A short manual for monthly nurses / by Charles J. Cullingworth.

A SHORT MANUAL
FOR
MONTHLY NURSES

CULLINGWORTH

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A SHORT MANUAL FOR MONTHLY NURSES

BY THE SAME AUTHOR.

A Manual of Nursing, Medical and Surgical.

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A SHORT MANUAL

FOR

MONTHLY NURSES

BY

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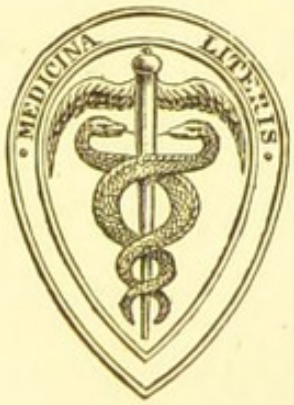

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PREFACE.

SOME regret having been expressed that, in my "Manual of Nursing," no mention is made of the subject of Obstetric Nursing, I have, at the request of my publishers, prepared the following brief work. It is to a considerable extent a reproduction (revised however and re-written throughout) of such of the chapters in a former work as have reference to this department, and will, I trust, prove useful to those monthly nurses who, already possessing an acquaintance with the details of ordinary nursing, desire some definite instructions with regard to their own special duties.

OXFORD ROAD, MANCHESTER,
January, 1884.

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CHAPTER I.

The Early Signs of Pregnancy: Cessation of Menses—Morning Sickness—Changes in the Breasts—Enlargement of the Abdomen—Calculation of probable Date of Confinement—Quickening.

THE first circumstance to make a woman suspect that she is pregnant is generally the non-appearance of her usual monthly discharge. This is called the cessation of the *menses*, or monthlies, and is one of the most constant signs of pregnancy. Cases do, indeed, now and then occur, in which, notwithstanding pregnancy, the customary flow takes place for the first few months just as usual, and in certain still rarer instances it has been known to appear regularly throughout the pregnancy.

On the other hand, its absence is by no means a sure indication of pregnancy, as it may be due to many other causes; such, for example, as an attack of severe illness, a

condition of general weakness, or even strong emotional excitement.

The next symptom to attract attention is usually a feeling of sickness, often most distressing in the early morning, and sometimes accompanied with actual vomiting. This commences about the fourth or fifth week, and continues to the middle of pregnancy, when it generally ceases. Occasionally it lasts to the end of the pregnancy, while, on the other hand, in some women it is entirely absent throughout.

Shortly after pregnancy has commenced, a sensation of weight and fulness is felt in the breasts. A little later these organs enlarge, and the nipples become more prominent; the skin, too, just around the nipples becomes darker in colour, an alteration most marked in women of fair skin and light complexion. Of course these changes are most noticeable in women who are pregnant for the first time; for when they have once occurred, the breasts never quite resume their original appearance, so that subsequent changes are less observable. It

must be here noted, however, that the breasts may increase in size, and may even contain milk, without pregnancy; as, for example, in the case of certain diseases of the womb.

About the end of the third month the abdomen begins to enlarge, and continues to do so from that time forwards; by the end of the seventh month the hollow of the navel has generally disappeared. It need scarcely be said, however, that the abdomen may enlarge from many other causes, so that not one of the four signs above described affords, when taken alone, positive proof of pregnancy; although, when two or more of them are found to be present, there is good ground for a very strong suspicion. Whenever it is important that the question of pregnancy should be established beyond doubt, a doctor should be consulted.

The usual method of reckoning the probable date of confinement is to learn on what day the last monthly flow ceased, thence to count three months backwards (or nine months forwards) and add seven days. This is, in practice, the best plan

that has been suggested, and will generally give a date within a very few days of the actual confinement, frequently the very day. The following example will show how the calculation is made:—A woman, we will say, was last unwell on March 10; counting three months back from March 10 gives December 10; add seven days and it will give December 17, which is the probable date of her confinement. If it is not the actual day, labour will in all probability take place within three or four days before or after it.

The movements of the fœtus are not perceived by the mother until between the fourth and fifth months—that is, until pregnancy has advanced about halfway. Not very uncommonly the occurrence of the first definite movement of which the mother is conscious is accompanied by a sensation of nausea and faintness. It is this fact which gave rise to the opinion long held, and still prevalent amongst the uneducated, that the fœtus then for the first time becomes living, an opinion that finds expression in the word "quickening," the use of which, like that of many other words, has outlived the theory

in which it had its origin. As a matter of fact, the fœtus is living from the very commencement of pregnancy, and the reason why movements are not felt during the earlier half of pregnancy is to be found in the fact that the womb itself is not sensitive, and that it is not until the middle of pregnancy that that organ has enlarged sufficiently to bring it in direct contact with a part fully endowed with sensibility—namely, the inner surface of the abdominal wall. From the moment when they are first perceived, the movements of the child become more and more distinct as pregnancy advances, and constitute one of the most important of the later signs of that condition. When from any cause it is impossible for the probable date of confinement to be calculated according to the rule laid down in the preceding paragraph (as, for example, when the date of the last menstruation is uncertain, or when one pregnancy succeeds another so quickly that menstruation has not been re-established in the interval), it may be approximately arrived at by reckoning it as four and a half months after the date of quickening.

CHAPTER II.

Management of Pregnancy: General rules—Constipation—Piles—Hardening the Nipples—Swollen Breasts—Varicose Veins—Falling Forward of the Womb—Obstinate Vomiting—Difficulty in Passing Urine, &c.

THE proper treatment of pregnancy consists for the most part in paying increased attention to the laws of health. A pregnant woman requires a full allowance of rest, and should therefore be careful to avoid late hours. She should take plenty of outdoor exercise whenever the state of the weather permits; and, while avoiding all unnecessary strain, such as the lifting of heavy weights, or reaching things from a height, she may engage in the lighter duties of her house, not only without risk, but with actual gain of health and strength. Her food should be taken with the utmost regularity, and should be plain and simple in its nature. Good new milk should form a consider-

able part of her every-day diet. Stimulants are entirely unnecessary, except when taken under special medical direction.

As the abdomen enlarges it is of the utmost importance that the clothing should not be tight. A foolish regard for appearances has led many a woman into most lamentable mistakes on this point.

During pregnancy the mind should be attended to as well as the body. All unnatural excitement is to be carefully guarded against, and distressing sights are to be especially shunned.

Great care must be exercised to ensure a daily action of the bowels. An excellent plan is to set apart a certain hour of the day for attending to this function, whether the desire for relief be urgent or not. Perhaps the most convenient time for most people is immediately after breakfast. By following this simple rule, a habit is established which will go far to obviate the necessity for aperient medicine. When such medicine is required it should be of the simplest possible kind ; for example, a compound rhubarb pill, or a little castor-oil.

When constipation is associated with piles, the aperient chosen should be a teaspoonful of sulphur in a little milk every morning, or a similar quantity of the compound liquorice powder made into a paste by mixing a little water with it; and the patient should be instructed to make her daily visit to the water-closet immediately before retiring to bed for the night. By these means the aching pain which, under such circumstances, is apt to follow every action of the bowels, may be considerably diminished. Injecting half a pint of cold water into the bowel, immediately before the bowels are moved, often proves highly serviceable. Should the piles become inflamed or unusually painful, the patient must keep her bed for a day or two, and bathe the parts with warm water from time to time. Where these measures are required, however, the medical attendant should be consulted.

The nipples, especially in first pregnancies, should be hardened by bathing them daily during the last month or two with a mixture of equal parts of eau-de-Cologne

and water, in order to render them less liable to crack and become sore and painful on the application of the child. Inflammation and abscess of the breast often originate in cracked nipples.

