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CLASS, GENDER AND PROFESSIONALIZATION: THE STRUGGLE FOR BRITISH MIDWIFERY, 1900-1936

By

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ABSTRACT

CLASS, GENDER AND PROFESSIONALIZATION: THE STRUGGLE FOR BRITISH MIDWIFERY, 1900-1936

By

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By the nineteen forties, British midwifery had become a highly stratified occupation located within a hierarchy of health services under the authority of the medical profession. An elite group of midwives whose aspirations and ideology often conflicted with the values of the rank and file dominated the occupation. At the turn of the century, midwifery had been unorganized, typically practiced by working class, lay midwives, and part of the network of economic and social relationships which characterized the working class community. The lay midwife's practice was based on her experience, her knowledge of the traditional healing arts and the occasional assistance from a physician. This dissertation explores the process by which the nature of the midwife's work, the scope of her authority and the composition of the occupation itself were transformed between 1900 and 1936--in short, the process by which midwifery became professionalized.

The movement to professionalize midwifery was spearheaded by an organized minority of socially influential, aristocratic and middle class women, formally trained as nurses and midwives who were professionally and intellectually grounded in the strand of pre-World War I British feminism characterized by social reform, suffrage, social purity, and eugenics. Among this organized elite, professionalization hinged on a constantly "upgraded" standard of midwifery practice. The archival records and the journal of the elite's professional organization, the Midwives' Institute (now the Royal College of Midwives), reveal that this standard was defined as much by class background and cultural values as it was by alleged deficiencies in training. The passage of licensing legislation such as the Midwives Acts passed throughout the period, the formulation of restrictive training and practice requirements and the creation of a powerful supervisory apparatus

enabled the elite to advance its own position within midwifery, simultaneously influencing the restructuring of the occupation.

Rank and file midwives resisted the reformulation of their work and the exclusionary strategies of the elite. Rank and file midwives had a well-developed understanding of their work and a strong sense of their identity as midwives. When they felt this was violated by the policies of the elite, they protested, resisted and, in one case, organized to protect themselves. While rank and file midwives were not "successful" in dislodging the Midwives' Institute from its position of power, their activities represent a tradition of resistance among midwives which continues to this day.

To Seth Wilschutz,

whose impending arrival inspired this study.

who introduced me to the work of Brigitte Jordon.

To Seth Wilschutz,

whose impending arrival inspired this study,

and to

Berit Sählstrom

who introduced me to the work of Brigitte Jordon.

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PREFACE

Our understanding of English midwifery history has been shaped by the converging aspirations and ideology of the profession's elite and the political and intellectual agenda of a generation of feminist scholars. While both have contributed their part to the field, neither has fully described the development of midwifery as a profession.

Accounts of midwifery history written by the elite and their supporters follow the assumptions and descriptions of what some critics have termed the traditional interpretation of the professions. Traditional interpretations have noted that professions are different from other occupations. Most striking is the considerable latitude they enjoy in the control over their work and the terms upon which they sell their service in an economic system where workers typically have little control over either. The traditional approach argues that this privileged position within the occupational structure has been granted to professions by society because of the technical nature of their expertise and their strong sense of service and altruism toward the community. Only those who possess the expertise, they argue, are qualified to determine the terms under which the work is done, the type of training which is required, the regulation of the actions and practice of the profession's members and the rewards they receive in exchange for their expertise. A profession's strong ethical code ostensibly prevents the abuses which might result from the group's exclusive control over the work. Midwifery history since the late nineteenth century has been seen as midwives' steady progress toward professional status and the social benefits which have been derived from this accomplishment. Occupational licensing, registration and mandatory training allowed the professional greater control over the work and contributed to the advancement of midwifery practice. With advances in the practice of midwifery the status of all midwives increased and the living which they made from their work improved. In turn, these midwifery histories point to the ultimate benefit which the client derives from the profession's self-regulation. The profession's control over its work and expertise is its reward for the service it renders to the community.[1]

Feminist interpretations of midwifery history have made significant contributions to our understanding of sexual inequality within the medical profession, of the ideological constructs of women's behavior which have passed for medical science, and the extent of the medical profession's power and control over the definition and delivery of obstetrical care. The central theme of these studies has been the oppression of women by men and sexual inequality as the central feature of society. That midwives were either eliminated altogether (as in the U. S.) or strictly limited in the scope of their work (as in Great Britain) is due to the male dominated medical profession's attempts to control not only childbearing women, but the women who attend them.[2]

The feminist and the traditional interpretations of midwifery history converged in the foremost work on English midwifery as a profession, Jean Donnison's Midwives and Medical Men.[3] Donnison's work focuses on the small group of midwifery reformers who were so instrumental in achieving the occupational licensing, registration and mandatory training which served as the legislative basis for professional control of British midwifery. When these midwifery reformers fought for state licensing and control over the work, she argues, they were fighting for the rights of midwives and their patients as women. Their cause was advanced by the implementation of the Midwives Act of 1902, licensing legislation which provided for the mandatory registration and training of midwives. Furthermore, the professional body created by the Act, the Central Midwives Board, provided midwives with the means to begin to exercise control over every facet of midwifery practice. That midwives have survived in Great Britain and prospered, while they have disappeared in the U. S., is (she writes), "the legacy of those who laboured so long and so hard to keep the office of midwife for women, and whose efforts were crowned in the Midwives Act, 1902. "[4] Donnison blames the rivalry of the male dominated medical profession for the failure of midwifery to experience the same advances in autonomy and control of their work which other professions have achieved.

Revisionist interpretations of the professions have illuminated the shortcomings of the traditional approach to the professions and to the feminist interpretation of midwifery history. Critics have argued that the traditional interpretation of the professions is largely a justification for professional privilege and control rather than an accurate depiction of the

role that professions play in the occupational structure or in the wider society. As Barbara Melosh has pointed out, the traditional interpretation implies that "hierarchical organization of knowledge is necessary and desirable, and that a profession's power is derived from the support of a broad social consensus."[5] Instead, revisionists have seen professions as occupational groups dominated by social elites who have attempted to secure control over the market for their services and the terms of their work in order to advance their position within the occupational structure. Within the profession, the priorities and values of the elite which comprise the leadership are often at odds with those of the rank and file membership. Conflict and struggle between them is common as the elite attempts to impose its strategies on a frequently resistant rank and file. In this regard, revisionists raise important questions about the accuracy of feminists' claims that women share common interests regardless of their class. Within the broader society, revisionists have argued, professions serve as conduits of dominant values and social relations.

Revisionists have argued that the traditional view masks the economic motivations behind professional demands for autonomy and control. Margali Larson has persuasively argued that the professions' demands for control over their work are largely the result of their attempt to capture the monopoly over the provision of their particular skill. In seeking to "constitute and control a market for their expertise", professions must control the specialized theoretical and practical knowledge which constitutes the foundation of the service which their members seek to sell in the market, control the actions of who delivers that service and take steps to exclude all competitors.[6]

Professionalization is largely the process by which a professional group attempts to put itself in a position to regulate the distribution of its service and thereby determine the price of that service and the living which its members can derive from their expertise. Revisionists recognize that professionals often see their work as service to the community in which they live and work. At the level of the occupational structure, however, the ethos of service and altruism helps to distance the profession from the charges of self-interest which may result from their demand for professional control. In this way, professions translate their economic demands for monopoly over the distribution of their services and control over the knowledge and practice of their members into concern for the public good.

Revisionists have criticized the traditional approach for not acknowledging that professions are linked to the dominant social elite, that they advance their position within the occupational structure under the sponsorship of that elite and that professions in turn help to advance the dominant ideology and support existing social relations. Historical studies have shown that the professions' advantaged position within the occupational structure does not rest on its technical expertise alone, but also draws strength from their members' social origins in, "groups already enjoying high status and power in the society."[7] The Midwives' Institute (now the Royal College of Midwives), the midwifery's official professional organization and the major subject of this study, represented not the whole of midwifery, but the views and interests of the elite leadership. As upper and middle class nurses and midwives, this leadership was part of a broader network of social reformers and health professionals who were helping to shape British social policy. The leadership sought to establish a monopoly over the practice of midwifery for midwives who were both formally trained and were drawn from backgrounds similar to their own. Such individuals endowed the profession with social prestige, but as importantly, they constituted a link to the levers of power through which the leadership of the profession could achieve its goals.

Studies of professionalization "in process" reveal that professions are far from being homogeneous and conflict-free, however. Celia Davies has argued that a profession's ideology and strategy are not the product of a consensus among its members, but of the views and priorities of the leadership. "The professional ideology is a leadership ideology, the strategy a leader strategy, or rather, it is the "official" view as propounded by leaders. . . ."[8] A profession advances and maintains its advantaged position within the occupational structure by guaranteeing that it continues to control the technical expertise which underpins its members' specialized service. As knowledge and technique advances, however, the profession is faced with the need to constantly upgrade the training of its members. Historical studies of the professions show that this "upgrading" of knowledge and technique frequently translates into the exclusion of those members of the profession who do not conform to the leadership's social standards and cultural expectations.[9]

The leadership of the Midwives' Institute exercised control over the midwifery profession through the influence they exerted on the regulatory arm of the profession, the Central Midwives Board. Midwifery historians have cited the fact that the Institute was granted only one official representative to the Board (and a medical representative at that) as evidence that midwifery was dominated by the male dominated medical profession. Although the Institute formally shared power with other groups which had been granted representation to the Board, the Institute was hardly outnumbered. Besides counting four out of nine Board members as either their supporters or Institute members, the Institute leadership shared with their colleagues on the Board a common background and a common vision for midwifery's future.

The strategy through which the Institute leadership hoped to improve professional status rested on the exclusionary policies adopted by other professions. Although inadequate or lack of proper training was the expressed justification for their policies, their aim was to exclude the working class woman from the practice of midwifery. While the working class, lay midwife who had been allowed to register under the 1902 Midwives Act was the target of their policies, exclusion extended to trained midwives who did not submit to the practice rules of the Central Midwives Board, or display the credentials, education and breeding deemed appropriate by the leadership. Whether through attrition or the Board's policies, by the 1920s the lay midwife had been removed. The leadership then turned against the older, married trained midwives, many of whom had been trained years before, many of whom were believed to have gained access to training made available through government grants to working class women. Once considered the backbone of midwifery, these women were made superfluous when yet another round of "upgrading" promised to yield a crop of more highly trained, middle class recruits.

The Institute sought to undermine any recognition of common interests among rank and file midwives which such policies might engender by continually cultivating divisions among them. Trained midwives were encouraged to view themselves as superior to lay midwives and those trained midwives who had been judged undeserving to practice. Once the majority of midwives were trained, the Institute sought to pit trained midwives against one another. The Institute identified the older (particularly the married

midwives) who were trained in midwifery only as the source of the profession's problems and their exclusion as necessary if the rest of midwifery was to advance.

Licensing legislation, restrictive educational and practice requirements, and punitive supervision was directed against thousands of women, not men. In the early part of the twentieth century, the Institute leadership, like many of their women colleagues, had joined with other feminists in the suffrage cause. While their campaign for equality took the form of a fight against male domination in the name of all women, many of these women reflected the attitudes and biases of their class toward the working class.[10] In matters pertaining to the working class midwife the Institute leadership expressed more kinship with the men of their class--medical or lay--than with the women of the working class.

Revisionsts have seen professions as more than "just special organizations of work but rather particular expressions and vehicles of dominant class and culture."[11] The exclusionary policies of the Institute leadership's professionalizing strategies were informed by bourgeois economics and ideology. The Institute leadership supported laissez-faire economics, the hierarchical ordering of society and the common acceptance among all classes of the values which underpinned capitalist social and economic relations--self-help, self-reliance and individual responsibility. For the leadership of the Institute, society was naturally ordered around the strict hierarchical relations between the classes. Within this hierarchy, each class would play its proper role. The upper and middle class would lead and the working class would defend the Empire, labor for the economy and produce the future generation of workers. The working class had to adopt the values of self-help, self-reliance, deference to authority, and an orderly life if they were going to play the role the leadership had envisioned for them. The leadership believed that workers could only learn these values through instruction from a representative of the superior class. Upper and middle class trained midwives would play their role in establishing and maintaining the proper relations in society by teaching the working class mother to accept and abide by the values which informed her place in the natural hierarchy. Drawn from the same class as the women in need of reform and prone to their same weaknesses, working class midwives could only undermine this social and political agenda and therefore had to be removed.

The exclusionary policies of the Institute's professionalizing strategy were not imposed without considerable resistance from the rank and file. Celia Davies has argued the leadership's "expressed ideologies for the group are not likely to be identical with the rank and file nor are their strategies likely to be received with enthusiasm. "[12] Resistance most often occurred over changing conceptions of work. In the years before the war, trained midwives frequently criticized the restrictive practice guidelines of the Central Midwives Board and the Institute's role in upholding them. Many openly defied the Board and the Institute by refusing to comply with the limitations on midwives' practice. Similarly, midwives opposed efforts to make nursing part of midwifery training on the grounds that it redefined the nature of midwifery practice. Where childbirth was a normal event, best conducted at home with a midwife in attendance, nursing associated childbearing with abnormality, the hospital, and the dominance of the physician.

In the period before the first World War, a recognition of common interests among them prompted rank and file midwives to join together to challenge both the Midwives' Institute and the power of the Central Midwives Board. Although this attempt proved unsuccessful in dislodging the Institute from its position as the official representative of midwifery, rank and file midwives illustrated that alternatives did exist to the Institute's vision of midwifery's future.

Midwives' understanding of their own history can be an important ingredient in shaping their opinions about their problems and the solutions which their leaders' propose. History seen as the product of great leaders struggling for the mutual benefit of all members of the profession can mask the very real differences between those leaders and the women they represent. History seen as the exclusive struggle between medical men and female midwives deflects our attention away from the alliances made between the female midwifery elite and male physicians and the result of those of alliances, the control of the rank and file female midwife. The revisionist approach provides the framework for a new understanding of midwifery's past, one which reveals how midwifery history has been shaped by differential social power, ideology and class interest. As such, this study is meant not only as a contribution to the academic debate over the professions and the significance of midwifery history, but also as a source from which

contemporary midwives can draw in making decisions about their leaders, their work and the future of their profession.

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12. Davies, 50.

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The Making of the Midwives Act, 1902

From 1889, the Midwives' Institute struggled tirelessly for the passage of legislation which would make the registration, licensing and training of midwives mandatory. They sought to not only improve the quality of midwifery attendance for the working class, but to enlist midwifery attendants in the reform of working class habits and values. Neither of the Institute's goals were possible to achieve as long as midwifery was dominated by working class lay midwives. Legislation which made registration and formal training a prerequisite for midwifery practice would force the lay midwife out of practice. Midwifery could then be taken over by middle class trained midwives. Because of their greater technical expertise and their higher moral sense as middle class women, middle class trained midwives could combine the benefits of safer midwifery attendance with qualified instruction in the behaviors the Institute believed most fitting for working class women and their families.

In the Midwives Act of 1902 the Institute won only a partial victory in their efforts to claim midwifery for the middle class, trained midwife. The Act provided for state registration and mandatory training of midwives, but in order to prevent a shortage of midwifery attendants, it also included a grace period during which lay midwives could register as legitimate practitioners. As a member of the regulatory arm of the Act, the Central Midwives Board, the Institute joined with its colleagues to strictly limit the scope of the midwives' practice and to implement a powerful apparatus of supervision through which to enforce their compliance.[1]

Midwifery Attendance in the Nineteenth Century

The majority of midwives in the nineteenth century were older, married or widowed working class women who attended other women in their neighborhood or village and who had undergone no formal course of training in midwifery. The most common image of these lay midwives is the

one fashioned by the middle class midwifery reformers who sought to replace them with middle class trained midwives. Reformers not only believed that these lay midwives were dangerous to parturient women, but they viewed them with considerable distaste and contempt. As one reformer wrote of lay midwives practicing in rural areas.

> The village midwives are, as a rule, well advanced in middle life, with faculties blunted for want of trained exercise; they are exceedingly illiterate, and full of the self-satisfaction and audacity of ignorance. . . . They generally take to the employment from a variety of motives, not from any taste or calling, they have no qualification, they hope to make a certain number of fees to eke out other earnings; one such "midwife" in this neighborhood is a "hauler of coals."[2]

As in any "myth", this characterization of lay midwives was not without an element of truth. Midwives frequently worked in other capacities, for example, most particularly as layers-out of the dead.[3] Yet, more recent scholarship has attempted to understand the practice of these midwives within the context of their own working class culture and in relationship to the state of contemporary medical practice.[4] At a time when medical knowledge about contagion and the causes of disease was limited and even the best obstetric care could be dangerous, the lay midwife offered at least as safe a service as many medical practitioners.

It was not until the late nineteenth century that medical knowledge and treatment began to reflect the scientific advances of the previous forty years. Until then, the methods of medicine continued to rely upon the empirical collection of data--largely through observation--and a descriptive, symptomatic and classification of disease. Physicians knew little about the physiological workings of the human body or about the underlying causes of the pathologies which caused disease. [5] Much of medical practice and treatment was instead based on the traditional Aristotelian notion of humoral balance. According to this theory, health constituted a "condition of balance between the four "humors"--black bile, yellow bile, blood and phlegm."[6] When a person became ill, physicians believed the cause to be an imbalance in these four humors. Of the symptoms and problems of

pregnancy, for example, many physicians ascribed to the notion of a 'plethora', an excess accumulation of blood in the body. Problems in pregnancy, from miscarriage and convulsions to nausea, constipation, and maternal depression were attributed to the buildup of menstrual blood in the pregnant woman. Venesection, or bloodletting, was the typical treatment used to restore the woman to her proper balance.[7]

Developments within the sciences increasingly eroded the theoretical basis of the Aristotelian view. By the 1850's French physicians' innovations in clinical observation and experimental physiology and German scientists' refinement of laboratory techniques had begun to yield the beginning of a more accurate understanding of underlying biological processes. The application of basic science research techniques--experimentation yielding repeatable and predictable results--prepared the ground for an indisputable break with both the theory and the practice of contemporary medicine. Increasingly, it became possible to identify the pathophysiology of the human biological system with more precision, thereby enhancing the ability of the physician to diagnose and treat disease.[8]

In obstetrics, the influence of these developments was most immediately seen in the debate over the causes of the most deadly of maternal complications, puerperal sepsis. Humoral obstetricians and physicians recognized the symptoms of the infection--high fever, restlessness, delirium and usually death--but attributed its causes to an "epidemic influence" or to "atmospheric conditions". However, independently of one another in the 1840's, the American physician Oliver Wendell Holmes and the Viennese physician Ignaz Semmelweis came to the conclusion that puerperal sepsis was transmitted from patient to patient by the attendant. Semmelweis discovered that women were more likely to contract the infection when they were attended by physicians and medical students who had just come from the post-mortem room. He required all students and physicians to disinfect their hands prior to entering the lying-in ward of the hospital. Through this simple procedure, Semmelweis was able to effect impressive reductions in maternal mortality in his obstetrical ward. Like Holmes, Semmelweis incurred the wrath of his colleagues for suggesting that physicians were themselves responsible for their patients' deaths. It was not until the 1880's, when Louis Pasteur demonstrated that puerperal sepsis was caused by microbial chains which he called streptococci, that the debate began

to come to a resolution. Although some physicians remained unconvinced by Pasteur's evidence, others did begin to adopt the antiseptic techniques which the surgeon Joseph Lister had pioneered.[9]

The techniques used to prevent infection were often undermined, however, by physicians' intervention in parturition. Pasteur had shown that the streptococci could only enter the bloodstream through an open wound. Instrumental intervention aggravated the trauma which the vaginal and cervical tissues sustained from the natural mechanism of birth and increased the woman's vulnerability to infection. Busy general practitioners were believed to routinely use forceps to hasten labor. The obstetric establishment frowned upon such practices, yet it had to admit that even in the most advanced teaching hospitals in the country similar intervention by obstetricians was routine. The failure of general practitioners and consultants alike to recognize the virulence of the bacteria and the carelessness which often resulted from that ignorance continued to produce a high rate of puerperal sepsis in doctors' cases both at home and in the hospital as late as the mid-nineteen thirties.[10]

Working class families usually saw the doctor in only the direst of circumstances--extreme poverty or a medical emergency. In the 1870's, for example, a physician might charge as much as 21 shillings to deliver a baby. A midwife on the other hand might charge as little as 7 shillings.[11] If a woman was too poor even to pay a midwife, she could apply for medical care at either a voluntary hospital or a Poor Law hospital. If complications developed in the course of a woman's labor at home, the family might call in the doctor if they felt the symptoms warranted the drain on family resources his services would mean.

Both of these alternatives posed considerable risks for the parturient woman. Maternal mortality rates were high in all hospitals even after the introduction of antiseptic procedures. Most notorious, however, were the Poor Law hospitals where filthy conditions were the direct cause of scores of deaths. Of these conditions, one Poor Law doctor wrote at mid-century: "That death relieved these young women of their offspring was only to be expected, and that frequently the mothers followed in the same direction was only too true. I used to dread to go into this ward. . . ."[12] Out of every 1, 000 babies born in Poor Law hospitals in 1902, for example, "no less than 40 to 45 die within a week" compared to 25 who die within the same period "amidst the

unregulated conditions of the average home."[13] Even if she were able to avoid the Poor Law hospital, a parturient woman might still have medical help if she developed complications in the course of her labor. In an emergency, extracting the infant was generally the first priority and the forceps were the only effective means which the physician had at his disposal. Much damage could be done in the confusion and rush which naturally accompanied these circumstances. Until physicians understood and routinely practiced antisepsis, infection was often a by-product of their visits.

Largely because of the cost, the majority of working class women had midwives to attend them. A small minority of the midwives who practiced at the end of the nineteenth century had undergone a formal course of midwifery training in one of the voluntary or maternity hospitals throughout the country. There was little standardization among the formal credentials of these trained midwives until 1872, when the London Obstetrical Society, formed in 1825 by a London group of physician midwifery lecturers, established a midwifery examination and diploma. Although the Society did not offer its own training course, it did serve as a standard by which other midwifery programs could be judged. Women who had undergone a course of midwifery training and who had, under proper supervision, personally attended twenty labors were eligible to sit for the Society's examination. Candidates were examined for their theoretical knowledge and their skills in nursing techniques. The Society took particular care to ascertain that the candidates were thoroughly versed in proper antiseptic procedures.[14] The diploma, or the LOS as it came to be called, certified that the recipient was, "a skilled Midwife, competent to attend natural labours."[15]

Very few women went through these midwifery training courses, however. By the 1880's, Lying-In hospitals throughout the United Kingdom were only training a hundred or so midwives each year. The British Lying-In, the General Lying-In and Queen Charlotte's Maternity Hospital, for example, trained 49, 52, and 93 midwives respectively in the five years between 1881-1885.[16] In the first year that the LOS was offered, only six candidates sat for the examination. By 1900, only 5, 529 had received the Society's certificate--or a little under two hundred midwives a year.[17] Trained midwives were most likely to attend either the very affluent or the very poor. Voluntary hospitals and charitable societies which offered maternity attendance to the poor often

employed trained midwives to attend women in their homes. At the other end of the social scale, trained midwives attended middle and upper class women, usually in conjunction with a physician.

The majority of women were attended by lay midwives whose qualifications for midwifery practice were their experience and their familiarity with traditional healing methods. That lay midwives lacked formal knowledge of anatomical structure, physiology and the underlying processes of contagion did not mean they had not been trained for their work, however. As a young girl, a lay midwife might have attended birthings with female relatives or been present as her own mother gave birth to the next sibling. Often, a girl or a young women would apprentice herself to an older midwife. The older woman would pass on to the younger woman her own accumulated experience and the knowledge of childbearing and healing that had been taught to her. Together, they would attend births until the younger woman was ready to go out on her own.[18]

Lay midwives' practice was generally limited to the neighborhood or village. In addition to charging a lower fee than the physician, lay midwives would attend the woman during the labor and would help to take care of the house and the family for a time after the baby was born. Although the money they charged for their services was as crucial to their families' livelihood as it was to the women they attended, midwives were known to forgo their fees or to take payment in kind. One midwife recalled, "They hadn't always got the money . . . . So you'd do it for free. But even then they had to give you extra, food you see. "[19] Since the women they attended were likely to be their friends and neighbors, the lay midwife would have personal knowledge of their lives and their problems.

Experientially trained, lay midwives had a well-developed sense of the process of childbirth. Testimony from women who worked as midwives at the turn of the century indicate that they considered birth to be a normal event, fraught with some anxiety and a good deal of pain, but one which the human body and the woman's will could be relied upon to successfully complete. As one lay midwife recalled, "Some labours would only give you four lots of pain and then the baby was there. And the child worked for me. And we knew the waters had broken--we used to call them silver water--then we knew that the baby was on its way, and we also knew, when the baby was pitched right for birth, whether is was going to be long or short."[20] A wide

range of presentations were defined as medically normal--multiple and all kinds of breech births as well as the difficult face and brow presentations--and the lay midwife attended them all.[21] When a woman did experience problems, midwives might resort to herbal remedies. Raspberry leaf tea, for example, was used to help alleviate labor pains. A midwife usually called a doctor only for the complications that were beyond her experience and expertise. As Flora Thompson recalled in her book Larkrise to Candleford, "The doctor was only seen when . . . some difficult confinement baffled the old woman who, as she said, saw the beginning and end of everybody."[22]

In the context of late nineteenth-century medical care delivery, lay midwives offered at least as safe a service to parturient women as physicians. Because lay midwives never used instruments and rarely conducted internal examinations, their risk of exposing women to infection was much less than that of a physician. As Mary Chamberlain has observed, "The 'naturalness' of [their] technique often meant fewer complications and, unlike some of the doctors did not inspire fear."[23] Midwives' remedies were largely non-invasive and benign. Some were effective. Ergot was often used successfully to stimulate a protracted labor and breast milk soothed a baby's inflamed eye.[24] Other remedies, such as those using spells and charms, were less so. In either case, lay midwives' remedies were probably no more harmful or ineffective than common medical therapeutics including (in some instances), bloodletting which inadvertently weakened the patient and the instrumental intervention which often brought infection.[25]

The Midwives' Institute: the elite of trained midwifery

The upper and middle class nursing and midwifery elite of the Midwives' Institute were a world apart from the culture and life experience of the working class, lay midwife. From that evening in 1881 when the wealthy philanthropist Louisa Hubbard brought together a group of well-placed trained nurses and hospital matrons, the Midwives' Institute combined the purpose of providing respectable employment for middle class women with broader efforts to reform the working class. The Institute's early members had earned their credentials in the midwifery programs of some of the most prestigious training schools in the country, but few of them ever practiced

midwifery. Rather, they were the supervisors and managers of obstetric wards, maternity institutions, and philanthropic organizations. They had been drawn into the cause of midwifery reform not through their first-hand experience with the lives or the problems of the poor, but as a result of their involvement with a broader network of reform-minded social and professional activists with whom they shared the same values, outlook and vision for the future.

From inception, the Institute leadership, its members and supporters were drawn from the elite of the health fields. Two of the three original midwife founders, for example, Miss E.J. Freeman and Mrs. Hornsby-Evans were matrons of two of London's largest lying-in hospitals. Zepherina Smith, the first president of the Institute, was married to a professor of surgery at King's College London and was herself trained at the British Lying-In Hospital. Supporters of the Institute's work were equally as well-placed. The signatures of the original Articles of Association reveal some of the more prestigious names in the medical profession at the time: the surgeon and strongly conservative social critic, Mary Scharlieb; the President of the Royal College of Physicians, J. S. Bristowe; Thomas Bryant, the President of the Royal College of Surgeons; and John Williams, the President of the London Obstetrical Society. Three Members of Parliament, F.W. Fitzwrayn, William Rathbone and H. Fell Pease, also lent their name to the new venture. Later medical allies included some of the most foremost names in obstetrics: John Cullingsworth, John Fairbairn, Frances Champneys, and J.H. Aveling among others.[26]

The leadership, a core of younger women who went on to control the policies and administration of the Institute, were all well-educated middle and upper class women who had risen to managerial positions in their chosen field of health work. Most of them had graduated from the reformed nursing regimes established by Florence Nightingale and her disciples. Paula Fynes-Clinton, the Institute's organizing secretary, had been trained at the London under the Nightingale disciple, Miss Lückes and later held the position of Obstetric Ward Sister.[27] Similarly, Amy Hughes president of the Institute from 1911 to 1919 had trained at St. Thomas' under the Nightingale protégé, Mrs. Wardroper. "When we began," Rosalind Paget later recalled, "all had the L.O.S. certificate", the highest certification of formal training available at the time. [28]

Many of the Institute leaders held managerial positions in those philanthropic organizations most closely associated with health work among the poor. Jane Wilson, for example, who served as Institute president from 1894 to 1911, was Secretary to Louisa Twining's Work House Infirmary Association.[29] Rosalind Paget was the first Superintendent General of the foremost district nursing association in the country, the Queen Victoria Jubilee Institute for District Nursing (hereafter Queen's Institute). Originally formed through a special fund in honor of Queen Victoria's Jubilee, the Queen's Institute tied together in one national organization the numerous local philanthropic district nursing efforts which had proliferated across the country in the late nineteenth century to provide nursing care to the poor.[30] The Queen's Institute both affiliated existing associations and worked to form new associations under its aegis.[31] District nurses were then supplied through the central headquarters of the Queen's Institute to both urban and rural areas in England, Wales and Ireland. Looking back on the history of the Queen's Institute a Times leader claimed in March 1908 that " it has stimulated, organized, improved, and extended the whole movement . . . until it has become one of the most remarkable and influential factors in the social organization of our time. . . . "[32] After training at the Metropolitan and National Nursing Association under the influential and autocratic Mrs. Florence Lee Amy Hughes, the Institute's third President, rose rapidly in the district nursing hierarchy and succeeding Paget as Superintendent of the Queen's Institute.[33]

Rosalind Paget, probably the most well-known Institute leader, exemplified the leadership's class position, their professional backgrounds, and their attraction to welfare work and social reform. Paget came from a wealthy Liverpool family who had made their money in shipbuilding. She counted among her relatives the well-known and much respected William Rathbone, philanthropist, nursing innovator, and Member of Parliament. In 1859, Rathbone had helped to found the Liverpool District Nursing Association, a philanthropic organization which had provided nursing services to the poor. Rathbone's association became a prototype for other district nursing associations such as the East London Nursing Society formed in 1868 and the Metropolitan and National Nursing Association formed in 1874. When Queen Victoria sought help in founding her Queen's Institute, it was William Rathbone to whom she turned for help. Like her uncle, Paget

wanted to use her wealth and social position to make a positive contribution to society. "She was endowed with Rathbone energy, intelligence and a restless social conscience," Mary Stocks (historian of the Queen's Institute) once wrote.[34] Under the Nightingale disciple Miss Lückes, Paget received her nursing certificate from the London Hospital in 1884. In January 1885 she received her LOS certificate from the British Lying-In Hospital. In 1887, she was appointed Superintendent General of the Queen's Institute.

Like most of the Institute leadership, Paget never practiced as a midwife. It was her supervisory and personal connections which brought her in contact with others who were anxious to take-up the cause of midwifery reform. Her matron at the British Lying-In, Miss Freeman, had taken her to her first meeting of the then Matrons' Aid Society in 1886. "There were about ten persons present", Paget recalled, "and it was very dull."[35] She agreed to join only if there was, "a Midwives Club and lectures and a library . . . Next day I was asked to help them organise one."[36] Under Paget's energetic supervision, a society of rather limited aims was turned into a center of midwifery reform. At a time when the word midwife was hardly spoken in polite society, Paget brought a certain respectability and intellectual verve to the Institute's cause. She lived in Sloane Square and made her home available to a wide circle of social and professional connections. Financially independent, her wealth supported the Institute for many years. She organized lectures on midwifery by some of the most prestigious medical names of the day. She arranged to take rooms in the Charity Organization Society's headquarters so that the society--now calling itself the Midwives' Institute and Trained Nurses Club--would have a permanent headquarters to which members could come for meetings, for professional enrichment and to socialize. In 1887, she founded the Institute's journal Nursing Notes and, with Emma Brierly, edited it for decades. "As its proprietor, and as author of many of its articles", her biographer has written, "Rosalind Paget was the controlling influence behind the policy, the educational standard and general quality of the journal."[37] For several years she combined her activities at the Institute with her full-time work, but from 1896 she devoted all her time to the Institute's cause.

At a time when even privileged women suffered from social and political inequality, the Institute offered a haven in which professional women could draw strength from others like themselves. Nursing Notes

editor and long time member Emma Brierly articulated the environment of encouragement and support which the Institute offered.

> Bustling down the steep little street with happy friends, our faces towards the Old Water Gate, turning in to the bright, cheerful rooms of the Club for lectures, for books, for talk or tea, sure of meeting there other congenial, kindred spirits and being helped along in our work. [38]

In those rooms they found others who shared their beliefs and feelings, others who saw midwifery reform as a great social mission to improve the lives of the poor. A woman's participation in the work of the Institute took her out of her narrow and individual world and thrust her into one beyond herself. No longer just an individual, she became an instrument for the greater good. "It was in dear old Buckingham Street", Brierly continued, "that some us began to realise for the first time that we, as midwives, had glorious work to do, and that, please God, we would do that work faithfully."[39]

Midwifery Reform and Social Reform

Between 1889 and 1902, the leadership and their supporters had several bills introduced which would have made midwife registration and training mandatory. However, it was not until middle class philanthropists' growing concern over the health and welfare of the working class coincided with the wider political concerns over the future of the British Empire that the Institute's cause received a favorable hearing. With Britain's worldwide dominance threatened by competition from other industrializing countries, the condition of the working class became a matter of national importance for which many believed national solutions were needed. The Midwives Act of 1902 was the first in a series of social legislation directed toward increased state involvement in the public health, and particularly in maternal and infant welfare.

Beginning in the 1880's, middle class social reformers had grown increasingly concerned about the conditions under which large sections of the working class population lived out their lives. The worst conditions were in

the cities. Workers were crowded into unheated, dimly lit and poorly ventilated slum housing. Many were too poor to buy proper clothing or adequate nourishment. The working class, but particularly the poorest of the cities' populations, experienced shorter life expectancy rates than the middle or upper class, greater morbidity, and despite a overall decline in the general mortality rate, an alarmingly high rate of infant and maternal mortality.[40] Social reformers were as concerned over the effects of this poverty on the social fabric as they were for the suffering of the poor. Philanthropic organizations sought to supplement the efforts of the Poor Law not by outright relief, but through digging out what reformers believed to be the root of the problem--individual failing. Although they usually provided some kind of material help, these organizations generally considered that their real work lay in teaching the poor to adopt the values of individual responsibility and self-reliance. Because this process of education could only be carried out by those who already lived by these values, services were usually dispensed by middle class welfare workers, (many of them women) who, because of their superior social background, were considered to be most capable of exercising the proper influence on the recipient in his or her journey to an orderly and independent life. Many considered this work of transforming the habits and behavior of the poor a moral mission. "If one sentence could explain our work," wrote Reverend Samuel Augustus Barnett of his Charity Organization Society, "it is that we aim at decreasing not suffering, but sin."[41] Those who could not, or would not, conform to these ideals were considered undeserving and therefore ineligible for further help.

By the end of the century, however, many had come to believe that the problems of the poor could not be solved by philanthropy alone. Growing fears over Britain's weakness in the face of the increasingly serious economic competition from other industrializing nations (most particularly, Germany and the United States) began to concentrate on what appeared to be the physically debilitated and morally degraded working class. Such a population--wracked by poverty and ill-health--was hardly adequate to either defend the Empire or to labor productively for the British economy. In 1899, during the failing Boer Campaign, the Inspector General of Recruiting reported that three out of five men in Manchester who had applied for military enlistment were rejected as being physically unfit; the reality of what some called "national degeneration" appeared to be confirmed.[42] Since the

most debilitated of the working class also appeared to be the most prolific, reformers grew increasingly alarmed that the "worst" of the population would soon outnumber the "best", that is, their more socially stable and physically sound class superiors.[43]

Within this context, the theory of eugenics gained increased acceptance. Eugenicists argued that neither social reform nor philanthropic benevolence had succeeded in improving the poor because the root cause of their poverty was not moral aberration, but biological deficiency. Eugenicists argued that no reform of the poor was possible without limiting the extent to which they could reproduce and further pollute society with their defective heredity.[44] Although the logical outcome of eugenic arguments--direct manipulation of human breeding stock to produce a superior class of human beings--was never seriously entertained by British mainstream opinion, the theory of eugenics did exert an influence on many social reformers. The pessimistic biological determinism of the original, one-dimensional eugenics position was replaced by an amalgam between eugenic ideals and environmental causality. Caleeb Saleeby, a physician and a well-known proponent of what historians have called "reform eugenics", argued that while heredity set the overall biological pattern, manipulation of the individual's environment could improve the quality of both the nation's present and future population. In order to influence this environment, reform eugenicists sought to enlist both state and voluntary aid to intervene in the conditions of childbearing, in infant care, and in child health.[45]

Since the quality of maternity attendance was so crucial to the reproduction of the population, politicians and government officials began to consider the subject of midwifery reform more seriously than ever before. That the Institute leadership and their supporters were the only ones making concrete proposals for midwifery reform was not the only reason their efforts were finally successful. The Institute linked the need for state licensing and midwifery training with the broader concerns over national degeneration and the growing belief that the behaviors and the morality of the poor had to be reformed. In this way, the Institute leadership made their own professional aspirations synonymous with the national good.

With many of their reformer colleagues, the leadership believed that the best way to help the poor was to teach them to change their ways. By

reforming the requirements for midwifery practice, the Institute leadership hoped to improve the standard of midwifery care among the poor. With formal training in the most current theory and technique, trained midwives would be equipped with the knowledge of how to prevent puerperal sepsis. Yet, midwifery reform was more than theoretical knowledge and technical improvements. It was part of a wider effort to reform the habits and behaviors of the poor. Generally, the leadership of the Institute believed that infant and maternal mortality was largely a result of working class women's inability to care for their themselves or their children. Only by adopting the values and behaviors that her social superiors thought best for her could the working class mother rescue herself and her family from the chaos of working class life. Furthermore, the leadership concurred with their reformer colleagues that the working class mother would be unable to successfully assimilate these values and behaviors without the supervision of the more educated and refined influence of her social betters.

To the leadership, the lay midwife was the primary obstacle between the trained midwife and the working class mother they hoped to reform. The lay midwife's lack of training and her inferior class background made her technically and morally unfit (according to Institute guidelines) to attend women in childbirth. The Institute leadership, like most other social reformers, had little first-hand knowledge of working class midwifery practice. What they did know was largely filtered through the lenses of their own class and cultural perceptions of the working class, and was influenced by a fictional character created by Charles Dickens. Sairey Gamp, the untrained midwife in Dickens' novel Martin Chuzzlewit, combined her midwifery with nursing the sick and laying out the dead. She was fond of gin and was more likely to place her own comfort before that of the patient's. Proud in her ignorance and not afraid to speak her mind, Sairey surveyed her territory with confidence. To many social reformers Sairey epitomized the lay midwife. Emma Brierly illustrated how prevalent the Gamp image was among midwifery reformers when she recalled: "The majority of women calling themselves midwives . . . were not only untrained and inexperienced, but ignorant, superstitious and often of very low character. . . ."[46] Such a woman could never "exert a wholesome influence over her patients." Only a middle class, trained midwife could offer the working class mothers both the technical efficiency and the needed moral uplift. Only she, an article in the

March 1890 issue of Nursing Notes explained, could "raise and refine their feelings and make them see the benefit of cleanliness and order. . . ."[47]

The Midwives Act passed in 1902 was but one part of the broader movement to redress the problems of maternal and infant health. By the turn of the century, a fresh wave of voluntary activity had been initiated and the government had begun to lay the foundations for increased involvement in public health. Over the following two decades, the combined efforts of local government and voluntary organizations created the beginnings of a network of government sponsored maternal and infant welfare services. In Maternal Welfare Centers, Mother's Welcomes and Schools for Mothers, voluntary organizations taught working class mothers the proper techniques of infant care and feeding, current nutritional principles and, as in the previous century, the necessity for cleanliness and order.[48] Frequently, these organizations employed health visitors, middle class women who would take these lessons to the poor in their own homes rather than waiting for them to come to the center.[49]

Social legislation provided for needed infant and maternal welfare programs and provided the basis for both local and central government to became increasingly involved in the public health. In 1906, for instance, school meals were provided to needy children; in 1907 the registration of births was made mandatory so that local authorities could have health visitors visit each new mother and infant; and in 1911, the Health Insurance Act introduced maternity insurance for certain categories of female workers and for the spouses of male insured workers.[50] On the eve of the First World War, the Local Government Board (the body assigned the responsibility to oversee municipal health departments) had begun to distribute grants to local authorities to help them in their maternal and child welfare efforts for "securing improved ante-natal and natal conditions . . . [and] for continuing the work in relation to children beyond the first year of life."[51] Between 1914 and 1918, for example, the number of health visitors increased from 600 to 2, 577 and the number of voluntary and government maternal welfare centers increased from 350 to 1, 278.[52] Many of these centers, government and voluntary, expanded their services to include medical consultations for infants and toddlers, as well as milk and food for both infants and nursing mothers.[53]

Although these programs represented a new departure in the government's involvement in maternal and infant welfare, they were still informed by the philosophy of individual responsibility. The government had intervened because the results of working class "negligence" threatened the nation's future and could no longer be ignored. Services were offered but would do little good without attention to the individual's role in rectifying their own failings. "The problem of infant mortality is not one of sanitation alone, or housing or indeed of poverty as such, but it is mainly a question of motherhood . . . ", George Newman wrote in 1906 one year before he was appointed Chief Medical Officer of the Board of Health. Healthy children were not the result of state or municipal programs, but of the "intelligence, the devotion and the maternal instinct of the mother."[54] Therefore, services were offered in such a way as to instill in the woman a responsibility for her own welfare. Unless a thorough investigation of her financial situation proved her truly needy, a woman was usually expected to pay something toward the cost of the service she received. In addition, any help she did receive was often accompanied by tutorials in self-help and self-reliance.

The movement for social reform and the problem of national degeneration converged at a time when the health and welfare of the working class had become an issue of national and international importance. In the social legislation of the early twentieth century, the state intervened in an attempt to use its powers to improve the foundation of the country's present and future, the mothers and children. The implementation of these programs was influenced by social reformers' belief that to help the poor was to change their behavior to meet middle class expectations and values.

Redefining and Limiting the Midwife's Work: The Midwives Act, 1902

The Act had been passed on a wave of concern over infant and maternal ill-health. The Institute and its supporters had been able to convince politicians, government officials, and a section of middle class opinion that state registration and mandatory training of midwives would reduce the high mortality levels among women and children. The Act created a powerful instrument for the supervision and control of midwives' practice. Any woman who wanted to practice as a midwife was required to register with the

state. Those who practiced without the benefit of registration were liable to prosecution in criminal court. The regulatory arm of the Act, the Central Midwives Board, redefined and restricted the scope of registered midwives' practice, formulated a course of training which prepared midwives to conform to this limited scope and created a powerful supervisory apparatus by which to enforce these restrictions. All registered midwives, regardless of training, who did not conform to these new stipulations would lose their ability to legally practice midwifery.

