutured with three stitches. The stitched parts were then tied above and below to remove those portions for further examination, and placed in a bottle, which witness believed contained a weak solution of formalin. The witness said the reason why he believed it was put in a solution of formalin was because Mr. Savage had taken out a jar containing that fluid, and had remarked that it was not strong enough to injure the structures.

Continuing his evidence in regard to the exhumation, Dr. Bedford said the incision in the cæcum was drawn together by ten or twelve stitches, and the other by three stitches. These structures were cleaned a little, the sutures were removed, and the wounds scrutinised. The incision in the cæcum was, from eye measurement, about 1½ in. in length, and the higher incision seemed to be the width of a large operating scalpel, of ½ in. or something less. In the stomach there were two lines of stitches, one in the duodenum and one in front of the stomach. When the stitches were removed it was found there was a perforated ulcer of the duodenum, and over the other line, through the edges fraying by the pressure of the stitches, it had eroded somewhat. There was no actual perforation. At first, the witness said, he thought there was, but after examining the hardened specimens he found there was not. At the first examination he believed it to be a perforation or thinning, because the eroded edges impressed him that it was the outlet of a gastric ulcer. The specimens were then a brown, slimy, semi-decomposed mass, but when examined subsequently it had hardened considerably.

Proceeding with the narrative, Dr. Bedford said: In the first instance I may say that I made a mistake in supposing there were two ulcers. I would like to say I am satisfied there was only one ulcer in the duodenum.

Mr. Reed: How did you come to make a mistake in regard to the ulcer in the stomach? You say it was sutured, and the edges of the suturing were torn away?—The man had been buried four months, and the pressure exerted by the stitches must have caused some erosion of the structure. The way it appeared to me as the stomach was lying was that it was the outlet of an ulcer. In that I was mistaken. There was no discussion, and in making my report to the Board I did not know what Mr. Savage's report was to be.

On reaching the intestines, did you observe whether or not there were adhesions between the coils?—We were standing at the door of the compartment, and the view was not good, but there appeared to be some adhesions.

Did you have reason for altering your opinion afterwards?—I had no chance of testing it. There were no fresh facts, or nothing to change or alter my opinion.

Did you find the peritoneum friable or not?—I should say it was friable, judging from its condition under the operating wounds. I mentioned in the commencement of my statement that under the appendicular line there was a piece of what I believed to be gut suture, more than 3 in. in length, and less than 4 in. The suturing must have either come out end on, and from the peritoneum-edges, or during the transit of the body from the grave it was torn out.

Replying to Dr. Collins, the witness said his impression why the Board decided to appoint the Medical Superintendent was in consequence of a rider brought in by a jury at an inquest on a person who died under chloroform. At that time two juniors were doing the duties of residents, and after the death there was a public clamour for the appointment of an experienced man, and the Board yielded to it. The decision was arrived at contrary to the wishes of the honorary staff, but when they realised it was a necessity they adapted themselves by drawing up rules to make the working of the institution harmonious.

Dr. Collins: Was I appointed to do the emergency work?—That was the wish of the Board, I believe, when they decided to make the appointment. It had been complained that operations had to be deferred owing to the honorary not being able to be present, and as emergency cases needed immediate attention. When he was medical adviser to the Board he got the Board to adopt a scheme for a maternity home, but the then Board went out of office, and, to his surprise, he found that it had been decided to build an operating-theatre with the money. This was some time before Dr. Collins came to Auckland.

In answer to Mr. McVeagh, witness said that only two persons could conveniently get in the building in which the first examination was made of the exhumed remains at Waikumete. He walked away for fresh air for a yard or two during the examination, and he never got closer to the coffin than about 4 ft.

Mr. McVeagh: Your eyesight is not very sharp, I believe, doctor?—Well, I am not a young man.

In answer to further questions, witness said he saw only one suture displaced. He did not remember whether there was a knot in it. The suture might have been displaced whilst the coffin was being removed on the sleigh.

Mr. McVeagh: That is your conjecture?—Yes; it can only be a conjecture.

You cannot say whether the knot was tied or untied?—No.

You found occasion to withdraw your report to the Board?—Yes. I made a mistake, and I was anxious to correct it. The error was due to the fact that I had not the same opportunity of making a minute examination as Mr. Savage and Dr. Bull.

In reply to Dr. Roberton, witness said he fought against the adoption of the rule which provides that the Senior Medical Officer "shall be present at all meetings of the honorary staff," but it found favour with the Board of the day. [The honorary staff had recommended that the Senior Medical Officer may be present at any meeting of the honorary staff.] This rule had caused more heartburnings than any other rule in the book.

Mr. McVeagh: Do you think the present Board is a suitable one?—I have nothing to say against the members of the Board, but I do not think the constitution is of the right sort, and I should like to see two capable women on the Board, seeing that more than half of the patients are women and children. I should also like to see one medical member. The remaining seats could be filled by those who find the money.

Dr. Parkes, a surgical member of the honorary staff, stated that he was present at the operation on Wallis White. He was summoned by telephone. He was delayed, and arrived at the Hospital about half-past 8. The patient was then on the table. Witness asked for a history of the illness, and after he had examined the patient he agreed that the man had septic peritonitis, due to a perforation. From the swollen and tense condition of the abdomen, it was impossible to give a positive diagnosis, but he thought the lesion might be in the appendix.

Mr. Beetham: Why did you not perform the operation?—Because it was not my week.

Witness, describing the operation on White, said that the usual appendicular incision was made. Just as the large intestine came into view witness had to leave the room to go to the telephone. When he returned Dr. Collins was closing up the wound over the appendix. He saw nothing of the incision in the bowels or the discovery of the appendix. Dr. Collins made a median incision and examined the small intestine. No perforation was found there, and the incision was continued upwards to examine the transverse colon. No perforation still being found, some one—he thought it was Dr. Craig—suggested that the trouble might be in the stomach. The stomach was opened up, and a perforation was found. This was sutured up. Witness moved away over to the fireplace at this stage, and just then he heard some one remark that there was another perforation. He did not make any close inspection, but his impression at the time, from what he saw, was that the stomach-wall was thin over an area near the lesser curvature. He saw no actual opening as in the other case. Dr. Collins drew together the edges of what witness took to be an ulcer, but the stitches would not hold. He then took in a larger area from each side, in order to get the stitches to hold.

Mr. Reed: You have heard it said that the *post-mortem* showed that there was no ulcer there. How do you account for that?—The conditions were quite similar to those existing in gastric-ulcer cases. I was unable to get very close, and thus did not have a clear view. I think all present were quite sure that it was a gastric ulcer.

The Chairman: How can you tell that all the others were sure?—From the remarks they made at the time.

The Chairman: Did Dr. Neil appear to be sure?—I did not hear him express any opinion.

Mr. Reed: Was the course followed by Dr. Collins in opening the intestines good surgery?—I did not see the actual condition, but if Dr. Collins was unable to get at the appendix, owing to the distension of the intestine, I consider it would be justifiable to puncture the intestine to let out the gas. The propriety of an incision for the removal of scybala depends upon the amount of scybala present. If the intestine was blocked by fæces it would be a necessary part of the treatment to remove them. In case of peritonitis, the emptying of the bowel is recommended by some authorities.

Dr. Neil says that you said to him next morning, in reference to the operation on White, "Wasn't it sickening!" Did you say that?—No; I could not have said that after saying the night before that everything that could be done for the man had been done.

When did you first hear of any adverse criticism on the operation?—Some weeks afterwards.

Questioned in regard to the Duke case, witness said a message was sent to him. He was out at the time, but on receiving the message he went to the Hospital, and found that the operation had been performed. He asked why the bladder had been opened by means of an incision instead of being aspirated. On the circumstances being explained witness approved of the operation as the best under the circumstances. Witness saw the patient nearly every day after that. He told Duke that to insure permanent relief another operation would be necessary, but Duke refused to undergo another operation.

Mr. McVeagh: You say you arrived at the Hospital on the night of White's operation at half-past 8. The attendance-book is signed "8.15 to 10.50"?—I said about half-past 8, but I could not fix the time definitely.

Was not the fact that the patient was on the table when you got there an indication of an intention to proceed with an operation if you had not arrived?—I had urgent business at my own house that night, and I could not go at once, and they did not know when I would arrive.

Were you informed that White had been taken ill about eighteen hours previously?—No; I was informed that he had been taken ill the previous evening.

Did you see the case-book or the bed-chart, or was the consultation-book presented to you for signature?—No.

Did you say at the Board's inquiry that you agreed with Dr. Craig's statement?—I probably agreed in some points, but I could not agree in all, as I was absent from the room during part of the operation.

Well, you agreed with that part of his statement which related to what took place when you were there?—Yes, I agreed on the main points. I did not mean that I agreed with all the details of Dr. Craig's statement. Dr. Craig said there were three ulcers, and I said two; therefore I did not agree with the whole of his statement.

You said just now that during the operation you moved away towards the mantelpiece, and that you formed your impression as to what you took to be the second ulcer partly from appearance. Why did you not state this at Dr. MacGregor's inquiry?—I did not because I believed then that I was right.

Do you think it fair to Dr. Neil not to make the statement then?—At that time I was under the impression that a second perforation existed.

When the diagnosis is indefinite, is it not proper to make a median incision?—Not necessarily. I thought at the time that the case was more than likely to be one of appendicitis.

Were you told that the man had been a cook, that he had complained of a pain on his left side, and that there had been prolonged indigestion, followed by a sudden acute pain?—No.

If you had had such a history placed before you, would you have suggested a median incision?—I would.

In regard to the two rules relating to the duties of the Senior Medical Officer, witness said that one rule appeared to nullify the other, and that they were clumsily arranged.

Mr. McVeagh: You said at the Board's inquiry that the walls of the stomach were so friable that no sooner was one perforation closed than another would be made. Was that a fact?—I meant that no sooner would the tension be placed on one piece of tissue than it would tear away in other places, and thus leave other perforations.

Do you say now that there were a series of perforations?—I say that the stitches would not hold.

Do you say now that the stomach was friable?—Yes; the area I am speaking of.

Would not such friability be likely to be intensified after burial for four months?—Yes, provided the stomach was not put into a preservative, such as formalin.

We have had evidence that the stomach was not put in formalin till after the examination?—I did not hear that.

Witness, on being asked why two incisions in the intestines should be necessary, said it would depend upon distances. The gas could be relieved through one incision for a distance of, perhaps, a foot, provided that there was no intervening blockage.

Witness, in answer to another question, said that the diameter of the colon was capable of being extended as far as 5½ in.

Would two pieces of scybala, each the size of a walnut, be sufficient to block the colon?—I do not see how it could come about.

When you examined the man, in what condition did you find him?—He had a bad pulse, and a subnormal temperature. It was a desperate case.

Do you not think it would have been good surgery to close up the first incision when the appendix was found to be normal, and then to explore elsewhere?—Yes, if there was no necessity to open the bowel.

Time would be of importance?—Yes, it always is. The sooner a patient is got back to bed the better.

And if the anæsthetist was urging the matter of time upon the operator it would be still more important?—If there was no reason to open the intestine, I would close up the incision as soon as possible.

Witness, replying to Mr. McVeagh, said he performed an operation on Mrs. Tracey, and Dr. Collins assisted. He remembered Dr. Collins performing a similar operation on a dead body in the mortuary a few days before. Witness was in the mortuary once with Dr. Collins when the technique of the operation was being illustrated by Dr. Collins. The patient got along very well at first, but finally suppurated and died. It was a very bad case.

Mr. McVeagh: Were you at a meeting of the honorary staff when a motion was moved to the effect that those manipulating dead bodies should not take part in surgical work?—Yes. A motion to that effect was carried, and I voted for it because I thought it was the right thing to do. I do not approve of surgeons or any one connected with operations visiting the *post-mortem* room. It tends to create the liability to suppuration.

Replying to Dr. Roberton, Dr. Parkes said it was not usual at hospitals that the honorary surgeon should be present at major emergency operations and not assist. He did not approve of the Senior Officer being given power to do major emergency operations. The Board had been approached to make accommodation for better classification of patients. Witness's work was chiefly in the typhoid wards. Only sometimes the resident physician accompanied the honorary round the wards, that person being largely engaged in the operating-theatre. Witness's work was hampered through the resident not being able to accompany him, and he felt his responsibility was greater than his control.

Loftus Austin said he was admitted to the Hospital on the 7th July of last year. His leg was broken, and the limb was set by Dr. Walsh, Dr. Scott coming in during the operation. The attendance in the ward witness was in was first-class, and the food was very good,

except once or twice, when the fish was a bit stale. Other food was offered at that time, and the practice was generally followed in the ward.

