I do hereby declare upon honour that the accompanying thesis on "Early Midwifery and the Practice of Obstetrics in Ceylon" has been composed by me.

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1st Cross Street, Pettah,
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20th February 1889.
Early Midwifery and
the Practice of Obstetrics in Ceylon:
Thesis
of
Charles Walter van Geypzel
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Early Midwifery and the Practice of Obstetrics in Ceylon.

In writing a paper on the "Practice of Midwifery in Ceylon", it occurred to me that it would be an interesting study to trace the practice of midwifery by midwives, a practice which is largely in vogue among the native races of Ceylon, backwards to the earliest times. Unlike other branches of medicine, obstetrics was for a long time wholly in the hands of women; all the routine of an ordinary case of labour was managed by them, and the difficulties of a complicated case were gone through by them unaided, to the detriment or advantage of mother and child.

Smellie in his Midwifery (see New Sydenham Society's edition of Smellie's Works, Vol. i. p. 29.) says, "It seems probable that, in the first ages, the practice of this art was altogether in the hands of women, and that men were never employed, but in the utmost extremity; "indeed," he continues, "it is natural to suppose that, whilst the simplicity of the early age remained, women would have recourse to none but persons of their own sex in diseases peculiar to it; accordingly we find that in Egypt midwifery was..."
was practiced by women.

Dennyman (see his "Introduction to the Practice of Midwifery", 4th Ed., vol. i., Preface, p. vi) goes further and says, "it is probable that the Greeks were instructed by the Egyptians, and that these, as many contend, by the women of India." So that the women of "enlightened" India, as many contend, were far and away the pre-cursors in the practice of this art of the nine-tamed fliers of enlightened Greece and Rome.

Indeed, it would appear that among all primitive peoples midwifery is stille in the hands of the midwife. Dr. Feltinii of Edinburgh, in a most interesting article in the "Edinburgh Medical Journal" in April 1854, entitled "Notes on Labour in Central Africa," says that "a woman in labour is turned over to the men, only when given up by the women;" it is only then that the Magician, dressed in the peculiar garb which proclaims him as such, begins to sharpen his ugly-looking knife准备 to performing the generally fatal operation of the "Cesarean section," which, strange as it would seem, is sometime performed successfully by these simple surgeons.

The first writers on Midwifery, antin to the time of Hippocrates, who lived 400 B.C., were women. In the "Harmonia Gynaecorium," says Smellie, "there are extant several directions and
and recipes on the subject of midwifery, collected from the writings of one Cleopatra, interspersed with those of Moschion and Porcian;" and "Galen advises the reader to consult the writings of one of that name, "Actius," Smellie further goes on to say, "transcribes some chapters from the works of one Alphasia, touching the method of delivery and managing women in natural labours."

It is interesting, as a negative proof that the practice of midwifery continued for a long time mainly in the hands of the midwife, that Celsus, who lived near the beginning of the Christian era (B.C. 53 - A.D. 7), has devoted only one chapter to an obstetric subject, entitled "Foetus in utero matris Ermatium," in which he describes the method of extracting a dead foetus out of the womb (see Dr. Milligan's Edition of Celsus, lib. vii, Cap. xxix).

If we go back to the oldest of historic records, the earliest books of the Bible, we find in the first chapter of Exodus reference made to the midwife as the only person in attendance in casing labour: in that chapter too we find reference made to the earliest obstetric chair. "The expression, upon the stool, in that chapter receives remarkable illustration, from modern usage. The Egyptian practice, as described by Mr. Lane, exactly answers to that indicated in
The book of Exodus. Two or three days before the expected time of delivery the ‘Layeh’ (midwife) conveys to the house the ‘Kursee Elwala’eh’, a chain of a peculiar form, upon which the patient is to be seated during the birth” (See Dr. Smith’s Concise Dictionary of the Bible, Article “Midwife”).

Glancing still further back, we come to a time when we lose all mention of midwives, to a time when in Obstetrics, as in other departments of medicine, there was no suffering humanity only the rude but well-meant endeavours of a friend to relieve distress, when one woman looked to her neighbour to help her in her confinement ; and we could just imagine her, in those far-off times, one woman distinguished above others for skill in manipulation and wealth of resource in difficulty, would be in greater requisition than others in labour, and be ‘set apart’ as midwife in her own circle of friends & acquaintances.