The Institute and its supporters had sought to prohibit any midwife from practicing who had not undergone a course of formal training. With so few midwives of this kind in 1902, however, the country would have been bereft of midwifery attendants if this proposal had been accepted. Instead, the Act provided for the gradual phasing out of lay midwives over a period of eight years. Thus registered midwives were of two types. First, those midwives who had undertaken formal training either through the London Obstetrical Society (LOS) or one of the several schools recognized by the Act were, as trained midwives, immediately eligible to register under the Act and thereafter to practice as midwives. Second, a lay midwife who could prove that she had been in practice for at least one year before the implementation of the Act and who could produce a certificate of her good character from a minister could, until 1905, apply for registration as a "bona fide" midwife.[55] After April 1905, any woman who called herself a midwife but was not registered under the Act could be fined £5 and sent to jail. Until 1910, unregistered women could still attend women in childbirth as long as they did not call themselves midwives. This clause was meant to allow unregistered midwives to come to the aid of a woman in the event of an emergency. After 1910, however, unless she worked "under the direction of a qualified medical practitioner", a woman who was not registered under the Act could be fined £10 and sent to jail if she attended births "habitually and for gain."[56]

Midwives' training and practice was to be regulated, supervised and controlled by the newly created Central Midwives Board (CMB). The CMB was given the authority to designate and approve training institutions, to set the syllabus and examinations, to issue certificates upon successful completion of training, and to formulate and codify rules by which midwives' practice would be defined and supervised and, in the event of

malpractice, the procedures by which midwives would be disciplined.[57] As in most public health legislation, day-to-day supervision was delegated to local government. County Councils and Borough Councils were officially designated as the Local Supervisory Authority (LSA) authorities made responsible for implementing the Act in their areas. The LSAs were charged with keeping track of all those registered midwives (trained and bona fide) who had notified their intention to practice within their jurisdiction, to make arrangements for the supervision of their practice through routine inspection, to investigate any charges of malpractice, negligence or misconduct on the part of registered midwives in their area and to report any midwife who appeared guilty of such violations to the Central Midwives Board.[58]

The Act established the legal framework to govern the regulation and control of midwives' practice, but it was the Central Midwives Board which formulated the fundamental principles upon which midwifery training, practice and supervision would be conducted. Nine organizations were granted representation to the CMB. None of these represented the majority of midwives--the working class, bona fides. Rather, representation was granted to the government and to organizations which spoke for the various professional groups which had a vested interest in midwife regulation. The Royal College of Physicians, the Royal College of Surgeons, the Society of Apothecaries were each allowed one medical representative. The Privy Council was given two representatives, one of which had to be a woman. The Association of County Councils, the Queen's Institute, and the Royal British Nursing Association were each allowed one representative. The Midwives' Institute, which represented the "aristocracy" of trained midwives, was granted one seat on the Board, but they had to appoint a medical practitioner to represent them.[59] Together, this elite drawn from medicine, nursing, midwifery and government service developed the principles upon which the rank and file of midwifery--the trained and bona fide practicing midwives registered under the Act--would carry out their work. The product of their deliberations, the Rules Framed under Section 3 of the Midwives Act (commonly called the Rules), were best described by the Board's chair and obstetrician, Frances Champneys in 1908: "As regards midwives, in return for recognition, they are now under proper restraint. As regards the medical

profession, midwives are put into proper relation to it, and are definitely restricted in the scope of their practice."[60]

The Rules clearly delineated the scope of the registered midwife's work. She was to guarantee that the patient and the lying-in room were properly protected against infection by using the antiseptic technique designated by the Rules. She was to attend the patient during her labor and to take care of her and the infant for ten days post-partum. The Rules told midwives what to wear, what equipment and supplies they were to carry in their bags, specified the step-by-step procedures for washing and disinfecting the patient, and made them responsible for the cleanliness and comfort of the patient during and after the delivery.[61] When complications developed, the midwife was required to call for medical aid. As Stanley Atkinson, the Institute's representative on the Board wrote in 1907, "It is not the function of a Midwife to diagnose, but, as with all 'first- aid' practice, when in difficulty or in doubt to send at once for a doctor."[62] The Rules provided midwives with a long and detailed listing of instances in which the midwife was required to call in a physician. If a pregnant patient was dwarfed or deformed, had experienced loss blood, or if there was any apparent complication such as "excessive sickness, puffiness of hand or face", the midwife was to recommend that the woman saw a the doctor. If after the delivery the patient experienced "abdominal swelling or tenderness; offensive lochia; rigor with raised temperature; rise of temperature; unusual swelling of the breasts; secondary post-partum hemorrhage; or white leg" the midwife was to call the doctor.[63] Whereas formerly face, brow and footling breech presentations were considered within the midwife's province, the Rules required her to call a physician in all but the "uncomplicated vertex or breech."[64] Finally, a physician had to be called if the infant suffered from any injuries received during birth, any malformation or deformity, "dangerous feebleness", inflammation of the eyes, skin eruptions, or inflammation of the navel.[65] Thus, the midwife's work was defined through the Rules' requirements and its restrictions.

The CMB training syllabus prepared a midwife to perform the tasks which had been relegated to her--the attendance on normal midwifery cases and the summoning of medical aid in the event of complications. During a three month course, midwifery training schools were required to prepare their pupils in both the theoretical and the practical sides of normal

midwifery. "Elementary anatomy of the pelvis and generative organs", the principle complications of pregnancy, the "symptoms, mechanism, course and management of natural labour" and the "nature, causes and symptoms" of puerperal sepsis were the principle topics of their theoretical training. Pupils received only enough instruction in the abnormalities associated with parturition and the puerperium to would permit them to recognize the conditions requiring a physician's presence. Most of their education was practical. They were taught the correct procedures to prevent infection, how to read a clinical thermometer, and how to use a catheter for vaginal douches. They were taught how to care for the newborn and how to instruct women in breastfeeding and, if necessary, in artificial feeding. In order to gain practical experience, the CMB required pupils to have "attended and watched the progress of not less than twenty labours, making abdominal and examinations during the course of labour, and personally delivering the patient."[66] In addition, pupils had to take care of twenty women for ten days post-partum. In those cases when the physician was delayed or was unavailable, CMB training did prepare pupils to manage the most common obstetric emergencies until the physician arrived. However, any independence which such knowledge might encourage in the midwife was countered in two ways. Because the CMB training focused on preparing the pupil to assume responsibility for normal midwifery cases, training schools did not provide the pupil with practical experience in managing complicated labors. Furthermore, the entire syllabus was structured around teaching the pupil her own limitations as a midwife and the necessity to call a physician when she had reached them.[67] Only those pupils who had successfully completed this course of training and who could offer proof from individuals acceptable to the CMB that they were, "trustworthy, sober and of good moral character" could present themselves for the CMB examination.[68] Once she graduated, the newly trained CMB midwife joined her trained and bona fide colleagues in the rank and file of registered midwifery.

To ensure that midwives adhered to CMB restrictions on their practice, the Rules granted the Board and the LSAs extensive powers to supervise and discipline midwives suspected of violating the Rules' limitations on their authority. At the local level, the Board allowed the LSAs free rein to investigate any aspect of a midwife's practice. Midwifery inspectors, most commonly appointed by authorities to perform the routine supervision,

could follow a midwife on her rounds, question the women she attended as to whether she adhered to the proper procedures, question the midwife's neighbors as to her personal behavior, and investigate the midwife's house for possible sources of infection. Since she was required to make her practice open to periodic inspection, a midwife had little choice but to accede to the inspector's investigations. Because the Rules were at once so detailed regarding the specific procedures of the midwife's work and so encompassing as to cover both her personal and her work life, the powers which the Board bestowed upon the LSA amounted to almost unrestrained authority over midwives' lives and practice.[69]

Similarly, the Board granted both itself and the LSAs wide ranging powers to bring and prosecute cases against midwives suspected of violating the Rules. To refer a case, the Act required that the LSA had only to establish a prima facie case against the midwife. Unlike a court of law where the burden of proof is on the accuser, a prima facie case made it incumbent upon the midwife to prove herself innocent of the charge against her. The Board's procedures set down by the Rules further disadvantaged her relative to her accusers. A midwife was notified by the Board of the charges against her and allowed to prepare her own defense or to have a representative or a solicitor speak for her. She was also allowed to cross-examine witnesses and to make a statement on her own behalf. She defended herself, however, against the combined resources and expertise of the Board members and the LSA. The Board underwrote the entirety of the expenses the LSA incurred in bringing the case--the cost of depositions, for example, and travel and lodging for witnesses and officials when necessary. The midwife, on the other hand, was granted no such dispensation from the Board and had to bear the entire cost herself. Finally, not only did the Board bring the charges, but it prosecuted the case against her and determined the verdict. If the violation was serious enough, the Board could revoke her certificate. The Act had granted midwives the right to appeal the Board's decision in High Court, but this was an expensive procedure beyond the reach of many rank and file midwives. If the Board did not think the incident warranted such a step, it could render a judgement of caution or censure. Any judgement against her, as any record of her being called before the Board in the first place, was noted in the LSA records.[70]

The Board justified the restrictions of the Rules and the formidable apparatus of supervision which had been created to enforce midwives' compliance in the name of protecting the safety and moral well-being of parturient women and their children. Yet, the Rules also protected the interests of the medical profession. By restricting the midwife's practice, the Rules increased the number of cases available to the medical profession. By requiring her to call in a physician in every complication no matter how small, the Rules facilitated the medical profession's access to the working class market for maternity services. By establishing such a powerful means of enforcing its will, the Board guaranteed that registered midwives, either by discipline or their own conviction, would service the interests of the medical profession.

The Means to the End: The Midwives' Institute and the Act

The Rules' restrictions on midwives and the inequities in the Board's penal process were not as objectionable to the Institute as one might expect. The Institute leadership had achieved many of its goals through the Midwives Act: the title of midwife was protected, normal midwifery had been identified as the midwife's preserve, a recognized body, the Central Midwives Board, had been established through which midwives training and practice was to be regulated, and the Midwives' Institute had secured a seat on that governing body. As the only official representative of registered midwives, the Institute was well-placed to influence the development of the profession at the highest level. In their nursing training, the leadership had been taught to accept subordination to the medical profession and to regard supervision as a necessary means by which even the most highly trained nurse or midwife was kept up to the mark. Although they acknowledged that the Rules were inordinately strict, the leadership saw them as the chief instrument by which the bona fide midwife would be forced from the ranks of midwifery.

As a member of the Central Midwives Board, the Midwives' Institute was an active partner in the promulgation and imposition of the Board's philosophy of midwife supervision and control. Half of the Board members were either Institute members or supporters. The leadership felt no qualms

over the requirement that they appoint a medical practitioner and indeed preferred to have a male consultant, rather than a midwife, represent them.[71] Three of the nine other representatives who sat on the Board between 1903 and 1918 were Institute members. Rosalind Paget had been appointed by the Queen's Institute. The representative for the Royal British Nursing Association, Mrs. Latter and her later replacement Miss Oldham, were members of the Institute's governing body, the Council. Jane Wilson, the Institute's president from 1894 to 1911, was given the prestigious government appointment from the Privy Council. Her replacement, Lady Mabelle Egerton, was also an Institute Council member. Of the presence of these women on the Board, Nursing Notes concluded, "we cannot but think that women as women may be fairly satisfied. . . ."[72] Frances Champneys , an influential (and since he was now the Board's chair) an indispensable advocate for the Institute's vision of midwifery reform, rounded out the Institute's "unofficial" representation. With almost a majority of the representatives, the Institute was well-placed to influence the Board's policy. Through her position as the chair of the committee which "drafted the reports and recommendations" concerning midwives' practice, for example, Rosalind Paget helped to define the limitations on midwives' practice and to formulate the restrictions under which they were required to perform their designated tasks.[73] As members of the penal committee, both Rosalind Paget and Jane Wilson actively participated in the Board's disciplinary work. Although the leadership occasionally might disagree with another Board member or Nursing Notes might criticize a decision on which the Institute had been outvoted, these disagreements occurred only within the framework of the shared philosophy which Champneys had outlined in 1908.[74]

The Institute leadership did not object to the limitations on midwives' practice. Although they sought to make midwifery into an independent profession, the leadership had never considered that the midwife would be able to function independently of the medical profession. Jean Donnison has shown that from its inception the Institute had no intention of challenging the authority of the medical profession. "To this end", the leadership made, "it clear that the Society's midwives were considered competent to deal with natural labour only, and required them to send for medical assistance in all difficult and dangerous cases."[75] Although Donnison accurately interprets this

as a tactic with which to gain medical consultants' support for the cause of registration, it was more than mere political opportunism.

During their formative years as young nurses many of the Institute leaders had come under the influence of Florence Nightingale's nursing philosophy of which strict obedience to hospital hierarchy and to the doctors orders were the first and lasting hallmarks. "Training", wrote Nightingale in 1882, "is to teach the nurse to handle the agencies within our control which restore health and life, in strict obedience to the physician's or surgeon's power and knowledge."[76] Articles in Nursing Notes concurred. "Every medical man has a right," asserted L.B. " to look for loyalty, a steady upholding of his authority to the patient . . . and the remembrance of the nurse that she is there to do what she is told, and not either to give, or try to carry out, her own opinions."[77] Not all agreed that a woman had to be a general trained nurse before she trained as a midwife, but midwives were inevitably judged by nursing standards. Council midwife members were all trained nurses and perhaps agreed with Rosalind Paget when she wrote to John Dakin: "Being a nurse myself, I naturally in no way under rate, in fact I am inclined to over rate, the importance of the midwife being a good nurse. . . ."[78] Far from wanting to confront the medical profession or demand more authority from the CMB rules, the Institute viewed the physician as the midwife's superior and the medical profession as its natural ally.

For the Institute leadership, the only blemish on an otherwise favorable outcome was the Act's dispensation allowing bona fide status for lay midwives. By allowing these women to register, and thereby giving them legitimate status, the Act had undermined the leadership's campaign to appropriate the practice of midwifery from the working class lay midwife. "No one regrets the admission of the bona-fide midwife on to the Roll more than the trained midwife (who has spent time and money to become qualified)" claimed a 1909 Nursing Notes article. "It is an insult they should have the same status, and this certifying of unqualified persons has brought the Act into disrepute."[79] The strict requirements of the Rules promised to curb the bona fide's ostensibly filthy and dangerous practice and thereby prevent her from disgracing the trained midwives. If she could not or would not abide by these Rules, the latitude of the Board's disciplinary powers promised to facilitate her elimination from the ranks of midwifery.

That trained midwives--the very practitioners whom the Institute believed the Act was to encourage--would have to labor under the same restrictions was not lost on the Institute. Yet, in keeping with Nightingale's philosophy, the leadership believed that even for trained midwives, "due supervision is essential, for literally the issues of life and death are now legally delegated to the practicing midwife."[80] Left alone and faced with the routine of normal confinements, even the well-trained midwife would begin to grow slack in her habits, the many, " 'details' are allowed to slip and then come the old time excuses for the consequences that ensue."[81] Supervision guaranteed that even a trained midwife would be helped "against her will and often almost unconsciously from falling to a lower level of work."[82] The Institute did not deny that the Rules which governed this supervision were strict. The leadership argued, however, that trained midwives, schooled as they already were in principles of antisepsis, experienced in the proper relations between midwife and physician and conscious of the need to document medical histories and record notifications, would not, with the proper inspection, find it difficult to comply with the Rules' restrictions. Nursing Notes acknowledged that the "powers given to the Local Supervisory Authority by these Rules may open the door for much vexatious interference . . . ",[83] but argued that as long as the trained midwife dutifully abided by the Rules requirements that the trained midwife had nothing to fear. "The *trained* midwife must be loyal to the Board which would look to her to carry out her Rules", John Cullingworth, the Institute's first representative to the CMB reminded the meeting of Institute members assembled to hear his report on the workings of the Board. "And in difficulties arising therefrom she might confidently reckon upon being backed up by its authority."[84]

The Rules had defined the division of labor between midwives and physicians and had created a formidable apparatus of supervision with which to enforce midwives to comply. All midwives, regardless of training, were subject to the same definition of their work and the same regulation of their practice. Yet, not all midwives were equally vulnerable before the power of the Act. The rank and file of midwifery--of which trained and bona fide practicing midwives were members--were given no representation on the Central Midwives Board and therefore had no voice in the decisions which governed their lives and practice. Through the medium of the Midwives'

Institute representation had been given, however, to the elite stratum of nurses, midwives and midwifery reformers. When the Midwives' Institute spoke it was their opinions, beliefs and biases it articulated.

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11. Chamberlain, 111.

12. Chamberlain, 109.

13. Quoted in Chamberlain, 110.

14. See, for example, Midwives' Institute, Executive Council, minutes, December 6, 1901, Ellen Shand to Dear Sir, November 15, 1901.

15. Donnison, 78; Candidates for the LOS also had to be between twenty-one and thirty years of age and be able to present a certificate of good character before they could take the examination. For the story of the LOS, see, Donnison, chapters 4-5.

16. Donnison, n. 37, 216.

17. McCleary, 133.

18. See, for example, Chamberlain, 113-114; Little, 61-63.

19. Chamberlain, 112.

20. Chamberlain, 114.

21. "Practical Notes", NN, August 1905, 119.

22. Quoted in Chamberlain, 115.

23. Chamberlain, 113.

24. "Colostrum contains high levels (and human milk lesser amounts) of the antibody immunoglobulin A (Iga). Iga evidently is produced within the lactating breast and the antitoxic activity of breast milk against Escherichia

coli, a common cause of infantile diarrhea, correlates well its Iga content. Thus, there may well be a scientific basis for the folk belief that the eye infection conjunctivitis can be cured in newborns by putting breast milk in the baby's eyes." Chamberlain, 178. For examples of midwives who continued to use these remedies after the Midwives Act was passed, see, "Midwife Notes", NN, January 1910, 15; "Penal Cases", NN, March 1906, 36, which reported that Jane Tween, was struck off for "feeding the infant on oatmeal and gin".

25. Oakley, 23; Oakley cites two sources published in 1897 and 1903 which recommended venesection as a means to drain the system of the poisonous toxins which were believed to cause puerperal convulsions; For examples of midwives and "old wives" spells, see, Chamberlain, 161-171.

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Connolly, "Health Visiting 1850-1900: A Review", Midwife, Health Visitor and Community Nurse, vol. 6, no. 7, July 1980, 283-285; "Health Visiting 1900-1950: A Review", Midwife, Health Visitor, and Community Nurse, vol. 16, no. 9, September 1980, 375-378; McCleary, 25-37, passim; For the resentment a health visitor could engender among working class mothers, see: Davin, 37-38.

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Chapter 2

"Hygiene and Morality": The Midwives' Institute and Social Reform

For the leadership of the Midwives' Institute, the struggle for the reform of midwifery was inseparable from the broader movement for social reform going on around them. As feminists, the leadership fought for middle class women to share in the full political and social rights granted to men of their class. For the Institute leadership, equality was not a abstract precept but rather the means by which the nation would be rescued from social and moral degeneration and the appropriate standards of morality and the proper relations between classes restored. Like many feminists, the leadership believed that men's sexual immorality was largely responsible for a host of social problems from venereal disease to white slavery to the erosion of family life. Only through the suppression of male vice and the full exercise of women's inherent higher moral sensibilities (not only in the home, but in the wider world) could women, children and the nation be protected from ruin. While the leadership demanded equality in the name of all women, they did not expect that working class women would share in the fruits of democracy. Rather, the leadership envisioned a strictly hierarchical society in which each class accepted its proper position and performed its expected social tasks. While the middle and upper classes would lead, the working class would provide labor for the economy, produce healthy workers, and adhere to middle class standards of morality, order and responsibility. As the center of the working class household, the working class mother was the crucial link in this chain of social order. When she did not comply with these standards she transgressed not only middle class sensibilities, but endangered the entire structure of society as the leadership envisioned it. As trained midwives, middle class women would bring more than the principles of scientific midwifery into the homes of the working class. Through their superior culture and bearing, middle class women would educate the women they attended to adopt the values and behaviors considered appropriate for their proper station in life as working class women and mothers. Trained midwives were the vanguard of a great crusade to save the country from the

national degeneration which threatened the foundations of British society and the power of the Empire around the world.

Essentialism and the Trained Midwife

The leadership believed that restrictive laws, oppressive economic conditions, and personally degrading social and sexual mores kept women from making their full contribution to this reform effort. Like many of their contemporaries, the Institute leadership countered the frustration of their aspirations with feminist arguments. Nursing Notes' editorial policy supported all aspects of early twentieth century feminism: an emphasis on sexual morality and purity, an abstract defense of the rights of all women regardless of their class, and a decided anti-male bias which made women into victims of ill treatment and vice. The leadership demanded the right to vote as the means to make their full contribution to the great social crusade for which their class and their sex had prepared them.

By the late nineteenth century, feminism had evolved into a body of ideas which emphasized the essential differences between men and women over any characteristics they might share.[1] Those thinkers like Mary Wollenstonecraft, John Stuart Mill and Harriet Taylor, who had written in what has been termed the Humanist tradition, had argued that while men and women were biologically different, in their capacity for rational thinking they were the same. It was on the basis of this shared characteristic, they argued, that equal rights should be extended to women. Essentialism, on the other hand, emphasized the fundamental biological differences between men and women. Women's reproductive capacity and the instincts needed for mothering indelibly bestowed the characteristics of nurturance, altruism and a higher moral sensibility upon them. Humanism--the claim that women deserved equal rights because of their equal capacities--did not disappear by the early twentieth century, but became absorbed into Essentialism as feminists accentuated sexual difference and emphasized family and motherhood as the basis for women's distinct but full social participation.

While anti-suffragists used the same Essentialist arguments to strengthen the notion of separate spheres, feminists used them as a springboard from which to justify women's full participation in society.

Feminists did not deny women's role within the home and family, but rather expanded the notion of home to encompass the broader social and political world. "After all", Emmeline Pankhurst wrote, "the home is a very, very big thing indeed . . . home is the home of everybody in the nation."[2] Women's skills as wives, mothers and homemakers were invaluable in those social reform efforts which extended state involvement into the areas of home and family life. "Woman's place, we hear, ad nauseam," a Nursing Notes article complained, "is the home; public life is no sphere for her; . . . . But the home is only the unit of the communal life after all . . . and [a woman should] be able to give of her essential feminine qualities that help towards the general betterment of the whole nation which cannot be achieved by one sex alone."[3] Feminists believed that women's participation in the affairs of state would transform the quality of social and political life. Women's ability to reproduce and to mother, one feminist wrote, "is the strongest force in existence that makes for altruism, and altruism is the most essential factor in the wide and beneficial ordering of the state."[4]

In defense of the Essentialist argument that women's role in the home required her full participation in the rest of society, the Institute leadership enlisted the popular ideas of eugenics. Eugenicists were united in their exhortation to middle class women, as the more desirable breeding stock, to produce more of their superior offspring for the Empire. They were divided, however, about the means to persuade them to do it. Some might have agreed with Karl Pearson, who had declared in 1885: "If child-bearing women must be intellectually handicapped, then the penalty to be paid for race predominance is the subjection of women."[5] Caleb Saleeby, a frequent contributor to Nursing Notes and an advocate of reform eugenics, took an approach more amenable to feminists' sensibilities. Saleeby infused middle class motherhood with a renewed significance. Responsible for both bearing and raising healthy children, the mother was the lynch pin between the national needs of the state and the welfare of its future citizens. "Woman", Saleeby wrote in his Parenthood and Race Culture,

> is Nature's supreme instrument of the future. The eugenicist is therefore deeply concerned with her education, her psychology, the conditions which permit her to exercise her great natural function of

> choosing the fathers of the future, the age at which she should marry [etc.]. . . .[6]

Saleeby supported middle class women's desire for education and equality, but argued that they were never more equal with men than in upholding their national duty of reproducing the race.

> Women must indeed give themselves up for the sake of the community and its future; so must men. Since women differ from men, their sacrifice takes a somewhat different form, but in their case, as in men's the right fulfillment of Nature's purpose is one with the fulfillment of their own destiny. There is no antimony.[7]

Eugenics was the ultimate equalizer, for it demanded that both man and woman be equally fit for procreation and if they were not then they must refrain from marriage.

The leadership was attracted to Saleeby's notion that middle class women did not have to be married to contribute to the eugenically ideal society. Saleeby had recognized that if women adhered to pure eugenic principles as he suggested they may not find appropriate mates. Although women should refrain from marriage under such circumstances, he believed that women could still carry out their feminine function.

> This is woman's wonderful prerogative, that, in virtue of her psyche, she can realize herself, and serve others, on feminine lines, and without a pang of regret or a hint of failure, even though she forgo physical motherhood.[8]

Institute literature cast trained midwives within this role of, in Saleeby's terms, "foster-mother" to the race. Nursing Notes articles combined the mission of the trained midwife with the aims of true motherhood. She should be "the 'Mother' of her village or district in which she lives, who loves, cherishes and admonishes all those who come under her care, to whom all the mothers go for advice. . . ."[9] When Francis Fremantle, County Medical Officer for Hertfordshire, criticized middle class women who exchanged childbearing for attempts to gain an education and to work for

their living, Nursing Notes retorted: "The women who take up social and public work, are usually those who have the highest ideal of motherhood, while many of them do not happen to be wives and mothers."[10] Nine years later, when Mrs. Lloyd-George suggested that midwifery inspectors would be more effective if they had children themselves, Nursing Notes continued to use Essentialist arguments to support the decision not to marry. "The most understanding and motherly woman is not always and only the mother", the journal admonished the Prime Minister's wife. "There are numberless women who are more truly mothers than some who have had children, and there are others who have had children who have neither imagination or sympathy enough to be any help to another mother."[11] As "foster-mothers' to the race, trained midwives would make their contribution to the improvement of society and the nation.

Having made the case for women's participation, feminists bitterly denounced the social and political inequality which prevented women from performing their true function within the wider world. Central to this inequality was the "double standard of morality". Society sanctioned what feminists regarded as men's unrestrained sexual immorality, while it limited women's higher moral influence to the individual home and family. There, it was argued, women could most appropriately exercise the higher moral sensibilities which were an essential part of their nature. Feminists railed against the societal proscriptions which allowed men free sexual license while preventing women from exercising the elevating influence so integral to their nature. "There is nothing in the feminist programme about which the feminist feels so keenly," wrote Ethel Snowdon, "as the double standard of morality."[12] Feminists did not fight for women's right to the same the sexual practices as men, but rather aimed to overturn this double standard by forcing men to adopt the higher morality of women.

Feminists argued that, within marriage or without, women were subject to physical and sexual domination by men. With few opportunities to support themselves outside of marriage and with no legal recourse to protect themselves women had no choice but to submit to men's sexual appetites and, in some case, their physical abuse. All women, feminists argued, no matter their class or social background, were equal before the dangers posed by men. Women were regarded as innocent victims who had often found their health broken and their lives ruined by their husband's sexual excesses.

> It is not an infrequent experience to find a woman, rich as well as poor, who has never been well since her marriage, or it may be since the birth of her baby, and in whom chronic ill health has set up. There are cases in which a husband receives much sympathy from his relations and friends on account of his ailing or invalid wife. In a proportion of those cases the husband deserves no pity, but censure that his wife is no longer the healthy woman she formerly was.[13]

In this vein, Nursing Notes editorials criticized the tendency to lay complete blame upon the mother for the high levels of infant mortality. "Almost the entire responsibility for the care of the children is being thrown upon the mother. Where are the laws to force the father to take his share of it?"[14]

The inequality expressed in the legal and public sanction of male domination had more serious effects than injustice against women. Feminists believed men's unrestrained sexual license threatened to undermine the very integrity of the nation. The symptoms of "national degeneration"--ill-health, venereal disease, drunkenness, child abuse and infant mortality--could all be traced to men's sexual immorality. Frances Swiney wrote, "The degeneracy we deplore lies at the door of a selfish lustful diseased manhood. . . . "[15] Nursing Notes writers expressed resentment of men who blamed women for the chronic ill-health of the country's infants when the connection between the "ravages which unrestrained sexual immorality are inflicting upon the physical condition of the race" clearly pointed toward men themselves.[16] Women's oppression made the dire effects of men's actions all that more alarming. As long as women were denied full participation in the social and political matters of the nation, the superior moral influence which women could exert to counter men's immorality would be lost. "Truly it is time", Nursing Notes declared, "women brought a purer atmosphere into things political if it is to this open confession of the creed of brute force prevailing over moral sense that the domination of one sex over another has brought us as a nation. . . . "[17] Until this double standard of morality was reversed, not only would women always be vulnerable to physical abuse and lack of personal freedom, but the very foundations of the

family, the health of its members and as a result, the nation itself, would be threatened.

Suffrage and sexual regulation were the two solutions which feminists pursued as a means of overturning the double standard of morality and thereby establishing women's equality. Many feminists became advocates of what historians have termed social purity, a movement which sought to curb men's sexual excesses by regulating their sexuality. "I say as a woman, representing thousands of women all over the world", Emmeline Pankhurst wrote in 1913, "men must find some way of supplying the needs of their sex which does not include the degradation of ours."[18] Social purity advocates insisted that young men and boys practice sexual abstinence prior to marriage. Nursing Notes recommended that men be forced to submit to a pre-nuptial screening before they could marry.

> When thinking men and women fully realise that the health of many people is largely menaced in consequence of the need of a pure life and high moral standard amongst a large number of men and boys, they will insist that before they give their daughters in marriage they must ask and receive proof that the man is free from all taint of communicable disease.[19]

Many feminists believed that rather than use contraception couples should have sexual relations only for the purposes of procreation. The rest of the time couples should practice sexual abstinence. Some feminists chose not to marry at all rather than bind themselves to the restrictions and dangers of marriage. [20] "In fact", a Nursing Notes article asserted, "as thinking women have long recognised, there can be no 'moral union of the sexes' until such time as the brute dominance of one sex over another is abolished forever."[21] For those men who could not restrain themselves, advocates of social purity formed organizations to help them do so. Their tactics ranged from education about the dangers of venereal disease and white slavery to the public exposure of men whose activities helped perpetuate these crimes. Rosalind Paget, an ardent feminist and suffrage supporter, donated money to one of the foremost social purity organizations, The National Vigilance Association.[22]

Without the vote, however, feminists knew that women would never be able to effect the changes they demanded. Most immediately, the franchise promised women's full political integration into society. Rosalind Paget captured the texture of the significance of the vote particularly for those middle class educated women whose political invisibility contrasted with their class background, culture and expectations in life. "My experience has taught me", she wrote, "that without a vote the views of women are not considered in regard to the making of laws that concern them. I pay taxes; I want a word in the spending of the money. At this moment I am neither a pauper, a certified lunatic nor a criminal, but being a woman I am classed with them."[23] But beyond this, feminists believed the double standard of morality lay at the heart of women's degradation, that men's sexual dominance had resulted in the host of social ills such as white slavery, venereal disease and prostitution, and that men's political dominance had done nothing to alleviate the poverty, unemployment and ill health of which women and children were seen as the primary victims. Feminists wanted the vote not only as a symbol of equality, but as a means to reconstruct society according to their moral sensibilities and social reform priorities. "Deep down in this opposition to giving women full citizenship is the old primitive instinct of sex-dominance", a Nursing Notes article asserted. "It is for the removal of this savage element in our humanity that we claim full citizenship, realizing the social evils with which it is extricably bound up."[24]

In the pages of Nursing Notes the leadership endorsed all attempts to publicize the demands of the suffrage movement.[25] The journal consistently covered the larger suffrage demonstrations, particularly those in which the membership participated. In June 1908 Rosalind Paget headed a contingent of members from the Institute to a suffrage meeting at the Albert Hall. Jane Wilson, Paula Fynes-Clinton, twelve members of the Council, a Vice-President, the treasurer of the Incorporated Society of Trained Masseuses and Emma Brierly, the editor of Nursing Notes, attended the meeting.[26]

Editorials and articles urged midwives and nurses to support the suffrage cause. The leadership believed that involvement in social concerns was a logical extension of their professional work and that a commitment to social improvement "should be more strongly developed in midwives and nurses than in any other women."[27] Yet without the vote, they not only had no say for themselves, but had no means of influencing the policies which

affected the lives of the women they attended. It was their responsibility to show by their example the virtue and truth of the feminist cause.

> To nurses and midwives we appeal to foster that spirit in themselves and each other, and to combat by every means in their power the unworthy and wholly illogical superstition that the keenest interest in questions that concern the community as a whole is incompatible with the fulfillment of home and family and professional duties by women.[28]

Nursing Notes encouraged trained midwives to involve themselves in local affairs and, since women were allowed to vote for County Council and Board of Guardian candidates, to apply women's influence by voting in those elections.

Nursing Notes supported all personalities and organizations involved in the suffrage struggle, but gravitated toward the "militants", that wing of the suffrage movement which used the disruption of political meetings, hunger strikes and later, the destruction of property, as a means of bringing attention to the suffrage cause. A 1908 article reminded readers that the "whole- hearted devotion to a cause shown by the women of the Social and Political Union is one to be taken to heart by those who call themselves suffragists, but who will not cross the street to do battle for the cause."[29] When a midwife was brought before the Central Midwives Board for having been arrested and sentenced to two months in Holloway Prison "'for willful damage to Government property'", the Board tabled the case as a way of showing their approval. "The midwife in question is a suffragette and her offence is a political one."[30] Militant speakers gave lectures at the Institute. Of an address given at the Institute club rooms on the "'Methods' of the Militant Suffragists" one writer reported effusively that "it must have been impossible for anyone to go away unimpressed by the single-hearted enthusiasm of the women who are prepared to sacrifice everything to the cause in which they believe."[31] A month later, Christabel Pankhurst herself spoke at the Institute on "Votes for Women".[32]

Readers who criticized the militants' activities were accused of "narrow professionalism which never yet produced the best worker."[33] Jane Wilson remarked in a letter published in the November 1909 issue of Nursing Notes

that although nurses might not agree with the militant's tactics "they are giving their tacit approval to the forced-feeding of suffragists by not speaking out against it."[34] The editors of the journal defended militant tactics in the language of social purity. "The women who broke windows to the tune of a few pounds are sentenced to six months hard labour, but the men who assault little girls and brutally ill-treat their wives are given the lightest sentence the law allows. . . . "[35] Midwife correspondents often agreed. "Would it not be well", one wrote, "if your correspondent reserved her blushes for those of our legislators who pose as women's protectors, and yet continue to block Bill after Bill brought forward in the House of Commons against White Slavery? . . . . [may they] keep their blushes for something worse than the window broken by the hand of a weaponless woman, fighting for the benefit of her sex."[36]

The leadership had entered the maelstrom of the feminist movement and suffrage politics as a natural extension of their social reform efforts. As the arbiters of society's culture and morality they believed that women had the right to participate in shaping the future of society, not only in the home but in the wider world. Men's immorality had proven them unfit to rule without the corrective of women's higher moral sensibilities. Yet, when feminists demanded political equality on the same terms as men they did not "seek merely an entry to a male-defined sphere", rather they wanted the "opportunity redefine that sphere."[37] Social purity and racial improvement were crucial elements of a new moral order in which men and women ascribed to a shared, feminist-defined, standard of morality. For the Institute leadership, this shared standard of morality would serve as the springboard from which genuine social reform would be realized.

Ordering Society Through Social Reform

The leadership defended the rights of all women and argued for the improvement in their lot, but their vision of the future was not one in which all women would participate equally. The democracy which suffrage extended was not intended to supplant but to strengthen the existing social relations between the classes. The leadership took for granted that the vote would be extended to women of property only and that most working class women

would continue to be excluded from political participation. For them, this was a natural and desirable state of affairs. Generally, the Institute leadership believed that as reformers they faced a "working class [who] do not realise their own needs or their own interests . . . " and therefore it fell to the largely middle class social reformers to determine those needs.[38] Institute literature railed against the double standard of morality and blamed men for women's problems, yet more often working class women were portrayed as largely responsible for the nation's high levels of infant mortality and its children's poor health. The leadership believed that the quality of working class life could be best and most lastingly improved through the transformation of the working class character, with working class mothers as the first objects of their reform. Infant mortality could only be arrested by "the individual care and attention . . . which the mother must give her child. Such care and attention cannot be brought about by legislation."[39] The leadership believed that the upper classes had a duty to bring enlightenment to their social inferiors and that social reform could best be served through the preservation of the strictly hierarchical class system in which the working class knew its place and adopted the behaviors and values their superiors thought most appropriate for them. In this sense, social improvement and midwifery reform were inseparable. The Institute promoted trained midwives, armed with their knowledge of antisepsis, as standardbearers of science in the home. The inculcation of bourgeois morality was an indispensable element of this "science" and one which fused the midwife's work to the preservation of existing social and political relations.

The sense that the working class, particularly the poor, were beings who were fundamentally different from their social superiors permeated Institute literature. Probably no one was more responsible for bringing substance to this notion in the pages of Nursing Notes than the district nursing reformer, Marjorie Loane. Loane was a prolific writer, often drawing on her extensive experience as a nurse for the Queen's Jubilee Institute for District Nursing (Queen's Institute). Loane did not possess the intellectual stature of a Rosalind Paget or Jane Wilson, but the simplicity of her presentation gave an immediacy to reformer's concerns in a way more sophisticated analyses could not always accomplish. Her renderings of working class culture and life were rather crude and starkly drawn, even though she portrayed herself as objective, the conclusions she drew from her

experiences were often tinged with intolerance for workers. Yet, her many articles served as indispensable translations for middle class health workers who, committed to reforming the poor "for their own good", were often bewildered by the frequent cultural clash of these two different worlds.

Loane's articles created an image of the working class (and the working poor in particular) as evasive and untrustworthy. "Deceit is perhaps the most common failing," she wrote, " . . . and of course runs in a leash with talebearing and mischief making."[40] Much more serious, however, was the habit of lying to social betters. Lying "is shown not in mere verbal inaccuracies, but in deliberate concealment of facts from persons who have an undoubted right to know them."[41] The poor learned such dishonesty at a young age, the "familiar 'honor bright' of better class nurseries is unknown, and it is often disheartening to find how little conception of its meaning has reached the children of the poor."[42]

Loane frequently warned of the tactics used by the poor against health workers in the field. To embarrass and frighten off middle class health workers, patients would answer questions "with such brutal frankness as to matters which an educated person would die any ordinary death rather than reveal, that it is frequently practiced with complete success even on the most experienced workers."[43] Even a respectful attitude could be just another dodge. "Mr. Atkins at home always refers to us as 'Lady Nurses'", wrote Loane, "but occasionally his voice floats in at my open window and the more picturesque expression used then is 'them Jubilee Tramps'."[44]

Loane acknowledged that kindness and toleration were often present in working class life. Yet in her eyes, the forms which these otherwise positive attributes took were merely further evidence of the inferior morality among the working class. Loane often chose anecdotes which merely in their telling were contrast enough between the culture and values of the working class and those of the middle class women who worked among them. Hearing a woman questioned by the local police sergeant as how she could, "be seen in the streets with such a person" as her neighbor, Loane recounted the woman's answer in one of her articles.

> Last time she went into town she came back drunk, and both her and the baby wet through. I sent my eldest girl to light up the fire for her the moment I

> see her coming, so's she shouldn't put the poor little dear to bed without drying it, but I found afterwards that she's just stuck in into its cot as is then fell on the floor and went to sleep. So I told her that the next time she went into town to let me know and I'd go with her, and bring her back sober.[45]

This story of a "very respectable woman, the careful mother of a large young family" who befriended her neighbor despite the woman's prison record, her drunkenness and the loss of her children to the authorities needed no commentary to a readership of health workers with quite different ideas of morality and appropriate behavior. For the district worker, it was not kindness to befriend such a woman and toleration of her activities would only drag down those who helped her.[46]

Working class mothers came in for particular scrutiny in the pages of Nursing Notes, because the leadership believed that the only effective remedy for the high infant mortality rate was to change the mother's behavior and values. Although some contributors conceded that working class women faced considerable environmental obstacles, most articles reinforced the notion of individual responsibility for social problems.[47] Articles frequently attributed both the high levels of infant morality and national degeneration either to drunkenness among working class mothers or to their employment outside the home. "When one thinks then, of the sad, miserable, wretched existence of the drunken woman," lamented I. F. Peart in his address to the Institute sponsored Certified Midwives Total Abstinence League, "of the neglect, the misery and filth in which as a consequence the offspring is reared, and the hardship resulting to the husband, who in turn may be driven to drink, some may truly shudder. . . . "[48] Contributors repeatedly recounted instances of the ignorance working class women displayed in the face of reformers' attempts to educate them. "The uneducated mind is very slow to grasp what is said and a lecture given to Mother's Meetings falls for the most part on unheeding ears." Mrs. Davis asserted in her talk, "The Deterioration of the Race", given before the Institute's sister organization, The Trained Nurses Club.[49] Moreover, articles claimed that the ignorance of working class women was matched only by their contempt for the efforts of the middle class women who sought to "improve" their situations. "We have to reckon not

only with the incapacity, in most cases, to learn," one author wrote, "but also with their unwillingness to learn."[50] Marjorie Loane graphically captured the haunting sense of danger evoked in middle class reformers when she described "the slattern with one wretched infant in her unmotherly arms and five in their untimely graves, [who] listens with scarcely veiled contempt and mutters a coarse version of a coarse proverb as the baffled nurse turns away."[51] Loane's description undoubtedly had an ominous ring for a readership imbued with the philosophy of individualism and the hierarchical relations between the classes. If social stability and the future of the nation depended upon the ameliorative influence of the middle class professional what would be the consequences of their failure to influence such charges?

Institute literature emphasized the need to instill an understanding in working class women that their appropriate duty lay in the proper bearing and nurturance of the nation's posterity. Articles in Nursing Notes asserted the centrality of the woman in the home, "the pivot on which all the little set of human machinery turns. . . . "[52] As in her commentaries on other aspects of working class life, Loane provided clear formulations for her readers on the appropriate role of the working class mother. Within the working class family, the duties of mother and father were to be strictly delineated. The husband's duty was to support the family, "to give moral aid and support, and in all times of special stress to supply such help as can be given without interfering with his primary obligation as the breadwinner." The entire duty of the wife, on the other hand, was "to nurse and tend her child and to acquire such knowledge and self-control as may be needful for this purpose."[53] Loane urged her readers to warn the women they worked among against anything which interfered with the function prescribed their sex. Above all, working class women were not to work outside the home.

> My advice to every woman who tells me that her husband 'has lost his job' and that she is going out to the laundry, or out charing, or back to the factory, always is, if your husband sits crying by the fire and says he cannot find work, sit down on the other side and cry until he does find it. Whatever you do don't ever earn money yourself. Better to feel hunger and cold sharply for a few days, or even weeks, than for you and the children to be half fed

> and half clothed for the rest of your life. That is what married women's labor means."[54]

Further, Loane argued that society would never remedy the high levels of infant mortality as long as the working class mother defied the "undisputed truth that whatever deprives infants of maternal care raises infant mortality, for nothing will replace a mother's devotion and watchfulness."[55]

The views on working class women articulated in Nursing Notes appeared to present a contradictory picture. While the leadership supported female suffrage as a means to participate in the movement for social reform and to gain equality, access to employment and a life not wholly confined to marriage, children and family, for the working class woman they advocated a life entirely restricted to those functions from which middle class women sought to be freed. Yet, for the leadership this position was entirely in keeping with their own world view. As members of different classes, middle class and working class women had different roles to play in the improvement of society. Middle class women had a duty to bring social and moral enlightenment to working class women whose "low ideals [and] inability to help themselves" made intervention from above necessary.[56] The two classes of women were seen to be involved in different aspects of the same task of "mothering the race". Social harmony would be achieved if women remained true to their respective functions in pursuit of a common good.

Although the leadership's class background provided fertile soil for their belief in the inequality of the classes, it was their exposure to contemporary ideas of philanthropy which influenced the leadership's definition of the proper relations between the classes of women. In the philanthropic and welfare literature of the late nineteenth and early twentieth century the poor were "generally pictured as coarse, brutish, drunken and immoral; through years of neglect and complacency they had become threats to civilization. . . . "[57] This philosophy was especially evident in district nursing--the prototype for much of late nineteenth century welfare work and the area with which the Institute leadership was most closely associated.

