blood being mixed with saliva or mucus. There was sometimes a profuse quantity of saliva tinged with blood. The right lung was normal. There was dulness over the left lung, and the respiratory murmur was feeble. Dr. Sansom saw him the day after this, August 28th, and supplied the following notes:

"There is evidence of hypertrophy of the left ventricle. The heart's apex is felt and mapped out beneath the seventh rib and costal cartilage. There is a systolic murmur of slight intensity, audible at the aortic cartilage, and in the third and fourth left intercostal spaces close to the sternum. There is no evidence of dilatation of the right cavities. The irregularities of the heart's rhythm are very peculiar. After a group of three pulsations—on some occasions of two—there occurs a long pause. This pause, as timed carefully from the sphygmogram, lasts just five seconds. Its time duration is rather less than that occupied by the group of three pulsations. In linear measurement the former was 56 millimetres, the latter 32 millimetres. It is concluded that this extreme bradycardia must be due to an irritating lesion of the vagus, the problem being how the irritation was produced. The breath sounds are notably diminished over the upper lobe of the left lung. There is marked inspiratory stridor."

September 21st. He complained of shooting pains about his body, especially in the upper part of the left arm, also in the chest, thighs, and right arm, which pains were sharp and momentary.

October 21st. Pain in the chest continued; he had had some hæmoptysis. There was dulness on percussion over the great part of the left side of the chest to the line of the sternum, and also dulness behind. The heart's impulse was most distinct to the left of the nipple towards the axillary line. The breath sounds over the left side were feeble, especially over the upper part. There was pain, with difficulty in swallowing, referred to about the mid sternum. He had had only one slight rush of blood for a fortnight. The inspiratory stridor was not so distinct. The pulse was 44. The pupillary reflex was better. Knee-jerks were normal.

October 25th. The pulse was 46 and much more regular in rhythm; there were occasional groups of two or three beats. Dulness still existed over the left side, with the exception of an area of resonance over the site of the pulmonary valves. Here also there was a rough systolic *bruit*.

October 29th. Dysphagia was very troublesome for solids. Fearing that there was some intrathoracic tumour, possibly either a malignant growth or an aneurysm, another consultation was held with Dr. Sansom, who on October 30th gave his opinion in favour of an aneurysm of the aorta pressing upon the œsophagus and the root of the left lung. There were no signs of any outward determination of the sac towards the chest wall, and there was considerable displacement of the impulse of the heart towards the left, almost to the axillary line. He was ordered rest in bed, with light diet, and iodide of sodium gr. 25 thrice a day.

December 12th. The dysphagia had been very troublesome of late, but was now better for fluids. The cough was better, being only occasional and not severe. There was no dyspnoea when lying quiet in bed, but there was if he made any kind of exertion. The pain in the chest was better, and also the rushes of blood. Palpitation still occurred at night. The pulse was 48 to 50, and was variable. Sometimes it was regular for thirty-six or forty-eight hours, and at other times it relapsed into groups of three or four. Change of position altered both its rhythm and rate, and after an attack of palpitation it would beat regularly at 50 for a long time. The *bruit* over the chest was less distinct. The heart's beat was more tranquil, and the impulse had receded more towards the normal position. The dulness over the chest was still the same. The inspiratory stridor was not so distinct.

January 14th, 1895. A great change for the worse had taken place within the last few days. There was now considerable dyspnoea, mostly inspiratory. The pulse was 60, running up to 69. The urine was very scanty, and loaded with lithates; and there was marked hoarseness. He was very weak, and complained of pain at the epigastrium and at the posterior lobe of the left lung. The dulness extended across the sternum to the right. There was exaggerated respiration

over the right lung, and forcible pulsation in the epigastrium (right ventricle?). There was a creaking sound over the ribs at the left lateral base, and over the precordium with each impulse of the heart.

January 15th. There was considerable dyspnoea. The pulse was 60, and quite regular. Cardiac displacement was marked to the right of the sternum, and percussion dulness also. He died quietly that night. There was no hæmorrhage at the end. With the exception of the pulsation at the epigastrium the day before he died, which was due to the heart being gradually displaced to the right by effusion into the left pleura, there had been no evidence of any pulsation or pulsating tumour over any part of the chest.

