

MIDWIVES' UNION SECTION

The Management of Labour *

TALKING TO THE PATIENT

One thing that always irritates me is when the students or nurses talk to the patient in the second stage. The patient should either be asleep or occupied with pains, but the attendant worries her all the time to "bear down" until she is so exhausted she wants to do nothing afterwards but sleep for 100 years. Never give the patient anything to pull. It is useless, and it will overtire her. The best thing is to give her something to put her feet against and press, not pull.

About the best sedative for the second stage, either chloral and bromide, or adaline or morphia may be used, though most people do not use morphia late in labour. I have had excellent results from gas and oxygen, but its disadvantage is that it is cumbersome for private cases. It does not make the patient sick, and if she gets flabby the gas can be discontinued and the oxygen carried on alone. Both mother and baby get better, as the baby gets the oxygen through the cord.

You know all about delivery. The great point is to keep the head flexed as long as possible. Very often the nurse who is holding the left leg lifts it much too high; this stretches the perineum, and makes it more liable to tear. The leg should be held as low as possible, allowing just room for the head to pass.

ONE CAUSE OF SEPSIS

Now a word about that controversial point, how many vaginal examinations should be made. There is no doubt that the constant examination of the patient to see how she is getting on is one cause of sepsis. Of late years we have heard much of the advantages of rectal examination in the place of vaginal, as being safer for the patient. For eighteen months we tried this method, and our records showed a higher rate of raised temperatures than when we examined vaginally. Some examinations must be made by students during training. When it is done by the rectum the anterior vaginal wall is pushed forward and rubbed over cervix, and the cervix is just as likely to be infected in that way as by making a vaginal examination. Rectal examination offers no real advantage, as you can tell just as well when your patient is going into the second stage by observation. I never sterilise the vagina unless the patient has a septic discharge. There is a bacillus in the vagina which is protective in nature, and if it is left alone it will keep out infection. In the septic ward we sometimes introduce pessaries of lactic acid because it stimulates this bacillus, and makes it more active.

When the head is born then child's eyelids must be very gently wiped with soft little dabs of sterile wool. Too much force is often used. The mother should immediately be turned on her back, and there is then a nice place for the baby to lie between her knees without straining the cord and causing an umbilical hernia. In this position, too, the anterior and posterior walls of the vagina fall together, and there is less danger of germs and air getting in.

Most students then grab the uterus, and think it must not be left for a moment. Really you should never touch it at all in a normal case until it is time for the placenta to come away. Of course, if there is hæmorrhage it is

* Notes of a lecture given by Professor Louise McIlroy, D.B.L., at the Nursing Exhibition.

another matter. However, life is full of compromise, and if you like you may just keep your hand lightly on the uterus to watch and be ready. You must not be impatient to get the placenta away. Sometimes the husband worries, and knocks on the door to ask if it is away. If it is a long time everyone being to get restless, but it does not matter. When it has left the uterus you may press it out with the hand on the abdomen, and you may know that it has left by the lengthening of the cord.

If a piece of membrane or a small piece of placenta is left behind it is not necessary to explore. It nearly always comes away later, and it is a great risk to explore. If the patient became septic you would blame yourself for having introduced sepsis, though possibly it may have been there before. If the placenta is adherent, and you are obliged to introduce your hand, it is a good dodge to pull on the placenta by the cord after you have scraped it off the uterine wall. The advantage is that you can draw it out without withdrawing your hand, and it will not be necessary to introduce your hand a second time.

Now what will you do for a case of post-partum hæmorrhage? I never give pituitrin until labour is complete. I think it a most dangerous drug to give before the placenta is out. You must just rub up the uterus and try to get the placenta delivered. After the placenta has come away we never give a douche. I consider it most dangerous. We follow the method of Dr. Remington Hobbs, and introduce 60 to 100 c.c. of glycerine into the uterus, and it is extraordinary how it stops the hæmorrhage. The reason we get so little hæmorrhage is that we do not tire our patients; we give them a sedative and leave them alone.

In the resuscitation of the new-born child my methods are not orthodox. By the older method, when the baby did not breathe properly at birth artificial respiration was performed. We never do that. A blue baby is not getting air in the lungs, but its heart is all right, and we give it drugs—camphor or lobelin. With white asphyxia the heart has failed, and the child should be treated as we should treat a man who had been knocked down in the street, and was suffering from shock. It should be kept quiet and warm and not touched. I have found a mixture of 5 per cent. C. O. 2 and 95 per cent. oxygen under very low pressure very helpful in these cases, but until recently the apparatus for administering it has been too cumbersome to be carried in private practice. There is now, however, a very compact little thing that would be useful for country practitioners.

FOR THE QUIET HOUR

The Strange Story of a Stanza

BY THE REV. CANON DYSON HAGUE

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One Sunday evening, when I was Rector of St. Paul's Church, Halifax, "The Westminster Abbey of Canada," as the Governor of Nova Scotia used to call it, I told towards the close of my sermon the following story:—

Many years ago, Dr. Valpy, a well-known English scholar, wrote a *li* verse of four lines as the longing of his heart and the confession of his *f* This was the simple stanza:—

"In peace let me resign my breath,
And Thy salvation see;
My sins deserve eternal death,
But Jesus died for me,"