

A LECTURE TO MIDWIVES.

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(Continued from Page 283).

TREATMENT of Normal Labour :—

First Stage i.e., from commencement of true pains (as evidenced by its effect on the cervix) to full dilation of the Os called *the stage of dilatation*:—
Give a large enema of soap and warm water with an ounce of turpentine in it, as an antiseptic; after the bowel is emptied proceed to give the patient a good warm bath with clean water, preferably under a tap; if a tub is used, it must be seen to, that it is thoroughly clean. Then prepare the vulva by washing thoroughly with soap and water. Tr. Iodi is a good application for painting the part, but objectionable, as it will burn and cause much pain. Perchloride of Hg. lotion is also very good as an antiseptic but it makes the skin feel thick and irritates. Bin Iodide of Hg. lotion is one of the best, it can be conveniently prepared (1 in 1000 strength) with B. W. & Co.'s tabloids. After thoroughly washing the vulva, place over it an aseptic covering of sterilized gauze, which is sold in packets containing about 5 yards of closely folded gauze—as much as is required could be picked up with a pair of sterilized forceps, cut off with sterilized scissors and put over the part—over this a pad of any sterilized material may be clapped on. Then proceed to wash your hands thoroughly and render them quite aseptic; carefully separate the labia with the fingers (of your gloved left hand) and introduce the fingers of the other into the vagina and make your examination. In this stage the patient should be encouraged to walk about to favour the descent of the head into the pelvis, or rather the dilatation of the cervix. Prevent exhaustion by diet and sleep.

To sum up : *Treatment of First Stage.*

Prepare patient for labour and delivery :—

- (a) Bowels
- (b) Skin
- (c) Toilet of vulva
- (d) Prevent exhaustion.

- (1) Bland, nutritious, easily assimilable diet such as egg-flip, broth, soups, milk and barley-water, Benger's, Mellin's etc.
- (2) Proc. re sleep, especially if in labour;—give a draught of what is known as 3-fifteens viz :
 - ℞. Chloral Hydrat : grs. xv.
 - Potassii Bromid : grs. xv.
 - Liqr. Opii Sidativ. m. xv.
 - Aq. Chloroform ad oz. 1.

Fiat Haust repeat if necessary, or a dose of "Nepenthe," m. 40 or 45 in a little water for a dose,
or $\frac{1}{2}$ gr. Morphia Hydrochlor. hypodermically. Scopolamine and Morphia is also good, but this will necessitate the patient being watched.

(e) *Frequent observations* (not internal examinations) at regular intervals.

(f) Encourage erect posture as much as possible during the day to get the cervix properly dilated.

All the above points should be attended to by the nurse. In this, the first stage, the doctor need not see the patient oftener than once in every six hours. In a normal case *no vaginal douching is necessary*, the normal vaginal secretion is aseptic and the plug of mucus in the cervical canal, called the "operculum" serves as an effectual seal against the introduction of septic bacteria. Unnecessarily frequent examinations and douching only serves to remove these natural safety barriers, and are therefore very objectionable.

Treatment of Second Stage:—*Stage of expulsion*: from complete taking up of cervix and rupturing of membranes to birth of child.

(1) Put the Patient to bed and teach her to "bear down"

(2) A little, (just a few drops) of ChCl_3 with each pain. To do this properly is an art. If full doses are given the patient goes off to sleep and the pains are delayed. 15 or 20 drops on the cap when the pain is coming on eases sufficiently and although the patient may cry out, in ninety-nine per cent of cases the patient will tell you afterwards that it was not on account of pain that she did so. Scopolamine and morphia not recommended, as they prolong the stage by annulling the pains temporarily, and a further objection is that the child is generally narcotized and has to be revived.

(3) *Usual observations*.—Every 20-30 minutes.

(4) *Control* expulsion of head, shoulders and body, so that delivery may take place with least amount of damage to mother and child. To effect this, keep pressing on forehead of child with the first and second fingers of left hand and keep forefinger and thumb of right hand on sides of perineum, until the occiput is properly engaged under the pubic arch, then allow the perineum to be gradually stretched and gently allow it to glide over the face. When the head is born, look for the cord round the neck and if there release it either by bringing it over the head, or if this is not easy, by slipping it down past the body. Then keeping the anterior shoulder under the pubic arch, carefully slip the posterior one past the perineum and then let the anterior one come out. The body and lower extremities are then usually easily delivered—the uterus being followed down and *supported only* by an assistant.

Treatment of Third Stage :—Place patient on her back, put your left hand on the fundus—note its height above the symphysis and wait for spontaneous contraction, as long as the uterus is not increasing in size and blood does not escape externally. At the same time look for and remove any condition which would inhibit uterine contractions, particularly a full bladder. When signs which indicate detachment of placenta are present, the placenta may be expressed. These signs are :—

- (a) Lengthening of the cord.
- (b) Uterus rising higher in abdomen, because it is standing as it were on the displaced placenta.
- (c) Uterine body more mobile.
- (d) Uterus flattened from before backwards.
- (e) Wave of impulse caused by tapping on fundus, is transmitted to the cord.

The placenta may be allowed to remain in the vagina (it is done in some parts of Germany) but all things considered, it is better to express it out of the vagina.

When the placenta is separated and lying in the lower uterine segment and vagina, take the empty uterus with the left hand and push it down on placenta. Then gently pull the placenta downwards *towards the floor*. If the membranes get "taut" and stiffened out into a cord, it means that it is nipped by the contracted upper uterine segment; it is then better to wait till uterine contractions have passed off, when the membranes will come out easily. It is better not to twist the membranes, there is no particular advantage in doing so; in fact it may break and push the retro-placental clot into the uterus. When expressing a separated placenta, place the uterus in the middle line.