When the breasts become swollen and painful they should be frequently fomented with flannels wrung out of hot water, and, in the meantime, should be supported, as in a sling, by a broad handkerchief passing under the arm of the affected side and over the opposite shoulder.

Sometimes the veins of the legs, thighs, and lower part of the body become swollen and uncomfortable. Under these circumstances, the patient should lie down as much as possible every day, and at once discontinue the use of tight garters.

In women who have borne many children, the abdominal walls are apt to become relaxed, and the pregnant womb, being insufficiently supported, is then in danger of falling forward, so as not only to produce deformity but to prove a hindrance during labour. A flannel binder, or one of the abdominal belts sold for the purpose, should

in these cases be constantly worn during the daytime.

Now and then the sickness, already alluded to as a common accompaniment of the early months of pregnancy, becomes so troublesome and incessant as to cause serious loss of strength. Under such circumstances medical advice is imperatively needed.

Towards the end of pregnancy it is not at all unusual for there to be some difficulty in passing urine, and for the desire to pass it to become very frequent. Should these symptoms, however, occur during the earlier months, and especially during the third and fourth, a medical man should be consulted; as they may be due to a displacement of the womb, which requires immediate attention.

Troublesome heartburn, diarrhœa, palpitation, persistent neuralgia, salivation, itching or swelling of the external parts, swelling of the face or ankles, all require the personal care of the medical attendant.

CHAPTER III.

Uterine Hæmorrhage during Pregnancy; its usual Significance and Temporary Treatment—Placenta Prævia—Precautions after previous Abortions—Treatment after Miscarriage.

Uterine hæmorrhage, or a discharge of blood from the womb, during pregnancy, is usually a sign that miscarriage is threatening, and hence requires prompt medical attention. In summoning a doctor under these circumstances it is always desirable to send a note, rather than a verbal message, and to state clearly the nature and urgency of the case. Meantime an endeavour should be made to restrain the hæmorrhage by causing the patient to lie down, with the head low and a pillow under the hips, by admitting plenty of cool, fresh air into the room, and by ensuring perfect quietness.

The services of a trained nurse should be

obtained at once, if possible, and she, with perhaps one other person, should alone remain in the room. Cloths, dipped in cold water or in vinegar and water, must be applied to the external genitals for a few minutes at a time, the application being frequently repeated. If wet cloths are kept on for a longer period they are sure to become warm, and so, by acting as a poultice, defeat the object in view, and indeed tend rather to increase than to check the flow of blood. When the hæmorrhage continues, or becomes very profuse, the nurse must not hesitate to send for the nearest doctor as well as for the ordinary medical attendant. In such cases it will be desirable for her to take a dry napkin or two, and, having folded them in the form of a pad, to press them forcibly against the external genitals and hold them there. All the discharges, whether solid or fluid, should be carefully retained for the inspection of the medical attendant.

These alarming hæmorrhages are often brought about by accidents, such as blows or falls, or by the lifting of heavy weights.

But when flooding first makes its appearance, at the seventh month or later, and there has been no such accident to account for it, the probability is that the case is one of *placenta prævia*, in which the after-birth is in an unusual position—namely, over the mouth of the womb, constituting a very dangerous complication. The temporary treatment of flooding due to this condition in no way differs, however, from that already described.

When previous pregnancies have been cut short by miscarriage, it is very necessary that the greatest precautions should be observed to avoid the repetition of such an accident. Now, we know from experience, that miscarriages are most apt to take place at those times which, in the absence of pregnancy, would have been the ordinary menstrual periods. It is on these occasions, therefore, that preventive measures are most needed and most likely to be useful. Every month, then, during the time that the patient would, under other circumstances, have been unwell, she should maintain the recumbent posture, if not in

bed, at any rate on a couch. If this simple rule were attended to, many a miscarriage would be averted. A woman known to be liable to abortion should, moreover, be specially careful to avoid all its most common causes; she should abstain from exciting entertainments, violent exercise, fatiguing or rough journeys, strong purgative medicines, and exposure to cold. And, lastly, as it is very doubtful whether any of the causes I have named are sufficient in themselves to bring on abortion, without a predisposition thereto from some local or general weakness or disease, it is very desirable that patients who have formed the so-called "habit" of aborting, should consult their medical attendant at the commencement of pregnancy with a view to being placed under a regular course of treatment.

The after-treatment of patients who have miscarried is a most important matter, and one which receives far too little attention. It is no uncommon thing among patients of the labouring and middle classes for women to go about their ordinary duties as early

as the second or third day, and some do not even rest for more than a few hours. Now, although this neglect of proper precaution may not result in any immediate ill-effects, it frequently lays the foundation of chronic disease with much attendant misery and suffering. Whenever nurses have an opportunity they should tell their patients what there is in store for them if they resume their ordinary duties too soon after such an occurrence. No absolute rule can be laid down as to the length of time during which rest is necessary; it depends so entirely on circumstances that vary in different cases. Thus, in a case of abortion during the early months, for instance, where the loss has been small and the health has not suffered, four to six days' absolute rest in bed, followed, during the next ten to fourteen days, by the greatest care and prudence, will, in the absence of special directions from the medical attendant, be generally found sufficient. When the health is unaffected it becomes very irksome to lie in bed for the time here indicated; nevertheless, this rule cannot

be neglected without running grave risk.

Should the pregnancy be further advanced, or the circumstances less favourable, a longer period of rest will be required. Where there has been severe or long-continued flooding, a patient is frequently reduced to a condition of weakness quite equal to that following an ordinary confinement. In such cases it is only reasonable to expect the same care to be exercised as after a labour at full term.

On no account should a patient leave her bed, after a miscarriage, so long as any discharge of blood continues, as, while that persists, it is uncertain whether there is not some portion of the after-birth or membranes still remaining in the womb, and rendering the patient liable to further attacks of flooding.

CHAPTER IV.

Sketch of the Process of Natural Labour: Signs of Approaching Labour—Its Division into Stages—Labour-pains—The "Bag of Waters"—Description of First Stage—of Second Stage—of Third Stage.

TOWARDS the latter part of the ninth month, certain changes take place which give warning that labour is not far off. One of the earliest of these is sinking of the abdominal swelling; the upper end of the womb, which, at the beginning of the ninth month, reaches as high as the pit of the stomach, now falls a little below that point. Great relief to the breathing follows this alteration, as the pressure upon the organs within the chest is thereby greatly lessened. On the other hand, owing to this change in the position of the womb, certain new inconveniences arise from pressure of its lower portion on the various important parts contained in the pelvis. Thus, walking

becomes more difficult, the bladder requires relieving more frequently, and piles are apt to form.

A sign that makes it probable that labour is actually about to commence is the appearance of a slight discharge of mucus, streaked with a little blood. This is spoken of, in the lying-in room, as the "show."

Labour is divided, for the sake of description, into three stages. The first of these is called the stage of dilatation of the mouth of the womb; the second lasts from the moment when that dilatation is completed up to the birth of the child; while the third, or last stage, includes the time from the birth of the child to the coming away of the after-birth, or placenta.

The so-called pains of labour are, in reality, contractions of the muscular wall of the womb. At the early part of labour they are slight, occur at long intervals, and are felt mostly in the lower part of the front of the abdomen; as labour advances, they become longer and more energetic, follow one another more quickly, though always with a certain regularity, and are

generally felt chiefly in the back and loins. Each pain is comparatively feeble at its commencement, increases in intensity until it reaches its height, and then gradually passes off. This character, together with the regularity of their recurrence, serves to distinguish pains really due to uterine contraction from colicky and other pains, for which they are sometimes mistaken.

