OBSTETRIC NURSING.

BY

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In talking to you this evening on the subject of Obstetric Nursing I shall endeavour to confine myself strictly to the practical side of the question, and will deal with the subject of the obstetric nurse and her relationship to the patient and to the physician, sketching more or less in detail an outline of her duties and responsibilities from the beginning to the end of her engagement with an individual case.

Commonly, in this city obstetric patients engage their nurses without reference to the physician, and there are in this city two classes of obstetrical nurses, first, those who confine themselves absolutely to obstetric nursing; and those who have received a general training in some large hospital and who occasionally take an obstetrical case, particularly if it is complicated. The relationship of these two classes to obstetric work is absolutely different. The first class are usually subject to engagements months ahead, and have an opportunity to pay a preliminary visit to their patient and to make all preparations for the expected confinement. While the second class are not usually called until the patient is in labour, and thus these nurses have to take things as they find them.

Those who make engagements ahead, I would advise to try and make a hard and fast arrangement with the patient as to engagement from a certain date, to a certain date, and to have a distinct understanding as to the date on which pay begins, as some women are very unbusiness-like and seem to expect that a nurse should wait for days or even longer without receiving pay. When a nurse is under engagement but is not actually staying with her patient, she should consider that her time belongs to her patient and should never be out of reach day or night, so that she can be called any moment.

When making an engagement to attend a patient the nurse should note the general condition of her patient, and, if possible, should be shown the room that will be used as a labour room. She should note the general cleanliness of this room, its ventilation and what means may be available for regulation of temperature, in winter or in summer. For instance, in winter a warm room, large, well lighted and well ventilated, and of a southern aspect should be chosen. In summer the room should be chosen with special reference to its coolness. The room should be in a quiet part of the house, not, for instance, at the head of the stairs, where all the business of the house will reach the patient's ears. It should be, if possible, convenient to the bath room.

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The bed, preferably a single bed, should be so placed that the direct light from the window should not fall on the patient's eyes, and in summer so that the draft from the open window shall not blow directly across it. The condition of the mattress should be observed, it should be firm without being too hard, and should not be sufficiently soft to form a trough when the patient is lying on it, and, above all, it should be clean. If the bed is low, blocks should be prepared so that it may be raised to a convenient height. This precaution will do a great deal towards saving wear and tear of the physician and nurse. If the general cleanliness of the room is open to suspicion the patient should be advised to have it thoroughly house cleaned a week or ten days before the expected date of confinement.

At this time the nurse, if the physician has not already done so, should give the patient a list of the articles that she will have to provide for herself and the child. In making out this list a nurse should distinguish between those things which are essential and those things which are more or less luxurious, and should seek to adapt the outfit to the purse of her patient as far as possible. Some patients complain of the elaborate nature of the outfit requested by the nurse, therefore, try to arrange your list of articles to suit the varying purses of your patients.

The following constitutes a very useful outfit:—

Six abdominal binders, 1¼ yards long by 1½ yards wide, which should be washed and ironed so as to make them soft and comfortable. They may be made either of plain cotton, unbleached, or of thin Canton flannel. Personally, I have for some time given up the use of these binders, employing an ordinary "T" bandage in place of it, as I find the binders have a certain unfavourable influence in causing displacement of the uterus.

Three obstetrical pads, 1 yard square, made of cheap, unbleached cotton, and padded with cotton batting until about three inches thick. These pads are placed under the patient during labour or after, to catch the discharges.

2½ doz. vulva pads, made of absorbent cotton, 10 by 3 inches, and 2 inches thick, covered with cheese cloth or absorbent gauze. These should be done up in packages of six and sterilized.

One-half doz. old towels, freshly laundered, should be laid away with the other things and should be sterilized if possible, though this is not indispensable.