Palmer Wilson, a fish-cleaner, said he was in the Hospital in June of last year, and was an inmate for six weeks. The attendance of the doctors and nurses during that period was good, and the food was also very good. His bill amounted to over £10, and it was reduced to £7 by the Board.

Mr. Savage said he would like to explain how it was that some doctors were under the impression that the stomach and intestines of White were put into a bottle containing formalin. Mr. Savage said he took out a bottle of formalin.

The Chairman: Formalin has a peculiarly fiendish smell, has it not?—That is so. The exhibits were not put in formalin, as witness decided it was best not to do so.

The Chairman stated that the Commission had previously accepted Mr. Savage's evidence on this point.

Dr. Scott, who was previously called on behalf of the Medical Association, was recalled. He stated he was well acquainted with antiseptic treatment, and had large experience in abdominal and intestinal operations. He had specially considered the White operation.

Several authorities were quoted by Mr. Reed, and the opinion of witness asked upon them as applicable to the White operation.

Mr. Reed: Do you consider it good surgery on the part of Dr. Collins before closing up the first appendicular incision to remove distension caused by gas and fæcal contents?—I answered previously, stating it was good surgery.

Dr. Scott agreed with D'Arcy Power that it was far better for the patient to recover with a scarred belly than die with an abdomen full of pus. He agreed, too, that there was a chance of losing cases if the surgeon was frightened of the severity of collapse previous to operation by the proper cleansing of the abdomen, or to perform it in a perfunctory manner. This work had to be done deliberately, although the shock would be increased.

Mr. Reed: Is it right to assume an ulcer if the wall is thin?—It is.

Dr. Scott stated that it was assumed by the honorary staff at the time of the Board's decision to appoint a Medical Superintendent that he was not to occupy the subordinate position as held by Dr. Baldwin, but was to be as a colleague of the members of the staff, and to have certain active work assigned to him. Dr. Collins had not, in witness's opinion, arrogated a position higher than that conceded him by the Board. Witness, as chairman of the honorary staff, had not had friction with the Hospital Board, nor had he any complaint to make against that body. There was now an easier means for the staff to get their wants attended to by the Board than formerly, a state of things he attributed to the presence of Dr. Collins at the Board, Dr. Collins being able to explain matters. Dr. Collins had not at any time taken a case at the Hospital during witness's week without first consulting him.

To Dr. Collins: In the Peake case I advised that the patient should be allowed to remain on in the Hospital for three months longer, and in the meantime the suppurating wounds and other matters were attended to. I intended operating on Peake just at the time he was leaving the Hospital.

Witness said that latterly consultations of the staff had been carried out according to Dr. Neil's desire. In connection with the charge against Dr. Collins of negligently failing to insure the removal of pus from the abdomen, it was not possible to insure the removal of pus. The trocar and canula was an inefficient instrument for removing gas from the intestines, and the most modern system was the use of a knife.

Witness said he was present at a sub-committee meeting of the surgical side when a general resolution was carried that those taking part in *post-mortem* work should not be present in the operating-room. He favoured the motion. He remembered a discussion on the rules relating to emergency work, and at that time ventured the opinion that a change in the rule would interfere with the fundamental principles on which Dr. Collins was appointed to the position.

Mr. McVeagh asked Dr. Scott about an operation performed on Mrs. Plesher, about four months ago, but the witness said he could not remember if the operation took place without his consent or if he objected to some nurses in the morning. Witness knew that his name was removed from the chart over Peake's bed. That ward (No. 8) was in charge of Dr. Collins, and the honorary surgeons did not visit that ward. It was the same at present conditionally, because the rules made Dr. Collins completely responsible for all fractures and dislocations, excepting in cases requiring operative interference.

Mr. McVeagh: Wasn't Peake's case one for interference?—No.

To Dr. Roberton: Dr. Baldwin's position was a menial one, and he was not a colleague of the staff in any particular. Attending to the administrative work was minor in comparison with the duties assigned to Dr. Collins.

Questioned by Dr. Roberton as to changing his views on the question of the status of the Medical Superintendent from those expressed in a letter, the witness said he only stated his opinions in the letter.

The Chairman: Like the American politician, "There are my opinions, and if they don't suit you I can alter them."

Dr. Scott: Only a fool and a dead man will not change their opinions in the face of solid arguments.

The Chairman: The rules give Dr. Collins sole treatment and responsibility over fractures and dislocations, and evidently can exclude the honorary staff from seeing those patients. Do you know of such a rule existing in any other hospital?—No, I do not. The rule was experimental.

You say the honorary staff and the Medical Superintendent have been in complete harmony. How many members of the staff have resigned since Dr. Collins has been appointed?—Two, I believe, have resigned, and one or two have not sought re-election.

Dr. Ferguson, resident physician at the Auckland Hospital, said he joined the staff last April. He was assisting at the operation on Wallis White. An appendicular incision was first made, and he then noticed the cæcum bulge into the wound. There was great difficulty in finding the appendix. A puncture was made with a knife into the colon to let out gas. The cæcum was distended with fæcal concretions, several pieces of which were taken out by means of an incision. The appendix was found, and its condition was normal. Another incision was made on the middle line. The small intestines were distended, and he believed a puncture was made in one of the coils and gas let out. The incision was continued upwards till the stomach came into view. An ulcer was found, which witness thought at the time was in the stomach, or at the junction of the stomach and duodenum. This was sutured, as well as a thin portion of the stomach-wall.

Mr. Reed: When the sutures were put in the thin portion did you think there was an ulcer?—I had the idea that it was an ulcer that had not perforated.

Witness referred to the Duke case, and said it was a very bad one of stricture. The operation performed was preferable to the Wheelhouse. The patient absolutely refused to undergo a second operation. In connection with the operation on Martha Gordon, when an incision was made in the middle line over the stomach-area blood simply welled out, and Dr. Collins removed several handfuls of clotted blood when a second incision was made over the lower part of the abdomen. From the history of the case witness got he learnt the patient was a "bleeder." Witness described the operation on Clarence Walters, and said he was not at the *post-mortem*, as stated by Dr. Neil. He did not think there was anything special in administering hypodermics. The male porters passed soft catheters, but not silver ones. There was no danger if they were properly sterilised.

Witness, on being questioned in regard to the Swinbourne case, said that when Swinbourne was admitted a letter from Dr. Jones stated that he was suffering from delirium tremens. [The letter was produced.] Witness said that Swinbourne was in a very shaky condition, but he said that he had not been drinking for a week or more. On seeing Mrs. Swinbourne she said her husband had taken a dose of chlorodyne. On seeing Swinbourne again the latter said that he had taken chlorodyne the night before to make him sleep. He was taken into the ward, and the same night he became delirious, and had to be strapped down.

Mr. Reed: Did you see a bed-chart with "chlorodyne poisoning" on it until recently?—No; I did not know that it had been entered up as such. When the charges against Dr. Collins were made I looked up the records concerned. I remembered the case as one of delirium tremens. I looked up the chart and saw that it was signed by Dr. Collins as "chlorodyne poisoning and accident." That was before the Commission sat, but after the charges were received. I took the chart to Dr. Collins, and told him that the diagnosis was incorrect, and that the case was one of delirium tremens. I asked if I should make up a fresh chart. Dr. Collins said "Yes," and I made out the fresh chart and tore up the old one.

In answer to Mr. McVeagh, witness said he could not remember exactly when he tore up the old chart, but it was before the Commission sat.

The Chairman: But after it was constituted?—Yes.

Mr. McVeagh: How many charts have you destroyed since you have been in the Hospital?—This is the only one.

Was the fact that this one was in Dr. Collins's handwriting the reason for its destruction?—No. The reason was that the diagnosis was incorrect.

Who told you to destroy it?—No one. I thought it was of no further use.

Do you swear you had no suggestion from anybody to destroy it?—Certainly I do.

Did you make out the fresh chart the same day that you destroyed the old one?—Yes.

Did you put anything on it to indicate that it was not a true copy of the original chart?—No.

You initialled it, I think?—Yes; I have done so in all cases lately since Dr. Collins has been occupied with the Commission.

Did it not strike you that initialling it was tantamount to certifying that it was a correct copy?

Mr. Reed pointed out that the charge in reference to Swinbourne was one of not attending to him immediately upon admission, and that there was nothing in the charge that could possibly have suggested the destruction of the chart.

The Chairman: That is another matter; but I think, Mr. Reed, that you would be the last to advise the destruction of part of the Hospital records.

Mr. Reed: Certainly, Your Honour; I think it was the biggest mistake in the world, and had any such suggestion been made to me beforehand I would have said, "Do not destroy it on any account." At the same time there was nothing in the charge to suggest that the chart would be required.

Witness: I did it in entire ignorance, Your Honour.

Mr. McVeagh said the whole thing was very objectionable, as it suggested the destruction of evidence and the fabrication of false evidence.

Mr. Reed objected to this remark. There was no such intention as Mr. McVeagh insinuated.

Mr. McVeagh (to witness): Did you make a statement at the Board's inquiry relative to Wallis White's operation?—I began to make a statement to the effect that I agreed with Dr. Craig's statement with certain exceptions, but I was interrupted by Dr. Scott saying he did not think a junior physician should be asked to criticize an operation performed by a superior officer. Dr. Collins then said he would not ask any more questions, and what I intended to say was not given at all.

Did you hear Dr. Craig say that there were three ulcers?—I was not allowed to get as far as that.

Did you afterwards tell Dr. Craig that there were not three ulcers?—No.

You heard Dr. Neil say there were two incisions in the intestines, and you heard that questioned at Dr. MacGregor's inquiry?—I was not sure then whether there were two or not.

Oh, you have become sure since?—Yes; I was present at the exhumation.

Did you tell Dr. Collins of your doubts upon the point?—Yes; I told him before this inquiry commenced.

Did you ever suggest to Dr. Craig that there were two incisions in the intestines, or that there were not three perforations in the stomach?—I cannot say that I did.

You say the stomach-wall was thin. Do you dispute Mr. Savage's statement that, with the exception of the ulcer, the stomach was normal and healthy?—At the operation I thought it was thin.

Did you handle it?—Yes; I held it in my fingers whilst Dr. Collins was doing the suturing.

In that case would you not expect to find some friability in it now?—Yes, unless there was saponification.

Replying to Mr. McVeagh, Dr. Ferguson said chlorodyne had a delirient action a few hours after being taken. The patient was not delirious till at least twenty-four hours after swallowing the dose, and at that lapse of time the natural effect of the drug would be to induce stupor, and not delirium.

Mr. Reed inquired if the Commission wanted any more evidence in regard to the question of food, because if they were satisfied that the food was generally good and only sometimes unavoidably bad he would let it drop for a while The Chairman assented, and further evidence on the question was not brought out in the succeeding witnesses.

Nurse Dewar, assistant in the operating-theatre at the Hospital, said that, having lately been attached to the theatre, she had not the chance of seeing what time Dr. Collins arrived at the Hospital. Formerly she had seen him inspecting the pantry at 9 o'clock. Lately she had seen him in the Hospital late at night and early in the morning. Generally speaking, the doctor's attention to patients was good. The honorary staff did not make their visits at fixed hours.

Nurse Brewer, who had been on the staff at the Hospital for three years, said she had seen Dr. Collins at the Hospital at 6 o'clock in the morning, at 9 o'clock, and late at night. Dr. Collins had visited the ward she was in very often when it was needful. Witness said William Peake was a troublesome patient, and would not obey instructions. He always wanted the bandages off his jaw, and often had his hand in his mouth working at it.

A series of charges had been received by the Commission from Eugene Hulse, reflecting on the work at the Hospital of Dr. Bull and nurses in the treatment of complainant's son, who was admitted to the Hospital suffering from consumption and who had since died. The complainant stated that his son was treated by Dr. Bull for typhoid fever while he was suffering from consumption, and the nurses cruelly treated him.

After looking over the complaints the Chairman referred them to Mr. Reed, who, after perusal, remarked that they did not concern his client.

The Chairman: For which, I suppose, you are devoutly thankful.

The Chairman instructed the complainant to lodge a copy of the complaint with the persons affected, and intimated that the charges would be gone into on Saturday.

Mr. Reed intimated that he expected to close his case on Friday.

The Commission then adjourned.

On Thursday, the 3rd November, the calling of witnesses on behalf of the Hospital Board and Dr. Collins was continued.

Dr. Pabst, who had previously been called by the Medical Association, was the first witness. He said he had had a good deal of experience in abdominal operations, and was the first doctor to successfully perform a gastric-ulcer operation in New Zealand.

Quoting the symptoms of the operation on White, Mr. Reed asked, Is it good or bad surgery to make incisions in the bowel?—It is not bad surgery, in my opinion.

