An Address ON THE MIDWIFERY OF THE PRESENT DAY.

DELIVERED BEFORE THE LAMBETH DIVISION OF THE
BRITISH MEDICAL ASSOCIATION.

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GENTLEMEN,—The evolution of antiseptics and asepsis has wrought a revolution in medicine and all its branches. On the practice of midwifery the effect has been enormous, and it is my privilege to-day to tell you what this has been up to the present time, and to indicate the path of progress in the future.

Let me call your attention to the fact that, whilst the physician and the surgeon and the specialist are dealing as a rule with disease, or some deviation from the normal, the accoucheur deals in the vast majority of cases with no disease at all, and with no deviation from the normal state, but with a physiological act of Nature. It is difficult to state precisely how many confinements are normal, but certainly statistics prove that they constitute not less than 90 per cent. Probably 95 per cent. would be nearer the mark, but even at the former figure it means that nine cases out of ten are normal.

It would take me far beyond the time at my disposal to deal with abnormal labour, except incidentally, or even to indicate how to find out whether a given labour is, or is about to be, abnormal. One of the most remarkable facts in Nature is that no animal the female member of which gives birth to progeny after impregnation and gestation, requires as a rule any assistance during parturition. It is quite true that help is often rendered to horses, cows, sheep, pigs, goats, and to some wild animals kept captive. But those who have to deal with these cases admit that each animal when left to its own devices will as a rule deliver itself successfully of a living offspring.

Mankind is no exception to this rule. A woman can in most cases deliver herself successfully, without help, without instruction, and without knowledge beyond her own instincts. Only recently the newspapers contained accounts of a case in which a woman was delivered in a tram, another in an omnibus, and a third in a motor car. They all did well. Doubtless many of you can remember the first time you ever attended a confinement. How ignorant you felt! How fearful you were lest something should go wrong! How glad you were when everything went right. And how proud you felt when all the *kudos* was bestowed upon you by the husband and relatives, although you knew the case had managed itself, and that you had practically been a mere spectator.

Poor women often deliver themselves quite satisfactorily with no help beyond such as a neighbour can give, and this help is more that of companionship and that of waitress than assistance in helping on the birth. In other words, Nature carries out the physiological act. Again, a young girl, who has never seen a parturition, and who is quite ignorant of all its details, will creep into a hiding place to conceal her shame, and yet will deliver herself unaided of a living child and take no harm.

All these facts prove, if proof were needed, that parturition is an act of Nature, and, like all other physiological acts, it is well-nigh perfect. If you compare it with other physiological acts, such as swallowing, breathing, defaecation, or micturition, you will find that it is very similar to them in that it is a reflex act, which can be modified to a limited extent by volition.

The labour can be helped or hindered by voluntary muscular efforts on the part of the woman. But, on the one hand, such help is not absolutely essential, as is proved by those cases in which there is complete severance of the will power through a lesion of the spinal cord, and yet delivery takes place by uterine action alone; and, on the other hand, hindrance is limited, for no woman could prevent delivery taking place at term by mere voluntary efforts. And, indeed, if you will watch a woman in labour you will be struck by the fact that instinct alone teaches her how to help herself; she will plant her feet against whatever gives support, flex her

thighs, and often open them, clutch the bedclothes, and hold her breath, and bear down, all of which acts help parturition.

If you will look backwards at the practice of midwifery in the past you will be struck by the fact that parturition was looked upon as a very dangerous thing to the woman.

All the textbooks dwell upon this danger, which was looked upon as partly due to changes which took place in the blood during pregnancy, rendering the individual extremely prone to inflammation, and partly due to the continuance of the effect of the curse of Adam and Eve when they were driven from the Garden of Eden—"In sorrow thou shalt bring forth children."

It certainly did appear to the obstetricians of the past that parturition was an extremely dangerous thing, and the data we have at our disposal prove that indeed it was dangerous in those days. The frightful mortality in the lying-in hospitals in London and elsewhere, when almost every woman confined within their walls died from "fever," leading to the closing of the hospitals for periods of many months in the hope of getting rid of the bad atmosphere which a congregation of patients in one ward was supposed to set up, makes one shudder. The *bête noire* of the practitioners of the past, namely, puerperal fever, was no mere bogey raised to frighten people, but was a reality which caused untold misery and grief.