It is interesting in this connection to enquire whether labour was in any way easier in early times than now, whether there occurred in primitive times the same difficulties and mishaps which the accoucheur of modern times has often to face. There can be no doubt that some of the difficulties of labour are only of modern date, that deformities of the pelvis due to Rickets and Osteo-
=malaria were unknown in early times; but on the whole it may be safely asserted that in early times there occurred the same difficulties and the same mishaps, that the mortality in early times of true child-birth was very much greater than now, owing to the fact that no science or art of obstetrics then existed. One has only to read Dr. Felkin's paper referred to above to be convinced of this: among such a primitivistic people as the African tribes, difficult labors are of frequent occurrence and from a variety of causes, and the felkins must frequently have been called upon to perform abdominal section, because they perform the operation with great skill and sometimes successfully.

In the discussion which followed upon the reading of Dr. Felkin's Paper in the Edinburgh Obstetrical Society, Professor Simpson said that "the accidents and difficulties described as so frequently occurring amongst such primitivistic peoples, prove that labor among the black races"—he might have said primitivistic peoples in present or past times and in all parts of the world—"was not the safest and easy process it was sometimes supposed to be" (see Edin. Med. Journal, March 1884).

The only apparent exception of any authentic ascertainability is to be found in the history of the Early Hebrews as narrated in the first chapter of Exodus: there, in the 19th verse we read, "The Hebrew women are not as the Egyptian women, for they are lively and
are delivered nor the midwives come in unto them'. The Hebrew word translated into "lively" is also rendered by some authorities "living creatures", implying that the Hebrew women were like animals, quick in parturition. Genesis explains it by the term "vividae robustae". In any case the general sense of the passage Exod. i. 19. is the same, viz. that the Hebrew women stood in little or no need of the midwives' assistance.

Another reason alleged for believing that labour among the early Hebrews was unusually easy is that in Exodus i. 15 only two midwives, Shiphrah and Puah, are mentioned as among the whole race, although Knobel and others suggest that the two named were the principal persons of their class (see Dr. Smith's larger Dictionary of the Bible, article Midwife).

Now, the exception to the general rule that labour has been and is at the same at all times, is here only apparent. We are reading in Exodus of God's special dealings with a peculiar chosen people: to one who believes in the authenticity of the Scripture and in God's direct and often miraculous interposition in the history of the early Hebrews, the apparent ease and quickness of childbirth among them could be readily explained as having been so ordained in their case by a special Providence. We have no parallel of the same ease and quickness in labour in the history of any other nation, past or present.

I am at a loss to know what authority the writer of the article "Midwife" in Dr. Smith's Dictionary of the Bible, the Rev. Henry Wright, Phillott
Shillott, had to make the general assertion that
“parturition in the East is unusually easy”: “The office of
a midwife”, he continues, “in many Eastern countries
is thus of little use, but is performed when necessary
by relatives.” The same difficulties and misfortunes in
parturition occur in the East as in the West, and
there is a free distribution of ignorant midwives in
Eastern countries.

The management of labour among the natives
of Ceylon is wholly in the hands of the midwife: it
is on the information supplied by her that the
“Vedellarra” or native doctor administers medicines
supplied by the oil for anointing the abdomen. Beyond
feeling the pulse, the ‘Vedellarra’ makes no examina-
tion to satisfy himself of the progress of the labour.
The Ceylon midwife— I do not include under this term
the uneducated domestic nurses trained at the lying-in
home, who are generally intelligent and know their work
well—the Ceylon midwife, I say, is an ignorant woman;
she has received no training and has no idea
of the several stages of labour; and it is this
want of knowledge which is at the bottom ground
of the mishaps in native women during labour.
If the first stage is delayed beyond a certain
time, the midwife, instead of advising the woman
just to be patient and to keep her spirits up till
the onset of the strong bearing-down pains of the
second stage, asks her to bear down, with the
result of course of exhausting the maternal
powers and inducing uterine contractions just at the time when tone and strength are required.

