in 1880, when the Matron considers that "*it was manifest that the Wards were sadly under-nursed both on day and night duty, that the attendance on the patients was even less than it appeared to be*," and that "*it was equally evident that larger numbers were required to relieve these overworked women.*"

To the calm consideration of Members of the House Committee and of the Medical Staff of the London Hospital we commend the comparison between 1890 and 1880, and the statements made by their Matron, and reserve further comment on the revelations for another occasion.

OBSTETRIC NURSING.

— By Obstetrica, M.B.N.A. —

PART I.—MATERNAL.

Chapter VIII.—Deviations from Normal Convalescence.

(Continued from page 160.)

THE next point is to secure repose; and here a Nurse must have the aid of every adult member of the household. No sounds must be heard, no intrusion permitted into the lying-in room, except it be the husband or very near relative of the lady. If in the country, and weather permits, keep the bedroom window open top and bottom, for there is nothing will such "a slumbrous influence rest" as the soft, sweet, pure, sun-warmed air that seems almost to caress lovingly the pale fair face of the sufferer, just, and only just, restored to life! In large cities we cannot get quietude for our patients any more than pure air, the only consolation we find in these cases being that town dwellers are so accustomed to street noises they do not disturb their slumbers, neither in sickness nor health. We have secured warmth, repose, and fresh air. We must now turn to feeding, which must be done with the greatest care and patience. We have a tedious reparative task before us, and we must "make haste slowly." To bring this matter home to the minds of my younger nursing readers, let me give them a little homely illustration of it. You go into your room and find the fire has gone down so low you can scarcely tell whether it is alight or not. How would you proceed to fetch it up? Not by putting half a scuttle of coals on *at once*, that would extinguish every spark of fire left! You would begin by using the most easily combustible materials *first*, such as matches, paper, sticks, *small* pieces of coal, renewing them cautiously; and in due time you would be rewarded by having a bright little fire. Just so with that poor feeble spark of life that has gone down so low we scarcely know whether it be extinct or not—we must strive to fan it into life with tender, gentle hand, and hope for our reward in the recovered health of our patient. We have as Nurses but little to do with medication, but I may as well tell what drugs are most often used in cases of post-partum hæmorrhage, and why. Opium, to tranquillise the nervous system; salines, especially acetate of ammonia, to act on the blood, and counteract a tendency to over-fibrination, that is one of the sequelæ of hæmorrhage (we must bear this fact in mind in giving foods also); pure terebine, a nerve tonic and hæmostatic, useful in *every* form of uterine hæmorrhage, ten minims taken *in sugar* (castor preferably) two or three times a day. I have known all these remedies lead to good results in skilful hands.

What shall be the first nourishment given? Milk, which I think upon the whole it is wiser to have boiled, and cooled down, and given tepid, slightly sweetened, and *peptonised* with a Zymine powder; brandy only to be added under medical direction. A tea-cupful of milk at a time, every two hours, if the patient be awake—never waken her to give food; slumber is as important as food; "nature's sweet restorer" can never be surpassed by anything else. Our next change, second day, will be strong broths, such as beef tea and chicken broth. The last is very delicate and nutritious if properly made; you can add a little of the *best* isinglass (teaspoonful dissolved in a little hot water, and *then* added to half a pint of beef tea), or you can thicken either broth with arrowroot. To drink toast and water at first, afterwards barley water acidulated with lemon juice, and later on aerated waters. As *absolute* repose in the recumbent position is imperative, all nourishments must be given through feeder or feeding tubes. The state of the bladder will require our attention, and we must resort to catherism, which, being an important part of Midwifery Nursing, we will enter into somewhat fully. We use the catheter in our portion of Nursing work most commonly under three conditions—retention, simply, most frequently met with in primapara; certain lesions; and after severe post-partum hæmorrhage, when it is *essential* that the patient should be kept in the recumbent position for at least twenty-four hours after delivery, which is the case now before us. The first question is, how soon after delivery shall we relieve the bladder? We can only answer this question by asking two others. How long was it *before* delivery that the bladder was relieved? How soon *after* delivery did pressure symptoms show themselves? Speaking generally, the longer we can defer using the catheter, other things being favourable, the