THE IRVING W. POTTER METHOD OF PRACTICING VERSION.*

BY

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Two years ago, Dr. Irving W. Potter of Buffalo, N. Y., reported to the American Association of Obstetricians and Gynecologists, 500 cases of internal version of the child for all causes, but especially for reasons not sanctioned by the learned obstetricians of the past and present, viz., shortening of the act of labor for the purpose of giving relief to the mother, of preserving the vitality of both mother and child, and of economizing the time of the accoucheur. Dr. Potter, at the time, claimed that his maternal and fetal mortality and morbidity were not only not greater, but considerably less than those obtained by the average obstetrician; that in the great majority of primiparous women, he did the operation without tearing the os, the vagina, or the perineum; and that his patients experienced no shock and recovered more promptly from the effects of labor than when they were subjected to the process of spontaneous delivery under the guidance of well-trained man-midwives who always are firm believers in faithful "watchful waiting."

The discussion which followed the reading of Dr. Potter's paper obtained little or no support of his views and of his practice. Indeed, Dr. Potter was flatly and unhesitatingly denounced; many of the Fellows present declined to believe him, and his paper was refused publication.

One year later Dr. Potter appeared again before this Association with the report of 200 additional cases of version performed by him during the previous year with hospital records and temperature charts of every case. The discussion following his second paper did not differ much from that of the previous year. But Dr. Potter was strongly supported in his practice by Dr. H. E. Hayd of Buffalo, who had witnessed several cases of version performed by Dr. Potter, and who had examined the patients, immediately after delivery, found them free from injury, and observed their prompt

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and perfect recovery from the effects of labor and confinement. The second paper of Dr. Potter was recommended for publication by the Executive Council, and it was printed jointly with the first paper he had read on the same subject the year before. It cannot be said, however, that Dr. Potter's obstetric practice had found earnest supporters; indeed, nearly all present deprecated his views as to the justification of frequent version for the sole purpose of alleviating pain, shortening labor, and the saving of his own time.

I there and then determined to visit Dr. Potter and to witness for myself his method of performing version, and the conditions under which he did it, all of which were so eloquently endorsed and described by Dr. H. E. Hayd. On Monday, September second, while the guest of Dr. Hayd in Buffalo, the wished-for opportunity presented itself. During the month of August, Dr. Potter had personally attended 105 cases of labor; in 70 per cent. of these cases he delivered the patient by the aid of internal version and with the most gratifying results, and mostly for the reasons mentioned above.

When I met Dr. Potter to witness his work, on the evening of the second day of this month, he informed me that he had attended and delivered nine women within the last forty-four hours; and in nearly all of them he had resorted to version. About 8.00 P. M., Dr. Hayd and I met Dr. Potter in the Buffalo Deaconess Hospital for the express purpose of seeing him deliver by version, in an otherwise normal labor case. This was the tenth case within a period of less than two days.

CASE I.—II-gravida, aged twenty-three; perfect in health; of good build and well nourished. Full-term pregnancy; abdomen very large; pleural pregnancy suspected; only one fetal heart faintly audible far to the right of the median line and below the level of the umbilicus; vertex presentation, head at the brim; cervix obliterated; os fully dilated; membranes intact; pulse and temperature normal. Version upon the feet was performed under complete chloroform anesthesia. The case proved to be a twin-pregnancy. The first child was delivered, hale and hearty, within ten minutes from the time the Doctor introduced his fingers into the vulva; the second child was born seven minutes later in the same manner. Each child had its own amniotic sack and placenta. The membranes of the second child were not torn during the turning and extraction of the first child. Both placentas were delivered by the Credé method, without traction upon the cord, within ten minutes after the second child was born. Duration of the operation, with labor completed in all its details: twenty-seven minutes. Indication for version: shortening the period of labor and duration of pain, the

preservation of the mother's and child's vitality, as well as saving time for the obstetrician. Weight of both twins: 14 pounds.

