the language employed. Although what follows may appear like laying down the law in a somewhat curt fashion, such is not my intention. What follows are simply my own opinions on certain obstetrical problems colored by the personal medium. Nobody is more anxious than I am to be set right where I have been wrong. The late Dr. J. C. Warren, in his classical work on "Tumors," gives us this good advice: "He (the surgeon) must get the opinion of other surgeons. Even those who have not so much experience as himself may afford him excellent hints, and strike out from his own mind thoughts which without this collision would not have been elicited." Dr. Barnes also truly asserts that "there is no man whose experience is so great that nothing is left for him to learn from the experience of others." Such societies as this one answer that purpose.

FORCEPS.

I prefer curved to straight forceps. They are about as easily applied, and are less liable to slip. If a beginner can only afford one it should be a long pair, either nickel or silver-plated. But it is convenient to own a short pair, and I always carry one in my obstetrical bag, along with a No. 6 gum-elastic catheter (male), a Davidson syringe, a hypodermic syringe, a few feet of flat covered wire (such as milliners use), ether, ergot, chloral and whiskey.

The short forceps may be used at any time when their employment will benefit the patient or her coming child. We should *not* use them merely to save our own time. But the long forceps (when applied within the uterus) should seldom or never be used without a consultation. Indeed, it is a wise precaution, in most difficult or dangerous cases, to call in a brother practitioner to share the responsibility. I make it an invariable rule to pass a soft catheter into the bladder before applying forceps. In some cases using the catheter helps progress, even when forceps are not needed. If the rectum contains solid fæces I also give an enema of warm soapsuds.

How should the forceps be applied? In Scotland the woman is placed on her left side, with her hips projecting from the bed. In this country the the dorsal position is preferred, and it is the one I most frequently use. Lately I have tried a new way, which has certain advantages. The woman lies on her back in the centre of the bed or anywhere, and is not moved at all. Of course, it is not convenient to use long forceps in this position; but, when practicable it avoids the appearance of preparing for a surgical operation, and I think the less fuss we make the better it is for our patient.

In most cases I insert each blade at the side of the pelvis, without regard to the position of the the child's head. If the vertex presents, you can scarcely go wrong by following this rule, and it saves the patient the annoyance of searching for an ear and other annoying manipulations. I make traction only during a pain, and relax pressure when the pain abates. I think it is advisable to pull with a slight pendulum motion, instead of using direct traction, on the same principle that it is easier to pull down a pair of tight pantaloons by drawing on alternate sides than by pulling on both sides at once.

ERGOT.

As a means of shortening labor, ergot is seldom employed nowadays. The forceps have crowded it out of use for that purpose. But as an agent in promoting uterine contraction, after delivery of the placenta, and especially in cases of threatened flooding (some women have a hæmorrhagic idiosyncrasy), it is a valuable remedy. One reason why ergot has fallen into disrepute is the poor quality of many specimens offered for sale. Dr. Squibb's aqueous extract rarely disappoints me. It should be borne in mind, however, that no drug is readily absorbed during extreme depression.

After much blood has been lost our main reliance should be placed on other agencies, such as injections of very hot water and mechanical pressure. The accoucheur's hand inside the womb, with external counter-pressure, is the most reliable method. In milder cases I have succeeded in arresting severe hæmorrhage by injecting hot water and vinegar into the flaccid uterus. But the water must have a temperature of 130° F. in the basin, as it cools during its passage along the tube.

TURNING.

As this operation requires no surgical instrument, it obviously antedates the forceps, and, since the days of Ambrose Paré, has been a favorite with many practitioners, and even with skilled midwives. I was acquainted with a physician who, if one might draw an inference from his usual practice, seemed to think that nature had made a mistake in placing the child upside down in the womb In our own day the late Sir James Simpson, Dr. Barnes, and Dr. Braxton Hicks have done much to bring version into favorable notice. On one occasion, before labor had fairly commenced, while making an external examination, I detected the child's head above the brim, and succeeded in converting a cross presentation into a normal one by the Braxton-Hicks method. I was agreeably surprised at the ease with which the change was effected. But, notwithstanding the plausible arguments advanced by Simpson, Barnes and others, I have come to the conclusion that turning, after the evacuation of the liquor amnii, is a very dangerous operation for the child, and not much safer for the mother. I admit that cases occur where no other alternative (except Cæsarean section) is left us. If we conclude to turn, the operator's left hand should be used, and, in most cases, it is better to bring down one foot than