The 'vederralla' adds to the difficulty by pouring down the porridge patients' throat large quantities of a decoction which he prepares: the decoction, which is generally of the root of the castor oil plant is said to have the same effect as opium, but it is extremely stoutful. She is also made to drink large quantities of coconut milk, a talcum, to speak more accurately, King-Cocoa-nut water, with a view of stimulating the uterine. I have often found women treated previously by the midwife and 'vederralla' have the bladder greatly distended and from a large swelling in front of the gravid uterus. The large draught of fluid they take, in one form or another, during labour accounts for this. The bladder is to be distended not for some days after delivery it remains paralysed and has to be relieved.

During the first stage of labour, the woman is made to walk up and down the room and at each pain she stands and holds fast to a rope which is suspended from the roof of the room. When the pain ceases she again resumes her walking, to take hold of the rope or a return of the pain. This reminds me of what Dr. Felkin says is the custom which prevails in the Congo District of Central Africa: - a branch of a tree is laid horizontally between two other trees, so that a woman can just grasp it firmly, in the intervals between the pains she walks up and down at a slow pace.

* King-Cocoa-nut: The tree is much taller than the other species, the rind of the nut of a beautiful orange colour.
as soon as a pain comes on, she seizes the branch with her hands, places her feet apart, and bears down.

When the labour enters upon the second stage, the patient takes to her mat which is spread upon the floor. (Most native women are delivered upon the floor or a mat). She lies on her back with her knees drawn up. The midwife sits in front of her and fixes her toes on her feet, the toes being turned outwards, against the hips of the patient, the left foot against the right hip, and the right foot against the left hip. As each pain comes on, this position helps the patient to bear down effectually. In the intervals between the pains, the midwife keeps pouring inside the vagina Peruvian small quantities of Crocinum or guingilly* oil, in order to relax the parts, lubricate them, and thus facilitate the passage of the child.

When the child is born, the cord is not cut till the afterbirth is expelled: I have seen a child lie between the thighs of the mother with the placenta still on the cord, and the cord uncut for over twenty-four hours; it often happens though, that the placenta follows the child in ten or fifteen minutes.

In some cases, where there is delay in the expulsion of the afterbirth, the cord is cut and the child removed from the mother; and the cord, if it is long, is tied round one of the thighs of the mother; if it is short, it is secured to one of the thighs through the intervention of a bit of string. The natives have an idea that, if the cord is not so secured, it is apt to be drawn back again into the mother’s belly. *Sesamum or Til oil, the oil expressed from the seeds of Sesamum indicum.
The evil which the native midwife has to guard against in the management of the third stage is meddlesome interference; as soon as she sees the placenta, slowly expelled by the uterine contractions, make its appearance at the vulva, she is very apt to put her hand, lay hold of the presenting part of the placenta, and draw it hurriedly away, thus very frequently leaving behind a larger or smaller portion of the membranes. I have again and again witnessed this, and as often had to check her overgreat hurry. It is not long ago a poor woman came hurriedly to my place from the neighbourhood one evening about 7 o'clock, to say that her sister, who was confined three days before and who was attended by a native midwife, had a portion of her "bowels" (as she expressed it) protruding from the vulva; I went with her, and found that what she called "bowels" was the whole or nearly the whole of the membranes, now protruded and hanging out of the vagina: I had to remove them with a little care, as a good portion was still adherent.

After the completion of the third stage, a wide bandage is applied round the mother's waist, and tied in a large knot just a little above the contracted womb. I have found this native method of applying a bandage a very effective aid in keeping the womb contracted in threatening post-partum haemorrhage Cases: the knot pressing upon the womb which tends to relax and dilate, stimulates it contract and helps you to relieve your wearied hand; at the same
same time, you can at any moment feel and exert pressure upon the umbilicus, which you cannot do if an ordinary broad bandage was applied.

After the removal of the child from between the thighs of the mother, it is washed and swaddled in a bit of soft white cloth, the arms being kept well down on each side, and the cloth secured round the child by two or three ties. This is done, they say, with a view of preventing any deformity. It is a time-honoured Eastern custom of dressing new-born infants, and reminds one forcibly of what was done to the infant Jesus at his birth: “She brought forth her first-born Son,” says St. Luke, “and wrapped him in swaddling-clothes.” The navel-string is generally left undressed, sometimes the enders of a little burnt rag is placed over it and the whole fixed with a turn of soft cloth.