Would the chance of life have been lessened by the action of the incisions?—I don't think so.

Witness said stomach and duodenal ulcers, if not attended to surgically, generally had a fatal result, and when attended to a very small percentage recovered. A scalpel was preferable to the trocar and canula in evacuating gas from a bowel. If two enemas had no effect on the bowels it was proof of obstruction of the bowel. The fact that the patient White lived twenty-four hours after the operation showed that shock was not an essential of death.

Mr. McVeagh: Assuming that when the appendicular incision was made and gas escaped, and the appendix was not immediately found, would it not be better to close up the incision and explore elsewhere?—If gas escaped it was evident that there was an ulcer elsewhere.

Witness said it was not bad surgery to open the intestines, as it would relieve the bowels of distension and fæcal matter. If witness had found an appendix normal and had operated for appendicitis, he would make a fresh incision. Incision into the bowels in this case had, in his opinion, facilitated the action of the bowels. He did not think the two incisions would tell against the operator. The small incision had apparently been made first because if the larger incision had been made first there would have been no necessity for the small one. The small incision would relieve gas.

Dr. A. O. Knight said that he practically agreed with the evidence of Dr. Scott regarding the operation on Wallis White.

Mr. Reed: Do you consider it would be good surgery, in a case such as that of White, to make incisions in the intestines for the escape of gas and the removal of fæcal concretions before proceeding to make the middle-line incision?—It is good surgery certainly to make an opening in the intestines to evacuate gas. As far as the fæcal concretions are concerned, it would be a matter for the surgeon operating to decide whether it should be removed or not. The concretions might not be giving trouble at the time, and yet it might give rise to trouble at some future time.

Would you consider that if two enemas, one of turpentine and one of Epsom salts, had failed to take effect, that that would indicate trouble?—Yes; it would probably indicate paralysis or want of tone in the bowel.

Would the fact that the patient lived for twenty-four hours after the operation indicate that the patient had died in any way through the effect of collapse of the bowels?—Certainly not.

Do you agree with Sir Frederick Treves that almost all cases of duodenal ulcers are fatal?—Not all cases; but the large majority are. Very few have been operated upon successfully.

Mr. McVeagh: I take it that the proper course, after the appendicular incision had been made and free gas found in the abdominal cavity, would have been to look for the trouble elsewhere?—Yes; if the appendix is found to be healthy.

You would not make two intestinal incisions within less than 2 in. of each other?—No, I do not think I should at the same time; but, of course, the man doing the operation would be better able to judge at the time than any one speaking now. He might have strong reasons for making two incisions, but I should hardly judge it necessary.

Would two pieces of fæcal matter, each about the size of a walnut, be sufficient to block the colon of an ordinary adult?—I should think not.

Mr. Reed: Do you think that if there were an obstruction, and it was necessary to remove the fæces, it would be advisable to do so even at the expense of a little more time?—Yes. No good can come from scamping work to save time.

It would be better to risk collapse in such a case than to leave the obstruction?—Certainly. Otherwise you would have certain death.

In answer to another question by Mr. Reed, witness said it would not necessarily be bad surgery to make two incisions in the intestine close to each other, as after one incision had been made and closed another might be found necessary, and this might easily be made close to the first one without the operator being aware at the time that it was so close. This was a possibility that might occur to any one.

Is it possible to mistake discolorations in the stomach for unperforated ulcers?—Yes, certainly. That might happen to any one.

Mr. McVeagh: Would it be possible to mistake dark discoloration for perforated ulcers?—No. If a surgeon saw suspicions of ulcers underlying the discolorations it would be right to deal with them. Otherwise he would be neglecting the case.

Dr. King, honorary physician of the Auckland Hospital, said he remembered the case of Arthur Duke. The patient was seen by witness on the evening prior to the day and on the morning of admission. His condition was serious, so he sent him to the Hospital. The operation performed was the correct treatment, and the one for which witness sent Duke to the institution. Previous to these proceedings witness said he had heard no complaint from Duke as to his treatment while in the Hospital.

Witness said he was present for a time at the operation on Wallis White. He consulted with Dr. Collins at the patient's bedside, and the opinion witness formed at the time was that it was a case of appendicitis. Witness only saw a part of the operation, that when an incision was made over the appendicular area, and when the intestines bulged up into the wound and a puncture was made to relieve gas. He had to leave then, and returned shortly after, when fæcal matter had been removed. He was there part of the time when the incision was made over the middle line. He saw the duodenal ulcer. A remark was made——

The Chairman: We can't take what you heard as evidence.

Mr. Reed said similar evidence had been accepted from Dr. Neil and other witnesses. The remark was made at the bedside, and was evidence.

Dr. King said he believed Dr. Craig made the remark that there was another ulcer.

The Chairman: This is too absurd. The witness heard some one say something at the bedside, and cannot say who it was.

Dr. King said the remark was made that there was another ulcer, and he believed he saw it sewn up.

Mr. McVeagh: Were you at the Hospital Board's inquiry?—Yes.

Did you corroborate Dr. Craig's statement of the case there?—I really could not say, but believe I did.

The witness said he arrived at the inquiry when Dr. Craig was in the middle of the examination, and he remained to the close.

Dr. Craig said there were three ulcers?—Yes.

And you corroborated that? Can you suggest where they have disappeared?—No, I cannot.

You told us you were away from the operation at times?—Yes.

Were you taking a close interest in the operation?—Not a very close interest.

It was quite possible that you were misled as to what actually occurred?—Very likely, as I was out of the room some of the time.

To Mr. McVeagh: The conditions of Duke's case showed that the strictures were not impregnable.

Replying to Dr. Roberton, the witness said, as honorary physician, he had carried on his duties at the Hospital under satisfactory circumstances, excepting that the resident physician was not always available.

J. T. W. Stevenson, Acting-Secretary of the Hospital and Charitable Aid Board, was called, and stated he had compiled the statement (produced) of expenses of the Auckland Hospital from reports made by the Inspector-General of Hospitals.

Mr. John McLeod, a member of the Hospital Board, said there were a number of members of friendly societies who were patients at the Hospital, and as general secretary witness expected to hear of complaints if the treatment was not satisfactory. He had only heard one complaint, and on personally investigating it found it was groundless. No case of hardship in the payment of fees had come under his notice. During a period of five years, from 1898 to 1903, an amount exceeding £20,000 had been written off the Hospital books against patients who had paid nothing at all. The average amount paid by the general public was quarter-fees, while an arrangement existed till April last with the Hospital Board that friendly-society members paid half-fees for adults. Witness said he was elected to the Board just prior to the appointment of Dr. Collins, and the reason why the Board decided to make such an appointment was on account of the unsatisfactory arrangement existing then.

Mr. Reed. Do you consider the present arrangement is satisfactory?—It does not appear to be. I do not consider it satisfactory, on account of the friction between the medical fraternity, the Board, and the staff.

Questioned by Dr. Roberton, the witness said the amount paid by friendly-society members during the period quoted was £1,700, and the amount wiped off would exceed that amount. Some members were indigent, and others were well-to-do, but witness could not say if any of the latter had taken advantage of the half-fees.

Is any member now on the honorary staff excepting Dr. Scott, who was on the staff when you were on the Board?—I am not certain, but I believe that is right.

Can you suggest any reason why such a change should take place?—No reason has been stated.

Has the Board taken any steps to find out the reason of this great change?—I do not think so.

James Stichbury said that for many years he was a member of the Hospital Board, and was Chairman of the Board from 1896 to 1899, and in 1901-2. In regard to the erection of the present children's hospital the Board consulted with the honorary staff in every instance, but did not always take their advice. As the staff disapproved of the site they declined to make any suggestions as to the internal fittings of the Hospital.

Mr. Reed: Was there much friction with the honorary staff during your time?—Part of the time, but we always had peace and quietness with the medical fraternity during the absence of Dr. Lewis and Dr. Purchas.

Do you know anything of Dr. Baldwin's experiences during the time he was Medical Superintendent?—Yes; he confided in me a great deal. He was harassed in every possible way by some of the members of the honorary staff.

Can you give any instance of a complaint against Dr. Baldwin?—Yes. Dr. Purchas waited upon me at the Board's office and complained that Dr. Baldwin was not fit for his position, and he said that if he was not removed——

Dr. Roberton: May I ask, Your Honour, whether, in the absence of Dr. Purchas, such matters should be introduced?

The Chairman: We are quite prepared to hear any general statement of fact as to friction or complaints, but we cannot go into all the particulars.

Mr. Reed: I do not wish to go into unnecessary particulars, but I want to show that a threat was made as to what steps the honorary staff would take if something was not done. If the Archangel Gabriel came down to the Auckland Hospital and tried to run it, some of the doctors would still raise objections.

The Chairman: No doubt if the Archangel Gabriel came down to the Hospital he would find some one to prune his pinions at once.

Dr. Roberton: As this is a covert attack on Dr. Purchas, and as no notice has been given of it, I do not think it should be gone into.

Mr. McVeagh said that if such evidence as suggested was admitted Dr. Purchas should have an opportunity of meeting it.

The Chairman said the Commissioners could not, as he had already said, go into the details of what every one said.

Mr. Reed (proceeding with his examination): Was there friction between Dr. Baldwin and other doctors besides Dr. Purchas?—There was, but I do not care to mention names.

The Chairman: The witness wishes evidently to mention some names, but not others.

Mr. Reed: We have had evidence from Dr. Lewis that the Hospital in Dr. Baldwin's time was the *beau idéal* of what hospital-management should be. Was there any friction between Dr. Baldwin and Dr. Lewis?—Yes.

Do you know whether Dr. Baldwin's position at the Hospital was a happy one?—When I was Chairman it was not.

The witness said that he wished to make a suggestion as to the inspection of private hospitals, but the Chairman said that matter did not come within the scope of the inquiry.

Mr. Reed: You object, I believe, to the children's hospital being moved into surgical wards?—Yes. It was furnished by the benevolent people of Auckland for the benefit of the children, and if it is devoted to another purpose those who subscribed the money would have a right to take every stick of furniture out of it. The proposal is most disgraceful, I think.

Mr. Beetham: Dr. Williams said these wards are not suitable for surgical wards.

Witness said there were several reasons which induced the Board to appoint a Senior Medical Officer. He knew of two instances in which patients were crippled for life. There were many letters in the newspapers and much talk about there being no senior resident in charge of the Hospital. He also thought it was indecent, as well as wrong, that in such an institution young men should attend to middle-aged women.

The Chairman: You would not mind them attending the young women, then?

Witness: That is another matter. I do not think that young unmarried men should attend women until they have had more experience.

Mr. McCarthy: Do you think that female nurses should not attend on men?—In some cases they should not. The probationers do not attend on men in some cases.

The Chairman: I am afraid we cannot take your views as conclusive, Mr. Stichbury.

Speaking of the appointment of the Senior Medical Officer, witness said he considered that the present system was the best. He thought there should be a medical head.

Mr. Beetham: Are you aware that the Wellington and Christchurch Hospitals are run without such heads?—I think they have similar heads. Dr. Ewart, I believe, occupies a similar position at Wellington.

Mr. Beetham: That is not so.

In answer to Dr. Roberton, witness said the Board did not adopt the suggestion of the honorary staff in regard to the children's hospital because they thought it would be a waste of money. As to the Senior Medical Officer attending meetings of the honorary staff, the Board formerly did not know what was going on in connection with the staff, and it was thought that the presence of the Senior Medical Officer at the staff meetings would keep the Board more in touch with the staff.

Would that not be putting the Senior Medical Officer in the position of a spy?—I do not think so.

Do you think that if it had been known what was expected of the Senior Medical Officer in this respect, that you would have got any one to apply for the position?—We had no such intention. We only wished to work amicably.

Did you not work amicably when Dr. Bedford was medical adviser?—Yes, except for the complaint that there were only two boys in charge of the Hospital.

This was when Dr. Inglis was away on holiday leave. Why did you not appoint Dr. Inglis as Medical Superintendent, as recommended by the Board?—I have nothing to say against Dr. Inglis, but he had not had enough experience then. It was necessary to have a Medical Superintendent, as the honorary staff are not always available.

The Chairman: As far as the evidence goes, it seems that the honorary staff is as easy of access as the Medical Superintendent. If one man is not available another could be called up.

The witness: They may be all engaged at once.

The Chairman: Yes; the whole population of Auckland may be ill at once, but it is not likely.

Dr. Roberton: Dr. Purchas has said that, with the exception of some slight unpleasantness at first, the staff got on well with Dr. Baldwin?—That is not so, so far as some of the members of the staff are concerned.