And yet, when you come to look upon the practice of midwifery at that time, as it is graphically described and recommended in the various textbooks, you will see, thanks to the light thrown upon it by our knowledge of the causation of inflammation and its prevention by suitable methods, that this very dreadful fever was not due to some pathological condition of the blood caused by pregnancy, rendering it prone to inflammation, nor to any continuance of the curse on Adam and Eve. It was caused by the accoucheur himself, or, at all events, by him, or her, or those who assisted in the act of parturition. They had no idea that when they made a vaginal examination they were introducing on their fingers the seeds of the poison that was about to kill the patient or make her ill. Hence there was no limit made to the number of such examinations during each and every stage of the labour. With no knowledge of bacteriology, with no precautions therefore against the introduction of germs, what wonder was it that so many patients died from "fever," and that few, if any, escaped some sort of inflammation? The wonder is that any woman escaped alive even after what was looked upon as normal labour.

Then when you read of the methods employed in the delivery of the placenta—as, for example, pulling on the umbilical cord—you are not astonished at the large number of cases of excessive *post-partum* haemorrhage.

When Pasteur, the Kepler of medicine, published his classical paper about milk—why it turned sour, and how it could be prevented—and when during the reading of this the inspiration came to Lister, the Isaac Newton of medicine, to apply it to wounds, then began that glorious epoch which has revolutionized every department of medicine.

Limiting myself to-day to its effect upon the practice of midwifery, and more especially its effect upon the actions of the accoucheur in an ordinary normal labour, let me sketch the main features of the change that has been wrought. The germs which caused the fever were said to exist in the air, and some thought they might also exist in the parturient canal, more especially on the vulva and in the mucous membrane of the vagina and cervix uteri. Hence began the practice of washing the external genitals and of syringing the vagina with antiseptic lotions, more especially with carbolic lotions of various strengths, because carbolic lotion was the antiseptic used and recommended by Lister in surgical operations. The number of cases of "fever" of all sorts following labour decidedly decreased; and when the uterus itself was washed out, as soon as the placenta was born, with a solution of mercury perchloride sufficiently strong to kill the supposed germs, "puerperal septicaemia" was practically eliminated—from the lying-in hospitals, at all events.

More and more facts were discovered, and it was found that the germs were not so much in the air as on the fingers of the accoucheur. Hence began the practice of hand disinfection, with marvellous results.

Some of us pointed out that the syringing of the uterine

cavity after every labour was a measure attended by a slight risk, and that where no germs had been introduced by the accoucheur, syringing was to say the least unnecessary. Doubtless so long as hand disinfection was imperfect, routine vaginal and uterine douching with antiseptics was beneficial. Its advocates, however, were obliged to admit that with the evolution of antiseptics and asepsis, with the knowledge that not only is the vagina itself aseptic as a rule, but also in its upper part and within the cervical canal there is usually an antiseptic secretion, it was unnecessary to wash out the uterus after every labour. Some of them, however, went on recommending routine douching of the vagina after labour, and up to a few years ago it was almost impossible to convince a nurse who had been trained at a lying-in hospital that a patient would go on quite all right without any rise of temperature unless she had the vagina washed out regularly after labour. But it was found that if no germs were introduced the patients made a perfect recovery without syringing of any kind, and inasmuch as there was always a slight risk in syringing, this was given up entirely by most authorities at all events.

Again, the fact that in the majority of cases the poison which caused the puerperal fever was not autogenetic—that is, already existing within the patient's parturient canal—as was not unwillingly imagined and believed by those who unfortunately had these cases, but was heterogenetic, that is, arose from outside, and was introduced into the parturient canal by those who examined, namely, on the fingers of the doctor or of the nurse or of both, led to the evolution of hand disinfection, including the wearing of boiled indiarubber gloves.

In the inaugural address which I delivered before the Obstetrical Society of London in 1901¹ will be found some interesting facts in regard to progress of the practice of midwifery during the nineteenth century. In 1893 I published a paper in the *Clinical Journal* on the management of natural labour. In 1903 I delivered an address on puerperal sepsis in Oldham which was published in the *BRITISH MEDICAL JOURNAL* for February 13th, 1904. In each of these, in debates on cognate subjects, and in my lectures and teaching at Guy's Hospital, I have endeavoured to show how all advances made in our knowledge of the causation of troubles arising during and after labour prove that the nearer we can approach to Nature's methods, the more perfect are the results.