The necropsy was made the next evening. The body was emaciated. There was a large quantity—8 to 10 pints—of fluid, slightly tinged with blood, in the left pleural cavity. There was also a small quantity—about 10 ounces—in the right pleural cavity. With the fluid from the left side there were some old blood clots. The left lung was entirely collapsed, occupying the upper and posterior part of the cavity, and lying upon the spine. The upper part of the lung was hard and dense, the lower portion was in a condition of hypostatic congestion. The whole left lung was no larger than two closed fists. The right lung was hypertrophied, and in a partially emphysematous condition; it was deeply congested. In the posterior mediastinum was a large mass of new growth, quite fibrous and hard, which filled up the posterior mediastinum, and enclosed all structures in its vicinity. The root of the left lung was especially involved, the growth having completely occluded the left bronchus, and compressed the pulmonary artery and veins. There were trabeculous extensions of the growth into the adjacent part of the left lung. The pneumogastric nerves and the œsophagus—down to the diaphragm—and the trachea were surrounded by the growth. The descending aorta was also implicated, being somewhat constricted below, and dilated above the constriction. The growth was perfectly hard and fibrous, and no ulceration or breaking down had occurred that could be seen. It was firmly adherent to all its surroundings, to the spine and the diaphragm, and involved and compressed in its growth all structures at the back of the thorax. The heart was hypertrophied and slightly fatty, the hypertrophy being most marked in the right ventricle. The liver was very much enlarged from venous congestion. The spleen was the same. Nothing abnormal could be found anywhere else.

It is in the highest degree probable that the remarkable bradycardia and the grouped beats with the long pauses between were due to an irritant lesion of the vagi, for the necropsy showed that these nerves in a portion of their course were surrounded by the malignant growth.

CASE OF SEROUS EFFUSION INTO THE PLEURA OF EIGHTEEN MONTHS' DURATION,¹

TREATED BY REPEATED PARACENTESIS, AND SUBSEQUENTLY BY FREE INCISION, PROBABLY TUBERCULOUS IN ORIGIN, AND ASSOCIATED WITH CHRONIC ASCITES; RECOVERY COMPLETE, WITH RE-EXPANSION OF THE LUNG AND LITTLE CONTRACTION OF THE SIDE.

By SAMUEL WEST, M.D., F.R.C.P.,

Assistant Physician to St. Bartholomew's Hospital; Senior Physician to the Royal Free Hospital, etc.

IN June, 1893, I was asked to see Miss B. P., aged 31, whose abdomen and right side of the chest had been full of fluid for more than twelve months. The object was to obtain my opinion as to whether anything could be done to relieve her.

It appeared that until September, 1891, she had been in perfect health, and was active, energetic, and athletic. She then began to feel weary and to lose her usual energy. In October she became troubled with severe pains in the abdomen, which came on and off, both night and day. She had

¹ Read before the Medical Society of London.

a good deal of discomfort after meals and the abdomen increased in size. In November ascites was diagnosed, which, in December, was stated to be of a tuberculous nature. She was treated by rest, local inunctions, and tonics. She was now troubled with a good deal of obstinate diarrhoea, and she lost weight and strength rapidly. On January 2nd, 1892, she first felt pain in the right shoulder, and a few days afterwards a small pleuritic effusion on that side was diagnosed. From this time until March she was in bed, but made no improvement. The fluid in the abdomen and pleura had greatly increased, and at Easter the question of paracentesis was raised, but, after consultation with two other doctors near her home, it was decided against. As far as I can learn, the opinion was expressed that the case was one of widespread tuberculosis, and therefore unsuitable for any operative interference. The patient was allowed to get up daily and to drive out whenever the weather was favourable.

All this time she dragged on a miserable existence, the abdomen being of considerable size and the cause of great discomfort on account of the weight, while the breath was very short. She became wasted almost to a skeleton, and her family was informed that she could not recover.

From July to December she remained *in statu quo*, the question of paracentesis was raised more than once, but each time decided against.

During the next three months she improved, and was able to go out daily for a drive or short walk; but in the spring the fluid increased, and she was sent up to London to see me in June, 1893. I found her then greatly wasted, little more than skin and bone, and looking like a patient with advanced phthisis. The temperature was normal. The abdomen was full of fluid and greatly distended, though the walls were lax. The right pleura was also full of fluid and was dull to the clavicle, the heart being displaced as far as 1 inch outside the left nipple line.

The family history was bad. An aunt on the mother's side and an uncle on the father's side had both died of phthisis. She was one of five children; one sister died not long ago of acute phthisis, and one of her two brothers had been phthisical for some years.

The questions put to me were: "Ought she to be tapped? and what prospect was there of doing her any permanent good, the fluid having been permitted to remain so long without interference?"