On the third or fourth day after confinement the woman is made to stand up, and a very long narrow bandage is carried tightly round the waist twice or thrice. I have again and again been told to see women suffering, they said, from child-bed fever, whose fever and uterine tenderness were simply due to this ill-applied bandage: the removal of the bandage was always followed in these cases by a subsidence of the fever and a lessening of the uterine tenderness. Two cases recur forcibly to my mind, and, what is a strange coincidence, the
The two women were the wives of two brothers; in one case, the woman suffered from severe uterine tenderness from the 3rd. or 4th. to the 13th. or 14th. day, before I was sent for; and, in the other case, I was taken to see a woman on the 21st. day after confinement, suffering from strong fever and oppression (as they termed it); in both these cases, I undid the bandages, which were tightly wound round the abdomen, with the result that all symptoms disappeared the next day.

From the time of the birth of the child, for some days afterwards, there is burnt in the living-room morning and evening, "incense," that is, a kind of sweet-smelling resinous substance, whose fumes permeate every part of the room, and act as a medical disinfectant. The child too is warmed over the fumes as they arise from the receptacle used for the purpose.

Soon after the birth of the child, margosa oil* is rubbed on the sides of the face of the mother, and a handkerchief tied round the head by the sides of the ears under the chin: the same oil is also rubbed on the abdomen. This strong-smelling disproportionate oil, beheld by the natives, to be a disinfectant, is used in the way described with the view of preventing chills and fevers.

The natives have no idea of ventilation: the doors, and the windows (if there are any), are kept closed; but, generally speaking, the soiled clothes (those removed from under the mother) are not allowed to remain long in the room; the washer-woman visits the house daily, and carries these away. This, in some measure, acts as a cleansing and disinfecting agent.

* Margosa oil is the oil extracted from the Nimtree or Margosa (Azadirachta Indica).
in Ceylon told me, for the comparative rarity of permanent fever amongst native women.

The woman is kept on a very spare diet during the Periparum — dry biscuit and coffee (without milk) and annarooft Canjic. This, for the first three days or so, and then she is allowed rice and other broth. She leaves her bed at the end of the week, to attend the household duties.

The child is put to the breast on the third day, but in addition, it is fed daily for the first week or two days with castor oil sugar, or cow-ghee sugar, twice or thrice a day. This accounts for the Thrush which is a very common form of occurrence amongst the newborn children of the natives: it is a disease, I have seen, cover thickly the whole tongue, palate, inside of the lips, cheeks, and even extend backwards into the throat, and it often proves fatal.

The successful practice of obstetrics among the natives of Ceylon is beset with great difficulties. If we could get accurate information, the number of women who die during labour or soon after it, I am sure, surprise us. It often happens that a poor woman is allowed to labour till the vital forces are exhausted, or the uterine muscles set in with Oedema of the buttock, vagina, and even of the lips of the os. A Medical man is only sent for at an extremity, and he generally finds the woman in a state in which interference is likely to do her no
much harm as possible. A number of these cases has lately occurred in my practice, and they have made a deep impression upon me. I shall succinctly narrate some:

Case i.

Mas Leyla, aged 25, Puntipara, Malaya.

I was sent to see this woman on Slave Island; when I arrived at the house, I found her cold and pulseless; she was in labour for over forty-eight hours. On examination, I found the head very low in the vagina, the child dead, and the case one of pure uterine inertia; I felt inclined to interfere, but desisted on second consideration; the woman died soon after I left.

Case ii.

Poddi Nona, Simgalesal, aged 20, Puntipara.

This case occurred in Kelaniya, a village 3 miles from Colombo. She was in labour for nearly 3 days: all this time she had hardly any food or sleep; she was extremely weak, and the pulse small and rapid; the head was at the pelvic outlet, with a huge caput succedaneum: the case was one of simple uterine inertia; I waited for some time, giving the patient milk stimulants, and then proceeded to deliver: the child was born alive, but the woman died of most appalling haemorrhage on the delivery of the afterbirth.
Case III

Kiri Hemi, Sinhalese,
at. 27, Pinnipara.