The study of the subject causes the unbiassed mind to leap to the conclusion that the fewer the examinations, during labour, the less the risk of infection. Science says Hands off! But she also says that if an examination be made then indeed a great responsibility is placed upon the person making the examination.

I have shown how a man might make his examining hand as aseptic as is possible and yet how he might get it contaminated *en route* to the vagina, through touching the bedclothes or the vulva. It was shown that a woman who was delivered without any examination at all generally did perfectly well, and that the nearest approach to such an ideal labour was to make only one examination and to let that suffice when it was found that everything was normal. I described a method of attaining a practically perfect asepsis of the examining hand, and a method of examining without soiling the hand during the introduction of the examining finger into the vagina.

The number of letters I received from medical men, the number of medical men whom I met in consultation who told me how the reading of that address had altered their practice, the evidence there is that other teachers have begun to adopt and to teach the same practice, all these have been very gratifying. At the same time much has yet to be done to convince practitioners that a woman can deliver herself safely without help of any kind in the vast majority of cases, and that the less he interferes the better.

I need hardly say that in these days it is little short of criminal to terminate normal labours as quickly as possible by the use of forceps or manual interference. It may be true that with all-metal, boiled, aseptic forceps, with aseptic hands and parturient parts, a child may be delivered quickly without setting up puerperal sepsis. But unless there is good reason for such quick delivery, such as undue delay of the head at the brim or in its course along the pelvis, it is quite unjustifiable. To do it to save one's own time, or to shorten the sufferings of

labour (of course I am speaking of normal cases) is not justifiable. You cannot terminate labour before the parts are ready without doing some damage.

Indeed, I have come to the conclusion that you cannot interfere at all without detriment to the process. For example, one practitioner said to me, "I quite agree with all you have said, and intend to follow the instructions given; but at the same time I intend to continue my practice of following down the uterus with my hand on the abdomen during the second stage of labour, as I believe this prevents *post-partum* haemorrhage." It is a very difficult thing to overcome prejudice. But if you will watch the next normal case of labour, and not touch the abdomen with your hand during any of the stages of labour, you will be perfectly satisfied with the result. The physiological act of parturition evolved by Nature in the countless ages that are gone has not been left so imperfect as to require pressure on the uterus during the second stage. A study of the phenomena of contraction and retraction shows that it is better for the uterus to do the work itself.² The results of omitting this interference prove that *post-partum* haemorrhage is not prevented by following down the uterus during the second stage of labour. That it is, to say the least, an unnecessary procedure. Personally, I think it is injurious, though the injury may be slight and unimportant.

Again, another medical practitioner said he agreed with every point except one—namely, that he felt sure he had saved the perineum from being ruptured by a careful support with the hand during the distension, and a slipping backwards of the perineum over the head at a suitable moment in between the pains. But he admitted that in most primiparae this so-called support of the perineum did not prevent laceration of the posterior fourchette, and perhaps just a little of the perineum, but he felt convinced that, but for the support, the perineum would have been torn much more extensively. You will see how difficult it is to say in a given case whether the perineum would have given way more or less had it not been supported.

What I appeal to, however, are facts. You must, if you wish to arrive at the truth, investigate the subject by examining the perineum in a large number of normal labours, where there has been no so-called support of the perineum, but where Nature has been left alone. If you will do this you will arrive at the same conclusion as I—namely, that it is unnecessary to support the perineum; that to do so in normal labour is, to say the least, an unnecessary proceeding; that the extent of rupture of the perineum varies considerably in different women, according to the relative size of the child's head and the parturient canal, and to some extent according to the rigidity or elasticity of the parts and according to the speed of the birth.

Doubtless there are cases in which a judicious interference will save the perineum, but to-day I have not time to enter into the particulars of such cases. I am speaking of the 90 per cent. and more of cases which are normal, and telling you that you need not support the perineum at all in them. Your results will be just as excellent, if not more so.

If, then, you have followed my arguments, you will see that all the facts that we have gleaned from the evolution of antiseptics and asepsis point to this: namely, that in a woman who delivers herself without being examined or helped at all—that is, when Nature is left alone to perform a physiological act—the result is, as a rule, perfection so far as mother and child are concerned.

The question arises, therefore, what is the good, then, of a doctor?