The bag of waters consists of the membranous coverings of the fœtus, enclosing within them the *liquor amnii*, in which the child floats. During pregnancy this fluid serves to preserve the child from injury; during labour it forms a pouch at the mouth of the womb, which it acts upon like a wedge, and so assists in dilating. Experience tells us that, when the waters escape early, labour is rendered more tedious. The explanation of this is to be found in the fact that the bag of waters, being round and even, and pressing on the mouth of the womb (*os uteri*) equally all around, the mouth of the womb is opened out more rapidly and easily by this even pressure

than by the uneven surface of the presenting part of the child.

As the *os uteri* opens, and the end of the first stage draws near, the pouch formed by the protruding membranes is pushed further into the front passage, or vagina, and, the pains becoming more violent, the membranes at last give way during a pain more severe than the rest, and so the waters escape. In natural labours this usually happens as soon as the mouth of the womb is fully opened, and thus the first stage of labour is ended.

The head of the child now begins to pass through the *os uteri*. After a certain time, usually much shorter than that occupied by the first stage, it reaches the vaginal opening, through which it gradually escapes, and thus the child is born, and the second stage is completed.

The pains of the first stage are called "grinding pains," and are different in character from those of the second stage, which are known as "forcing" or "bearing pains." The cry which is called forth by the pains during the first stage is also different

from the groan which escapes from the patient when the pains of the second stage commence. An experienced nurse knows from this circumstance alone that the first stage is over, and as the sending for the doctor ought on no consideration whatever to be delayed beyond this period, it is a point of great practical importance.

The pains now become stronger and more frequent: the patient, holding her breath and bearing down at each return of the pain, becomes hot and flushed, and breaks out into a profuse perspiration. At the end of each pain the head of the child goes back a little, which prevents the strain from being so continuous as to be hurtful and exhausting. Nevertheless, almost every pain marks an advance upon the one preceding. This slight withdrawal of the head is frequently perceived by the patient herself, and unless explained to be natural and necessary, is apt to make her think she is not making any progress. There eventually comes a point, however, when the head is so far expelled that it no longer recedes between the pains. The

intervals become shorter, and the pains more severe, until at last the head slips out altogether, and then the most painful part of the labour is over. The uterus usually now rests for a moment. Then the face of the child makes a little turn towards one of the patient's thighs, generally the right, in order that the shoulders may be brought into such a position that they may pass with the least difficulty. With another strong pain the shoulders are expelled. The rest of the body gives little trouble, for no part of it is as broad as those which have already passed.

The contractions of the womb now cease for a short time, varying from five to ten or twenty minutes, when a little pain is again felt, and the after-birth and membranes are discharged, along with a small quantity of blood, with which a few clots are generally mixed.

Such is a brief account of the order of events in a perfectly natural labour.

CHAPTER V.

Duties of a Nurse during Labour—Articles needed in the Lying-in Room—Preparation of the Bed—Personal Clothing of Patient—Number of Persons in the Room—Caution in Conversation—Attention to the State of the Bladder—Food—Vomiting—Cramp—Fomenting the Perineum in First Labours.

If the nurse is not already in the house, the appearance of the first discharge, or "show," is a sufficient warning that she should be summoned. No time should be lost in obeying the call, for many women, especially if they have borne children previously, pass through all the stages of labour very quickly. On arriving at the house, the nurse should make the necessary changes in her dress, and appear before the patient ready for duty. An opportunity will soon occur of forming a judgment as to whether the patient is really in labour, and, if so, how far it has advanced. If labour has actually commenced, the

patient will, before long, cease speaking, suddenly grasp the nurse's arm, or the back of a chair, or whatever happens to be at hand, and exhibit other signs of suffering. The nurse will know, by the characters enumerated on a previous page, whether this is a genuine labour-pain or not, and will observe how long it lasts and the degree of its severity. When it is over, she should inquire when the pains began, how often they return, whether the waters have been discharged, and other similar questions, in order that she may know what kind of message she is to send to the medical attendant, who ought at once to be informed that his patient is in labour.

Let me now suppose that the nurse has made sure that her patient is in labour, and that she has acquainted the medical attendant.

If the bowels have not been freely opened within the last six hours, it will be desirable to give a simple enema of soap and water. The emptying of the lower bowel will facilitate the labour, and will

save both the patient and the attendant the annoyance caused by the passing of fæces during a later stage. This having been attended to, the patient may be allowed to sit up in a chair or walk about the room, according to her inclination, provided it is clear that the labour has not yet reached its second stage. If it is night-time, however, it is better for her to remain in bed, in order that she may, if possible, get a few moments' sleep between the pains. During the early stage of labour it is of no use for patients to "hold their breath and bear down" during each pain, as they are often urged to do by untrained and inexperienced nurses. It must always be left to the medical attendant to decide when bearing-down efforts have become desirable and ought to be encouraged.

It is often a great relief to a patient for the nurse to support her back with her flat hand during a pain. In the meantime she should see that all things are in readiness for the actual confinement. The following are always wanted :—

Basins.
Binder.
Napkins.
Needles and thread.
Nursery, or safety, pins.
Olive-oil.
Pieces of old linen.
Receiver.
Roller-towel.
Scissors.
Sponges.
Thread, or strong worsted, for tying cord.
Towels.
Vaseline, cold cream, or lard.
Water, hot and cold.
Waterproof sheeting.
Puff-box, and complete set of clothes for the baby.

In addition to the above it is advisable to have in the room some good brandy, a fan, a Higginson's syringe, a foot-bath, and a nursing-apron.

The *binder* usually consists of two pieces of stout twilled cotton, each two yards long and of good width, the edges of which are stitched together so as to make the binder of double thickness. On an emergency, a small table-cloth or cotton sheet, suitably folded, answers the purpose very well.

The *receiver* should be of flannel made of double thickness, and large enough to wrap the child thoroughly. The flimsy receivers offered in some houses are only fit to protect

a doll. A good thick flannel petticoat, or a cot-blanket, is as good as anything.

The *thread or worsted for tying the cord* must be made ready in the following way :—Twelve equal lengths, measuring about a foot, are to be laid side by side and arranged evenly. Six of these lengths, are then to be knotted together at a distance of about two inches from each end, and the remaining six in the same way. Having been thus prepared, the threads must be laid on the dressing-table, and a pair of good scissors by the side of them, ready for handing to the medical attendant at the proper moment.

The preparation of the bed is a matter of considerable importance, and ought to be attended to during the early part of labour. In this country women are delivered lying on the left side, with the knees drawn up towards the abdomen. The right side of the bed, therefore, is the one which requires preparing, and that part of it near the foot is preferable because the upper part of the bed is thus kept clean and comfortable for the patient when the labour is over, and

because of the help derived from being able to plant the feet firmly against the bed-post during the pains.

