might have been perhaps premature to have distributed medals before the campaign was over. But now that Registration is an accomplished fact, now that the battle of the Association is won and that it has received the highest State recognition of its merit, may it not be fairly asked that the rank and file of its Members should obtain the decoration for which they ask, and which by their steadfastness, courage, and devotion they have most certainly deserved?

OBSTETRIC NURSING.

By Obstetrica, M.B.N.A.

PART I.—MATERNAL.

Chapter IX.—Lesions.

Deviations from Normal Convalescence.

(Continued from page 64.)

At their completion, this Course of Lectures will be published as one of the Series of "Nursing Record Text Books and Manuals."

With respect to warm fomentations, I prefer to use soft old pieces of flannel to sponges (to which, I fear, I have a pet aversion) for our portion of Nursing work. Not one Nurse in fifty knows how to *really* keep them clean. The flannels should be wrung out of hot water as dry as possible, and applied all over the surface of the perinæum *during a pain;* leave them there during the intervals, and re-apply a fresh flannel during the pains. The only amount of *pressure* to be used is of the *lightest*, just enough to keep the fomentations *in situ during* the distention of the perinæum, and before applying the flannels lubricate the integument over its whole surface.

With respect to "guarding" the perinæum, the *less* that is done with that intention the better, and hence it is right that you should know *why* we interfere at all, and *how*. There are three objects we have in view in this manipulation: first, to take off the *lateral* strain of distention; secondly, moderate the force of the expulsive pains upon the advancing head; thirdly, to receive it at the very moment of expulsion, and relieve *central* strain at the raphé, the point of laceration. Now, how shall we do all this? We will first take a clean, warm, soft napkin, and place it over the *left* wrist and forearm (which is bare to the elbow, leaving the *hand* perfectly free). *During a pain*, plentifully lubricate the tissue with your *right* hand, and if there are signs of inflammation, apply a warm, moist flannel all over it, and keep it *in situ between* the thumb and fore-finger of your *left* hand, resting the palm on the napkin, and with a *light* but firm pressure, hold the perinæum *together* as it were, and with the two fore-fingers of your *right hand* press on the vertex, and moderate the force of the pains upon it, and when the expulsion of the head takes place, *catch the chin* quick as thought between the space of the thumb and fore-finger of the *left hand*, and hold it up towards the pubis (but nothing more), and guard the perinæum during the expulsion of the shoulders. It may be desirable to withdraw one of the fœtal arms if there is much strain on the tissue, but do as little as possible in that direction.

I have found these simple manœuvres of great benefit in cases of rigidity, and believe injury can be averted by them, and they are such as any Nurse Midwife can safely exercise, remembering never to *interfere* at all unless there is a *reason* for it; for in Midwifery at any rate it is infinitely wiser to do *nothing* than to do *wrong*.

There is another point I must earnestly impress upon my young Nursing sisters in our portion of work—to *avoid* the pernicious practice that used (and I fear still does in some quarters) to prevail of *incising* a rigid perinæum. I *know* some Nurses have been instructed to do this, and even pride themselves on their performances in that way! The operation (?) is done with a pair of frenum scissors, and two small vertical incisions are made on each side of the raphé. Now what is the result of this "heroic" interference? You simply anticipate one disaster by making sure of a *worse*, and ever remember *fears* are not *always* realised. I am prepared to admit that the integrity of the integument cannot always be maintained, and that we may have to face more or less laceration; we shall still find it better with respect to those important healing processes that have to take place after the lesion to deal with a clear *spontaneous* rent than an artificial incision.

I have pointed out some of the conditions that may may lead to spontaneous perinæcal injury, principally as affecting the tissue itsslf; others may arise from dystocia, or tumultuous uterine action, but it is not necessary to dwell upon them here. Those due to traumatic causes are more frequent, and as a rule far more serious, and but too often traceable to careless instrumentation. The advances that have been made in recent times in gynæcological surgery may palliate the mischief, but no surgery can atone for it—and as a matter of practical midwifery we know it is not an absolute guarantee against a recurrence of the trouble in subsequent labours; and after all there is no "surgery" like "prevention." We must ever bear in mind that *all* lesions to the genital tract, great or small, add to the septic risks of

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