In answer to the first question, it seemed clear to me that she ought to be tapped at once. In respect to the second question the answer was much more difficult; in the first place there was no doubt in my mind that the affections both of the abdomen and pleura were tuberculous in origin, but the prognosis was very different in the two cases. Tapping the abdomen was certain to give great relief, and it was quite possible that even after a single tapping the fluid would not return. This opinion was a great encouragement to the patient, for she attached more importance to the condition of the abdomen on account of the disfigurement it produced than she did to the state of the chest. In respect of the pleura the prognosis was doubtful, for all depended upon the extent to which the lungs might re-expand; and considering that they had been compressed by fluid for more than twelve months, it was most likely that they were bound down by adhesions, perhaps even permanently. Under any circumstances the paracentesis would have to be repeated; and recovery, if it took place at all, would be a question of time.

It was decided that she should remain in London and be under my care. Accordingly accommodation was found for her, and in the beginning of July I tapped the abdomen, removing about two gallons of clear serous fluid. She was of course kept entirely in bed and fed liberally. I can dismiss the abdomen now from further consideration, for the fluid never returned and the single tapping cured the ascites.

On July 13th I tapped the right pleura, not using the aspirator but an ordinary needle with a tube to the floor. Ninety ounces of clear serous fluid were removed easily. I was pleased and surprised to find that the lung appeared to come freely out, the heart's apex returning nearly to its normal place, resonance and breath sounds reappearing over the upper part of the right side as far down as the fifth rib.

That the lung should re-expand to this extent spontaneously without the use of any suction with an aspirator seemed to me very hopeful and encouraging. The fluid removed from the pleura was clear serum, specific gravity 1013, and almost solidified on boiling. The patient was greatly relieved and inspired with fresh hope.

The history of the case from this point for a long time consists in a record of repeated tapplings of the pleura and of rapid recovery of flesh and strength. It was quite remarkable how rapid the improvement was with simple nursing after the removal of the fluid. The following is a record of the tapplings of the pleura:

Date.	Operation.	Oz.	Remarks.
July 13th...	Paracentesis	90	With siphon.
" 19th...	"	110	—
August 3rd...	"	103	—
" 14th...	"	100	—
September 5th...	"	120	—
" 14th...	"	50	—
" 25th...	"	50	—
October 2nd...	"	60	With the aspirator.
" 9th...	"	15	With the siphon; no more with the aspirator, but fluid was evidently left.
" 16th...	"	60	With siphon.
" 30th...	"	23	With aspirator; some air passed into the pleura.
November 16th...	"	90	With siphon.
" 27th...	"	72	With aspirator.
December 8th...	"	40	Aspirator used henceforth.*
" 15th...	"	30	—
" 22nd...	"	40	—
" 27th...	"	30	—
January 4th, 1894...	"	30	—
" 11th...	"	30	Fluid a little blood-stained.
" 19th...	"	22	Fluid difficult to find; cannula seemed to touch lung easily on all sides.
" 26th...	"	25	—
February 1st...	"	15	—
" 13th...	"	8	—
" 22nd...	"	9	—
March 2nd...	"	62	There had been a good deal of pain in the right side and shoulder during the last week, but the temperature was normal.
" 8th...	"	28	—
" 16th...	"	42	—
" 22nd...	"	28	—
" 29th...	"	27	—
April 5th...	"	33	—
" 13th...	"	24	—
" 19th...	"	15	—
" 26th...	"	17	—
May 7th...	"	35	—
" 15th...	"	35	—
" 22nd...	"	33	—
" 29th...	"	35	—
June 5th...	"	30	—

* The needle was inserted in the eighth space in the posterior axillary line. It always caused pain felt at the spot, but most in the epigastrium, due no doubt to the intercostal nerve being irritated by the needle. The ribs were now so close together that it was difficult to introduce the needle. The side had very greatly contracted, and the heart had long been in its normal place.

For the first three or four months she was kept rigidly in bed, but then was allowed to get up, though remaining in her room. Towards the spring she went into another room, and when the days were fine went out at first in a bath chair and later walking. As the summer came she was able to go some distance without fatigue or shortness of breath. She had become quite fat, and looked in excellent health, as indeed she felt.

There was no appreciable difference between the two sides, and the movements were almost equal. The breathing was natural over the whole side except at the base behind, where the sounds were deficient. The fluid seemed to be confined in a small pocket in the mid axilla. There had never been any rise of temperature, and the fluid remained serous throughout. I felt no doubt that in time recovery would be complete. However, the length of the case and the expense to which the parents were put in consequence rendered them impatient, and at last it came to this—that either she must go home as she was, or something else must be done to accelerate the cure.