Well, please remember that in a very small percentage of cases you get an abnormal labour. For example, you might get a transverse presentation, where version would save the child; a prolapse of cord, replacement of which would save the child; *post-partum* haemorrhage, where suitable treatment would save the mother, besides many other conditions that threaten injury or death to mother and child or to both. It is on account of these cases that at all events one examination should be made. By this one examination you can, as a rule, discover whether you are dealing with normal labour or not. Possibly in a few instances you might require to make a second, or even more examinations, in order to satisfy yourself that all was right. At all events, having done so, it is not neces-

sary, as used to be taught, that you should go on making repeated examinations to see how things are progressing. On the contrary, you know by one examination that everything is normal, you have eliminated most of the ordinary abnormalities, and you can leave the rest to Nature, and in very rare instances will you find anything abnormal coming on subsequent to your examination. Of course it might. For example, you might examine just before the end of the first stage, and later on, when the membrane did rupture, the umbilical cord might become prolapsed with the rush of liquor amnii. Hence some men prefer to make this one examination after the end of the first stage, or if an examination has been made during the first stage, a second one could be made soon after the rupture of the membranes.

I will now deal with the modern practice of midwifery so far as regards normal labour, which will include upwards of 90 per cent. of all cases.

A lady comes to engage you in her confinement, and you will have to decide the question of examining her to see if everything is normal. My advice to you is not to make any hard and fast rule in regard to routine examinations. At Guy's Hospital for many years the women whom we attend—more than 3,000 per annum—are not examined at all when they obtain their cards entitling them to send for the extern attendant. The distribution of the cards is carried out by a clerk in the medical office, who is not even a medical student, and, so far as I am aware, no harm has resulted from this practice. In private practice, if the lady is a dwarf, or obviously deformed, or suffering from spinal curvature, or has one leg shorter than the other, or has any condition which might affect the normal conduct of labour, then you should suggest an examination. Again, when the patient herself, or her husband, or mother, or other relative or friend expresses any anxiety as to whether things are right, by all means suggest, or fall in with the suggestion, of making an examination.

Under any of these circumstances let your examination be thorough. Examine the breasts and nipples; examine the pelvis, especially measuring the distances between the anterior superior spines and the crests of the ilia. Examine the vulva and note any abnormalities. Make a vaginal examination and estimate the oblique conjugate diameter. Note the height, depth, and width—in other words, estimate the size of the uterus and compare this with the period of gestation indicated by the period of amenorrhoea. Note any abnormalities in the vagina, cervix uteri, Douglas's pouch, broad ligaments, rectum, bladder, or pelvic bones.

You will find that in the great majority of cases no examination at all is necessary even amongst primiparae. Amongst multiparae, if you have attended the lady before, you know if things are normal, and if you have not attended her before she will be able to inform you whether her past labours have been straightforward or not. If they have, you can assume that all is right.

If you are allowed to select the nurse, you will naturally recommend one on whom you can rely; but if the lady selects her own nurse, you should find out whether she has been properly trained in modern midwifery practice, and you should inform her what you wish her to do, and what not to do. She should not, for example, make any vaginal examination. I am, of course, speaking of a nurse only, and not of a midwife. When labour begins you must be summoned to the case, and you should examine the patient to find out if she is in labour, and if everything is normal. For this purpose your examining hand should be prepared with as much care as if you were about to make an abdominal section. There are different methods of preparing the hand. The one I adopt myself, and which is practically perfect, is to get it thoroughly clean domestically by means of very hot water, soap, and a nail brush, then to scrub well with a 2 per cent. solution of lysol, and finally to immerse the whole hand in a solution of mercury perchloride, 1 in 1,000, for not less than two minutes. It is important that the hand be kept immersed during the two minutes; it is not sufficient to move the hand in and out of the lotion. The wearing of an india-rubber glove which can be rendered aseptic by boiling has been greatly recommended, especially by some German authorities. The objection to gloves is that the thicker they are the more they interfere with tactile sensibility, and the thinner they are the more readily do they tear, and the more readily can germs

permeate them. Under certain circumstances gloves, however, are a great help, especially in protecting the hand itself from contamination in cases of virulent sepsis. Nevertheless, when the hand is ready, it should not be allowed to touch anything *en route* to the vagina. No unguent need be used.