CASE II.—Half an hour later Dr. Potter, his anesthetist, and his visitors, Dr. Hayd and I, were at the Buffalo Homeopathic Hospital, where Dr. Potter performed another internal version on a nineteen-year old I-gravida. This patient, too, was of normal build, and at the end of term; she had been in the first stage of labor from five to six hours; the os was fully dilated; the membranes intact; vertex presenting in the first position with the occiput at the brim. Patient's condition excellent; pulse and temperature normal. Indications for turning of the child as in the first case. Duration of the operation, including the delivery of both child and placenta, twenty-three minutes. An examination showed no visible or tangible evidence of injury to the mother's soft parts. Child living, strong, weighing 8½ pounds. The cord was twice around the baby's neck.

Description of Dr. Potter's Manner of Turning the Child In Utero.—While the patient is being chloroformed to the extent of total unconsciousness, Dr. Potter thoroughly scrubs his hands and forearms with soap and water, after which he puts on a long-sleeved, sterilized gown and skull-cap. He then places upon the left hand and forearm a long-sleeved rubber glove extending up to and slightly beyond the elbow; upon his right hand he wears an ordinary short rubber glove. He invariably uses his left hand to perform version, no matter what the attitude of the child *in utero* may be. The patient, in the recumbent position, is brought to the edge of the confinement table so that the buttocks extend slightly over the edge. Each leg is supported by a nurse. The thighs are not flexed upon the abdomen, as in the lithotomy position, but simply separated and held apart while the legs hang, loosely flexed in the knees, over the supporting arm or hand of the nurse on each side. The pubic, vulvar, and perineal regions have been previously shaved and rendered aseptic. The bladder is catheterized by the operator himself, and entirely emptied, if possible. After lubricating the rubber glove on his left hand and forearm with liquid soap, he proceeds first by dilating the vulva and perineum with the fingers of that hand, introducing one after the other, and effecting gradual dilatation of the parts by alternately spreading the fingers gently apart. In the short space of a minute or two, his hand is within the vagina. His first effort consists in carrying the uterus and child above the brim. This done, he begins to detach the membranes from and around the dilated os. If dilatation of the os is not complete, he introduces his whole hand into the lower segment of the uterus, then extends his fingers in every direction and withdraws the hand

slowly from the uterus. This maneuver is repeated until he has obtained full dilatation. His hands and fingers act on the principle of a Bossi dilator; the difference is that the hand is a better and safer dilating instrument. During the withdrawal of the open hand and separated fingers, he gently takes hold of the membranes and carefully pulls down the bag of waters, always taking care not to break it. To my surprise this maneuver was not attended by loss of blood in either of the two cases I witnessed.

As soon as full dilatation of the os has been secured, and complete detachment of the membranes within the lower uterine segment is effected, the membranes are ruptured and the left hand goes at once in search of both feet, while the right hand supports the uterus from above. When the feet have been found and have been firmly seized between the thumb, index and middle fingers, traction is made upon them, while the free hand upon the abdomen, immediately above the symphysis pubis, pushes the fetal head toward the fundus of the uterus. All of this is done in a quiet, gentle manner. The forearm of the operator closes the vulvar orifice and most effectually prevents the rapid escape of the liquor amnii until the lower extremities plug the os. In this way nearly all of the amniotic fluid remains within the birth canal. The feet, once at the vulva, are held there. The body of the child is expelled entirely by the contractions of the uterus. During the expulsion of the child's body, the operator merely assists in the rotation which Nature directs, and the shoulders are made to descend, dorsum anterior, in either the right or left oblique diameter of the pelvis. No traction is made upon the child while the body is being delivered. A piece of gauze is placed between the legs of the child to catch any meconium that escapes from the anus. When the shoulders of the child have arrived within the pelvic cavity, the operator rests the body of the child upon his left hand and forearm, and covers it with a warm cloth. With the index and middle fingers of the right hand the arms of the child are brought down as soon as the scapula shows under the pubic arch, first the anterior one, and then the posterior. When this is accomplished, he directs the legs of the mother to be lowered until they are almost in a Walcher position; and then with his right hand the flexed head is pressed into the pelvis from above, while the index finger of his left hand, placed in the child's mouth, makes gentle traction upon the head from below. Flexion of the head is thus not only favored, but increased, and with little effort the lower half of the face is brought to the vaginal outlet. The body of the child is now extended toward the mother's abdomen, thus exposing