In the late nineteenth century, district nursing associations organized to provide nursing services to the poor had proliferated throughout the country. Upon determination that the applicant was deserving of help, a

nurse would attend the recipient at either no charge or a smaller fee than a private nurse would require. District nurses were expected to care for the sick, but they also had to ensure that the patient and the family were instructed in hygiene, cleanliness and domestic order. Commenting on their crucial role in this regard, an article in The London Times declared, "of the science of health . . . the district nurse [is] the most penetrating, pervasive, and influential missionaries . . . . She is a leavening and permeating influence of enlightenment just where it is most needed and where others cannot penetrate."[58] The benefits of this "science of health", however, were directed toward moral ends, ones which established individual responsibility as the means to social improvement. "The highest qualities which make for the building up of the character of the individual," Mary Minit, a Midwives' Institute Vice President and Council member wrote, "and so, necessarily, for the building-up of the character of the community of which the individual is a member, are what I may call 'self' qualities: 'self-knowledge', 'self-reverence', 'self-control' to which let us add 'self-help' and 'self-reliance'."[59] The terms upon which relief was offered had to reinforce the characteristics of which Minit wrote. "Any form of philanthropy which weakens these qualities in the object of it, which, in other words, does for a man what he should do for himself, is therefore bad."[60] A change of heart among the more feckless and ignorant of the poor could only be accomplished through the ameliorative influence of their social superiors. Reformers placed particular emphasis on the type of woman a district nurse should be. William Rathbone's Liverpool plan, for example, had required that district nurses "be drawn from a better class of society", that they "should be thoroughly trained", and "should work under a responsible organisation."[61] Minit concurred. The nurse should not be a working class woman, she warned, "for as a rule such women were lacking in the education and the moral influence necessary to enable them to command the obedience and confidence of their patients."[62]

The leadership believed that in their relationships with their working class patients, trained midwives would play the same reforming role as the district nurse. Through her scientific knowledge of antisepsis and her efforts to inculcate cleanliness and hygiene within the working class home, the trained midwife would contribute to a decrease in infant mortality and to the general improvement in the health of the nation. "For the sake of our future

men and women," one Nursing Notes article asserted, "surely everything possible must be done to impress on the mothers of the people the importance of the Common Rules of Health in Regard to their children. Who has such an opportunity for this as the midwife? . . . "[63] Articles likened the midwife to a missionary spreading the words of health and hygiene to the less fortunate and uninitiated. A December 1906 Nursing Notes editorial asserted, "It is as 'Health Missioner' that the nurse plays her most useful and ideal part in the world's work . . . by making herself a little centre of light and knowledge amidst the ignorance and misery she longs to mitigate."[64]

Yet midwives' attempts to improve the physical health of the working class would be meaningless without a corresponding change in working class morality. The leadership did not limit the definition of morality to sexual matters, but rather understood the term to include the entire spectrum of values which guided individuals in their determination of proper behavior. For midwifery reformers, morality was no less a concern of science than the pathological mechanisms of infection and disease. In fact, morality and science were inextricably linked. Cleanliness and hygiene could not be adopted without a simultaneous change in moral outlook. The September 1913 Nursing Notes quoted nursing leader Albinia Broderick that it was the duty of the nurse and the midwife, "As willing handmaidens of Science",

> to inculcate always and everywhere the principle of self-control and self-discipline, the steady discipline of young children in the home from early cradle days; to teach naturally the ways of nature to the receptive mind of the growing child--to remove ignorance and dirt, in short, wherever we may find it.[65]

When midwives taught cleanliness, they simultaneously taught the social and personal values reformers found essential for a well-ordered society--- self-discipline, self-control, and individual responsibility and initiative. While the Institute leadership believed that working class life would be improved by adopting these values, theirs was not a vision of social equality. Training the working class to accept their appropriate place in society as the Empire's factory hands, laborers and childbearers was a crucial aspect of the midwives work.

> The one gleam of hope in all this terrible nightmare, is the idea that we may be able to rouse the women of the poorer classes to a sense of their responsibility, to teach them to think of the future for themselves, for their husbands and children. This I am sure is the midwives' work. We want to make these women ambitious; ambitious, not to rise out of their own class, but to raise the standard of their own class to an altogether different plane.[46]

Ultimately, this was the leadership's social vision: a hierarchically ordered class society reinforced by a mutual agreement that each class had its proper place in the pursuit of common values.

The Trained Midwife: "What She is Expected to Be"

The leadership's conception of the midwife who could most effectively carry out the tasks which had been claimed for her was molded by the largely middle class image of the lay midwife on the one hand and by the leadership's professional aspirations, their class background, values and feminist Essentialist arguments on the other. In contradistinction to the powerful image of Dickens' lay midwife Sairey Gamp, the Institute projected an image of their own--the morally superior and socially responsible trained midwife. Where Sairey flaunted her penchant for gin, the Institute championed temperance; where Sairey's personal morality was in question, the Institute supported every institutional and legal means possible to enforce their standard of personal and sexual morality on all registered midwives. Where Sairey was always on the lookout to turn a penny for herself, the Institute lauded service and self-sacrifice; and where Sairey confidently proclaimed her expertise, the Institute insisted upon submission and humility before the medical profession. In Essentialist terms, Sairey was not even a woman, but a freak of nature. As Sairey's opposite and clearly in step with the broader intentions of the maternal and infant welfare movement, the morally and culturally superior trained midwife would take her rightful place as the primary attendant in normal midwifery.

By insisting upon temperance among midwives, the Institute aimed to draw an immediate line between the trained practitioner and the drunken and therefore disreputable Sairey Gamp. Sairey's association with alcohol reflected the place that it played in working class life. For the midwife, being included in such family celebration rituals as "wetting the baby's head" were both her due for the help she rendered in a time of uncertainty and worry and an indication of her standing with the family she had attended. Alcohol in some form was often used to get the "milk to come down", or to warm a weak or sickly baby. Since alcohol made up a vital part of working class culture for both men and women, it was predictable that it would gain the attention of middle class reformers. Reformers believed that not only was alcohol detrimental to working class health, but it was responsible for much of the nation's infant mortality, because, as one Nursing Notes correspondent claimed, "The effect of alcohol is to undermine will power, destroy the intellect and take away moral responsibility."[67] So that midwives might remain above any association with the immoralities of alcohol or the iniquities of its effects, temperance supporters advocated total abstinence. In 1910, with Council support, Institute members formed the Certified Midwives Total Abstinence League. Having pledged themselves to total abstinence from alcohol, the group urged practicing midwives to convince their patients to do the same.[68]

Sexual immorality ran a close race with drunkenness as part of the image of working class midwifery. Dickens did not embroil Sairey in any sexual liaisons, but working class women's sexuality was widely regarded with suspicion by social reformers. In contrast, Institute literature identified the trained midwife an example of social purity. She "should be a pure minded woman," L. G. Moberly wrote, "she should go through life 'wearing the white flower of a blameless life'."[69] The Institute agreed with the Rules' stipulation that a woman provide verification of her "good character" as a prerequisite for admission to the Midwives Roll. The midwife with the appropriate character brought with her a higher standard of morality, a woman's standard of morality, to the work. As such, by force of both her example and her belief, she could counter the sexual viciousness so prevalent in working class homes and from which stemmed venereal disease, child abuse and infant mortality.

The controversial case, Mary Stock v. the Central Midwives Board, revealed that sexual purity not only separated the trained midwife from the Gamp, but was, (like temperance), an integral part of the leadership's claim for the trained midwife's privileged access to the market for normal midwifery services. In July 1914, the Board struck Mary Stock, a CMB midwife, off the Roll for misconduct. There had been no complaints about the quality of her work as a midwife. Instead, Stock had been charged with having a child and subsequently living with a man who was not her husband. She had left her own husband two years before and had worked as a midwife to support herself and her two children. Claiming that the Board had committed irregularities in the course of its deliberations, Stock won her appeal against the Board's decision in High Court. To the Institute leadership, the High Court's decision jeopardized the standing of trained midwifery and they quickly moved to place their disapproval on the public record. In defense of their position, a Nursing Notes leader quoted extensively from a sympathetic Lancet editorial which had criticized the Court's support of Stock's appeal. "Those enjoying unique and exclusive rights should be beyond question worthy to enjoy them," the editor of the Lancet argued, "and in the case of midwives the privilege must be thoroughly deserved by the possession of an unblemished character. . . . "[70] At the same time, the leadership sent a memorandum to the Central Midwives Board supporting its original decision to remove Mary Stock from the Midwives Roll (despite the fact that this was only accomplished by breaching the customary rules of evidence) and requesting that the Board continue "to support the moral as well as the professional status of the practicing midwife."[71]

While temperance and sexual purity was used to define the trained midwife as morally superior to the working class Sairey Gamps, it was in her spirit of service and self-sacrifice that the trained midwife was most "womanly". Florence Nightingale had incorporated Essentialist ideas when she described the product of her own reformed nursing programs. "To be a good nurse", she wrote, "one must be a good woman, here we shall all agree. . . . What makes a good woman is the better or high or holier nature: quietness, gentleness--patience--endurance--forbearance. . . ."[72] Miss Lückes, Matron of the London Hospital and a Nightingale protégé, agreed, that the best nurse was "a tender-hearted woman whose devotion to her work is inspired by a genuine love of, and satisfaction in helping, those who are in

need of what she has to give."[73] With the immediate experience of training in reformed nursing programs, many of the Institute leaders were undoubtedly influenced by these ideas. Of such attributes in midwifery, Catherine Wood, a prominent nursing leader and later a Vice-President of the Midwives' Institute echoed these ideas when she wrote, "we want to awaken the spirit of self-sacrifice and self-discipline, the giving of one's best for another which is the highest of all woman's privileges."[74]

The doctrine of service and self-sacrifice not only guided trained midwives to serve their patients, but defined the relationship between the physician and the midwife. The leadership believed midwifery to be "the inferior branch of the healing profession", and medicine to be midwifery's "natural leader and superior."[75] Like Florence Nightingale, Institute literature counseled midwives to assume a posture of deference and obedience to the medical profession. As in nursing, physicians and midwives performed their tasks within an appropriate division of labor. As Rosalind Paget told the 1910 Departmental Committee charged with enquiring into the working of the Midwives Act: "The Midwives' Institute's years of work have been constantly directed towards providing [a] trained midwife who knows when to send for the doctor. . . . "[76] The Institute demanded that trained midwives be treated with respect, but the leadership rarely (except during an occasional fit of pique) entertained the possibility that midwifery could challenge the medical profession on its own ground. Any suggestion that a midwife might be trained to perform the same functions as the physician was greeted with amusement. When a Dr. Patton wrote to the Board, for example, to inquire whether candidates for the CMB examination, "should be taught the operations for applying forceps, version, and stitching of ruptured perineum", the astonished Nursing Notes reporter wrote that the request, "was surely not intended to be taken seriously. . . . Whether someone had been amusing themselves at the expense of Dr. Paton or whether he was amusing himself at the expense of the Central Midwives Board, remained a mystery."[77] While midwifery reformers acknowledged that midwives' responsibilities exceeded those of the nurse, her legal and technical authority was always, like the nurse, circumscribed by the physician.

Temperance, sexual purity, self-sacrifice and submission to the medical profession were characteristics which separated the trained midwife from the Gamp. The leadership did not explicitly identify these characteristics with

women from a middle class background. Yet, they believed that midwives without the benefit of such life-long cultural and moral conditioning--those from the working class exposed to middle class values for only a short period of time during training--were quite likely to relapse into the familiar ways of the Gamp. Both nursing and midwifery reformers believed that no amount of training could overcome the deficiencies of a flawed character. "I speak now altogether of mental and moral qualities, not of training", Miss Murphy told her audience at the Association of Queen's Superintendents in the Northern Counties. "A nurse whose training has been deficient can have the gaps filled up, if she is willing. If her hospital training has been merely rough, it can be softened. But if she is slack, it is almost impossible to make a good district nurse of her,"--or a midwife either.[78]

The logical extension of defining character in this way led straight to the need to turn the practice of midwifery over to middle class women. In a paper delivered at the Conference of the National Union of Women Workers, Institute President Jane Wilson asked of her audience,

> Can we reasonably hope that a few months training given to an uneducated woman will dispel the habits of a lifetime? If we wish the poor to appreciate in daily life, the wonderful benefits of fresh air, soap and water and suitable food for the infants and young children, we cannot hope to do so by training a class of midwives who share their views and prejudices on these questions. There will remain for the next few years quite sufficient number of untrained women to carry on the old traditions: let us beware lest we increase that number.[79]

The midwife had a social role to play for which no amount of training could help her if she did not have the "character" for her task. "The rules of the Board distinctly define what a midwife is expected <u>to know</u>," Wilson continued, "wise selection will largely determine what in the future she is expected <u>to be</u>. . . ."[80]

The leadership's descriptions of the trained midwife and of her opposite, the Gamp, are the staples of British midwifery history. Yet, while each of these descriptions had elements of truth to them, neither were

accurate readings of the composition or characteristics of the women they purported to describe. The trained midwife and the Gamp were instead images which represented the complex of class values and professional motivations of the Institute leadership and their supporters. In Sairey, Dickens had created a caricature. He had exaggerated her features as a means to criticize not only the quality of midwifery attendance, but also the general quality of medical care available in mid-nineteenth century England. Yet to reformers, Sairey was not a mere literary device. The depiction of her characteristics were as real as if Dickens had sketched her directly from life. In reformers' minds, she *was* the lay, working class midwife. Sairey was all they perceived and found abhorrent in the working class: drunkenness, self-interest, and (equally important to these middle class women) manipulation and deceit when in the company of their social superiors. Thus, the reality of working class midwifery with which reformers were largely unfamiliar was confused with the fictional characterization of Sairey Gamp. Similarly, the trained midwife of which the Institute leadership spoke was also an image, a future projection of what should be: middle class, educated ladies with specialized training who regarded midwifery not merely as a means of making a living but as work directed toward social and political ends. The trained midwife represented more than an attendant armed with the knowledge of contagion, antisepsis and the limitation of her own practice. The trained midwife was a crucial part of the social improvement and moral uplift of the working class family. For this task she needed to be socially above and emotionally removed from the women she attended and she had to inculcate in the working class family, and the mother in particular, cleanliness, sobriety, self-reliance and an acceptance of their position in the social hierarchy.

Working from these diametrically opposed images--and not the flesh and blood reality of either trained or untrained midwives' lives and practice--the Institute fostered the perception that an irreparable division existed within the rank and file. One, the trained middle class midwife, deserved to practice; the other, the working class bona fide, had to be excluded. Prior to the passage of the Midwives Act, when untrained midwives practiced freely, these images helped to justify the legitimacy of the middle class trained midwife to government officials, the medical profession and middle class public opinion. At a time when both bona fide and trained midwives were

frequently drawn from similar backgrounds and faced similar hardship endemic to the working class population they attended, these images also served to teach trained midwives that their interests lay not with their bona fide colleagues, but with the future envisioned by the Institute leadership.

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Chapter 3

"Such Good Friends the Lot Of Them": The Rank And File Midwife and the Working Class Community

Midwifery reformers painted a picture in which responsibility for the country's high infant and maternal mortality rate was placed at the feet of ignorant working class mothers and untrained midwives. Painted in broad strokes, this picture acknowledged little of the daily struggle for survival the majority of working class women faced. With few resources, suffering from overwork, chronic ill-health and frequent and often debilitating pregnancies working class women lived, as Margaret Llewelyn Davies of the Women's Cooperative Guild wrote, lives "unimaginable to those who are born in the more fortunate classes of society."[1] Neither did this picture acknowledge--nor even recognize--working class women as human actors who struggled to maintain decent lives for themselves and their families. Even with the best of intentions social reformers had difficulty seeing past the significant differences between their own lives and those of the women they hoped to reform. They ignored the wider social context which placed limits on human choice among the working class and instead attributed working class behavior they considered deplorable to individual failing and immorality.

Yet, for the working class rank and file midwife--trained or bona fide--the reality was much different. To them, the women they attended were not the remote figures that they were to the elite. They were neighbors, friends and relatives with whom they shared a common culture and experience. Daily, they confronted poverty and its consequences not only in the lives of the women they attended, but in their own. This commonality of culture and experience among working class rank and file midwives and these women became the basis for an alliance between them, in defiance of the Midwives Act.

The Rank and File Midwife and Working Class Life and Culture

For many working class families, life at the beginning of the twentieth century was virtually a hand to mouth existence. Mrs. Pember Reeves wrote in 1913 that "The rent is too dear, the houses are too old or too badly built, or both; the streets are too narrow; the rooms are too small; and there are far too many people to sleep in them.[2] Limited budgets affected not only the housing but the amount and quality of food the working class could afford. Normal diets included "bread, and butter for breakfast, enlivened by some cheap cuts of meat on Sunday and purchases from the fried fish shop during the week, when funds permitted. . . . "[3] Despite these difficulties, working class families struggled, "in the face of brutally disheartening economic facts, to lead an independent, orderly, and less than brutal existence."[4] The line between respectability and ruin was a thin one. Any unexpected expense might plunge the family into circumstances worse than the one they already experienced. Through their emphasis on cleanliness, sobriety and skillful management of household resources working class families, and particularly working class wives, sought to maintain a level of social and personal stability in the face of their limited and precarious economic position.

The responsibility for managing the family's available resources customarily fell to the working class wife. If a woman had a "good" husband his pay packet was usually turned over to her; she, in turn, gave him back a small portion for his "pocket money". From the remainder she was responsible for paying rent, fuel, food, clothing and any other of the family's personal needs. Consequently, securing credit from neighborhood shops ranked as essential in survival. "It was known as tick", one woman recalled. "In fact some shops had a clock with no hands on--no tick here. But most shops did [give] credit. . . . In most cases it was neverending. It was never paid off. . . . you either owed the milkman, the coalman, the doctor, or you were in arrears with the rent."[5] Working class wives routinely supplemented family income with part-time or casual work, because it left schedules free for family responsibilities. Another way women supplemented their family's resources was to exchange needed services with other women in their street or

neighborhood.[6] In this way, working class wives built up a network of reciprocity with their neighbors which could be as crucial as money to their family's survival. [7]

Midwifery could provide a means by which working class women could contribute to the family income. Some midwives attended birth part-time for supplementary income, but others were often the sole support of their families. Midwife S- 's husband had been a collier who suffered from rheumatism and could no longer work. Midwife B--wrote: "tell Me What to do as i have got a husband Who as done No Work for 24 years and i have Worked and kep im no i ham stokp from going out." [8] Similarly, Midwife B- wrote: "I have no husband to depend on two little boys 14 + 15 years old, besides my work."[9] If a midwife only worked part-time, she could probably manage to combine caring for her family with her midwifery, but long labors and a high demand for her services could make her life hectic. A busy midwife could be up for nights on end. Midwife T- wrote to the Board that, "I had not seen bed for three nights. . . . " Midwife S- suffered from similar problems, "Nursing, cooking housework, shopping, everything that there never seems time. . . . "[10] As a result, her own family life could be disrupted and her children and husband forced to fend for themselves.

Yet other aspects of the work compensated for these drawbacks. Since midwives (and most doctors) rarely conducted routine ante-natal examinations, their responsibilities were generally limited to attendance on the woman while she was in labor and for the required ten days post-partum. Frequently, the woman's relatives waited until the second stage to summon the midwife. Until then, a woman relied on female relatives and friends to shepherd her through most of her labor; as one woman told her midwife, I "always bears all the pains myself."[11] The midwife could, to a certain extent, arrange the post-partum visits to the mother and her new infant around her own family's schedule and thereby avoid neglecting them for sustained periods of time.

In addition to the constant financial juggling, working class women were responsible for the eternal round of cooking, cleaning and washing necessary to keep a family going. Middle class social reformers repeatedly

claimed that working class women were insensitive to hygiene and cleanliness. Yet, given their poor housing conditions, limited resources and inadequate facilities for cooking and washing, working class women's efforts seem all that more remarkable. The process of washing, cleaning and cooking was backbreaking. A line of clean clothes could take as much as full day to accomplish.

> In houses without heated copper boilers, water was boiled first on the stove and then transferred in buckets to the copper. Even with a proper boiler the laundress was usually saddled with the task of filling it by hand. In went the clothes, having soaked, perhaps, overnight, in went the soap and the soda. Out again, and into the dolly-or peggy-tub, a wooden contrivance with mallet which was used to thump the clothes clean. Then, finally, to the line which, on rainy days, would be strung in the kitchen.[12]

Household cleaning and maintenance was not only equally as strenuous, but made the cleaner herself dirtier than her object of attack. Finishing the stove with blacklead, "fills her nails and pores with a filthy mixture of grease, lead and soot, and coal dust."[13]

Middle class midwifery inspectors were horrified if they arrived at a midwife's house and found her up to her elbows in soap suds or blacklead. Accused of being dirty, Midwife B- wrote to the Board that when the Inspector visited, "I had been washing all day + I had started to clean up + black lead."[14] Another wrote,

> I have always carried out my duties as a midwife in a scrupulously clean way, it has been necessary when at home to change my clean dress etc as I have had my household duties to on account of having my Daughters 5 children (who are orphans) to bring up from Babies. Therefore it is impossible for me to be always dressed up in uniform when Miss B- called . . . . fromerly she came without letting me know and has found me cleaning the

> floors or washing the childrens clothes but not with collars and cuffs on or a white starched apron which she seems to think very wrong--she says the house was not clean.[15]

Such statements revealed the considerable differences between the life of the more privileged Inspector who frequently had no family responsibilities and that of the married working class mother and midwife.

A working class woman's reputation was frequently judged on her housewifery abilities. Working class women felt a certain pride at a clean table, stair or doorstep despite the backbreaking drudgery of the work.

> They [the stairs] were wooden, and the table tops were wood with polished legs, but it was who could have the whitest table top. The stairs were scrubbed every day, they shone snow--white, the wood spotless. The table tops were white. Now after this washing-day, all this lovely soapy water, they used to do all their heavy cleaning with it. The floors would be washed. . . .Then there was the toilets outside in the yard. They had a long board with the whole in the middle, and that had to be scrubbed snow white. They used to pride themselves, they were really clean.[16]

> You sort of had to wash your step, then wet. . .the sandstone, like you do a pumice stone style, sand it along right on the edge and then you had to get your fingers and go nice and smooth. . .[I] used to love scouring those steps. It's a work of art, you know.[17]

Standards were exacting. "I can mind the first time I done the stair," one woman recalled,

> I was sorry I ever offered. It was a wooden stair, you see. Here I hadnae done it to my mother's liking and she oot and looked at it. She says, 'No Ina! That's no right. No. You'll get a knife wi'ye and

> you get into the corners.' I says, 'Well I didnae know I had to dae that.' 'Well', she says,'You do a thing, you do it right."[18]

The importance of cleanliness to a working class woman's reputation probably accounted for the indignation rank and file midwives expressed when accused of uncleanliness by a midwifery inspector. Charged with being 'unclean', Midwife G-- wrote to the Board in 1919, "I can say that in the 33 years I have worked I have never had such a thing said about me."[19] Another midwife wrote, "Well I must say that it is a falsehood as to me being Filthy as reported by Dr.-- at Chester I have lived in this Village over 40 years and was always considered clean."[20] To say that a midwife was unclean was a direct attack on her standing in the community.

While pregnancy and labor were commonly regarded as normal events in a woman's life, poverty and its effects brought special risks to working class women and their children. Struggling to make ends meet, working class women were often overworked. One woman recalled in a letter to the Women's Cooperative Guild: "The first part of my life I spent in a screw factory from six in the morning till five at night; and after tea used to do my washing and cleaning. . . . I took in lodgers and washing, and always worked up till an hour or so before the baby was born."[21] Poor nutrition was common. If a woman could not make ends meet and she could not obtain credit, the burden of austerity frequently fell on her. Feeding her husband first and then the children, the working class wife often went without. One woman recalled, "Looking back, I remember that we children never expected mother to have dinner. She always took a bit of bread. Now it has come to my own turn and I don't like it."[22] Poor housing conditions also played their part in poor maternal and infant outcomes. One midwife reported that in the case of a December delivery, she had returned to the house to find "the mother sitting up in bed with the child with nothing on its head and the bed was quite close to the window and one of the panes were out. . . ."[23] Years of virtually uninterrupted pregnancies exacerbated working class women's poor health overshadowing and limiting their lives rendering "a healthy bodily and intellectual life impossible."[24]

From these conditions flowed high levels of infant and maternal mortality and chronic ill-health and developmental problems among the survivors. In Maternity, a compilation of letters from married working class women in the Women's Cooperative Guild, the effects of these appalling problems are evident. "Nothing could be more significant", Margaret Llewelyn Davies wrote in the introduction, "than the bare fact that out of 385 women who have written these letters, 348 have had 1,396 children, 83 still-births and 218 miscarriages."[25] One woman wrote to the Women's Cooperative Guild, "I can only look back now on the terrible suffering I endured, that tells a tale now upon my health."[26] Midwifery reformers interpreted the stoicism which working class women exhibited in the face of these conditions as a lack of attachment toward their children, but there is little evidence to support their view. "She buried some. She had them too often. . . ." one woman recalled of her mother. "I can remember her carrying that little coffin with the baby in. . . . She said that every baby she saw she wanted to snatch. She would have stolen anybody's baby to fill that want. She had all those, but she wouldn't spare one. "[27] While working class women accepted the loss of their children as an inseparable part of their lives, there is no reason to believe that they did not suffer as a result.

Midwives also had to confront the tangential effects of a life lived on slim resources. Money and drinking were the most frequent cause of the quarrels, and even physical violence, which erupted between husbands and wives. One woman wrote that "if her husband saw how much money she was borrowing he'd 'hammer' her."[28] The effects of drinking touched both midwives' work and their own personal lives. One midwife wrote to the Board that the husband of one woman she attend came home drunk and was later arrested for "illusing her and tried the same day."[29] Abusiveness brought about by drink could affect midwives as well. Midwife P-- convicted of using bad language--"ordinary bad language" as her daughter put it--against her physically abusive husband wrote to the Board,

> i shouted back a bad word & said if he did hit me again i should give it to him with his b bottle he had been having alot of beer in the day but i have

> had a sore life or it especially since my two sons have gone to France they have been gone two years if could let you see the letters from them to me saying how they have missed such a good & faithful hardworking mother wich I have always been i should not have stayed with my husband so long only for the dear children.[30]

Similarly when Midwife R- was censured by the Board for not attending the mother and infant for the required ten days. Her defense was that she "had quarrelled with her husband and was leaving her home."[31]

Institute temperance advocates would have regarded the drunkenness and abuse of such scenes as typical of working class life. Yet, for many working class families differences existed between having a drink and habitual drunkenness. Having a drink was part of social life; habitual drunkenness harmed the family and brought the street or neighborhood into disrepute. [32] Drinking was a normal part of working class life for both men and women. Ellen Ross found that in the East End of London, drinking and going to the pub were part of working class women's social life. As the daughter of one Edwardian working class mother recalled, "Mothers' day they used to call Monday . . . it was Monday they seemed to go out and have a drink together. . . .They's have a--perhaps one or two drinks--come back and start dancing."[33]

As participants in one of the most important of family events and as members of the working class community, rank and file midwives exhibited similar drinking habits to their friends and neighbors. Midwives were often encouraged to partake in the ritual of "wetting the baby's head", the traditional toast celebrating the baby's birth. One midwife wrote, "They offered me a drink in the house at the confinement . . . . they entice you to have a drink."[34] This particular midwife declined the offer, but some midwives did not. Drinking might also follow a period of stress in the midwife's life. Mrs. H-- was found by her midwifery inspector "lying on a couch in a cloak and a very dazed condition. She smelled strongly of drink. . . ." Mrs. H-- replied to the Board that she "had just come home from seeing my son away at the station. I was very upset at him going away."[35] That

a midwife had a drink did not mean, however, that she necessarily allowed a social practice to turn into habitual drunkenness. At least one Medical Officer of Health (MOH) discredited this notion when he wrote, "I can emphatically say this is unjust, having paid a good many surprise visits, and never seen a sign of such a thing."[36]

Financial worries, household responsibilities, the stresses and strains of childbearing and childrearing and the social activities which helped working class women forget these problems, formed the common culture of rank and file midwives and the women they attended. Rank and file midwives, as part of this culture, were able to see what the Institute leadership, influenced by their own class limitations, were unable to see: a culture which exposed both strengths and weaknesses, but which thrived despite the poverty which shaped it.

A Relationship of Equality

The relationship between rank and file midwives and the women they attended was molded by their common experience as working class women, wives and mothers. The problems faced by the midwife's neighbors and her friends were her problems too. As their equal, there was little basis for the rank and file midwife to put on "airs". She often followed her instinct to help a family in trouble before she worried about the law or the restrictions of the Midwives Act. In return, she earned the respect and the loyalty of the women she attended.

Many midwives had lived in the same neighborhood for years. Mrs. T--, who had trained at Manchester Maternity Hospital and had practiced for many years, described her "practice, in a populous district, the neighborhood in which I was born. . . ."[37] Over the years these midwives attended hundreds of labors and knew the women they attended throughout their lives. Mrs. D-- was probably not unusual. Over a period twenty-seven years, she had attended one woman six times and another, seven times over a period of twenty-one years. [38] Elizabeth Roberts found that midwives could be as close

as friends with the women they attended. "She used to have these midwives come," one woman recalled speaking of her mother, "and they were such good friends the lot of them."[39]

Of course, midwives' relationships with the women they attended were not immune to friction or even conflict. Midwives and the woman's relatives clashed over a variety of issues, often related to the authority over the laboring woman and the newborn infant. Mrs. M-, a bona fide midwife, recounted that she found the woman on the third day, "fully dressed in the room smoking and drinking. . . .They would not listen to anything I said to them. . . .They are a most untruthful lot of people."[40] Another wrote, "I told them to take care of him if they had done as I told them and look after the child in a proper way and kept the child clean it would went on all right."[41] Neither were CMB midwives immune from these battles. When the woman she attended lodged a complaint against her with the LSA. Mrs. F-- wrote an angry rebuttal to the Central Midwives Board. "Her own object from the beginning," she contended, "has been compensation for her own dirty neglect."[42]

Despite such ups and downs that neighbors might experience or conflicts might create, in general midwives' relationships with the women they attended were characterized by a natural familiarity which contrasted with the more distanced and formal ideal promulgated by the Midwives' Institute and the medical profession. Midwives would often stop and talk in the street with the women they attended to inquire after the baby or about the woman's health. Or they would stop and pay a "friendly visit" to see how the family was getting along.[43] Women judged their midwife by her kindness and strength in the face of the simple, but fearsome process of childbirth. A woman knew she faced real dangers. By the time of her labor she had heard many stories of her neighbors' travails. Family and friends around her helped, but nothing could replace the steady nerves and the comforting hand of an experienced midwife. A midwife was appreciated who did not judge, but accepted the woman and her family for what they were. "i do not like . . . to be treated as a pauper if i am poor," one woman wrote to the Board in the defense of her midwife. "i have had mrs. M- this last five times and have

always been quite satisfied with her and if i have any more i do not want any body else only mrs. M- to attend me. "[44]

Both trained and bona fide midwives were known to risk the loss of their certificates or lay themselves open to criminal prosecution to help the women they attended. It was not uncommon for midwives to falsify birth notifications, for example. Insurance companies paid out less in burial expenses on an infant that was born alive and died than they did on an infant that was stillborn. Midwives would register an infant that had been born alive and died as stillborn so that families could claim the higher benefit from the insurance company. At her hearing before the CMB, Ethel Irwin (a CMB midwife) "acknowledged the charge and took upon herself full responsibility for her action, saying . . . that no pressure had been put upon her, but that she had done it to save the mother the expense."[45] Giving similar reasons, Charlotte Downsell (also a CMB midwife) told the Board that she "acted out of sympathy with the parents who were very badly off. . . ."[46] Midwives were also implicated in cases of abortion. In the absence of effective methods of birth control and the high cost of those contraceptive devices there were, abortion was a common means by which working class women attempted to control their fertility. When things went wrong, the midwife was often the only person a woman could turn to for help. Physicians charged fees which often beyond the reach of working class women and they were more likely to involve the police. Although the CMB required that a midwife call a physician in all cases of abortion or suspected abortion, some midwives did not comply with this rule. "Everything had come away", Mrs. T-- recalled of a woman who had come to her suffering from the effects of a self-induced abortion and because she "wished to spare the patient the expense" she didn't call in a physician.[47] Mrs. B-- gave similar reasons for her decision not to call in a physician. The woman who came to her "said Oh Mrs. B- what shall I do my husband had not had any work for weeks. I said never mind as everything is away I think we can manage without a doctor."[48] Others appeared to purposely mislead the police. Questioned several times by the police and the LSA as to her knowledge of the circumstances surrounding the abortion performed on the woman who came to her for help, Mrs. A--

apparently helped to make a confusing case even more so. "It would appear", the LSA in its report to the Board, "all concerned had conspired to hush up the whole proceedings to protect, if possible, the patient."[49]

Rank and file midwives were often getting into trouble with the local authorities and the Central Midwives Board for one reason or another. Families tended to overlook any alleged incident of wrongdoing when rank and file midwives conformed to their cultural expectations. More important to them was their own experience of comfort and care they had received at her hands. Of Midwife S- one woman wrote, "I therefor know her trouble and downfall; but non the more for that I had the best possible attention that I could wish for, when I needed it. . . .[50] Two women wrote to the Board on behalf of their midwife pleading to have her reinstated so that she could attend them. "We know", they wrote, "that some time she was very worried and that caused her to fly to the drink in a moment of weakness, but we are quite convinced that she has seen the folly in it. . . .We have every confidence in her motherly patient and skilled attendance. . . ."[51] Women and their families were known to go to considerable lengths to defend their midwives. The support which rank and file midwives received, even when they were brought before the Board for a violation of the Rules, testifies to their importance in the community. Neighbors submitted petitions to the Board filled with hundreds of signatures testifying to the midwife's good character. In the case of Mrs. E--, an LOS midwife, the sequence of addresses listed by petitioners implies the 200 names collected on her behalf were solicited door to door.[52] In the case of Mrs. H--, the signatures appear to have been randomly solicited from 300 families living on 22 streets.[53] The July 1909 issue of Nursing Notes could not ignore the lengthy trial of Mrs. Pittman, a bona fide midwife from Somerset who submitted a petition with 3,000 names and attached testimonials. [54]

The mutual respect and affection between rank and file midwives was laudable, but was this offered at the expense of quality midwifery care? The Institute argued that if was and that the bona fide midwife provided the worst care of all. Yet, reports from the local supervisory authorities frequently testified to the merits of bona fide midwives' practice. In his 1914, the County

Medical Officer of Health for Northamptonshire, for example, reported to the CMB,

> Though not used to technical terms, it astonished me very often the amount of practical knowledge they possess, and the self-reliance they show. Most of them always welcome being shown and told better methods than their own though, of course some of them are quite illiterate and think the Midwives Act all fuss, they nevertheless endeavor to comply with the rules.[55]

Other officials agreed. The Lancashire LSA reported that many of their bona-fide midwives,

> appear to understand the rules of the CMB fairly well; they had pride in some cases in showing their bags and appliances. . . . The majority of registers are intelligently kept, though not always entered up to the last case: this is not surprising as in many instances the writing has to be done by relatives. . . . the majority were anxious to learn and always seemed to welcome her [the inspector] visits.[56]

One Inspector wrote that the key argument used against bona fide midwives--that their practice put parturient women at a higher risk for puerperal infection--did not hold up. Between 1907 and 1918 bona fide midwives in her district consistently registered a maternal mortality rate in their practices of 1.9 per 1,000 births, a rate considerably lower than the national rate of 3.3 per 1,000. "These figures show the lowest death rate among mothers attended by the very women that the Midwives Act, 1902 was passed to do away with. . . . How is it?, " she asked, "These women were old, illiterate (many could not read or write) . . . points in their favor were that they had infinite patience, powers of observation, and left Nature to do her own work."[57]

In comparison to today's midwives, the bona fide may seem like a poor substitute for the "ideal" which the Institute promoted. But judged in the context of the absence of affordable medical care and general practitioners'

limited medical training in obstetrics, bona fide midwives provided a needed service. Grounding in the theoretical material which the CMB training provided--the principles of contagion and the means to combat it with antisepsis, instruction in simple procedures such as temperature taking, the use of boracic acid and methods of record keeping--would have improved their ability to care for the women they attended. Yet, that their practice could have been improved did not nullify the contribution they did make in keeping midwifery safe and responsive to the needs of the parturient woman and her family.

The relationship of equality which rank and file midwives--trained and bona fide--shared with the women they attended reflected a common cultural background and experience. While subject to the stresses and strains which appear in any relationship, it was characterized by mutual loyalty, respect and, in some cases, real affection. It was rooted in the most fundamental and most powerful of human events, childbirth, and was strengthened by years of close association, common travails and shared social rituals. Defined by working class experience, this relationship between rank and file midwives and the women they attended represented a resilient and formidable bulwark against attempts by middle class social reformers to undermine working class control over their health, their culture and their personal lives.

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4. Meachum, 29.

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7. For the excellent article on women's exchange networks, see: Ellen Ross, "Survival Networks: Women's Neighborhood Sharing in London Before World War I", History Workshop Journal, 15 (1983), 4-27.

8. Great Britain, Central Midwives Board, Penal Committee. 1905-1919; 009, CMB, 1910. For a discussion of this source, see Appendix. The citation designates the case number of the midwife, her certification and the date she was called before the board. Number have been substituted for the names in accordance with the confidentiality requirements of the United Kingdom Central Council which was kind enough to allow me access to the files. Hereafter these files will be cited by the assigned number of the case, certification and date. In the quotations from these files I have not changed the language, the spelling or interrupted the flow of the statement by using (sic).

9. 072, CMB, 1916: Also, 022, CMB, 1915 who had to support her war wounded husband; 017, CMB, 1913, who had to support her child born outside of marriage; 048, BF, 1919; 025, CMB, 1915; 014, Hospital, 1912; 056, LOS, 1913; 068, Hospital, 1909.

10. 057, LOS, 1915; 067, Manchester Maternity, 1908: For the similarities with the unregistered handywoman, see: Bob Little, unpublished Master's Thesis, University of Sussex, 1983, 34-73).

11. "Rhoda Rose", NT, September 9, 1919, 1909.

12. Quoted in Meachum, 89; see also, Roberts, 126-129.

13. Quoted in Meachum, 89; The ingredients for blacklead were combined to make a kind of paste. Once the stove had been cleaned the paste was spread over the cooking top to protect the surface. Thanks to my mother Ann Heagerty – who certainly did her fair share of blackleading growing up – for this description.

14. 072, CMB, 1916.

15. 048, BF, 1919.

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18. Quoted in Lynn Jamieson, "Limited Resources and Limiting Conventions: Working-Class Mothers and Daughters in Urban Scotland c. 1890-1925", in Jane Lewis, ed., Labour and Love, Women's Experience of Home and Family, 1850-1940 (Oxford: Basil Blackwell, 1986) 53.

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33. Quoted in Ross, 12.

34. 056, LOS, 1913.

35. 056, LOS, 1913.

36. "The Act in the Country", NN, March 1907, 40.

37. 067, Manchester Maternity, 1909; for other examples, see: 005, BF, 1909; 015, BF, 1912, ; 038, BF, 1917; and 011, CMB, 1911.

38. 041, BF, 1918.

39. Quoted in Roberts, 107.

40. 037, BF, 1917.

41. 003, BF, 1908.

42. 027, CMB, 1916.

43. 045, BF, 1918, who was called before the Board for failing to notify the local authority that she had advised a woman to call a doctor for her infant's inflamed eye; 028, CMB, 1915, who had failed to notify the authority about an infants eyes after she, "paid a friendly visit (to the mother) before I left the district."

44. 048, BF, 1919.

45. "Central Midwives Board (Ethel Irwin)", NN, July 1916, 160.

46. "Central Midwives Board, (Charlotte Elizabeth Downsell)", NN, July 1915, 176; "Central Midwives Board (Elizabeth Lloyd)", NN, May 1914, 140, who simply stated that she had falsified the certificate, "in order that the father might claim the money from his Insurance Society." For examples of others who paid more attention to the parents needs than the Act's demands regarding certificates of still-birth, see: "Midwives and Still-Births", NN, February 1909, 27; "Central Midwives Board (Maria Penfold)", NN, January 1910, 16; "Central Midwives Board (Sarah Dean)", NN, January 1911, 16; "Central Midwives Board (Jane Harvey)", NN, January 1914, 16; "Central Midwives Board (Alice Louise Roadnight, CMB certified)", NN, July 1917, 120; "Central Midwives Board (E. Miller)", NN, August 1908, 159.

47. 019, BF, 1914.

48. 047, BF, 1919.

49. 063, BF, 1918; See 072, CMB, 1916; Two others were suspected, but not convicted: 062, LOS, 1918; 066, Salvation Army, 1908. For examples in Nursing Notes, see: "Central Midwives Board (Annie Marion Sadler)", NN, August 1911, 201; "Central Midwives Board (Mary Ann Pickering)", NN, September 1911, 226; "Central Midwives Board (Jane Brook)", NN, July 1912, 196; "Central Midwives Board (Sarah Carford)", NN, January 1908, 11.

50. 057, LOS, 1915; see also: 038, BF, 1917; 048, BF, 1918.

51. 057, LOS, 1915.

52. 065, LOS, 1919.

53. 033, BF, 1918.

54. "Central Midwives Board, NN, July 1909, 140, After this spectacular show of support Frances Champneys, chair of the penal committee, was quoted as saying of Mrs. Pittman that it "appeared that she was more stupid than willfully neglectful".; See also "Central Midwives Board", NN, February 1918, 30, Charlotte Risebrook, a bona fide midwife, who submitted 340 signatures in her support.

55. Central Midwives Board, The Work of the Board Ending March 1914, 9; See also: Central Midwives Board, The Work of the Board Ending March 1911.

56. "The Act in the Country", NN, March 1907, 40.

57. "The Toll of Motherhood", NN, March 1931, 36; See also: "How the Act is Working in the Country", NN, December 1904, 193; "How the Act is Working in the Country: Northamptonshire", NN, November 1904, 172; "How the Act is Working in the Country", NN, March 1905, 38; "The Act in the Country", NN, March 1907, 40.

Chapter 4

Reassessing the Guilty: Discipline and the Central Midwives Board

The Central Midwives Board Rules of Practice were the expression of the professional interests and the class goals of the Board members and their constituents. By strictly defining the scope of the midwife's practice, the Rules prevented the midwife from encroaching upon the territory of the physician. As she was bound to call him in the event of an emergency she served as a convenient conduit to the working class obstetrical market. The midwife was no longer to answer to the wishes of the working class mother and her family, but to the requirements of the Rules and the middle and upper class hierarchy of the Local Supervisory Authority and the Central Midwives Board. At the same time, the midwife herself was expected to conform to the moral and cultural standards of middle class social reformers, rather than those of the working class community in which most midwives had their roots. From this framework of stipulations and restrictions would emerge the ideal midwife: one who no longer placed the women she attended before her submission to the medical profession and her deference to social betters.

The imposition of this regime was neither a simple nor a straightforward process. The Board had to fight to impose its criteria of quality and appropriate behavior on the traditions and the relationships in which working class midwifery was embedded. In this struggle to transform midwifery, the powerful supervisory apparatus which the Act had created and the Board controlled was an indispensable weapon. The Board endowed itself and the Local Supervising Authorities with almost unlimited authority over the women they supervised. The Rules stipulated that LSAs were free to investigate any aspect of a midwife's practice, from following her on rounds, to questioning her patients, to investigating her living arrangements and her personal life. The Midwives Act had stipulated that for cases of alleged violations of the Rules to be prosecuted, the local authorities had only to prove a prima facie case against a midwife.[1] As a result, the greater burden of proof fell on the midwife and not the authorities. The Rules freed the LSAs and the Board from having to act only on judicial rules of evidence. The

Board strengthened its ability to convict accused midwives by allowing hearsay as a valid form of evidence. Probably most indicative of the Board's power lay in its relationship to the entire process itself. The Board not only formally charged the midwife and prosecuted her, but it judged her as well.

The dynamics of the Board's struggle with the rank and file over the practice of midwifery are clearly revealed in the original case files of the midwives called before the Central Midwives Board. Individually, each file offers a glimpse into the thoughts and beliefs of these rank and file midwives as well as their interpretation of the series of events which brought them before the Board. The official correspondence, reports and testimony contained in each of the files provides insight into the dynamics of local supervision and the attitudes of the Inspectors, the relationship between the midwife and the women she attended and between the woman and local midwifery officials. When placed together with correspondence, articles and reports from the nursing and midwifery journals the sample of cases drawn from the surviving CMB files not only give a demographic picture of these midwives brought before the Board. They also, reveal that the process of discipline, from the local authority to the Board itself, was shaped by the differing, and often opposed, expectations and life conditions of the rank and file and their patients on the one hand, and the Act's officials on the other. The files show that the Rules, formulated as they were to protect the professional and class interests of the Board members and their constituents, bore little relation to the actual realities of midwifery practice. The conditions of poverty in her life and the women she attended were often more responsible for a midwife's violation of the Rules than any willful disregard of their principles. Middle class local officials, with little experience of the true nature of these difficulties, were often unable (or unwilling) to differentiate between the deliberate resistance of a truly dangerous and incompetent practitioner and the objective limitations on a working class midwife who was trying to do her best for the women she attended. As a result, relationships between local officials and the midwives they supervised were characterized by friction and often outright hostility on both sides. The Board's liberal policy on evidence was widely and effectively used. Cases were brought against midwives and judgements were rendered by the Board on hearsay, coerced testimony, or sometimes on no evidence at all.

