

supervision of the milk supply and must, therefore, demand that his city be safeguarded against the possibility of unclean milk. Here is an opportunity for the close working together of the local health officer and the women's club as well as other civic groups that are eager for their community to enjoy all the benefits which a pure milk supply may bring them.

Dr. Haven Emerson, one of our leading public health physicians, is responsible for this challenging statement—"A city without sanitary control of its milk supply is taking quite as great risks with its citizens as if there were no fire or police protection provided."

MIDWIVES' UNION SECTION

Management of Normal Labour and the Puerperium*

I think the midwife is handicapped in some ways in the management of normal labour, especially in not being able to use anæsthetic measures as a doctor can. The ideal arrangement is to have both doctor and midwife each with their own function. I do not for a moment depreciate the splendid work you do alone, but I believe two people better than one, though I know your patients cannot always have two people.

Now about the general conditions of labour. I think it very important to tell the patient beforehand to send as soon as labour starts, and to tell her how labour does start. Most women are very frightened with their first baby, they fear the unknown, so tell them what to expect—breaking of the water, pain, a little blood.

Among important early preparations we have the patient's bath and the enema, for a loaded rectum delays labour. Then you must clip the hair short and thoroughly wash the parts with soap and water and dry them. On no account give a douche unless instructed by a doctor to do so. The room must be clean and should be dusted with a damp cloth, all curtains and ornaments should be removed, and the floor protected. Bowls should be well scrubbed and cleaned with methylated spirit. You will need separate bowls for hands, lysol, perchloride of mercury, placenta, and gloves, and a dish containing 2 pairs of Spencer Wells forceps, scissors and thread in methylated spirit. Of course, the ideal thing is a sterilised drum with towels, swabs and gauze, but as you are not usually able to have that you must insist upon perfectly clean towels and boiled wool swabs. Everyone who takes on maternity work should be in perfect health, and you should never go to a case if you are not in good health, especially if you have septic teeth, or tonsils or anything like that. Another thing is that you should never get your hands really messy. We all have to do dirty jobs sometimes, but when you have to touch anything that is not clean you should put on rubber gloves so that your hands will never be contaminated with septic organisms. Then about gloves worn during the delivery, you must remember that, though they have been boiled before putting them on, they do not remain sterile after they have touched anything, and that after you have examined the patient with them on they must be washed and boiled again.

* Notes of a lecture given by Miss Gertrude Dearnley, M.D., B.S., at the Post-Certificate Course for Midwives at Maidstone.

AN ABDOMINAL EXAMINATION

An abdominal examination will give you information about the bladder the position of the foetus, and whether the head is going in satisfactorily, and counting the foetal heart will be a guide as to its condition later on. I usually make a vaginal examination early to decide the dilatation of the cervix, and with one hand inside, one outside, I measure the head in the pelvis. Then if everything is normal I let the patient walk about. The first stage varies very much in length, and a long first stage tries the patient very much, especially when it is a first labour. The second stage is less unbearable in most cases. Something should be done to help the patient in the first stage; I usually give a dose of morphia when the os is 5s., and the patient then sleeps, comfortably. You may give an opium pill gr. 1 or a dose of chloral and bromide, 20 grains of each, with aspirin gr. x. This has very good results, the patient becomes quieter, and instead of retarding labour it often hurries it.

During the second stage the patient should be on the bed. The perineum must be kept swabbed with lysol, and it is the custom to make a vaginal examination when the membranes rupture; there is a possibility of prolapse of the cord at that time, and you can also tell the dilatation of the cervix. There is one point I should like to make about this stage of labour; never let the patient bear down until you are sure the cervix is fully dilated. I see many of these women in the gynæcology department, and see them from a different angle. I know that if they are allowed to bear down before full dilatation they not only waste their strength, but the head often bursts through the cervix, and the result is a tear and occasionally a severe hæmorrhage. These cervical tears are not only due to the wrong use of forceps, and they lead to chronic inflammation of the cervix, with a discharge later and predispose to prolapse. It would be a great help at this stage if all patients could have light anæsthesia, and that is another reason why I think a partnership between doctor and midwife is the ideal arrangement.

PASSING A CATHETER

Another important point is the bladder. Always think of it if the patient is not getting on well and pass the catheter. We cannot make an arbitrary rule about the length of the second stage, but you might make a bargain with yourself that, when it has lasted 2 hours, you will always reconsider the situation and find out why the child is not born. Think of the rectum, the bladder, note the pulse, the contractions, whether you have made a mistake about the presentation, and whether the patient is becoming exhausted. It is better to find out early if anything is wrong than to wait until the patient has been 4 or 5 hours in the second stage and is at her last gasp.

About the actual delivery the great thing is to keep the head flexed and prevent injury of the perineum. The head should be delivered in the interval between pains, just as the uterus has ceased action, and the occiput should have come out from the symphysis pubis before the head is allowed to extend. You need the happy medium between letting the head burst out and tremendous delay. Then when the head is safely born you must not get careless about the shoulders and so have a huge tear. Be sure that the interior shoulder is right out under the symphysis first and then deliver the posterior one over the perineum. When the head is born there is no need to get the wind up if there is a few minutes' delay, even if the baby is a little blue. There is plenty of time to wipe the eyes, and pulling is bad, for the head is delicate and the nerves are easily injured. If there is too much delay it is better to push on the fundus than to pull.