The mattress being uncovered, a large piece of macintosh sheeting is to be spread over it, and upon this a calico sheet folded several times. Next to this should come the clean under-sheet, on which the patient is to lie, and upon that another piece of waterproof sheeting, large enough to reach above the hips. Over this upper macintosh, and ready to be removed with it after the labour is over, are to be then placed a folded blanket, and, lastly, a folded cotton sheet, both of which should reach well above the hips, so as to absorb the discharges. Two pillows are then to be put in the centre of the bed, so that the patient may lie with the upper part of the body directly across the bed, the hips being as near the edge as possible. The upper bed-clothing during labour should consist of a sheet, one blanket, and a thin counterpane, which should completely hide from exposure every part of the patient's person, except the head and neck. A long roller-towel should be

fastened to the bedpost at the patient's feet. Nurses often make the mistake of fixing this to the post at the opposite corner, or even to one of the posts at the bed's head. A very little consideration, however, will make the inconvenience of this arrangement apparent. By grasping the end of a towel, attached in the way I have recommended, the patient pulls herself still closer to the edge and foot of the bed; whereas, by pulling at a towel fastened to one of the posts on the further side of the bed, she drags herself away from the very position which it is desirable she should preserve. The same objection, of course, applies to supplying the place of the towel by means of the hands of an attendant standing on the left side of the bed. This should never be encouraged, as it always has a tendency to displace the patient, and to render it difficult for the medical attendant to give needful assistance.

As labour advances, and it becomes necessary for the patient to be placed in bed, she should put on a clean chemise and night-dress, which should be rolled up

under the armpits out of reach of the discharges, while the soiled chemise and night-dress should be slipped down from the arms and shoulders, and loosely fastened round the waist.* The hair should be dressed in such a way that the continuous lying in bed after the confinement will not drag upon or entangle it more than is inevitable.

It is very undesirable for a woman in labour to be surrounded by a number of friends and neighbours. In most cases the nurse herself is the only attendant that is really needed, although the presence of one other person should not be objected to, if the patient wishes it.

No nurse should ever allow herself to be teased into prophesying that the labour will be over by a certain hour. If such prophecies turn out incorrect, as they are most likely to do, the patient loses courage and confidence. All gossip is to be avoided,

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* Amongst the working classes it is still too much the custom for women to be confined in their every-day dress. It is a practice that ought always to be discountenanced, being both dirty and extremely inconvenient.

and nurses should be particularly careful to make no reference to their past experiences, especially such as have been unfavourable. A good, kind nurse will not be at a loss for a few helpful and encouraging words as labour goes on, and will not need to have recourse either to foolish promises or dismal anecdotes.

Every now and then the patient should be reminded to pass water, lest the bladder should become so full as to hinder labour. This point is often neglected, partly because the attention is so preoccupied that the desire to empty the bladder is scarcely perceived, and partly because, when the waters have broken, the escape of a little gush of amniotic fluid during each pain often misleads the patient, making her think she has passed urine when really she has not.

In the early part of labour, when pains are slight and the intervals long, there is no reason for interfering either with the character or regularity of the patient's ordinary meals, provided there exist the desire for solid food. During the later stages, however, it is wise to confine her

to fluids, such as beef-tea, gruel, milk, and tea, and to administer them in small quantities at a time, so as not to overload the stomach and excite sickness. Patients often ask for a little cold water, and many nurses, influenced by old traditions, fear to gratify the wish. A sip of pure water can never do harm, only it must be a "sip" and not a tumblerful, the patient being assured that small draughts, frequently repeated, assuage thirst far better than larger quantities. On no account must stimulants be given, except when expressly ordered by the medical attendant.

Vomiting is a troublesome symptom and distresses the patient, but its influence on the progress of the labour is in no way unfavourable. Should it, however, be excessive, it is well to give a little iced effervescing water from time to time.

Many patients suffer very severely from cramp during labour. Relief can frequently be obtained by stretching the limb straight out, and at the same time bending the ankle so as to put the muscles of the calf well on the stretch. Gentle rubbing of the affected

part with the hand also affords great comfort.

In the case of patients who have not borne children previously, it is an excellent plan diligently to foment the perineum from the very outset of labour, so as to render the skin softer and more yielding, and lessen the risk of tearing.

CHAPTER VI.

Duties of a Nurse during Labour, continued: The Second Stage—What to do in the Absence of the Medical Attendant—Supporting the Perineum—Assisting at the Birth—Tying the Cord—Breech Cases—The Third Stage—Application of the Binder, &c.—Convulsions—Fainting—Falling Forward of the Womb.

When the pains alter in character, compelling the patient to make efforts to bear down, and the face begins to get flushed and the skin to become moist with perspiration, the nurse may feel pretty well assured that the first stage is over; and if the medical attendant has not arrived, she should request him to be summoned without delay. In the meantime, the patient must be put to bed, and encouraged to bear down and assist the pains. The binder, napkins, and receiver must be spread near the fire in readiness.

Should the child's head press upon the

perineum before the arrival of the medical attendant, a warm folded napkin may be placed in the palm of the nurse's left hand and held against the bulging perineum, the fingers being directed backwards, so that the front edge of the perineum may receive the chief support. The object of this is to prevent the child's head passing too quickly and suddenly forwards to the vaginal outlet and to preserve the perineum from being torn. The great point at this stage is to avoid doing too much. Nothing but harm is likely to result from attempts to enlarge the opening by stretching the lips apart with the fingers, or to push back the edge of the perineum in the hope of facilitating the escape of the head. Contrary to the popular belief, the attendant's duty is rather to keep back the head by gentle pressure, than to hasten its expulsion. Above all things there should be no pulling ; Nature is to be allowed to do her own work.

If the medical attendant be still absent when the head is born, the nurse must spread the flannel receiver close up to the

vaginal orifice, and receive the head of the child upon her right hand, still keeping up gentle pressure upon the stretched perineum until the shoulders have passed out. Even then the body and legs must be left to follow of themselves, the nurse meanwhile holding up the parts which are already born. The upper bed-clothes should be now turned back sufficiently to allow the child to breathe, without causing any exposure of the patient herself. If the navel-string is found coiled around the child's neck, it must be slipped over its head as quickly as possible, lest the life of the child should be sacrificed owing to a stoppage in the circulation of the blood through the cord. Very occasionally it happens that the child is born with the membranes unbroken; they will in such cases be found drawn tightly over the little face, and will cause death from suffocation, unless quickly torn open and the mouth freed. Amongst poor people this occurrence is known as being born with a veil or caul.

The cry which a child usually utters as soon as it is born, helps to fill the lungs

with air, and is on that account rather to be encouraged than checked. If the child does not cry, the nurse must examine the mouth to ascertain whether there is anything either over it or within it, preventing the breathing. Sometimes there is some frothy mucus in the mouth which can be cleared away with the finger. It is often useful, also, when breathing is delayed to turn the child on its face, and give it a few gentle slaps on the back with the flat hand.

The navel-string must not be tied until the breathing is established, unless it is quite evident that the child is still-born. The first ligature must be tied an inch and a half from the navel, and the knot must be pulled tightly two or three times so as to squeeze out of the way the jelly-like material which surrounds the blood-vessels of the cord ; otherwise the vessels may not be closed by the ligature, and bleeding from the stump may occur to a fatal extent while the nurse is attending to the mother. The second ligature is placed an inch further from the child than the first one, and

the cord is then divided with scissors midway between the two. All this must be done outside the bed-clothes, lest some other part than the cord be cut in mistake.

Now and then it happens that a nurse has to take temporary charge of cases where not the head, but the breech, passes out first. Delivery with the child in this position is full of danger to the life of the child. The nurse must not hasten matters by pulling, even when the legs are already born; but, when the whole of the child's body has passed except the head and the arms, and when these parts appear to be arrested, she may endeavour to assist Nature by bringing down the arms from the sides of the child's head in the following manner:—Passing her forefinger up the child's back, and over its shoulder, she draws the arm gently down across the front of the chest by hooking her finger into the bend of the elbow. The same manœuvre is repeated with the other arm. The head will then be the only part remaining unborn. It is possible that, now that the arms have been brought down, the

efforts of Nature may be equal to the task of expelling the head. Should the pains, however, prove ineffectual, the nurse may render further assistance by pressing with the fingers of one hand against the back of the child's head and so tilting the head forwards, while with the two first fingers of the other hand, placed one on each side of the nose, she endeavours to draw down the face. This plan is greatly preferable to the one, not unfrequently adopted, in which traction is made by placing the fingers in the child's mouth. In all breech-cases a warm bath should be in readiness, in the event of the child requiring to be resuscitated.

