Obstetric Nursing.

— By Obstetrica, M.R.B.N.A. —

PART II.—INFANTILE.

Chapter VII.—Special Duties.

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

We have touched upon premature births and still-births, but there is another and singular condition peculiar to the newly-born that is neither life nor death. In Midwifery we call it suspended animation, and measures for resuscitation have to be promptly resorted to—and here I must digress to impress upon the minds of my readers, that the one point that marks out Obstetric Nursing from all other Nursing is the *care* and *treatment* of *the newly born* and a knowledge of the varied phenomena of birth, is a part, and a very necessary part, of the instruction of an Obstetric Nurse, and for this reason I have dwelt so earnestly, perhaps even tediously, upon it.

To return to our duty—in ordinary cases we can excite a respiratory act by reflex irritation, and a smart light blow upon the buttocks or shoulders of the infant at birth will bring it about, but there are times, and often times, when these simple measures will not suffice, and we must have recourse to artificial respiration. What is it? It may be briefly described as the introduction of air into the lungs by the artificial imitation of the respiratory movements, *oxygen being once more absorbed by, and Carbonic Acid given off from, the venous blood reaching those organs.* I have italicised this last sentence, for we must remember there is an important difference between the condition of the fœtal and adult lungs—the former have *never* been expanded, there is no venous blood in them, and hence *no* Carbonic Acid to get out—we simply have to get air to them. Our first duty is to ascertain if the cord pulsates, if the heart beats. This latter is of vital importance—cord pulsation may be *temporarily* suspended and the infant revived, but the cessation of the fœtal heart-beats indicates *fatal* injury to the medulla—the new centre of respiration—if then this momentuous pulsation can be made out, be it *never* so feebly, there is hope that our efforts may be crowned with success. We must first drain out all mucus from the trachea and nostrils by raising the infant up and turning him face downwards, and well downwards, for a few seconds; we then turn him over and wipe out the mouth with a soft napkin. The next point is, shall we sever the cord or not? I advise the former, for in my judgment, the placental circulation is no use to us, and puts an undue pressure upon the right side of the heart; for instance, in cases of impending asphyxiation, from delay after the delivery of the head, when the umbilical circulation is going on, the intense turgescence and lividity of the face marks this fact, and I have noticed that unwise delay in completing the delivery tells against the infant's chance of life. Having then severed, shall we ligature the cord? On both these points I have just mentioned differences of opinion prevail, and I merely state my experiences in my own practice. I think it better *not* to ligature until the pulmonary circulation is established, and a diagnostic mark of that result is a flow of *arterial* blood from the umbilical end of the cord.

We now lie baby on a pillow on the bed, the head hanging well down over one side of it, so as to keep the mouth open; taking the infant's hands in our own, we draw the arms up over the head and well back, keep them there for a few seconds, then draw the arms down over the thorax, make firm pressure with your hands over the chest walls in an *upward* direction, *suddenly* remove that pressure, and *instantly* raise the arms again to the top of the head—these manœuvres may be followed by a *feeble gasp*, the first inspiratory effort—you repeat the movements described, and they must be continued in a calm measured manner—with great gentleness and no "hurry"—and I have often found at this juncture the smelling salts (prepared in the way I told you of in an early paper) most serviceable, held at a little distance from the nostrils whilst the arms are *raised over the head.* Of course we require assistance here, and a Nurse should know how to help us. The next advance is the ever welcome "cry," feeble at first like the gasps, but strenthening as we go on, and at last our efforts are crowned by success. We now ligature the cord. What next? Our little patient is cold and weak. A cot blanket or large piece of flannel must be made hot, ready for our use. Placing the infant straight on the pillow, we remove it from the bed and bring it close to the fire; spread the blanket over the pillow, lie the infant down again, turning him towards his right side, feet towards the fire; wrap the blanket

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