This case is another illustration of what I have said in a previous part of this paper occurred on Grand Pass Road, Colombo. The woman was in labour for two days, they said. When I saw her, she was in the birth, with a feeble pulse of 130. The bladder distended; the membranes ruptured. The head, of a green colour; discharge, foetid; but, nothing to say, the foetal head still the head bearing the head, in the occipito-posterior position, loci in the vagina: after giving her some arrack* (a country spirit) as stimulant, and waiting for some time, I proceeded to deliver: the child was born alive; weighing in the 3rd of an hour, and giving her a full dose of Bingham's ammonia and some wine: alcohol. I tried to express the placenta; not succeeding, I introduced my hand into the uterus and removed it. The immediate followed by the haemorrhage; the blood kept literally running out after in a rapid stream. At while quite I tried to check it, but, until the

Case IV

Lacco Nima, Sinhalese,
at. 19, Pinnipara.

* Arrack, an alcoholic drink derived from the vinous fermentation of toddy, a saccharine juice obtained by the excision of the spadix of a young flowering branch of the Palmyra. (Coconut or)
This case occurred lately in Sadaawatte, a village six miles from the town of Colombo. The woman was, according to account, at labour for over twenty-four hours, but I vainly believe the labour was of longer duration. When I saw her, the parts were all open, the foetus was dead in the vagina and the child dead; the forces were readily applied, and the child easily delivered. The placenta and the discharge, normally formed. There were two midwives and two Vederaulas in attendance. The woman eventually died well after a tedious puerperium.

Case V
Munikas Nasi, Sinhalese,
at 36, Multihara.

This case occurred lately in Galkirri, 8 miles south of Colombo. The woman, a mother of two children, was in puerperal convulsions for over 12 hours when I saw her. Her face was floated; tongue bitter & swollen; she was totally insensible, blind and deaf; a Vederaula and a midwife were in attendance. She had over eighteen fits; forces were applied, and a living child delivered. The mother did well after having been wholly blind for six days. The child died in 12 hours.

Case vi
Anseep Umma, Moor,
at 25, Multihara.
This with case occurred in the Moorish community in Slave Island. The woman was in labour with her third child for nearly 36 hours. It was quite evident that she was made to bear down long before the onset of expulsive pains, so that there was a total cessation of pains when it was sent for. There were three midwives in attendance. The membranes were ruptured, and an enormous Cephalus succedaneum was protruding through the os, the lips of which were edematous, as were also the anterior vaginal wall. Forceps were used. Both the mother & child did well.

Of these six cases just narrated, three women died and three children, and in every case the midwife & redriller were falsely tried before a medical man was sent for, and his timely interference succeeded in saving only half the number of mothers and half the number of children. In one single woman a child have died, had it been sent for in time.

From the quarterly reports for 1887 of the Registrar-General of Births, Marriages and Deaths, I find that about 715 Sinhalese women die annually at child-birth (see Table I), and 453 in the first week or at after confinement from what is described as “Suppurative Endometritis” (see Table II). The total population of Sinhalese women, as last estimated, is 884,200, and of these, there die annually.
Total population of Ceylon for 1887 = 2,900,000:
it consists of Europeans, Burghers (or European
descendants), Singhalese (the natives proper of the
island), Tamils, Tamil Immigrants, Moors, and
Malays.

<table>
<thead>
<tr>
<th>Total population of the different sections of the whole population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Europeans</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>1655</td>
</tr>
</tbody>
</table>

Table I*

Showing the number of women that died at childbirth
during the year 1887

<table>
<thead>
<tr>
<th>Quarters of 1887</th>
<th>Europeans</th>
<th>Burghers</th>
<th>Singhalese</th>
<th>Tamils</th>
<th>Tamil Immigrants</th>
<th>Moors</th>
<th>Malays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Quarter</td>
<td>1</td>
<td>1</td>
<td>160</td>
<td>18</td>
<td>22</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>2nd Quarter</td>
<td>1</td>
<td>2</td>
<td>146</td>
<td>24</td>
<td>19</td>
<td>27</td>
<td>2</td>
</tr>
<tr>
<td>3rd Quarter</td>
<td>0</td>
<td>3</td>
<td>185</td>
<td>25</td>
<td>23</td>
<td>26</td>
<td>4</td>
</tr>
<tr>
<td>4th Quarter</td>
<td>0</td>
<td>3</td>
<td>224</td>
<td>29</td>
<td>28</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>9</td>
<td>715</td>
<td>96</td>
<td>92</td>
<td>100</td>
<td>8</td>
</tr>
</tbody>
</table>

* This table, as well as Table II & III, have been compiled
from figures which appear in the quarterly quarterly reports of the
Registrar General.
### Table II

Showing the number of women that died of "Puerperal Convulsions" during the year 1887.

