The Midwife.

THE PRACTISING MIDWIFE.

Miss Gilligan, whose remarks on Midwives in Antiquity at the Nursing and Midwifery Conference we printed in our last issue, had much of interest to say also in regard to the practising midwife. The name of midwife is synonymous with that of the German "Birth helper," the Italian "Deliverer," and the French "Wise-woman," and is a Middle English term made up from the preposition "*Med*," equals with, and the substantive "*Wyf*," equals woman. It is interesting to compare the meaning of this homely term for such a utilitarian person with that of the male specialist, "obstetrician," derived from the Latin, and meaning, literally, *one who stands in front*.

The midwife is unique among professional workers because she is responsible for at least two lives for ten days. Like a doctor, she "delivers" the patient; she also attends upon the patient and infant. The rules of the Central Midwives Board to which she is subject regulate her training, examination, practise, inspection, and removal from the Roll. Midwives attend about 80 per cent. of the total births. Unlike doctors, they may not employ an unqualified substitute The Roll of Midwives contains upwards of 50,000 names, yet only 51 cases were tried by the Central Midwives Board in 1921, and of these only 27 were struck off the Roll.

The Central Midwives Board being recently petitioned by the Federation of Medical Women and others to prevent to Midwives the use of opium and pituitrin, replied it had never known a midwife to use a drug improperly.

Miss Gilligan says that gradually the influence, the status, and the income of the midwife in this country will be raised. Amongst the means to accomplish this end are, she considers:—Longer training, given by more efficient trainers. There ought to be a higher standard of education, and definite qualifications for the high and responsible task of training of midwives. Post-graduate courses to midwives whose names are already on the Roll, such as have been organised by the L.C.C. and various training schools. The slackness of many of the profession in availing themselves of opportunities offered is regrettable. They are content to go on in the old-fashioned grooves, unprogressive, ultra conservative. Improved economic conditions.

The keeping of the C.M.B. Rules and the inspection of midwifery are, she points out, intended alike for the safety of the public and the midwife. Midwives can have no complaint against the Central Midwives Board, consisting as it does of well-known experts accredited to it from bodies of experts. The Local Authorities (such as the L.C.C. and the County Councils) are the midwives' Local Supervising Authorities, which frequently means in actual fact the County Medical Officer of Health.

OBSTETRICAL SHOCK.

Various accidents, due to political unsettlement, have hitherto prevented reaching this country any report of the Obstetrical Section of the Royal Academy of Medicine in Ireland held last December. *The Lancet* now gives the following interesting report. "At this meeting, Prof. Hastings Tweedy made an important communication upon obstetrical shock. H. H. Dale and other workers had, he said, conclusively proved that a poison generated in bruised muscle was a potent factor in obstetrical shock. Other protein material could generate this poison and obstetricians had every opportunity of observing that it could arise in freshly effused blood. Ruptured tubal pregnancy, concealed accidental hæmorrhage, and hæmatoma of the vulva all supplied evidence of this fact. Liquid blood was more poisonous than that which was clotted and thus hæmatocele could be accounted for. If the woman survived the initial toxic dose the blood would have time to clot. Shock was associated with a general elongation of all muscle fibres. The pupils, the anus, the bladder, the intestines, and the cheeks demonstrated this. The veins, and at a later stage the arteries, seemed to be also affected; indeed, a great dilatation in the capillaries and veins might account for the phenomena of shock. In the uterus this elongation was better demonstrated than in any other organ, and the condition was evidently one of "retraction reversed." Contraction, a temporary shortening of muscle fibre, was under the control of the nervous system; retraction was a property inherent to the muscle itself; it took place in a flabby inert muscle and was the chief factor in preventing hæmorrhage. The process was slowly reversed during the growth of a pregnant uterus and rapidly reversed in shock. Accidental hæmorrhage, Prof. Tweedy contended, was of toxic origin; if the blood did not quickly escape its products caused shock, which led to dilatation of the uterus. The condition was, therefore, not due to a diseased atonic uterus, and the fallacy of hysterectomy for it itself was apparent. Cæsarean section, with a smaller mortality, was more effective in the control of hæmorrhage. Uterine inertia was no contra-indication for delivery by forceps, for inertia was no bar to retraction. It was shock and not inertia that was to be dreaded. Lastly, Prof. Tweedy reminded his hearers that the 'retraction reversed' fibre was quite capable of contraction, and this was probably the condition found in the arteries during the early stages of shock."

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