There was of course but one other thing to do, and that was to open the side. This would in all probability convert what was a serous effusion into an empyema, and I naturally shrank from that, especially with the strong family history there was of phthisis, and the certainty that the disease in the patient was of tuberculous origin. Over and above this risk there was another to be reckoned with, namely, the danger of exciting a fresh outburst of tubercle in the lung or elsewhere. It seemed also to me too bad to expose the patient to all these risks, considering the good state of health in which she was. Moreover, there was a complete uncertainty whether the operation would have the desired effect of really expediting the cure, supposing that the patient escaped the risks referred to. At the same time it seemed probable that the pleural cavity was in great part obliterated, and that if the chest was opened and an empyema produced, it would only be a local empyema that would have to be dealt with. What I chiefly dreaded was a fresh outburst of tubercle. I pointed out that the operation would certainly necessitate a further stay in London of quite indefinite duration. However, after having all the *pros* and *cons* placed before them, the family decided that the operation should be done, and with great misgivings I consented.

A few days later, in the first week of June, 1894, the side was opened by my colleague Mr. Bowlby, by a free incision along the seventh rib in the posterior axillary line, a portion of the rib being removed. A pint or more of fluid escaped, and, to my surprise and disappointment, the lung was found not to be adherent anywhere, so that it collapsed entirely. The operation was perfectly simple, and the side was dressed with antiseptic dressings.

The next day the temperature began to rise, and in the course of a week became markedly hectic, rising to 102° or 103° every night. The fluid discharge from the side, which for a few days remained serous, gradually changed its character and became purulent. The opening was quite free, and there was no retention, so that some other cause for the rise of temperature had to be looked for, but none could be found, and I began to fear that what I had dreaded had come to pass—namely, that the operation had led to an acute outbreak of tuberculosis.

The patient rapidly lost flesh and strength, became wandering and almost delirious at night, and appeared to be going down hill as fast as she could, and that without any obvious reason—at any rate as far as the empyema was concerned—for the discharge was never large, remained sweet throughout, and there was no retention.

So this went on from day to day, until on my return from my holiday at the end of July I was shocked to see the condition to which the patient was reduced. She was wasted, as thin as a skeleton, and looked very ill and feeble. The temperature still remained high, though it rarely passed 102°. Now for the first time some pleuritic friction with fine crepitation was discovered at the left base, and this seemed to confirm the fear that the fever was due to the development of tuberculosis in the lung, so that I now began to feel almost in despair about my patient, and to regret bitterly that I had consented to allow the operation to be done, for it was sad to compare her condition now with that at the time she was placed upon the operating table.

She remained in a critical condition for some two or three weeks longer, and then began slowly to mend. The temperature fell and gradually the fever left her. She began to gain flesh and strength, and by September it became clear that after all she was going to get well. From beginning to end there had been no reason to complain of the side; that had gone on uninterruptedly well, the discharge had become less and less, the cavity smaller, the side was contracting slowly, and the lung expanding. Nothing now remains to report except a steady and continued improvement until the patient was sent home in time to spend Christmas with her family. On leaving London her weight, which at her worst had been no more than 6 stone, had risen to 9½ stone. She looked well and was strong, and the condition of her lungs was as follows: The right side was a little contracted but not much. The cavity in the pleura had entirely disappeared except for a long narrow track, in which the tube lay running apparently above the diaphragm in the direction of the ensiform cartilage; the greater part of this did not measure more than half an inch

in width except just within the ribs, where a shallow cavity, about 1 inch in diameter, lay. Over the whole of the side the breath sounds were audible, and there was no definite impairment of percussion anywhere except at the base behind and in the axilla.

I have since had reports of her progress. The tube is now only about 2 inches long, and the cavity has almost closed. She feels perfectly well, and able to walk about when the weather permits, and looks as well and strong now as she did before her illness. The opposite lung is, as far as can be judged, quite healthy, and nothing to suggest phthisis has developed in either lung.

The case presents many features of interest. In the first place, it is astonishing that nowadays a patient should have been left so long with her chest and abdomen full of fluid and no attempt have been made to relieve her by tapping. I suppose this was due to the persistence of the old fallacy that fluid effusions in the pleura check the progress of tuberculous disease in the lung—a theory for which there is little foundation, and which will certainly lead to grave errors in practice if applied as a general principle. Even if this explains the leaving of the chest so long untapped, it does not explain why the fluid in the abdomen was not removed. A single tapping cured this at once, and there is no reason why the same success should not have been obtained long before. The chief points of interest centre, of course, in the pleura. They are the following:

(1) That after the pleura had been full of fluid for twelve months and more the lung should not be bound down, but should be capable of rapid re-expansion.