the child's throat, which is gently stroked with the index finger from the chest toward the mouth, for the purpose of emptying the trachea and esophagus of blood and amniotic fluid the child may have swallowed or sucked in during efforts of premature respiration. If the head admits of easy evolution, it is delivered at once; if not, Dr. Potter is in no hurry, because the child can breathe freely with the mouth exposed at the vulva, and the mother is in no danger whatever. In the two cases above described, the heads were promptly born. Should there be undue delay at this state of birth, the forceps can be applied without difficulty and the head extracted without injury to it or to the mother.

The head delivered, the child is placed upon the mother's abdomen and covered with a fresh, warm cloth. The cord is not tied and cut until its pulse becomes weak or has ceased to beat altogether. The third stage is terminated with the aid of the Credé method. Dr. Potter gives the uterus ample time to contract and makes no traction upon the cord. A hypodermic injection of ergot is now administered, after which the patient is dressed and put to bed.

One of the remarkable features observed in the delivery of the two cases witnessed was that Dr. Potter's gown, clothes, and shoes were as clean after the operation as before. The floor of the operating room, too, was free from blood and amniotic fluid. The patient's body showed no blood stains. The method of keeping the patient, the nurses, and the physician so immaculate throughout the operation lies in his placing a thin pad of several layers of moist aseptic gauze over his left forearm directly in front of the vulva while he was performing the version. When, occasionally, a little blood escaped sterile water was poured from a pitcher over the vulva and perineal regions. The patient's buttocks rested upon a rubber-pad which ended in a tub on the floor. Both patients awoke immediately upon the termination of labor, and neither of them, nor Dr. Potter, seemed in the least fatigued.

Comment.—It would be entirely out of place here to discuss the numerous and well known indications for internal version. The principal question involved in Dr. Potter's almost daily, if not hourly, practice of obstetrics, is this: *Is the operation of internal version of the child justified in cases of normal labor without the presence of a sign indicative of danger to the health or life of either mother or child?* It is not too much to say that every well-trained and conscientious obstetric teacher and practitioner, the world over, to whom Dr. Potter's practice is made known for the first time, will exclaim without a moment's hesitation, that internal version of the child

is never justifiable in cases of perfectly normal labor, in the absence of any or all of the usually and generally accepted indications for this obstetric procedure. Every one who knows anything of the art and science of midwifery, will at once feel that he must earnestly protest against the introduction of an obstetric intervention so utterly at variance with the established teaching and practice of midwifery of the past and present. Indeed, the whole profession will stand a solid bulwark against this practice, *but not forever; of this I am certain now.*

What is there to be said in favor of Dr. Potter's practice? The shortening of the duration of labor, and the consequent early relief from pain and suffering, as well as the maintenance of the patient's strength and power of recuperation, are certainly points worthy of the most earnest consideration. The saving of time, and the securing of rest and sleep for the accoucheur, while of secondary import, should not be lightly regarded. Is it not true that many of our best general practitioners and gynecologists do not accept care of obstetric cases because of the enormous sacrifice of time, small pay, and great responsibility involved? Most medical men seek other and more lucrative specialties for their life-work. Dr. Potter's method of practicing obstetrics will do away with many of the objectionable features just stated. His method will invite, rather than repel, men to become specialists in this department.

But are there no other conditions which might result in benefit for the patient and her child by resorting to an early version in cases, apparently, perfectly normal in every respect? What of those instances in which, after an easy and spontaneous labor under strictly aseptic precautions, a sapremic or septic infection of the parturient tract results from even a comparatively brief exposure of the amnion or its cavity, to the saprophytes and other microörganisms which are always present in the lower third of the vagina, in spite of the best means employed to dispose of them prior to labor? In a case of this kind an early version and delivery of the child might prevent a profound and fatal infection of both mother and child. The same might be said of those cases in which an infection of the amniotic cavity occurs through the maternal circulation, or when disease germs reside within the Fallopian tubes which find their way to the ovum. Again, an early version in a case in which no disproportion between the parturient canal and the child is suspected, but does, nevertheless, exist, will be of the greatest advantage to both mother and child. The use of forceps, which later might have become necessary under such circumstances, will thus have been unwittingly

avoided, together with all the unpleasant and sometimes even dangerous consequences which frequently follow in the wake of forceps delivery.