The bedclothes should be raised by the nurse and the right gluteal region and the right labium majus; the patient, being in the left lateral position, should be raised either by the nurse or by the non-examining hand of the accoucheur. In this way the vagina is exposed, and the examining finger can be introduced without touching any external part. If the patient is on her back, the labia majora can be separated by one hand, and the examining finger can be introduced similarly directly into the vagina, care having been taken not to touch any of the bedclothes. Of course, whilst you are preparing the hand the nurse can be preparing the patient, if she has not already done so; and that means, not merely getting her into the required position, but also washing the vulva.

Some have gone so far as to recommend shaving the vulva, but this has not been found essential to success. So that most authorities are agreed that a thorough washing with soap and water and a 2 per cent. solution of lysol, or some other equivalent antiseptic, is all that is required. The nurse should confine her cleansing to the vulva, and should not try to wash or wipe the vaginal walls in any way. A thorough examination of this kind will take twenty minutes, unless everything is ready when the doctor arrives, in which case it may take much less. But, in any case, it can hardly take less than ten minutes. A practitioner may argue that he is too busy to spend so much time. All I can say is that it is worth the time, and, in fact, it will probably save his time in that when he finds, as he will in nearly all cases, that everything is right he can go away feeling quite happy about the result, assuring the lady that all is natural, and that she need have no fear. In the ordinary run of practice he will look in again after an interval, which depends on the state of things when he examined, and he will be able to judge very well as to the progress made by inquiring about the frequency and character of the pains, and their situation. If at his first visit the membranes are not ruptured, he may, if he thinks fit, make a second examination after their rupture to satisfy himself that the cord is not prolapsed, and that his conclusion that everything was normal is still correct; but he must do it again with the same elaborate precautions. Finding everything satisfactory, he need not wait if he is busy with other things. All the same some ladies insist on the doctor remaining from the very onset of labour until it is over, and most of them feel very aggrieved if he chances to be away when the child is born, even though everything is normal. By experience a doctor with a large midwifery practice becomes very expert in judging how soon the child will be born, but I fear in most instances his knowledge has been derived by repeated examinations so as to note the advance of the head.

The number of children before the arrival of the doctor in our own lying-in charity is very considerable, and a study of these cases shows that, as a rule, the mother and child do well.

Very often a lady will beg and pray the doctor to give her chloroform or to terminate labour quickly, as she cannot endure the pain. Now please remember there is no such thing as a painless labour. It would be abnormal if it were painless. There is no known method of rendering it painless without injury. If you administer chloroform or any other anaesthetic, or give morphine or other preparation of opium, you retard or stop the uterine contractions, and thus retard labour to the detriment of mother and child. Some believe that the administration of anaesthetics during labour causes *post-partum* haemorrhage. No doubt there are women of a very sensitive nature who suffer so acutely from labour pains that practically the labour becomes abnormal, and one is obliged to resort to chloroform. Such cases, however, are few, and hence in the majority of parturient women anaesthetics ought not to be given. Some practitioners always give a few whiffs of chloroform during the most painful part of the second stage, but my advice to you is not to give any at all if you can possibly help it. It is unnatural for a woman to be unconscious when the child is born. The reflex stimuli or afferent impulses are interfered with, and

the resulting parturient forces are to some degree, at all events, impaired.

Again, do not follow down the uterus with the hand during the delivery of the child. Some women find a great help and comfort in having the back supported or pressed upon by the hand of the doctor or nurse during the pains. It is good to have the patient arranged on the bed so that she can plant her feet against a firm support, and hold on to something like a towel tied to the end of the bed. She can then exert her voluntary forces to help the involuntary forces.

Again, it is best not to interfere with the perineum. The child's head will distend it, and eventually there will be in primiparae a slight tearing of the posterior fourchette and of the perineum. But in the majority of cases such tearing will not require a stitch. Notching of the cervix uteri at the os externum, and this slight laceration of the perineum, may be looked upon as normal, inasmuch as they occur in the large majority of primiparae. Further extension of the lacerations in subsequent parturitions depends upon many circumstances, such as the size of the child and the speed at which it is born, and upon the condition of the parts, that is, rigidity, elasticity, etc.