The Board and its supporters justified the Rules' restrictions and the extensive powers of the supervisory apparatus in the name of controlling the practice of the bona fide midwife. The files of the penal cases reveal that trained midwives were as much the target of the Board's discipline as was the bona fide. Trained midwives were neither exempt from the restrictions of the Rules nor were they protected from the wide ranging powers of the supervisory apparatus. As a result, trained midwives were as likely to be charged for violations of the Rules as were the bona fides. Out of 74 midwives 35 (47%) had received formal training and 37 (50%) were registered as bona fide (in two cases the midwife's training was not designated). Further, there was little difference in the judgements made against them. Only 2 (both CMB midwives) out of 74 midwives were cleared outright of any charges. Five more were let off only after intensive monitoring over a period of six months had uncovered no irregularities. The remaining 67 midwives (91%) were judged guilty of the charges against them. Trained and bona fides received the severest penalties--cancellation of their certificate--in roughly the same percentages. 58% of the bona fides in the sample and 54% of the trained midwives were struck off the Roll. The percentages were similar in the category with highest number of charges, "failure to advise and send for a physician". The Board cancelled the certificates of 55% of the bona fide midwives and 43% of the trained midwives accused of this charge. Regardless of training, rank and file midwives suffered equally at the hands of the Central Midwives Board.[2]

The CMB Rules and the Context of Midwifery Practice

The conditions of poverty in which most rank and file midwives worked prevented them from complying fully with the Rules' requirements. Midwives could do little about the larger questions which influenced maternal and infant outcomes, such as a woman's living conditions, her ill-health brought about by poverty, or even the lack of the seemingly simple provision of a change of clean sheets for the bed. Midwives were required to call in physicians for families who had no money to pay and who were often reluctant or even refused to accept the midwife's recommendation. Midwives were charged, cited and even removed from the Roll for outcomes which

they may have wished to change, but given the context of their practice they often had little ability to effect.

Midwives' own poverty could inhibit the extent to which they could comply with the Rules. Although many midwives made genuine attempts to adhere to these guidelines, the reality of everyday life could intrude. Midwives were required to wear certain kinds of clothing and have certain kinds of supplies, yet received no subsidy to help them acquire them. Midwives had to carry an appliance bag "furnished with a washable lining" and "an appliance for giving vaginal injections, a different appliance for giving enemata, a catheter, a pair of scissors, a clinical thermometer and a nail brush."[3] Midwives were required to wear washable dresses, "the sleeves of the dress made so that the Midwife can tuck them up well up above the elbows", a clean washable apron, and approved "efficient antiseptics for disinfecting the Midwife's hands, the skin of the patient, and the instruments."[4] Midwives were also responsible for acquiring their own medical aid forms and frequently had to shoulder the cost of posting the notification of medical aid to the supervisory authority. Altogether, a midwife's expected supplies represented an investment of significant magnitude and one which not all midwives could afford. A 1905 Nursing Notes article estimated the cost of these appliances and bag to be between 18 shillings and one guinea. Midwives were often cited for incomplete midwifery bags, broken equipment and washable dresses which although clean, might be stained and washed too many times to suit the midwifery inspector. Midwives were required to keep their homes clean, but were not to do the cleaning themselves. Stanley Atkinson recommended that a midwife should "keep her nails short, and preserve the skin of her hands as far as possible from chaps and other injuries."[5] Nursing Notes recommended that midwives "should avoid any very rough work, such as scrubbing, grate cleaning, or polishing. . . . "[6] Few could afford to have others do the cleaning for them.

The Rules held midwives responsible for the cleanliness of the women they attended but sometimes the poverty of the woman and her family made this requirement difficult to fulfill in the required manner.[7] Midwives were instructed to wash the woman's external genitalia and to remove "soiled linen, blood faeces, urine and placenta" from the patient and the house.[8] Nursing Notes warned its readers to "use plenty of clean linen, [and] insist on cleanliness on the part of the patient. . . . "[9] When she wrote the Board

explaining why one woman's bedclothes had not been changed, Mrs. L-- illustrated the difficulties midwives faced in complying with the cleanliness rule. "Mrs. H--" she simply stated, "could not supply the necessary change of clean linen."[10] How could a midwife find "plenty of clean linen" if a family only had one sheet and no money to buy another?

The Rules made midwives responsible for calling in medical help as soon as complications developed.[11] The midwife's ability to comply with this most fundamental principle of the Rules was informed by the family's financial resources on the one hand, and the willingness of the physician to answer her summons on the other. If they were poor, families were often reluctant to call a physician even if the midwife insisted. Complications requiring medical help, for mother or child, could have catastrophic consequences for the family's resources. "It is not sufficiently realized", one correspondent wrote to Nursing Notes,

> how often a poor mother, as the treasurer of the home's expenditure, pleads for delay in sending for medical help; it is she who knows how little there is to spend, and the position of the midwife has been rendered most difficult, standing as she did between the Rules laid down by the CMB and the urgent desire for delay on the patient's part.[12]

Although she had no means to make the family comply with the Rules, the midwife was nevertheless held responsible if a physician was not called in. In 20 of 51 cases in which "failure to advise and send for a physician" was the primary charge it was the expense of the physician's services which prompted either the family to refuse to have a physician or the midwife to delay in sending for one. In 13 of these, the family refused to have a physician even though the midwife had recommended that one be called. "She said she had not money to pay for other help," Mrs. C-- wrote to the Board, "but I had to insist. . . . "[13] Midwife S-- advised the family to send for help, "but the grandmother said that there was no money for a doctor."[14] A local doctor wrote on behalf of Midwife S-- that she had "advised the Doctor and the people promised to send for one. No doubt their extreme poverty . . . delayed their doing so."[15] In the seven other cases, the midwives' themselves made the decision. In the case of the death of a premature infant the LSA reported that the "Midwife did not see the necessity of sending for a doctor as the

patient was very poor."[16] Midwives' decisions were also influenced by the common knowledge that families who could not pay had difficulty in finding a doctor who would agree to attend even if the midwife verified the need for medical aid. "They do not meet their obligations as they might do," a physician wrote of the family involved. "Nurse T-- was acquainted with this fact, and as an immediate result it would be somewhat of a difficulty to obtain medical advice."[17] The consequences of such decisions into which working class families and their midwives were forced could be fatal. "She would have a doctor for The Child.", wrote Midwife H--, "but not for herself".[18] Both the infant and the woman died.

If a physician was called in and he refused to come, the midwife could be held responsible for the poor outcome which might result. Physicians' refusal to answer their summons was probably one of the most frightening and dangerous problems practicing midwives faced. One midwife wrote to Nursing Notes, "Eighteen hours elapsed after getting the order before the doctor attended. This woman died at 8:30 a.m. the morning following her admission to infirmary, and leaves two other mites beside the new baby, which is still alive."[19] The anxiety of wondering if the physician would come at all could be excruciating.

> It is dreadful to have to send to two or three before one will come. One Sunday I had a case of twins, premature; they were both asphyxiated. The husband went for eight doctors, but could not get one. The next day I went round to a doctor and begged him to come which he did.
>
> On Christmas day I had two cases at once, one a primipara with adherent placenta and inverted uterus. It was three hours before the doctor came, although I sent for him an hour after the baby was born. . . . I wrote two notices that time in case one would not come, and the first doctor would not come but the second did and then sent in a bill for a guinea, which we are almost unable to pay. The patient nearly died. In the case of the twins, they lived a fortnight.[20]

Technically, the CMB Rules protected the attending midwife against the consequences of the physician's actions, but there were cases in which the Board held midwives responsible nevertheless. Midwife R--, for example, called the physician the day of the birth, but he did not come until the next

day.[21] The physician Midwife F-- summoned did not come until three hours after he had been requested.[22] The infants concerned, eventually diagnosed with opthalmia, suffered permanent damage to their eyes. Both Mrs. R-- and Mrs. F-- were struck off.

Moreover, the Board also held midwives responsible for poor outcomes in their patients when it was actually the misdiagnosis or incompetence of the attending physician which was at fault. In seven of the 51 cases, the evidence in the files shows that responsibility for the outcome lay with the physician and not the midwife. In one case, upon the physician's instructions, the midwife had administered treatment to the infant's inflamed eyes. Yet the Board held the midwife responsible when the child's eyes grew worse and the physician refused to admit he had been involved in the case. In the six other cases, the physicians' misdiagnoses resulted in a poor outcome. Midwives L-- and C--, for example, fetched the doctor as soon as they found a rise in temperature. "He examined the patient," the Inspector's report recounted, "and told the midwife it was not Sepsis but the excitement that had upset the girl."[23] The woman died. The doctor called in by Midwife B-- in a case of suspected abortion signed a declaration that he did no know how to treat the woman believing that "a supper of fried eels on Saturday evening" had caused her symptoms.[24] The women died in five of these cases. The sixth recovered from puerperal sepsis. While it appears the physicians were not even reprimanded, the midwives involved suffered heavy penalties. Four of the midwives were struck off, two were severely censured and two were cautioned.[25]

Midwifery reformers argued that when women and children became sick or died, it was the midwife's negligence, her contempt for the Act and her overweaning pride in her abilities which were responsible. Formulated without reference to the actual realities of working class life the benefits of even the most beneficial aspects of the Rules--such as antiseptic procedures--were limited when the burden for compliance lay solely with families and midwives who were without the resources to comply.

Local Supervision: The Front Line of Enforcement

It was on the local level that the process of weeding out of those midwives who did not conform to the Rules' restrictions began. The local officials who enforced the Midwives Act, drawn as they were from exclusively middle or upper class, educated backgrounds, had little practical knowledge of the life of the working midwife or the families she attended. While arrangements varied from area to area, routine supervision was usually turned over to a midwifery inspector. It was her duty to ensure that midwives who had notified their intention to practice within the local authority's jurisdiction adhered to the Rules of Practice set down by the CMB. It was the inspector who determined if some breach of the rules had occurred, carried out the investigations and recommended a disciplinary hearing. In the early years of the Act, an inspector was likely to be a member of the local gentry, a clergyman's daughter or a relative of the local Medical Officer of Health.[26] Experience indicated the need for an official with professional training and increasingly women with certificates in health visiting, nursing and midwifery were employed as inspectors. LSAs continued to prefer "a lady", however, who (by her station in life) was accustomed to supervising subordinates.

Midwifery inspectors were notorious for their condescending and patronizing attitude toward the women they supervised.[27] Midwife D-- in her defense before the Board expressed the discomfort a working class woman could feel in the presence of an educated lady with the authority to take away her livelihood. The inspector, having visited Mrs. D-- (a bona fide midwife with 30 years experience) only once in the previous year, instructed the midwife to demonstrate that she could read a thermometer. Although she knew how to read a thermometer, Mrs. D-- became so upset that she gave an incorrect reading and was subsequently cited for being unable to perform this required procedure. "As to reading the Clinical Thermometer," the midwife wrote, attempting to explain her side of the story, "it was a very chill day and my glasses were not at and she certainly upsets me very much with her questions for she went so far as to ask if I had bed to lie on but I am glad to say that I have a clean one."[28]

Inspectors' reports were filled with judgements which were often more illustrative of their own values and assumptions than relevant evaluations

of the midwife's practice. Inspectors expected the women they supervised to treat them with deference and respect. Practicing midwives, particularly if they were older women and had been in practice for many years, often resisted what they interpreted as a younger, less experienced woman (and many times not even a trained midwife) merely putting on "airs". As a result, the relations between inspectors and midwives were frequently characterized by friction and hostility. Inspectors frequently registered their side of the story in their reports. Of Mrs. R--, (a midwife with forty years experience) the inspector complained, "always promises to improve. Difficult to deal with . . . properly satisfied with herself."[29] Another midwife, Elizabeth Harris, was characterized as "being sober and hard-working, but too ignorant and stubborn to improve by instruction."[30] Inspectors appeared to have evaluated a midwife's character according to the largely middle class standards of order, education and refinement. They found many of their charges woefully lacking in such attributes. "There is obviously some attempt to keep the house fairly clean," the inspector wrote of one midwife, "but Mrs. G-- lacks method."[31] Inspectors' reports frequently registered their frustration at attempts to instill these characteristics in the women they supervised. Inspector Hardy described Catherine Seabury as "dirty and hopelessly ignorant."[32] Inspector Merry Smith (an Institute member) described Elizabeth Patillo as "deaf and unintelligent; [Smith] had given her instructions . . . but she seemed unable to carry them out."[33]

Inspectors were known for letting their emotions and their authority get the best of them. Instances of inspectors' personal vindictiveness were common.[34] Letters from inspectors to Board members confirmed the practice of intimidation and harassment as a means of ridding the local authority of a midwife who had been judged troublesome. In one case the inspector "came herself," the midwife complained to the Board, "and urged me to resign saying I would be struck off if I did not do so."[35] Miss B--, the inspector and a prominent member of the Midwives' Institute, confirmed the midwife's charge, admitting, "I am most anxious to get rid of her."[36]

LSAs and their inspectors routinely used intimidation, slander and hearsay to build a case against a midwife who they suspected of violating the Rules. The initial investigations which LSAs conducted into a suspected midwife's practice often turned up little substantial evidence of wrongdoing. The reconstruction of events often relied either on the midwife herself or the

testimony of the women the midwife attended, the woman's husband or the relatives. Midwives rarely confessed (except when they believed themselves to be guilty). The families they attended displayed a marked reluctance to speak against their midwife and often openly resisted any attempt to make them do so. A Town Clerk wrote to the Board that, "This woman [the witness] I understand, has at various times when the Inspector of Midwives has called has been most abusive, and I anticipate some difficulty in obtaining her declaration. It is quite probable she will prove to be a hostile witness."[37] Neither the local authority nor the Board had the legal power to subpoena witnesses, so when faced with a patient's resistance local authorities often resorted to pressure and intimidation to secure their testimony. An inspector might visit a woman repeatedly each time trying to convince her to sign the statement against the midwife.[38] If she didn't have any luck at this, she might take the woman to the LSAs' office and talk with her there.[39] These meetings with middle class local officials were undoubtedly intimidating to the working class woman (and probably meant to be). Although local officials frequently encountered strong resistance from the women they questioned, they were often able to bring enough pressure to bear to secure the testimony. "After considerable trouble being met with direct refusal in the first instance," one County Clerk reported that he had ultimately been successful, and "Mrs. T-- had made an affidavit herein. . . . "[40]

To bolster the weaker cases, local officials attempted to discredit the midwife's character and thereby make her testimony and that of her witnesses less credible. The intimation that a midwife drank was probably the most common of this type of evidence. Based on hearsay and rumor it was extremely difficult to prove, but nevertheless could be very damaging to a midwife's cause. Evidence of a midwife's drinking could be submitted in a qualified manner, such as by the inspector who claimed that Midwife W-- had "certainly been drinking, though she was not reeling drunk."[41] Of Midwife C-- the Inspector entered as evidence, "It is said that this women drinks," but openly admitted that "I do not know if the statement is true."[42] In other cases hearsay, particularly when it came from a middle class source, was considered as true as fact. Local officials hounded Midwife P-- on the unfounded claim by a physician that he had frequently seen her drunk "in the streets, but not at a Confinement."[43] To strengthen this evidence, the inspector wrote to the Board that she had heard of Midwife P--'s "drunkenness" from the physician "five

years ago."[44] Since the two had been competing over patients for years the physician could hardly be considered a disinterested party. Nevertheless, both statements were submitted as part of the evidence against the midwife. Similarly, with no documented substantiation, the Medical Officer of Health asserted: "It is a well known fact in the neighborhood that Mrs. S-- is very much addicted to drink"[45]

As the front line of the Act's implementation, it is not surprising that local supervision was fraught with friction and turmoil. The problems between midwives and their supervisors were not only a matter of personal difficulties between individuals, but represented the clash of two different cultures and expectations. As officials of the Act, local supervisors were enforcing the goals of the Board and its supporters in every county and city in the country. This brought them into direct conflict with the traditions of working class midwifery and the intricate network of working class relationships, of which the one between the midwife and the family was one of the most important. Dismantling these "close barriers [which] are firmly erected and closely guarded by the poor," was an essential prerequisite to the Act's full implementation.[46] The extensive powers granted to the local authorities under the CMB Rules were only in keeping with this formidable task with which they had been charged.

The CMB: Enforcement Through Discipline

For the Central Midwives Board and its supporters, the Rules were the instrument by which they would be able to accomplish their professional and class goals. So intertwined was the instrument with the goals that any violation of one was considered opposition to the other. In the penal hearings, the Board's foremost purpose was not to ensure that accused midwives were given a fair and impartial hearing. It was to use the powers of the disciplinary process to remove any opposition to the Board's agenda for midwifery. In this context, customary judicial safeguards--such as established rules of evidence and the right to an impartial hearing--were irrelevant. Midwives were judged instead according to the Board's expectations of what a midwife should be and what role she was to play. Those midwives who would not or could not conform felt the full extent of the Board's powers.

While only a minority of midwives ever actually found themselves face to face with this highly educated, cultured elite of midwifery, nursing, medicine and government service, it was an experience widely regarded with dread throughout the rank and file community. Board chairman and obstetrician Frances Champneys was known to be a stern and fearsome judge. Reports of the penal proceedings in Nursing Notes frequently cited how Champneys rebuked midwives who were not, in his opinion, appropriately deferential to the social hierarchy or submissive enough to the Board's authority. Of Mrs. Ritman, a midwife with "an excellent record of over twenty-five years practice", who had presented a petition of over 3,000 signatures on her behalf, and who had been judged innocent of all charges, Champneys declared to all present at the hearing that "it appeared she was more stupid than willfully neglectful."[47] Champneys publicly made known his contempt for the midwives brought before him at the penal proceedings. For every, "conceited and reckless midwife who is too proud to advise medical help," he told his audience at the 1915 Annual Association of Inspectors meeting, "there are ten too stupid to be able to realize what failure to attend strictly to the Rules really entails, and whose main defect is absence of imagination and sheer stupidity."[48]

For the Rules to work, midwives had to submit to the authority of the supervisory apparatus and the medical profession. The attitude of the accused midwife to the Board's authority could make the difference between keeping her license and having it revoked. When Midwife Quinton protested the "lack of help and sympathy on the part of the Inspector", Champneys retorted that, "the Rules of the Board were to be obeyed, whether a midwife liked them or not; and that the superior officers were there to be obeyed whether a midwife like them or not."[49] Similarly, a midwife was never to exceed the authority given to her under the Rules even if circumstances demanded she do so. In the case of Mrs. Pocock, for example, who "evidently thought too much of her own opinion instead of doing what she was told," Champneys warned, "it was not for her to decide if it was a bad or a slight case"[50] Those women who expressed deference to the Board and acknowledged wrongdoing were more likely to be treated with leniency, regardless of the severity of their actions. Despite the fact that a child had gone blind from ophthalmia neonatorum under her care, the Board, due to the fact that "she had acknowledged her error, and in consideration of her good character" decided,

"not to strike her off the Roll, but to censure her severely."[51] Conversely, Champneys rebuked Ellen Kerens after the inspector reported that the midwife would not admit she was to blame. "Before re-admission to the roll," he stipulated, "she would have to prove, not only that she realized the enormity of her action, but of her own attitude toward it."[52]

The Board considered that a midwife's compliance with middle class standards of morality, whether that meant sexual, social or legal morality, was as essential as her submission to the authority of the Board and the medical profession. Without adherence to these standards, whether through belief or force, a midwife would refuse to carry out her role as the linchpin between doctor and parturient woman or the state and the family. Midwives who were reported for having given birth to children outside of marriage, for example, had their certificates immediately revoked. As Champneys warned one midwife, "Such conduct was incompatible with her continuing her work as a midwife."[53] In these cases, the Board did not concern itself with the midwife's abilities, but rather her "character", that is her behavior, her values, her comportment in daily life. In reply to Miss E--'s request to be readmitted to the Roll, the secretary replied,

> The Board will require a testimonial of penitence and present good conduct from persons who have known you both before and since you were removed from the Roll . . . such as the Reverend Mother of the Convent from which you write . . . and are acquainted with the reason which caused you to forfeit your certificate.[54]

The midwives charged with "immorality" did not appear from the evidence offered against them to have a history of sexual promiscuity. Their letters to the Board revealed that even as they pleaded for leniency they agreed with the standard of morality by which they had been judged and punished. Midwife F--, a CMB midwife, wrote,

> I must confess that I did not commit the sin in an innocent way for of course I did know right from wrong and I have suffered cruel for my sin but that is only what I deserve . . . . it was my fault of course that I gave way to him when he tempted me, but I never neglected my duty to my patient and I do not think as far as my nursing goes

> there was any fault with it or with anything until I misconducted myself in that way I have.[55]

Those who did not conform to the Board's standard of morality were cited with misconduct and almost always had their certificates revoked. Of the 14 midwives in the sample accused of this charge, ironically only two bona fide midwives were cited, both for drunkenness. On the other hand, five trained midwives were cited for drunkenness, four for sexual immorality, one for having been convicted of procuring abortion, and one for helping a woman to become a midwife who had given birth to a child outside of marriage. The remaining midwife, whose certification officials did not record, was cited for advertising her willingness to advise parents on venereal disease. All but two of the midwives were struck off.

The Board was generally disposed to extend greater sympathy to women whose class background or whose social connections were similar to those of its members. Leniency could be expressed in seemingly minor favors such as withholding the names of two midwives "removed from the Roll for lapses from the moral code; they both held the C.M.B. examination certificate." At a time when many rank and file midwives' names and their transgressions were published throughout the midwifery press, for these women, Nursing Notes reported, "The Chairman requested the press withhold their names in consideration for their friends."[56] The Board was almost deferential to Mary Jane Barrett, the middle class Institute member and Matron of the Monmouthshire Training School for Midwives, who had been brought before the Board on charges similar to many bona fides. At a time when even midwives proven innocent were often castigated by the Chair, and never offered an apology, Champneys judged that the Matron had, "obviously done all that ought to have been done," and regretted, "that they [the Board] were unable to defray the expenses of the witnesses for the defence."[57] Similarly, Midwife H--, a member of the Midwives' Institute, who had mistaken puerperal fever for hysteria, did not take the woman's temperature although the Rules required it, and stated her only reason for calling the doctor being that, "I felt I could not manage her any longer", was merely cautioned to observe the Rules. In her file was a letter from Paula Fynes-Clinton, the Honorary Secretary of the Midwives' Institute, who had

written, "It would give me great pleasure to hear that the Board has been able to judge her case leniently."[58]

Against those women who did not fit their criteria the Board exercised the full extent of its powers. Judgements were rendered on a wide range of evidence. Sometimes, the testimony, pattern of practice and the record of notifications clearly established the midwife's guilt. In other cases, however, judgements were rendered on far less. The Board did not require that evidence be substantiated. An official's claim that the violation had occurred was often proof enough. Although the midwife had denied the charge and the LSA presented no reliable witness Midwife D-- was severely censured on the Inspector's claim that the midwife had admitted to putting milk in a baby's eyes.[59] Similarly, Midwife B-- was struck off on the Inspector's claim that the midwife had told her that she had not washed her hands before examining the patient.[60] Midwife T-- was struck off on the Inspector's report that she had been practicing with a septic hand.[61] Midwife W-- lost her certificate on the claim by local officials that they had heard "that while in C-- . . . she has been keeping low company, and has been seen intoxicated."[62] Similarly, two other midwives were struck off who, while they had not had one problem with their practice, had been rumored to have been seen drinking.[63]

Midwives were frequently disciplined and struck off the roll on the basis of conflicting evidence or even no evidence at all. Although the witnesses had rescinded their coerced testimony and the LSA provided no other proof of the midwives' guilt, the Board cancelled both Midwife W--'s and Midwife Mc--'s certificates. Midwife L-- was severely censured even though the charges were based on an incident of puerperal mania which had occurred four months earlier, the woman she attended refused to testify against her, and the physician who attended the case could not remember the particulars.[64] Midwife H-- was severely censured despite her good record, the fact that the family would not testify against her, and that she had in fact called in a physician even though the family had opposed it. Nursing Notes reported that two midwives were struck off in June 1911 despite the fact that "very conflicting evidence was given" in one case, and "very little direct evidence was given in another."[65] Reports in Nursing Notes revealed just how fine the line could be between the evidence presented and the opinions Board members had formed in their own minds outside the boundaries of

that evidence. To Annie Broomhead, a midwife against whom the charges were not proved, the chair threatened that if, "she came up again before the Board on account of disobedience to the rules . . . her certificate would be cancelled and her name removed from the Roll."[66] Despite the conflicting evidence as to her guilt, the Chairman accused Midwife Smith of showing "herself careless in observing the rules and somewhat defiant, and that she gave the impression that she had been spoilt by the local Maternity Association. . . . "[67]

The formidable powers which the Board wielded so liberally were their primary weapon in their struggle to transform rank and file midwifery. That the Rules' irrelevance to the realities of midwifery practice made them almost impossible to obey mattered little against the Board's determination that midwives would learn to submit to the medical profession and the authority of their class superiors who supervised and disciplined them.

References

1. Great Britain, Laws, Statutes, etc., Midwives Act, 1902, 2 Edw. 7 Ch. 17. sec. 8. (2).

2. Great Britain, Central Midwives Board, Penal Committee, Case Files, 1905 - 1919; For a discussion of this source, see the Appendix. As noted in Chapter 3, the citation for this source designates the case number of the midwife, her certification and the date she was called before the board. Number have been substituted for the names in accordance with the confidentiality requirements of the United Kingdom Central Council which was kind enough to allow me access to the files. Hereafter these files will be cited by the assigned number of the case, certification and date. In the quotations from these files I have not changed the language, the spelling or interrupted the flow of the statement by using (sic).

3. "Rules Framed under Section 3 of the Midwives Act", Rules E., 2, quoted in Stanley Atkinson, The Office of Midwives in England and Wales (London: Balliere, Tindall & Cox, 1907) 74.

4. Rules E., 1.

5. Atkison, 72-23.

6. "Practical Notes for Practicing Midwives", NN, June 1907, 89.

7. Rules E., 10 and 11.

8. Rule E., 10.

9. "Practical Notes for Practicing Midwives", NN, July 1907, 106; August 1907, 121.

10. Great Britain, Central Midwives Board, Penal Committee, 015, BF, 1912; Also, 033, BF, 1918.

11. Rules E. 18-21.

12. "Local Government Board Circular: Medical Aid", NN, October 1907, 157.

13. 052, LOS, 1908.

14. 012, BF, 1912; 005 BF, 1909.

15. 020, BF, 1914; 027, CMB, 1916, where the woman waited six hours before she sent for the physician; 055, LOS, 1913; 003 BF, 1908, the woman waited two days before calling the physician; 015, BF, 1912; 037, BF, 1917, who wrote that "they would not listen to anything I said to them." ; See also, 07, April 25, 1910; 040, BF, 1918.

16. 001 BF, 1917.

17. 019, BF, 1914; 026, BF, 1916, who "in many cases advised, the parents being poor people, that the child should be taken to the local Hospital."

18. 005 BF, 1909.

19. "The Doctor's Fees Again", NN, November 1912, 298.

20. "The Payment of the Doctor's Cases", NN, March 1908, 66: See also: "Helpless Husband's Doctor Hunt", NN, March 1909, 50; "Notes From Far and Near, Gravesend", NN, April 1913, 103.

21. 064, LOS, 1919.

22. 027, CMB, 1916; see also: 041, BF, 1918; The Institute covered these issues persistently. See, for example: "Birmingham Practitioners Union", NN, March 1904, 38; "Midwives and Medical Attendance", NN, July 1907, 104; "Notes of the Month", NN, February 1908, 31; "Committee of Representatives", NN, February 1911, 48; "Central Midwives Board", NN, November 1912, 306. For the issue of physicians' use of unregistered midwives or "covering" see, for example, "Malling", NN, January 1912, 16;

"Central Midwives Board", NN, February 1915, 286; "Central Midwives Board", NN, April 1916, 91; "Central Midwives Board", NN, July 1916, 158; "Central Midwives Board", NN, May 1918, 71.

23. 025, CMB, 1918.

24. 062, LOS, 1918.

25. 7 cases were brought, 8 midwives were involved; for the Board's position on physicians' refusal to answer midwives' calls for help, see: "Central Midwives Board", NN, June 1912, 166; See also: "Midwife Notes: Central Midwives Board", NN, January 1907, 7, in which the Board agreed in the case of a midwife's problem with physician non-attendance "it was not in their power to assist her". See also Atkinson, 89-94.

26. "Summary of Work, 1904: The Midwives Act", NN, January 1905, 2.

27. "Dirty Midwives", NM, September 18, 1909, 32; For others see: "Correspondence", NN, August 1908, 174; "From a Northern Correspondent", NN, July 1909, 146-147; "Correspondence", NN, March 1909, 63; "Correspondence", NN, January 1912, 27; "Why was the Midwives' Act Passed?", NN, March 1915, 157; "The Practicing Midwife: Harassing the Midwife", NN, January 1916, 10.

28. 041, BF, 1918.

29. 070, Coombe Hospital, 1916.

30. "Penal Board", NN, February 1917, 34.

31. 031, CMB, 1917.

32. "Penal Session", NN, March 1915, 70.

33. "Penal Cases", NN, June 1906, 85; See also: "Penal Cases", NN, July 1911, 178 in which Ellen Leatherland was characterized as "incurably ignorant"; and, "A Want of Tact", NN, September 1919, 75.

34. See, for example, "The Local Authority and the Midwife", NN, September 1909, 177-178; "The Truth of the Matter", NN, August 1909, 160; "?", NN, July 1906, 102; "Midwife Notes", NN, March 1912, 72; "Injustice to a Midwife", NT, May 25, 1912, 574; "Midwife Notes", NN, February 1913; "Midwife Notes: Suspension for Three Months", NN, December 1908, 243.

35. 048, BF, 1919.

36. 048, BF, 1919.

37. 022, CMB, 1915.

38. 065, LOS, 1919; Sometimes officials did not take the care to explain their questions to the women from whom they wanted testimony. Mrs. S-- signed a statement that her midwife never took her pulse, but rescinded her testimony once she understood what taking a pulse meant. "I did not know exactly what was meant by taking the pulse. Mrs K-- used to get hold of my wrist every morning when she came." 038, BF, 1917.

39. 038, BF, 1917.

40. 004 BF, 1908.

41. 045, BF, 1918.

42. 052, LOS, 1908.

43. 002 BF, 1906.

44. 002 BF, 1906.

45. 043, BF, 1918; 039, BF, 1917.

46. "Book Notes", The Queen's Poor, M. Loane, NN, December 1905, .

47. "Central Midwives Board", NN, February 1918, 30.

48. Frances Champneys, "Address Delivered to the Association of Inspectors of Midwives", NN, July 1915, 170.

49. "Penal Board", NN, April 1916, 92.

50. "Penal Cases", NN, January 1914, 18.

51. "Central Midwives Board", NN, July 1912, 196.

52. "Penal Board", NN, February 1917, 35.

53. "Penal Board", NN, September 1916, 200.

54. 017, CMB, 1914.

55. 009 CMB, 1911; See also: "Penal Board", NN, December 1913, 346.

56. "Penal Proceedings", NN, March 1912, 74.

57. "Penal Cases", NN, August 1910, 198.

58. 024, BF, 1915.

59. 004 BF, 1908.

60. 040, BF, 1918.

61. 060, LOS, 1917.

62. 053, LOS, 1911.

63. 068, trained nurse and trained midwife, 1909; 039, BF, 1917: Also: 043, BF, 1918; 056, LOS, 1913.

64. 001 BF, 1906.

65. "Central Midwives Board", NN, July 1911, 178.

66. Penal Cases, NN, January 1906, 9.

67. "Penal Board", NN, December 1918, 164.

Chapter 5

Rank and File Midwives: Protest, Resistance, and Organization

Midwives' common problems laid the basis for their common action. All rank and file midwives were vulnerable to being charged, disciplined and being struck off the Roll for reasons which often appeared to be capricious and unfair. Even if a midwife was never called before the Board, she was nevertheless subject to the numerous restrictions of the Rules and to the exacting supervision of local officials. Many rank and file midwives refused to be victimized by the vagaries of the disciplinary process and resisted the imposition of what could be culturally alien values and standards. Some midwives moved beyond individual resistance to organized action. In its April 1910 leader Nursing Notes testified to the "stir of life and activity which is being evinced by midwives all over the country . . . . " and in the wake of such activity, "the rapid increase in the number of societies and local associations."[1] These small groups were independent, almost spontaneous responses to midwives' immediate economic and work-related problems. Most met and organized outside the influence of the Midwives' Institute. That many of the local organizations had similar complaints and problems quickly became apparent. Pressure increased for a national organization which could speak directly to the concerns of the rank and file. By 1910, many of these local groups had joined one of two new national organizations, the 1910 British Union of Midwives or the National Association of Midwives. Both organizations advocated curtailing the powers of the supervisory apparatus, expanding the scope of the midwife's authority and broadening midwife representation on the Central Midwives Board to include not only the elite of the Midwives' Institute, but the rank and file of midwifery.

Midwives' Individual Resistance

The frequent injustices of the supervisory apparatus were widely experienced and resented among midwives. The correspondence columns of the nursing and midwifery journals were filled with criticisms of the Board's

procedures and the treatment midwives received at the hands of local officials. When a midwife was called before the Board, it was often because she had grown tired of this treatment and acted upon what were commonly held resentments. In this context, defiance of authority was not necessarily evidence of a dangerous practitioner, but was rather an expression of individual midwives protecting themselves against what they believed to be an attack on their character and their ability to make a living from their work.

Midwives did not have to have been investigated or called before the Central Midwives Board to be able to tell stories of rude and disrespectful inspectors. Midwives complained that inspectors refused to treat them as the skilled and experienced practitioners they were. "Many a midwife can teach a County Superintendent a good deal, is more experienced, and has attended a far greater number of cases," one midwife wrote to the Nursing Mirror.[2] Similarly, correspondents criticized the same disrespectful treatment that midwives experienced at the CMB disciplinary hearings. "There can be no reason why the secretary should address the midwife in a manner of a policeman speaking to a prisoner, " one woman complained of William Duncan's (the Board's secretary) attitude toward the accused, "and not a very polite policeman at that. . . . "[3] Rank and file midwives were offended by these attitudes, but many were as equally disturbed by the capriciousness of the disciplinary process itself. The journals routinely reported cases in which the personal prejudices and opinions of local officials had been the grounds for an investigation into a midwife's practice, for charges to be made against her, and for the Board to revoke her certificate.[4] In some cases, midwives discovered that they had been cited and judged without being notified of the charges against them--a violation of the Board's own Rules.[5] "Even should the investigation prove her blameless," one midwife wrote, "the inquiry is harmful to reputation. . . . "[6] It was increasingly understood that a woman did not have to fit the image of the Gamp to be vulnerable to mistreatment at the hands of the supervisory apparatus. "I have not the courage to start as a midwife, " wrote a general trained nurse who had once thought of taking up midwifery. "I should always be afraid I should do something wrong and be hauled before the Board."[7]

The letters which rank and file midwives--both trained and bona fide--submitted to the Board revealed that their standards of competence often differed from those of the Board and of local officials. The Board tended to

regard deference, adherence to the Rules and a readiness to summon a physician as the mark of a good midwife. Yet, the midwives in the CMB penal files sample pointed to other characteristics: their kindness to the women they attended, the positive outcomes of their work, and their expertise and independence developed over years of practice. They expressed confidence in their abilities and pride in their records. Mrs. W-- wrote that she had been a attending births for over forty years. "Both my mother and grandmother were midwives."[8] Mrs. T-- wrote: "I have been in practice in leeds for 11 years + have had 900 cases of confinement + have a good practice + never lost a case by death."[9] A midwife only had to look around her to see the evidence of her skill. A midwife for twenty-five years, Mrs. W-- wrote, "I have at present some of the finest children in the parish. . . ."[10] Similarly, Mrs. S-- wrote, "I have always been a favorite with my Patients, every one of which in 20 years has been well in a fortnight. . . ."[11] Experience had taught them that many of the births which the Rules defined as beyond their province were manageable and normal (albeit difficult and not routine). In fact, midwives unwittingly brought attention to the attendance on such births in defense of their good records. Mrs. B--, a bona fide midwife who had undergone the CMB training, wrote one last letter to the Board after her certificate had been revoked. "I was on the work a very long time before I went in for my training," she wrote, "for in December 1908 I put Mrs. B-- to bed of triplets with out a doctor + a large number of twins since trained."[12] Midwifery reformers frequently interpreted midwives' confidence in their abilities as evidence of their unwillingness to submit to any limitation on the scope of their work. Yet, midwives' letters showed that they understood their own limits. As Mrs. R-- told the Board, "As of long experience of nearly 40 years when I saw a patient ill I recognized it and sent for a doctor."[13]

Midwives' experience in practice and their confidence in their abilities formed the basis of their expectations of how they should be treated by the Act's officials. As older, married women with years of experience in practice rank and file midwives were often resentful of inspectors' attitude toward them. Some doubted that their inspectors--as young and as inexperienced as they were--were even competent to supervise them. Sarah Jackson, a midwife from Lancashire who could not attend her hearing because "her son had gone on strike" complained to the Board that she "failed to understand why single, young persons should be appointed inspectors of midwives; they should in

her opinion, be married, with children; then they would know as much as she did, instead of which they only knew what they read in a book."[14] When they felt themselves to be harassed or unjustly accused, rank and file midwives had few reservations about challenging the authority of the Act's officials. Some responded like Fanny Emory, who was reported for being, "abusive and resentful to [her] inspector."[15] Others merely refused to cooperate. Mrs. F-- was called to the town hall twice for a preliminary hearing with local officials. In neither instance was the matter resolved. Believing that she had been falsely accused in the first place, she wrote, "I purposely kept out of employment to attend but I cannot afford to so any longer . . . and I refuse to go again. . . . "[16]

Midwives' resistance to the Board's authority might extend to their refusal to stop practicing even when their certificates were revoked. Some, like Mrs. B--, refused to acknowledge that the Board had any legitimate authority over them at all. "If you have the right to suspend my Certificate Please enforce your right. I have Practiced as a midwife for 40 years and have never lost a case. So you proceed as you see fit."[17] Similarly, Mrs. M-- vowed to continue practicing and refused to return her certificate to the Board, writing, "Sir, I must remind you that it is my property and I paid for it."[18] Others were less vocal about their intentions, but defied the Board nevertheless. A few months after she lost her certificate Mrs. K-- was fined 20 shillings in Police Court for attending a woman in childbirth.[19] In 1914 Mrs. P--, who had earned her LOS in 1899, was "discovered attending births again" one year after her certificate had been revoked. [20]

Rank and file midwives fought against the Board's attempt to impose its standards of competence and its hierarchy of supervision on them. They refused to sit passively by when they felt their rights had been violated. When they were treated with contempt by inspectors and local officials they responded in kind. When the Board revoked their certificate for what they considered unjust reasons, they refused to comply with the judgement. Rank and file midwives' resistance were not, as midwifery reformers claimed, the act of socially marginal and dangerous practitioners, but was part of a broader dissatisfaction with the terms upon which midwives worked and were forced to conduct their lives.

The Rank and File Move to Collective Action

Midwives had begun to form local associations from the time the Act had first been implemented, but it was not until 1910 that events offered these groups of rank and file midwives the opportunity to challenge the existing method of their representation in midwifery affairs and to confront the power of the supervisory apparatus. In that year, the government appointed a Departmental Committee to investigate how the Act was working, to evaluate its operation and to make recommendations if they considered any revisions in the legislation were necessary. At the same time, as a "wave of industrial unrest swept the country" working class women in a variety of trades organized themselves into trade unions under the Women's Trade Union League and joined with their male counterparts to protest poor conditions and insufficient wages.[21] On the one hand, this series of events at once held out the opportunity that the Act, the operation of the Board and the means by which midwives were represented in midwifery affairs might be reformed and, on the other, gave momentum to the efforts of two national organizations, the National Association of Midwives and the 1910 British Union of Midwives, which sought to gain representation for the rank and file on the Central Midwives Board and to improve the terms under which midwives worked.

The 1910 British Union of Midwives, (hereafter British Union) appears to have been initiated with the organizational support of the Women's Trade Union League (WTUL). The British Union explicitly aimed to organize midwives, as Mary MacArthur, the secretary of the WTUL declared, into "a trade union, a democratic body, a registered society and organization. . . ."[22] As a trade union, the British Union aimed to organize all midwives in order to protect their economic right to good work conditions and a decent standard of living. "The majority of midwives take up the work as a means of earning a living," one midwife trade union supporter wrote, "therefore they must of necessity pay heed to the bread and butter side of the question."[23] Unlike the Midwives' Institute, the British Union had no interest in reforming the women they attended. Instead, they advocated the provision of state subsidies for maternity attendance which would increase women's access to midwifery attendance while at the same time freeing them from the reforming networks of the Poor Law and charitable institutions.

The British Union believed that midwives would not be able to improve their situation until they, and not the CMB and the state, controlled the terms under which they sold their labor and carried out their work. To achieve this, the British Union believed that midwives had to break the powers of the supervisory apparatus and to force the government to assume more of the cost of maternity attendance. The British Union argued that midwives stood in a similar relation to the state (in the guise of the Midwives' Act) as did the employee to the employer. The State did not pay her, but the Act had in effect placed the midwife in its service. Midwives made their own arrangements with the women they attended, but they had little control over their work beyond setting the specifics of attendance and negotiating the fee. The state defined the extent of her work, specified every step she took, and penalized her when she was suspected of violating the Rules. Thousands of midwives were harnessed to the state's campaign to reduce infant and maternal mortality and the Act provided the legal body to monitor and control their work. The British Union believed that the CMB, far from being a body which represented the interests of the rank and file, merely enforced the will of the state. For midwives to begin to gain control over their work, the restrictions on the scope of their practice had to be lifted. Most importantly, they should not, as one Union member demanded, "have to send for the doctor for the slightest abnormality."[24] Furthermore, midwives had to be freed from the harassment and interference which the powers of the supervisory apparatus allowed.

The British Union believed that the state should bear the cost of maternity attendance rather than the mother or the midwife. As things stood, if a woman was too poor to pay for a midwife's services she often had to resort to the Poor Law for help. Even when women engaged a midwife, one unexpected family emergency might take all her savings. In such cases, either the woman was left without a midwife or (more likely) the midwife didn't get her fee. Women could not afford much even when they could pay their midwives. Families often couldn't afford the services of a physician and when complications developed midwives had to pay his fee themselves to make sure he would come. Rank and file midwives had difficulty making a living under these conditions. Midwives reported they were overburdened by the additional expenses which the conditions of their practice made necessary and the Rules required. "The fees are small," one trained midwife wrote,

"and do not constitute a living wage. . . . Out of her scanty fees she must pay for books, postages, etc., extorted from her by the Rules of the CMB. In some instances she is expected to pay the doctor. . . . "[25] Faced with the "impossibility of wringing 'money from our poorer sisters'" and unable to make a decent living from their work the suggestion of state subsidies fell on fertile ground. "If the poor women whom we attend are unable to pay," one midwife wrote to Nursing Notes, "it ought to be forthcoming from another source, not necessarily the Poor Law, for is not the midwife doing important public work, and ought she not to be paid for it?"[26] Others had made the explicit connection between the government's rule over their work and the responsibility to provide them a decent living in return. "If it [the government] wishes to inspect and punish, let it pay, protect and pension midwives."[27] The Union of Midwives agreed. Mrs. Robinson, the President of the Union and the editor of the Union's paper, The Midwives' Record, declared that "What midwives really wanted was State aid and they must fight for it."[28]

The British Union argued that midwives could not successfully carry out their fight for state aid and greater authority in their work unless all registered midwives, regardless of training, were organized into a trade union. Rank and file midwives' did not have money, political power or influential friends, but they did have a skill that society needed. By joining together to withhold that skill if necessary, midwives could force the changes they demanded. "The STRIKE is an instrument which has been employed with good effect in other quarters, and may have to be used by midwives. Union is strength. . . ."[29] If some midwives continued to practice while others withheld their skills, the effectiveness of the strike as a weapon would be seriously undermined. All midwives, no matter their training or background, had to be convinced to join the British Union and participate in formulating its policies and determining its strategies. For the British Union, nothing short of full organizational democracy would accomplish the unity in which the strength, and therefore the future, of midwifery lay.