However, the crux of Dr. Potter's practice in resorting to frequent and early version, in the absence of the generally accepted indications, lies in the fact that he not only does no harm, but actually benefits both mother and child. Curtailing labor pains and the conserving of strength of both lives concerned, are strong arguments. Dr. Potter states, and I believe him, that since he resorts frequently to early prophylactic version, he has observed fewer injuries to the mother's soft parts, such as lacerations of the cervix, vagina, and perineum, than in his former years of practice. We all know with what frequency these injuries occur under the ordinary and well established rules of practice. More than that, if Dr. Potter demonstrates beyond a doubt that version may be resorted to, in normal cases of labor, not only with impunity, but to the distinct advantage of all concerned, the procedure necessarily finds its justification in this alone. If Dr. Potter is able to perform internal version with a dexterity and gentleness free from danger to mother and child, and for their benefit at the same time, there is no good reason why others should not be able and willing to do the same. Think of a man personally attending and delivering safely eleven women within forty-six hours, in different hospitals and homes, and still finding time to eat, drink, and sleep.

My advice is: Go to see Dr. Irving Potter, witness his work, and judge for yourself. It is said: "the proof of the pudding lies in the eating of it." Women who have had the benefit of Dr. Potter's obstetric services want him again. There may be some exceptions, but they only prove the rule. In my opinion Dr. Potter has taught us a lesson. Buffalo, N. Y., will be henceforth a Mecca for the young and ambitious obstetricians. Opposition to Dr. Potter's practice will be universal, severe, and, probably, vicious. We should all heed what will be said against it, but whatever the nature of adverse criticism, let it be just and, above all, devoid of bitterness.

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Time is our best ally in these cases. Again, we should take into consideration the fact that these women have not been sick; and that their resisting power was good.

With regard to the remarks of Dr. Davis, all the women that conceived were the youngest of the series. They suffered the least amount of damage as far as the induction of abortion was concerned. In many of these cases the fimbriæ could not be demonstrated at the operation. A dissection was made about the ostium of the tube till the lumen was reached. The end was then "cuffed" back. When we consider the migratory possibilities of the ovum some assistance can be given to the ovum by attaching the ostium of the tube as near to the ovary as can be done without causing undue injury to the circulatory apparatus of these organs, or if the ovary is prolapsed by relieving it of its adhesions and attaching it as near the ostium of the tube as possible.

Dr. E. Gustav Zinke, of Cincinnati, read a paper on

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(For original article see page 829.)

DISCUSSION.

Dr. Hugo O. Pantzer, Indianapolis, Indiana.—I wish to compliment the scientific spirit which prompted Dr. Zinke to investigate this matter of version. His presentation of the value of that procedure is such that it requires no further comment. After listening to this paper, I am sure the work of Dr. Potter will be precept to those who practice midwifery.

Dr. Gordon K. Dickinson, Jersey City, New Jersey.—I have often observed in many families that the first born was not 100 per cent. efficient, and where there are a number of children in the family the last was the brightest, cleverest and most genial. I have been told or have read that compression of the brain leads to petechial hemorrhages in the cerebral tissue. The obstetrician is thinking only of tearing the perineum. The father, the mother, and family want a baby with 100 per cent. efficiency in every brain cell; they do not care whether the perineum is torn or not, and should not care, because any obstetrician can sew that up, but you cannot repair damaged brain tissue. In Cesarean section you have the possibility of 100 per cent. efficiency of the brain, and, from what has been said, with short compression of brain you have a quick delivery. You have next following the Cesarean section a better, eugenically speaking, child than by the old process, and this feature pleases me.

Major J. Henry Carstens, Detroit, Michigan.—I have delivered a large number of women from time to time, probably five or six thousand, and consequently I have done many versions, and in the class of cases described by Dr. Zinke you can resort to version very successfully. However, there are some cases where you

cannot do it. I cannot see how Dr. Potter with his hand and fingers can open the cervix in ten or fifteen minutes when it takes hours and hours to do it by other manipulations.