Two papers of large size safety pins, and 1 paper of small size; 2 new nail brushes, one for the physician and one for the the nurse,

which should be wrapped in cotton and boiled; ½ lb. absorbent cotton; 4 ozs. lysol; 4 ozs. green soap, or one bottle of synol; 6 ozs. alcohol, to be used for rubbing the patient; 2 pieces of rubber sheeting, each two yards square. Instead of rubber sheeting, enamel cloth may be used for this purpose, as it cheaper; 2 enamelware wash basins; 1 bed pan; 1 douche bag, 2 quart size; 1 clean slop jar or pail for soiled dressings, with cover if possible; 1 doz. clean towels, besides those above mentioned should be available, and a good supply of sheets, pillow cases, and night gowns should be at hand for the patient's use.

For the infant one requires:—

Eight ozs. olive oil; 1 tube white vaseline; 1 cake Castile soap; 6 flannel binders, 6 inches by ½ yard long; 1 soft flannel blanket one yard square, to wrap the infant in immediately after birth; 4 doz. diapers at least should be provided; 1 infant's bath tub; 1 bath thermometer; 1 box talcum powder; 1 powder box and puff; 1 infant's hair brush; 2 sponges, one for the body and one for the face.

The following clothing should be provided as a minimum supply:—

Four undershirts of knitted wool; 4 flannel petticoats; 4 flannel night gowns; 10 slips, as simply made as possible. These should be made to open at the back.

A supply of old linen is useful for swabs, and may be provided. These various articles should be laid away in a cupboard or bureau drawer, all ready for use beforehand, so as to avoid confusion and delay after the labour is under way.

In addition to these articles there should be provided a small package of tape or stout linen to serve as ligatures for the umbilical cord.

Nurses should avoid giving medical advice to their patient outside of the question of clothing during pregnancy, the condition of the bowels and the care of the nipples.

A few remarks at this point on the hygiene of pregnancy may not be out of place. The pregnant woman should be careful to avoid over fatigue, though plenty of exercise in the open air should be indulged in. A warm bath, of temperature 105°, should be taken at night, at least twice a week. If the woman is in the habit of taking a cold bath every morning, there is no reason why she should interrupt this habit during pregnancy, provided reaction is prompt. Movements of the bowels should be obtained regularly, and the patient should be warned against constipation.

The diet should consist chiefly of fruits and vegetables, and meat should be somewhat limited. Plenty of water should be drunk between meals. The condition of the mouth and teeth should receive attention,

as during pregnancy the secretions, which are normally alkaline,tend to become acid and facilitate carious processes. Alkaline mouth washes should be used after each meal and before retiring, and it is not a bad plan for pregnant women to drink a large tumbler full of cold water containing one-half teaspoonful of cream tartar dissolved in it just before going to bed. The nipples should, during the last six weeks of pregnancy, be washed with Castile soap and hot water, and friction applied to them by means of a piece of flannel. They should then be bathed in a solution of equal parts of alcohol and witch Hazel. They should be rubbed two or three times a week between the fingers, and drawn out, at the same time being well covered with white vaseline. The patient should be instructed never to touch her nipples with unclean hands.

Prompt attention should be paid to an obstetric call and the patient should be reached as soon as possible. Usually, in the wealthier class of patients the nurse is called before the physician, who generally leaves instructions to that effect, and the calling of the physician is thus frequently the responsibility of the nurse, so that the obstetric nurse should be familiar with the signs and symptoms attending the various stages of labour.

The nurse should first, even before changing into her uniform, see her patient and find out from her when the pains began, and should note their frequency and character. She should then plan her proceedure according to the time she judges at her disposal before critical stage of labour will be reached. This varies, of course, according to the circumstances. The nurse on seeing her patient for the first time in labour should note her general condition, and, if time permits, should record the pulse, temperature and respiration. She should also note carefully the patient's statements as to when the pains began, their site and frequency. A careful enquiry should be made as to vaginal discharges, and their character should be examined.

One of the most essential things in the preparation of the patient is the clearing out of the rectum by means of enema. This should be done if at all possible. In the ordinary routine of preparation of the patient it may be given immediately before or after the bath, and, if the first stage of labour lasts over eight hours the enema should be repeated.