Correspondents' letters indicate that some rank and file midwives were amenable to the idea of joining a trade union. When Nursing Notes criticized the British Union for undermining the dignity of midwifery by advocating a trade union, Annie Taylor retorted, "Why should a midwife be expected to uphold the 'dignity of her calling' on the miserable pittance she is too often obliged to take in payment for her services . . . Let us combine and

insist upon receiving good pay for good service rendered and thus shall we 'uphold the dignity of our calling.'"[30] From late 1909 and through the spring and summer of 1910 the British Union held a series of meetings to recruit midwives to their cause. The journals did not usually record the number of midwives who joined the organization, but they did report that these meetings were well attended and well received. [31]

The British Union recognized that without representation on the Central Midwives Board rank and file midwives would remain outside of the structure of power. As the legal mechanism by which the rank and file was controlled, the Board could not be ignored. Through representation on the Board, rank and file midwives could make that mechanism work for them and not against them. The British Union demanded that these representatives be elected directly to "the Central Midwives' Board by the popular vote. . . ."[32] No distinction would be made as to training or class background, all would have an equal voice in the choice of representation. Through their democratically elected (and therefore accountable) representatives, rank and file midwives would "have the power of ventilating grievances and demanding justice."[33]

The second national midwife organization, the National Association of Midwives, joined the British Union in its demand for direct representation. The National Association of Midwives had been created through the combined efforts of a number of local midwife organizations centered in Manchester. Having recognized the similarities in the problems midwives' faced, these associations had come together to form a national association which could redress these problems on a national level. Because of the limited sources, it is difficult to reconstruct the National Association's views and its program for change. Reports of their activities and meetings did not indicate whether the National Association aimed to form a trade union as well, but the organization did have trade union affiliations. The secretary of the Manchester based Women's Trade Union Council, Mrs. Aldridge, for example, spoke at one of the National Association's meetings in Sheffield in October 1910. [34] It also appears that the National Association believed that there were too many restrictions on midwives' practice and, as the President, Mrs. Lawson, told her audience, "too much interference on the part of the supervising authority. . . ."[35] They also agreed that midwives had to elect their own representatives to the Central Midwives Board if they were ever to have

their interests represented. Mrs. Lawson, a Manchester midwife and president of the National Association was frequently reported touring the North recruiting midwives into the organization. "The speakers were listened to with interest," the Nursing Times reported in October 1910, " and at the close every midwife joined. . . . In three months five new branches have been formed, and the membership is increasing.[36]

The leadership of both organizations expected that direct representation would end the Midwives' Institute's privileged position as the exclusive representative of registered midwives. That the Institute represented only the elite of midwifery was widely known by rank and file activists and openly acknowledged by the Institute leadership.
It was the elite's interpretation of midwifery's problems and their vision of the future which was represented on the Central Midwives Board and not that of the rank and file. Neither the British Union nor the National Association recognized the Institute as a legitimate representative of the interests of the majority, but rather an ally of those groups who were currently the source of midwives' problems, "the 'bossing' on the Central Midwives' Board of doctors and non-registered nurses."[37] Midwives needed their own representatives. As Mrs. Lawson argued, "Midwives had no strong association at the time of the passing of the Act and had consequently no voice in framing the regulations under which they were governed."[38] The Union of Midwives went even further and proclaimed that the Institute "has no moral right to the title which it assumes. . . . "[39] The Midwives' Record's analysis overtly recognized the vast class and cultural divide between Institute leadership and the rank and file.

> At the recent meeting in the Cavendish Rooms one lady who seemed to be associated with the Institute, objected to the principle of direct representation on the feeble plea that working midwives could not find the time to sit on the Board. At the same meeting five smartly dressed women rose and rudely left the meeting, giggling hysterically like naughty school girls, while Mrs. Lawson the respected president of the Association of Midwives was speaking. These exhibitions of grande dames and the patronesses of midwives, 'dressed in a little brief authority' do not tend to inspire respect

> among working women. Serious minded midwives, intent on the practice of a great science and on the elevation of their profession, do not need to be fussed over and patronized. They are tired of 'charity-mongers'; they are sick of being 'bossed'. Strange as it may seem to these outsiders, they have the audacity to believe that they know what they want better than their would be patrons, and that they can get on very well without the help of the latter.[40]

If the Institute hoped to survive it had to be brought, "into line with the great body of rank and file midwives." If the leadership refused to allow this to happen, "the sooner the Institute is smashed the better," The Midwives' Record asserted, "or in such case it would simply be a wolf in sheep's clothing."[41]

* * *

When the 1910 departmental committee decided against making any revisions in the Midwives Act, rank and file midwives' challenge to the legitimacy of the Midwives' Institute and the power of the supervisory apparatus vanished from the national nursing and midwifery press. Yet, the rank and file's dissatisfaction with the supervisory apparatus and their desire for alternative representation did not. Although the fate of the National Association of Midwives is unknown, the British Union of Midwives continued to publish The Midwives Record at least until 1914. Midwives continued to protest their treatment at the hands of the supervisory apparatus and demand, as one midwife wrote in 1919, that they "should have more freedom of action and less rule and regulation. . . . "[42] One letter suggests that the increased class hostility of the post-war period affected rank and file midwifery as well.

> In the penal cases, in giving evidence against the midwife, inspectors often say they are self-opinionated. Does this mean a woman who chooses midwifery as a means of a living must be in such subjugation as to have no opinion of her

> own? On another occasion the chairman at a C.M.B. meeting told a midwife to be more humble. The day for humility in England's workers (be they men or women) is gone by; it is buried in the graves of our soldiers.[43]

Some regarded the Midwives' Institute as part of the problem. "I do not think it can help [midwives]," one midwife wrote, "because it does not know or understand their needs." That Institute members sat on the Central Midwives' Board, "is no recommendation" she continued, "rather it is deterrent. They only administer the Rules. . . . "[44] In these midwives' minds, the rank and file was still without leadership or representation. "Midwives if they are not to be strangled," one midwife wrote, " must form a union to protect themselves. . . . "[45]

References

1. "Union is Strength", April 1910, 81; See for example, "Notes for Midwives", NN, February 1907, 22; "Notes for Midwives", NT, March 2, 1907, 191; "Notes for Midwives", NT, May 25, 1907, 455.

2. "Dirty Midwives", NM, September 18, 1909, 32; For others see: "Correspondence", NN, August 1908, 174; "From a Northern Correspondent", NN, July 1909, 146-147; "Correspondence", NN, March 1909, 63; "Correspondence", NN, January 1912, 27; "Why was the Midwives' Act Passed?", NN, March 1915, 157; "The Practicing Midwife: Harassing the Midwife", NN, January 1916, 10.

3. "Midwives Before the CMB", NT, April 6, 1912, 361.

4. See for example, "The Local Authority and the Midwife", NN, September 1909, 177-178; "The Truth of the Matter", NN, August 1909, 160; "?", NN, July 1906, 102; "Midwife Notes", NN, March 1912, 72; "Injustice to a Midwife", NT, May 25, 1912, 574; "Midwife Notes: Suspension for Three Months", NN, December 1908, 243.

5. "?", NN, July 1906, 102; For Rosalind Paget's response see: "Central Midwives' Board", NN, December 1907, 196; For other examples, "Penal Cases (Lucy Smith)", NN, January 1920, 8.

6. "Midwifery as a Profession for Gentlewomen", NN, May 1908, 108.

7. "Correspondence", NN, January 1912, 27.

8. 045, BF, 1918.

9. 019, BF, 1914; 026, BF, 1916; 056, LOS, 1913; 005, BF, 1909.

10. 044, BF, 1918.

11. 057, LOS, 1915.

12. 073, CMB, 1916.

13. 070, Coombe Hospital, 1916.

14. "Penal Sessions", NN, May 1912, 131.

15. "Penal Session", NN, January 1913, 12.

16. 027, CMB, 1916.

17. 050, BF, 1919.

18. 037, BF, 1917.

19. 038, BF, 1917.

20. 055 LOS, 1913; see also, "Burnley", NN, February 1910, 36; "Gloucester", NN, February 1911, 40.

21. Barbara Drake, Women in the Trade Unions (London: Virago, 1984, reprint ed. Labour Research Department, 1920) 47-67.

22. "The 1910 British Trade Union of Midwives", NT, February 26, 1910, 180; See also, "Correspondence: Midwives and Trade Unionism", November 1911, 276.

23. "Midwives and Trade Unionism", NN, November 1911, 276.

24. "1910 British Union of Midwives", NT, February 26, 1910, 180.

25. "Midwifery as a Profession for Gentlewomen", NN, May 1908, 108; "A Letter" NN, January 1917, 11; "Central Midwives Board", NN, June 1906, 85.

26. "Midwives and Trade Unionism", NN, November 1910, 276; Subsidies for midwives were implemented in some areas. In March 1912, NT reported that

Stoke-on-Trent paid 10 shillings a week each to two midwives to practice in poor areas. "Subsidies for Midwives", NT, March 30, 1912, 337.

27. "Midwifery As a Profession for Gentlewomen", NN, May 1908, 108.

28. "The 1910 British Union of Midwives", NT, February 26, 1910, 180.

29. "Treasons, Stratagems and Spoils", The Midwives' Record, May 1910, 138.

30. "Midwives and Trade Unionism", NN, November 1910, 276.

31. For a general idea of the reporting, see: "The 1910 British Union of Midwives", NT, February 26, 1910, 180; "The 1910 Union of Midwives", NN, February 1910, 28; The Midwives' Record, May 1910, 137-139, RCM Archives; For the Institute view on these developments, see: Midwives' Institute, Executive Council, minutes, July 1, 1909, courtesy of RCM Archives.

32. "Northern Midwives Meeting", NN, 1908, 181.

33. "Northern Midwives Meeting", NN, 1908, 181; Both organizations were open to "all midwives who were on the register". "Northern Midwives' Meeting", NN, September 1908, 181; "The 1910 British Union of Midwives", NT, February 26, 1910, 180. "The Nursing and Midwifery Conference", NT, May 7, 1910, 385.

34. "National Association of Midwives", NT, September 3, 1910, 740; see also, "Midwifery: The National Association of Midwives", NT, January 22, 1910, 80.

35. "National Association of Midwives", NT, September 3, 1910, 740.

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Chapter 6

Professional Ideology and Strategy: The Midwives' Institute and the Rank and File

The Institute leadership agreed with the British Union of Midwives and the National Association of Midwives that trained midwives needed more control over their work and that the purpose of any midwives' organization should be to aim "at a standard of pay that shall ensure to working women a 'living wage'."[1] Yet for the Institute leadership, midwifery was not merely an economic pursuit, but a great moral mission to reform the working class mother and family and to contribute to the more stable reordering of society according to the principles and social priorities of laissez-faire economics. Control over the work was not merely the means to enhance trained midwives' economic position--although this certainly was an element of their demands--but rather lay at the heart of their ability to carry out their larger task.

In explaining midwives' economic difficulties, their problems with the supervisory apparatus and their representational status, the Midwives' Institute had to respond to the same economic and practice environment as the British Union and the National Association of Midwives. All midwives sold their skill in the marketplace for normal midwifery services. The price, and therefore the living, which midwives were able to expect in return for their work was influenced by many factors external to the work itself, such as the fluctuations in the local economy, midwives' network of relationships with neighbors and friends, and the competition from other midwives practicing in the same area. Furthermore, by requiring additional expenses and limiting the kinds of cases they could attend the Rules' requirements and restrictions also influenced the living midwives could make from the work. Midwives' complaints had made it clear that their patients' poverty kept the fees low, while the Rules requirements drained a sizeable amount of even the small fee they received.

By demanding that the state employ the midwife and pay her salary, the British Union sought to protect her from the various forces beyond her control which influenced the price she could receive for her work. As a

salaried employee, she would no longer be in competition with other midwives for cases. Her union would bargain for better pay and work conditions and her representative (whom she had elected to the Central Midwives Board) would defend her authority over the work. The British Union had no desire to reform the women that midwives attended. With state aid for the midwife, childbearing women would be freed from the burden of having to pay for maternity attendance and would no longer have to subject themselves to charitable groups which expected so much in return for the help they gave.

The Institute leadership, however, had no desire to place the economic relations of midwifery against the dominant economic relations in society. For them, a midwife's skill was a commodity to be bought and sold in the market. Its price and the quality of the service would be regulated by competition among practitioners and the broader influences on that market. In order to compete within the market environment, the midwife had to be free to enter into contracts with the individuals who engaged her and to be at liberty to set her own fees. Any restrictions on the terms of the private transaction between midwife and patient jeopardized the midwife's ability to sell her services and thereby disadvantaged her in the competition for cases. For the leadership, the Rules and the supervisory apparatus did not constitute restrictions on the midwife's work, but rather guaranteed that midwives would provide a safe, high quality service.

By preventing other practitioners who offered the same service from securing an advantage over trained midwives, the Institute sought to strengthen trained midwives ability to compete in the marketplace for midwifery services. Despite temporary dispensation that had been granted to lay midwives, the thrust of the Midwives Act had been to transfer the practice of normal midwifery to trained midwives and to protect their access to that market. Lay midwives could no longer register under the bona fide designation after 1905 and no unregistered midwife could practice "habitually and for gain" after 1910 "unless under the direct supervision of a physician."[2] Any woman who did so was liable to criminal prosecution. At the same time, however, the Midwives Act had not granted trained midwives a monopoly over normal midwifery. Trained midwives had to share the right of the delivery of these services with physicians (who could, if they wished, still attend normal cases) and, for many years, with bona fide midwives. The

Institute relied upon the Midwives Act and the broad powers of the Central Midwives Board to protect the interests of trained midwives. When trained midwives were forced to compete with physicians for normal midwifery cases, the Institute asserted their legal rights under the Act. To further their campaign to eliminate competition from the bona fide midwife, the Institute supported the Rules, the system of supervision and the liberal use of the Board's disciplinary process.

As an organization, the Institute reflected the strategy of exclusion and the social philosophy of the leadership. Although the Institute did not require that aspiring members share the elite background and culture of the leadership, membership was limited to women whose professional and personal characteristics conformed to the leadership's standards. In keeping with their hierarchical social vision, the leadership believed that only women of breeding and education were suited to determine which policies and tactics would best protect the interests of trained midwives.

Protecting the Trained Midwife

The Institute sought to enhance trained midwives ability to compete with one another for normal midwifery cases by protecting them from the competition of other practitioners who offered the same service. The Act did not prevent physicians from attending normal midwifery cases if they chose to do so. As importantly, the lay midwife was still allowed to practice. The Act had established the trained midwife's claim on the market for normal midwifery services and it was this claim which the Institute asserted in their struggle to prevent the trained midwife from being disadvantaged relative to these other practitioners.

The leadership considered the physician a legitimate practitioner whose right to practice normal midwifery they did not question. At the same time, however, they opposed any measures which allowed the physician a greater advantage in the competition for normal cases. When the first National Insurance Bill was introduced in 1911, for example, it did not include any provision for midwife attendance. The bill provided a maternity benefit with which insured women and wives of insured men could use to cover the cost of the confinement, but which only reimbursed the family for

the services of a physician. If the bill had passed in that form trained midwives would have been excluded from a sizeable section of the market for their services and, as their fees would be paid through an insurance plan, from a guaranteed source of income. The effect of the bill, Nursing Notes declared, "will be to practically nullify the Midwives Act, for there will be nothing left for the midwives to do, and there will be no excuse for them continuing to exist."[3] By demanding that the bill grant insured women the freedom to choose the type of trained practitioner they engaged to attend them, the Institute hoped to secure trained midwives' access to this market for their services. Furthermore, the Institute demanded that not only did midwives have to be covered under the maternity benefit, but they must also be covered under the same terms as physicians. Midwives, just like their physicians colleagues, would set the fees according to their requirements. Finally, the leadership demanded that there be no difference in the methods by which midwives and physicians were reimbursed for their services.[4]

For the leadership, the greatest threat to trained midwives' livelihood was the bona fide midwife. The majority of working class women, insured or not, had a midwife to attend them. In the competition for normal midwifery cases, the bona fide midwife could have significant advantages over a freshly trained midwife who was new to the community. Usually an older, married woman who had lived in the same neighborhood or street for many years, the bona fide was part of the community. Because she shared the same life as the women she attended she was more likely to understand their problems and to refrain from judgements about their actions. Her reputation had been established over many years and the evidence of her skill was readily seen in the children playing in the street or the infant resting on its mother's hip. Correspondents' letters to Nursing Notes frequently chronicled the difficulties newly trained midwives had in breaking into the midwifery market. One midwife wrote from Kent that in her town of 14,000 residents she had found it impossible to find work. Four bona fide midwives, "both aged", attended almost 200 births per year while she had attended 16.[5] 'Lancashire' wrote that she and her daughter, the only trained midwives in a town with fourteen bona fides, "have had two cases between us since Christmas."[6] The Institute blamed patients' ignorance and the natural dishonesty of the bona fide for their competitors' relative success. "Certified midwives report to us", the Institute claimed in a letter to the London County

Council protesting the series of educational lectures the Council had offered to bona fide midwives, "that they constantly come across uncertified women who tell patients that they are quite as good as certified midwives. . . . The poor people do not distinguish between the certified and the uncertified and the latter are often employed. . . . "[7]

The Institute looked to the powers of the Central Midwives' Board to aid them in their struggle against the bona fide midwife. The Board had authority over all aspects of registered midwifery, such as setting training standards, supervising training programs, and acting as a clearinghouse for enquiries, but for the Institute it was the "penal part of the Board's work [which] is nearly, if not quite, the most important part of its duties."[8] The leadership considered the Rules a necessary weapon with which to purge the bona fide from the ranks of midwifery. Almost every issue of the journal contained an expose of some unfortunate result of bona fide practice or an appalling account of bona fide behavior. Such images as the Staffordshire midwife who was found "engaged in killing a pig, which she explained 'would have died anyhow'--and she hoped she would not be sent to the patient till the job was finished,"[9] or the case of Mary Ann Pickering who was charged and convicted of being an "abortionmonger" and sentenced to penal servitude [10] or the case of Emma Jones who had to be "picked up from a flower bed in the garden hopelessly drunk" into which she had collapse after she had left the confinement provided sensational and fruitful publicity for the Institute's position. Nursing Notes repeatedly asserted that bona fide midwives posed dangers to the public health, that they were offensive to middle class sensibilities and they deserved the harsh judgements they received at the hands of the Board. As bona fide midwives were forced off the Midwives Roll, either through discipline or attrition, it was intended that trained midwives would take their places.

> The reasons for this wholesale clearance are sufficiently interesting in themselves . . . . to the practicing or would be practicing midwife it surely opens up fresh opportunities, their places must be taken by someone; and naturally, health authorities who are determined to rid themselves of inefficient and dangerous practitioners will require, instead, well-trained, up-to-date midwives.[11]

The Institute's arguments were well received by those trained midwives who experienced the bona fide as an economic competitor. "I have no doubt that there are many towns like this, which are overrun with bona fide midwives", one midwife wrote. "Cleared of these bona fide midwives there is good work in the town for four trained midwives."[12] The Board's disciplinary powers, therefore, provided not only the precise means of eliminating, as Jane Wilson put it, "the defective supply", but of eliminating the thorn of organized midwifery's immediate competition.[13]

The leadership defended the use of the Act against trained midwives' competition in the name of the great social mission which they had undertaken. They did not claim protection for mere material advantage, but in order to rid the nation of the socially dangerous bona fide midwife and replace her with those who were, through training and social background, the most fit to attend, educate and uplift the working class mother and her family. They vehemently opposed proposals to organize midwives into trade unions, for example, on the grounds that these organizations were dedicated solely to enhancing the economic welfare of a primarily working class membership engaged in manual labor. The leadership wanted not only to differentiate trained midwifery from the manual labor performed by working class women, but to avoid any associations which might throw into question the magnanimity of their motives. "We are in no sense a trade union", one Institute leader declared. "For we do not believe that any society ever won greatness through self-seeking."[14] "Midwifery", Nursing Notes proclaimed, "is in its very essence not a trade, but a profession called into being by the needs and weaknesses of humanity. . . . "[15] For the Institute, the professional self-control and advantaged position which trained midwives sought under the legal rights extended to trained midwives by the Midwives' Act were merely the means to strengthen their hand against a dangerous enemy. So intricately intertwined, in the leadership's mind economic advantage and class purpose became indistinguishable from altruism and service.

Making the Act Work

The Institute could not ignore that the supervisory apparatus often made no distinction between the trained and the bona fide midwife. All

midwives--trained and bona fide alike--were subject to the same Rules and the same restrictions. Although the better educated and the more influential of those trained midwives were often acquitted, they still had to undergo the investigation, pay the cost of their defense and suffer the possible damage to their reputation. For the leadership, the problem was not the Rules or the system of supervision, but the failure of individual local officials to understand the true purpose of the Act. As a result, they advocated that LSAs appoint midwifery inspectors who, by attitude, training, and supervisory experience, would understand how to use the Rules to encourage the trained midwife and who would know how to handle the bona fide.

That the Rules which were to be used against the bona fide were used to investigate, charge and bring the trained midwife before the Board proved to the leadership that local officials failed to understand the true purpose of the Act. The leadership did not expect that bona fide and trained midwives would be treated the same, but rather that the local authorities would use their powers of supervision to exclude the bona fide and provide constructive supervision to the trained midwife. Instead, trained and bona fide midwives alike appeared in the Board's docket. Trained midwives "are bound to suffer . . . . ," Nursing Notes protested, "they have every right to feel themselves the victims of an **undiscriminating** legal machinery'."[16]

Local officials' failure to discriminate between the two types of practitioners threatened the Institute's cause to attract middle class women into midwifery. Correspondents' complaints to the nursing and midwifery journals were evidence enough that educated, middle class women would rather take up nursing or health visiting than put up with "petty persecution" at the hands of local officials. By placing the cream of midwifery on the same level as the most "degraded" of practitioners, local officials actions would "deter the very women we most want from taking up the task . . . . " and the field would be left to the women the Act was intended to supplant.[17] If some reform was not effected in local supervision, Nursing Notes warned, "the work the C.M.B. has done . . . . [will] be wasted and the Act . . . [will] become a dead letter."[18]

The Institute demanded that LSAs appoint midwifery inspectors who were qualified to make the Rules work according to what the Institute considered their true purpose. As the primary contact between the rank and file and local officialdom, the midwifery inspector's attitude toward the

women she supervised, her experience with the technical problems of midwifery and the quality of her skills in personnel management were pivotal in the successful working of the Rules. One midwifery inspector and Institute member observed that the most common failings among inexperienced and improperly educated inspectors were "the over-inspection of the trained midwife whose books and records, being in order, are easily criticized and the under inspection of the uneducated, whose faults especially if protected by the gift of the gab are much more difficult to run to earth."[19] The leadership believed an inspector needed to treat trained midwives with respect, to understand the practical side of their work and therefore the problems they faced, and to be tactful in her suggestions. In this way, she would improve the quality of the work done by trained midwives under her supervision without having to resort to rancorous investigations and hearings. Institute Council member Elsie Hall pointed out: "Many a time [the Board's] decision would not have been asked for . . . if the M.O.H. and the Inspector had a truer knowledge of the C.M.B. rules and the Midwives' Act."[20]

For the Institute, the ideal inspector would be a middle class professional woman. A woman physician who specialized in obstetrics was preferable, but a midwife would qualify as long as she had "considerable practical experience" and was also "trained nurse . . . who had experience in the training and supervision of subordinates."[21] The upper and middle class women whom the Institute hoped to attract into midwifery would only defer to women whose social and technical credentials were superior to theirs. They would not stand for "dictation and control by inspectors with inferior knowledge to their own," warned Hall.[22] Through the proper understanding of inspection, educated and prestigious midwives in supervisory positions who encouraged the trained midwife and strictly supervised the bona fide with an eye to using the disciplinary process to remove her could play their part in making the profession more attractive to middle class educated women. As importantly, inspectors who understood the purpose of the Act allowed the Act to do its work.[23]

Ideology and Organization

Where the British Union explicitly sought to organize all midwives regardless of training, the Midwives' Institute was exclusive, hierarchical and representative of the elite of trained midwifery. Members were counseled to support the Act's officials, to abide by the Rules, and to cooperate with the medical profession. To reinforce the Institute's economic and social views, members were encouraged to exercise self-help and to encourage the same in their patients. From 1910 onward the Institute made efforts to recruit more rank and file trained midwife members, but these members were allowed little voice in policy decisions. Instead, they were required to defer to their natural leaders, the upper and middle class elite of the Institute leadership and the supervisory apparatus.

Membership in the Institute had always been limited to the elite of trained midwifery and to those practicing trained midwives who could prove that their background and their moral standards met those of the Institute leadership. In 1909, the Institute had 1, 040 members. "600 or 700" were trained midwives, most of whom were drawn from managerial positions in hospitals and philanthropic organizations.[24] The rest were physicians, politicians, nurses, social reformers, sympathetic government officials and officials of the Act. In an exchange with Sir Almeric Fitzroy, the chair of the Departmental Committee investigating the Midwife Act, Rosalind Paget made clear that the Institute did not pretend to represent the rank and file of trained midwifery.

> Fitzroy: How far does the Midwives' Institute represent the whole body of midwives?
>
> Paget: It represents a select part of it--not the rank and file--very well.
>
> Fitzroy: The aristocracy of midwifery?
>
> Paget: Yes.[25]

The Institute did not need the force of numbers to press their cause. Their social and professional connections assured them a hearing in the highest

circles of power. Their strength on the Central Midwives Board allowed them ample opportunity to protect the interests of those whom they represented.

To the extent that the British Union and the National Association were organizing the Institute's constituency among the trained midwives they were challengers and competitors. Both organizations offered an analysis of midwives' problems and solutions which differed radically from the Institute's. In the leadership's mind, these views had to be discredited and trained midwives organized to follow the leadership's vision for trained midwifery.

In 1910, the Institute launched a campaign to bring the local midwife associations which had been springing up all over the country under the aegis of the Institute. It was largely through the efforts of Elizabeth Glanville, the chair of the Institute's Representative Committee, and her associate Miss Eaton that the organization grew during the years before 1920. Glanville worked tirelessly, visiting midwife associations up and down the country, lecturing and urging midwives to join with the Institute. In the month of June 1912, for example, Glanville visited midwife associations in six different areas, Devonshire, the Pottery District, Liverpool, Bedford, Hertfordshire and Birmingham. The following month, in which she visited eight different cities, was just as hectic.[26] The schedule could take its toll. "She looked so tired and weary when I saw her off at the station," one member wrote to another, "I do hope she is not ill."[27] By 1913, others had joined as organizers, but Glanville remained the primary contact and speaker. The hard work appeared to pay off. Reports to the Council revealed a good deal of initial enthusiasm: at a meeting in Oxford 25 attended and "21 joined at once", 38 midwives attended in Warwick and 22 affiliated, 50 in Exeter, 40 at a meeting in Leicester. By 1920, the Representative Committee could report that 69 associations (60 of which were paid up to date) had affiliated with Institute.[28]

Midwives' associations were offered the opportunity to affiliate with the Institute at a subscription rate of 5 shillings per year for groups over 25 and 2s and 6d for those with fewer than 25 members. A midwife who joined an affiliate did not automatically become a member of the Institute. For that, she had to pay an annual subscription of 5 shillings. Associations were allowed one representative to the Representative Committee for every 25 members in the affiliate. Each representative was required to become a direct member of the Institute. These direct members became the formal contact

between the affiliate and the Institute and it was through them, "that the principle of representation in the parent society [was] maintained."[29]

The Institute required that affiliates cooperate with and obey the Board and local officials, that they exercise self-help in managing their own problems and that they encourage their patients to do the same. The Institute taught its affiliates that midwifery inspectors were the trained midwife's "friends and protectors" and the Central Midwives Board was a "protection to the good midwife."[30] Of Frances Champneys, that controversial figure among midwives, Nursing Notes virtually glowed in praise. "Midwives as a profession cannot be too grateful that they have so experienced and so just an obstetrician as Sir Frances Champneys in the chair. . . . "[31] Nursing Notes articles acknowledged that supervision could be irksome, and could even spill over into harassment, but the leadership urged trained midwives to weigh these inconveniences against the long run benefit of excluding the bona fide competitor.[32]

Since the leadership believed that midwives' problems were caused by incompetent individuals and not by the system of supervision, they counseled Institute affiliates to protect themselves against incidences of individual incompetence or recalcitrance. Affiliates were urged to form insurance funds for those times when the family could not pay and the physician refused to come unless he had his fee. By paying the fee herself, the midwife would avoid losing the patient and risking an enquiry and possible charges before the Board. At its February 1913 meeting the Ipswich and Suffolk Association approved "a scheme put forward by the Midwives' Institute, whereby adding 1 shilling to their usual fee charged to the patient, they assumed the responsibility of paying the doctors' fees. . . . "[33] Similarly, the Institute recommended that affiliates form defense funds to pay the legal expenses of their members if called before a local tribunal or the Central Midwives' Board.[34] Representative Committee accounts reported that, if they could afford to do so, affiliates complied, some incorporating such provisions in their constitution.[35]

The leadership opposed state aid for midwives because they believed it would undermine the control of the midwife over her work and damage the profession's efforts to inculcate self-reliance in the working class mother. Paying a salary to a midwife would eliminate that positive and necessary engine of the market, competition. Without the "wholesome competition

between midwives [which] tends to keep up efficiency" the salaried midwife having no "object in increasing her cases, tends to get slack."[36] As an employee, she would not have the stringency of the Rules to keep her up to the proper standard. As the one who paid her salary, the employer, and not the Board, would set the terms of her work and determine the criteria by which its quality was judged. Finally, the leadership argued that by relieving the women of the responsibility to meet the midwives' fee a municipal service would undermine their efforts to ensure that "independence is maintained and pauperism discouraged . . . . " among working class mothers.[37]

Instead, the Institute insisted that the mother pay for the services she received. The leadership suspected that a working class woman's failure to meet the midwife's fee was largely a result of her own irresponsibility. "The money is there," Rosalind Paget told her readers. "Surely it is better that some of it should be spent in paying you properly for your arduous services than on extra clothes, jewelry, gramophones, etc."[38] Paget counseled affiliates to refuse to attend without advance payment. Once they did so "that fee will be forthcoming. . . . "[39] Such proposals placed the onus on the buyers to meet the set fee. Like buyers of any other commodity in the market, if they could not meet the price, they could not obtain the service. Apparently affiliates took the recommendation to heart. Some midwives refused to attend if a woman could not pay in advance.[40] The Representative Committee noted with approval that many Associations had developed "a Black List of patients who have not paid, which is a great help to midwives when booking again."[41] The Institute acknowledged that having to pay a higher fee might be a hardship for some of the women midwives attended. The solution was not in proposals, like state aid, which allowed working class mothers a means of circumventing their responsibilities, but rather in solutions which demanded that they exercise self-reliance and independence. Midwives were urged "to use their influence in the formation of maternity clubs along provident lines" so that working class families would not only provide for the midwife's fee but would learn a lesson in the bargain.[42]

Although the Institute's membership increased to include more of the rank and file trained midwives, the formulation of policy and the power of decision making remained in the hands of the elite. The Institute's governing body, the Council, was comprised of a prestigious and well-placed group of

matrons and managerial midwives and nurses who had been appointed by the leadership for their expertise and their personal status and prestige. The Council addressed the larger policy questions (sometimes in conjunction with the reports and analyses of the various committees it appointed) and was the final arbiter in all formal organizational and policy decisions. Through the Executive Committee, the smaller leadership core of Council members, were responsible for the day to day running of the organization. Policy formulation and organizational direction emanated from the informal, but powerful influence of this core leadership group of general trained nurses and CMB midwives, most of whom had been with the Institute for many years.

Within the affiliates, the Institute sought to place local elites in positions of leadership. Reports of the initial organizing meetings often catalogued the presence of supervisory officials and local gentry. Mrs. Glanville wrote to Miss Fynes-Clinton in May 1914 that at a meeting of a newer association the "M.O.H for the County, & the M.O.H. for the City, also Miss B- the Inspector of Midwives, and Miss B- Queen's Suptd. for Devon . . . the Health Visitor for E- was there . . . . " and the Superintendent of the local Queen's Home for District Nurses who the Institute had installed as honorary secretary of the new affiliate.[43] In Plymouth and in Northampton, for example, the matrons of the local hospitals represented the respective local affiliates to the Institute and in the Portsmouth and Swansea Association the midwifery inspector held the position of honorary treasurer for several years.[44]

Those midwife associations who did affiliate with the Institute found the Institute organizational structure allowed them little opportunity to influence organizational policy or decision making. Affiliates were allowed one representative for every 25 people in their association, but these representatives functioned primarily as the association's contact with the Institute. Because they were required to join the Institute as direct members, affiliate contacts could vote on certain matters and thereby make the affiliate's wishes known to the Institute. The affiliates were not directly represented before the Council, however, but rather through the Representative Committee which rendered a synthesis of midwives' concerns to the Council. Affiliates could vote in the election of Council members and the Institute's representative to the CMB, but the power to nominate individuals for these positions remained with the Council. Further, affiliates could raise issues

through their representative, but the decision as to which issues would be addressed lay with the Council, and more specifically with the Executive Committee.[45] While the Institute encouraged independent action and self-help among the affiliates Council approval had to be obtained on any policy decision or public statement. The Council reserved the right to veto any affiliate's action which did not accord with their wishes.[46] The rather narrow representation granted to the Institute affiliates was widely acknowledged. A Fabian study published in 1917 commented:

> In practice the Institute is directed entirely by the more educated women who have taken the midwife's certificate, but are themselves matrons of hospitals, superintendents of nursing homes, or organizers . . . . practicing midwives who are members of the Institute themselves take very little part in its government. "[47]

The Institute's policy on representation was underwritten by a concept of leadership which reflected the hierarchical social vision for which the Institute stood. There was no contradiction for the leadership between their requirement that the affiliates abide by the Council's decisions while at the same time limiting their voice in making those decisions. It was natural that rank and file trained midwives be placed in a subordinate position to women "whose education, experience and position make them worthy to be leaders of that great army of women such as is represented by the Midwives Roll."[48] In the debate over direct representation, the Institute openly questioned whether a rank and file midwife was capable of representing the interests of her colleagues. A leader, Nursing Notes advised, "must combine qualities not commonly found amongst those who have spent years practicing an all-absorbing profession that has given little time or opportunity for the cultivation of wider interests."[49] Although unequal, both leaders and followers nevertheless had crucial roles to play within their proper place. While women of status and education labored on the, "truly thankless task of fighting the battle for their profession . . . ," rank and file midwives made their most important contribution by abiding by the requirements of the Act and cooperating with its officials. Beyond this, while midwives were encouraged to improve themselves and to keep abreast of issues of professional concern, the Institute insisted that their rank and file midwives

leave the larger questions of the future up to those most suitable to lead. In placing limitations on rank and file trained midwives' participation and emphasizing education and status as the overriding criteria for leadership the Institute was merely translating what they understood to be the natural hierarchy of the social world into the organizational structure.

Not all midwives who joined affiliated associations agreed with the Institute's policy of hierarchical leadership and of deference to the Act's officials. By integrating local officials and rank and file midwives into one organization the Institute leadership sought to strengthen the operation of the Act locally and preserve the hierarchical ordering of leaders and followers. According to the leadership, midwives did not need an organization which was independent of the supervisory structure. What they did need was a forum in which they could protect their common interest of making sure that the Midwives Act operated according to its true purpose. Yet midwives' and their supervisors' interests were not necessarily the same. Local officials were responsible for supervising local midwives, enforcing the Rules and implementing the policies of the CMB. Furthermore, they were responsible for investigating and charging any midwife whom they suspected of violating the Rules. Midwives, on the other hand, were faced with implementing the Rules in an often difficult environment, of defending themselves against the Rules and protecting themselves against the powers of the supervisory authority. One Medical Officer of Health captured this conflict of interest inherent in local officials control of Institute affiliates when he wrote declining the Institute invitation to serve as the President of the local affiliate. "This Association is evidently intended not only to increase the status and knowledge of its members, but also to aid in guarding their rights," but as it would be the Local Supervising Authority which would bring any charges against the midwife, "being the executive officer here, I cannot both charge and defend."[50] The purpose of midwives' combination--protection of their interests--could be undermined when the affiliates were controlled by those who represented the system against which they sought to protect themselves.

Midwives' letters to the Institute revealed their dissatisfaction with the influence local officials exerted in the Institute affiliates. Midwives found that local officials could use their positions of control to stifle independent discussion and debate among the midwives. When the Woolwhich

Association had wanted to discuss the local authorities' requirements for notification of opthalmia neonatorum, for example, they found that because the Medical Officer of Health, in his capacity as President of the Association, chaired the meetings "they had no opportunity for free discussion on this or any other subject."[51] Some midwives openly challenged the Institute's policy of cooperation and deference to the local authorities. One midwife resigned in protest when the Institute refused to confront local officials over the problems the members of the local affiliate had had with the midwifery inspector.[52] More than ten years later, midwives continued to complain that the Institute's policies weakened midwives efforts to protect themselves. "Many of us are beginning to find the present position intolerable," one Association wrote to the Institute in 1927. "When we look to the Association for help and protection we find [it] helping those who oppress . . . We look to you to fight for us and not to put us off with platitudes about ideals when we need practical help."[53]

For the leadership, the key to the realization of their vision lay in allegiance to the Act and alliance with those who were responsible for its administration. The Institute had identified specific areas in which they believed the working of the Act could be reformed, but beyond this they regarded the friction which rank and file midwives experienced as merely an inevitable part of the process of reconciling the disparate needs of the interests involved in the Act's administration. The reforms which were needed would come not as a result of attacking authority (as the leadership argued the British Union and the National Association had done) but from " a calm, logical survey of the whole matter and from the inside . . . . hysterical shouting will do no good."[54] As that organization on the inside, only the Midwives' Institute was, "in spirit and all willingness" capable of "the expression and transmission of the interests of the members of the profession."[55] Trained midwives needed to keep abreast of the key issues facing their profession, but most importantly they needed to, "help and loyally support their leaders" by following the Institute's direction.[56]

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1. "Midwives and Trades Unions", NN, February 1910, 31.

2. Great Britain, Laws, Statutes, etc., Midwives Act, 1902, 2 Edw. Ch. 17, Section 1. (1) and (2).

3. "The National Insurance Bill", NN, July 1911, 171; The National Insurance Act came to into full operation in 1913. The Act provided for a fund into which eligible workers, their employers and the government paid contributions. Benefits were distributed through the private insurance companies and "friendly societies". Workers making less than £160 a year and all manual workers were eligible for insurance. Benefits included a "basic income during sickness (and for certain workers during unemployment). . . and a system of primary care." Benefits were only available to those who were employed and could pay their weekly contributions. With the exception of the maternity benefit, medical care was for the insured worker only. For an analysis of the 1911 Act, see Lesley Doyal, The Political Economy of Health (London: Pluto, 1979) 163-171.

4. For examples of the discussions of the Insurance Bill in Nursing Notes, see, "Midwives and National Insurance", NN, June 1911, 141-142; "Women Under the Insurance Bill", NN, July 1911, 167-168; "Why Midwives and Nurses Need Votes", NN, December 1911, 299; "The Maternity Benefit Under the Insurance Act", NN, January 1913, 9; "Midwives and the Insurance Act: Memorial to Mrs. Masterman", NN, January 1913, 9; 11; "Maternity Benefit for Fathers", NN, April 1913, 95-96; "Amendment of the Insurance Act", July 1913, 187-188; "Insurance Notes", NN, October 1913, 282.

5. "Midwives, Bona-Fides and Otherwise", NM, June 12, 1909, 178.

6. "The Bona Fide Midwife", NM, April 20, 1907, 51.

7. Midwives' Institute, Council, minutes, November 3, 1914, To the Clerk of the County Council, June 16, 1914; See also: "Lectures to Bona Fide Midwives", NN, May 1905, 67; "Manchester Certificate", NN, April 1904, 52.

8. "The Penal Cases", NN, June 1907, 87.

9. "Rural Midwives Association", NN, June 1905, 83.

10. "Law and Police", NN, May 1911, 128.

11. "Vacancies for Certified Midwives", NN, July 1914, 206; See Jane Wilson's testimony before the 1910 Departmental Committee, Minutes of Evidence, Departmental Committee Appointed to Enquire into the Midwives' Act, 1902, February 17, 1910.

12. "The Bona Fide Midwife", NM, April 20, 1907, 51.

13. For other less punitive means of placing trained midwives in a position of advantage of their bona fide competition, see the controversy over nameplates. Midwives' Institute, Council Minutes, January 1908, Elsie Hall to Dear Sir, January 8, 1908, courtesy of RCM Archives; For the Council petition see: Sectional Committee Minutes, January 7, 1908, courtesy of RCM Archives; "Midwives and Nameplates", NN, January 1908, 22; "A Call for Unity Among Practicing Midwives", NN, September 1908, 181; When the CMB ruled that a trained midwife could not advertise her credentials Institute Council member Elsie Hall wrote to Frances Champneys, "I feel assured that you, whose object it is to encourage the trained midwife to practice, do not in any way intend it should place her at a disadvantage with the bona fide midwife. . . ." Yet not allowing her to advertise her difference would, she wrote, defeat the "object of the Act that the public should be able to distinguish the trained midwife from the untrained midwife."

14. "Midwives General Meeting", NN, February 1910, 43-45.

15. "Midwives and Trades Unions", NN, February 1910, 31; See also, "1910 Union of British Midwives", NN, January 1910, 14-15; "The 1910 Union of Midwives", NN, February 1910, 28; "Strikes for Midwives", NN, July 1910, 170; "Midwives and Trade Unionism", NN, October 1910, 245; "Midwives' Trade Unions", NN, February 1911, 39.

16. "The Protection of the Midwife", NN, December 1911, 295. emphasis mine; "The Penal Cases", NN, June 1907, 87; "CMB", NN, February 1910, 35; For two examples of Institute members called before the Board, see, "The Monmouthshire Training Home", NN, August 1910, 194; The Institute continued to defend the interests of Miss Barrett through their influence on the Board. Rosalind Paget attempted to intercede for her in a local problem, "Central Midwives' Board", NN, May 1911, 130; For more of the tribulations of Matron Barrett, see: "Central Midwives' Board", NN, June 1913, 167; July 1913, 197; and for the case of another member, Dorcas Hodgson, see, "Why was the Midwives' Act Passed", NN, March 1915, 57; "Penal Session", February 1915, 40.

17. "The Monmouthshire Training Home", NN, August 1910, 194.

18. "The Delegation of the Inspection of Midwives", NN, March 1917, 45; See, "The Parting of the Ways", NN, March 1911, 57-58; See, "The Local Supervisory Authority", NN, December 1904, 187-188; "The Midwife and The Supervising Authority", NN, December 1904, 190-191; "The Protection of the Midwife", NN, December 1911, 295-296; "Injustice to a Midwife", NT, May 25, 1912, 574; "Midwife Notes", NN, April 1914, 110; "Delegation of Powers", NN, March 1918, 35-36.

19. "The Inspector of Midwives", NN, November 1920, 125; also, "The Ideal Inspector", NN, December 1920, 125-126.

20. Elsie Hall, "Inspection from the Midwives' Point of View", NN, June 1914, 173; See also: "The Qualifications of Inspectors", NN, June 1914, 180; "Inspectors of Midwives Association", NN, February 1915, 39.

21. "Inspection from the Midwives' Point of View", NN, June 1914, 173.

22. "Inspection from the Midwives Point of View", NN, June 1914, 173; See also, "The Delegation of the Inspection of Midwives", NN, March 1917; See also, "Midwife Notes: Lancashire", NN, October 1904, 155; "How the Act is Working in the Country", NN, March 1905, 38; Frances Fremantle wrote that the influence these Lady Inspectors, "will be of the first importance in establishing and maintaining an adequate system of midwives attendance. . . . " September 1909, 181; "Inspections from the Midwives Point of View", NN, June 1914; "The Inspector of Midwives: From the Point of View of the Practicing Midwife", NN, November 1920, 114-115; and "The Inspector of Midwives: From the Inspector's Point of View", NN, December 1920, 125-126.

23. See, "The Local Supervising Authority", NN, October 1916.

24. Great Britain, The Privy Council, Minutes of Evidence Taken Before the Departmental Committee to Consider the Workings of the Midwives Act, February 4, 1909 [515]. In 1909-1910 there was a total of 29, 209 midwives on the Midwives' Roll. 13, 608 had notified their intention to practice. Great Britain, Central Midwives Board, Report of the Work of the Board for the Year Ending March 1910.