The Chairman here reverted to the previous remark in regard to the Wellington, Christchurch, and Dunedin Hospitals, and said that the rules (which had just been looked up) showed that at these hospitals there were no medical officers with powers as great as those given to the Senior Medical Officer at Auckland.

The witness said he had been told that Dr. Ewart, of Wellington, and the officers at certain Australian hospitals held a similar position.

The Chairman: We have the rules before us. You speak only of what you have been told.

Witness repeated that Dr. Ewart had sole control at the Wellington Hospital.

The Chairman: The rules do not give that power.

Witness: They do from what he told me.

The Chairman: Well, then, he told you wrong.

Dr. Roberton: He does not perform major operations.

Mr. Reed: Yes, he does. Rules are not always observed.

The Chairman: Perhaps not, Mr. Reed. There would be little use for you and I if they were always observed. (Laughter.)

Mr. Beetham: Does it not strike you that the result of the appointment of the Senior Medical Officer has been to create confusion?—No; there are some people whom you can never please, and there are doctors whom the Board do not want who are always trying to get on the honorary staff. There has always been friction.

Mr. McCarthy: There is no friction in Wellington, Christchurch, or Dunedin.

Dr. Walsh, resident surgeon of the Auckland Hospital, said he recollected the patient Arthur Duke, whom witness saw on admission. He was in a serious condition, but witness did not see the operation. Martha Gordon's condition on admission was one of profound collapse, with indications of abdominal mischief. He had not seen a worse case of hæmorrhage than this case. When an incision was made blood poured out from the abdominal cavity, and the blood could not be kept out of the operating-area. Every effort was made to discover the source of hæmorrhage. Clarence Walters's was a very urgent case. Witness assisted in the operation, draining an abscess round the appendix and removing an intestinal obstruction. He described what was done. He also assisted at the operation on Mrs. Mooney, who broke her leg in falling down the Hospital steps. She was attended to the following day, an urgent operation not being necessary.

Witness said he had not known until the Commission that patients helped themselves to hypodermics. There was no objection to nurses giving the hypodermics. If it was left to the resident staff a man would require to get up at night and administer them. In the Melbourne Hospital there were eight honorary surgeons, three of whom were demonstrators of anatomy. At certain times of the year they would be dissecting dead bodies every day, and witness had never seen a case of suppuration until he came to Auckland.

The Commission then adjourned.

On the Commission resuming on Friday, the 4th November, Dr. Bull asked the Commissioners whether they would guarantee the expenses of meeting the charge made against him by Mr. Hulse, on the ground that the charge was in respect of work done as a member of the honorary staff, and that if members of the staff were to be liable to be put to the expense of meeting such charges it would impair the efficiency of the Hospital.

The Chairman said that he did not think that the Commission had any power to grant the request.

Dr. Lewis made a statement in regard to a portion of the evidence given on the previous day by Mr. Stichbury, ex-Chairman of the Board. Mr. Stichbury, he said, had stated that there had always been friction between Dr. Baldwin and himself, and insinuated that he had been partly the means of the former leaving the Hospital. This, he said, was not true. It was quite true that during the first six months of Dr. Baldwin's term he (Dr. Lewis) had certain differences with him regarding surgical matters at the Hospital. As soon as matters were satisfactorily arranged between them the greatest harmony existed between them, and continued for some four years. As a proof of the friendly feelings between them, he might mention that on the two last occasions on which Dr. Baldwin visited Auckland he had spent an evening at his (Dr. Lewis's) house. He had also given Dr. Baldwin a testimonial in connection with his application for a position at Mercury Bay, and Dr. Baldwin had since then consulted him by letter in regard to various cases. He wished to make this statement in order to put himself right with the public.

Dr. Purchas also asked, and was granted, permission to make a statement relative to the evidence given by Mr. Stichbury.

The Chairman: Well, what do you complain of?

Witness: I have not very much to complain of, Your Honour, but I must say that the evidence given very thoroughly bore out my statement as to the Board members being unsuitable to occupy the position of administrators of a Hospital. His evidence showed that the Board wanted a man for the position of Medical Superintendent who could watch what went on at the staff meetings. I always thought the Superintendent was put there to act as a spy, and after hearing the evidence I am perfectly certain that was the object for which he was put there.

Dr. Purchas explained that he had complained while Dr. Baldwin was in charge that he was unable to get asepsis details attended to, but when that was remedied complete harmony existed between himself and Dr. Baldwin. He denied the statement that he had threatened to request the dismissal of Dr. Baldwin.

Mr. Reed handed to the Commissioners a plan showing the location of the Hospital buildings, and also a plan showing that the Hospital building actually overlapped the Domain boundary, and to remedy this a grant of land was made from the Domain. Reservations were placed on this grant. It was not to be built upon, but to be used for ornamental purposes, and had the suggestion of the honorary staff been complied with in building the children's wards this land would have been built upon. Mr. Reed agreed to have a sketch of both plans made for the use of the Commissioners.

The calling of evidence by Mr. Reed for the defence was then resumed.

Dr. Walsh, resident surgeon, continued his evidence from Thursday, when the Commission adjourned. The wardsman, named Cook, in the male ward did not, he said, pass silver catheters, this being done by witness. Surprise visits were not made by witness to the wards to see that instructions were carried out.

Replying to Mr. McVeagh, witness stated that the demonstrators of anatomy in the Melbourne Hospital were doing dissecting work every day while they were on the honorary staff of the Hospital. Witness had seen them doing operations on indoor patients, but never an abdominal operation.

Mr. McVeagh: Was it not the practice to sterilise the dead bodies?—I don't know how they would sterilise them.

Was it not the practice to inject arsenic in the veins and arteries to protect the demonstrators from the dangers of the work?—Witness said there was some injection made of colouring-matter, but could not say what it was.

Dr. Roberton: The object is to prevent putrefaction?—I think so.

And protect the dissecting surgeon from the evil consequences of handling dead bodies?—I think it is done for their own comfort in doing the work.

Also to prevent the poisoning of wounds?—They do get poisoned wounds occasionally.

And when they do, is it not considered carelessness, or as showing that the body had not been properly preserved?—I don't know.

Mr. Reed intimated that he had intended calling Dr. Collins as a witness for the Board, but the doctor had had a very trying three weeks of it, and was ill in consequence. The strain on his nerves had been greater than the strain on the nerves of others engaged on the Commission, and none of them, he felt sure, were at all comfortable after the sittings in which they had taken part. Under the circumstances Mr. Reed said he felt justified in not calling Dr. Collins as a witness for the Board, but would put him in the box to enable questions to be put to him on oath. He did not propose to lead or examine Dr. Collins, but wanted to let him go away as soon as he was finished with.

Mr. McVeagh stated that, after hearing Mr. Reed's intimation that Dr. Collins did not propose to give evidence-in-chief, he was justified in deciding not to cross-examine Dr. Collins.

Dr. Collins was called and sworn.

The Chairman formally asked Messrs. Reed and McVeagh and Dr. Roberton if they had any questions to ask, and negative replies were received.

The Chairman: No one wishes to examine you, so you may go down, Dr. Collins.

Dr. Collins then requested and obtained permission to retire from the Commission.

George Joseph Garland, Chairman of the Hospital Board, was recalled by Mr. Reed. Speaking of the inquiry held by the Hospital Board, witness said the special meeting was held to straighten out an allegation made against the Hospital management and against the Medical Superintendent in particular by Dr. Neil. It appeared then that there was considerable friction between Drs. Collins and Neil. The Board considered it their duty to get the parties face to face, hear their opinions, and obtain the views of Drs. Mackellar and Bedford, consulting surgeons, if necessary. The decision of the Board, after hearing the evidence, was that the allegations had not been proved, and the Board, after conferring with the two medical advisers, came to the conclusion that they could not discharge Dr. Collins. There was nothing to prove that Dr. Collins was to blame, and his supervision of the Hospital was necessary. Further, that Dr. Neil's services could be dispensed with, as the department he supervised had previously, for some years, been in charge, and was still, of Dr. Scott. It was useless to try and get the two medical men to work in harmony while the friction that was evidenced existed, so Dr. Neil was suspended. Witness said that the Board appointed the Senior Medical Officer principally on account of public opinion, which insisted that there should be a medical head at the Hospital. The honorary staff was not always available when required. He considered that if the honorary staff were going to run the Hospital they should give some assurance that they would keep their engagements.

Mr. Reed: Has there been any friction with the honorary staff during your Chairmanship, except in regard to Dr. Neil?—No; with this exception, greater harmony has existed between the Board and the staff than has been the case for a great number of years.

It has been suggested that the Senior Medical Officer was appointed for the purpose of being a spy upon the honorary staff?—That is not correct.

Mr. Reed: You have heard it suggested by Dr. Purchas that members went on to the Board for what they could get out of it?—I give that an emphatic denial.

The fact of an undertaker being on the Board has been mentioned?—I was not Chairman then.

Is there any member of the Board who, so far as you know, derives any benefit, directly or indirectly, from any Hospital contracts or services?—No.

Does the *personnel* of the Board compare favourably with that of other local bodies in the district?—I would rather not judge. I will leave the public to judge. They are all well-known men, and I do not think that very much can be pointed at them.

The Chairman: They are representative men?—Yes, they are; men of good quality and sound opinion, with whom I have had much pleasure in sitting.

In regard to the operating-theatre, witness said that the money spent on it was a bequest by the late Mr. Wolfe.

The Chairman: For what purpose was the bequest left?—For any purpose desired by the Board.

Witness said the plans of the operating-theatre had been submitted to and approved by the honorary staff. The staff also advised that the Senior Medical Officer and the Board's architect should visit some of the southern hospitals, and the Board acted upon this advice. The two letters from the honorary staff (one approving of the plans and the other recommending that the Senior Medical Officer and architect should be sent South) were produced and read, both being signed by Dr. Neil, as secretary of the staff.

Mr. Beetham: How was it proposed to utilise the theatre in connection with the work of the main building?—The Board's scheme was to erect a two-storied brick building, containing four surgical wards.

The Chairman: Mr. Reed told us the other day that it was your intention to turn the children's hospital into surgical wards?—It was intended to do that until the new building was erected.

The Chairman: Dr. Williams has told us that the wards are unfit for surgical cases.

Mr. Reed: Dr. Neil said, in his evidence, that when he applied for the position of Senior Medical Officer he had no intention of returning to New Zealand for a year. Did he state that at the time?—His letter made no mention of that.

Witness said that his interpretation of the rules regarding operations was that when the surgeon for the week was not present the Senior Medical Officer should perform the operations.

The Chairman: But the rules say that all major operations shall be performed by the honorary staff?—That, I take it, means urgent cases.

The Chairman: But "major operations" includes "urgent" cases.

Witness: I do not think so.

The Chairman: Then you cannot understand English.

Witness, questioned as to the rules, said that they were the result of the combined wisdom of the honorary staff.

Mr. McVeagh: And the Board?—Yes, and the Board; they acquiesced.

Mr. Reed: What did Dr. Neil say to you in regard to the operating-theatre and Dr. Collins?—He said that he (Dr. Collins) was turning the Hospital into a "damned shambles." There was no doubt about the expression in my mind.

Continuing, witness said he approved of the members of both the Board and the honorary staff being elected for three years, members of each body to retire in rotation, and to be eligible for re-election. He approved of the appointment of assistant honorary surgeons. He favoured the following mode of electing the Board: The local bodies to elect six out of nine members, the medical men two members (not of necessity medical men), and the Government to appoint one member.

Do you think the Hospital Board should be distinct from the Charitable Aid Board?—That is a minor matter, and it makes very little difference, as one set of men would raise the money and another set would spend it. If two rates were struck things might go better, but there would be double administrative expenses.

Do you think the Hospital should be free to all?—No. I think the present arrangement of a fixed charge (with reductions in deserving cases) is the best one.

Supposing the rules said that the maximum charge should be £1 a day, and that patients should be charged according to their circumstances, would that be better?—I do not think so, as it might deter people from going into the Hospital.

Mr. McCarthy said that under present circumstances a wealthy man could go into a hospital and get an operation, worth, perhaps, £100, performed for the small amount of the Hospital fees.

Mr. McVeagh: Did you not think that Dr. Neil's complaint should have come through the Senior Medical Officer?—Yes, or through the honorary staff.

Why did you not suspend Dr. Neil when he first made his statement to you, instead of waiting from May till August?—Because I was satisfied that it was a lie. I made inquiries at the time, and found that it was incorrect.

Why did you not suspend him directly it was made?—Well, Dr. Neil had made the statement then only to me, and not to others.

Did you suspend him ultimately because he made communication to others?—Partly, and partly because I saw there was an untenable position.