One often hears the statement that the bowels have moved repeatedly during the few hours before the onset of labour, and, therefore, the enema was not thought necessary. It is just in these cases that the enema should be given, as the bowels are usually overloaded with retained

fæces when such a history is obtained. Therefore, I again repeat the most essential things in the preparation of the patient are the clearing out of the bowels, and the thorough cleansing of the vulva and thighs.

If the patient has not had a hot bath within twenty-four hours, and time now permits of it, she should be advised to take one at once. As a rule, it is better for the patient not to sit down in the bath, but to kneel therein, and to pour the water over herself, as in multiparæ especially, the water may enter the vagina and carry infection. Special attention should be given to the cleansing of the abdomen, vulva and thighs, and these parts of the body should be bathed after the bath in a 1-2000 solution of bichloride of mercury.

From this time the use of the toilet must be forbidden and the patient should wear an antiseptic pad, which should be changed from time to time as may be necessary until the latter part of the second stage. Each time this pad is changed the parts should be bathed with antiseptic solution.

While the patient is giving herself the bath the nurse may be preparing the labour room. Unnecessary furniture and toilet articles, etc., should be removed, though it is unnecessary to make the room into an ordinary operating room. The really necessary articles of furniture are, the bed, a low table, two ordinary chairs, a slop jar or pail, and an old rug or some protective paper to keep the carpet from being soiled.

The labour bed should be made as follows:—To the right side of a double bed and about its middle should be placed one of the rubber sheets provided for this purpose. This is covered by a clean white sheet, and both are pinned to the mattress so as to maintain them in place. Over these is placed the draw sheet, which should lie midway between the head and foot of the bed, so that the patient's buttocks will rest in the middle of it. These must be pinned securely at the corners in order to prevent slipping. Over this should be placed a second rubber sheet over which a second draw sheet should be placed, and both securely pinned. Over this draw sheet is placed one of the prepared obstetric pads, also securely pinned.

This obstetric pad may be changed when the final preparations for delivery are being made, should it become soiled in the meanwhile. To cover the patient, a fresh, clean sheet should be used and a light blanket or other necessary covering.

The patient should be clothed in a clean nightgown, over which she may wear a suitable wrapper while moving about, and clean stockings and slippers. In cool weather she may wear besides this a silk or thin wool undervest. Her hair should be carefully combed, brushed and braided.

The nurse should see that a plentiful supply of the hot sterile water is obtainable, and should fill a carefully cleansed bedroom jug with boiled water, placing it where it will cool as rapidly as possible, and covering it with a clean towel, so that a supply of cold, sterile water may be available. All water used for solutions should be boiled, and never under any circumstances, should water freshly drawn from the tap be used for this purpose.

A pair of scissors, three or four ligatures for tying the cord, one-half dozen gauze swabs, about two inches square; a glass, and a rubber catheter, and possibly one or two pair of artery forceps, should be dry sterilized, or placed in a 2 per cent. solution of lysol until needed. One cup full of warm boracic acid solution should also be prepared, and a bundle of absorbent cotton swabs, each swab being about the size of an ordinary hen's egg. These should be placed on the small table set aside for the physician's use.

A basin to catch the after-birth, or other dish suitable for this purpose, should also be at hand. A soft piece of linen and a piece of old blanketing or flannel should be placed at hand for the reception of the baby.

The nurse should make all her preparations quietly and without undue fuss or disturbance. She should avoid, if possible, all hurry and confusion. Her manner should be calm and collected, she ought to move about her work as if it was a matter of every day routine, her object being to inspire her patient with confidence, and to support her moral strength throughout what is at the very best a trying experience.

In the early stages of labour it is unnecessary for the patient to remain in bed if she cares to move about, in any case, she may sit up in an easy chair, and if the pains are not occurring with too great frequency, she should be provided with some simple occupation, such as attending to her hair, manicuring her nails, or some little duty that may be of help to the nurse.

