the delivery of a living child, or to allow the pregnancy to go on to full term and to effect delivery under symphyseotomy, if this proves to be necessary.

The first problem as to the justifiability of embryotomy done upon the living child, I take it, has been settled in the negative. The question no longer is, Shall both mother and child be permitted to die? nor is it, Shall one be destroyed in order that the other may live? The problem now is, Shall the effort be made by the Cæsarean section or symphyseotomy to save both mother and child, thereby increasing the prospective mortality of the mothers from one to three per cent. as contrasted with embryotomy? Or, to put it in another way, Shall one hundred children be destroyed in order that the lives of from one to three mothers shall not be put in jeopardy? As this question has only a relative bearing upon the subject under discussion, we shall not consider it further at this time.

The second problem is one which is now only coming up for solution, and has been brought to the front partly because of the large number of children who perish as the result of difficult labors, either during birth or shortly thereafter, and partly because of the very considerable number of children who are injured for life from the same cause. These are the "spoiled babies," having sustained injuries to the head, such as depressions or fractures, or great distortions of the skull, or injuries to the tissue of the brain itself, resulting in hæmorrhages and subsequently in localized palsies, epilepsy, or in greater or less impairment of mental vigor.

The comparative safety of symphyseotomy suggests that the accepted teachings of the present be critically revised with reference to the conduct of labor in cases in which the obstruction is considerable and yet not insuperable. I am inclined to believe that in the near future these considerations will considerably alter the present rules of practice. In the interests of the child, version will be less frequently resorted to. And in cases of moderate contraction of the pelvis, in which the unaided efforts of the mother, assisted by the judicious employment of forceps, do not succeed in accomplishing delivery, instead of employing violent traction efforts (which so generally injure the child, and are liable to injure the mother) symphyseotomy will be done. These remarks are not made in a dogmatic spirit, but simply indicate the drift of my own opinion concerning this subject.

The third problem is the one which immediately concerns us to-day, and it is my purpose in this paper to present the advantages of symphyseotomy as contrasted with the induction of premature labor in the management of cases of labor in women having moderately contracted pelves. The class of cases more especially referred to is the flat pelvis with a conjugate diameter of three inches or more, and the generally contracted pelvis with a conjugate diameter of three and a-quarter inches or more, and even flat pelves with as short a conjugate diameter as two and three-quarter inches. It is recognized, of course, that disproportion between the head of the child and the pelvis depends not only upon the diameters of the pelvis, but also upon those of the head, and that spontaneous labor, or labor assisted either by the forceps or version, is quite possible in this class of cases when the head of the child is small or more than usually compressible. Given a woman in the eighth month of pregnancy, having a pelvis of the class under consideration, what shall be done? Shall labor be induced sufficiently before full term to permit the spontaneous delivery of the child, or its delivery assisted by forceps or version; or shall the pregnancy be permitted to go on to term, and then, if necessary, symphyseotomy be performed? This question, of course, must be studied from the standpoint both of the mother and the child. From the standpoint of the mother we have to consider the mortality and morbidity of the operation of inducing premature labor as contrasted with that of symphyseotomy. The general mortality of the induction of premature labor is given in the text-books as five per cent. The general mortality of symphyseotomy is stated to be about ten per cent. As a matter of fact, I believe that both these statements are decidedly erroneous. Five per cent. is undoubtedly too high a mortality for the induction of premature labor. I have reason to believe that in good hands, when the indication for its performance is contraction of the pelvis, its mortality does not exceed one per cent. The dangers to the mother under these circumstances are far less than they are, for example, when the indication is puerperal