When Dr. Neil was suspended, did you decline to give him the reason when he asked for it?—Yes; I never give reasons for anything unless I like. It is only a fool who tells all he knows.

When you called the special meeting of the Board to discuss the question, did you tell Dr. Neil the purpose of the meeting?—No; but he knew, and the proof of his knowing was the fact that he drew a brief from his pocket and read it.

Was he acquainted by you or any official of the Board with the object of the meeting?—No; but he got a letter similar to that received by the other members of the honorary staff.

Mr. McCarthy: He was the only person that was charged. Is that not so?—Yes.

Mr. McVeagh: What notices were sent to the members of the honorary staff, Dr. Garland?

Witness: Don't call me "doctor"; I do not like it.

Mr. McVeagh: I beg your pardon; they are not in very good repute just now. Was not more than one letter sent to some members of the honorary staff?—I cannot say, but the letter-book will show.

On the letter-book being produced, it was shown that a second notice was sent to Drs. Craig, Parkes, and King by the Secretary,

stating that he was directed by the Chairman to inform them that their attendance was absolutely necessary, and requesting them to be present.

Mr. McVeagh: Why did you have the second letter sent to these three doctors?—Because I was informed that they were present at the operation.

Questioned about what he said regarding the double letters at the inquiry conducted by Dr. MacGregor, the witness said he did not remember what he stated, provoking a retort from Mr. McVeagh: "You carry your memory back very well to the 'damned shambles' incident." After being reminded of what he said, the Chairman admitted that he sent a second letter to the doctors who were present at the operation, particularly requesting their attendance at the Board meeting. The discussion at the Board inquiry was chiefly in regard to the White operation, and statements were made by five or six doctors.

Mr. McVeagh: And the Board was directly influenced by the discussion on the operation?—We heard the evidence, and came to the conclusion we did.

Was the Board entirely influenced by the discussion on the operation?—It would appear, from what happened, that they were.

You made a charge that Dr. Neil was absent from the Hospital for a period of over seven days?—The books proved it.

Did not Dr. Neil say he was not absent for such a period?—I believe he did.

The position was, then, that Dr. Neil's statement was not relied on?—We took the book as reliable.

Have you gone to the trouble to ascertain if any other doctor had been absent for more than seven days?—After some hesitation witness replied in the affirmative, and said he had found that other doctors had been absent for that period.

Have not they been suspended?—Well, a satisfactory reason was given in one case, at least.

The witness said it had not been officially brought under his notice that patients had suffered through Dr. Neil's absence from the Hospital. He may have told Mr. Bruce that Dr. Neil had been suspended because he had been absent from the Hospital for seven days.

In the course of further cross-examination witness said that, owing to the difficulty in getting the honorary staff at the Hospital, it was thought desirable by the Board to appoint a Senior Medical Officer. Dr. Collins, since his appointment, had always lived outside the Hospital grounds, unfortunately, but occupied houses which were connected with the telephone service. The practice of admission by certificate had been inaugurated after a conference of local bodies, the conference making the recommendation on account of the statement made that all and sundry were admitted to the Hospital. Such a statement did not suggest to witness that there was some laxity of method on the part of the Hospital resident staff. The Board would be responsible, because the practice of admitting all who went along to the Hospital had grown up before Dr. Collins's appointment.

Asked about his statement at a meeting of the Board to the effect that he would, if he remained Chairman, abolish the honorary staff, the witness said he made the pronouncement in the heat of the moment to Drs. Bull and Scott, and was sorry afterwards that he had made it.

Mr. McVeagh: But you said later on, at the same meeting, that you were convinced, after five years' experience, that it was the best thing, and you would do your duty and move for the abolition of the staff. Evidently you did not change your opinions.

Dr. Roberton: And in your evidence the other day you still thought the same?—To a certain degree.

Have you estimated what would be the cost of getting rid of the honorary staff?—I haven't any idea.

On the matter of the honorary staff not always being available, Mr. Garland said he would not contest the statement made by Dr. Mackellar that during the doctor's long experience there was only one occasion on which he could not attend the Hospital, and immediately got another member of the honorary staff to take his place. The medical man in charge would know better than witness as to whether a honorary could always be secured to attend an urgent case.

You say that the honorary staff wished to take charge of the Hospital. When was that wish expressed?—I think the evidence at this Commission has gone to prove that that was so.

The witness said Rule 140, requiring the medical men in giving a certificate for admission to state the complaint, circumstances, and surroundings of the patient, was not enforced on the suggestion of the medical men, but was the outcome of the Local Bodies' Conference.

Witness said, in the proposal to convert the children's wards into surgical wards, matters would have to remain as they were until the Board could carry out the contemplated scheme already outlined to the Commission. The honorary staff had not been informed of the Board's proposals, nor had it been recorded on the Board's minute-book.

Dr. Roberton: Was not the interpretation of the rules made so that the Senior Medical Officer could do as he liked?—That was not the Board's intention. Mr. Garland stated further that he believed the rules had been approved by the Inspector-General of Hospitals.

The Chairman: The Commissioners would like to ask you a few questions. We have heard a good deal of Dr. Hooper. He is the person to whom applicants for admission to the Hospital are sent if the porter or the manager do not feel that their diagnosis of the case is satisfactory. (Laughter.) How far from the Hospital does he live?—

Dr. Hooper occupies the position for the purpose of giving medical certificates to indigent persons, and to any person whom the Board may send to him.

I am asking another question; I am not asking what his duties are. Are patients sent by the manager and the porter to Dr. Hooper to obtain free orders for admission?—They can go to him free of cost.

How far from the Hospital does he live?—I suppose it is a mile.

The Chairman: That is satisfactory!

You say there is no abuse of the powers given the Board to issue orders for admission?—I don't think so.

The Chairman: You were a patient. Can you tell us who gave you an order to enter the Hospital?—My medical attendant.

How long were you there?—About three weeks.

What ward did you occupy?—One of the small wards in Costley.

Who usually occupies it?—The doctors or nurses.

And the nurses were turned out to make room for the Chairman?—No one was there at the time, Your Honour.

But you say it was occupied by nurses?—Not at the time; it was not wanted.

The Chairman: From what we saw of the apartments for the nurses, I should say that the small ward was very much wanted.

You say you were there for three weeks, and got medical advice?—Yes.

The statute says a patient should pay according to his means. Will you tell us what you paid?—I went to the house steward and asked for my account.

What did you pay?—I paid the regulation fee.

There is no regulation fee. There may be an illegal fee; but what did you pay?—I believe I paid 4s. 8d. a day.

As Chairman you obtained an order to go in, you occupied the small ward, to the exclusion of the nurses——

The witness: My doctor insisted on me going to the public Hospital. I wanted to go to a private hospital, but Dr. Scott said I should, as Chairman, go to the public Hospital.

The Chairman: You went, being Chairman of the Board. I don't see that you were bound to follow the insistence of your doctor. And you had medical advice while you were there?—Yes.

And you say you are a representative man?—Yes.

The Chairman: I have been on the bench forty-two years now, and a very large number of Chairmen have been before me, but this is an entirely new experience. You can go down now.

Before proceeding to examine his next witness, Mr. Reed inquired of the Chairman if the terms of the Commission entitled them to take evidence outside the Commission proceedings. He pointed out that questions had been asked the Board Chairman which had not been elicited in any way in the course of the proceedings, which made him (Mr. Reed) wonder if any communications had been made to the Commission.

The Chairman replied that the particular matter referred to had been the subject of public discussion in the newspapers at the time, but the Commission was not taking outside evidence.

Mr. Reed: I took it that the information had been conveyed in some way, Your Honour.

Supposing the information was conveyed, that makes no difference. Anything that takes place outside the Court does not enter into consideration. You don't suggest, Mr. Reed, that the particular question is not one that comes within the limits of the Commission?

Mr. Reed said he thought that communications had been made to the Commission outside of the Commission proceedings.

The Chairman: We cannot restrict communications; we cannot restrict the post. You had better proceed with your witness, Mr. Reed.

Mr. Reed: I was just going to ask Your Honour that if communications are made behind the backs——

The Chairman interposed that Mr. Reed had no right to ask what communications had been received. The Commission had received any number of communications.

Mr. Reed: It is unfair to us, if they are likely to influence the parties affected.

The Chairman: Nothing but what we hear in Court is likely to influence the Commission. You had better go on with your witness.

Mr. Reed said he would like to point out that with some previous Commissions evidence was collected outside of the Commission, and he wondered if the same power had been conferred on the Hospital Commission.

The Chairman replied that they were not confined to any one.

Mr. J. R. Walters said he was chairman of the Fees Committee. The means of all patients were investigated, and the Board did not take proceedings against any one upon whom it would be a hardship.

Questioned by Dr. Roberton, the witness stated that he could not account for the complaint made by people to medical men that they were too poor to pay the fees.

Mr. Beetham: You did not charge more than the minimum to any one?—No.

Mr. Reed intimated at this stage that he had only one other witness, Mr. Bollard, M.H.R., who was arriving from Wellington by the "Rotoiti," which had been delayed by bad weather.

The Commission decided that it would be convenient to take Mr. Bollard's evidence to-day, when some complaints by Mr. Eugene Hulse are to be inquired into.

Dr. MacGregor rose to make an explanation in regard to the statement made by Mr. Garland that he (Dr. MacGregor) had approved the

rules framed by the Hospital Board as to Dr. Collins's position. He stated that the consent of the Colonial Secretary had to be obtained under the Act. The rules would be referred to him (Dr. MacGregor) by the Colonial Secretary, but he had not approved of the modifications made in connection with Dr. Collins's authority. He had condemned the rules absolutely, and the construction placed on them by the Board. Since the Act was passed in 1886 there had been two mutually exclusive systems, and the one he had always advocated was a staff of two or three junior residents, under the absolute control of the honorary medical staff. A departure from that had been made in the case of Dr. Floyd Collins, with the result that he was in much the same position as Dr. Collins now found himself. The Board had persisted in trying to establish a middle ground, which was nonsensical and absurd, and tended to establish a state of things with which no self-respecting medical man would consent to associate himself. The doctor said he had been waiting for the Board to be convinced of the absurd position they were trying to set up, but neither the Government nor himself had called upon the Board to stop experimenting. Under these circumstances he advised the Colonial Secretary to approve the rules, because the Colonial Secretary and he were doubtful if they could refuse. The only way to have any effect would be to stop the subsidy to the Board, but they were both doubtful if they could do that.

Further questioned, Dr. MacGregor stated that in the other three large city hospitals the same rule obtained as at Auckland in regard to the payment of fees, but he gave the latter body credit for making an honest effort to collect the fees from persons for the treatment they expected to get gratuitously out of the State, which they should be ashamed to accept, because it was charity. He said his opinion was that the whole hospital legislation of the colony went in the direction of putting a premium on the pretence of pauperism.

The Commission then adjourned.

The Commission continued its sittings on Saturday, the 5th November.

Mr. William Peake made a statement in connection with evidence given by Nurses Lyon and Dewar. At the time, he said, that he removed the bandages from his jaw the circumstances were that the bandages, being calico and tightly fixed, had shoved his jaw out of position and jammed his teeth painfully against the roof of the mouth. He had to shift the bandages to get the jaw back in position and thus relieve the pain. Regarding the statement that he had persisted in sitting up, he had to do that when his jaw was being attended to. When in a private hospital, under the treatment of Dr. Lewis, he was permitted to sit up, even though the fracture, after being broken and reset, was then in a worse condition.

Mr. John Bollard, M.H.R., said that when he first became a member of the Board, fifteen years ago, the honorary staff had resigned in a body, as well as the resident staff. The Board then advertised for an experienced medical man to take charge, Dr. Floyd Collins being appointed out of forty applicants. An inquiry was afterwards held into a complaint, and Dr. Collins resigned. Dr. Baldwin was appointed, so that an officer would be in charge who could attend to emergency work, but his life at the Hospital became so unbearable that he took the first opportunity to leave. Dr. Baldwin did not have the same status as the members of the honorary staff. In the appointment of Dr. Collins the Board had determined to have a man who could competently do serious emergency work, and to place him on the same footing as the honorary staff. Dr. Collins was looked upon as a great acquisition, and witness had never heard that he had done more than his share of the surgical work. He had never heard it complained that patients had any hardship inflicted on them through the payment of fees. A return prepared by the Board's Secretary showed that only 7 per cent. of the people entering the Hospital were able to pay the fees levied.

Mr. Reed proceeded to question the witness relative to a conversation which occurred between him (Mr. Bollard) and Mr. Garland in connection with the latter's admission to the Hospital. The Chairman ruled the matter out of order, maintaining that Mr. Garland had already given his reasons for entering the Hospital, and for them to be repeated secondhand by the witness was not evidence. Mr. Reed then said he would obtain from the witness what advice he tendered to Mr. Garland on the occasion, and His Honour said that such advice could be stated.