DR. ZINKE.—He does not interfere until the os is fully dilated or easily dilatable.

MAJOR CARSTENS.—It takes quite a time to dilate the os. I have no doubt it is very good practice in some cases, especially in multipara, but in primipara, in the hands of men who have not a very large experience, I would suggest that they do not try it. All things considered, I think relying on the *vis medicatrix naturæ* is the best way. In cases where there is a normal presentation, and the women are going on in a normal way, you had better take a chance with nature.

DR. ARTHUR H. BILL, Cleveland, Ohio.—I am still a skeptic and am not at all convinced. There are several points to be considered, one of them just mentioned by Dr. Carstens in connection with Dr. Zinke's paper pertaining to the dilatation of the cervix. It is said that the cervix is dilated by Dr. Potter without any injury whatever. I do not believe that it is possible for a cervix to be dilated rapidly with the fingers in a safer way than it can be dilated by the membranes or fetal head. There is certainly danger in dilating the os rapidly in cases in which it is not completely dilated, especially in primiparæ.

I can remember in my hospital experience as a student seeing versions done in various clinics in which this was considered the proper procedure. I think I can truthfully say more babies were lost by version than by any other obstetric procedure, particularly in cases in which there was faulty judgment on the part of the operator in choosing to perform version, where there was a slight disproportion between the head and pelvis. To be sure versions are done by good men, men who are considered good clinicians, who think they can deliver a baby by means of version better than they can by forceps, but where considerable traction is exerted on the aftercoming head the fetal mortality is high.

Version is a bad procedure in cases in which there is a disproportion between the fetal head and pelvis. There is only one type of pelvis in which it is possible to deliver the aftercoming head in an easier manner than the advancing head, and that is the simple flat pelvis of normal width. I do not believe that one can deliver the aftercoming head with greater facility than the presenting head in any other type of pelvis. There is no molding the fetal head in cases in which version is performed by Dr. Potter, and molding means much in the delivery of a case in which there is a moderate disproportion between the fetal head and the pelvis. I personally am doing fewer versions now than I did ten years ago because there is seldom an indication for podalic version. In my opinion there was no indication for version in the two cases reported by Dr. Zinke.

As to saving Dr. Potter's own time no comment is necessary. As to eliminating the bulk of the labor and also avoiding injury to the fetal head, why stop at version? Why subject the patient to any

part of labor? Why not do a Cesarean section in every case and be done with it and, in addition, have a perfect baby in each case?

Dr. William M. Brown, Rochester, New York.—I do not see any danger in this method in Dr. Potter's hands or in the hands of any Fellow of this Association, but I do see one danger at the present time in this proposition. You know that probably 75 per cent. or more of the labors are not in your hands or my hands, but in the hands of the very plain ordinary practitioner. If this proposition goes out from this Association and is advocated as a proper procedure for every one to do, it will let down the bars; the practitioner in the country who is in a hurry, will do a version, and you will find that there would soon result an enormous morbidity and mortality if this thing should be universally adopted. The danger I see in it is not on account of its practice by Dr. Potter or the members of this Association, because they can in a hospital under proper conditions do these versions safely and well, but the question arises, is it safe teaching for the large run of general obstetric practice throughout the country? I do not think it is.

Dr. C. Hollister Judd, Detroit, Michigan.—From what Dr. Zinke has said, I believe Dr. Potter is correct in his statements and has done what he claims. Dr. Potter has acquired tremendous skill by long practice in this difficult procedure; I do not believe I could be anything like as skilful as he is. If he taught me, I might do version better than I do it now. If this procedure is advocated and it goes all over the country, and men are not conscientious in doing it, it is capable of doing tremendous damage. I have done a great many versions and perhaps I do the operation rather crudely, but I have learned to do them slowly and carefully, I try to have the baby breathe, and not extract the head when it comes to the outlet. As I have remarked, Dr. Potter has acquired great skill in this operation, but how much damage he did in acquiring that skill it is hard to say. I feel that we may do more damage than good in acquiring that skill, and that it is safest for most of us to go carefully.