<table>
<thead>
<tr>
<th>Quarter of 1887</th>
<th>Europeans</th>
<th>Bourners</th>
<th>Single Cases</th>
<th>Families</th>
<th>Immigrants</th>
<th>Moors</th>
<th>Malays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Quarter</td>
<td>0</td>
<td>1</td>
<td>130</td>
<td>40</td>
<td>0</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>2nd Quarter</td>
<td>0</td>
<td>1</td>
<td>118</td>
<td>33</td>
<td>0</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>3rd Quarter</td>
<td>0</td>
<td>0</td>
<td>93</td>
<td>20</td>
<td>0</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>4th Quarter</td>
<td>0</td>
<td>0</td>
<td>112</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>2</td>
<td>453</td>
<td>94</td>
<td>1</td>
<td>37</td>
<td>0</td>
</tr>
</tbody>
</table>

### Table III

Showing the number of children that died under one year, during the year 1887.

<table>
<thead>
<tr>
<th>Quarter of 1887</th>
<th>Europeans</th>
<th>Bourners</th>
<th>Single Cases</th>
<th>Families</th>
<th>Immigrants</th>
<th>Moors</th>
<th>Malays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Quarter</td>
<td>1</td>
<td>11</td>
<td>2339</td>
<td>609</td>
<td>383</td>
<td>319</td>
<td>11</td>
</tr>
<tr>
<td>2nd Quarter</td>
<td>2</td>
<td>4</td>
<td>2107</td>
<td>589</td>
<td>294</td>
<td>336</td>
<td>13</td>
</tr>
<tr>
<td>3rd Quarter</td>
<td>4</td>
<td>19</td>
<td>2271</td>
<td>496</td>
<td>370</td>
<td>254</td>
<td>18</td>
</tr>
<tr>
<td>4th Quarter</td>
<td>1</td>
<td>10</td>
<td>2390</td>
<td>608</td>
<td>323</td>
<td>310</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>44</td>
<td>9106</td>
<td>2302</td>
<td>1370</td>
<td>1219</td>
<td>62</td>
</tr>
</tbody>
</table>

*"Puerperal Convulsions": This is a very loose term to use; there are included under it not only " eclampsia", but also cases of death from marked Asthenia or pronounced Anaemia, a fainting fit being also called "Wullijk" or Convulsion by the native.*
ally at childbirth or from "natural convulsions" nearly 1200. I believe this number to be an under-estimate, and that in the villages and in the interior of Layton the number that die would at least triple the number to double 1200. A very large number of deaths are unregistered, and will yearly remain unregistered, in spite of the activity of the Registrar-General's Department. The reports of the Registrar-General do not help one to estimate the number of children that die at birth or in the first days of life; I believe the number to be very large indeed; I附上 an interesting table (See Table III.) made from the reports in question, showing the number of children that died under 1 year; it will be seen from it that 9,000 children under 1 year died during the year 1887 among the Ghilghals.

What is the remedy for this state of things? I am perfectly aware that the 'practice of midwifery by midwives' is a time-honored custom, handed down from generation to generation, and that the Vedermann has the confidence of the bulk of the Natives especially in the villages. That I urge it, not any radical departure from the old custom of attendance on labour by midwives, but that only trained midwives should be allowed to practice, who could safely direct a labour to its natural termination and could judge when a case requires the assistance of a medical man. I know from my own experience that it is so easy matter to shake the confidence in the native midwife or vedermann. I can recall case after case of day, malignant intermittent fever, breaking out

Nature
native families, where the Vederralla was in attendance for weeks, may, even months, and the medical man was eventually called in and six quinia powders stayed the course of the fever; but, all the same, when the following year fever appeared again in a member of one of the same families, the Vederralla was first sought for, and he was allowed to pursue his "destructive" treatment for weeks before he was asked to stay and give over the case to European treatment, so strong is the confidence engendered in him by years of定制 of course.