The child, having been now separated, is to be wrapped in the receiver, with the face alone exposed, and placed out of harm's way on the other side of the bed. The patient must be warned to lie perfectly still, and to wait patiently for the one or two insignificant pains which accompany the expulsion of the after-birth. These generally occur from five to twenty minutes after the birth of the child. Meanwhile the

nurse must provide the medical attendant with a basin or other vessel, previously warmed before the fire, to receive the after-birth, and one or two warm napkins.

Should the medical attendant, however, be still absent, the nurse must place her hand upon the abdomen of the mother and ascertain whether there is another child. If she should find such to be the case, she must convey the news to the mother very cautiously, assuring her that the second child will be born with much less pain than the first. If there is no second child to be felt, the nurse will do well to keep her hand laid upon the mother's abdomen until a slight pain occurs, when she must spread out her hand like a fan and gently press the uterus so long as the pain continues. Meantime, she is to hold a suitable vessel in her left hand ready to receive the placenta when it is expelled, taking care on no account to pull upon the cord. Sometimes the placenta and membranes are expelled during the first pain; more frequently two or three pains occur before this takes place.

If the uterus can be felt, under the hand, hard, firm, and as small as a good-sized cricket-ball, the placenta, if it has not already made its appearance, will in all probability be found lying in the vagina. In order to make sure about this, the hand may be withdrawn from the front of the abdomen, and the forefinger passed gently up by the side of the cord. If the insertion of the cord into the after-birth can be easily and distinctly made out, it is pretty certain that the placenta has escaped from the uterus into the vagina, and it may therefore be carefully hooked down by the finger. As the placenta passes out, it is a good precaution to twist it round once or twice, so as to make a wisp of the membranes and bring them all away at the same time. A slight discharge of clotted and fluid blood usually accompanies the termination of the third stage.

When the placenta and membranes have come away, the hand should again be placed over the uterus, in order to make sure that it is firm and well contracted. If, instead of this being the case, it is felt to be large,

soft, and uncontracted, firm pressure should be continued, so as to excite contraction and prevent flooding, which, in such circumstances, is greatly to be feared.

Should a gush of blood make its appearance in spite of the pressure, the hand must still be kept over the uterus and the pressure increased, cold wet cloths being in the meantime repeatedly applied with suddenness to the external genitals. Of course, if the medical attendant has left the house, he must be again summoned at once.

The uterus being firmly contracted, and the flow of blood having ceased, the thighs and surrounding parts are to be gently sponged with warm water and dried by means of a soft warm napkin.

If there has been no flooding, the soiled chemise and night-dress may now be drawn down, and, along with the folded sheet, blanket, and upper macintosh, removed from beneath the patient, who must not be permitted to make the slightest effort while this is being done. Then she may be slowly and gently rolled over on to her

back, to allow of the application of the binder. The binder, well aired, must be rolled up to half its length, and the roll passed underneath the lower part of the patient's back. Being caught on the other side, it is then unrolled, and having been smoothed out free from wrinkles, is so applied as to encircle the hips tightly, and the overlapping end is then secured by means of three or four good safety-pins. All this is to be done with as little exposure of the patient as possible. The pillows having been duly replaced, the patient may now be carefully lifted into her usual position in bed; a fresh warm napkin being applied against the vulva, and the clean chemise drawn down into its place.

If, however, there has been any flooding, the patient, after the bandage has been tightened, must still remain undisturbed for some time after the discharge has ceased, the nurse from time to time examining the napkins to make sure that there is no return of the bleeding.

When the medical attendant is present, he will probably prefer to undertake many

of these duties himself; at any rate he, being the responsible person, will give instructions according to the requirements of each individual case, which instructions it will be the nurse's simple duty to obey.

During the passage of the child's head, it facilitates matters if the patient's knees are separated. This is sometimes effected by placing a pillow between them, but the pillow is apt to be in the way, and a better plan is for the nurse to pass her hand beneath the right knee, and keep it well raised during each pain.

Sometimes the medical attendant desires the nurse to make pressure upon the womb, during the third stage of labour, to assist it in expelling the after-birth. To do this she should stand behind the patient at the doctor's left hand, and passing the hand under the bedclothes, she should place it on the abdomen, where she will feel the round, firm body of the uterus above the pubes. Spreading out her hand over this organ, she should keep up a steady pressure downwards and backwards as long as the attendant desires it.

Convulsions, coming on during labour, are always alarming, and place the patient's life in great danger. Should they occur before the arrival of the medical attendant, no time should be lost in sending for him. In the meantime all that the nurse can do is to keep her patient lying flat down; to see that there is no tight clothing about her head or chest; to prevent biting of the tongue, by pushing it, if possible, behind the teeth, and placing a cork or piece of india-rubber between them; to admit plenty of fresh air into the room; and, lastly, to restrain the meddlesome interference of the bystanders. It is altogether worse than useless to attempt to force water or stimulants down the throat while the patient is struggling and unconscious; and although sprinkling the face with water, rubbing the hands, and applying smelling salts to the nose, can do no harm, it is more than doubtful whether they ever produce any real benefit. When the fit is over, should the medical attendant not have arrived, the nurse may administer a soap-and-water enema with advantage.

Fainting during labour should always lead to a suspicion that there is some loss of blood going on, and the medical attendant ought to be immediately summoned, even if there is no blood to be seen externally, for internal bleeding may be going on notwithstanding. The important point to remember about fainting is, that the patient is on no account to be raised up, however much she may desire it. The level posture, plenty of cool, fresh air, sprinkling a little water on the face, and firm, steady pressure with the hand over the uterus, comprise all that it is desirable for a nurse to do in the way of treatment. If there is external hæmorrhage, an endeavour must be made to control it in the manner described on another page.

Some women, who have previously borne children, suffer from a falling forward of the womb, causing an unusual prominence of the lower part of the abdomen. Such persons require to be put to bed at a very early stage of labour, and should either be

allowed to lie flat on the back, or be supported in the half-sitting posture.*

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* The late Dr. Radford, to whom I am indebted for the recommendations contained in this paragraph, has recorded two fatal cases in which this condition was present, and in each of which rupture of the uterus took place at the very moment of the patient rising to her feet during labour. See "Trans. Obstet. Soc. Lond.," vol. viii. pp. 26 and 38.

He suggests that, in order that the uterus may be safely guided into, and maintained in such a position as will facilitate labour, the nurse should, in all cases of this kind, put on a broad bandage at a very early period of the labour, and tighten it as labour advances. After the membranes have ruptured and the waters have been discharged, this bandage should be applied as follows :—The end lying upon the bed is to be fastened to the side of the bed, so as to constitute a fixed point, while the other end is held obliquely by the nurse, and gradually tightened as the child descends into the pelvis. The direction of the pressure will thus be slightly upwards as well as backwards.

This mode of support, by what he terms a "regulating bandage," effectually assists the entrance of the child's head into the pelvis. See "Assoc. Med. Journal," Feb. 16, March 1, and April 12, 1856.

CHAPTER VII.