25. Minutes of Evidence. . . February 4, 1909, [514].

26. Midwives' Institute, Representative Committee, minutes, July 12, 1912; November 8, 1912, courtesy RCM archives.

27. Midwives' Institute, Representative Committee, Mrs. E. Hughes to Miss Coleman, December 11, 1916, courtesy of RCM Archives.

28. These examples are taken from various Representative Committee reports during these years and can be found in Representative Committee, minutes, 1910-1918, courtesy of RCM Archives.

29. "Meeting of Representatives of the Midwives' Associations affiliated to the Midwives' Institute", NN, February 1915, 46; "The Practicing Midwife: Affiliation To The Midwives' Institute", NN, November 1910, 272; Midwives' Institute, Representative Committee, minutes, October 5, 1910;

Associations were also expected to help in the distribution and sale of Nursing Notes. Midwives' Institute, Representative Committee, minutes, May 8, 1912, courtesy of RCM Archives.

30. "Co-Operation Meeting at Whitechapel" NN, February 1917, 35; See also, "The Inspection of Midwives", NN, March 1912, 65-66; Rosalind Paget, "Wake Up Midwives!", NN, March 1915, 114.

31. "The Work of the CMB", NN, January 1912, 8.

32. "The Rules of the Central Midwives' Board", NN, October 1903, 135; See also,"Co-operation Meeting at Whitechapel", NN, February 1917, 35-36; "The Rules of the Central Midwives' Board", NN, October 1903, 137; "The Central Midwives' Board and its Proceedings", NN, July 1904, 105-106; "Penal Cases", March 1906, 35-36; On the necessity to cooperate with physicians, see, "Doctors and Midwives", NN, May 1908, 95; "Non-Medical Representation", NN, May 1906, 67.

33. "Ipswich and Suffolk Association of Midwives", NN, March 1913, 82; For the plan put forward by the Institute, see: Midwives' Institute, Council, minutes, January 27, 1913, courtesy of RCM Archives; "Midwives Notes", March 1913, 73; "Doctor's Fee Guarantee Fund", NN, March 1913, 78.

34. "Midwives Defense Union", NN, March 1907, 36; "Midwives Defense Association", NN, August 1907, 124.

35. "Committee of Representatives", NN, February 1911, 48; In 1909, the Institute did attempt to form a defense fund for its members in cooperation with the Royal Maternity Charity. For the controversy and ultimate failure of this attempt, see, "Midwives Defense Union Notes", NN, February 1907, 59; "Midwives Defense Union", NN, March 1907, 35-37; Midwives' Institute, Sectional Committee, minutes, March 1907, courtesy of RCM Archives; "Midwives Defense Association", NN, August 1907, 124; "Extraordinary Meeting", NN, February 1909, 38-40.

36. "Municipal Midwives", NN, June 1917, np.

37. "Municipal Midwives", NN, June 1917, np.

38. "Midwives, Are You Awake!", NN, May 1918, 66.

39. "Midwives, Are You Awake!", NN, May 1918, 66.

40. "A Midwife's Fee", NT, February 17, 1912, 170-172; "Reports from Associations", NN, February 1917, 36.

41. Midwives' Institute, Representative Committee, minutes, March 17, 1922, courtesy of RCM Archives.

42. "Committee of Representatives", NN, February 1911, 48; See also, "How the Act is Working in the Country", NN, December 1905, 177-178; "Conference: Association of Queen's Superintendents in the Southern Counties", NN, October 1908, 210-211; "Suggestions for Starting a Midwife", February 1909, 32-33; Nursing Notes did occasionally print articles which supported a Fabian inspired type of social reform, see: "New Worlds for Old", NN, May 1908, 101-102.

43. Midwives' Institute, Representative Committee, Miss Glanville to Miss Fynes-Clinton, May 1914; See also: Midwives' Institute, Representative Committee, minutes, June 26, 1914, courtesy of RCM Archives; See also Jane Wilson's lament that more inspectors had not enrolled as Institute members. "Midwives' Institute, Annual General Meeting", NN, February 1907; For other references to close ties with supervisory personnel, see Midwives' Institute, Representative Committee, A. B- to 'Dear Madame', October 25, 1916; Mrs. C- to Miss Coleman, November 20, 1916; Mrs. H- to Miss Coleman, November 20, 1916; Mrs. H- to Miss Coleman, December 11, 1916; L. B- to Miss Pearson, November 14, 1917, courtesy of RCM Archives.

44. Midwives' Institute, Representative Committee, minutes, June 26, 1914, courtesy of RCM Archives; See also, "Reports from Associations: Portsmouth and Southsea Affiliated Association", NN, February 1917, 36; "Meeting of Midwives Association", NN, February 1915, 46-47.

45. "The Practicing Midwife", NN, November 1910, 272; See also, "Gloucester City and County Midwives Association", NN, March 1913, 82.

46. For communications of this kind, see, for example, Midwives' Institute, Representative Committee, Dear Miss Fynes-Clinton from Hester Loman, May 15, 1914; June 4, 1914; and June 10, 1914; To the Secretary, Coventry Midwives Association, November 12, 1917; To the Chairman of the Public Health Committee, June 7, 1922.

47. Quoted in, "Organization of Midwives", NT, April 28, 1917, 467.

48. "The 1910 Union of Midwives", NN, February 1910, 28; See also, "Midwives' Representation", NN, July 1907, 103.

49. "Direct Representation", NN, October 1908, 202; See also, "Strikes for Midwives", NN, July 1910, 170; "The Representation of Midwives", NN, June 1910, 134; "Meeting of the Representatives", NN, February 1914, 37.

50. Midwives' Institute, Representative Committee, T. Morrisson Clayton to Mrs. Mitchell, March 24, 1926.

51. Midwives' Institute, Representative Committee, minutes, June 15, 1923; The Institute did intercede by appointing another chair, "thus giving them the opportunity to appoint a chairman from amongst themselves who could call committees to discuss anything when necessary". They did not, however, reevaluate their policy of encouraging the participation of midwifery management.

52. Midwives' Institute, Executive Club and Council, minutes, July 3, 1914, H. L- to Miss Goodlass, June 10, 1914,; Also, Midwives' Institute, Executive Club and Council, H. L- to Miss Paget, June 4, 1914, courtesy of RCM Archives

53. Midwives' Institute, Representative Committee, Helen K- et al to 'Ladies', October 22, 1927.

54. "Linking Up", December 1909, 235.

55. "Union is Strength", NN, April 1910, 81.

56. "Meeting of Representatives of Midwives Association Affiliated to the Midwives' Institute", NN, February 1914, 37.

Chapter 7

Transforming the Maternity Services, 1918-1936

In the years after the war, the State, through the new Ministry of Health, became the catalyst for redefining maternity care standards and reorganizing its delivery. This process was halting and uneven, and often constrained by economic and ideological considerations. Nevertheless, in its effort to fight a steadily rising maternal mortality rate, the Ministry oversaw the development of a system of clinics, a greatly increased provision for institutional childbirth, and revisions in the training of medical and midwifery practitioners. Although loosely coordinated, locally based, and limited to those who either could pay or were willing to undergo scrutiny of their financial and personal affairs, the maternity service, by the middle nineteen thirties, represented a trend toward greatly increased government involvement in matters of public welfare. As such, the maternity services were shaped by the pressing social problems of the inter-war years on the one hand, and the political and economic priorities of the State on the other.

The scandal of maternal mortality was one of the dominant issues of the public health movement during the inter-war years. Despite the overall decline in mortality rate among the female population, the maternal mortality rate rose from 5.16 maternal deaths per 1, 000 live births in 1922 to its highest point of 5.55 in 1931.[1] Although some reductions were accomplished over the next eight years, the total maternal mortality rate continued to hover around the 4 to 5 deaths per 1, 000 live births.[2] These rates translated into the death of approximately 3,000 women annually from an event which was widely regarded as a normal, physiological function.

The growing concern over maternal mortality was a practical outgrowth of almost three decades of infant and maternal welfare work. While infant mortality had declined, the increase in mortality rates among mothers prevented reformers from claiming complete victory in their long campaign for safer motherhood. "Premature death in any circumstances is a poignant tragedy, " wrote George McCleary, "it is heartrending and terrible in the lying-in room."[3] The pressure exerted by infant and maternal welfare advocates on the government to apply the same responsibility to maternal

welfare as the state had taken for infant life was, within this context, the logical outcome of the goals of the movement itself. Yet, the issue of maternal mortality touched a broader social debate than that generated by the more immediate and internal momentum of the infant and maternal welfare movement. The numbers of women who died every year as a result of childbearing was small when compared with tubercular mortality rates among the female population. Compared to the broader turmoil represented by the strikes on "Red Clydeside", the threatening immobilization of the General Strike, and the collapse of the international economy, the death of a few women might not have appeared to constitute a national priority. Within the matrix of inter-war social concerns, however, the question of maternal mortality became highly politicized.

The spreading international economic depression and the resulting mass unemployment comprised the field on which all social and political issues were played out during these years.[4] Millions of people lost their jobs during the inter-war years because of the restructured British economy and the worldwide depression. During the two decades between the wars, there were never less than one million unemployed; in 1920-1921, almost two million were unemployed; from 1931-1935 the number never fell below two million; in 1932-1933 the count went up to three million.[5] By far the greatest number were concentrated in the so-called depressed areas of the northern England, Scotland, and Wales where the heavy export industries such as coal mining, shipbuilding and steel manufacturing were located. In the north England town of Jarrow, near Newcastle-on-Tyne, almost 70% of insured workers were out of work in 1934.[6] Many of these men and women suffered from years of unemployment. The Pilgrim Trust, in its study of six of the most devastated communities in 1936, found that 52,000 men had been out of work for over five years and 205, 000 for two or more. In one of their sample towns, Crook (also near Newcastle), investigators found that almost three-fourths of the unemployed had been so for over five years.[7] The plight of these communities was all the more dramatic when compared to the relative prosperity of other areas where the new light industries and technologies had been established. In Coventry and Oxford, for example, the percentage of unemployed insured workers in 1934 was 5.1% and St. Albans was 3.9%.

While few disputed the unprecedented nature of such unemployment, its effects were a matter of acrimonious debate. Attention focused on health--

the most sensitive indicator of well-being--and particularly on the alarmingly steady rise in the maternal mortality rates. Two different schools of interpretations emerged from this debate, each advocating different solutions. The Ministry of Health, newly formed in 1919, along with a constellation of professional organizations involved in maternal and infant care, considered maternal mortality a medical problem which could be solved by improvement and expansion of professional services and medical facilities. On the other side, a coalition of nutritional experts, Medical Officers of Health, feminists, social reformers and physicians argued that maternal mortality reflected a broader social problem that could not be remedied by medical and administrative solutions alone. They held that women died or were debilitated from childbearing because they were too poor to secure a diet adequate enough to guarantee a minimum standard of health. These critics emphasized both the government's responsibility to organize and coordinate medical service, and to address the root cause of women's ill-health--inadequate levels of income.

The Ministry's narrow medical solution during the inter-war period, reflected established medical opinion, and buttressed the laissez-faire priorities of successive governments. By focusing on improvements in training, administration and supervision of women during the childbearing period, the government tried to shift discussion away from the broader influences on maternal mortality. They believed that minimal reforms in medical services would ameliorate the problem without saddling the central government with the responsibility for the health and welfare of childbearing women. The development of the maternity services during the inter-war period was not just a product of advancing science, individual concern or collective benevolence, but of a political and ideological struggle which encompassed, but also went beyond, maternal mortality.

Maternal Mortality as a Medical Problem

Janet Mary Campbell, relatively young at 41 when appointed Senior Medical Officer to the Maternity and Child Welfare section, became the Ministry's primary spokesperson and foot soldier in the struggle over maternal mortality.[6] Campbell's 1924 "Report on Maternal Mortality

Associated with Childbirth" laid the intellectual foundation for the Ministry's maternal welfare position during the inter-war period. Her study concluded that the majority of maternal deaths resulted not from social and economic factors, but from the introduction and spread of a pathogenic organism in the parturient woman. She argued that puerperal sepsis, the clinical designation given to the signs and symptoms of the bacterial infection, was the single most frequent cause of maternal death. Of the 2,971 women who died in childbirth in 1922, 1,079, more than a third, died from puerperal sepsis.[9] The figures for 1927 were similar. Of the 2,860 women who died in childbirth, 1,109 deaths were due to sepsis.[10] For Campbell, the key to reducing maternal mortality lay in eradicating the practices which allowed the bacteria to spread.

In formulating the Ministry's response to the problem, Campbell turned to the specialty of obstetrics for answers. Although obstetric consultants, like their colleagues in other disciplines, came from the ranks of the elite, within the medical profession obstetrics was regarded as a minor and unimportant speciality. But with the controversy over maternal mortality, and the government's decision to develop the maternity services, obstetrics' star began to rise. As in other medical fields during this period, obstetrical knowledge was largely empirical and accumulated through clinical study. Clinical observation and experience gave crucial insights, but did not explain why a natural process or a problem developed; nor how it could be understood and treated.[11] Even leading obstetricians were prone to mix folklore and established fact. For example, Louise McIlroy, a professor of obstetrics and gynecology at the University of London's Royal Free Hospital, implied in an article for The Nursing Times that maternal impressions could be a factor in foetal deformity.[12] The technology of obstetrics had none of the features with which we are familiar--intravenous feedings, the regulation of parturition by the introduction of drugs, fetal monitoring. X-rays, much to the detriment of both the foetus, mother and physician, were just coming into use in the nineteen twenties.[13] Forceps were the routine means of intervention, and cesarian section and surgery were the standard of care for urgent and complicated cases.

At the same time, however, medical research during this period began to expand knowledge of the physiology of childbearing as well its occasional pathology. Although researchers remained uncertain about the length of gestation and therefore could not accurately predict the onset of labor, by the

late nineteen twenties they had begun to understand the cycle of menstruation and by 1928 an accurate pregnancy test had been devised. The etiology of the maternal convulsions which at the onset of labor signalled the then almost always fatal eclampsia was also unknown, but researchers had established a connection between these convulsions and the presence of high levels of albumin in the blood.

Puerperal sepsis was probably the most dreaded of maternal complications because of its high fatality rate . Physicians and midwives recognized the high fever and restlessness which signalled its onset, the advanced symptoms of delirium, rapid pulse, inflammation, and the development of pleurisy and pneumonia, or the thrombosis which could lead to embolism and metastatic abscesses. Yet, little was known about the etiology of puerperal sepsis when Campbell issued her first report in 1924. "As someone has remarked," wrote the well-known obstetrician Comyns Berkely, "there are two things known for certain about puerperal sepsis: one is nothing, and the other is that the medical attendant will be blamed."[14] Physicians understood that the infection was most likely transmitted through physical contact such as intra-uterine manipulation, via infected hands or instruments. Excessive internal examinations, unnecessary and prolonged use of forceps, and the lacerations of the cervix, perineum and vagina which resulted from lack of skillful intervention were thought to increase the possibility of infection as was any condition, such as severe hemorrhage, which might lower the patient's resistance to infection.[15] To keep infection from the placental site, or any bruised and lacerated tissues, obstetricians throughout the twenties recommended the washing and disinfecting of the vulva and the rigorous sterilization of instruments and hands. To this end, they developed highly technical procedures for mixing disinfectants, sterilization of instruments and the water, choice of soap, and the treatment of the hands. With the discovery in the early thirties that bacteria could also be transmitted through droplet infection, obstetricians began to insist upon the necessity for attendants to use sterile masks and gloves.[16]

From this body of clinical experience and medical research grew an obstetric opinion that advocated non-interventionist, preventive maternity care. Leading obstetricians agreed with the obstetrician John Fairbairn who told his audience in a lecture for the National Association for the Prevention of Infant Mortality, "The process of reproduction--pregnancy, labour and

lactation--are natural and physiological. . . ."[17] The duty of the attendant was "to let Nature do her own work whenever she can", wrote T. W. Eden, one of the foremost obstetricians of his day. "The great practitioners of the past . . . understood theirs to be that of watcher."[18] Intervention was still regarded as a necessary weapon in the obstetrician's armory, but only if other means at his disposal were exhausted. Rates of intervention with both forceps and caesarian section did increase during these years. Available statistics indicate that by the nineteen thirties the rate of obstetrical interference in the course of labor had increased. In one London hospital, for example, the rate increased from 1.35 in 1875 to 18.6 in 1928. By 1934, it was estimated that general practitioners used forceps in as many as 60% of their cases.[19] Yet, established obstetric opinion disapproved of this trend. While this view corresponded to the physiological nature of childbearing, it was also rooted in the limitations of obstetrical knowledge itself. In a period in which infection could not be controlled, intervention was dangerous. Professor W. Blair Bell observed in 1921 that most practitioners were more skilled in the application of forceps than they had been in the past but did not "think that the good done atones for the damage that too often follows the indiscriminate of them."[20]

Obstetricians readily acknowledged that complications could develop unexpectedly in any stage of the childbearing process, but they believed that careful management of pregnancy through ante-natal supervision could help to prevent the problems which required intervention during labor. The various problems which a woman might encounter through her pregnancy--anemia, a contracted pelvis, edema or high levels of albumin in her urine--were all factors which could lead to puerperal complications which would require manipulation and intervention thereby making her more vulnerable to infection. As a result, some simple procedures had been identified which proved useful in predicting the course of a woman's pregnancy and labor. Testing urine for albumin, measuring the pelvis for size and deformity, examining the woman's teeth and conducting a physical examination to determine overall health became the substance of ante-natal care. As with puerperal sepsis, most treatment was preventive. For those women who showed high levels of albumin (the primary indicator of preeclampsia), for example, the standard treatment advised a nutritionally balanced diet coupled with sufficient rest.[21] For those women who developed edema, rest and the elevation of the affected part were prescribed. Medical theory held

that controlling these factors would reduce the chances of unexpected complications. "Our object," John Fairbairn wrote of the physiological nature of childbearing, "is to maintain [it] as such and prevent [it] from becoming abnormal."[22] If complications were expected, the physician could make advanced preparations for the labor rather than go in at the last minute, unfamiliar with the woman's history, and hurriedly apply forceps or conduct caesarian surgery in an altogether unsuitable environment, and thereby increase the risk of infection.

Ministry officials embraced the medical analysis that childbirth was a physiological event which needed not interference, but protection against possible complications. "Childbirth is a natural and physiological process," George Newman, the Chief Medical Officer at the Ministry of Health, wrote in his introduction to Campbell's 1924 report. "But to assure its safe discharge it is necessary that there should be available for every confinement an irreducible minimum of knowledge, experience and aseptic method."[23] Broad social reform was unnecessary if maternal outcomes could be controlled through a series of medical examinations. "More essential than the environment or the personal health and occupation of the mother," Newman wrote, "is the dominant need of ante-natal supervision."[24] Ante-natal care under medical supervision would identify those women who were likely to experience problems in their pregnancies and labors. "Its special value, as far as puerperal sepsis is concerned," Campbell wrote, "is to reduce the number of difficult labors which always involve manipulation and especially emergency operations."[25] Routine complications would be treated by the general practitioner and the more severe problems referred to the obstetric consultant. Ante-natal care could take place in the general practitioners surgery, in a clinic designed for the purpose or by the midwife in her own or the pregnant woman's home. "We must prevent", Campbell's superior George Newman wrote, "and we can only prevent by preparation."[26]

While ante-natal care would form the cornerstone of the preventive maternity services, Campbell also proposed that institutional care be provided for those problem cases which were beyond the scope of the midwife's practice and the general practitioner's expertise. Puerperal sepsis had been associated with difficult and complicated deliveries that necessitated hurried intervention, which frequently prevented careful and systematic antiseptic procedures. Under the proper conditions, ante-natal supervision would

identify those women who were likely to experience problems in their pregnancies and labors and refer them to the hospital. With adequate time for planning, the potential problems could be anticipated and the pregnancy and labor appropriately managed. If necessary, intra-uterine manipulation and intervention could be more safely conducted in the confines of institutional facilities, with highly-trained personnel using standard antiseptic procedures for normal and abnormal deliveries alike.[27] To meet this need, Campbell recommended that the number of maternity beds be expanded for women whose home situation made labor there unsuitable, for those situations with abnormal ante-natal findings and where difficult labor was anticipated, for emergencies, and for women who preferred to deliver in an institution.[28] Campbell's report urged administrators of general and voluntary hospitals, teaching institutions and small maternity homes to provide maternity beds for abnormal cases, ante-natal beds for those women with toxemias, and post-natal beds for those who might be too ill to return home immediately. While her recommendations encouraged the increase in maternity beds, she regarded institutional provision as but one part of the complex of services which included ante-natal and post-natal care. For Campbell, institutional provision supplemented comprehensive preventive supervision of childbearing. "It is not necessary," she commented, "to take the extreme view that all confinements should be regarded as surgical operations, and therefore treated in hospital, to realise that sufficient maternity beds . . . are an essential part of a Maternity Service."[29]

Campbell's proposals to control the influence of maternal morbidity on childbearing focused almost exclusively on the relationship of a woman's previous pregnancies to future ones. She recommended that post-natal examinations become part of routine, extended medical care. Any problems which had developed as a result of pregnancy and childbirth could be identified and treated and any potential problems could be noted. In this way, a woman and her attendant would be "spared difficulty at any future confinement"[30]

Beyond this, Campbell and the Ministry regarded the broader factors which might lead to maternal morbidity a matter of *personal*, rather than *social*, responsibility. To the extent that childbearing women were not healthy, it was because they had not been "taught that it is necessary to pay attention to the mother's own physical health before, during and after

pregnancy."[31] All of the components of her proposed maternity services could educate women of "the dangers they invite and the risks they run through neglect of themselves", but it was the mothers themselves who had to choose to save themselves from overwork, to maintain a nutritionally sound diet and to guarantee that they proceeded through childbearing successfully by conforming to the physician's orders.[32]

Refining the Division of Labor

As Campbell delineated the tasks of an extended and expanded provision of maternity care, she also outlined a division of labor among general practitioners, obstetricians and midwives. At the time of Campbell's writing, there was little organization or coordination of medical practice except for those relatively few physicians who worked for the public health system. General practitioners, midwives and obstetricians worked privately and, broken into their individual professional interest groups, were fiercely protective of what they regarded as their professional prerogatives. Neither Campbell nor the Ministry of Health had any desire to intrude upon the private organization of medical care or to dictate to the professions. At the same time, however, the Ministry invested increasing amounts of money and energy into the development of maternity services. The Ministry therefore had an interest in influencing not only the delivery of the service but the credentials and quality of those who were part of it. As a result, in her 1924 and 1927 reports Campbell made recommendations as to the appropriate role each practitioner should play in the maternity services and the type of training which would prepare them for that role.

According to Campbell, obstetricians needed little improvement. They were in the vanguard of the struggle against maternal mortality, they practiced in the most ideal of conditions, and their training was the most advanced and scientific. Because their training and their subsequent practice were concentrated in a single specialty, they were able to deepen their knowledge and develop their expertise in a way the general practitioner could not. "All consultants," Campbell wrote, "necessarily possess a wider knowledge of their own subject, and there is little difference between the skill of one and that of another."[33] Since their practice set the standard of obstetric

care, she considered their solutions to the problem of puerperal sepsis as the last word on the subject.[34] From 1924, Campbell urged local authorities to appoint obstetric consultants to institutions which supplied municipally-funded maternity beds. In return for a fee and a schedule which allowed them to maintain a private practice, consultants should be available to advise general practitioners on particularly difficult cases, manage cases beyond the scope of the general practitioner and the midwife, and take the surgical and emergency obstetric cases.[35] Ante-natal care and routine cases should be left to general practitioners and the midwives.

General practitioners, though, came in for a blistering attack from Campbell. She argued that the general practitioner was more likely to introduce infection into the parturient woman and more likely to perform inadequately when faced with emergencies and difficult cases because his midwifery cases were merely one of many kinds for which he was responsible. The general practitioner's risk of exposure to and transmission of infection was high. "In working class districts he seldom wears gloves or a washing coat or gown and facilities for careful disinfection of his hands or instruments are limited."[36] Because few physicians provided ante-natal care, abnormalities were rarely identified before the woman began labor. Faced with the results of poor ante-natal supervision, the general practitioner was often called in at the last minute, often had no skilled assistance, and, if in a busy practice, "may be tempted to expedite the delivery in normal cases by means of forceps."[37] Equally alarming, the general practitioner did not recognize the limitations of his expertise. "One cannot escape the conclusion," Campbell wrote, "that operative procedures are not infrequently undertaken without sufficient skill and judgement, and without full appreciation of the risk incurred. . . . "[38]

Despite his failings, Campbell recognized the general practitioner as the "first bulwark against obstetrical failure."[39] For Campbell, the question was how to improve the physician's contribution to maternity care given his unique position as the center of the country's medical services. In 1922, the General Medical Council (GMC) had passed a resolution which required medical schools to implement systematic training in obstetrics through a series of lectures in obstetrics, gynecology, ante-natal conditions and infant care, through clinical demonstrations, and through attendance in both outpatient and inpatient labors.[40] In 1923, Campbell had devoted an entire

report to the failure of medical training to adequately prepare physicians for ante-natal care and obstetric evaluation and intervention.[41] By 1927, Campbell could report that some of the GMC's requirements had been implemented in the better medical schools.

Yet the pressures of the general practitioner's other cases, the dangers of infection those cases presented to the parturient woman, and the resulting difficulties which a hurried physician might bring to a midwifery case could not be remedied by improved training alone. Neither did the physician have the time to sit with the parturient woman for hours while a labor progressed. As a solution, Campbell delineated the division of labor between the general practitioner, the midwife and the obstetrician. Campbell agreed with John Fairbairn that a physician was an "expensive social instrument" used most efficiently when others could be recruited to take over the less essential tasks. Campbell believed that by lifting the burden of routine midwifery from the general practitioner's shoulders and transferring it to the midwife he would be better able to perform his appropriate function.

> This involves rather a shifting of the medical service from the part where least essential to those parts it is most essential; the observation of pregnancy, the study of the individual characteristics of the woman, and the determination of the best methods of management; supervising her labour merely so far as to be assured of the absence of complications, and deciding what is advisable to maintain good uterine action and to avoid fatigue, and generally to be ready to answer the summons of his midwife and act on her report; after the labour to give more attention to the puerperium, lactation and the young infant than has been the case in past years.[42]

The general practitioner would still maintain his supervision over the entire childbearing period, but the routine tasks of normal cases would be delegated to the midwife, leaving the practitioner to attend to more pressing medical cases. While his authority would be strengthened on the routine and normal end of midwifery, the general practitioner had also to recognize, as one Departmental Committee later reported, that, "in the interests of the mother there are limits to his sphere."[43] The general practitioner's understanding of the "early differentiation between normal and complicated cases in order that

he may refer to institutions all those which are unsuitable for domiciliary treatment"[44] constituted his central role in the maternity service. Providing him with adequate auxiliary services--for example, clinics where he could seek advice or consultation, or obstetric consultants appointed to the local hospitals who could consult on difficult cases, or skilled nursing, or institutional facilities to which he could refer patients beyond his expertise--such services would improve his practice and lessen his burden rather than interfere with his authority.

Although Campbell insisted upon medical supervision during the entire childbearing period, she did not intend for midwives merely to become the physician's assistant. A clearer delineation of the midwife's tasks would, as with her general practitioner colleagues, strengthen rather than weaken her authority. Once the medical practitioner was satisfied that the case would proceed without complications the midwife should take full responsibility for ante-natal care, attendance on the woman during labor, and the care of the woman and infant during the required ten days postpartum. If complications arose at any time during this period the midwife would notify the physician supervising the case. Otherwise, there was little reason for the physician to be involved. Although a midwife's practice was statutorily limited to attendance on those cases which proceeded normally, Campbell believed that within that limited scope, the midwife's understanding and expertise could be deepened just as any specialists could.

Campbell believed that the expanded role which she outlined for the midwife placed "greater demands upon her intelligence and professional competence" than what most existing training programs had prepared her for. Campbell had no quarrel with the content of the curriculum which the Central Midwives Board required in the midwifery training programs. She did question what she considered an inadequate length of time in which to master the material, and the inevitable unevenness of the results. She supported the changes in midwifery training which had occurred since the original Midwives Act had been implemented. Initially, CMB training requirements focused on teaching the pupil the physiology of labor, the correct procedures to protect the woman against infection and recognition of deviations during parturition from what was regarded as normal. While these elements formed the core of midwives' training, the curriculum also included instruction in the physiology of pregnancy and its complications.

When the period of training was extended in 1916, the revised curriculum reflected the growing belief that attention to the ante-natal period held the key to better infant and maternal outcomes. Instruction in the physiology of pregnancy and the diseases associated with the ante-natal period were expanded. Midwives were taught the principles of ante-natal care and how to conduct an examination, including the testing of urine. Midwives learned the effects of disease in pregnancy on not only the woman but the infant she carried. [45]

Campbell suggested only two additions to the existing content of the midwifery curriculum. First, while midwives were trained to recognize any deviations from the normal during the puerperium, Campbell argued that midwives had to be taught to do more than take the temperature and pulse, which the Rules required of them. Schools had to ensure that midwives could recognize the more subtle indications of developing complications or the slight tears and lacerations which might provide sites for infection. Second, in keeping with her overall proposal to extend professional supervision over the entire childbearing period, she urged that midwifery education pay more attention to post-natal care of mother and infant. The midwife needed to be more fully exposed to current teachings on infant care. She needed to know how to resuscitate an asphyxiated baby, to recognize and to nurse ophthalmia neonatorum, and to recognize infantile infectious diseases such as pemphigus.[46] As the health practitioner closest to the woman and the family, the midwife was also well-placed to educate the new mother on proper breastfeeding techniques, "the care of the breasts, the number of feeds, the variations to be made for weakly or premature infants . . . " and thereby establish a healthy basis for the infant's development.[47]

Although Campbell's conception of the maternity services was based on the belief that childbirth was a physiological process, and that care should be largely preventive, the role she had assigned to puerperal sepsis required that midwife training include more attention to pathological conditions. Campbell sought to reinforce the midwife's role in normal childbirth, but she emphasized the need for the midwife to both understand and attend to, the pathological to a much greater degree than previously done. As a result, Campbell suggested that midwives' practice would be far safer if they were trained in that area of work which specialized in attendance

on the pathological, general nursing. She recommended that a greater part of midwives' training be devoted to,

> knowledge of general nursing so that she may be better equipped to recognise and, in emergency, even to nurse cases of severe illness. . . . The midwife who is not a nurse is usually at a great disadvantage in dealing with a case of puerperal infection because she knows so little of the significance and treatment of the constitutional symptoms of illness. . . . [48]

The 1929 Departmental Committee, charged with making recommendations for the training and supply of midwives, supported Campbell's call for general training of midwives. The Committee asserted that making general nursing a prerequisite for midwifery training would "be good for the profession as a whole and the community at large. . . . "[49] Although both Campbell and the Committee members stopped short of recommending general nursing as a prerequisite to midwifery training, their recommendations nevertheless helped to set general nursing as the standard of care to which midwifery training should aspire.[50]

In her redefinition of the role midwifery would play, Campbell did not intend for midwives to be relegated to a subsidiary position within the maternity services. On the contrary, in a period in which medical care, even obstetrical emergency care, was limited among the working class, the success of the maternity service depended more upon the midwife than the medical man. Campbell did not want a midwife who merely "trusted blindly to the knowledge of those who trained her," but one who relied upon her own "common sense and experience" buttressed by a thorough grounding in theoretical knowledge. [51] For this theoretical knowledge, midwives needed a training which provided "a wide education with time to think, to learn intelligently, time to face difficulties, time to question and to criticise."[52] By extending the period of training, increasing the number of cases needed to qualify from twenty to twenty-five or thirty, and improving the coordination and methods of teaching, Campbell hoped that training programs would give the midwife confidence in her abilities before she graduated rather than having to learn from her mistakes when on her own. Confident in herself, she would instill confidence in the often fearful or exhausted mother. No

longer suffering from the fears of the initiate, the midwife would pay attention to the wider dimensions of her work which were equally important in the prevention of maternal morbidity and death. "It is only when the pupil is reasonably sure of herself," Campbell wrote, "that she is able to . . . successfully create an atmosphere of confidence and trust; only in this way can she make [the mother] as comfortable and content in mind and body. . . . "[53] Only by encouraging self-confidence and independent thinking in their pupils could training institutions produce midwives capable of adhering to the standards needed to reduce maternal morbidity while at the same time coping with the realities of midwifery practice.

Campbell sought to harness obstetricians, general practitioners and midwives to the needs of the maternity services. By delineating their respective tasks, she sought to make the best use of the expertise of each. Educational reform would teach future practitioners to conform to this new division of labor. Through streamlining practitioners' roles within maternity care delivery Campbell hoped to strengthen the medical solution to maternal mortality.

The Medical Solution Takes Hold

In her 1927 report, "The Protection of Motherhood", Campbell found that local authorities had implemented some of her recommendations, nonetheless, much still needed to be done. The number of ante-natal clinics had increased, but Campbell argued that "only a fraction of pregnant women are in fact getting [care]."[54] Clinics needed to expand their services, upgrade their personnel to include physicians who were thoroughly familiar with ante-natal conditions, and increase their attempts to persuade women of the necessity of ante-natal supervision. Relative few institutions performed post-natal examinations, and the morbidity which they discovered prompted Campbell to further encourage local authorities and general practitioners to institute provisions for such follow-up visits. She also reported that local authorities had increased their support of maternity beds to 2, 290 beds in 149 institutions (for a capacity of 50,000 patients), but here too she found the provision wanting. Not only were there insufficient maternity beds, but Campbell argued hospitals' services were frequently uncoordinated with

domiciliary work. In 1926, for example, of the 42 maternal deaths in one hospital, 36 were emergency cases. Some of those "lives would have been saved had hospital treatment been sought earlier," Campbell claimed.[55]

Alarmed by the unevenness of maternity provision and the lack of cooperation among providers, Campbell called for the creation of larger and closely coordinated maternity service. She emphasized that local authorities had to do more than continue to provide services in an ad hoc manner. They had to guarantee that the full range of maternity services were made available in their areas.

> A complete Maternity Service must have as its nucleus domiciliary midwifery by doctors or midwives in private practice, but this should be amplified and rounded off by facilities arranged and offered by the Local Authority and made available for all women requiring them, whether those women are 'necessitous' or able to pay part or whole of the cost."[56]

If authorities needed to augment their existing services, they should subsidize new ones. If the necessary components of Campbell's proposals were already present, authorities ought to guarantee the most efficient use of existing services through greater coordination and cooperation.

Campbell argued that the Maternity and Child Welfare Act of 1918 gave the legal and financial means to local governments to assume this responsibility. The Act required local authorities to provide not only domiciliary provision for "necessitous cases", but also to guarantee that a full range of maternity services were available to their constituents. The government provided up to 50% of the start-up cost of ante-natal clinics, operational expenses, support for personnel from midwives to health visitors, and for the provision of maternity beds in local hospitals or maternity homes. Both Campbell and George Newman (Chief Medical Officer at the Ministry of Health and Campbell's superior) agreed that these proposals were not designed to increase the burdens on the local authorities, particularly when the current "financial situation of the country makes it impracticable to embark upon costly developments or uneconomical expenditures."[57] Rather, Campbell's complete maternity service could be

achieved by "an all-round improved practice and more skilful use of existing agencies."[58]

At no time did the Ministry or its various committees which were brought together to consider maternal mortality and the maternity services believe that either central or local government should assume the full social obligation for maternal welfare. As Campbell emphasized, "By a complete maternity service I do not mean a municipal or a State service."[59] Local government, in partnership with the Ministry of Health, would assume responsibility for provision of services and their administration, but this care would be extended only to those who were employed and paid into the insurance program, or to those who could afford to pay through private means. Local governments were empowered to cover all or part of the cost for those who could not afford the fees of attendants, but these subsidies were bestowed on the applicants only after the families' had met stringent eligibility requirements.

Two important departmental committees, the 1929 Departmental Committee on the Training and Employment of Midwives and the 1932 Departmental Committee on Maternal Mortality and Morbidity, supported Campbell's call for a maternity service. The 1929 Committee had been formed to investigate how midwives could be efficiently integrated into the developing maternity services; the members concluded that improved training for midwives would mean little unless reform was accompanied by a maternity scheme which addressed the problem of maternal mortality "on a broad, even on a national basis."[60] They recommended that a certified midwife, a general practitioner and an obstetrical specialist should be available in all areas, that care had to be extended to cover ante-natal, puerperium and post-natal periods, and that National Insurance should be expanded to cover all required maternity services--not merely childbirth attendance.

In its final report, published in 1932, the Departmental Committee on Maternal Mortality and Morbidity proposed that reduction of maternal mortality required the integrated maternity service Campbell had proposed five years earlier. The Committee identified eight elements as essential to appropriate standards of care. The Committee found that in 46% of their sample of 5,805 cases of maternal death, one or more of these elements was missing. From this they concluded that maternal mortality could be reduced

through the consistent application of the standard of care they had outlined. The individual elements included: early booking and making arrangements for the confinement; ante-natal care with a doctor or a midwife in order to determine if there were any complications; antiseptic precautions taken; a skilled doctor or midwife made available; the availability of institutional facilities and transportation provided if necessary; the availability of an anesthetist; and suitable facilities for skilled specialist care. All of the elements related in one way or another to the necessity for medical supervision and the expanded provision of medical services. The necessity for confinement to take place in a suitable environment, was the only item not wholly related to the provision of medical services.[61] That such a prestigious committee had determined so high a percentage of maternal deaths could be prevented through expanded medical services heightened the credibility of the Ministry's position.[62]

By the mid-nineteen thirties, local authorities had developed a network of maternity services throughout the country which, although locally controlled and subject to variation from area to area, reflected the overall thrust toward increased professional services and medical facilities. Local authorities started ante-natal clinics, either built and operated maternity homes or financed maternity beds in voluntary or maternity hospitals and subsidized district nursing associations to provide domiciliary care in their areas. In addition, private practitioners were often incorporated into the system through reimbursements for attendance on "necessitous cases". Maternal and infant welfare programs, like other social services, were supported through a gradual increase in allocations from the central government and from the various sources which local authorities had available to them, such as loans and revenues from the rates levied in their areas. Between 1913 and 1934, the central government increased its spending on social services from £22 1/2 million to £204 million. Local authorities also increased their spending in social services. In the areas of public health, housing and education, for example, authorities spent £45 million in 1913-1914 and £271 million by 1938-1939.[63]

There were 772 ante-natal centers in England and Wales when Campbell published her report, "The Protection of Motherhood" in 1927. 474 of the centers were operated by local authorities; 298 by voluntary agencies.[64] Although many local authorities subsidized voluntary efforts, by 1932 the

ratio of municipal clinics to voluntary ones had almost tripled. In 1932, there were 860 clinics supported by local authorities and 190 conducted by voluntary agencies.[65] By 1936 the total number of ante-natal clinics organized by local authorities had increased to almost 2000.[66] The primary function of the clinic was to conduct examinations and offer the women advice regarding their pregnancies. The clinics did not offer any treatment, however, and if they had medical problems women were referred either to a physician or a hospital.[67]

Institutional care increased most dramatically during the nineteen-thirties. Few facilities for inpatient maternity care existed at the time of the 1918 Maternity and Child Welfare Act. Most women had children at home. The institutional maternity care that was available was concentrated in larger cities. The standard of the facilities varied widely, the expertise of the staff was uneven and in many "there were practically no proper arrangements for the treatment of puerperal sepsis."[68] Because the Ministry and Local Authorities were "faced with an acute and widespread shortage of maternity beds"[69] the government paid particular attention to increasing institutional capacity. The Ministry offered grants to local authorities to expand the number of beds available for maternity cases and to maintain the new beds.[70] Because local authorities chose how to implement the Ministry's requests, arrangements varied according to local circumstances. Local authorities subsidized voluntary Maternity Homes, a number of beds in a Maternity hospital, or, with the help of Ministry of Health grants, established and administered small, municipal maternity homes. Under municipal subsidy, the Hull Maternity Home, for example, grew "from a hospital of 14 beds and 6 nursing staff . . . into a unit with a 60 bed hospital, isolation wards, a nursery with cot, ante- and post-natal and dental clinics, and a domiciliary extern practice" by 1935.[71] Local authorities had increased their control over hospital beds when the Local Government Act was passed in 1929. With this legislation, the Poor Law was finally dismantled, with responsibility for the poor passed to the local authorities, along with what William Frazier described as "a vast system of hospitals and institutions in which a large proportion of the in-patient treatment of the sick was being carried on."[72] Although understaffed and ill-equipped, the former Poor Law hospitals provided a solution to the local authorities' obligation to furnish maternity care to necessitous cases and to a large extent accounted for the jump in institutional births.[73] In 1927, 15% of births took place in the hospital. By 1937 35%-40% took place there.[74] In some

cities, the increase in the number of institutional births was even more dramatic. In Manchester, for example, the percentage of births taking place in institutions rose from 11% in 1924 to 40% in 1933.[75]

Domiciliary birth still continued to represent a significant, if declining, percentage of confinements. Local authorities instituted a variety of arrangements for maternity attendance at home. Some authorities employed a midwife to attend women who could not afford to pay the midwifery fees typically charged in the district. Other local authorities arranged to reimburse privately practicing midwives whose patients could not afford the entire fee. In both these cases, the authority usually agreed to pay only part of the fee while the woman was responsible for the rest. Less than 30% of the local authorities used this method of subsidizing home maternity care, however. To save themselves the administrative costs, local authorities more commonly subsidized the work of district nursing associations. The "unofficial" Maternal Mortality Committee found that between 65% and 70% of County Councils and Metropolitan Borough Councils provided some subsidy to local district nursing associations.[76] These associations offered midwifery and nursing services to families who could not afford the standard fee charged by independent, privately practicing midwives. The district nursing associations affiliated with "the Queen's Institute" (the Queen Victoria Jubilee Institute for District Nursing, an umbrella organization for the associations) achieved an overall mortality rate of 2.5 deaths per 1, 000 live births — the lowest maternal mortality of any of the organized care providers.[77] Midwives in private practice, already economically vulnerable, were increasingly marginalized by this increase of subsidized providers who could provide the same service at a lower cost.

By the early thirties considerable limitations on the growth and effectiveness of the system were becoming evident, however. Although government social services expenditures increased during the inter-war years, the rate of growth fluctuated. The rate of government spending had increased rapidly from £22.5 million in 1913 to £179 million in 1922. The government did not sustain this growth, and spending in these areas increased to only £204.5 million by 1934.[78] As a result of the depression, local governments were subject to greater financial pressures. Although central government supplied a growing percentage of local authorities' operating funds, local governments still found they had to levy higher rates and to undertake extensive

borrowing to meet their obligations.[79] Social service spending became an immediate matter of concern to the rate-payers and therefore a matter of political controversy.

Changes in government allocation procedures also influenced the extent to which beleaguered authorities could invest in maternal and infant welfare services. Under the 1918 Maternity and Child Welfare Act, the government supplied 50% of the funding to start, operate and maintain ante-natal clinics, maternity homes and various other elements of the maternity services. Under a new system instituted in 1929, however, the matching funds system was eliminated. Instead, authorities received a block grant for public health expenditures.[80] While the 50% grant had encouraged local authorities to develop their maternal and child welfare programs, hard-pressed local governments began to reallocate their funds after the requirement was lifted. Probably the most illuminating statistic was the one published by the Daily Herald. Underneath a cartoon depicting Britannia marking the upward march of maternal mortality on a chart while a politician and an admiral looked on, the caption pointed out that "Britain spends on one battleship more than twice the amount she spends on the maternity service. . . . "[81]

The question of payment for maternity services became an increasingly important one. Whereas interest in childbearing had once concentrated on the comparatively few hours of parturition, the focus had been extended over time and expanded within that time. Ante-natal clinics, maternity homes, hospitals, and various attendants had to be reimbursed for their services. Although central and local government provided some of the cost through grants and national insurance contributions, the patient was also expected to contribute to the cost of this service. But the government considered health care an individual's responsibility, and consequently considered subsidizing health care as undesirable. Ministry officials and the committees which pondered the question attempted to expand the services covered by the national insurance's provision for maternity benefit. Although little is known about how women spent their maternity benefit, most officials agreed that it was inadequate to purchase the full range of services now advocated by the government. The Royal Commission on National Health Insurance in 1926, Campbell in 1927, and the 1929 Departmental Committee all proposed the expansion of the maternity benefit to provide both a cash payment to the

mother and support for the expanded maternity services through insurance.[82] Such insurance would preserve the principle of individual responsibility for health, while permitting workers to buy more services than they could otherwise. With such an insurance scheme, "the general practitioner, the midwife the nurse, the specialist and the institution would all take their respective parts in the scheme of extended medical services."[83] These recommendations came to nothing, however, leaving growing pressure on the government as the most reliable source of payment.

