radically different from their sturdy mothers and grandmothers, so much the greater reason that we should learn to handle them at least as skilfully as our teachers. When I remember how Isaac E. Taylor could coax the fœtal head carefully and patiently through a contracted pelvis with his old-fashioned straight forceps, I do not feel very proud of my fœtal mortality with the improved axis-traction. After all, we are not so much wiser than our predecessors, and do well to heed the injunction, "Remove not the ancient landmarks which the fathers have set up." But in one respect at least we have the advantage of our forbears. We can insure perfect asepsis, and can anticipate the work of the gynecologist by careful repair of lesions of the soft parts immediately after delivery. Let us no longer be content with saving the lives of the mother and child, even after the most difficult delivery. Let our ambition be to leave the mother in just as good condition as we found her. I shall not repeat, what I have so often written, that it is not enough to simply suture raw surfaces, but we must repair the deeper, invisible tears of the pelvic floor which are the direct cause of future displacements. Union of the lacerated sphincter ani (and he who has never had this accident has not had many difficult cases) must be deliberately and aseptically effected, with the confident expectation of primary union.

Let us not be content to dismiss an obstetric case two or three weeks after delivery. Examine the patient four or six weeks later and you will be surprised to find how often the uterus is retroverted, even after a perfectly normal confinement. Many of these displacements right themselves with simple postural treatment, and the majority are cured by the judicious use of a pessary. In fact, the late Dr. Paul F. Mundé, a strong, honest man, admitted as the result of his vast experience that these are practically the only cases which are really "cured" by this useful instrument (about 5 per cent. of all cases of simple retroversion). Why not try one, and thus save the patient a subsequent Alexander's operation or ventro-suspension?

It is affirmed that sepsis should practically be an unknown factor in modern obstetrics. This may be true in well-equipped hospitals, where the mortality from this cause has been reduced to less than one per cent., but it is not the case in the homes of the poor, at least in New York City, where so many women are attended by midwives. The statistics of the Board of Health, as well as the experience of those who are connected with our public hospitals, still shows a most reprehensible proportion of septic