Dr. Abraham J. Rongy, New York City.—Two years ago I refused to accept Dr. Potter's teaching and said so. A year ago I refused to accept his teaching with Dr. Hayd's endorsement, and this year I refuse to accept it with Dr. Zinke's endorsement. I will go one step further than Dr. Brown and say that I do not believe 50 per cent. of the men in this room can do what Dr. Potter does. I believe Dr. Potter and believe in what he says, but half of the men in this room cannot accomplish what Dr. Potter has accomplished in the last three or four years. If we should permit this teaching to go out from this Association and be disseminated throughout the country, it would do more damage than any other obstetrical procedure within my memory. I know that I cannot perform version as well as Dr. Potter describes it, with the least amount of danger to the woman and child. I have tried to follow his technic in the last year and I did not save the perineum. In many patients the shoulders were extended above the brim of the pelvis; I had to introduce my hand and bring the arms down. There

must be a certain amount of tearing of the soft parts. Like many others, I would like to see Dr. Potter do this work. We ought to be more conservative and not allow teaching of this sort to be disseminated broadcast. We *must* not use prophylactic version for the convenience of the doctor.

DR. IRVING W. POTTER, Buffalo, New York.—I want to thank Dr. Zinke for coming to Buffalo. I did not know he was coming, and his visit was rather a surprise to me. This paper was still more of a surprise. He saw me do two versions and watched me very carefully. Both of those patients and babies are well.

At the Indianapolis meeting two years ago I received a sound thrashing. I reported 500 cases of version which were my own work. I had absolutely disregarded everybody's teaching, but I was perfectly honest in my statements, and the health reports of the city of Buffalo are open to anybody's inspection at any time, and if I did not get such results as I reported I would not be allowed in the hospitals which the city of Buffalo supports; neither would I be allowed to go on with the business that I am doing. The 500 cases I reported at Indianapolis were not very well received. I appeared before the Association at Newark with a series of 200 cases the year following the Indianapolis meeting, and that paper was published after considerable discussion, and I was told that that would be the end of it.

For the year ending August 31st, I have personally delivered 746 women. My assistant is in Europe in the service; two other men I have had with me are gone, and this work has been done by myself. Of these 746 women, I delivered 508 by version. The year before I reported 200 cases and was told I would have to stop, and this year I have reported 508. That makes a series of over 1200 versions without a maternal death, and with a fetal mortality less than I would have had by other methods.

I was told at Indianapolis and at Newark that I had brought nothing new to the Association. While I may have brought nothing new, nevertheless my method is distinctly different from any method of version I have read of or heard anybody describe, and the trouble with the whole situation has been that the paper was never properly discussed.

In the first place, I advocate deep anesthesia. I do not believe there is any place in obstetrics for the so-called obstetric anesthesia. I have a regular anesthetist who goes with me and does nothing else. In the second place, the proper position of the patient is of the utmost importance. This work cannot be done on a low double bed, it can be done on a high single bed, or it can be done on an ordinary kitchen table. Deep anesthesia and proper position of the patient are two very important essentials. I said the cervix must be dilatable or dilated. I know when a cervix is as thick as my finger I cannot dilate it and I do not try. I do not want anybody to go away with that idea. The cervix must be dilated and must be completely dilated to have a successful termination of the version. The anesthesia, the proper position of the patient, and complete

dilatation of the birth canal, Dr. Zinke has described most accurately.

Another point which is of the utmost importance and which is not described in your text-books, or was not described by any of my teachers, or advocated by anybody, is bringing down both feet. All the versions I saw when I was a medical student or heard talked about were those where the obstetrician reached up and pulled down one foot, plugged the outlet with one hip. If he got the posterior foot, the anterior hip caught on the symphysis, and if he got the anterior leg the posterior hip caught on the promontory, and he either went away and left it there or pulled the leg off. I bring down both feet, then have complete control of labor. It can be terminated as abruptly as you like without any damage to either one hip or the other because traction is equal; you do not dislocate the hip or break the leg. Those points were never mentioned in this discussion. The Association merely condemned it. I am not talking to medical students; I am talking to teachers of obstetrics, and you cannot teach students so that they can do the work in a short time. It requires practice. My assistants can now do version as well as I can.

