and the right knee held well up out of the operator's way by an assistant.

In face presentations, where the presenting part is not engaged, the patient may be postured on the left side in right-mento posterior and right-mento anterior positions; the breech then tends to fall over to the right. This favours flexion of the head. In the other two positions the patient should lie on the right side. If, however, increased extension is desired in mento-posterior positions, she should lie on the same side as that to which the abdomen is directed. If the hand presents, or prolapses, it may be due to uterine obliquity. This should be corrected.

The obstetrical emergency, when posture is of the greatest value, is in presentation or prolapse of the cord. It is sometimes so effective that when the membranes are unruptured no further treatment is necessary. The patient is put on her elbows and knees, the pelvic inclination is then 10 degs. The fundus is now the lowest part of the uterus, and the os uteri the highest. The action of gravity secures the sinking of the cord away from the os to the fundus. In this position rupture of the membranes, always a regrettable incident under these circumstances, is delayed. After about a quarter of an hour, if the cord has receded, the mother should be on the side opposite to that on which the cord came down. She should not bear down, and if the uterine contractions are strong it is useful to raise the pelvis. An American obstetrician, Edgar, warmly advocates what he calls the latero-prone position, with elevated hips in presentation or prolapse of the cord. The patient lies in the left lateral position, pillows are placed under the hips so that the pelvis is raised; other pillows are put underneath the head and chest. She thus rests upon the side of one knee, the entire breast, and the side of the head. It is urged that the position is far more endurable than the knee and elbow, and no less efficacious. Both these positions are useful in retro-displacement of the uterus.

For the introduction of bougies, dilators, or dilating bags the patient may be in either the left lateral or lithotomy position. For version and plugging the latter is preferable. The high pelvic positions have many advantages for turning; the uterus tends to fall away from the pelvis, so allowing more room for manipulations. They are also indicated in rupture of the uterus; the intestines fall towards the diaphragm, and the uterus can be easily seen. The one usually adopted in this emergency is the Trendelenberg, or hanging dorsal position. The patient lies with head and arms flat on the operating table; the trunk and thighs are raised to an angle of about 45 degrees, the legs hanging over the foot of an inclined plane. If it is necessary to improvise an arrangement for this purpose a chair may be inverted on a bed. A mattress should be thrown over it; the trunk is supported by the back of the chair; the knees are strapped above, or secured with a roller towel. When the method was first used the woman rested on the back of a strong assistant with her knees bent over his shoulders and her legs held.

For the administration of an anæsthetic the patient should lie on her back with her head low and the arms to the sides.

During a normal third stage of labour the patient may lie in the left lateral position, with head low; but if there is hæmorrhage the dorsal position is best. The foot of the bed should be raised to save the patient from cerebral anæmia. The same postural treatment is indicated in ante-partum hæmorrhage, faintness, collapse, and for the giving of salines. Patients suffering from heart disease usually find relief supported in the half-sitting position.

For explorations and perineal suture the lithotomy position is desirable.

During the puerperium a recumbent position is very essential. The patient should lie on her back with head low during the first 24 hours. The semi-lateral position is the most convenient for nursing the infant. After a day or so the patient may lie on either side, or on the abdomen if she likes. This favours the free drainage of the lochia, and is less wearying than the constant dorsal position. If she has difficulty in passing urine she may assume the knee-elbow position after other simple methods for inducing micturition have failed; but if this is done soon after labour the risk of pulmonary embolism must be borne in mind. If a catheter is passed, or a douche given, the patient should be on her back with knees bent and everted.

In cases of bad varicose veins, thrombosis, or white leg, the limb should be raised on pillows and kept immobile if necessary by bags.

The lying-in woman should stay in bed at least ten days, and though it is a mistake to regard her as a helpless invalid, rest is most necessary.

In conclusion, let midwives and nurses remember that there is no golden rule in obstetrics. Experience may lead them to think other positions better than those indicated; if it is supplemented by scientific reasons, well and good. M. O. H.

Qualified Midwives in Ireland.

From the last report of the Irish Local Government Board it appears that there are 625 qualified midwives in the Irish Poor Law Service. It is the aim of the Local Government Board to have a trained midwife in each dispensary district. The Guardians are first invited to appoint such midwives, and if they persistently refuse a sealed order is issued. The salaries paid these midwives are usually £20 per annum, with, perhaps, an additional £5 for car-hire in large districts. These salaries must, we presume, be regarded in the light of a retaining fee, as "these women give their services upon such reasonable terms that they generally have as much as they can do."

Dearth of work is not usually a thing the woman worker has to complain of—there is plenty for her. Dearth of adequate payment is a much more frequent occurrence. The yearly salaries offered to midwives in the United Kingdom, and the fees which, as a rule, they receive for attending single cases are, out of all proportion, inadequate for the work done. And yet people wonder at the dearth of midwives.