As soon as the child's head is born, note whether the cord is round the neck. When the child is completely born, see that it is in a good position to breathe, and if respiration begins satisfactorily do not tie the cord for at least five minutes. This gives the child more blood, and its movements as it lies against the mother are beneficial in that she feels them and it gives her joy and satisfaction and probably acts reflexly in promoting uterine contractions. If the child cries the sound has the same beneficial effect on the mother. After five or more minutes the cord should be tied an inch or so from the navel, a second ligature being put further away to prevent loss from the placental side, though this is slight after waiting as recommended. Any kind of ligature may be used—strands of thread, pieces of tape, pieces of silk, etc.—so long as they are surgically clean, which is easily ensured by having them boiled. The cord is then divided between the ligatures, giving a good half-inch beyond the first ligature. The child is then wrapped in a warm cover and removed.

As soon as the second stage is over the mother's pulse should be felt, and the amount of bleeding should be noticed by looking at the vulva. If the pulse is about 80 to 90, and the visible haemorrhage is not excessive, a normal condition may be assumed without feeling the uterus. Some recommend that as soon as the child is born the uterus should be grasped through the abdominal wall to feel if it be contracted, and if it is not, then it should be well rubbed and kneaded to make it contract. Such a practice is quite unnecessary so long as there is no excessive visible haemorrhage, with a pulse of 80 to 90, which indicates that there is no internal haemorrhage. For as a fact the uterus may be found either in active contraction, when it is hard, more or less spherical, well defined and easily grasped, or it may be relaxed, when it is soft, less spherical, ill-defined, and difficult to feel. Both these states are normal, and indeed they follow one upon the other quite naturally and rhythmically.

The management of the third stage of labour is of great importance. To make traction on the umbilical cord is so easy to do, and so tempting, that one is not surprised to find it being practised by ignorant people. Indeed, you will find in the textbooks of some generations ago it is mentioned, and it was advocated by the then teachers of obstetrics. The number of cases of *post-partum* haemorrhage following upon this practice led to its gradual condemnation and abandonment.

The method recommended by Crd was a great improvement—namely, to wait for twenty minutes at least, and then to express the placenta by squeezing the uterus through the abdominal wall. Certainly this method is very effective, and is followed by excellent results, because it approximates very closely to Nature's method. What happens if you leave the patient alone? You will find that she lies still, and sometimes she will even go to sleep, and after the lapse of a time varying from a few minutes to an hour or more, but certainly averaging thirty to forty minutes, she will begin to experience more pains, like, though less severe than, the pains already suffered. The uterus is beginning to expel the placenta. After a few pains the patient contracts the diaphragm and

^a abdominal muscles, at the same time closing the glottis. She thus bears down, and in this way intra-abdominal pressure is brought to bear to help the force of the uterine contraction, and the placenta is driven out. Sometimes it is driven out of the uterus, but remains in the vagina, where it may lie for a long time, unless it be removed.

You will observe that Nature's method is by pressure from above, and that it is done partly by involuntary contractions of the uterus and partly by voluntary bearing down. These involuntary contractions of the uterus are of great importance, in that they attain the complete retraction of the muscular fibres, so essential to the prevention of haemorrhage. Hence, Nature's method is the most perfect of all, and my advice is to let Nature perform the third stage as well as the others. It is true that it takes a longer time, but in normal labours I maintain that this time is not ill spent. During the interval between the birth of the child and the expulsion of the placenta changes are taking place which are beneficial. The circulation of fetal blood through the placenta has ceased and the flow of maternal blood through the sinuses has become checked. As the complicated network of muscular fibres contracts during the separation of the placenta these sinuses are closed, the maternal circulation through them is stopped, and bleeding is prevented. Haemorrhage is often caused by partial separation of the placenta, and this is more likely to occur if pressure is made on the abdomen during the second stage of labour. Hence, by leaving the patient alone there is better retraction at the termination of the second stage and less likelihood of partial separation.

Again, by allowing Nature to expel the placenta you get a better and more complete contraction and retraction of the uterus, and hence the minimum risk of excessive haemorrhage. Some accoucheurs set to work as soon as the child is born to get rid of the placenta by kneading and squeezing the uterus, trying to excite it at once to contraction, and failing that to expel the placenta by forcible manual expression, the patient often crying out because she is hurt. One need scarcely say that in normal labours such a method is to be condemned. Often enough it is found impossible to expel the placenta because it has not yet become detached. The violent efforts made occasionally succeed in partially separating it and so starting a profuse haemorrhage.