Mr. Bollard said that when Mr. Garland expressed to him his intention of going into a private hospital he (the witness) strongly advised him to go into the public Hospital, on the ground that it would tend to restore and maintain public confidence in the institution. If the Chairman of the Hospital Board went into a private hospital, as was his keen desire, it would not have been in the interests of the public Hospital.

Mr. Reed: Do you know if the reason of Mr. Garland going into the public Hospital and receiving treatment there was to save the difference in the charge between that institution and a private hospital?—I am fully satisfied from our conversation that his intention was to go to a private hospital.

Questioned by Dr. Roberton, the witness said he did not know of his own knowledge if Dr. Baldwin carried out emergency work, but the honorary staff had complained that he was incompetent to do the work. Dr. Baldwin had said his position at the Hospital was made unbearable by the honorary staff, and two members had done their best to induce the Board to dismiss him. Witness thought it would be an oversight in the rules if it did not state that Dr. Collins was to have the same status as members of the honorary staff.

Dr. Roberton: You say there never has been such harmonious working as during Dr. Collins's term of office. Have you at any other time seen so many changes in the honorary staff?—Some of the honorary staff made themselves so disagreeable that the Board decided not to reappoint them.

You are aware that lately the resignation of nurses has been unprecedented?—I know one or two resigned at one time, but I think there has not been such harmony amongst the nurses since Dr. Collins's appointment than previously. I heard that nurses had been induced by doctors to leave and go into private hospitals.

Questioned by the Chairman, the witness said he remembered the case of Rigly, to whom he gave the usual certificate of admission. The certificate said that if there was room and the patient was a fit person for admission, to take him in. Witness had at different times given similar orders.

Mr. Reed intimated that he had no further witnesses to call on behalf of the Board.

Mr. Beetham drew attention to No. 18 of the charges made against Dr. Collins, and which, he said, had not been inquired into, and which, on the face of it, appeared to be a very serious matter. The charge was, "That the said James Clive Collins, on the 14th July, 1904, at the Auckland Hospital, performed the operation of hysterectomy upon Ethel Maud McIndoe, aged eighteen years, and the said operation was unnecessary and unjustifiable."

Dr. MacGregor was called up and his opinion asked on the matter. The doctor said he knew nothing about the case beyond what Dr. Neil had stated in the presence of the Minister and himself at Wellington. He had expected that particulars of the case would be supplied during the Commission, but none of the facts had come out in evidence.

Mr. Beetham reminded Dr. MacGregor of a conversation they had had that morning, when the doctor drew attention to the fact that the charge had not been inquired into; further, that the doctor had said the patient had been admitted on an order from Dr. Marsack, who diagnosed the case as one of abscess in the pelvic cavity, and cellulitis, a certain treatment of which would probably have saved the girl's life. Dr. Parkes, however, it was alleged, had diagnosed fibroid tumour, and had commenced the operation of hysterectomy, which Dr. Collins finished, the patient eventually dying. Mr. Beetham asked Dr. MacGregor whether he understood these to be the facts of the case.

Dr. MacGregor: Yes.

Mr. Beetham: Under these circumstances the Commissioners will probably desire some other evidence on the matter.

The Chairman: Certainly.

Dr. Roberton stated that he had no doubt that Dr. Parkes, who was a member of the Medical Association, would be quite prepared to explain what he had to do with the case.

Dr. MacGregor added he had been told it was not a charge against Dr. Collins, but his (Dr. MacGregor's) feeling was that it was not a question of a charge against any individual, but a question of the surgical practice in the Hospital which had to be justified.

The Commissioners said that they intended to thoroughly investigate the charge.

Mr. McVeagh stated that he had not been able to get complete evidence as to the case. He had not been able to get all the witnesses who were present at the operation, while he could not very well go to the two doctors mentioned and ask them for a statement.

Mr. Beetham: What about Dr. Marsack?

Mr. McVeagh: I was not aware that Dr. Marsack was concerned.

The Chairman said they would issue subpœnas calling on the doctors concerned to attend, and it was decided to go into the charge this morning.

The complaints made by *Mr. Eugene Hulse*, on the score of improper treatment at the Hospital of his adopted son by Dr. Bull and nurses, were proceeded with. At the outset Mr. Hulse asked for the production of the bed-chart, and complained to the Commission that he had been balked in his searching of the Hospital books by a member of the resident staff, although Dr. Collins had given instructions to afford him (Mr. Hulse) every facility in his efforts to collect the requisite particulars relating to the treatment of his son.

The complainant (Mr. Hulse) went into the box, and stated his son was admitted to the Hospital on the 5th March last on a certificate given by Dr. Lewis to the effect that he was suffering from enteric fever. Witness and his wife frequently visited the Hospital to make inquiries about their son, and were told that he was doing well. From the Hospital books since witness learnt that three tests had been made of the patient's blood within fourteen days, and after the third it was discovered that his complaint was not typhoid fever. For five weeks the real complaint had been kept a secret from witness, and he contended that through negligence in making a wrong diagnosis a lung-affection had developed into acute consumption. Only sterilised milk was given the patient, and this, the witness said, was not sufficiently nourishing for the boy. The bed-chart stated that he was discharged as "cured," whereas when witness took him to Dr. Bakewell three days after his discharge from the Hospital the doctor said the left lung was very bad and that he was past recovery. The patient had since died.

Questioned by Dr. Bull, witness said that it was about the sixth week when he became dissatisfied with the treatment, but he thought he would have been dissatisfied before had he not been kept in ignorance of the patient's complaint. The only person he stated his objection to was Nurse Margetts. The lung-disease had been brought on,

in his opinion, by improper diet. Had he not been ignorant of the real state of things he would have reported the improper treatment to the Hospital authorities.

The Chairman (to Mr. Hulse): I suppose you have all your witnesses ready?

Mr. Hulse: I will have them on Monday morning.

The Chairman said they could not keep the Commission open interminably. Witness had had three weeks in which to prepare his case and should be ready.

Mr. Hulse called *Nurse Jordan* as the next witness. She said she was in charge of the typhoid-fever ward in March last, and knew Mr. Hulse's adopted son. She did not know the actual complaint. There was no difference between the treatment of him and other typhoid patients.

Replying to Dr. Bull, the witness said the doctor saw Hulse shortly after admission, and continued to examine him frequently afterwards. Fluid diet was not restricted to sterilised milk. Light diet was given subsequently.

Dr. Walsh, resident Hospital surgeon, stated that he was resident physician when the patient Hulse was admitted. His diet was not confined to sterilised milk, but contained the usual variety given in such cases. The blood-tests for typhoid gave negative results, but subsequent tests of sputum (which were delayed by absence of expectoration) disclosed tuberculosis, and Dr. Bull saw the patient three or four times a week. He had never heard of the patient fainting on the verandah. As to a consultation, that was only necessary in doubtful cases, and this case was not regarded as a doubtful one. On being questioned by Mr. Hulse as to the open-air treatment of consumptives, witness said there might be no harm in placing the bed under an open window in all weathers, fresh air being a great essential. The patient was suffering from a disease which produced crepitation of the lung. Witness had not made out the bed-chart, but if the chart said that the patient was discharged as cured it was incorrect. When the patient's temperature went down he was given more solid food.

Mr. Schofield, manager and house steward at the Hospital, produced the bed-chart, which contained the entry, "Phthisis; cured."

The Chairman: Whose handwriting is that entry in?—I think it is Dr. Collins's.

Mr. Hulse: In whose handwriting is the other portion made out?—I do not know.

How long is it since that entry was made?—About the time the patient was discharged.

Nurse Margetts, who had been on duty in the ward whilst the deceased was there, also gave evidence as to the quality and quantity of the food supplied, and which, she said, could give no cause for complaint.

On being questioned as to whether patients' complaints were entered in a book, she said they would be attended to at the time and would not necessarily be recorded.

The Chairman: If they were, all the hospitals in creation would not hold all the books which would be required for the entries.

The Chairman: Have you any other witness?

Mr. Hulse: No.

Dr. Bull: I would like to state, Your Honour, that the entry on the bed-chart as to the phthisis being cured was made without my knowledge or authority, and that I was not in any way responsible.

The Chairman: We are quite satisfied, Dr. Bull, that you have nothing to answer. It is very much to be regretted that this poor lad should have died after leaving the Hospital, especially after the bed-chart said he was cured, but there is nothing to show, so far as the evidence goes, that his treatment at the Hospital was not all that could be desired. The whole thing seems to have arisen from an apparent misconception by Mr. Hulse, who had got hold of the opinion that because a pint and a half of sterilised milk per day was ordered, that that was all the patient had. Nothing is shown against you, Dr. Bull, and you have nothing to answer.

Dr. Bull: Thank you, Your Honour.

Mr. Hulse: I am sorry, Your Honour, that you did not permit me to proceed a little further and examine Dr. Bull.

The Chairman: You closed your case.

Dr. Bull: I am perfectly willing to be cross-examined.

The Chairman: It is not necessary.

The Commission then adjourned.

Monday, the 7th November, was devoted by the Commission to an investigation into the circumstances attending the death of Ethel Maud McIndoe, on whom it was alleged the operation of hysterectomy had been unjustifiably performed in the Hospital. Mr. J. R. Reed appeared on behalf of the Hospital Board and Dr. Collins (Senior Medical Officer), Mr. F. Earl on behalf of Dr. Parkes, and Mr. Singer (for Mr. Baume) on behalf of the relatives of the late Miss McIndoe.

The case inquired into was the one referred to in No. 18 of Dr. Neil's charges against Dr. Collins, which read as follows: "That the said James Clive Collins, on the 14th July, 1904, at the Auckland Hospital, performed the operation of hysterectomy upon Ethel Maud McIndoe, aged eighteen years, and the said operation was unnecessary and unjustifiable."

Mr. McVeagh stated that he had further investigated the case since Saturday, and as he felt that the charge could not be substantiated he did not propose to call any evidence.

The Chairman: Well, then, considering the quarter from which we obtained our information, we think it necessary to call evidence ourselves.

Dr. Marsack, the first witness called by the Commissioners, said that he saw the late Ethel Maud McIndoe on the 18th April, when she was taken to him by her mother. Witness examined her and found her suffering from pelvic cellulitis. Her mother asked for an order for admission to the Hospital. Witness gave the order, and he considered it absolutely necessary that she should have skilled nursing and certain treatment which could not be carried out in her own home.

The Chairman: What treatment did the case suggest?—Constant douchings with antiseptic solutions. I did not have an opportunity of examining her under an anæsthetic. I never saw her again.

In reply to Mr. Singer, witness said that the condition he had described was always accompanied by a low state of the general health. It was a condition which was always dangerous sooner or later.

Mr. Singer: If the treatment you recommended had been followed, would the patient have been likely to recover?—That is a difficult question to answer. There was a possibility at any time of an abscess forming, which might have burst and led to either chronic invalidism or death. There was nothing to show that an abscess had burst when I saw her.

Was the condition such as to justify a serious operation?—At that time, no.

If the organs removed were in a healthy condition, should they have been removed?—If perfectly healthy, I should not think it justifiable to remove them.

Mr. Singer said that he would like Dr. Marsack to examine the organs which had been removed, and the completion of his evidence was postponed till later in the day.

Dr. Frost, honorary pathologist at the Hospital, said she saw Miss McIndoe the day before the operation. Witness was asked by Dr. Collins to examine her. Witness examined her in the presence of Dr. Scott and Dr. Collins. The examination disclosed what was termed a fluctuating mass in the uterus. Dr. Scott suggested puncturing the mass with a trocar and canula. Nothing was said in reply to this suggestion, so far as witness remembered. She did not form any definite opinion herself, as it was a peculiar case. It was not a formal consultation, but she believed one had been held previously. Next morning an operation was performed, there being present Drs. Parkes, Collins, Ferguson, Walsh, witness, and some nurses. Dr. Parkes, on examining the patient under an anæsthetic, said there was a fluctuating mass. After the usual dilatation the operation of laparotomy was performed, and an unsuccessful attempt made to remove the mass. Dr. Collins then said that hysterectomy would be necessary, but witness did not remember whether Dr. Parkes said anything about that. Part of the uterus, with appendages, was removed.

Mr. Beetham: What was Dr. Parkes doing?—He was assisting, I think.

What conclusion did you arrive at?—I had no opinion; it was a very curious case.

You did not have any opinion at the time as to whether hysterectomy was justifiable or not?—No.

What was the condition of the portions of the organs removed?—I think they were healthy.

