all over him, leaving the face only exposed to the air, being careful that the radiant heat from the fire does not fall on it. Some practitioners advise at this juncture rubbing the chest with brandy, or sal volatile. I do not myself think these manipulations are necessary, having established the pulmonary circulation by the means just described. I think we can dispense with counter-irritants. The infant must be *left in absolute* repose for an hour or more before any attempt is made at washing or dressing, and from time to time he must be watched to see if there be any accumulation of mucus in the trachea, and if so remove it in the way I told you of. If the surface of the skin keeps cold, a teaspoonful of milk and water, quite warm, and a two drops of brandy in it will be useful, repeated every ten minutes. I have dwelt somewhat fully upon the subject of artificial respiration because in my judgment an Obstetric Nurse, especially those engaged for country or foreign cases (generally the pick of our ranks), should understand and be perfectly well able to resort to it in case of need.

An elementary knowledge of Midwifery, and its *safe*, practical application in time of need, is a matter of great service to an Obstetric Nurse, and I will just point out *how far* and in *what way* it can be wisely made use of. And we here come to a point of much importance to my mind in the instruction of Midwifery Nurses. *How* and *where* can they ever gain the *experience* necessary to give them *self-reliance—not self-confidence*t, hey can get that from text books—to enable to act alone when necessary? Not *in* the hospital, I emphatically assert, but *out* of it. Hence during residence, and at about the middle of their course, our young students, under prudent restrictions and at safe distances, should be sent out to the homes of the patients, *first* to make the best of what they find around them (baby included perhaps) until the arrival of the Midwife who has charge of the "outside" work. Half-a-dozen cases on these lines will be more useful in teaching a Nurse self-reliance, and a little practical Midwifery as well, than twenty cases in a Hospital with a dozen people about them, and everything to their hand (at least such is the outcome of my experience), resulting in *reliable* Nurses. Assuming then that you are in charge of a lady, and everything indicate the rapid approach of delivery, you are *not* to delay sending for the Doctor, *because* you can separate, but go on with your duties, and *in no wise interfere with the labour*. Suppose that, before the Doctor come baby is born, you must tie the chord and cut it. I have given you instructions how to do it, and how to treat the infant at birth, in a previous paper, and need not repeat them, but refer you to those papers. If baby is alive, defer any further attention to the infant until after the expulsion of the placenta, as the patient should be watched till that comas away, and the uterus is safely contracted. When that is over you can turn your attention to the baby, and leave the mother to rest. When the little patient is put into his cot, you put the lady to rights and bind her; and all these matters can be completed pending the arrival of the attendant; and these duties are to be done *in order*, *hurrying* nothing, neglecting nothing. Some Nurses are in such haste to get everything clean *before* the Doctor comes that they are apt to be neglectful of the *safety* of the mother; *follow* the course of events, but do *not* hasten them. Other Nurses, again, having had no training by *experience*, lose their heads in simple emergencies, and lead to pretty nearly everybody else in the house losing theirs, and spread dismay and unfounded fears around. Steer clear of these two extremes and you get the confidence of your employers, lay and medical.

In one of my early papers, I pointed out the signs and symptoms that mark ordinary labour, and instructed you how to proceed on these occasions, but there are certain grave emergencies peculiar to child-birth that are *not* accompanied by the usual phenomena of labour, and yet are of the gravest significance, and a slight knowledge of them is of great importance in Obstetric Nursing, as it enables a Nurse from her own *observation* of them, to summon, without hazardous delay, Medical aid. And here I must emphasise the value of *intelligent observation* in our portion of nursing, where so much responsibility rests upon a Nurse in the *first* instance. Cultivate this faculty—some have it as a gift, but all may acquire it in a measure. You may have your head stuffed full with facts *from books*, but unless your brain can turn them to good account in time of need what avail is your knowledge. Experience is the great teacher we all know, but alas! "numbers of Nurses never seem to learn from it."

To return to our subject, there are three occurrences having a momentuous influence upon labour, but not accompanied by the ordinary manifestations of it. I will bring before your notice *Præ-partum hæmorrhage*, *prolapse of the funis*, *and puerperal convulsions*.

With regard to the first, we know that sanguineous discharge *preceded* by pains is a sign of commencing labour, and is due to the rupture of the *minute* cervical blood vessels, and the blood is mixed or capillary blood—of darkish hue. But there are rare occasions when, *without any pain*, a stream of *arterial* blood flows from the vagina; if it comes on at night when the lady is at rest and asleep, the amount of loss may become serious before it is suspected; if it occurs in the daytime when she is up, it cannot for long escape observation. This

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