The Midwife.

THE NEW QUEEN CHARLOTTE'S HOSPITAL.

The new Queen Charlotte's Hospital, of which the first section (the Isolation Block) was opened by Princess Mary, Countess of Harewood, on July 10th, is situated on a beautifully wooded five acre site in the Goldhawk Road, Hammersmith (approximately the central point of the districts covered by Queen Charlotte's maternity services). When completed, it will be the largest maternity hospital in the Empire. It will comprise:—

The main hospital buildings, four storeys high, consisting of two 100-bed units and 48 pre-natal beds. An annexe at the rear will contain the staff dining-rooms.

The paying patients' block of five storeys, with 80-100 beds.

The administration block, students' college and nurses' home, fronting the Goldhawk Road, and five storeys high.

The out-patients' block, ante-natal and infant welfare department, also fronting the Goldhawk Road.

The isolation block, containing beds for 30 patients and nurseries for 30 infants (now being opened).

The research laboratories (now building).

The boiler house.

The whole of these buildings will be grouped round a central lawn. There will be 358-378 beds and the buildings will be so planned that all wards have a charming outlook on green trees and grass.

Sterilisers and Laundry.

The sterilising equipment is extremely up-to-date and very ample. On each floor is a room for sterilising the mackintosh bed sheets—a provision which is a new departure in hospital planning. The sink-rooms for dealing with the bed pans have a sink fitted with a jet and douche over which the pan can be inverted. A large steam steriliser completes the work, and the bed-pans are then transferred to a chromium-plated rack carrying sufficient bed-pans for all the wards on the floor. Each bed pan is numbered to correspond with a bed. This room is also fitted with a "specimen" cupboard let into the wall, closed by an hermetically sealing door on the inside and communicating direct with the open air on the outside except for a sheet of gauze.

Soiled linen, which, in an isolation block such as this, cannot be sent to a laundry, is collected in bags and dumped on a landing opening from each corridor and in the open air. A hand-worked lift on the exterior of the building collects the bags from each floor and delivers them to a trolley which runs on a concrete way to the boiler house. Here the soiled linen bags are dumped into a steam washer and then are placed in a hydro extractor (centrifugal), whence they emerge in a fit state to be sent to the laundry—completely sterilised and disinfected.

On each floor is a steriliser for the patients' crockery and knives and forks. Another form of sterilising used is the provision of Marco refrigerators in order that milk for the infants, and special dietary for the patients, may be kept at a temperature which conserves food.

OBSTETRICAL PRACTICES YESTERDAY AND TO-DAY.

Dr. C. B. Oliver, of Chatham, Ontario, in a Paper given at a meeting of District Registered Nurses Association of Ontario and published in *The Canadian Nurse* says in part:

"I think Cæsarean section is positively indicated in all cases of placenta prævia in elderly primiparæ. It matters not whether the situation is central or marginal. Done immediately the diagnosis is made it means the salvation of two lives, whereas attempts to deliver by vagina would mean the almost certain death of the baby, and serious injury if not worse, for the mother.

I have long made a practice of inducing labour where prolonged and energetic efforts at elimination had failed to lower blood pressure or reduce the quantity of albumen. After 34 weeks or even earlier, the child runs much less risk from the menace of prematurity, than from continued residence in the uterus of a toxic mother.

Forty years ago anæsthetics were employed in obstetrics only to a very limited degree. To-day it is generally conceded that all women in confinement are entitled to the relief anæsthesia affords.

The anæsthetic I have always employed is chloroform, and not in a single instance where I have used it have I seen any untoward effects. Very little is required for any operation such as version or forceps delivery. It is not distasteful; it is exceedingly prompt in its action, and nausea and vomiting rarely follow its administration.

The judicious administration of pituitrin has been a great boon to women in confinement. Much has been written about its use and abuse, and everyone knows it has been frequently employed with sinister results. But like the Cæsarean operation, it will continue to hold an important place in obstetrical practice.

With the os fully or almost fully dilated and soft there is no contra-indication to its employment. Immediately after its administration chloroform anæsthesia should be started. The mother, in nearly every case, sleeps peacefully through the delivery and is saved hours of suffering.

It has been frequently urged that its action predisposes to retention of the placenta. My own experience has taught me that the exact opposite is true.

High forceps operations have now been practically abandoned, podalic version, which is safer, having taken its place.

But in spite of these advances De Lee is right. Obstetrical practice is on a low plane. Maternal and child mortality is shockingly high.

Children are being lost through premature and injudicious efforts to deliver, and many more go out daily through failure to offer help in time.

Attempts at forceps delivery before moulding has taken place; the administration of pituitrin before dilation; failure to do an episcotomy, and thus facilitate the birth of the head in a breech case, are some of the errors that spell disaster for the baby. Subdural hemorrhages, tears of the tentorium, convulsions and a dead baby twenty-four hours more or less after birth. Then on the other hand, if there is complete dilation of the os why should precious hours be wasted, waiting for spontaneous delivery? If the head is on the perineum with the scalp showing at each pain, and the mother too physically exhausted to push it through, what earthly reason has the physician for further delay?

Looking back over forty years of strenuous practice I can say without egotism that my record will bear inspection fairly well. At the same time it might have been much better had not the importunities of a general practice discounted my best efforts.

What then is the remedy?

We will never see obstetrical practice raised to the plane it should occupy until it is done by trained specialists. There are about 90 per cent. too many men in obstetrical practice to-day to look for ideal results."

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