(2) The number of times the side was tapped and the probabilities that complete cure might in the end have been obtained in this way.

(3) The fact that after thirty-seven tapplings the fluid remained clear and serous as at the first, and that, too, in spite of air having been admitted more than once into the pleura.

(4) The opening the side for a simple serous effusion.

(5) The ultimate complete recovery, with practically no deformity and perfect re-expansion of the compressed lung.

1. It is certainly remarkable that a lung which has been completely collapsed by an effusion of tuberculous origin for more than twelve months should have contracted no adhesions, and should be capable of immediate re-expansion on the removal of the fluid. The discovery of this on the first paracentesis made the prognosis at once much more favourable.

2. In respect of the number of times the pleura was tapped, I do not know of any instance in which paracentesis has been so frequently performed. Yet it is clear that there were only three courses open: (1) to leave the patient alone after the first two or three tapplings had failed to cure; but in that case the patient would soon have been as bad as before; (2) to open the side, an operation rarely done for simple effusion, and not to be lightly decided on; and (3) to do as I did, to repeat the paracentesis as often as might be necessary. The result fully justified my decision to try to cure the case by repeated tapplings, for the simple removal of the fluid caused the most striking and rapid amelioration of the patient's condition; she was not only relieved of all her distressing symptoms, but rapidly gained health and strength. The fluid steadily decreased in amount, and I believe if the patience of the family had not become exhausted paracentesis would have ultimately cured her. If she had lived in London, so that the expense of providing accommodation for her had not had to be considered, I should not have consented to any other measures, but in this case, as in so many others in practice, what had to be done was not the best absolutely, but the best possible under the circumstances.

3. The fact that after so many tapplings the fluid remained clear and serous as at the beginning is another evidence of the safety with which these operations may be done if ordinary care be taken to use clean and carefully disinfected instruments. I always used my own instruments, which I strictly disinfected myself, both before and after using. One used to hear of the risk of converting by paracentesis a serous effusion into a purulent one, but that was due not to the operation, but to the dirty instruments used, and if such a

result followed paracentesis now, I should hold the operator, and not the operation, to blame.

4. The deliberate opening of the side for a simple serous effusion has, I believe, been rarely practised, and rightly, for do what we will it is practically impossible, I believe, to prevent the effusion becoming purulent. That certainly happened at any rate in this case, in spite of the strictest antiseptic precautions. In this case, with so strong a tuberculous history in the family and with the strong presumption that the disease was of tuberculous nature, it seemed especially desirable to do nothing which might lead to an empyema. So I resisted the pressure put upon me to open the side as long as I could, and it was only after putting the whole case before the family and insisting that they should share in the responsibility of the decision that I at last consented. My fears were fully confirmed, for although I did not confess it I felt many times tempted to despair of her recovery and to reproach myself for having yielded to the pressure put upon me. So far as the operation was concerned it was a complete success. The anxiety was caused, not by the condition of the pleura, but by the general condition of the patient, and this still remains a puzzle to me, for I cannot see any plausible explanation of the fever and rapid failure of health. There was not enough discharge to account for it, and there never was any retention of pus. Still there is the fact that she nearly died, and at times I felt almost without hope of getting her through. No signs of tubercle ever developed, and except for the effects of her pleurisy the patient seemed sound.

5. Not the least remarkable part of the case is the complete *restitutio ad integrum*. There is now but very little external deformity, the lung has expanded, healthy breathing is audible everywhere, and I believe that when the tube is at last out there will be little but the scar to show what has been the matter. Yet the lung was completely compressed for about eighteen months, and another eighteen months were spent in getting well.

THE OBSTETRICAL SOCIETY OF LONDON AND THE MIDWIVES QUESTION.

*Being an Abstract of the Inaugural Address delivered before the
Society on March 6th, 1895.*

By F. H. CHAMPNEYS, M.D., F.R.C.P.,

President of the Society; Lecturer on Midwifery, and Physician and
Accoucheur to St. Bartholomew's Hospital.

