two feet. The accoucheur's left hand is the obstetrical hand *par excellence*. Physicians should learn to use it adroitly more than they do.

ANÆSTHETICS.

The foremost question under this head is, Do anæsthetics injure the patient? I am pretty sure that they do not. Since 1849 I have used ether, chloroform, or a mixture of the two with alcohol, in every case where the woman was willing to breathe an anæsthetic. Some object; they are afraid to take it, and these I do not urge; but the majority are glad to get it before the labor is over. As a general rule I do not give ether during the first stage.

High authorities tell us that there is a greater tendency to post-partum hæmorrhage after ether or chloroform has been administered. During the last sixteen years I have not employed chloroform in midwifery practice, except as a remedy for convulsions; but I believe that ether, in moderate doses, does not tend to bring on flooding. Ether is seldom given to the extent of unconsciousness. The patient knows what is going on, and can render voluntary assistance when solicited.

A small dose of ether acts beneficially in two ways: it blunts sensibility to pain and allows the abdominal muscles to aid in propulson. Without ether the patient's will-power is instinctively exerted to delay the labor; with it the canal is more likely to be relaxed, and the voluntary muscles are not so much restrained. The contractile power of the womb itself is not affected by moderate inhalation of ether.

ANTISEPTICS.

Cleanliness is a good thing in midwifery, and antiseptics are its aides-de-camp. A young doctor who keeps his nails in mourning will eventually have to mourn the absence of a lucrative practice. Still it is possible to have too much of a good thing. Dr. Thomas, of New York, has recently taken a stand on this subject which most physicians would call ultra. The rules and regulations he lays down might possibly be enforced in a hospital, but hardly in private practice. And even if they could be carried out, I question the advantages of trying to surround a physiological process with all the paraphernalia needed in a surgical operation. Carbolic acid has had its flood-tide, and begins to ebb. Corrosive sublimate will probably follow suit at no distant day. Please observe, I do not object to disinfectants or antiseptics in themseves. Both of the chemicals mentioned will no doubt, be used occasionally with advantage. But I believe that carbolic acid nearly killed Dr. Thomas Keith, and not a few unfortunate patients have suffered from its wholesale reckless employment. I greatly prefer a weak solution of iodine, prepared with iodide of potassium, which may be diluted with water without precipitation, or a hot solution of permanganate of potas. In ordinary cases absolute cleanliness is all that is needed. The routine employment of vaginal injections is likely to do more harm than good. I concur in the opinions expressed by Dr. Adams, of Framingham, in his interesting paper read at your last meeting. Dr. William Godell's suggestion that lying-in women should be encouraged to assume the erect posture ealy, with a view to facilitate the removal of clots and *débris*, is an excellent one.

As already hinted, it is a good plan for the obstetrician to wash his hands, keep his finger nails pared pretty close, and to fill the small remaining space with softened soap before making a vaginal examination. A Syracuse æsthetic M.D. kindly suggests that no harm would result if he also washed his hands afterward.

CRANIOTOMY.

During the last nineteen years I have performed craniotomy three times, all of the cases occurring in the practice of other physicians. No operation tries a surgeon's nerve more than this one. When we are sure that the child is dead, of course it is plain sailing. But there are cases when the fœtal heart cannot be distinctly heard, and yet the child is alive. To plunge a perforator into a living child's skull, and deliberately take its life, with the view to save that of its mother, is, to say the least, a sad alternative. I hope I shall never feel compelled to do it again. In these days of successful abdominal surgery, would we not be justified in appealing to the patient to allow us to perform the Cæsarean section or laparoëlytrotomy? But we should not wait till the woman is at death's door before operating. In this, as in all other life-saving operations, promptness and decision win the day.

The medical profession is deeply indebted to Dr. Thomas for his efforts to popularize laparoëlytrotomy. I understand that he tried the operation several times on the cadaver before performing it on a patient. Nearly all great surgeons have been in the habit of doing this. In this case the principal difficulty will be to get the consent of the patient and her friends in season to be of any service. We all love to put off the evil day, or even the evil hour, and so the golden opportunity slips through our fingers. But as successful results in this line increase the dread of the operation itself will decrease, and obstetric surgery may achieve a new triumph in the salvation of human life.—*Boston Med. & Surg. Journal.*

SUGGESTIONS FROM DISPENSARY EXPERIENCE, FOR THE SURGERY OF GENERAL PRACTICE.

BY DR. C. W. DULLES, PHILADELPHIA.

It has often seemed to me that the experience gained in the many dispensaries of our large cities