Because of the variation in local resources and systems of administration, the level of services varied considerably from area to area. In 1934, the unofficial Maternal Mortality Committee reported that although there had been significant expansion of services since 1918, only 47% of County Councils and 52% of County Boroughs were, "putting into force half or more of the services they have power to provide."[84] In the same year, for example, only 61% of the county councils supported ante-natal clinics while between 95% and 100% of the Borough Council and the Metropolitan Borough Councils did so.[85] Overall, fewer resources went into maternal and infant welfare programs and authorities were, as Campbell commented after she had left the Ministry, "in the main content to mark time and make small additions to existing staff and facilities."[86]

Under the Ministry's direction and financial subsidies the number of providers offering maternity services rapidly increased. At the same time, however, these services suffered from lack of coordination, uneven development and, by the nineteen-thirties, reductions in funding. Furthermore, the requirement that women pay for these services limited their availability to the women who were most likely to need them. As a result, the potential benefits of the provision of medical services remained limited.

Diet, Income and Maternal Mortality

By the nineteen thirties, nutritional researchers, many public health physicians and social activists were becoming increasingly critical of the government's health policies. Reductions in funding for maternal and infant health programs had limited the extent to which the maternity services were

accessible to those women who were in most need of them. Perhaps more important, critics charged, was the government's failure to acknowledge the relationship between women's health, their income level and the maternal mortality statistics. Maternal mortality could not be reduced, critics charged, until the government addressed the deteriorating standard of living of the increasing numbers of the population.

An avalanche of nutritional and dietary studies conducted in the nineteen thirties linked ill-health to poverty and specifically to inadequate income. According to many Medical of Officers of Health and independent researchers, the nation's health was being eroded by malnutrition brought on by people's inability to meet even the minimum nutritional and dietary requirements. Probably the most controversial study was the one conducted by the respected nutritional expert and Director of the Rowett Research Institute, Sir John Boyd Orr. Orr compared the cost of a diet of nutritional requirements necessary for health with the income level of social classes I-V. Although he had constructed his hypothetical diet on the most "stringent standards for optimum diet", his findings still indicated that alarming numbers of the population did not have the income to provide a minimum level of nourishment. In, Food, Health and Income (1933) , Orr revealed that malnutrition would be common among the unskilled and skilled workers which constituted social groups III-V and that even some members of social group II ("intermediate" between skilled workers and professionals), would be threatened.[87] Orr's work was severely criticized for methodological weaknesses, and the Ministry of Health attempted to suppress the publication of the book. But subsequent studies supported his final estimate that as much as 50% of the population was malnourished.[88] Local and regional studies confirmed that malnutrition, particularly in the depressed areas, was common. One study, conducted in 1934 in Newcastle-on-Tyne using a combination of biochemical testing and clinical observation, concluded that 36% of the children from one of the poor city's district were malnourished.[89]

Mortality rates--an accepted health indicator--were also much higher in the areas of high unemployment than in areas of low unemployment. The Medical Officer of Health for Stockton-on-Tees, Dr. M'Gonigle, compared the mortality rates of the employed and the unemployed in the same area between 1931 and 1934 and found that the unemployed suffered a higher mortality rate than the employed.[90] Richard Titmus examined Ministry of

Health infant mortality figures and found that higher percentages of working class infants and children died than those whose parents lived in more comfortable circumstances.[91] The Depressed Areas reported much higher infant mortality rates than the national average. While the national average for England and Wales for 1931-1932 was 62 per 1,000, seven wards in Oldham (near Manchester) reported infant mortality rates in excess 170. One ward in Manchester reported a rate of 143. The rates in these areas varied according to social class. In Lancashire and Cheshire, for example, infant mortality rates were 31.3 per thousand for the affluent social class I, 78.9 for social class IV, and 93.3 for social class V.[92]

Childbearing women in the depressed areas were particularly at risk. In her 1913 work, Round About a Pound a Week, Mrs. Pember Reeves chronicled her shock that working class women who looked as if they were, "in the dull middle of middle age" were in fact young women.[93] Studies throughout the twenties and thirties revealed little improvement in the quality of health among working class women. Jane Lewis found that 1932 national insurance commission statistics revealed that insured married working class women experienced "140% more sickness than the insurance commissioners had anticipated, compared with the 25% more sickness experienced by unmarried women and the less-than-expected sickness rates of men."[94] In her important 1939 study, Working Class Wives, Margery Spring Rice reached similar conclusions. Of the 1,250 women interviewed in her study, Spring Rice found that the health condition of the majority ranged from "indifferent" to "very grave". Only a third (31.3%) reported they felt in "apparently good health."[95] Spring Rice acknowledged the data reflected the women's own perception of their health rather than a purely scientific study of medical records and examinations. She found that far from exaggerating their poor health, "without conscious self-deception the woman has a conception of fitness far inferior to that of the more favored and prosperous sections of the community."[96]

Nutritional research had already linked the most common maternal medical problems, such as anemia, low protein and low iron levels to poor diet associated with poverty.[97] Working class families with limited resources could have difficulty purchasing the necessities for a healthy diet. Within the family, the working class wife typically had the poorest diet. The 1938 Pilgrim Trust study, Men Without Work, found that 170, 000 wives in their sample

consumed only 70% of the calories consumed by men, in contrast to the recommended level of 85%.[98] Poor women were not able to afford the extra dietary requirements necessary for a healthy pregnancy. In the mid-nineteen thirties, one pint of milk cost more than the entire weekly additional allowance for a wife of a man on government relief.[99] Many Medical Officers of Health (MOH) became convinced from witnessing the deterioration of the health of their charges first hand, that, as one wrote, "there is no doubt that the women are suffering from the results of the industrial depression . . . I attribute a considerable proportion of these [maternal] deaths to poor nutrition on the part of the mother. . . . "[100] The dramatic disparity in the maternal mortality rates between affluent and depressed areas confirmed the committee's report. In its final report in 1932, the Departmental Committee on Maternal Mortality found that between 1923 and 1925 the total maternal mortality rate in the depressed areas averaged between 6 and 7 per 1, 000 live births.[101] Such averages masked even higher yearly rates. For example, in the textile town of Bury (near Manchester), the average rate was 6.8 per thousand, but for three years the rate was as high as 10 per 1, 000.[102] In contrast, in the more prosperous areas of southern England the maternal mortality rate never rose above 3.5.[103]

A number of experiments had shown that attention to diet could have a profound effect on maternal and child health. Campbell often incorporated this literature into her reports, but she largely ignored its implications. In her 1924 report, for example, she cited an article by Miss M. Bruce Murray entitled, "The Effect of Maternal and Social Conditions and Nutrition upon Birthweight and Birth-Length" which found a positive correlation between improved nutrition and favorable infant and maternal outcomes.[104] Although she did not cite any other studies with similar conclusions, she and her colleagues at the Ministry must have known of the Dr. Cory Mann's study of poor law institution children, Edward Mellanby's findings linking Vitamin A to the prevention of infection or the widely publicized results of the National Childbirth Trust Fund's experiment in the Welsh mining district of Rhondda. In 1926, Dr. Cory Mann had reported that giving a pint of milk a day to each child in a poor law institution had yielded significant improvements in their health.[105] Two years later, Edward Mellanby had demonstrated that sufficient doses of Vitamin A increased a woman's resistance to sepsis. He recommended that the daily diet for pregnant women

include green vegetables, one or two pints of milk, eggs, fruit, codliver oil and fish and liver at least once a week.[106] Probably the most dramatic proof of the need to consider diet and nutrition in solving maternal mortality was provided in the Rhondda experiment. The Welsh district of Rhondda (an area with one of the highest unemployment rates in the country) also had one of the highest maternal mortality rates. By simply distributing dietary supplements to pregnant women, the maternal mortality rate was reduced in one year from 11.3 per 1,000 in 1934 to 3.9 per 1,000.[107]

The Ministry had not been entirely negligent in this area, but the dietary levels recommended by these studies were far beyond what the government was willing to sanction. In 1922, for example, the Ministry forced Hull to reduce its minimum income eligibility requirement for a family of five from 38s 2d to 37s 6d.[108] Pregnant women could receive free food and milk from local authorities, but like any other relief which the poor received, eligibility requirements were stringent and the investigations into income and finances tiresome and humiliating. "Milk and other foods should not be freely distributed without careful scrutiny," the 1932 Annual Report on Local Expenditures warned, "and some payment, however small, should be required in all but the most necessitous cases.[109] Although the Ministry was willing to suspend the power of Board of Guardian and Public Assistance Committees whose dispensation of relief appeared too generous, they were unwilling to do more than encourage local authorities to spend more on maternal food and milk programs.[110] Despite reformers' complaints that the block grant system reduced the amount of expenditures particularly in the food and milk programs, the Ministry continued to support the system because it was cost-efficient.[111] Milk programs were often the first to be eliminated when local budgets were reduced and reallocated. In Monmouthshire, a depressed area with very high maternal mortality, the local authorities reduced the milk and feeding program "to ensure that the supply should be strictly limited to those who are in need on medical grounds."[112]

Critics argued that widespread unemployment, particularly in the depressed areas, and the inadequacy of relief contributed toward a malnourished and sickly population. Medical services were welcomed, but as one commentator pointed out, that to "develop a huge system of clinics" without provision for "protecting the mother and child against the damaging

influence of deficient family resources" doomed them to failure.[113] Critics argued that women could not maintain their health without adequate nutrition and a reasonable amount of rest, not only when they were pregnant, but as a matter of routine. And they could not have an adequate diet or rest without the income to purchase proper food and to have a modicum of free time from work. If either women or their husbands could not secure this income and the government wanted to guarantee healthy and safe motherhood, then, critics argued, the government would have to find some way of providing it.

The Government Response

For the government, maternal mortality was a political as well as a medical problem. The medical solution represented the government's need to address the problem of maternal mortality while at the same time limiting the extent to which the government became responsible for what was still considered a matter of individual responsibility--personal health. As the depression wore on, however, the critics showed that the government's public health programs, and particularly those concerned with maternal, were falling short of their stated aim of reducing maternal mortality. Given that health indicators revealed that the greatest problems appeared in the Depressed Areas where thousands existed on government relief, such evidence were politically explosive. Concerned to hold the line in government responsibility for public health, the Ministry either denied their critics' accusations or sought to suppress the more controversial of the claims.

Campbell's 1924 report--the intellectual foundation for the government's response to maternal mortality--revealed that inherent flaws existed in the government's solution from the beginning. Campbell had identified puerperal sepsis as the primary maternal killer and a condition wholly preventable through improved professional education and medical facilities. As a result, government solutions focused on the reduction of puerperal sepsis as the means to reduce the maternal mortality rate. Yet, Campbell's own evidence, as well as reports which she published from Medical Officer's of Health in those areas with the highest rates, reveals that sepsis was not the only, or perhaps even the most important, factor in

maternal mortality. Campbell published several tables in both her 1924 and her 1927 report, "The Protection of Motherhood", which indicated that every year the rate of deaths from "other causes" was consistently higher that the rate of deaths from puerperal sepsis. In 1900, for example the two rates were quite close. Mortality from puerperal sepsis was 2.18 per 1, 000 births and 2. 63 from "other causes". After this, however, the sepsis rate steadily declined from 2.13 in 1903 to 1.46 in 1922. Death from "other causes", however, remained comparatively stable. In 1903, the mortality rate from "other causes" was 2.31 and 2.12 in 1922.[114] Similarly, in her 1927 study her figures show that the mortality rate from "other puerperal causes" was higher than that from puerperal sepsis. By 1926, the puerperal sepsis mortality rate was 1.60 and the rate from other causes, 2.52.[115]

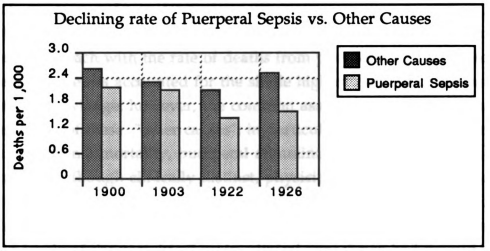

Figure 1: Declining Rate of Puerperal Sepsis vs. Other Causes, 1900-1926

The reports from Medical Officer's of Health which Campbell included in her 1924 report confirmed that puerperal sepsis played no more of role in maternal deaths than "deaths from other causes." In a comparison of the two English rural counties and the three Welsh counties with the highest maternal mortality rates, Campbell found puerperal sepsis was often an insignificant factor in maternal death. In Breconshire, for example, the MOH

reported that of the 44 maternal deaths which occurred in 1919-1922, 35 of these were a result of causes other than puerperal sepsis.[116] Of the 30 maternal deaths which occurred in the English county of Westmorland none were a result of puerperal sepsis. Campbell also included reports from eight industrial cities with the highest maternal mortality rates; three of these provided breakdowns of the causes of maternal death. Death due to puerperal sepsis was no higher than the national average in these three cities and considerably lower than the rate of deaths due to other causes.[117] Campbell did not investigate this aspect, commenting only, "It has not been practicable to fully investigate the conditions which may lead to a high maternal death in these areas."[118] The Department Committee on Maternal Mortality and Morbidity report found that these numbers had not changed significantly by 1932. The Committee found that in the areas with the highest death rates, deaths from "other causes" either equalled, or more often, exceeded the deaths from puerperal sepsis.

When Campbell divided "other causes" into their clinical categories and compared each with the rate of deaths from puerperal sepsis, she found that puerperal sepsis accounted for the single highest number of deaths. She failed to acknowledge, however, the common association physicians made between some of these "other causes"; in particular, the next two highest causes of maternal mortality, puerperal albuminuria and puerperal hemorrhage. Although clinically distinct, physicians had associated puerperal albuminuria and puerperal hemorrhage with the common source of poor diet and ill-health. Although physicians did not understand what caused elevated levels of the protein albumin, clinical experience had proven that they could be lowered with changes in diet and bed rest. Hemorrhage was more unpredictable, but physicians had connected its onset (and Campbell had echoed their findings) to difficult labors suffered by women of debilitated health. Further, difficult labors had also been associated with the prevalence of the contracted and malformed pelvis among the rickety, malnourished girls who had now grown into childbearing women. In 1922, 390 women died from puerperal hemorrhage and 556 from puerperal albuminuria and convulsions. When taken together (946) and compared with the number of deaths from puerperal sepsis (1079) the difference of 133 deaths seems hardly great enough to warrant the exclusive concentration on the latter as the primary factor in maternal death.[119]

Despite an increasing maternal mortality rate and a rising chorus of critics, the Ministry held fast to its original assessment of the problem. In the Ministry's 1932 Annual Report, George Newman claimed the Ministry's policies had achieved the "irreducible minimum" in infant mortality and that malnutrition between 1925 and 1932 had declined to a mere 1% of the population.[120] As a result, Newman declared that there was "no available evidence of any general increase in physical impairment, in sickness or mortality, as a result of the economic depression or unemployment."[121] Moreover, the Ministry flatly denied any connection between maternal mortality, unemployment and malnutrition. When a deputation from the unofficial Maternal Mortality Committee brought the connection to his attention the Minister of Health Sir Edward Hilton Young, responded, "the available evidence by no means supports any close relationship between malnutrition and maternal mortality and morbidity."[122] The Minister reminded the unofficial committee that the mortality rates were higher among mothers in the more affluent areas of Middlesex than in the depressed areas of Durham. Such statistics were used by other advocates of increased maternity services as a means of discrediting the connection between a nutrition and maternal outcome. In an article entitled "Maternal Mortality", Alice Gregory, a leading midwifery educator, founder of the Woolwhich Home for Mothers and Babies, and Council Member of the Midwives' Institute, agreed with the thrust of the Minister's argument. "The maternal statistics are worse in Hampstead than are those of Bethnal Green, Bermondsey, or West Ham."[123] The government and its supporters did not reveal, however, the specific factors which influenced these statistics. In the more affluent area of Hampstead, for example, the high sepsis rate reflected the higher percentage of doctor's cases (i.e., a higher rate of intervention). In the London working class districts which Gregory cited, on the other hand, most women were attended by midwives and therefore the opportunity for sepsis was lower. In these same areas, however, the death from hemorrhage--associated with exhaustion and poor health--were often higher than in the affluent areas.[124]

The Ministry did not deny that working class women suffered from chronic ill-health. But to the extent that they were malnourished and sick, the official Ministry position was that women had themselves to blame. "We all know how it is with the mother," Minister Young reminded the Maternal

Mortality Committee's deputation, "you cannot prevent her when she gets anywhere near the poverty line from feeding her children and starving herself. It is true that . . . even an expectant mother will probably prefer to feed the children she has to feed to feeding herself."[125] Young argued that the government made services available, but women refused to use them. According to Young, it was this neglect and refusal that was responsible for maternal mortality, not the failure of the government's policies. Ill-health among childbearing women was a matter of human weakness; it could best be corrected through educational programs which could train women in the fundamentals of personal responsibility for their own welfare.

The argument that women were incapable of taking care of themselves was frequently used to defend the Ministry's policies. Local authorities offered milk or dinners to women in their last three months of pregnancy and to nursing mothers. Ante-natal clinics had been created, subsidies had been given to pay for trained attendance in those cases where the mother could not pay, and national insurance provided a maternity benefit to help those who were insured. "It is true", Campbell conceded, "that facilities for advice are not always available, but the lack of it is often due primarily to the failure of the patient herself to seek counsel."[126] Women, in their refusal to avail themselves of these services, were themselves to blame for the high rates of their own mortality.[127] The 1932 Departmental Committee agreed that women's attitude to the maternity services had largely handicapped their effectiveness, despite the persuasive case made for the connection between a woman's poor health and her social and living conditions: "Until every woman accepts this continued supervision as a matter of course and because she finds it advantageous to do so, she will never make full use of such facilities as are offered."[128] To persuade women to take their responsibilities seriously, Campbell's reports recommended that voluntary groups and governmental agencies mobilize to do all they could to educate the mother as to "dangers they invite and the risks they run through neglect of themselves."[129] Their ostensible ignorance and neglect were the reasons given for central and local government surveillance. The maternal mortality rates disproved women's notion that the advice of their families or their own experience would suffice to see them through their pregnancy and labor. "It is essential that women should realize that pregnancy is a serious business" the Departmental Committee urged, and under the expert supervision of the

physician and the midwife the woman's poor health during her pregnancy and the outcome of her labor could be more closely controlled.

The idea that social and economic factors influenced maternal mortality challenged the Ministry's policies for maternal health and the government's policies for the unemployed. While the government had expanded the number of unemployed maintained on the dole, relief payments were kept below the market wage of unskilled labor. If the government raised the amount of relief wage levels would be correspondingly effected. As Arthur Greenwood wrote to Sir Arthur Robinson, "The unemployed cannot be put in a more favourable position than the unemployed."[130] For fifteen years, the Ministry of Health had attempted to persuade both the local authorities and the public that puerperal infection was the primary cause of maternal death and that the only means to reduce maternal mortality was to increase medical services. To acknowledge that malnutrition and poverty were equally as important would require, at the very least, that the government greatly increase the scope of the service to include attention to diet and in the end, income. As a result, the government would be forced to intervene in the market for wages either directly, by raising relief benefits, or indirectly, by providing supplementary food to those in danger of malnutrition and poor health. Neither solution was considered desirable by the government since they would force the minimum level of wages up and would undermine individual responsibility.

Where the government could not silent its critics with its arguments, Charles Webster found that Ministry documents indicate the Ministry attempted to suppress just such information from becoming public. Medical Officers of Health were pressured to submit more positive reports that supported the Ministry's contention that health was actually improving. Some complied. The MOH from St. Helens wrote in 1932 of his satisfaction with a infant mortality rate which had never dropped below 89 per 1, 000 and had risen to as high as 100.[131] Those who did not comply were harassed and threatened with dismissal. Ministry inspectors attempted to convince G. C. M. M'Gonigle, the MOH for Stockton-on-Tees, to change his "'freak' reports to give a more optimistic account of nutrition among school children in his area."[132] Groups interested in nutritional research, such as the People's League of Health, were regarded with suspicion and derision despite the prestigious credentials of its members.[133] To the report of Lady William's work in the

Rhondda district, the Ministry officially responded, "The Minister did not desire any lengthy reference to Lady Williams' speculations"[134] Similarly, the Ministry attempted to prevent the publication of Sir John Orr's work, Food, Health and Income.[135]

Recalcitrance and censorship could not suppress reality. The Ministry had worked hard to prevent any connection being made between the individual problem of maternal mortality and the broader problem of poverty and malnutrition. Wondering where it all might end, Newman likened maternal mortality to a "wandering fire that knows no bounds."[136] For the Ministry, maternal mortality opened a Pandora's box of demands which appeared only to mean the government's full assumption of responsibility for the individual's welfare. After the investigations into maternal mortality and malnutrition the Ministry conducted in the early thirties, Newman strongly advised against any further enquiries. It would have "but one ending only," he wrote to the Minister of Health Sir Arthur Robinson, "namely the demonstration of a great mass of sickness and impairment attributable to childbirth, which would create a demand for organized treatment by the state."[137]

References

1. For the total maternal mortality rates for the 1911- 1926, see Great Britain, Ministry of Health, The Protection of Motherhood, (by Janet Campbell), Reports on Public Health and Medical Subjects, no. 48, HMSO, 1927, 2; For total maternal mortality rates for 1911-1950, see J. M. Kerr, R.W. Johnstone, and Philips, ed., Historical Review of British Obstetrics and Gynecology, 1800-1950 (Edinburgh: E & S Livingstone, 1954) 154.

2. Kerr, 154; Readers familiar with the maternal mortality debate will notice that these rates differ from those often quoted by contemporaries, which was generally between 4 and 4.5 per 1,000 live births. It appears, however, that contemporaries most frequently referred to the lower total puerperal mortality rate rather than the higher total maternal mortality rate. The puerperal mortality rate indicated the rate of maternal deaths from all causes associated with childbirth only. The total maternal mortality rate reflected deaths associated with the entire childbearing period. Contemporaries tended to use these terms interchangeably. In the following discussion, the reader should keep in mind that, except where indicated, the rates refer to the puerperal mortality rate and not the total maternal mortality rate.

3. George McCleary, The Maternity and Child Welfare Movement, (London: P.S. King & Son, Ltd., 1935) 168.

4. For those historians who consider the inter-war period as one of overall improvement in working class standards of living and health, see: John Stevenson, British Society, 1914-45 (London: Pelican Books, 1984); Derek Aldcroft, The Interwar Economy in Britain, 1919-1939 (London: 1970); and C.L. Mowatt, Britain Between the Wars, 1918-1940 (Boston: Beacon Press, 1955); For this with a different view, see: Charles Webster, "Healthy or Hungry Thirties?" History Workshop Journal, Spring 1982, 110-129; Margaret Mitchell, "The Effects of Unemployment on the Social Condition of Women and Children in the 1930's", History Workshop Journal, Spring 1985, 105-127; Jane Lewis, The Politics of Motherhood, Child and Maternal Welfare in England, 1900-1939 (London: Croom Helm, 1980)

5. Stevenson, 266.

6. Stevenson, 273; Northern Ireland had the highest percentage of unemployment, but the government considered its problems out of the scope of its work. Stevenson, 270.

7. Stevenson, 274.

8. Campbell received her medical degree in 1901 and four years later entered the new school medical service. In 1908, she was appointed to the Board of Education. She was appointed to the Ministry in 1918. She retained her position there until 1934, when she married and was forced by the "marriage bar" to resign. Anne Oakley, The Captured Womb (Oxford: Basil Blackwell, 1984) 71.

9. Great Britain, Ministry of Health, Maternal Mortality Associated with Childbearing, (by Janet Campbell), HMSO, 1924, 40.

10. Campbell, 1927, 5.

11. For an overview of obstetrics during this period, see: J. M. Kerr, et al, 1954.

12. Louise McIlroy, "Nervous and Mental Health of The Mother During Pregnancy, Labour and the Puerperium", NT, October 22, 1927, 1265-66; See also, Dr. Crichton-Miller, "The Mentality of the Expectant Mother", NN, January 1926, 202-2030.

13. For a discussion of the use of X-rays, see, Oakley, 98-105.

14. Quoted in Campbell, 1927, 17; from the article, Comyns Berkely, "Save the Women and Children", British Medical Journal, January 2, 1926; By the early

thirties, researchers had established that puerperal sepsis was a systemic infection caused by hemolytic streptococci. Great Britain, Ministry of Health, The Report of the Departmental Committee on Maternal Mortality and Morbidity, Final Report, HMSO, 1932, 102.

15. Campbell, 1924, 47; See also: Aleck Bourne, "Our Midwifery Service and Women's Health", NT, August 19, 1922, 811.

16. The 1932 Departmental Committee report devoted eleven pages to their detailed discussion of antiseptic procedures, see, 106-117; For overviews of the research on the bacteriological and clinical causes of puerperal sepsis, see: Campbell, 1927, 15-18; Departmental Committee, 1932, 100-106; Also, see: Miss B.M. Johnson, "The Hygiene of the Domiciliary Labour Room", NT, July 5, 1930, 848; July 12, 1930, 878.

17. John Fairbairn, "The Midwife's Duties and Responsibilities", NM, March 24, 1926; For a comparison of British and U.S. obstetric opinion on this matter. see, William Ray Arney, Power and the Profession of Obstetrics (Chicago: The University of Chicago Press, 1982) 51-86.

18. Quoted in Campbell, 1924, 55.

19. "Annual Report of the Chief Medical Officer of the Ministry of Health For the Year 1933", NN, November 1934, 162.

20. Campbell, 1924, 55; See also, "National Baby Week: Mortality in Childbirth, Preventive Measures", NT, July 11, 1925, 661-662; It was not until 1936, with the introduction of sulfonamides, that obstetricians could treat women who were already infected, with any degree of security of recovery. And it was not until 1944, when penicillin was introduced, that treatment was considered 100% effective.

21. See, for example, J. Ellison, M.B., B. Ch., F.R.C.S, "Injuries and Disabilities Arising for Pregnancy and Labour", NT, February 18, 1928, 210-212.

22. John Fairbairn, "The Midwife's Duties and Responsibilities", NM, March 24, 1926; See also Fairbairn's paper read at the 1933 meeting of the British Medical Association reprinted in Nursing Notes, "British Medical Association", NN, September 1934, 135-36; Not all agreed, however. The division within obstetrics over intervention, which, judging by the growth in the pathological/interventionist view of the 1940's, probably reflected a growing philosophical and clinical rift within the speciality, is deserving of much more research. The obstetrician, Victor Bonney, for example, believed that midwifery needed to be considered, in Bonney's words, "'a pure surgical art' and . . . a confinement as a surgical operation.", Campbell, 1924, 48. For this reason he refused to join the fledgling Royal College of Obstetricians and

Gynecologists preferring to remain in the Royal College of Surgeons. Sir William Fletcher-Shaw, Twenty-Five Years, The Story of the Royal College of Obstetricians and Gynecologists, 1929-1954 (London: J.A. Churchill, 1954) 10-11.

23. Campbell, 1924, vi.

24. Campbell, 1924, v; Campbell herself regarded "most confinements as normal and straightforward, with but few minor complications." Campbell, 1923, 49; Similarly in 1927, Neville Chamberlain, then Minister of Health, echoed this sentiment in his introduction to Campbell's 1927 report. "Childbirth", he wrote, "is a physiological process and not a disease." Campbell, 1927, iv.

25. Campbell, 1924, 47.

26. Campbell, 1924, v.

27. Campbell, 1924, 48.

28. Campbell, 1924, 76.

29. Campbell, 1927, 57.

30. Campbell, 1927, 55.

31. Campbell, 1924, 88.

32. Under the Maternity and Child Welfare Act of 1918, local authorities had been empowered to set up food and milk programs for expectant mothers. Campbell acknowledged that these programs were of considerable benefit to these women, but thought it, "questionable whether this 'relief' should be given as part of maternity and child welfare work." Campbell,1924, 86.

33. Campbell, 1924, 70.

34. Campbell, 1924, 48; 52.

35. Campbell, 1924, 82-83; Campbell, 1927, 67.

36. Campbell, 1924, 44.

37. Campbell, 1924, 45.

38. Campbell, 1924, 52.

39. Campbell, 1927, 33.

40. Campbell, 1924, 70.

41. Great Britain, Ministry of Health, Notes on the Arrangements for Teaching of Obstetrics and Gynecology in the Medical Schools, (by Janet Campbell),Reports on Public Health and Medical Subjects, no. 15, HMSO, 1923.

42. Quoted in Campbell, 1924, 72; See also Fairbairn's article "The Midwife's Duties and Responsibilities" NT, March 24, 1923, 486-487 advocating 'team work' between the physician and midwife.

43. Departmental Committee, 1932, 37.

44. Departmental Committee, 1932, 37.

45. Great Britain, Ministry of Health, Janet Campbell, Memorandum on the Training of Midwives, Report in Public Health and Medical Subjects, no. 21 HMSO, 1923. Campbell, 1923, 2-3; The training was extended to three months for those who had nursing training and to six months for women without any previous nursing training.

46. Campbell, 1923, 25-26.

47. Campbell, 1923, 24.

48. Campbell, 1923, 21; 25.

49. Great Britain, Ministry of Health, Report of the Departmental Committee on the Training and Employment of Midwives, HMSO, 1929, 15.

50. Campbell, 1923, 21; Departmental Committee, 1929, 15-16.

51. Campbell, 1923, 20.

52. Campbell, 1923, 19.

53. Campbell, 1923, 20.

54. Campbell, 1927, 52.

55. Campbell, 1927, 57.

56. Campbell, 1927, 33.

57. Campbell, 1927, vi.

58. Campbell, 1927; See also: Great Britain, Ministry of Health, Maternity and Child Welfare Scheme Authorities (England) "Maternal Mortality", Circular 888, April 1930; Circular 517, June 1924.

59. Campbell, 1927, 33.

60. Departmental Committee, 1929, 7; The members of the committee were: Sir Robert Bolam, O.B.E, Hon LL.D., M.D., F.R.C.P.; J. W. Bone, Esq., MD; Lady Cynthia Colville; W.A. Daley, Esq., MD; J.S. Fairbairn, Esq., FRCS, FRCP; T. Eustace Hill, Esq. OBE, MB; Miss Alice Gregory; A.B. Maclachlan, Esq., F.N.; Kay Menzies, Esq., MD, FRCP; Mrs. Bruce Richmond; Miss Stephenson, CBE, JP; and by then Dame Janet Campbell, DBE, MD, MS.

61. Departmental Committee, 1932, 19-20.

62. The members of the Departmental Committee on Maternal Mortality and Morbidity were: Professor F.J. Browne, M. D., F. R. C. S.; Mrs. Ethel Cassie, M.D.; Leonard Colebrook, Esq., M.B.; Professor Archibald Donald, M. D., F. R. C. P.; C.E.S. Flemming, Esq., M.R.C.S., L.R.C.P.; Sir Walter M. Fletcher, K.B.E., C.B., M.D., F. R. C. P.; Harold Kerr, Esq., O.B.E, M.D.; W.H.F. Oxley Esq., M.R.C.S., L.R.C.P.; Professor Miles H. Phillips, M.B., F.R.C.S; C.E. Tangye, Esq., M.D.; Professor O.L.V. de Wesselow, M.B., F.R.C.P.; and Dame Janet Campbell, D.B.E., M.D., M.S.; and Sir George Newman, K.C.B., M.D., F.R.C.P.; See also: "Final Report of Departmental Committee on Maternal Mortality and Morbidity", NN, September 1932, 319-322; "More Maternal Mortality Rates", NN, November 1932, 345.

63. Stevenson, 306.

64. K. V. Coni, "The Growth of the Public Health Service", NT, April 14, 1928, 461.

65. Departmental Committee, 33.

66. Janet Campbell, The Maternity Services, (London: Faber and Faber, 1935) 20; See also: K.V. Coni, "The Growth of the Public Health Service", NT, April 14, 1928, 461-462; "The Nation's Health is the Nation's Wealth", NN, September 1933, 127-128; For the considerable limitations of these programs, see Lewis, 1980, 165-196; and Oakley, 1-132.

67. Campbell, 1927, 52.

68. Campbell, 1927, 27.

69. Campbell, 1927, 57.

70. Critics claimed that the Ministry exercised very little supervision over the quality of care delivered in the various institutions which they subsidized. For the official response, see: Campbell, 1927, 63-66.

71. "Conference at the Nursing and Midwifery Exhibition", NN, April 1935, 56; also, "The Ormand Home", NN, February 1938, 31.

72. William Frazier, A History of English Public Health, 1984-1939 (London: Balliere, Tindall and Cox, 1950) 386.

73. For discussion of the implications of the Local Government Act on the Public Health system see: Frazier, 385-394; and Lesley Doyal, The Political Economy of Health (London: Pluto, 1979) 171-176; For problems with small maternity homes, see "Maternity Homes", NN, October 1925, 147; By the end of the nineteen thirties local authorities were responsible for over 130,000 beds in general hospitals. Rosemary Stevens, Medical Practice in Modern England (New Haven: Yale University Press, 1966) 61-62.

74. Midwives' Institute, Maternity Services, Adapted From Ministry of Health Circular--Sept. 1953, courtesy of RCM Archives.

75. "Inquiry into the circumstances surrounding the Death of Mrs. Molly Taylor", October 31, 1934, 114-824, courtesy of RCM Archives. With a greater inpatient population, conducting clinical studies in the abnormalities of pregnancy and parturition and in the etiology and pathology of puerperal sepsis was more convenient. By 1932, the Departmental Committee on Maternal Mortality and Morbidity could chronicle the continued expansion of both clinical and bacteriological research, but investigations continued to be concentrated in just a five hospitals and three laboratories. Many of these investigations were supported through private and government Medical Research Council grants. Queen Charlotte's Hospital for Mothers and Babies, for example, was the recipient of a Rockefeller Foundation. Departmental Committee, 1932, 118. For the best work on the development of the hospitals during these years, see, Brian Abel-Smith, The Hospitals, 1800-1948 (Cambridge, Massachusetts: Harvard University Press, 1964) especially 303-384).

76. Maternal Mortality Committee, Maternal Mortality, Report, October 1934, (London: London Caledonian Press) 8, for figures of each see, 6 and 10; 35% of County Boroughs subsidized these associations. The prefix "unofficial" was commonly used to differentiate this committee from the Departmental Committee on Maternal Mortality and Morbidity.

77. Queen's Institute of District Nursing, Report on Midwifery Cases, 1935, courtesy RCM Archives. For descriptions of both Nursing Association midwives and institutional midwives, see: Departmental Committee, 1929, 31-42; For 'Queens Nurses' see: Mary Stocks, 100 Years of District Nursing, (London: G. Allen and Unwin, 1960) 145-167.

78. Stevenson, 306.

79. Stevenson, 308.

80. See, Great Britain. Ministry of Health, Deputation from the Maternal Mortality Committee, December 11, 1934, 4-5; The Maternal Mortality Committee, Maternal Mortality, Report, October 1932 (London: London Caledonian Press) 19.

81. Daily Herald, September 21, 1934, courtesy RCM Archives.

82. Campbell, 1927, 40-41; Departmental Committee, 1929, 8-9.

83. Quoted in Campbell, 1927, 40.

84. The Maternal Mortality Committee, Maternal Mortality, Report, October 1934, 6, 8; The Metropolitan Borough Councils with 76% fared somewhat better, but this was largely due to London County Council and the particular role it played in relation to the Midwives Act; Further, the Borough Councils were also the Maternity and Child Welfare authority unlike other areas where citizens were appointed to a separate Maternity and Child Welfare Committee.

85. Maternal Mortality Committee, Maternal Mortality, Report, October 1934, 4, 6, 9.

86. Campbell, 1935, 22.

87. Webster, 121.

88. See, for example, Aldcroft, 379, who suggests that Orr's figures were exaggerated and notes that Orr himself qualified his conclusions in later works. Yet Aldcroft admits in a footnote that Orr's findings were confirmed later by a much larger study by Sir William Crawford and H. Broadley, The People's Food, 1938; For the Ministry's attempt to suppress Orr's findings as well, see, Webster, 113.

89. Webster, 120.

90. Stevenson, 283.

91. Webster, 116.

92. Webster, 116; Despite Stevenson's argument that the overall standard of living improved for all workers, he indicates that the improvement was greatest for those in Class I, the professional white collar workers, Stevenson, 129.

93. Jane Lewis, Women in England, 1870-1950 (Bloomington: Indiana University Press, 1984) 24.

94. Lewis, 1980, 44.

95. Margery Spring Rice, Working Class Wives, (London: Penguin Books, 1939), reprint ed. Virago, 1981, 28.

96. Spring Rice, 29.

97. Webster, 120; Mitchell, 112-116; Webster lists many of these studies in his notes, for example, H.M.M Mackay, "Dietetic Deficiencies and Susceptibility to Infection", Lancet, no. 2, 1934, 1462-66; H.M.M. Mackay, " The Haemoglobin Level among London Mothers", Lancet, no. 1, 1935, 1431-33; L.S.P. Davidson, et al, " Nutritional Iron-Deficiency Anaemia", British Medical Journal, no. 2, 1935, 195-98; H.M.M. Mackay et al, "Discussion on Nutritional Anaemia", Proceedings of the Royal Society of Medicine, vol. 36, 1942, 69-85, which includes an overview of previous research on the subject.

98. Lewis, 1980, 47; Departmental Committee, 1932, 96.

99. Mitchell, 114.

100. The Maternal Mortality Committee, Maternal Mortality, Report, October 1934, 14.

101. Departmental Committee, 1932, 90.

102. Departmental Committee, 1932, 90.

103. Departmental Committee, 1932, 91.

104. Campbell, 1924, 86; The article was published by the Medical Research Council, no, 81, 1924.

105. Webster, 121; H.C.C. Mann, Diet for Boys During School Age, Medical Research Council Special Report Series, no. 105, HMSO, 1926.

106. Lewis, 1980, 174; Edward Mellanby, "Vitamin A as an Anti-Infective Agent", British Medical Journal, October 20, 1928, 691-8; Louise McIlroy, "The Toxemias of Pregnancy", Lancet, August 18, 1934, 345-50; The 1932 Departmental Committee had supported Mellanby's conclusions and recommended that "pregnant women should be assured ample sources of vitamin A and D through an, adequate supply of milk, eggs, green vegetables, carrots and butter. ", 118.

107. Webster, 121; See also: Lady Rhys Williams, "Malnutrition as a Cause of Maternal Mortality", Public Health, vol 50, 1936, 11-19.

108. Lewis, 1980, 173.

109. "Local Expenditure", NN, May 1933, 64.

110. Stevenson, 310; The Ministry suspended three Boards of Guardians in 1926 and those of Durham and Rotherham in 1932.

111. Great Britain, Ministry of Health, Deputation of the Maternal Mortality Committee, December 11, 1934, 19.

112. The Maternal Mortality Committee, Maternal Mortality, Report, October 1934, 15.

113. Quoted in Webster, 122.

114. Campbell, 1924, 3.

115. Campbell, 1927, 2.

116. Campbell, 1924, 19.

117. Campbell, 1924, 25-30.

118. Campbell, 1924, 25.

119. Campbell, 1924, 40.

120. Webster, 112.

121. Webster, 115; Both Webster and Lewis have discussed the weaknesses in the Ministry's system of data collection. One government official criticized the Ministry's system of collecting and evaluating data on malnutrition as, "so unreliable as to be valueless. . . . " quoted in Webster, 119; For Lewis' discussion, see, Lewis, 1980, 183-185.

122. Ministry of Health, Deputation to the Minister of Health, The Maternal Mortality Committee, December 11, 1934, 22.

123. Alice S. Gregory, "Maternal Mortality", A Quarterly Leaflet, January 1928, no. 37, 1; See also: M.S. Pembrey, M.D., F.R.S., "The Physiological Aspects of Pregnancy", NT, January 25, 1930, 55; 114.

124. Lewis, 1980, 179.

125. Great Britain, Ministry of Health, Deputation to the Minister of Health, The Maternal Mortality Committee, December 11, 1934, 23, courtesy of RCM Archives.

126. Campbell, 1924, 88.

127. Campbell, 1924, 87.

128. Departmental Committee, 1932, 30.

129. Campbell, 1924, 88.

130. Quoted in Mitchell, 114.

131. Webster, 114.

132. Webster, 112; Lewis, 1980, 175.

133. Lewis, 1980, 183; The League's Committee on Nutrition included, Professor James Young of the University of London Medical School, the well-known infant welfare advocate and physician Eric Pritchard, F.J. Brown, the obstetricians Comyns Berkely and Victor Bonney, and Sir John Boyd Orr.

134. Mitchell, 115.

135. Webster, 113.

136. Webster, 123.

137. Quoted in Webster, 123.

Chapter 8

'The Economic Problem is the Problem': The Struggle to Protect Private Practice, 1918-1934

The nineteen twenties were years of crisis for the Midwives' Institute. The expanded technical knowledge needed to supervise the entire childbearing period and the growing (if still limited) scientific understanding of obstetrics prompted far reaching changes in the nature of midwifery training and practice, and in the composition of midwifery itself. A longer period of training was accompanied by calls to raise the minimum educational standard of midwifery candidates to those women whose previous educational background proved them capable of assimilating an advanced course of tuition. Although reformers considered general nursing training the best preparation for midwifery training because of the advanced theoretical foundation and rigorous training in antisepsis, women with advanced general education were also considered better prepared to assimilate the intensive course of midwifery than the working class recruits who composed the bulk of contemporary midwives.

The Institute had never ceased to encourage the continual process of technical and social upgrading within midwifery. The leadership accepted the assumption that specialized and advanced training is the foundation of every profession's claim to a monopoly of services it sells in a market economy. As the knowledge upon which the training is based continually advances, so must the training itself conform to those advances. The acquisition of advanced technical and theoretical knowledge has a social aspect as well. The level of education required to undergo an increasingly advanced training was not equally accessible, but based on social position. Each round of upgrading excluded those women whose position in the social hierarchy had not granted them access to the educational advantages that the Institute leadership preferred. The continual elevation of midwifery's educational and social floor, however, raised the profession's status among the pantheon of health professionals.

Yet just as the opportunities for midwifery appeared brightest, changes in maternity service delivery threatened midwifery's future as a profession.

Increasingly, privately practicing midwives, the "independents" unconnected to physicians or local authorities, who received no government subsidy and who relied upon their midwifery skills for their livelihood, were forced to compete for patients with the subsidized providers. The subsidized providers were able to reduce the cost of maternity care below what the independent midwives could afford to charge. The independent midwives found that their standard of living steadily deteriorated as they were forced to drop their fees in an effort to match the subsidized competition. Few educated women and general trained nurses were interested in taking up midwifery under such conditions. More lucrative careers could be found elsewhere.

Consequently, the Institute established as its highest priority a strengthened economic foundation for midwifery. Although the leadership had always considered open discussion of economic needs as antithetical to the professional ethic of altruism and service, it became clear that the future of midwifery, as they understood it, would be in jeopardy if they did not grapple with the subject--no matter how distasteful. Throughout the 1920's, the Institute leadership struggled to preserve and strengthen the private practice of midwifery against the incursion of government sponsored nursing associations and large training hospitals and maternity homes. With the delivery and the standards of maternity care changing around them, the leadership sought to recarve midwifery's niche among other providers, to protect the independent midwife's access to the market for services, and to guarantee that she could earn a self-supporting living. The leadership took steps to increase the membership from a small club into an organization with thousands of members capable of elevating the profession to contend with the new forces now surrounding it.

"The Game of Midwifery is not Worth the Candle"

Midwifery practice in the 1920's was not a profession which attracted those whom the reformers considered the most desirable recruits. Intense competition, a declining standard of living and the unsolved irritations of supervision and physician hostility combined to make private practice increasingly untenable as a means for women to support themselves.