Management of the Newly-born Child: Washing and Dressing—Feeding and Feeding-bottles—Aperients—Sleep—Warmth and Fresh Air—Separation of Navel-string—Swelling of the Breasts in the newly-born—The "Thrush."

After making the mother comfortable, the next duty of the nurse is to attend to the washing of the child. This should be done, if possible, before the medical attendant leaves the house, in order that he may have an opportunity of examining the child thoroughly. For the washing, a foot-bath is required, or a basin at least one foot broad, one foot deep, and two feet long, so that the whole body, with the exception of the head, may be placed in the water for a minute or two. The nurse must also be provided with a piece of soft flannel, some olive-oil, a piece of good, unirritating soap, and, for the dressing, in addition to the clothes, a needle and thread, some safety-

pins, and a piece of linen rag six inches square, with a hole cut in its centre large enough to admit the navel-string. Sitting at a convenient distance from the fire, she then proceeds to unfold the flannel wrapper and anoint the child's skin with warm olive-oil wherever it is covered with the white greasy material usually present. This having been done, the child is to be put into the water, the temperature of which should be about 90°, and the head supported on the left hand out of the water. After having rested there for about two minutes, it is to be taken on to the lap and washed with soap and flannel, the eyes being carefully cleaned first, then the head, and afterwards the remainder of the body, great pains being taken to cleanse the little wrinkles at the various joints. After gently drying the skin with a soft warm towel, it must be well powdered, and especially those parts near the joints where chafing is most likely to occur—viz., under the knees and armpits, in the groins, and between the thighs. The piece of flannel used for the first washing should be burnt.

The skin having now been well washed, dried, and powdered, the square of old linen is to be held near the fire for a minute and slipped over the remains of the navel-string, which is to be folded in it and turned upwards upon the child's abdomen, where it is to be retained by means of the flannel binder until its separation, which usually takes place about the fourth or fifth day.

Up to the time of this separation, the child must be washed from head to foot on the nurse's lap, night and morning. Afterwards, when there is no longer any fear of injuring the navel, the child should be placed in the water for two minutes during the morning washing, the evening washing being done on the nurse's lap as before. Whenever a napkin is removed, the parts protected by it must be well cleansed by sponging with a little soap and water, and then thoroughly powdered, so as to prevent the skin becoming sore. This rule holds good even if the napkin has only been soiled with urine, though it is of course still more necessary when there has been also an action of the bowels.

It is part of a monthly nurse's duty to wash and dress the child during the time she stays in the house, and she should, for this purpose, be provided with a large soft flannel apron, which must be carefully dried each time it is used.

The child's clothing should be warm without being heavy, and should fit loosely so as to allow the organs free play, and the blood to flow unhindered. The body-binder should be of flannel, as it is impossible to prevent its being soiled with the urine, and flannel, when wetted, does not chill the skin so much as other materials. None but patent safety-pins should be used about a baby, and even for them it is better to substitute two or three stitches wherever it is possible.

The medical attendant must always be informed, when he makes his first after-visit, whether the infant has passed urine and whether the bowels have acted; also as to any marks or other peculiarities that may have been noticed. The state of the eyes, too, should be narrowly watched, and any unhealthy appearance or the least sign of discharge at once reported.

It is most undesirable to give a newly-born child butter and sugar, or other similar compound. For the first twelve hours at least, and indeed for a much longer time, the child will take no harm if left unfed. The proper course, however, is to apply it to the breast a few hours after birth—that is, as soon as the mother has recovered a little from the fatigue of labour. The breasts will probably not fill with milk for twenty-four or thirty-six hours, or even a little longer; but there is generally a little thick secretion of creamy fluid, called *colostrum*, much earlier than this, of which it is good for the mother to be relieved, and which acts as a gentle laxative upon the child. The early application of the child to the breast also helps to form the nipples, and renders the flow of milk easy from the first; it teaches the child how to suck, a lesson learnt less readily if it has previously been fed with a spoon; and, lastly, it provides it, in the majority of cases, with all the food it requires during the first day or two, and obviates the necessity of artificial feeding.

The child should be put to the breast

with clock-like regularity. Until the flow is fairly established, the interval should be four hours; afterwards, for the first month, an hour and a half or two hours in the daytime and four hours in the night. In the daytime the child may be awakened at the feeding-hour; in the night he should on no account be disturbed out of his sleep. Many infants will sleep continuously for six hours in the night, and suffer no harm from the long fast.

If it is important that a child should be fed as often as is here stated, it is no less important that he should not be fed oftener. Young infants very soon learn habits of regularity, and, besides, their stomachs need rest between their meals, just as in our own case, except that, of course, the intervals required are shorter. Many women put the child to the breast whenever it cries, forgetting that this is the only way in which it can express its sense of discomfort, from whatever cause arising, and that it is quite as likely to be crying because it is in pain, or because its napkin wants changing, as from hunger.

It is important from the first to apply the child to each breast in turn.

When the secretion of milk is long delayed, and it becomes consequently necessary to feed the infant, the proper food is good cow's milk, boiled, so as to prevent its being a carrier of infection, then mixed with about an equal quantity of water, and sweetened. Bread and oatmeal gruel are not fit food for newly-born infants. They irritate the stomach and bowels, and cause griping and flatulence. In short, during the first month of life no other food than the mother's milk or diluted cow's milk should ever be given, except under medical advice.

When the mother has not enough milk to satisfy the child, nursing may be combined with hand-feeding, which is generally preferable to hand-feeding alone. The additional food should consist of good milk, boiled, diluted with an equal quantity of water, and sweetened. After the first month the quantity of added water requires to be gradually lessened.

In case the mother cannot nurse her

child, the next best way of feeding it is to obtain a good, healthy wet-nurse, whose child is not much older than the one she is to nurse. The medical attendant should always be consulted in regard to the health and suitability of a wet-nurse, before she is engaged.

It may be that a wet-nurse cannot be obtained, and then hand-feeding becomes necessary. For this purpose good milk (from one cow if possible), boiled, diluted, and sweetened, as already directed, is for the first few months all the food that is required. Arrowroot, cornflour, and bread are all unsuitable at this tender age, and afford far less nourishment than milk.

Now and then a child is found with whom fresh milk does not agree, the curdy character of the stools showing that it is only partially digested. Should a change of dairy not suffice to set matters right, it will be desirable to try the concentrated Swiss milk, which, though greatly inferior to fresh milk, is the best of all artificial substitutes. Failing success with this, a malted preparation, known as Mellin's

Food for Infants, may be tried, at any rate until the digestive powers become sufficiently improved to return to milk.

The custom of using feeding-bottles with india-rubber tubes has become exceedingly prevalent. These tubes are difficult to keep clean, and a mere drop or two of milk left adhering to the bottle or tube will often be sufficient to turn the next supply sour. Hence have arisen flatulence and indigestion, and much sickness and suffering. Another objection to the use of tubes is, that nurses are tempted to place children in the cots with the bottle of milk by their side and the tube in their mouth, a practice which is highly objectionable on several grounds. It does away with all regularity in feeding, and is very liable to cause the milk to be turned sour owing to the heat given off from the child's body. Feeding-bottles without tubes, and fitted with teats only, have the advantage of requiring to be held in the nurse's hand, and are on every account to be preferred. There should always be two, for alternate use, one being kept under

water while the other is in actual use. Immediately after the child has had a meal, the bottle must be thoroughly washed in warm water.

It is an unnecessary and injurious practice to administer castor-oil to the newly-born. The first milk (or *colostrum*) from the mother's breast generally relaxes the bowels sufficiently, and if not, no aperient should be administered except under the advice of the medical attendant.