The whole atmosphere of the labour room should be one of calm, quiet, self-control, and, if possible, all nervous or excited relatives should be kept out. The proper management of the patient and her relatives during this trying time calls for the greatest tact and discretion on the part of the obstetrical nurse. The patient should be encouraged to talk of light, unconsequential things, and the nurse should avoid relating her experiences of other cases, and should keep the conversation away from the subject of obstetrics as much as possible.

When to call the physician is sometimes a matter of no little difficulty in deciding. I think that, as a general rule, the physician should

be notified as soon as the labour pains begin that his patient is in labour, and the nurse should endeavour to obtain direct orders as to when the physician desires to be summoned to the case. Personally, I may say that it is my custom to request the nurses to notify me of the onset of labour, except between the hours of midnight and 7 a.m. During the night I ask them only to call me if they really feel that my services are required. Thus, by being notified of day cases the physician can arrange his work so as to permit him a maximum of liberty in order to devote himself to his obstetric duties.

All obstetric nurses should be familiar with the clinical phenomena of labour. I will discuss briefly a few of the more common phenomena so as to call to your recollection the main facts, with which you are familiar. False pains may be distinguished from true pains by the fact that they occur irregularly, and are chiefly located in the front of the body. True pains may begin in the front of the body, but they soon extend to the back, and they occur with increasing regularity at intervals of fifteen to twenty minutes. The escape of a thick, bloody mucus, known as the "shew," attends the onset of true labour in many cases. When the membranes rupture early, or when the water escapes before the pains have begun, the labour pains are usually more frequent and more severe than when such is not the case. It is in these latter cases that the nurse often thinks delivery impending, long before the mouth of the womb has dilated.

When the first stage of labour has concluded, the os is completely dilated and the membranes usually rupture, permitting the escape of the waters. In multiparæ the physician should always be summoned when the waters have escaped, especially if the pains recur at intervals of from three to five minutes.

The second or expulsive stage of labour is characterized by the occurrence of straining or bearing down pains. The patient should not be encouraged to bear down in the first stage of labour, as such efforts are perfectly useless and tire her out. On the other hand, in the second stage the patient should be encouraged to bear down as much as possible during the pains, as by this means she can hasten delivery in a large proportion of cases.

In the first stage of labour the discharge from the vagina consists of blood stained water, in the second stage of labour the discharge becomes mucoid in character, so that during the second stage the nurse should be on the watch for the escape of thick, clear mucus from the vagina, as an indication of the rapid advance of the presenting part. The advance of the presenting part may be recognized by the pressure of the

advancing fœtal part upon the anus and perineum causing a certain amount of bulging outwards. A common sign of descent of the presenting part, is the impulse of the patient to have a movement of the bowels; thus, in a patient known to be in the second stage when this desire is expressed the nurse should make sure that there is no evidence of bulging during a pain, before allowing the patient to get up for this purpose. The advance of the presenting part may sometimes be felt by making pressure upwards from below with the fingertips placed half way between the anus and the tuberosity of the ischium, just alongside of the vulva. Pressure in this direction will encounter distinct resistance if the fœtal parts are just about to come on the pelvic floor.

Thus, the nurse should summon the physician in the case of primiparæ, as soon as there is any evidence of bulging of the perineum, especially when this is accompanied with the escape of a thick, clear mucus from the vagina, and frequent pains of a bearing down character. In multiparæ the occurrence of bearing down pains and the escape of the waters indicate that the physician should be summoned at once.

Should the labour advance rapidly and delivery threaten to take place before the physician arrives, the patient should be kept in the left lateral position in bed, and urged to pant, or cry out, with the recurrence of each pain, while the nurse should endeavour to hold the presenting part back, should the perineum bulge. This pressure of the nurse on the perineum should be made only during the acme of pain, and the nurse's hand should be wrapped in a sterile towel. Pressure on the perineum, if kept up constantly, tends to act as a stimulus to uterine contraction, thus this pressure should be avoided except when necessary to hold back the advancing fœtal parts.

