other respects. The rigid adherence which, in most cases, a poor woman will yield to a Doctor's instructions, or to those of a District Nurse, in whom she implicitly trusts, she will rarely accord to the injunctions of one in whose superior judgment she is not so firm a believer.

We foresee from the signs of the times a very bright future for District Nursing, and therefore for those amongst the sick poor who are perforce obliged to be tended in their own homes; because it appears most probable that within the next few years there will be a great development and extension of the existing agencies in this department, and, coincidently with this, a very great increase in the numbers of gentlewomen who will devote themselves to this branch of their calling. How these latter should be prepared and trained for the duties they will be called upon to perform; and how they should be organised and assisted in their difficult, but most honourable and invaluable work, are subjects to which we hope to devote some careful consideration at an early date.

OBSTETRIC NURSING.

— By Obstetrica, M.B.N.A. —

PART I.—MATERNAL.

Chapter III.—Duties Immediately After Delivery.

(Continued from page 248.)

THE veins of the gravid uterus are still more remarkable in the peculiarity of their arrangement as compared with other veins. Their relative size to the arteries is greater. They are composed of a number of *large short trunks* communicating directly with each other; their *coats are single*, composed only of the lining membrane of the veins, which is intimately adherent to the fibrous tissue of the uterus; they have *no valves*, but if the surrounding fibres contract, temporary valves are formed, which break off the communication between these short trunks; and these extemporised valves, which anatomists describe as semi-lunar or falciform, are formed by the lining membrane of two venous tubes as they meet together by a very acute angle, and this arrangement of the uterine veins and the contractile fibres of the uterus controls any hæmorrhage that may flow from them. Hence we see that the anatomical relation of the uterine arteries and veins to the contractile tissue of the uterus is such as to moderate the force of the uterine circulation and prevent a regurgitation of blood.

This very brief and imperfect sketch is intended to call the attention of my professional readers to the stupendous importance of the subject. Were it not for these wise and merciful safeguards against the perilous hæmorrhage that inevitably follows parturition, no woman would be a mother but once; and thus we understand the value of the general principle, that *contraction of the uterine fibres is the essential means* of arresting uterine hæmorrhage. I really think it is time we left theory for practice, however fascinating the former may be, and that we attended to our patient, whom we intend to bind in a manner quite worthy of us.

I need scarcely tell you to keep the binder spread open to the fire, with three or four of the largest napkins you have about, so as to have them all nice and warm. You take the binder and fold it in half long-wise, pulling the two edges perfectly level at each end; roll it perfectly smooth and straight to about two-thirds of its length; fold three or four of the napkins into squares, and have another not folded at all; place the binder and napkins on the left side of the bed, about the middle; and, of course, our trusty pins, stuck into a small pincushion, and at the *top*, not at the sides, as they are sometimes stuck. A Nurse should have a pocket pincushion of her own, and keep it there. Pins have a remarkable habit of *not* being handy when wanted, unless kept in safe custody. I think now we have all we want for binding.

It is a *rule absolute* that the binder is to be applied as the patient lies in the recumbent position she was placed after her delivery, and I do not hesitate to say that all the real practical good you do by binding in the dorsal position would be *nullified* were any other adopted. You may ask, why this position? I will tell you. The uterus after delivery closes laterally, and when the patient lies on her back it favours this approximation of the uterine parietes, helps to keep the uterus *in situ*, and enables us when we apply the binder to bring it as nearly as possible in the axis of the brim, and in this way to favour the escape of the discharges that follow delivery. So I hope you clearly see the obstetric importance of the recumbent position after delivery. I have taken some pains to show what neither "binder" nor "binding" cannot do, and will now explain what they *can* do, and answer the questions put at the beginning of the chapter—Why do we bind? and what is the value of the obstetric binder? I will reply to the first question first. Because it is an infinite comfort to our patients, and for that reason every Nurse should take pains to bind well and comfortably (they are not quite the same things, I shall point out to you).

After the strain upon the pelvic articulations and abdominal muscles during the expulsive

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