Children should not sleep in the same bed with an adult, but should, from the first, be placed in their own separate cot. Attention to this rule would annually save many lives which are now sacrificed. The number returned every year as having been found dead in bed is astounding. Sometimes both mother and child fall asleep, while the child is at the breast, whereupon the child's face gets pressed so closely against the mother's body that both nose and mouth are covered, breathing becomes impossible, and the child is smothered; sometimes fatal asphyxia is produced by the child nestling down in the bed and

going to sleep with its head completely covered by the bedclothes ; and sometimes, though of course very rarely, the cause of death in these cases is overlying. These dangers are best avoided by letting the child sleep by itself.

During the first month or two a healthy child sleeps the greater part of both day and night.

Children should not be allowed to form the habit of being put to sleep on the nurse's lap, but should be placed in their cot awake, and soothed to sleep there. This is a lesson learnt without difficulty, if taught from the earliest days.

On no account should any kind of soothing medicine be given, except under medical advice.

Young babies require to be kept very warm, and yet need abundance of fresh air. Nursery windows should be opened very frequently, and the room kept pure and wholesome. After the first two or three weeks, children should be carried in the arms out of doors every day in fine weather. In winter they should be well wrapped up,

and in summer the head should be carefully protected from the rays of the sun.

When the navel-string is an unusually long time in separating, no force is to be used; all will go on properly if left to Nature. Separation having taken place, a small round piece of linen should be covered with a little vaseline or simple ointment, and applied to the navel. If the process be accompanied or followed by bleeding, the medical attendant should be informed without delay, as children occasionally die from this cause. He should also be told if, after the separation, the navel is found to project more than usual.

It is by no means an unfrequent occurrence for the breasts of newly born children to become swollen and inflamed, and sometimes they are even found to contain a few drops of milk-like fluid. In either case the nurse must carefully avoid rubbing or squeezing them. The swelling will gradually disappear, and the fluid become absorbed under soothing treatment—as, for example, the ordinary water dressing; whereas rough manipulations, such as have just been men-

tioned, increase the inflammation, and are apt to result in the formation of abscess.

The appearance of a number of little white spots on the tongue, inside the lips and cheeks, and on the roof of the mouth, known in the nursery as "the thrush," is an almost certain sign that the child's food is in some way unsuitable, and ought, therefore, invariably to be reported to the medical attendant. In the meantime the affected places should be painted several times a day with glycerine of borax, by means of a camel-hair brush.

CHAPTER VIII.

Management of the Mother after Labour : Treatment during the first few Hours—The Lochia—Necessity of the Level Posture—Care when first Sitting-up—Change of Room—Going out of Doors—Changing the Linen—The Binder—Washing, &c.—Avoidance of Excitement—Occupation—Diet—The Bowels—Flooding—Rigors—Suckling—Sore Nipples—Abscess of Breast—Dispersion of Milk in the event of not Suckling.

After the patient has been made comfortable in the manner already described, it is above all things desirable that she should have several hours of undisturbed rest, and, if possible, sleep. There used to be a curious notion prevalent amongst nurses that a woman ought not to be allowed to fall asleep directly after delivery. This is altogether a mistake; sleep is to be encouraged by every possible means. To this end the room should be kept exceedingly quiet, and the blinds drawn down so as to subdue the light. In this way the

patient will be best enabled to recover from the exhausting effects of labour. In the meantime the nurse should keep an eye on the patient's face, and if she observe that it is becoming unusually pale, she must at once ascertain whether there is any flooding (*see* page 72).

For the first few days the patient will suffer more or less from after-pains, which only require to be brought under the notice of the medical attendant in case they are very severe or interfere with sleep. As a rule, no after-pains occur after a first confinement.

The proper food to be given directly after labour is a cup of tea, gruel, or warm milk; but if the patient prefers to wait a little before taking anything at all, there is no harm in allowing her to follow her inclination. When the patient has had a few hours' rest, and has recovered from her exhaustion, the child should be applied to the breast. The nipples can be drawn out much better before the breasts become filled with milk than afterwards.

Not more than six hours should elapse

after labour before the patient is reminded to pass water. She should not be allowed to wait until she feels a desire to do this, for, under these circumstances, the bladder may be quite full without the patient having any inclination to empty it. At the end of six hours, then, if it has not been already asked for, the slipper-pan should be passed, a little hot water having previously been poured into it and the vessel itself warmed before the fire. If she finds herself unable to use the slipper-pan, she may be allowed to turn herself gently on to her hands and knees, in which position she will almost always succeed, an ordinary chamber utensil being in that case substituted for the slipper-pan. Should she, even after changing her position, still be unable to pass urine, she must not make forcing efforts, but lie down again, rest a little, and then make a further attempt. The patient herself frequently imagines that she has passed urine, when she has not; hence the nurse, knowing this, must not be satisfied without seeing for herself the contents of the vessel after its removal.

Should no urine be passed during the first twelve hours, the medical attendant must be informed without delay, as it will probably be necessary to draw it off by means of the catheter.

For the first few hours after delivery the vagina and external genital organs are very sore and painful, and the discharge consists of pure blood. Ten or twelve napkins are required during the twenty-four hours immediately succeeding labour. On the second day the discharge becomes less, and each day the quantity diminishes, the discharge itself gradually changing from pure blood to a thick dark fluid, and lastly to a thin serum, like soiled water. The discharge always possesses a peculiar and distinctive odour, but if the odour become offensive the medical attendant should be informed. Similarly he should be told if, after having once ceased to consist of pure blood, the discharge should again assume that character.

The discharges after labour are termed the *lochia;* they sometimes last only a few days, and at other times continue for three or

four weeks. They vary, too, in quantity in different women, even when they are quite natural and healthy. When they have passed through the changes I have named, they ought presently to cease, and if, instead of doing so, they continue, and if, especially, they become purulent in character—that is, if they contain matter like that of an abscess—an examination is necessary and the medical attendant must be informed.

On the other hand, it is not very unusual for the lochia to cease rather early and suddenly, and although this often causes alarm both to patient and nurse, it need not do so provided there is no other sign of ill-health, such as shivering, thirst, and feverishness.

For the first three days after confinement a patient should on no account be raised into the sitting posture lest an attack of flooding should come on, or fainting and even sudden death occur. There is not the same danger in allowing her to turn on to the hands and knees; indeed, I have already said that this posture may

be resorted to in the event of any difficulty in using the slipper-pan in the ordinary way.

After the first three days, provided all is going on favourably, this rule as to the level position may be relaxed a little, by allowing the patient to be propped up by means of pillows or a bed-rest while she is taking food. At all other times, however, she must continue to lie down until the ninth day, when she may be assisted or carried to a couch and allowed to remain upon it for an hour or an hour and a half. At first very little dressing ought to be attempted on these occasions, the patient being protected from cold by wearing a warm dressing-gown, or by having a good blanket thrown over her. The length of time she is allowed to be out of bed may be increased day by day; and on the twelfth or thirteenth day she may be fully dressed. The temperature of the room must be regulated most carefully when the patient first leaves her bed, it being much more important for the room to be well warmed

then, than during the time she remained in bed.

Should there be a suitable sitting-room on the same floor, the patient may take advantage of it as early as the fourteenth day; the lying-in chamber being meanwhile thoroughly freshened by opening the windows, spreading out the bedclothing, and leaving the mattress or bedding uncovered for some hours. If, on the other hand, the only available room is downstairs, it will be prudent to postpone the change for a few days longer.