DR. CHAMPNEYS began by admitting that the Society's year opened with a disagreeable situation. He said: "The General Medical Council has threatened us with anathema for infringing the Medical Act and deceiving the public; it has even hinted at the word 'infamous' being applied to us (in a strictly professional sense, of course), and all the consequences which follow the application (in a strictly professional sense) of that adjective. We have been guilty of examining midwives, of giving them certificates (or diplomas), of saying that we had done so, and of expressing our opinion that those who passed were 'skilled midwives, competent to attend natural labour.' This we have done for twenty-three years without let or hindrance; and as some men have suddenly waked up and found themselves famous, we have suddenly waked up and found ourselves (nearly, but not quite, and in a strictly professional sense) 'infamous.'"

Now this requires a little explanation. Those of you who read the medical journals have noticed that for some little time agitators have been going about the country endeavouring to stir up an opposition to midwives, and particularly (please observe) to "skilled" midwives—that is, women who have received some sort of regular training, and have been taught how not to infect their patients, and when to call in the doctor.

Their interest in the Obstetrical Society is touching, but it is to be observed that their real object is not to "mend" but to "end" our examinations. Among the phrases which

have served these agitators may be noticed one that we are "creating a new order of medical practitioners."

This is as correct as the classical definition of the crab which was criticised by Cuvier; it is perfectly accurate, except that (1) we have not "created" any persons at all; (2) midwives are not "medical practitioners" (in the technical sense); and (3) if either doctors or midwives are "new," I fear that history tells us with no uncertain voice that midwives antedated doctors by an enormous length of time. It is hardly too much to say that midwives must have begun nine months after there were two women and one man on the earth."

Dr. Champneys then briefly sketches the history of midwives in England. The Church, Chamberlen, and Harvey all advocated the instruction and licensing of midwives. He notes that Her present Majesty is the first queen ever attended in her confinement by a man. He recapitulates the proposals and Bills projected since 1813 for the examination and registration of midwives. These efforts at legislation are doubtless well known to readers who take an interest in the question. The Report of the Select Committee of the House of Commons on Midwives' Registration (August 8th, 1893) is quoted at length. In this report the rights of the practitioner were especially considered; in fact, it concludes thus:

"Your Committee desire to refer to the apprehension expressed by certain witnesses belonging to the medical profession, lest their interests might be injuriously affected by an improvement in the status of the midwives. The great preponderance, however, of medical and other evidence, having regard to both the authority and number of the witnesses, was to a contrary effect. Your Committee, therefore, whilst giving due consideration to the expression of such fears, believe that the suggested injury is not likely to prove serious, and they are of opinion that medical men will not only be relieved of much irksome and ill-paid work, but also that improved knowledge on the part of midwives will induce them to avail themselves more frequently, and at an earlier stage than at present, of skilled medical assistance in time of emergency and danger. On this point your Committee had full and substantial evidence."

Dr. Champneys dwells on the charge of the Recorder to the grand jury at the Old Bailey on January 8th, 1894, where great regret was expressed that the registration of midwives was not compulsory. "Anyone at present," said the Recorder, "could call herself a midwife, however ignorant she might be of the very first principles of her duties." All great nations excepting the United States and the British Empire have regulations for the control of midwives.

He next dealt with the history of the Obstetrical Society in relation to this question. "On November 4th, 1870" (said Dr. Champneys) "the Council passed a resolution in favour of the institution of a voluntary examination for midwives.¹ This resulted from a committee under the presidency of Dr. Hall Davis. At the annual meeting of the Society, January 3rd, 1872, the scheme of such an examination, with by-laws, was presented to the Society and passed unanimously. It is essentially the same as at present, and the law referring to the granting of the certificates runs thus: 'V. That, on satisfying the Board of Examiners as to her qualifications, the midwife should receive a diploma certifying that she is a skilled midwife, competent to attend natural labours.'"

At the annual meeting, January 6th, 1875, the President (Dr. Tilt) in his address said: 'Last year Lord Aberdare and Mr. Stansfeld were in office; they favourably entertained the views repeatedly brought forward by the Society, and they were prepared to bring in a Bill for the better education and registration of midwives, when a change of Ministry convinced your Council that the question must be left in abeyance.....Ours is the only civilised country that has left unregulated the midwifery of the humbler classes, and it is a disgrace to obstetric medicine that there should be no means of preventing an incompetent and drunken woman from assuming the name and the duties of a midwife.'"

In 1873 the Council referred the matter of branch examinations and registration of midwives to a committee, who re-

¹ Council Minutes, p. 243.

² *Obst. Trans.*, vol. xiv, for 1872, p. 21.

³ *Obst. Trans.*, vol. xvii, for 1875, p. 33.