Still, I believe, from every-day experience of the superiority of European medicine, the confidence in midwife Vederralla is slowly but surely losing ground in the minds of the natives, and Government should take up the question of staying the practice of the ignorant midwife Vederralla. In the local Branch of the British Medical Association, one of the Members suggested that the Branch Association should take steps to get the Government to interfere to prevent the ignorant Vederrallas from practising medicine. Here, in the case of the midwife, there is as urgent a need for interference. Hundreds of midwives, ignorant and rude, are daily adding to the perils of childbirth, and daily swelling the death-rate among mothers.
mothers and new-born infants. I think the time has arrived when the licensing and registration of midwives should be had recourse to, when it should be made punishable by law for any woman to serve as midwife who is not licensed and registered. Steps should be taken to encourage women taking to the "lying-in home" to learn the duties of a midwife, and women of the poorer classes should be especially trained, who will be content to receive moderate remuneration for their services. As it is, the monthly nurses (who are few in number), turned out by the "lying-in home", are expensive, and the poor cannot have recourse to them. The license, could, as hitherto be done, be given by the "Principal Civil Medical Officer" and the Master for the time being of the "lying-in home"; and registration is not a matter of difficulty; it could be worked as a department of the "Registrar of Servants' Office", where every midwife, on receiving her license, goes to register herself, and, in the payment of a nominal fee, receives a sign-board with her name as licensed and registered midwife, the sign-board bearing the stamp of the Registrar. An effort, too, should be made to get women
from the various districts and provinces to study the duties of a midwife, and there after the complete training should be sent back to their several districts or provinces. Government might give them a moderate salary, and should prescribe to them a certain fixed rate of charges, which ought to be moderate, so that the poorest could take advantage of their services.

I end this paper with the narration, somewhat in detail, of a case, which is a good illustration of the condition into which lazy nursing women is allowed to drift before intelligent assistance is sent for:

Francina d’Abreu, aged eighteen, pauper, Sinhalese, was taken ill with labor pains on the 28th of August 1888; I was asked to see her on the evening of the 30th. August. The general health during the latter month was bad; the nausea was bad; she suffered for weeks from diarrhoea, which left her at the onset of labor anaemic and chlorotic: her feet, legs, thighs, and labia - in fact, her whole body was swollen, her face puffy.

When I saw her on the evening of the 30th, at 6.30 P.M., there was almost total cessation...
tion of pains, the skin was hot & feverish, and the pulse 120.

An abdominal examination, the uterine tumor was seen lying unusually high up, separated by a distinct sulcus from the over-distended urinary bladder.

An vaginal examination, the head was found lying low down, with a large exocystic succedaneum in the occipito-anterior position. The discharge was offensive.

On auscultation, I could not hear the fetal heart sounds, so that I was not in a position to ascertain positively the position of the relative parts, to determine the child was dead or alive.

The first indication was to relieve the bladder, which I emptied of over one and a half bottles of urine.

There cannot be the least doubt that the distended bladder was the direct cause of the uterine crisis. The uterus, however, was so exhausted that no pains set in on the relief of the bladder. I informed the relatives of the precarious condition of the patient and of the necessity for instrumental interference. After a deal of delay, and questioning, and consultation among themselves, they yielded their unwilling consent, and proceeded to deliver.

The forces were easily applied, and the head delivered slowly, with a view to prevent a bad laceration of the osseous portion. The head was no sooner delivered than there was an escape of such an offensive discharge that...
I was simply obliged to leave the room to subdued my retching. The child had evidently made no effectual attempt at breathing, because after the head was delivered there escaped from its mouth some of the offensive maternal discharge and blood. The body of the child was easily delivered. It was born asphyxiated, but with a little trouble I succeeded in making it cry.

My attention was next turned to the mother. I gave her a draught of the liquid extract of hystis or in water. I was slow in delivering the placenta, because the woman was just in the condition to suffer from post-partum hemorrhage. My experience in more than one case of delivery of the placenta, in nearly similar circumstances, even after the lapse of half an hour, was appalling post-partum hemorrhage and death of the patient.