The nurse should have ready all the things required for the physician to wash and sterilize his hands, and should now make final preparations for the actual delivery. She should have in the labour room all water and other material that she is likely to require throughout the further course of the labour. While waiting for the physician the nurse should avoid leaving the room or leaving the patient alone, especially if the pains are markedly severe.

During delivery the nurse is usually called upon to administer the anæsthetic under the direction of the physician. A few drops of chloroform on the mask with the onset of each pain is usually sufficient to produce obstetric anæsthesia. Care should be taken not to allow any drops to fall on the skin, or into the eyes, of the patient. To prevent

burning of the skin by chloroform the patient's face should be lightly smeared with vaseline.

In this country the patient is usually delivered in the left lateral position, and the nurse stands on the left side of the bed. She should endeavour to keep the patient's legs flexed and the thighs well separated. Usually a folded pillow is placed between the knees for this purpose. Some physicians employ a Kelly pad during delivery, and this covered by a sterile towel is slipped under the thighs of the patient at this time. The further duties of the nurse now depend entirely upon her instructions from the physician in charge of the case. Usually she is called on to take charge of the fundus of the uterus while the child's body is being delivered, and she should keep up this pressure until such time as the physician is at liberty to replace her, which is usually just after the cord has been tied and cut. She then receives the infant in the coverings she has prepared for this purpose, and, having wrapped it up warmly, she places it in a convenient place where it will be out of reach of harm and will not be in the way. The infant should be placed on its right side so as to favour the closure of the foramen ovale, and because the liver is on this side and is one of the heaviest organs in the child's body. She should see that the child is so placed, that its nose and mouth are free from pressure in order that the child's respirations may not be interfered with. Twice I have had the unfortunate experience of handing a living child to a nurse to be placed in its cradle, and when I have gone to see it twenty minutes later I have found it smothered to death through having been placed face downwards on a soft feather pillow.

During the interval, while waiting for the delivery of the after-birth, the nurse should replenish the basin containing the antiseptic solution in which the physician bathes his hands. During the delivery of the placenta the basin in which the after-birth is to be caught should be held close to the vulva by the nurse. As soon as the after-birth has been delivered, this basin should be covered with a clean towel and placed away until the physician is at liberty to examine its contents. If there are no stitches to be put in place, the patient is now cleaned up and all soiled linen removed. She should be washed as quickly as possible with a warm antiseptic solution and dried.

The upper obstetric pad, draw sheets and upper sheet should be now removed, a fresh obstetric pad placed beneath the buttocks, and a large vulva pad applied which may be held in place by means of a "T" bandage.

As a rule the physician keeps his hand on the fundus for at least one-half hour after the delivery of the placenta, and in cases where a

broad binder is used, it is frequently not put in place until after the child has been washed. In doing up a patient after delivery, the nurse, if left alone with the case, should from time to time make a little gentle friction upon the fundus, to be sure that the uterus remains well contracted. The patient should not be turned on her side during this washing up process unless the nurse keeps one hand upon the fundus, as this position favours relaxation of the uterus and permits the entrance of air within the vulva.

After doing up the patient, and before proceeding to clean up the room or bathe the baby, if this has not already been done, the patient's pulse should be taken and recorded, and the condition of the fundus of the uterus noted. If the pulse rate is at or near 100 per minute, and the fundus is high and soft, hæmorrhage is to be feared, and a close watch for this accident should be maintained. If all is well, the nurse should now clean up the room, removing all soiled linen, etc., and leave the patient in a quiet, darkened room to rest. While cleaning up it is well for the nurse to return from time to time to her patient, until she is satisfied that there is no further danger. After severe or operative labours it is well to have some reliable relative or friend to sit with the patient while the nurse is busy attending to the various duties which devolve upon her at this time.

The Infant.

In giving the baby its first bath certain details are of importance. It should be given in a warm room, in winter, by the warm coils or in front of a fire. In summer, care should be taken that the spot selected is not in a draft.

The bathing should be conducted as rapidly as possible. As a rule, I think, nurses are not careful enough in washing the baby's face and head; the child should be held so that water cannot run into the eyes. The face and head should then be dried with a soft cloth before the body is washed.