After the baby is born never knead the uterus unless there is abnormal bleeding; kneading causes irregular separation of the placenta and hæmorrhage. When the placenta has separated, as shown by the uterus becoming more prominent, higher, and harder and the length of cord outside greater, just gently push it out while the uterus is hard.

Always look carefully just inside the vagina for lacerations, and if there are any the sooner they are repaired the better—another point in favour of partnership between doctor and midwife. If the patient likes a binder she should have one, not a great erection but a small soft one, and let her keep it on just as long as she likes. I never put it on for about an hour after delivery, as it is easier to wash the uterus without it.

FRAGMENTS

It is our sad duty to announce the death of Miss S. Lillian Clayton, President of the American Nurses' Association and a Member of the Board of Directors of the International Council of Nurses.

Miss Clayton lived less than forty-eight hours after she was stricken with Pneumococcus meningitis, and passed away in the Philadelphia General Hospital to which, as Director of the School of Nursing, she had given fifteen years of devoted service. Funeral services were held on the afternoon of May 5th in the Nurses' Home of the Hospital, and she was buried in the Woodlawn Cemetery near-by, next to the grave of the founder of the School of Nursing at the Philadelphia General Hospital.

Her end came as she would have wished it, in the midst of her professional duties. While we mourn her deeply, we yet give thanks for her fine example of personal and professional leadership.

Singing to Sanity

Community singing may not always be very successful when applied to football crowds, but it achieved remarkable results among the patients at the Cardiff City Mental Hospital, according to Dr. P. K. McCowan, the Superintendent. Patients who have been mute for long periods have learned to speak, and unsociable, hostile patients have become practical, pleasant characters. Old well-known songs are sung with enjoyment at the weekly meetings of the patients, and the utmost fervour was shown with the popular Welsh hymn tune "Cwm Rhondda." It was this tune, said Dr. McCowan, which led a girl who had been mute for a month to recover her voice. Community singing is, in Dr. McCowan's opinion, undoubtedly an important contributory cause of the high recovery rate, which at this hospital is over fifty per cent. compared with the average of thirty per cent. of all other mental hospitals.—Reuter.

—*Madras Mail*

The History of the State Registration Movement

Now, that the past history of the International Council of Nurses has been put on record in the *International Nursing Review*, its official organ, by Miss M. Breay, Founder Member, in collaboration with Mrs. Fenwick, Founder, they intend to tackle a big bit of work in recording the "History of the State Registration Movement" during the thirty years' evolution of the Profession of Nursing from 1887 to the passing of the Nurses' Registration Acts in 1919.

From the founding of the British Nurses' Association in 1887, with the ultimate object of State Registration in view, the struggle for the legal status of the trained nurse was one of the most vital efforts ever made by a small group of women for their educational and economic rights. Some five thousand pioneers paid the price, and in the past decade some 68,000 nurses have availed themselves of the privileges won for them.

Mrs. Fenwick has carefully filed the monumental records of the "thirty years' war," so that the accuracy of the historic survey is assured, and should prove of immense interest to future generations of Registered Nurses and Examiners in Nursing History.

—*British Journal of Nursing*

Art and Disease

Art and the representation of disease was the topic of Lord Moynihan's speech at the Academy Banquet. The well-known bust of the dying Alexander was to the physician's eye a witness that the original model was suffering from cerebro-spinal meningitis. The gargoyles on the Church of San Maria Formosa in Venice, a church so greatly deplored by Ruskin for its ugliness and as the evidence of a depraved taste, should not stand for incarnate evil, but was an intelligent record of a recognisable form of nerve disease from which it was likely that a workman engaged on the building had been suffering. Be this as it may, it was the practice of the mediæval builders to allocate ignoble tasks such as acting as spoutheads or supporting heavy beams to the ugly and deformed, while beautiful and radiant beings were raised to high places and personified the virtues. In hospital, menial work for patients was given to deformed and even diseased hirelings or to persons doing a religious penance, and witness of this is found in the incidents depicted by Flemish and German painters of the period. To-day the point of view is that no work is ignoble, if rightly done.

"Who sweeps a room as for Thy laws
Makes it and the action fine."

Whence comes this changed mentality which reconciles the scientific and religious points of view? May it not be the beginning of a realisation that he who would be greatest must first become the servant of all?

—*Nursing Times*

Moist Heat

There never has been a time in the history of medicine when it was not apparent to the observant that the application of heat to local inflammatory conditions was not only beneficial to the disease process itself, but comforting to the patient. Modern scientific investigation has fully proved that at least one of the effects of moist heat to the skin is to induce hyperemia and reduce fever and inflammation by the action of fresh blood brought to the affected area.

This is only one of the reasons why Antiphlogistine is so effective in the treatment of sinusitis, bronchitis, otitis media, cholecystitis and other inflammatory affections. It forms an impermeable and protective covering as well and induces a heating effect which is sedative to pain and is most grateful. Antiphlogistine may be employed as an adjuvant to any physiotherapeutic heat-producing method and more than thirty-five years of successful applications have confirmed its value in all congestive and inflammatory conditions. Samples and literature may be obtained from The Denver Chemical Mfg. Co., 163, Varick St., New York, N. Y.