After waiting the twenty minutes recommended by Crd, it is true that as a rule it is not difficult to express the placenta, and the number of cases of haemorrhage following is small. But if you will not be in a hurry, but let Nature finish the work, the results are still better.

Again note the amount of visible haemorrhage and the frequency of the pulse, and if both be satisfactory, carefully examine the placenta to see if it is complete.

The draw-sheet should be removed and a dry sterilized pad should be placed against the vulva to soak up the lochia. The binder round the abdomen has become old-fashioned. It is not of much importance, but I advise you not to use one. It has been shown by Herman² that it certainly does not prevent haemorrhage, nor does it preserve the figure. It is disturbing to the patient to put it on and as often as not gets rucked up under the waist so as to be practically no binder at all.

If the patient is made clean and has the sterilized pad applied so as to receive the lochia she should be allowed to lie still and to rest and if possible to go to sleep, which indeed is what she generally does.

Before the accoucheur leaves the house he should assure himself by inspection that the perineum is not torn more than is normal, necessitating stitching, that there is no undue visible haemorrhage and that the pulse is not quick. If he does these things he need not try and feel the uterus to see if it be contracted or not, because it may be either one thing or the other and yet be normal. Of course he may examine the abdomen to see if there be a twin. But he need make no vaginal examination whatever, unless there is something abnormal in the way of haemorrhage, etc.

Possibly some of you may be thinking that in a lying-in ward, with all modern methods of attaining asepsis, with plenty of help in the way of nurses who can attend to the patient, wash her and keep her clean, remove all dirty garments and replace them with surgically clean things, with bed and bedding clean, and with every precaution

used to prevent infection, it is all very well to trust to Nature to do the business, but that it is a very different thing in private practice, especially amongst the poor, who have no proper conveniences for carrying out the ideal.

But let me ask you, has puerperal septicaemia in the past been confined to the poor? Has it not affected the rich quite as much, and indeed in a larger proportion? Has *post-partum* haemorrhage been confined to the poor? Certainly not. Poor women have often been delivered dressed in rags and with dirty skins and yet with perfect safety. So long as the poison was not introduced into the parturient canal by fingers or instruments, so long as she was not injured by injudicious attempts at helping her, by pressing on her abdomen, pulling on the child, making traction on the umbilical cord, etc., she generally did well, as statistics have shown.

To what do all these facts point? Why, simply this: that you cannot do better than to follow and to imitate Nature as closely as possible; that an ideal labour is one where everything is left to Nature, and that the nearest approach to this ideal means the least interference possible.

Please remember that this is not merely speculative opinion, but fact based upon experience.

Before concluding, there is one other point I would like to mention, and that is the baby. Unfortunately, it has become a settled routine practice for nurses to drop a few minims of a solution of mercury perchloride (1 in 4,000) or a single drop of a 2 per cent. solution of silver nitrate, so strongly recommended by Crd, into each of the child's eyes. This is to prevent ophthalmia. I strongly recommend you to allow the nurse to do no such thing unless you have reason to suspect that the mother is suffering from gonorrhoea or other irritating discharge. When you are aware of such a discharge, of course you would do your best to cure it before the parturition, and you would have the child's eyes washed thoroughly by salt and water as soon as it was born, and you would see that a germicidal solution, of which no doubt Crd's 2 per cent. of silver nitrate is the best, is dropped thoroughly into the eyeball between the lids and repeated if need be. But where there is no gonorrhoea, where the patient has no discharge staining her linen yellow or green, but where everything is normal, do not allow this routine practice of dropping something into the child's eyes. You should look at the baby yourself to see that there is no bleeding from the cut end of the umbilical cord, to note any abnormalities in fingers or toes, cleft palate, harelip, congenital malformations, spina bifida, etc. The nurse should wash the baby, and should be very careful not to contaminate the eyes with anything septic. If she carefully wipes the eyelids with some aseptic material, like sterilized gauze, that is all that is required. There will be no ophthalmia. Since adopting this plan in my cases in our lying-in ward at Guy's we have not had a single case of ophthalmia neonatorum. No one should be allowed to open the child's eyes, by separating the lids, in order to see what colour they are.