At the first bath the baby should be examined from head to foot for injuries or deformities, and, if any are found, the physician's attention should be called to them.

The cord should be bathed in alcohol and then dusted with some drying powder, such as starch five parts, salicylic acid one part, and a small gauze dressing applied so as to completely envelop it. This dressing should be changed as infrequently as possible, but each morning when the child is sponged, it should be carefully examined. If in good condition, fresh powder should be applied under the dressing. If soiled,

the gauze should be removed, the cord bathed in alcohol, and fresh powder and gauze applied.

The napkins should be pinned as loosely as possible, and should be changed whenever soiled.

The mouth should be gently swabbed with swabs moistened in boracic solution before nursing.

The infant should be applied to the breast every six hours till lactation is established, and then every two hours from 7 a.m. to 9 p.m., and at 1 and 5 a.m.

Nothing else should be given a new born child without the physician's order.

The baby when fed should be placed in its basket or cot and lightly covered. It should be protected from bright lights and from loud or sudden noise. It is undesirable that the new arrival should be the subject of the admiring attentions of its parents, relatives or friends, and the nurse should exert her tact to the utmost in order to prevent its constant disturbance.

Artificial foods, gripe waters, and the ever ubiquitous "Comfort" are interdicted, and should never be used without the physician's knowledge.

The Puerperal Period.

The vulva pads should be changed every four hours during the first six days, and more frequently if necessary. On each occasion the nurse's hands should be scrubbed with a nail brush and plenty of hot water and soap. They should then be held in a two per cent. lysol solution, or a 1-2000 bichloride of mercury solution for at least one minute.

The vulva should be swabbed with absorbent cotton dipped in either of the above solutions, from above downwards, care being taken to swab all the folds. It is undesirable to pour or douche solutions over the vulva, as there is danger of washing infected material into the vagina.

The vulva should then be swabbed dry and dusted with boracic acid or other dusting powder and a fresh pad applied. A pad once displaced should be removed, and a fresh pad applied.

The position of the fundus, character of lochia, and condition of the breasts and nipples, should be recorded on the chart twice daily. A record of the urinary and fœcal discharge should be kept, and the temperature and pulse charted every four hours for the first four days, and then twice daily till the patient is out of bed. A rise of temperature to over 100° at any time should be immediately reported to the physician.

The nipples should be bathed in boracic acid solution before, and immediately after, nursing. After nursing, if the nipples are tender, they may be bathed with a solution of equal parts of alcohol and Witch Hazel, in addition to the boracic acid, then dried carefully and dusted with Bismuth subnitrate.

If the breasts become engorged and tender they may be supported by means of a carefully fitted "R" binder or an ordinary "Murphy" binder, care being taken to bring them well toward the middle line of the body before pinning the binder.

The patient should be sponged from head to foot daily with hot water and soap, and should receive an alcohol rub afterwards.

Fresh bed linen should be used every second day during the first week at least.

The patient should not be permitted to assist to any great degree in the performance of her toilet during the first week, but may gradually resume this duty during the second week of her lying-in.

A dose of castor oil should be given on the third day and the physician's attention called to any irregularity in the action of the bowels after that time.

The diet should be very restricted during the first two days. Nothing but liquids, and toast or stale bread being permitted. On the third and fourth days half diet may be given, and after this the patient is placed on full diet.

The patient should be settled for the night as soon as possible after the 9 p.m. nursing.

The morning and evening toilets should be performed as expeditiously as possible. The nurse should see that she has everything at hand before starting, so that she will not have to leave her patient in the course of it, to look for something she has misplaced or forgotten.

The nurse should provide herself with a tray to hold her dishes, swabs, pads, etc., for the vulva dressing, which she can prepare and bring into the room with her all ready. She then prepares her patient, removing soiled linen pads, etc., covering her with a sheet. Having sterilized her hands, she then performs the toilet of the vulva, arranges her patient and removes her tray, soiled linen, etc., at once.

The nurse should give considerable thought to the development of system in her work so that she may perform her professional duties with as little disturbance of the patient as possible.