Can you express an opinion as to the desirability or otherwise of removing them?—I consider that the parts which were healthy should not be removed, but the surgeons may have had good reasons for it at the time.

Who actually removed the parts—Dr. Parkes or Dr. Collins?—I do not know.

Mr. McCarthy: One or the other?—Yes.

Mr. Beetham: Did Dr. Parkes commence the operation?—Yes.

Did he perform the whole operation?—I cannot say, but I know that Dr. Collins tied the arteries.

In answer to Mr. Reed, witness said that as an alternative treatment a trocar and canula might have been used. She thought Dr. Collins was present from the first, but Dr. Parkes was the surgeon in charge of the case. It was an extremely unusual case, and, whilst it might be easy enough to form an opinion on it now, it was very difficult to do so at the time.

In answer to Mr. Singer, witness said she agreed with Dr. Scott that a trocar-and-canula treatment would have been suitable. She was still of this opinion. This treatment would be simpler and less dangerous.

Mr. Singer: Is hysterectomy a common operation?—It is fairly common.

Did they start out with the intention of performing this operation?—I do not know; I was not at the consultation.

Do you think they had any idea that it was to be performed, or that it was premeditated?—I think it arose out of the necessities of the case.

Mr. Beetham: Was the mass, with the exception that it was drained, left as it was before the operation of laparotomy?—Yes.

Mr. Singer: Was the mass not an abscess?—Yes.

You discussed the matter afterwards?—Yes.

Did you then come to the conclusion that the operation was unjustifiable?

Mr. Reed objected to this evidence. The witness was technically the Commission's, but practically she was the witness of the person who had taken up the abandoned charge. He submitted that the witness could not be cross-examined by the person taking up the charge.

The Chairman: Mr. Singer is appearing for the relatives.

Mr. Reed: But he has practically taken up the position of prosecutor, and, under these circumstances, do you rule that he has a right to question the witness in this way?

The Chairman: Certainly.

Mr. Earl: The evidence shows that Dr. Parkes was the operating surgeon, and as such was the person in charge.

The Chairman: Assuming that that is so, there is no charge against him.

Mr. Earl: But a charge will probably be made; in effect, there is already a charge against him.

The Chairman: The charge which was laid by Dr. Neil against Dr. Collins was withdrawn, and on hearing the statement from Dr. MacGregor we decided to call evidence ourselves. According to the terms of our Commission, we are bound to go into it.

Mr. Earl: But if it develops into a charge against the operating surgeon, he is entitled, under the terms of the Commission, to twenty-four hours' notice.

The Chairman: The charge is against Dr. Collins.

Mr. Earl: The mere leaving-out of Dr. Parkes's name does not relieve him from the position of the person charged, and he is entitled to twenty-four hours' notice.

The Chairman: If a charge were made directly against him, of course he would be entitled to notice, but if his name only comes in incidentally it is a different matter. We cannot stop the evidence merely because another surgeon turns out to be connected with it. We shall rule against you.

Mr. Singer (to witness): In your opinion, knowing all that has passed, and having seen the parts which were removed, do you think that the operation of hysterectomy was justifiable?—No.

Do you think that the patient would have died so soon if the operation had not been performed?—I do not think the removal of the part caused the fatal termination at all.

What caused death?—Sepsis from the abscess.

Was there any evidence of a cancerous nature in the patient's condition?—I do not think so.

Mr. Beetham: Have you ever discussed the matter with either Dr. Collins or Dr. Parkes?—No. I spoke to Dr. Parkes about it one day, but did not discuss any essential point.

In answer to further questions at a later stage by Mr. Singer, Dr. Frost said that the shock incidental to the operation might have been an element in the causes of death taking place so soon after the operation. Witness said that when she gave her previous answer she did not know that death had taken place so soon.

Nurse Broun, in answer to Judge Ward, said Miss McIndoe was for a time under her care in the Hospital. She was present at the operation, but saw practically nothing of it, because she was supplying the wants of the surgeons. There was a consultation in her ward prior to the operation, but she did not know what took place. Dr. Parkes, Dr. Collins, and another doctor were present.

Nurse Maxwell said she was present at the operation. She took the patient to the operating-room. Dr. Parkes examined the patient. Dr. Collins came into the room, but did not offer to assist till he was invited.

Mr. Beetham: Who invited him?—Dr. Parkes asked him to assist, and he said, "Yes, certainly." The incision was made by Dr. Parkes, and they then went on with the operation, but I was busy.

The Chairman: Were both Drs. Parkes and Collins in the room all the time?—I cannot remember, except that Dr. Collins was not in the room when the examination began.

Who operated?—Dr. Parkes was the operating surgeon. Dr. Collins assisted him.

Anybody else?—Dr. Frost was present.

By Mr. Singer: Miss McIndoe was in the Hospital from the 18th April. The operation was on the 14th July.

Did she give any signs of wasting during that time?—I cannot say. She complained of headaches.

But she went for walks?—Yes; she was mostly up and about. She was attended by Dr. Parkes. She died on the 16th July.

Mr. Singer said that the operating-book showed that death took place on the 17th.

Mr. McCarthy: One operation-book says the 16th, the other the 17th.

Nurse Dewar said she was present at the operation, but did not see much of it, because she was attending to the wants of the surgeons. She could not say whether Dr. Collins left the room before the conclusion of the operation.

Nurse Wheeler, who was also present, said Drs. Ferguson, Walsh, Parkes, and Collins were in the room. When Dr. Collins came in Dr. Parkes said, "I have decided to do laparotomy. Will you assist me?" Dr. Collins said, "Certainly," and went and cleaned his hands. Dr. Walsh also assisted. Dr. Parkes made the incision, and after that I handed the instruments to Dr. Parkes.

Mr. Singer: Did you hand any instruments to Dr. Collins?—I did not. I am positive of that.

Mr. Reed: Can you say whether Dr. Collins remained in the room to the conclusion of the operation?—After the uterus was removed Dr. Collins washed his hands and left.

Mr. Singer: Did both Dr. Collins and Dr. Parkes use the knife?—There would be no reason for that.

Then you know, as a fact, that only one did?—Dr. Parkes was the operator.

And Dr. Collins did not use the knife?—I cannot say.

Did you see Dr. Collins with a knife?—No.

Dr. Frost, recalled, stated, in answer to Mr. Singer, that when the uterus was given to her there was no mass attaching to it. From her observation the mass was remaining in the body.

Dr. Walsh, resident surgeon at the Hospital, said Dr. Parkes decided to do laparotomy, and Dr. Collins was asked by Dr. Parkes to assist. The case was Dr. Parkes's case. Dr. Parkes opened the abdomen, and proceeded to remove the uterus. In my opinion, the greater part of the tumour or mass was removed.

Mr. Beetham: Why was the whole of it not removed?—It would have been difficult to remove from its connection with the organs.

No attempt was made?—It was separated from the bladder, but not from the floor of the pelvis.

Was there any chance of detaching it from the uterus?—I should say not.

In answer to Mr. Singer, witness said the diagnosis made of the case rested between hæmametra (blood in the uterus) or a tumour. That was at a consultation held two days before the operation. Witness was not present, but the consultation-book showed the names of Drs. Parkes, Scott, and Craig.

Mr. Singer: Was Dr. Scott, as a matter of fact, there?—I do not know.

Mr. Beetham: Then, the result of the operation did not bear out the diagnosis?—There certainly was a tumour.

Mr. Singer: Did Dr. Scott diagnose the case a day or two before?—He was in favour of hæmametra.

Can you see any justification for removing entirely healthy parts?—It may not have been possible to have left them behind.

If only healthy parts were removed and diseased parts left, would there be any justification for that?—Yes; because the condition of the patient was such that it was thought necessary to remove them.

But the object was to remove the mass; and if the mass was not removed, could you see any justification for the operation?—Yes, certainly. An attempt was made to remove it, and to do so certain steps were taken. When it was found impossible to remove the whole mass a portion of it was taken.

But if no part of the mass was removed, can you then justify the operation?—Yes, certainly.

Dr. Marsack, on being recalled by Mr. Singer, was shown the exhibits referred to in the evidence of Dr. Frost. By looking at them in the bottle he should judge that they were healthy.

Mr. Singer: Would the removal of these parts cause a severe shock?—There is always a certain amount of shock, which, however, may be transient. The extent of the shock depends upon the constitution of the patient.

The removal of these parts must give a further shock in addition to that given by any other act?—Yes, a certain amount.

If death resulted from one and a half to two days after the operation, would you say that death was accelerated by this operation?—It is very difficult to answer that question. Those present at the operation would be much better able to judge.

In answer to other questions by Mr. Singer, witness said he thought the case was one in which a trocar and canula might be employed. As to there appearing to be no disease evident on the parts as exhibited, he said it was possible that the diseased part might have been pulled off in the removal of it.

Assuming that these parts were perfectly healthy, can you assign any justification on the face of things for the removal of them?—Assuming that these were perfectly and absolutely healthy, I cannot. It was, from what I understand, a very difficult and peculiar case, and it might have appeared that what was done was the proper thing to do.

Would you have advised the puncture of the abscess?—I probably should, but I cannot say for certain.

In answer to Mr. Earl, the witness said that when the arteries were once cut, and the operation commenced, it would be necessary to complete it.

Dr. Parkes, on being asked by the Chairman whether he had any objection to giving evidence, said, "Acting under the advice of counsel, I prefer not to make any statement at present."

Mr. Earl said that Dr. Parkes was practically in the position of a person accused of manslaughter, and he thought somebody should father a definite charge against him.

Mr. Singer said that he was reluctant to formulate a charge, but he was willing to do so if it would assist matters.

Mrs. Ellen Smith, residing in Brighton Road, Parnell, said she saw Dr. Collins in company with Mrs. McIndoe after the operation. Dr. Collins told them that he did it as a last resource. From what Dr. Collins said she understood that he removed a tumour. She did not know that anything else was removed until a month after.

Dr. Hardie Neil, called by Mr. Singer, said he was present at the operation for two or three minutes. He understood that there was no result from the first part of the operation, and when he left he understood there was nothing left to do but laparotomy. He did not hear a word about hysterectomy.

Mr. Singer: Did you ever hear Dr. Collins say anything about hysterectomy?—I remember him saying he had never performed hysterectomy, but I have no distinct impression as to when it was he said that.

Did he express any desire to perform the operation?—That is not a fair question. Almost every surgeon would have a desire to do it at the proper time.

In answer to further questions, Dr. Neil said he saw the parts in the Hospital laboratory, and remarked that they were perfectly normal. He also saw them at a meeting of the Clinical Society.

Mr. Singer: Are your feelings at all strong on this particular case?

Mr. Earl: What have his feelings to do with it? I object to this nonsense.

The Chairman: You need not go into that. Besides, a medical man is not supposed to have any feelings.

Mr. Singer: I will refer to Dr. Neil's thoughts about the operation.

The Chairman: You must give us somthing positive. Really, we cannot take thoughts and feelings.

Mr. Singer then questioned Dr. Neil as to whether he thought the operation justifiable, and Dr. Neil replied that he thought the operating surgeon should be allowed to explain before he (Dr. Neil) answered the question.

In the case of death resulting a day and a half or two days after such an operation, would you say that death was due to shock from the long operation?—That would have been a contributing factor. The removal of these parts would undoubtedly cause shock.

Can you see any justification for the removal of these parts on the evidence you have heard to-day?—Dr. Walsh has given an explanation.

But Dr. Walsh said the mass was attached?—There is no mass attached.

If the parts were as they are now, in a healthy state, can you assign any cause for their removal?—I cannot at the present moment.

Mr. Singer then intimated that he wanted an opportunity of examining Mrs. McIndoe, who was coming from Henderson. He said Mrs. McIndoe's permission was asked for an operation, but no mention was made about the operation which was ultimately performed.

The Chairman: The claim on the other side would be that the operation having been commenced it was necessary, in order to have a chance of saving the life, to pursue it to the end. Even if what you claim is correct, it would only be an error of judgment, and it has hardly been shown to be that yet. The only point we have is that the organs removed appear to be perfectly healthy, and the consensus of opinion seems to be that where organs are healthy they should not be removed; but as to the necessity for removing them the surgeons performing the operation would, in all ordinary circumstances, be presumed to be the best judges.

Mr. Singer: Yes; but up to this point the surgeons have not justified their action.

The Chairman (to Mr. Earl): Dr. Parkes was subpœnaed as a witness. Do you claim exemption from giving evidence? There is only one ground on which you can claim that.

Mr. Earl: Dr. Parkes's position is practically that of an accused person, and he has not been given twenty-four hours' notice of the charge. I am not in a position to advise Dr. Parkes whether he should go into the box until the evidence for the prosecutor is finished.