And now my task is finished; and if I have succeeded in convincing any of you that the birth of a child is a physiological act which is more perfectly performed in the vast majority of cases by Nature herself than by any other known method; if I have persuaded you that the less interference on the part of the accoucheur the better, that in an ideal labour no interference whatsoever is required, and that therefore the fewer examinations are made the better, one, or at most two, being quite sufficient in the majority of cases; that patience is a greater virtue than usual in midwifery practice, and that it is never justifiable to hasten a normal labour to save your own time; that routine vaginal syringing before and routine uterine or vaginal syringing after labour in normal cases should not be practised; that routine application of germicides to the eyes of every newly-born child is unnecessary, to say the least—I shall feel amply repaid; for there is a great truth contained in the old Latin saying:

Natura enim non nisi a parendo vincitur.

REFERENCES.

¹ *Obstetrical Society's Transactions*, vol. xliii. ² *Journal of Obstetrics and Gynaecology of the British Empire*, vol. i, No. 1, Article, Retraction of the Uterus. ³ *Obstetrical Society's Transactions*, vol. xxxii.

THE German Society of Orthopaedic Surgery will hold its fifth congress at Breslau on April 3rd, under the presidency of Professor Adolf Lorenz.

An Address

ON THE

NECESSITY FOR IMMEDIATE DIAGNOSIS IN CASES OF UTERINE CANCER.

READ BEFORE THE BIRMINGHAM BRANCH OF THE BRITISH
MEDICAL ASSOCIATION.

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In one out of every four women who die of malignant disease the uterus is the organ affected; in England and Wales, therefore, about 4,000 women succumb to uterine cancer every year. The average duration of the affection from its commencement to a natural termination is between two and three years, so that at any given time there are approximately 10,000 patients suffering from this distressing malady.

Twenty years ago the diagnosis of uterine cancer at any stage was equivalent to a sentence of death. Patients therefore delayed seeking advice until the sufferings of the later periods of the disease compelled them, while the medical officer often postponed examination in order that the patient might not be deprived of hope. In the few early cases that came into their hands some operators practised supravaginal amputation of the cervix, the mortality of which was considerably greater than that of vaginal hysterectomy to-day.

In a discussion that took place at the Obstetrical Society of London in 1885 the Fellows generally agreed with Dr. W. Duncan that the risks of vaginal hysterectomy were so great as practically to condemn its employment in an attempt at the radical cure of cancer. Dr. Duncan showed that until that time the immediate mortality of vaginal hysterectomy for uterine cancer was 28.6, while that of abdominal hysterectomy was 72 per cent. Since then surgery has advanced in this as in other departments of practice, so that now the operative treatment of the disease is judged, not by its immediate mortality, but by its remote results as regards recurrence.

The total number of deaths due to vaginal hysterectomy for cancer does not at the present time exceed 5 per cent. Until December 31st, 1905, I had performed 48 vaginal hysterectomies for cancer of the uterus, with 1 death following the operation. In 40 of these cases, including the fatal one, the operation was done for cervical cancer, so that the immediate mortality of the operation for this variety works out at 2.5 per cent. In a large proportion of cases operated upon the disease reappears sooner or later. The great majority of these recurrences make their appearance during the first twelve months following the operation; afterwards return takes place with diminishing frequency until the end of five years; occasionally it may occur at a still later date, but this is so rare that it may be neglected. In reckoning the remote results of operations for uterine cancer it has therefore become customary to fix upon a term of five years' freedom from recurrence as being equivalent to a definite cure of the disease. On this basis vaginal hysterectomy has been found upon an average to lead to the definitive cure of one-third of the cases in which it is employed—an estimate that was arrived at in a paper of mine published in the first volume of the *Journal of Obstetrics and Gynaecology of the British Empire* in 1902.

The number of cases in my own practice operated upon at a sufficiently remote period is too small for a statistical consideration of the final results to be of much service. In only 14 cases was the operation performed more than five years ago, and of these 6 cannot be traced. Two, however, are known to be free from recurrence, so that at the very worst the rate of cure has been 14.3 per cent. One of these cases was of particular interest, in that it occurred in a woman presenting marked signs of congenital syphilis, and the pregnant right tube was removed at the same time.

CASE I.

L. Y., aged 38, had had seven children and seven miscarriages. She had been losing blood by the vagina for seven weeks, and for the last week there had been flooding with clots; for seven weeks there had also been aching and swelling in the vulva. Vaginal hysterectomy was performed on August