Both in the morning and afternoon of each day the patient should be encouraged to rest, and sleep, if possible, and for this purpose the

room should be darkened and the house kept as quiet as possible during these hours.

The temperature of the lying-in room should be between 65° and 68° F., and care should be taken to secure good ventilation. It is a good plan to cover the patient up warmly, and open the windows wide for a short time at least once a day, the patient being kept covered until the temperature of the room rises again to 65° F.

Visitors who tire the patient should be excluded altogether, this can easily be managed by reporting to the physician in charge of the case who will then give definite orders in regard to admission of visitors.

Every nurse should be able to get two hours off duty each day, except perhaps, during the first three days after delivery, when she ought to be able to manage at least one hour, for a walk in the fresh air. The nurse should definitely state to her patient before leaving the house, when she expects to return, and should endeavour to return exactly at the time stated. This habit will avoid considerable friction and difficulty.

When the physician calls to see his patient, the nurse should present him with her record of the case and report to him verbally anything special to which she wishes to call his attention. Having answered all questions and received her directions, she should then withdraw from the room, remaining within call, and should accompany the physician to the front door, unless he relieves her from this duty. This enables the physician to give his final directions, and permits her to report anything she does not wish the patient to know about.

If any stitches have been inserted they will be removed on the eighth or tenth day. For this purpose the nurse should have prepared a pair of dressing forceps, a pair of scissors, a supply of sterilized swabs, and a basin of lysol solution, and should see that a nail brush, soap and clean towels for the physician's hands, are ready. If the light in the room is not good, the nurse should see that a candle or lamp is provided, in case a good light may be necessary. Before preparing the patient for this little operation, the nurse should inquire as to whether she is to be placed in the dorsal or lateral position.

About the end of the second week the nurse should get the physician to carefully examine the child throughout, and should draw his attention particularly to the condition of the navel.

When the case is to be terminated by operative procedure the instruments required should be wrapped in a towel, and, being completely submerged in water, should be boiled for ten minutes. They should then, still wrapped in the towel, be laid on a large dinner platter, or

other suitable dish, which has been prepared for the purpose, and the whole carried to the labour room and laid on the physician's table. An extra supply of swabs should be at hand, and the nurse should see that a good artificial light is obtainable. During the operation the nurse's duties depend entirely on the instructions of the physician.

The obstetric nurse fills a very trying position, and to be successful in this department of nursing a woman requires special qualities of endurance, tact and good nature, as she has in her care two patients both night and day. On the other hand, as a rule, the relationship between patient and nurse in an obstetrical case is peculiarly intimate, and the successful obstetric nurse makes many warm friends and holds an unique place in the family life.

In the home life, the obstetric nurse should endeavour to adapt herself as far as possible to the surroundings, and to the habits of the people with whom she is temporarily living.

If anything is not satisfactory to her, if she is not getting sufficient rest, or if there is anything else that is undesirable, she should report it to the physician and not to the patient, as it is the physician's duty to try to adjust matters and place them on a satisfactory basis.

The relationship between physician and nurse should be cordial, and their mutual support loyal and unquestioned. The nurse is the physician's representative and should remember that on him all the responsibility rests, and she should endeavour to keep him thoroughly posted as to the condition and surroundings of his patient.

NARROWING OF THE UTERUS SUCCESSFULLY TREATED BY OPERATION.

BY

INGERSOLL OLMSTEAD,
Hamilton, Ont.

The patient, Mrs. G., aged 45, was seen with Dr. R. R. Parry on 16th July, 1907.

During the last two or three years the lady had suffered from a feeling of discomfort in her right side, which was more marked after exertion. The pain was of a dull, aching character, and was referred to the right upper quadrant of the abdomen, extending at times across to the left above the navel and behind beneath the right scapula. There seemed to be a fullness here at times. Occasionally there were pains of a crampy character. She had occasional attacks of indigestion. At no time did the pain extend down the groin line into the bladder, nor were there any attacks of frequent micturition