The Chairman: But we have a right to call him at any time.

Mr. Earl: I submit that you have hardly a right to call on him until the case against him is finished.

The Chairman: If you say that in fairness you ought to have twenty-four hours' notice, then ask for an adjournment.

Mr. Earl: That is what I have asked all along. No particular charge has been formulated in this matter, and I submit it is not a fair position to put Dr. Parkes and Dr. Collins in.

Mr. Singer: I don't wish to put Dr. Parkes in an unfair position. I will formulate a charge.

Mr. Beetham: Not against Dr. Collins.

Mr. Singer: Yes; against both.

Mr. Beetham: Dr. Frost had left the position open. The only person who could clear up the matter has refused to do so. Dr. Frost has thrown some doubt on the propriety of certain things done at the operation, but in my mind that is as far as her evidence goes. We have had a very straightforward account of the operation from Dr. Walsh, and if the matter is to be left in an unsatisfactory condition, all I can say is that the persons who took part in it are to blame.

Mr. Earl and Mr. Reed both intimated that they would be satisfied with an adjournment till the next morning, and Mr. Singer said he would at once formulate his charge.

The Commission then adjourned.

On the Commission resuming after the luncheon adjournment, Mr. McVeagh read a telegram which he had received from Dr. Baldwin, in which the latter denied that he was dissatisfied with his status in regard to the work of the Hospital, or that he had left the Hospital on account of friction with the honorary staff.

The Chairman: We cannot take that as evidence.

Mr. McVeagh: No, Your Honour; I only mention it in an informal way.

On the resumption of the sittings of the Commission on Tuesday, the 8th November, a joint charge in connection with the operation of hysterectomy on the late Ethel Maud McIndoe was lodged against Dr. Parkes and Dr. Collins by Mr. Singer, on behalf of the relatives of the late Miss McIndoe.

Mr. Singer intimated that he wished to call Dr. MacGregor. He said that he had also asked Mr. Copeland Savage to give attendance, but, as the latter had replied that he would probably be called by the

Commission, he (Mr. Singer) had taken no further steps in the matter.

The Chairman: We have not called Mr. Savage, and we have no intention of calling him.

Mr. Singer: There was evidently a misunderstanding, Your Honour; but I think it is absolutely essential that some independent surgeon should be called to give expert evidence. I think it is also advisable that there should be an exhumation.

The Chairman: We have no power to order that.

Mr. Singer: It was done in Wallis White's case, I understand.

The Chairman: Yes; but we did not order it. You should apply to the Colonial Secretary.

Mr. Singer (reading from a printed copy of the Commission): The Commission gives Your Honours power "by all lawful ways and means to examine and inquire into any matter or thing touching the premises," &c.

The Chairman: Our Commission, however wide it may be, gives us no power to order an exhumation. You must apply to the Colonial Secretary for that.

Sarah McIndoe stated that the late Miss McIndoe was her daughter. She saw deceased twice after she was admitted to the Hospital. On the day before the operation Dr. Collins, by means of a blackboard sketch, described the patient's condition to witness, and said, "We are trying in every way possible to get rid of the trouble without an operation." Dr. Collins added that he objected to an operation except as a last resource. Witness said she would leave the matter in his hands.

Mr. Singer: Do you know anything about other doctors being consulted?—He said that they had had consultations.

Witness said that she saw Dr. Collins again the next day shortly after the operation. He then again described the position on the blackboard, and said that they had with the greatest difficulty removed a large tumour, and that if the patient survived the shock he did not see why she should not improve.

Mr. Singer: Did he intimate that anything else but a tumour had been removed?—He said, "You understand now that all is removed." I understood from that that there was no chance of the tumour returning.

Witness said she had no further conversation with Dr. Collins till shortly after the girl died, when he expressed sorrow on account of her daughter's position, but said that if she had pulled through she would have been an invalid for a very long time.

Mr. Singer: Did he say anything about the size of the tumour?—Yes. I asked him how large it was, and he replied by putting his two hands together, giving me to understand that it was about as large as a bullock's heart.

Did Dr. Collins say he performed the operation?—I asked him if he did the operation, and he said "No"; that Dr. Parkes did it, and that he (Dr. Collins) was present.

Mr. Reed: You were naturally very agitated at the time?—Yes.

And you are hard of hearing?—Yes, I am; but I quite understood all that Dr. Collins told me.

Mr. Earl: Have you made a complaint to the Commission in connection with this case, or have you authorised any one to sign your name to a complaint?—No. I live a long way out of town, and my daughter has had most to do with the case.

Mr. Singer: It was explained to you this morning, was it not, that a charge had been laid in your name, and you approved of that?—Yes.

Dr. MacGregor, on being called by Mr. Singer and questioned as to whether he considered that the removed organs (exhibited on the previous day) were healthy, said it was impossible to answer the question from a mere casual inspection of the specimen in the bottle.

Mr. Singer: I should like Dr. MacGregor to examine the parts.

The Chairman (to Dr. MacGregor): Would you be able to answer the question if you examined the parts?—It is impossible to say until the examination takes place.

In answer to Mr. Singer, Dr. MacGregor said that if he had found such a condition in the patient as described a pelvic abscess would have been his first suspicion. The case, he said, was of such a nature that it should have been under the most careful observation from day to day, the character of the complaint carefully watched, and every possible detail of the history of the case taken, as everything depended upon the correctness or otherwise of the diagnosis. On being asked whether he would have made an exploration with a trocar and canula, the witness said that his first step would have been to use that or some other instrument to make a hole in the mass. He could not say whether this would have cured the trouble, but it would have established the nature of the complaint.

Would you risk hæmorrhage by cutting into the mass instead of cutting out the uterus?—There would be no hæmorrhage, and if there were it could easily be controlled.

It has been sworn by Dr. Frost that the parts were healthy when they came into her hands?—No one, so far as I know from the evidence, seems to know whether anything happened to them before they were received in the laboratory. A careful inquiry should be made as to whether anything occurred during the interval of transit, and also as to whether the parts were received in the laboratory in their present condition; also as to whether there was a mass attached, and, if so, the extent and nature of it. I must know all these particulars before I can answer any more questions.

Dr. Frost, who was present, stated that all specimens intended for preservation were taken intact to the laboratory by a nurse.

In answer to a question, Dr. MacGregor said he thought that a microscopic examination of the parts would show whether a mass had been attached to them or not. It might, however, he said, be necessary to make a microscopical examination of the parts in order to clear up the question. If it should turn out that there was no mass attached to the alleged healthy uterus, where was it? Was it still in the body?

Mr. Reed: I hope, Your Honours, that this Commission will finish before Christmas.

Dr. MacGregor: This Commission has most momentous duties to perform, and it would be justified in sitting three months if it were necessary.

Mr. Singer: The attitude that I am forced to take up is that the life of the late Miss McIndoe has been destroyed. This, I take it, is a somewhat serious position to my friends' clients, and I should think they would be willing to sit to Christmas to elucidate it.

Mr. Earl: Oh, I am willing to sit here for twelve months, but Mr. Reed has already been here three weeks.

Dr. MacGregor said he did not think Mr. Savage or any one could venture an opinion upon a point upon which so much would turn without making a minute examination of the specimens.

Mr. Singer: I wish to show that there was no mass attached to the parts when they were removed, and that there was no justification for their removal.

Mr. Earl (after consulting with Mr. Reed) stated that it would be no part of their case to show that there was any diseased mass attached to the parts removed. They had not called any evidence to that effect, and he thought it only right to make the statement at this stage.

Mr. Beetham: Dr. Frost said there was no mass, and Dr. Walsh said there was.

Mr. Reed indorsed Mr. Earl's statement, which, he said, was made at that stage in order that it might not afterwards be said that there had been a change of front.

Mr. Singer: That reduces the question as to whether the parts removed were healthy or not.

Mr. Beetham: It would also show us whether there was a mass there or not.

Mr. Savage, who arrived at this stage, in answer to a subpœna from Mr. Singer, was asked by the Commission to examine the exhibits, to determine whether the uterus was healthy, and whether there was any evidence of a mass having been attached to it.

Mr. Singer: Possibly Mr. Savage may be able to say whether the parts are now in the state in which they left the body.

The Chairman: I do not know whether he could do that. Even Mr. Savage has his limitations.

Mr. Savage, in the company of other medical men present, then made an examination of the exhibits in the yard at the back of the buildings. On returning to the Board room a few minutes later, Mr. Savage stated that the uterus and appendages were certainly diseased on one side. From the short preliminary examination which he had been able to make he should say that the condition was one of tuberculosis of the pelvic organs, but he would like to make a more minute examination before definitely pronouncing upon the subject.

It was agreed that a minute examination should be made by Mr. Savage (in the presence of other medical men, if they desired), and the Commission then adjourned.

The Commission resumed its sittings on Thursday, the 10th November.

Mr. Singer asked leave to recall one of his witnesses to show that he was fully authorised to sign Mrs. McIndoe's name to the charge against Dr. Parkes and Dr. Collins. He was anxious, he said, to clear himself of any reflection which might have arisen through Mr. Earl's questions in cross-examining a witness on Tuesday.

Mr. Earl said he was quite satisfied that Mr. Singer did not act in an unprofessional manner, and the Chairman said that in the circumstances there was no need for Mr. Singer to call his witness.

The Commission adjourned on Tuesday to give Mr. Copeland Savage time to examine the exhibits and determine whether the uterus removed at the operation was healthy, and whether there was any evidence of a mass having been attached to it. In his evidence on Tuesday *Mr. Savage* said the appearances which then led him to suspect that the uterus was tubercular was not correct. The answer to the question whether there was any appearance of part of a growth attached to the uterus was "Yes," and the answer to the question whether the uterus was healthy was "No." Strictly speaking, it was not one uterus, but two. There were two distinct cavities. The right one was healthy, and the left one had been distended by a swelling.

Mr. Singer: What justification would you allege for the removal of the uterus?

Mr. Savage said it would be reasonable to consider the left half as an appendage to a normal uterus, and this, being distended, would form a swelling which might be reasonably diagnosed as a growth attached to the uterus. If such a diagnosis was made, it was perfectly justifiable to remove the uterus with the idea of getting rid of the growth.

Mr. Singer: In your opinion, that diagnosis having been made, the uterus should have been removed?

Mr. Savage: It was a reasonable and justifiable course to take.

Mr. Singer: The conditions were exceedingly rare, and it would not be reasonable to expect a surgeon to diagnose it correctly?

Mr. Savage: There were two rare conditions. The probabilities against any man meeting a second case of the same kind are enormous.

Mr. Singer: On behalf of the McIndoe family, I think it is due to Dr. Parkes and Dr. Collins, after the revelation Mr. Savage has made, that this charge should be absolutely withdrawn in as handsome terms as I can put it. I, of course, have only been doing——

The Chairman: You need not apologize. You can make what statement you like to Dr. Parkes and Dr. Collins without making it to us.

Mr. Singer: Should it not be done publicly?

The Chairman: You can make any public announcement you like. The charge, I understand, is wholly withdrawn.

Mr. Singer: This is the most serious charge that has been before the Commission. My position has been a very difficult one. The position of Dr. Parkes and Dr. Collins has also been difficult.

Mr. Earl: Allow me to speak for Dr. Parkes. I don't think his position has been so difficult. He had a complete answer to the charge.

Mr. Singer: I consider something more should be said than the absolute withdrawal, but if Your Honour thinks not I will sit down.

The Chairman said there were no other charges before the Commission, and he declared the evidence closed. A long document had been sent to him the previous night, but the individual who sent it was not present, and there was nothing to do but close the evidence.

Mr. McVeagh: I wish to refer to a matter, although it may be somewhat premature, because the report of the Commission may not go in for some time yet.

The Chairman: I am not sure of that.

Mr. McVeagh: Probably the Commissioners will be leaving Auckland.

The Chairman: I don't think they will. I think they will prepare their report here.

Mr. McVeagh: It is the question of costs I wish to refer to. I do not know what the report will be, but under the Commissioners' Powers Act Commissioners have power to make an award for costs, and in that connection I would like to draw the attention of the Commission to the position of the Hospital and Charitable Aid Board. There were certain charges against the Board and certain charges against Dr. Collins. As regards the charges against Dr. Collins, the Board has taken upon itself to defend those charges, and made itself a party to the proceedings.

The Chairman: I don't know that. I thought Dr. Collins appeared for himself. We will take the question of costs into consideration, and will take your present statement into consideration at the same time.

Mr. Reed: Dr. Collins appeared at the Commission for himself, and I appeared for the Hospital Board. It was only in this last charge that I appeared for Dr. Collins.

The sittings of the Commission then closed.

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