With the placenta still undelivered, I administered a hot vaginal douche— with two objects, to clean the vagina of the fetid discharge, and to induce uterine contraction with this to prevent post-partum hemorrhage.

The uterus which was kept contracted by the hands of the midwife, I now found very large, too large in fact to contain only the placenta. I used a little "expressor," and succeeded in
Dislodging a huge clot of blood, I was still there delivering the placenta, more so as the pulse which was feeble from the first could give me no indication as to whether hemorrhage was likely to take place or not.

After waiting for a good three quarters of an hour, and after making every preparation for hemorrhage, I again used "expressin" and delivered the placenta. I then at once administered another very hot douche both of an uterine and general stimulant. After keeping up kneading of the uterus for another half hour, I left the patient still hot, with a pulse over 120.

August 31st: no fever, temp. 99°; pulse, still quick; relieve the bladder; discharge fetid. Ordered washing with Cindy's fluid, every 2 hours. Prescribed Lumina to drink, and a stimulant mixture.

In the evening, no fever, pulse 120; bladder not still acting.

September 1st: fever set in again, temp. 102-4; pulse 120; bladder relieved with the catheter; discharge very fetid; abdomen lymphatic; no sleep. Ordered same pills, mixture, and Cindy and warm water injections every 2 hours, and tincture stiles. (Of course, the vaginal injections were not done then the patient was asleep). Diet, milk and brandy.

Matthews
Matters continued more or less the same, tem-
perature 102°, and pulse 130, till the evening of
September 3rd, when the thermometer showed 60°,
the pulse still continued unsatisfactory.

September 4th. Temperature 102°, pulse 130. Urine
had still to be drawn. Patient complained of great
weakness. The dyspnoe, nearly all gone from the leg.

In the evening the patient was very much
colder, being 101°, but now a new symptom
showed itself, namely, great difficulty in breathing.
The patient moaning and tossing her head
from side to side and complaining of suffocation.
Sputum formed first to the abdomen, being dis-
charged with phlegm, and the bladder being full
of urine; but even after these were relieved,
the difficulty still continued: the pulse was
very much quickened, 150 and over; the face
which was always pale looked paler still; on
auscultation there was found tumultuous action
of the heart; there was no cough; the lungs
were in no way implicated: she looked very
ill indeed, and I feared that we had here to
deal with a case of obstruction of the right side
of the heart and Pulmonary Artery. What in her
history lent color to this opinion was her ill-
- health.
health during pregnancy, the hydramniotic condition of the blood at delivery, giving rise to imperfect coagula in the uterine sinuses, and the onset of puerperal fever, interfering with the normal involution of the uterus: further, she was lying in a large bed for the first three days or so, and, to have the vaginal injections, she had to shift her position and move about frequently on bed: and possibly a looseened clot may have travelled from the uterine sinuses to the heart.

I expressed a grave foreboding to the relatives, and the patient was again about to be inscribed to the hands of the native vederralla. I remonstrated, and begged of them to allow me to treat the case to the end, and to this they unwillingly consented.

I put the patient at once upon a mixture of carbolic of ammonia, aromatic spirits of ammonia, digitalis, and compound tincture of lavender, and water, every 3 hours, and ordered stimulants (brandy) to be given freely with the milk.

The patient was awake the whole night, complaining all the time of oppression, but in the morning, if anything, she seemed slightly better; the oppression I thought, was not so marked; the pulse still remained quick; the fever slight. I now put the patient on 20 minims of ipecacuanha, freely diluted, every 3 hours, as suggested by Richardson, in
in such cases, and contained the Brandy freely with
the milk. When I saw her in the evening, there was
a decided improvement: the oppression was much
less, the pulse better, and the fever lighter, the
same on morning.

Now, from the improvement which took
place on so short a time, it was evident that it
could not be a case of 'Obstruction of the right side
of the heart and Pulmonary Artery,' but merely a
temporary attenuation of the hydromic condition of
the blood or a temporary diminution of the volume
of the blood.

I have nothing particular to record after
this: the patient improved slowly, the bladder
began soon to act of itself, the fever to subside,
and the pulse to improve; but the patient, in,
left tenity, anaemia and break, and the dyspep-
which had subsided began to reappear in the
feet, legs, and the term left her under iron and
organous diet.