I do not go after the shoulders until the scapula is out. I bring the scapula down underneath the symphysis; I rotate the back of the child to the front by making a little traction on the anterior leg. Then you get the scapula outside of the body and bring one shoulder down with the forefinger. You do not put your arm alongside of the baby the way Dr. Rongy describes. Of course, he tears the birth canal. Now, when you get the anterior shoulder out, go for the posterior. It is a good deal easier to get the anterior shoulder out first than it is the posterior, the same as it is when you deliver the anterior shoulder with the oncoming head; if you work the anterior shoulder out you can save the soft parts by lifting it up. Get the anterior shoulder out and posterior shoulder out, and put the left forefinger in the mouth of the baby, flex the head with the aid of the hand on the outside, and bring the mouth down to the vulva.

With all the versions I have seen done, the trouble has been that the operator is in too much of a hurry. He gets hold of the first thing he can find and pulls. That is all wrong. Get the mouth of the baby down to the vulva and let the baby breathe; milk out the mucus from the larynx if necessary. There is no hurry. The cord may be two or three times around the neck. Even if you make gentle pressure from above to increase the flexion, the baby will come out over the perineum all right.

These patients do not bleed severely. I have not had a patient bleed to death, nor have I had severe hemorrhages. The loss of blood in these cases is not any greater than it is with normal deliveries; I do no think it is as great many times. But the great secret of success is to familiarize yourselves with your position. You must introduce the hand and map out where the placenta is, separate the membranes from the uterine wall, and get as complete separation as you can before you do version. That facilitates the

delivery of the placenta. When you do a Cesarean section, you introduce your hand and separate everything because it facilitates the third stage. You do the same thing with version, get the location of the child, find out where the child's cord is and the placenta, and explore the whole uterine cavity.

Just one point more. I do not think every man is constituted physically to do version. I do not think a man with a forearm as big as some of the forearms of the men in this room have any right to put it in a birth canal. A man with a long slender forearm and long gloves, properly lubricated, can explore the uterine cavity just as a surgeon explores the abdominal cavity without doing any great harm.

DR. ZINKE (closing).—Regarding conservation of the patient's strength Dr. Bill compared the statements in my paper on version, with Cesarean section. In Cesarean section the obstetrician mutilates the patient by invading the abdominal and uterine cavities through large incisions. A version does not necessitate anything like this procedure.

As to the danger of frequent version on the part of the general practitioners, it may be said that this applies with equal force to everything we do in the practice of medicine and surgery. He who does not know how to do a thing right, has no business to do it at all. It is true that many men perform operations for which they have not been trained. There is no longer an excuse, in these days, for such occurrences. In the past, when nearly every practitioner was a pioneer, experimentation was justifiable, but that time has passed. The discussion of to-day reminds me a little of what was said when I first advocated Cesarean section for placenta previa. There was not a man in the audience who agreed with me; and, subsequently, I was roundly condemned by the medical press in this country and abroad for advocating this operation.

There was a time when everyone denounced hysterectomy and oöphorectomy. It took men like Joseph Price to establish these operations in this country. Ovariotomy and appendectomy were viciously denounced; and this has been the case in the past with every operation of importance. To-day all of these operations are performed daily, not always with good results, it is true, but with the consent of everybody. A man who cannot perform version of the child as Dr. Potter does, should not attempt or condemn the procedure; but one who can do it as well as Dr. Potter, need not hesitate to perform it, if, by so doing, he injures neither mother nor child, yet shortens the period of suffering and maintains the vitality of both lives concerned. A man must be educated for this practice. Good obstetricians, I think, like good surgeons and artists, are born. They have the material in them. All they need is a conscientious and efficient teacher to lead them on.

DR. WILLIAM MORTIMER BROWN, Rochester, read a paper on

CESAREAN SECTION UNDER LOCAL ANESTHESIA.

(For original article see page 836.)