Time limit :—Wait for half an hour—if not cast by that time, try gentle expression and if this fails wait for another half hour and lastly try forcible expression. All this is permissible *only* if the uterus is acting well. If, as you are pulling on the membranes they break off, put your finger into the cervix, and if the membranes are protruding, pull them out. If attached inside the uterus, leave alone—as risk of sepsis by passing fingers into uterus, is great. No harm accrues by leaving tags of membranes in, on third or fourth day they are naturally expelled or absorbed, or *decomposed*; in the latter case, there is fever etc., but this is speedily cured by intrauterine douching.

Treatment after Third Stage :—At conclusion of third stage, *never* give Ergot while uterus is full. Should Ergot be given after emptying of uterus? If things are going on properly, none is required. In p. p. h. the best is a hypodermic injection *intramuscularly* of Ernutin or P. D. & Co's. Ergot aseptic in ampoules. If given by the mouth, several doses will be required in the 48 hours. For this purpose the

B. P. preparations are useless. The best are the standardized ones of Parke, Davis & Co. or B. W. & Co., when, however, the patient is (p. p.) bleeding and uterus not contracted, hypodermic injections (as above stated) are *the* most reliable. The next matter to engage one's attention is to see whether there are any lacerations. Every patient has wounds after labour, 50 per cent. of primiparae are more prone to sepsis than multiparae, therefore :—

(1) Inspect vulva for lacerations.

(2) Inspect vagina—separate labia and specially look at the posterior vaginal wall. You need not pass a speculum to examine the cervix for lacerations. (There are some who say that you should). The cervix will generally heal, and if it does not, then you might stitch it afterwards. Don't use a speculum, as the risk of sepsis is great. If, however, there is much bleeding, then you must stitch the cervix or plug. Wash wounds with saline solution or plain sterile water. Don't use antiseptics, as they are hurtful. If antiseptics are used at all they must be very weak, then suture.

(3) Toilet of vulva :—Clean vulva antepartum (already described) : then after examining, and again when child's head presents, and finally before stitching.

(4) *Dressing on vulva* :—In private practice, tell patient, before labour commences, to procure sterilized cyanide gauze, (several boxes), as it is cheap enough, also absorbent wool or gamgee tissue or small sanitary towels which are very cheap. Place a double fold of cyanide gauze direct on the vulva and a good pad of wool or tissue over this.

(5) *Tight Binder* :—Most useful and comforting to patients and as all the abdominal veins are distended, by the firm pressure of the binder they are given a chance of recovering.

(6) *Massage* :—Gentle massage of the abdominal muscles very useful. Patient, after 4 or 5 days, may be got to exercise herself by gently lifting both her legs (extended) straight up towards her body, and then the body straight up at right angles to the lower extremities (*a la* Sandow). These movements will strengthen and tone up the abdominal muscles.

Don't leave the patient for one hour after the birth of the child and at least half an hour after birth the placenta.

The Cord :—Divide it after it has ceased pulsating and after the child has cried well and has got plenty of blood into the lungs. Clamp the cord in two places before tying. Don't tie too near the skin for fear of including a small hernia which may be overlooked, on the other hand you don't want it too long, about an inch is quite enough, clamping the cord and thus crushing it before tying is good, because it will prevent septic absorption. More infants die in the first week of their lives from sepsis of the

cords than from anything else. Dressing of cord should be some sterilizing powder and pad.

Child. Should be examined for any malformations. Examine the whole body, beginning from the head and going down to the feet. Size and shape of head, fontanelles, eyes for opthalmia neonatorum, hair lip, tongue tie, cleft palate, deformity of spine or other bones, prepuce, anus etc. For opthalmia use one drop of a 1% sol. of Silver Nitrate, or 2% sol. of Protargol or Argyrol, and allow it to remain in the eyes for two minutes, then wash out with saline.

THE ETHICS OF PRIVATE NURSING.

Read at the Bombay Conference.

By COL. JENNINGS, I. M. S.

PRELIMINARY REMARKS.

WHEN I was invited to read a paper before this Conference I asked my friend Miss Mill to be good enough to furnish me with a suitable theme. She, however, declined any responsibility in this direction, deeming it more desirable that I should speak upon any subject which my own experience suggested as likely to be of use to the nursing profession.

Assuming that the transactions of the Conference would include abundant material dealing with all points connected with *hospital and institutional nursing*, I at once resolved to address you upon the *ethics of private nursing*.

While the main ethical principles which govern nursing in institutions do not materially differ from those which apply to what is known as private nursing, yet there are many points of detail to which more attention than one is in the habit of finding is needed in the case of those who engage in private nursing. At first sight many of these points may appear to be so trivial as scarcely to warrant the importance of being referred to in an assembly of this nature. I can, nevertheless, assure you that, although trivial, there is not one of them that I have not found, in the course of a somewhat lengthy experience, that some nurse or other would have been the better for having more carefully considered.

So far as I am aware there exists no code of ethics for the guidance of nurses. Such a work might be useful and helpful to some, but, as no code could possibly deal with the thousand and one occasions in which a nurse might be called upon to arrive at an important decision in a brief space of time, so, as in other professions, the exercise of common sense combined with constant tact must be relied on, and, in most cases, only long experience will develop the peculiar temperament which is so absolutely essential to success.