short distance, about two inches from the child. This will empty the blood vessels and make the cord easier to tie.

Miss McLernon emphasises the importance of keeping the cord in an aseptic condition, otherwise, if it becomes septic, phlebitis or arteritis, with extension along the vessels into the abdomen may occur. There is, she explains, little change on the first day, but afterwards it soon becomes dry and mummified, and a red line develops where the living tissue is casting off the dead. The cord should be kept as dry as possible, as mummification and separation of the cord is thereby hastened.

Miss Lewellen, with other competitors, points out the necessity for a second ligature on the stump of the cord after the bath of the child, the reason for this being that the warm water may cause shrinking of the cord, which would, of course, result in a loosening of the first ligature.

She also says: "Should I be nursing on the district and not continually in attendance on the infant, I should instruct the responsible person who is to look after the mother and infant to change the infant's napkins frequently, thus insuring a dry binder and a dry cord."

Miss E. F. Moakes, with several other competitors, advocates boracic powder as a dressing for the cord, and for the umbilical area after the cord has separated starch powder covered with lint, or castor oil on boric lint. She emphasises the point that "great care is essential with this delicate cord of life."

Miss M. Hamilton remarks that the nurse should in no case attempt to hasten the separation of the cord, and that the chief points to be observed with regard to the management of the cord are to keep it dry and aseptic.

Miss E. Douglas writes that when the child is born, it should not be placed too far away on the bed from the mother's buttocks so that a strain is placed upon it. The nurse should notice if there is anything unusual about it such as knots—if it is very thick or very thin, very much twisted or broadened out in places. It may be very long up to 40 or 50 inches, or abnormally short—only 6 or 8 inches. The usual length is from 20 to 30 inches.

Miss Douglas advocates tying the maternal end close to the mother's vulva. This serves to indicate when the placenta has left the uterus, as the cord lengthens as the placenta slips down.

QUESTION FOR NEXT WEEK.

"What care must be taken when removing the clothes of a person badly injured?"

A WISE RESOLVE.

The United Irishwomen hope shortly to hold a conference on the question of district nursing in Ireland. The heads of the chief nursing organisations in Ireland will be asked to attend and to state their case fully. The case of these experts is the case of the Irish poor, and we congratulate the United Irishwomen upon their determination to confer with trained nurses before attempting to organize their skilled work. Nothing but good can result from such a conference, and we feel sure Irish Superintendents will do all in their power to further the interests of those in need of district nursing. The exclusion in many districts in England of trained nursing opinion from lay committees which organize and superintend district nursing has been most fatal to its efficiency. We earnestly plead with Irish women to hesitate before inaugurating the Holt-Ockley or any such nursing system in Ireland. It is an insult to offer anything but the best to the poor and helpless when their health, their one and only asset, is at stake.

THE INSTRUMENT NURSE.

By the kindness of Professor Rutherford Morison, F.R.C.S., Professor of Surgery in the University of Durham, and Senior Surgeon to the Royal Victoria Infirmary, Newcastle-on-Tyne, we are able to publish the accompanying picture of "the instrument nurse" which was published in the *Lancet* in illustration of his most interesting and illuminating article "A Year's Work in Abdominal and Pelvic Surgery." Professor Morison is generously appreciative of the assistance of trained nurses in the care of abdominal cases. Under the heading of "The nurse" he writes: In the after-treatment of abdominal cases nothing counts for so much as a good nurse. . . . Certain nurses have a knack of doing well with abdominal cases, and both patient and surgeon are lucky if they get hold of such a one. To be raised up comfortably and packed up skilfully with pillows at the back and under the knees into a half-sitting position for a time, even on the second day, is a great relief to most patients. Rolling over occasionally from the back to one side, then to the other, and back again, if it can be done without great trouble, as it can by a skilful nurse, is a change that most patients are grateful for. A little drink, a little well-timed sympathy and encouragement, even perhaps a gentle reproof on occasion, are things certain to make the difference between a happy and an unhappy patient, and I for my part believe that in the majority of serious cases the skilled attentions of an intelligent sympathetic nurse can, and do, account for the continuance of life and for escape from death.

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