For the first month it is well for patients in this country to be content to remain indoors. If it happens to be mild, bright summer weather, and the patient's recovery has been rapid and satisfactory, the medical attendant may, in an exceptional case, consent to her taking a short walk or drive, at the end of three weeks.

After confinement a patient's linen requires to be frequently changed, both for health's sake and her own comfort. The patient must on no account be allowed to sit up or make any exertion while the clothes

are being changed; the nurse must take off the soiled clothing by drawing down the sleeves from one arm, gathering up the clothes on that side into a handful, passing them gently over the head, and then drawing off the sleeves from the opposite arm. The clean linen, well aired, must then be put on as the patient lies.

The first binder should always be placed next to the patient's skin; after the first twenty-four hours this is a matter of less consequence. Each morning during the first week a clean binder should be applied with moderate tightness, the nurse re-adjusting it from time to time during the day in case it should become wrinkled or loose.

The patient's hands and face should be washed, and her hair straightened, as far as is possible without raising her, every morning. The hands and face having been attended to, the external genitals should be thoroughly cleansed over a bed-bath by means of a sponge and some warm water, to which have been added a few drops of Condy's fluid, sufficient to give the water a decidedly pink tint. In the absence of a bed-bath,

a large slipper bed-pan may be made to answer the purpose, and if neither is obtainable, the patient must be made to turn on to the left side, with the thighs close to the edge of the bed, and the knees drawn up, when, the bed being duly protected by means of a macintosh and warm folded sheet, the nurse can proceed with the sponging in the manner ordinarily adopted immediately after labour. For the first few days, while the lochia are somewhat abundant, it is well to repeat this process again in the evening.

Should the nurse while bathing the patient, discover a wound or raw surface, or any unusual swelling, she must quietly mention it to the medical attendant at his next visit; and so, too, if she finds any piles protruding. In the event of the patient complaining of severe pain from piles, the nurse must frequently foment the part, or apply a bread-poultice, until she receives instructions from the medical attendant.

Vaginal injections and douches are only to be used under medical direction.

The mind of a lying-in woman requires rest equally with the body. No painful news, or other exciting or disturbing influences, should be allowed to reach her. The visits of friends to the lying-in room must be entirely forbidden, except in the case of those who have obtained special permission from the medical attendant.

It should never be forgotten that a peculiar and distressing form of mental derangement is liable to attack lying-in patients. Hence, if a nurse finds her patient irritable in temper and difficult to manage, she must avoid anything like contention or direct contradiction. By a firm, quiet, decided manner, a good nurse will be able to carry her point without exciting her patient.

As the patient grows a little stronger, there can be no objection to her occupying herself while in bed, if she is wishful to do so, with a little plain sewing or fancy work, and now and then with a little reading, so as to make the time pass more agreeably.

With regard to diet, many medical

practitioners have rules of their own, which the nurse must always be prepared loyally to carry out. It is not now generally thought necessary for lying-in patients to be restricted to tea and gruel for a whole week. When a nurse is left to her own discretion she will find her patients recover their strength most rapidly by being allowed some variety in their food from the beginning. Boiled milk should always enter largely into the dietary of a woman who intends to suckle her child. An occasional cup of good black tea is generally very grateful, with or without a little biscuit, toast, or bread-and-butter. From the first, beef-tea, chicken, mutton, or veal broth, rice-caudle, milk or oatmeal gruel, and other simple fluids, are perfectly allowable. If all is going on well, and the bowels have acted, there is no harm—in case the patient expresses a desire for more solid food—in giving, even on the second or third day, a little sole or whiting, a slice of chicken or tender roast beef, or a mutton chop. The diet, indeed, at this time needs to be nutritious and plentiful, while its kind

may safely be regulated very much according to a patient's inclination. No stimulants of any sort, however, must be given, except under medical direction.

A nurse should not give opening medicine on her own responsibility. The medical attendant will order what is necessary and state when it is to be given. Very often, instead of medicines, he will prescribe a simple enema of soap and water.

Whenever an attack of flooding comes on during the period of lying-in, the nurse must at once send for the medical attendant, stating clearly her reasons for sending, in order that he may know what will be required. In the meantime she must unfasten the binder, and make firm pressure with her outspread hand on the womb, which she will have no difficulty in finding, as it will not yet have returned to its natural size and position. She must also apply cloths dipped in cold water, or in vinegar and water, to the external genitals, keeping them applied not longer than a minute or two at a time. Where the flow is great it will be right for the nurse to try

to check it by taking a dry napkin and pressing it firmly with her hand against the external parts, while the other hand is still engaged in compressing the womb from above. The patient must, of course, be kept all this time strictly lying down, with the head and shoulders low, and cool, fresh air must be admitted through the open window.

The occurrence of a shivering fit, especially if it is a severe one, or is followed by others, ought always to be regarded seriously. No time should be lost in acquainting the medical attendant, and the nurse must meanwhile do all in her power to produce a feeling of returning warmth in her patient. With this object, a warm bottle should be put to her feet, an additional blanket thrown over her, and a cup of warm tea administered. This event is so often the sign of approaching illness that, when it has shown itself, the patient should be watched with the utmost anxiety.

The secretion of milk is not usually established until the second or third day; now and then, however, it makes its ap-

pearance earlier. This event is sometimes accompanied with a little constitutional disturbance, which soon subsides. When the breasts are becoming so full and hard as to be painful, great relief will be afforded by fomenting them every few hours, and supporting them, in the meantime, as in a sling, by a handkerchief tied over the opposite shoulder. This condition will generally soon subside if the child be applied at regular intervals. Nurses must beware of meddling too much with the breasts, and especially avoid rubbing them, except under special medical direction. The nipples and surrounding parts should be carefully washed each time the child leaves the breast, and should be excluded from the air by covering them with a small piece of linen rag on which a little vaseline or other simple ointment has been spread.

As soon as it becomes clear that the supply of breast-milk is insufficient, it is unwise to keep putting the child to the breast, as this only produces irritation and is very liable to set up inflammation and

abscess. Similarly, if the nipples are extremely sore, so that, even when they are protected by a nipple-shield, the application of the child is attended each time with intense pain, or if they are so depressed that neither the efforts of the child nor the cautious use of the breast-pump will draw them out, it is running a great risk of exciting breast-abscess to persevere beyond twenty-four hours in an attempt to suckle.

Should the nipples become red and swollen, a bread-poultice should be applied until the arrival of the medical attendant.

If the nurse notices a patch of redness on a patient's breast, and finds that the skin at that spot is painful and tender to the touch, she should take means to acquaint the medical attendant as soon as possible, and, in the meantime, should apply either warm-water dressing or a linseed-meal poultice, for it is almost certain that an abscess is forming. When an abscess has actually formed, it should be opened with as little delay as possible, lest it spread and become much more formidable.

When the child is still-born, or when, from any other cause, it is not going to be suckled, there is often great anxiety expressed about the dispersion of the milk. It is astonishing, however, how quickly it becomes absorbed if left to Nature. If the patient will only submit to the discomfort arising from the fulness of the breasts for a few hours, without insisting on their being partially emptied from time to time by the use of the breast-pump, or other similar means, whereby the breasts are stimulated to fresh secretion and the evil is aggravated, she will soon have the satisfaction of finding them softer and less painful, and will be amply rewarded for her patience. Should the feeling of tension be excessive, it will be best relieved by hot fomentations applied every few hours; if not excessive, the application for a few days of belladonna plasters, with a hole in the centre for the nipple, is often all that is necessary. In ordering these plasters the nurse should furnish the chemist with paper patterns showing the size required.

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THE END.

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