Complaints of tactless and domineering inspectors and the active hostility of physicians remained a frequent thread in discussions among midwives. "The manner in which many [inspectors] discharge their duties," one midwife wrote, "recalls to one's mind the sergeant drilling his recruits."[1] Many expressed their fears about the damage that could be done by an unsympathetic inspector. As one midwife wrote, "A midwife may find herself up before the CMB for some error of judgement to which, being but human, any one may be liable, or for some trivial forget, her character is ruined, and her living taken away."[2] Others just gave up on midwifery, "simply on account of the inspectors, although I loved the work and I had both general and midwifery training."[3]

Complaints against physicians had become as common as complaints against inspectors. The 1918 Maternal and Infant Welfare Act had empowered local authorities to pay the physician's fee if the patient could not, but throughout the early 1920's many midwives reported that physicians refused to attend their summons when complications arose. Years of experience had made some midwives less reticent about challenging physicians if disagreements arose, but such encounters always spelled trouble and anxiety for everyone involved. "When medical aid is required," one midwife wrote, "one almost has to beg a doctor to come. I have had two refusals in one day. I don't wonder at anyone not using the C.M.B."[4] Others had grown tired of the way in which physicians treated them. "Every practicing midwife has met the local doctor who expects her, in addition to her own work, to be a lackey for him."[5]

To make matters worse, while midwifery offered problems with inspectors and physicians, it failed to offer the higher pay and supervisory responsibilities traditionally associated with professional advancement. Midwives who worked in a hospital or maternity home could advance to the position of ward sister or (if very well-educated) to matron. Although the number of institutional positions increased during the 1920's, supervisory positions were frequently restricted to general trained nurses whose primary experience was in nursing rather than midwifery. In domiciliary midwifery, there was no structure for advancement. Midwifery inspectors and health visitors were possible exceptions, but this work took women out of midwifery altogether and, in the case of health visiting, required additional credentials.

The inability, however, of midwives to make a living from private practice was the major obstacle to drawing more highly qualified, women into the profession. Year after year the Annual Reports of the CMB revealed that more than half of the women who trained as midwives each year never practiced. General trained nurses did take midwifery training. In 1929, for example, the Departmental Committee on the Training and Employment of Midwives reported that of the 2,811 women who took the CMB examination the previous year 1,730, or 62% were general trained nurses. But many nurses only took the training to enhance their qualifications for nursing positions in hospitals, private homes and health visiting. "The great majority of these trained nurse-midwives are generally able to find more attractive and lucrative positions in the nursing than the midwifery profession," the Departmental Committee observed, "and may be regarded as non-effective so far as the maternity service of the country is concerned.[6] Reformers also believed that this loss to other nursing fields was greatest among the most educated, refined and, to the Institute, the most desirable potential recruits. Although midwifery advocates offered little hard data on this point, a study conducted by the Central Midwives Board had suggested this conclusion. The results of the study revealed that the more prestigious and exclusive the training school (resulting, ostensibly, in the most educated and refined recruits), the fewer practicing midwives it produced. Of the twenty London training institutions, only one, The British Hospital for Mothers and Babies, reported that 50% or more of their midwives were in practice. The most prestigious of the London obstetric hospitals, Queen Charlotte's Hospital, reported that only 8% of their graduating midwives practiced. St. Thomas' reported that none of its graduating midwives practiced; University College, only 1%; and the London Hospital, only 2%.[7]

The growing inability of independents to make a living from their work resulted from the increased competition from maternity services organized and subsidized by local authorities. Because subsidies made it possible for providers not to have to rely on the patient's ability to pay, the hospitals (many of which could also call upon revenue from other sources), ante-natal clinics, salaried midwives, nursing associations (which supplemented their revenues with subscriptions and donations) could charge lower fees than the independent midwife and still remain economically viable. Local authorities, anxious to make the most of their investments,

instructed their staff to actively encourage women to use their facilities and their personnel. "We know," one midwife wrote, "that many mothers are being advised & helped by payment offers to go into Hospital by Health Authorities."[8] Nursing associations and maternity hospitals attracted women with both normal and abnormal pregnancies by offering patients maternity care at a lower fees.[9] The larger institutions, particularly training maternity institutions, were known to cut their fees below the independents' going rate in order to fill their need for a constant flow of clinical material. Unlike the general practitioner or obstetrician, a midwife had no other means of making a living than the care of normal childbearing women. When the midwife took over normal childbirth attendance, the general practitioner still had his medical practice as well as his access to abnormal midwifery cases to guarantee him an income. The midwife, on the other hand, was prevented by law from "diversifying" in this way.

As private practitioners, midwives faced a growing dilemma. They had to maintain their fees at a level which would adequately compensate them for their time and expenses, and provide for retirement and times of sickness (as private practitioners they were not eligible for national insurance). They could not charge more than the market could bear without pricing themselves out of the market. Many independents responded to this situation by reducing their fees. Others were forced to work part-time. The Departmental Committee on the Training and Employment of Midwives found, for example, that in one county borough, "nine midwives attended in one year from 20 to 50 confinements each. With regard to a second [borough] . . . [of] 56 midwives in general practice, there were 17 others on the books who did little or no work."[10] It is not known how many women left midwifery altogether.

Reformers could not criticize women for not taking up midwifery when there was so few concrete incentives to recommend it. "There can be no small wonder," the Departmental Committee's report noted, "that the profession has failed to attract women whose education and training are best fitted to uphold its dignity and traditions."[11] Echoing reformers' fears, the Committee warned that midwifery would continue to be "regarded as a natural calling only for women whose standard of efficiency is too often lamentably low" until this better woman came forward.[12]

"The Right Type of Midwife"

Janet Campbell's proposals for the place which midwifery would assume in the evolving maternity services made the need to attract well educated, middle class women all that more urgent. Campbell, the Senior Medical Officer to the Maternity and Child Welfare section of the Ministry of Health, had argued that only midwives prepared for the rigors of midwifery training by a superior general education or three years training in general nursing would be able to assume the responsibilities required by the maternity services. Campbell recommended a renewed cycle of upgrading of midwives. In so doing, she sought to restructure midwifery by further restricting the requirements for entry into the profession. By setting the minimum standard at a level beyond the reach of less educated and refined women, the way would be cleared for the women who could meet the new requirements. "There is sometimes an unfortunate tendency to view the [midwife's] position in terms of the less educated and satisfactory midwife," Campbell wrote, "but if progress is to be made it is to the best type of midwife that we must look for co-operation. "[13]

Campbell's recommendations offered both danger and opportunity for the Institute. The Institute had no quarrel with Campbell's definition of the desirable midwife. Indeed, the leadership had helped to influence Campbell's own thinking on the subject. But, as the official representative of the profession, it fell to the Institute to lead the campaign to transform the profession. The Institute soon learned that this Herculean task was subject to a multitude of cross-influences which ultimately threatened to tear apart the profession as the Institute had defined it. At the same time, however, the new legitimacy which Campbell's recommendations had bestowed upon midwifery held out the promise that midwifery would move from its current status as an underpaid and unrecognized profession, to one respected by the elite and socially powerful.

The original 1902 Midwives Act was passed following a struggle to impose formal training as the minimum acceptable standard for midwifery practice. By the 1920's, this minimum standard had been achieved. By 1925, 87% of practicing midwives were trained; with only 13% registered as bona fide. By 1935, 97% of practicing midwives were trained, with virtually no bona fide midwives remaining in practice.[14]

Table 1: Practicing Midwives by Certification, 1919-1935

	Trained		Bona-fide	
1919-20	7865	(68.5%)	3623	(31.5%)
1925-26	12,414	(87%)	1864	(13%)
1929-30	13,542	(93%)	974	(6.7%)
1934-35	15,434	(97%)	451	(3%)

This workforce provided an impressively safe service. In a period of rising maternal mortality rates, with attention focused on puerperal infection, midwives cases continually showed a lower maternal death rate than doctors'. In statistics for London in 1922, for example, the mortality rate due to puerperal sepsis, in cases handled by midwives, was reported at .65 per 1000 births whereas the mortality rate for cases attended by doctors or attended in institutions were 1.1 per 1000. In Hertfordshire, in the same year, out of the 2,855 births attended by midwives, only one died of puerperal sepsis, a rate of .35 per 1000. In the 2,970 cases attended by doctors or attended in institutions, 11 died of puerperal sepsis, a rate of 3.7 per thousand.[15] In 1927, the national rate for mortality in midwives cases was 1.8 per 1000 live births, still a relatively low figure.[16]

Commentators disagreed on the reasons for this phenomenon. Some argued that since the Act allowed midwives to attend only routine cases there was less chance for complications at their hand. General practitioners experienced greater mortality in their obstetrical caseload than midwives because they were often called in at the last minute to attend emergencies involving patients with which they were unfamiliar and in which immediate action was necessary. The obstetrician John Fairbairn, argued that

midwives' low statistics were less a matter of their legal limitations and more the fact that midwives were trained to regard the process of childbirth as a normal process with its own rhythms and timetable. They were more likely, therefore, to let nature take its course. Midwives would not feel the need to continually check the progress of labor through potentially harmful internal examinations or to unduly call the physician, who often would do little more than use forceps to speed delivery.

Campbell acknowledged the enviable safety record of trained rank and file midwives, but she doubted that this could be sustained once the existing workforce was required to expand their responsibilities. Census reports of those women who gave midwifery as their occupation give a picture of the composition of the midwifery workforce in which Campbell had so little confidence. The Census indicates that while the percentages of younger and unmarried midwives had increased between 1911 and 1981, the midwifery workforce still exhibited high percentages of older, married or widowed women. As Table 2 indicates, although the percentages of unmarried midwives increased dramatically from 1911, married or widowed women still constituted a significant section of the midwifery workforce. Indeed, if one considers that married and widowed women shared the common characteristic of obligation to family and children, the percentage exceeds that of unmarried midwives. Campbell expressed doubts that married women tied to husband and family, were entirely serious about their education or their work. Rather, she believed, they looked upon midwifery merely as a means "to support themselves or to supplement their husband's wages."[17]

Table 2: Marital Status of Midwives, 1911-1931

	UM	M	W
1911	16%	51%	33%
1921	38%	33%	29%
1931	47%	33%	20%

Campbell was equally critical of the considerable number of older women within the profession. While the marital status percentages showed some variation, the age distribution of midwives changed very little from 1911 to 1931. The percentages of midwives between 24 and 44 years of age and those between 45 and 65 remained roughly the same for the entire period. While the younger midwives might have benefitted from the extended training implemented in 1926, the majority of midwives had undergone training which was no longer considered sufficient for the new requirements of the maternity services.[18] Older midwives were less likely to be familiar with recent developments in ante-natal and post-natal care. Equally as important for Campbell, the majority of practicing midwives had been trained in midwifery only, and as a result had little formal training in pathological care.

Table 3. Age Distribution of Midwives, 1911-1931

	≤24	25-44	45-64	65+
1911	11%	43%	44%	2%
1921	2%	46%	38%	14%
1931	4%	48%	41%	7%

Campbell felt that the class composition of midwifery candidates made matters worse. She believed that the large numbers of working class women who entered the midwifery schools dragged the standard of training down to lowest level. Many of them were, Campbell argued, "women of limited education, who learn with difficulty, are likely to forget much of the theory taught, and to remember clearly little but what they learn by practical work."[19] Such women were less likely to grasp the fundamentals. "Constant practice and repetition are necessary to inculcate habits of cleanliness and antisepsis."[20] Institute officials agreed. One member of the Institute's Teachers Committee complained that recruits were "often not the type of woman that is desirable if the profession is to be raised in status."[21]

Both Campbell and the Institute leadership agreed that the entire educational and social level of the profession had to be raised in order for midwifery to assume its rightful place in the emerging modern maternity services. For Campbell, the solution was relatively simple. The problem was the deficiencies of the recruits, not the content of the training required. By admitting only those candidates with a high level of general education, or with general nursing training, midwifery schools could better use the period of midwifery training. Teachers could spend their time teaching midwifery skills rather than spending time teaching notetaking, reading, or the basic sciences. "It is useless to raise the standard of professional education above the capacity of many of the pupils now seeking admission", Campbell

warned, "unless we can at the same time persuade a better type of entrant to come forward."[22]

For the Institute, raising the standard of applicants would improve midwifery training and distance the profession from its working class character. Despite the excellent mortality statistics of rank and file midwifery throughout the twenties, the Institute leaders continued to express the perception"that the best class were not doing midwifery."[23] In her September 1927 article for Nursing Notes, Edith Doubleday agreed. "The most glaring [problem] perhaps is the difficulty of attracting the right type of midwife into practice. In institutions, this point is not so startling, but in district practice it is clear, that the general trained nurse and the better educated midwives are rarely to be found."[24] Bringing the "right type of midwife" into the profession would raise its overall social standing. "The same point is so often made by speakers and writers, that we may take it as a general axiom", Nursing Notes explained, approvingly quoting from an article in The Medical Officer.

> If the midwife is to fulfil her functions and worthily uphold the traditions of medical science, in which sphere she must have a definite place, she must be fitted for her calling, not only by training and experience, but also by her breeding and general education.[25]

Greater technical expertise and a higher social standing would strengthen midwifery's claim to an equal place in the maternity services and open the way to further professional advancement.

The Midwife Redefined

The Institute believed that the profession would not be able to attract and retain "right type of midwife" until independent, privately practicing midwives could compete on a more equal basis with the publicly funded maternity services. Independent midwives found themselves marginalized by the growing competition from subsidized providers who could perform the same tasks at a cheaper cost. In response, the Institute articulated a division of labor among providers which placed the midwife at the center of normal maternity care. By establishing midwifery's niche in the

competition for place in the evolving maternity services the Institute hoped to reduce the competition from other providers. In the course of redefining the midwife's work to conform to Campbell's proposals the Institute sought to upgrade the social and educational level of the profession through educational requirements and opportunities for advancement.

The Institute argued that attendance on normal childbearing, whether during the short period of parturition or the extended childbearing period, was midwifery's special preserve. The Institute cited the 1902 Midwives Act to support this contention. The midwife was specifically trained in normal midwifery and was bound by the CMB Rules to "exercise that homely virtue, patience, to the greater safety of the mother and child."[26] The Rules had made the midwife responsible for taking care of women from the time they booked with the midwife to ten days after the birth. Typically, working class women waited until late in their pregnancies to engage a midwife. Once engaged, however, the midwife used the remaining time to answer the expectant mother's questions, calm her anxieties and give practical advice. During the ten days after the birth, the midwife watched for signs of illness in the new mother and her infant, and taught the mother the fundamentals of infant care.

This area of home care and education provided ample opportunity for friction between the midwife and the health visitor. Midwives complained that health visitors interfered in their management of cases by offering advice that undercut the midwife's authority; some health visitors were known to guide women to clinic physicians for ante-natal care--in essence, rejecting the midwife. According to the Institute, such behavior by health visitors constituted a transgression into the midwife's territory, undermined her authority, and undercut her livelihood. The Institute argued that health visitors should stick to their prescribed responsibilities of investigating the suitability of the family's housing conditions, giving advice on the general health of the children and encouraging women to book early with the midwife so that ante-natal care could have some influence. In return, the midwife was expected to hand on the new family to the health visitor after the midwife's ten day post-partum responsibility was up. The midwife would also use her influence to persuade mothers to attend the welfare centers where health visitors could provide continuing supervision. "There must be

close co-operation", Institute Council member Edith Doubleday wrote, "though no overlapping."[27]

In contrast to the midwife's work, which was oriented around the normal, the Institute argued that the physician's role in birthing was limited to the abnormal. General practitioners and obstetricians were arguably indispensable elements of any service, but their expertise and the services they provided should be oriented primarily toward the abnormalities of childbearing. It was here they were best suited to work. Since most pregnancies and labors progressed normally, an obstetrician would be needed in the relatively few cases where severe complications had been detected, in which obstetric or gynecological surgery was required, and in the case of emergencies during what had been expected to be a normal delivery.

The midwife's relationship to the general practitioner had always been more complicated. Unlike the obstetrician, who had little interest in normal cases, the general practitioner derived part of his livelihood from normal and abnormal midwifery cases. Yet, as Campbell's reports had revealed, the general practitioner was often so busy with his general medical cases that he had little time to attend to normal childbearing. Even when he was called in by a midwife his own circumstances often prompted him to expedite the labor through the use of forceps, thus increasing the risk of infection to the mother. The Institute claimed that leaving the supervision of normal cases to the midwife would allow the general practitioner to make the best use of his expertise. General practitioners would "find it [normal cases] a tremendous bore," Nursing Notes speculated, "taking up far too much of their valuable time which should be devoted to the care and observation of abnormal pregnancies."[28]

Similarly, the Institute argued that because parturition was in most cases a normal event, institutional care was generally unnecessary. Institutional care was relevant only for the minority of cases which fell within the obstetrician's specialized expertise. The majority of cases were best conducted at home, "the natural and best place for the confinement to take place in."[29] The Institute argued that because women were less anxious at home they could face the pain and fatigue of childbirth with more confidence and strength than if they were confined in a hospital or maternity home. As long as midwives took the proper antiseptic precautions, women experienced less chance of infection in their own homes than they did in maternity

institutions or small maternity homes. The Institute acknowledged that hospitals were more likely to admit women with high risk factors, but this only called for greater vigilance in the prevention of infection. When hospitals admitted normal cases, the Institute argued that this only exposed women to unnecessary danger. Instead, the Institute seconded Campbell's solution to the maternal mortality problem--domiciliary-based midwifery care, supplemented by trained specialists who had access to facilities which were operated according to strict antiseptic precautions. "These, and not removal from her home," a Nursing Notes editorial warned, "are the essential requirements. . . the good results of which are evidenced in the low mortality and morbidity rates of home confinements attended by midwives."[30] The Institute's position on these matters differed little from those of Campbell and of mainstream medical opinion.

The Institute's position deviated from much of medical opinion, however, on the issue of ante-natal care. In her reports, Campbell had taken the position that midwives were capable of conducting ante-natal care as long as they were under the supervision of a physician. The physician, not the midwife, should determine if complications or potential problems existed. Campbell proposed that a physician conduct the initial examination of the midwife's patient and, if he determined that no problems existed, refer the woman back to the midwife. The Institute, however, argued that the midwife should make the initial determination regarding the nature of the pregnancy. Ante-natal care was the midwife's legal obligation and professional right. The CMB Rules made the midwife legally responsible for the woman's care, "from the time of booking onwards," as one article pointed out, "and neither they themselves nor any other person can free them from this responsibility."[31] Institute literature emphasized the greater safety to the mother when attended by the same practitioner, rather than many, throughout the childbearing period.[32] Articles in Nursing Notes consistently argued that the midwife was entirely capable of conducting ante-natal examinations, determining which cases were normal and which required a physician's care. The midwife, after having "eliminated all abnormal cases from her practice as early in pregnancy as possible", could then assume responsibility for those cases which fell within her sphere.[33] In her testimony before the 1929 Departmental Committee, Mrs. Mitchell, then Honorary Secretary to the Associations affiliated with the Institute, indicated the

Institute's official position. The "midwife should undertake the ante-natal care of her own patients", she told the committee, "and should be able to refer them when necessary to a medical practitioner. . . ."[34]

The leadership's insistence that midwives conduct ante-natal care placed them in a difficult position. They were driven by the requirements of the law and of their own professional interests to claim the entire period of normal childbearing as their rightful preserve, yet this claim collided with the existing professional relationship between the medical professional and midwifery. The ability of the practitioner to differentiate between normal and abnormal and, on the basis of that finding, determine the course of action, was central to effective ante-natal care. "The physical examination may reveal some simple cause for discomfort, e.g., exaggerated ante-version, varicose veins," explained Olive Hadyn, the well-known midwifery teacher, describing the ante-natal evaluation, "but everything the patient says should be considered thoughtfully, with a view to deciding whether the symptoms are serious. . . ."[35] The authority to exercise such evaluation and decision-making had been invested in the medical profession, not midwifery. Indeed, since 1902 the medical profession had done its best to limit the extent to which the midwife was able to encroach upon the physician's perceived territory. When it could, the Central Midwives Board punished any midwife who exerted authority beyond the narrow limits set down by the Rules of Practice. The Institute never proposed that the midwife would diagnose, but only that she would determine which cases fell within her expertise and which ones should be referred to the doctor. The professions battled for control over the gray area between "diagnosis" and "determination." The Institute's interpretation attempted to extend the boundaries of midwifery's authority and thereby threatened to upset the established hierarchy.

Although this controversy over limits to the midwife's authority was not resolved during the 1920's, it did give impetus to the Institute's endorsement of general training as a minimum standard for midwives. Midwives' training was oriented entirely toward the protection of and attendance on normal childbearing. Instruction in antiseptic procedures and the recognition of the complications of childbearing were combined with lessons in the management of emergency cases, breech births and hemorrhage. In addition, the midwife advised the mother on topics ranging from baby clothes to breastfeeding. Midwives' training did not prepare them

for dealing with illnesses resulting from pregnancy and labor. Skeptics believed that midwives could not compete with the general trained nurse whose entire three year education had been oriented toward illness and disease. The prominent obstetrician Blair Bell, for example, expressed the somewhat extreme but not unusual view that midwives knew "nothing of ante-natal conditions and nothing about post-natal."[36] Campbell's concentration on the potential complications of childbearing implied the need for reforms in midwifery training that gave more attention to identifying the pathological condition than was the norm. Many agreed with Campbell that midwives could not be considered equal participants in the maternity services until midwifery included the expertise of general nursing.

To proponents of the general trained nurse-midwife, official belief that maternal mortality stemmed from high rates of puerperal sepsis and uncontrolled illness in pregnancy made the general trained nurse-midwife the ideal combination. Midwives were trained in normal childbearing, a nurse in the recognition and care of disease. A midwife who could claim both general nursing and midwifery training was equipped to attend the full range of tasks increasingly expected in midwifery. At a conference for midwifery teachers, Olive Hadyn emphasized the nurse's greater expertise in disease. There were "still many cases with complications and real illness" with which the midwife was confronted. She expressed her approval "that the importance of good nursing had been emphasised" by other conference participants.[37] Proponents of general training argued that a nurse with three years experience in the rigors of hospital procedures brought greater safety and efficiency to childbirth attendance. The hospital, they argued, offered a clean working environment in which everything a midwife needed was immediately at hand; most working class homes were in poor condition with few amenities. Only a nurse who had been rigorously indoctrinated with the principles of antisepsis would be able to overcome the possibility of infection during home deliveries. "A nurse who has had seen much of general surgery", Bell asserted, "acquires a sense of surgical cleanliness and technique unobtainable in any other way."[38]

While general training might strengthen midwifery's claim to the expanded responsibilities of ante-natal care, childbirth and post-natal care, it also brought with it a professional tradition different from that familiar to most practicing midwives. Whereas the authority and independence of the

midwife was a matter of constant struggle, general nursing existed within a medical hierarchy strictly enforced by training and hospital discipline. It was axiomatic that the nurse would be less likely to challenge medical opinion or action. "She is used to calling her superior, 'Sir'" stated one Nursing Notes article. A midwife without this training tended to have "more difficulty in acquiring the calm professional manner of the trained nurse . . . however good a midwife might be at her work, it is a pity when she fails in the right tone and attitude towards the doctor--that of a subordinate.[39] The established relationship between the doctor and the nurse stood in counterpoint to the tension between doctors and midwives over midwives' expanded responsibilities. While nursing training legitimized midwifery's assumption of expanded responsibilities, it also reinforced the medical profession's dominance in maternity care. A midwife who trained as a nurse was more likely to have been schooled in her limitations and more likely to keep her place. "The better she is trained the oftener she will call the doctor," Nursing Notes approvingly quoted one general practitioner. "It is the half trained woman who exceeds her duties."[40]

Not all midwives and physicians agreed, however, that the interests of midwifery and the women they attended would be best served by making the midwife a general trained nurse deferential to physicians. Critics of nurse training for midwives rejected the notion that midwifery and nursing had anything at all in common. They considered midwifery and nursing distinct areas of work, one managing a healthy, normal function; the other treating sickness. Midwives were trained to understand and work with the essential physiological nature of childbearing. Unless complications occurred, the midwife was professionally qualified and legally mandated to assume the care of the woman throughout this period without the aid of a doctor. One midwife wrote in bewilderment: "How can "a nurse who has spent three years taking her general certificate, and only four months (or six months as it is now) in taking her midwifery training" be considered as competent as a midwife who had trained "for twelve months and specialises in maternity work?"[41] Such midwives believed that it was precisely a nurse's professional training and experience which made her unsuited to midwifery work. Nurses not only trained solely to attend those who were ill and suffering from disease; they also spent their entire professional life waiting upon the doctor's

orders, and consequently were trained away from taking the initiative required in attending women in childbirth.

> They [nurses] cannot be the practicing midwives their patients and the nations need. The patient has no confidence and at her first pain cries out to a doctor; he is sent for, and naturally cannot wait for hours for the right moment. The things most feared, and which we are warned against, too early forceps, ruptured perineum, etc., may result. . . . . Her extra knowledge of disease, her years of admirable (or slavish) obedience to order from seniors often lead to trouble, childbirth being a normal function, not a disease.[42]

Collapsing midwifery into nursing would increase the prevalence of puerperal sepsis and exacerbate the maternal mortality rate.

In short, many of the midwives who wrote to nursing and midwifery journals considered the nurse-midwife ideal part of an alarming tendency to treat childbirth as abnormal and requiring medical and institutional care. These midwives acknowledged that some women suffered during their pregnancies from medical problems which required the attendance of a doctor and possible hospitalization for birthing. But many midwives felt that concern over complications overshadowed the normality of most pregnancies and confinements. They expressed uneasiness at women routinely being treated as if "they were already sick and liable to all sorts of dangers and diseases."[43] The press, the doctors and many officials made the situation worse by "frightening the patient and making her and her husband feel that childbirth is a dangerous disease."[44] Many midwives disagreed with the increased tendency toward "the enforced entrance for confinement to hospitals of normal cases."[45] "Home is in the ordinary circumstances a safe place for a normal confinement," wrote another midwife, "even under the usual conditions of working class life."[46] Hospitals were appropriate for abnormal cases, but to place a normal case in a hospital courted disaster since hospitals increased women's chances of contracting puerperal infection. If the woman was in a teaching hospital there was the risk of internal examinations for teaching purposes and "interference of various kinds."[47] "When a woman is confined at home," she usually takes her own risk, but "should she be a patient in a ward say with six beds, she shares the risks of the other five. . . . "[48]

Most midwives believed that women were more comfortable at home in any case "surrounded by all that is familiar to her [and therefore] more likely to have an easy labour than in hospital. . . . "[49] As importantly, the association of hospitals with sickness and death created a sense of dread in many expectant mothers. Many midwives routinely expressed the opinion that just this anxiety and fear were "the most dangerous of all preludes to lying-in. . . . " and as such added one more variable to those which pushed a normal pregnancy toward an abnormal labour.[50]

A nurse, "specialized in skilled nursing attention to those who were ill,"[51] had a difficult time regarding birth as a normal process. The midwife's training reflected the essential nature of childbirth. Although she had been trained to attend to the needs of a woman who had become ill, this was not the primary purpose of midwifery. "Midwifery", as one correspondent wrote, "is not sick nursing."[52] A midwife had been taught to watch over the progress of childbearing, she learned to distinguish routine variations from pathological developments and when complications arose, she called a physician. John Fairbairn did not think a midwife should have anything to do with nursing, but rather should leave nursing, as the doctor did, to those who were trained for it. "She is not a sick nurse" John Fairbairn wrote of the midwife, and only "if her patient becomes ill, [is] a trained nurse . . . needed."[53]

Midwifery advocates believed that while the training one received in school provided a foundation, the real midwife was made in the crucible of practice. "No one touches the fringe of it until after a year. . . . ", wrote 'An Onlooker'.[54] "It is my opinion", wrote 'MAC', "that it is the practical work in midwifery which counts, and I cannot understand why there should be all this talk of a three years general training. . . . "[55] Nursing training did not prepare women for the natural process of childbirth, and inculcated an attitude which prevented them from accumulating the experience and skill many midwives thought central to the work. Midwifery practice required an understanding of childbearing as a physiological process, the confidence to wait out the process of labor, and, if an emergency arose, the ability to take control until the doctor came. The midwife did not do the doctor's work, but neither could she abdicate her own. In contrast, correspondents believed that nursing training, which taught a woman to work only under the direct orders of the physician, drove out her independence. The nurse was thought to have "far too little self reliance, too little experience of the world, [she] has

been drilled too often in unthinking dependence on others to do well."[56] The well-known midwifery reformer and teacher, Alice Gregory, passed a similar judgement. "She must not take any responsibility, but immediately fly for the Sister, later on for the House Surgeon if anything unexpected occurs."[57]

The theme of the midwife's skill in applying her training and experience in difficult situations was often present in the true-life accounts which midwives' published in the nursing and midwifery journals. Such stories described the dangers which a midwife had to consider, and emphasized a midwife's ability to solve all problems she encountered. The stories emphasized experience, manual dexterity, quick thinking and resourcefulness. "M.C.", for example, was in the district only ten days when she was called to a woman pregnant with her third child. The expectant mother had been "taken ill that morning with pain and hemorrhage." The woman had had no previous ante-natal care and had not booked a midwife.

> I scrubbed up and examined; found some dilation of the os, with the placenta covering it, but I could feel the edge of the placenta and pushing the tip of my finger past it, could make out a vertex presentation of the foetus. The posterior wall of the uterus was thick, heavy and spongy. The anterior wall was thinner and firmer, with the hard head lying behind it.

Thus the stage is set. The midwife is presented with one of the most difficult and unpredictable complications of childbirth — placenta praevia.[58] The midwife sent for the doctor directly, who appeared in a half an hour. He confirmed her diagnosis and left promising to return with his partner. But he did not return and the midwife was left alone with the mother. All of the midwife's skill and resourcefulness are necessary to ensure the safe delivery of the infant and the health of the mother.

> Soon after the doctor had gone the pains began to be frequent and strong again, with considerable hemorrhage. I applied a tight binder and hoped the doctors would not be long. The pains grew worse rapidly, then the membranes ruptured. I examined again to see what was happening and found three-quarter dilation of the os with the edge of the placenta hanging loose. I gently pushed it to the rear to make more room for the head, which with

> good pains going strong now, was making progress, and pressure on the os had also abated the hemorrhage. I should have sent again for the doctor, but could not, as the husband had gone into town to get some necessary supplies, and I was alone. Strong pains came thick and fast now, the head rapidly advancing with every one. Twenty minutes later I separated a small, slightly premature, living infant, crying in a faint small voice. I rolled him up in a warm blanket and popped him down near the fire. The placenta slipped out without any trouble. I gave a dose of ergotin hypodermically, the uterus contracted beautifully, and I kept the patient warm with her head low. I began to feel quite pleased with my morning's work.

The midwife's final victory is the survival of the infant--"The baby lived and thrived; he was delicate for the first few months, but he was breast-fed, and when I saw him at twelve months no would have known that he was a placenta praevia baby."[59] Typically in such stories, the doctor failed to assist the midwife in the crisis, usually arriving "about half an hour after the birth of the baby." The midwife, with her experience, independence and quick-thinking, triumphs not only over adverse medical circumstance. She succeeds where the doctor fails.

Such stories evoke a much different perception of the midwife's work than that suggested by those who supported general training. Effective midwives were independent of physicians. They were grounded in the theory of the physiology of birth. They had confidence gained from experience of truly dangerous situations. Against this tradition, the nurse appeared to critics as a pale substitute. Where proponents of general nursing promoted the nurse as the avenue to the entire profession's advance, opponents saw her as a wedge to transform midwifery into an appendage of the nursing profession and to jeopardize the safety of the women they attended.[60]

The Institute threw its lot behind the proponents of general nursing as a means to advance midwifery as a profession with a privileged claim on childbearing attendance. Official Institute policy followed those midwife correspondents who defended childbearing as a normal event. The Institute was already officially on record in support of the physiological concept of birth, home confinement, and the midwife being allowed to carry out her duties without interference from the doctor. The Institute leadership was not

blind to the possibility that midwifery might be professionally absorbed by general nursing. Alert to this possibility, the Institute opposed attempts to incorporate general training into midwifery education, insisting that the two remained separate.[61] The leadership, however, also argued that the more midwives' professional training conformed to the tasks of midwifery as defined by Campbell, the stronger would be midwifery's claim to an equal place in the maternity services. Because nursing was increasingly regarded as an integral part of the care of childbearing women, the Institute leadership considered it an integral part of midwifery. In its response to the reports of the Departmental Committee on the Training and Supply of Midwives, for example, the Institute agreed with the Committee that, while making general nursing a prerequisite for midwifery training was unrealistic until conditions improved, it was "highly desirable" for a woman to have trained as a nurse prior to her midwifery training.[62]

Encouraging the general trained nurse to take up midwifery work was only one facet of the Institute's strategy for augmenting the professional status of midwifery during these years. While general training could enhance the technical side of the midwife's work, it was also only one means of raising the educational "floor" of the profession and its social status. Two other means were equally important. In order to ensure a "higher standard of general education" for midwifery "than that obtaining now," the Institute also advocated raising the minimum educational requirements for admission to midwifery training.[63] The Institute proposed that all training institutions and independent midwifery teachers require preliminary educational tests for all applicants. These tests would "eliminate those women who have neither the intelligence nor elementary knowledge to justify them entering upon a course of training which is . . . intensive and of short duration."[64] Preliminary testing was expected to weed out women considered unsuitable while educated women who could meet the higher requirements would be encouraged by the higher standard. "The higher the standard demanded," Janet Lane Claypon, an increasingly influential Institute member, assured her audience "the more will be thought of the profession, and the more it will appeal to those who are keen and capable."[65]

Altering the requirements within midwifery had other implications crucial to the Institute's professional strategy. Where once general nursing and a superior education had been considered characteristic of the cream of

midwifery, they were now considered the minimum requirement. While this would raise the educational and social floor of the profession, the ceiling was now undefined. The Institute leadership and its supporters increasingly advocated and worked for the creation of an advanced credential which would recognize a higher level of professional accomplishment and offer a means of advancement which had heretofore been missing. More than a means of attracting a "better type of woman", such a credential would reinforce the upgrading process which general nursing and preliminary education examinations had begun. "If we want to improve our status we must have a definite qualification which will show the high level to which we want to attain," Janet Lane Claypon declared in 1923. "A certificate is only a first step, but it is a step, and from it the whole profession can be pushed forward."[66]

For the Institute, the logical place to begin raising the standard was in the area of midwifery teaching. The Institute had taken an active role in midwifery education since the early days before registration. The Institute had organized lectures on a variety of medical, midwifery and public health issues given by the most prominent midwives and physicians in the field. It had offered its members the services of an up-to-date library. Nursing Notes regularly published clinical and theoretical articles to kept readers abreast of current developments. Teachers responsible for training new generations of practicing midwives were naturally drawn to the Institute's headquarters on Buckingham Street in London to compare teaching techniques and to share their common problems. Members who were midwifery teachers used the Institute to organize themselves within the profession. With the formation of a standing Teacher's Committee in 1916, midwifery teachers were granted formal recognition within the organization, and in 1924 midwifery teachers organized their own professional association, the Association of Teachers of Midwifery (under Institute auspices).[67] As a result, the Institute became a center of expertise in midwifery education and a forum for discussing the future of the midwifery teacher.

While the Central Midwives Board controlled the content of the curriculum and the standard of the training facilities, the Institute considered the individual midwifery teacher to be the crucial bridge between the untutored pupil and knowledgeable midwifery practice. All midwifery teachers shared the same task: to provide midwives with a comprehensive

understanding of the relationship between the theory learned in the classroom and the practical application of that theory in the real world of the hospital ward and the working class home. "I remember Sister Gregory taking me to cases," one student wrote of Alice Gregory's teaching style, "asking me questions on the way, teaching me things I would not have learned in lectures, showing me how to work in the homes . . . I found my feet in district work; I specially remember those evening reports to her. "[68] Such mentoring initiated the pupil into a professional culture as important to a midwife's practice and the prosperity of her profession as her theoretical and practical knowledge. Everything turned on the teacher. "It is more and more realised that the midwife-teacher has a great influence on those she trains," Olive Hadyn wrote: "On her depends to some extent their future career, their outlook on life, their interest in social problems, their attitude toward childbearing."[69]

The Institute leadership believed that midwifery teachers should be drawn from the most technically advanced and accomplished members of the profession. They agreed with other reformers that midwives with general training and those with a superior general education would make the most desirable candidates for midwifery teaching, "not," as Janet Campbell pointed out, "because the midwife who has only her Central Midwives Board certificate may not be a very competent midwife in her own way, but because the more advanced teaching can only be given successfully if based on a better education and a wider knowledge of general nursing and hygiene than she can possess."[70] Yet, the Institute did not qualify even these educated women, as superior as they may have seemed when compared with their less educated colleagues, on the basis of educational or social credentials. Most midwifery teachers were either independent midwives whose large practices had given them years of experience in attending women in childbirth or hospital midwives who taught pupils as one among many responsibilities in a teaching institution. For the Institute leadership, practical experience, even combined with refinement and the best training, was insufficient to qualify a midwife to teach. "Teaching is concerned with the theoretical side of the subject, with the principles and the 'whys'," Dr. Abernathy Willett, the author of the widely known handbook, The Midwife in Practice, asserted in his lecture at the Midwives' Institute Teacher's Instruction Course in 1926. "Mere recital of facts is not enough and the teacher must be prepared to

explain the principles upon which they are based. . . . "[71] The Institute argued that midwifery as a profession would be best served by training its teachers to teach. Through a course of advanced instruction in the theoretical subjects of midwifery, and with specialized training in teaching methods and techniques, the Institute assessed that a midwifery teacher would emerge with a credential which would set her apart from those teachers without such training. This "new" teacher would lay the basis for the improved instruction of future generations of midwives. The more advanced and technically trained midwifery teacher constituted the top of a newly developing professional hierarchy in which specialized training and formal credentials supplanted experience as the criteria by which professional accomplishment and status were judged.

The Institute succeeded in establishing its midwifery credential in the 1920's after several years of work. In 1918, at its prestigious conference, "Ideals in the Teaching of Midwifery", the Institute gathered some of the most prestigious names in medicine, midwifery and government service to launch its campaign to reform the educational foundation of midwifery teaching.[72] At the Annual Meeting the following year, the membership passed a resolution in favor of systematic training for teachers of midwifery and committed the organization "to especially promote and provide facilities for such instruction for teachers of midwives."[73] During the next few years, the Institute limited its activity in this area to a series of lectures for midwifery teachers and to facilitating the greater organization of the teachers themselves.[74] In 1925 the Institute began to offer its own certificate in midwifery teaching.[75] In 1930, the Institute's course was accepted as the basis for a CMB approved credential in midwifery teaching.[76]

By redefining the tasks of midwifery and restructuring the composition of the midwifery workforce the leadership sought to establish the profession's place in the evolving maternity services. A more clearly delineated division of labor established midwifery's unique contribution to maternity care and reinforced the profession's claim to a privileged place among the maternity services. More stringent eligibility requirements would increase the liklihood that candidates would be able to meet the expanded demands placed upon midwifery care. As importantly, these requirements would weed out the less socially desirable woman and (along with opportunities for advancement) help to attract the more socially refined women into the work.

The Defense of Private Practice

In delineating the midwife's tasks and supporting general training, the Institute had reasserted midwifery's claim to a position within the maternity services. If this claim could not be enforced, midwives would continue to experience an erosion of their economic and professional position. Prospects of advancement would mean little under such circumstances. The Institute demanded that midwifery's access to the market for normal maternity services be protected through the traditional means of medical etiquette and referrals and that the fees which the midwife received for her work be raised to a level which guaranteed a standard of living to which most middle class educated women would be accustomed.

The Ministry of Health supported the Institute's suggestions for improving the economic position of independent midwives. The Ministry was unwilling to fully subsidize maternity services, so it encouraged local authorities to base their relations with private practitioners on traditional rules of medical etiquette and referral. In 1919, a Ministry memorandum warned, "Every care must . . . be taken to safeguard the midwife's professional relations with the patient."[77] If a midwife referred her patient to the local clinic, for example, "she should be kept fully informed of the defects discovered", and of the recommended treatment. Most importantly, "care must be taken to secure that the woman is referred back . . . and the midwife should not be allowed to lose her fee."[78] If the findings indicated that the woman's pregnancy would proceed without complications, the midwife would assume responsibility. If, however, problems were discovered and the woman should need to be attended by a physician, the midwife should be engaged as a maternity nurse and "either the patient or the local authority should pay."[79]

Also in 1919, the Institute issued a memorandum on relations between the independent midwife and the local services which served as their desired model until the mid-1930's. The memorandum stated that the clinic physician or health visitor should not undercut the work of the independent midwife, either by making recommendations regarding attendants or by taking care of anything other than minor ailments, and then only for those who cannot afford the cost of a physician or a midwife. "The true function of the ante-natal clinic, " a Nursing Notes editorial asserted, "was to provide the

midwife with a "consultative centre to which any doubtful case can be referred."[80] If a health visitor discovered some problem in the course of her visits, she should report her findings to the midwife who was responsible for the case. The health visitor should under no circumstances give advice to the woman about her pregnancy as it "may differ from the equally correct advice given by the midwife," and therefore undermine the midwife's authority with the patient.[81] If a midwife referred a woman to the ante-natal clinic, that clinic should observe the rules of medical etiquette. A referring midwife should be regarded as the primary attendant, and as such all information about the case should go through her. Correspondence between the physician and midwife should remain strictly confidential. Under no circumstances should the clinic refer the midwife's patient to another practitioner or to an institution. If additional help seemed appropriate, the midwife should be informed so she "can refer her own patient to whom she wishes."[82] The Institute did not object to the midwife turning her patient over to another practitioner more suited to manage the problem at hand, but it did object to the loss of the midwife's fee when patients were improperly referred. Mrs. Mitchell, then Honorary Secretary to the Associations Affiliated to the Institute, insisted to the 1929 Departmental Committee that "some compensation should be paid to the midwife if for any reason a doctor or an ante-natal clinic advises her patient to go to a municipal home or a hospital. . . . "[83] Nursing Notes made a similar demand in 1931 in response to a Ministry memorandum that ignored the loss a midwife might incur "if a case subsequently is sent to hospital, or in any other way taken out of her hands on account of abnormality, we consider she should be paid compensation in respect of the services she has already rendered."[84]

The Institute wanted to not only protect midwifery's access to the market for services, but to raise the income midwives received for providing that service. They opposed any solutions which appeared to them to infringe upon the private relation between patient and midwife. Some reformers believed that both mother and midwife could improve their lot through a salaried service for midwives. A few local authorities had even employed midwives to attend necessitous cases in exchange for a salary. Local women had access to trained attendance, at a fee which they could afford. The municipal midwife, as she was called, had her remuneration guaranteed, her expenses paid and, because she was an employee, access to an insurance and

retirement plan. While salaried employment appeared to be the answer to midwives' problems, Nursing Notes warned that "it is, however, a question by no means simple." For the Institute, private practice was at the core of professional control. The freedom to make her own contracts, to set her own fees, to make her own arrangements, and to abide by, and be assured of, strict confidentiality, ensured the midwife's control over her work. The midwife and the woman negotiated the terms and agreed upon a mutually satisfactory arrangement. Professional etiquette demanded secrecy, so no other practitioner or competitor could interfere with the terms of the agreement or the particulars of the case. Any kind of interference, whether by another competitor, an outside authority, or an employer, threatened the exclusive authority of the midwifery profession. The Institute feared that the midwife-employee would no longer answer to the standards, procedures and arbitration of her profession, but instead answer to a local authority, or a Medical Officer of Health (MOH) or a Midwives Act Committee or any combination of health officials. Bound to her employer's regulations, she would no longer control the particulars of the case. Because she would be required to report all her findings to the authorities, she would not be able to defend herself or the patient from outside questions or interference.

The Institute defended the midwife's professional privileges as the best system for the maternity services, the community, and the patient. As an employee of the local authority, the midwife's work and her patient would be subject to interference and investigation. Protective of their privacy, women "had a distinct prejudice against Town Hall officials as tending to publicity and interference."[85] If women had to engage a municipal midwife, they might endeavor to limit their contact with the midwife, thus making complete ante-natal supervision impossible. The patient would not be the only woman discouraged by meddling authorities. Nursing Notes argued that Municipal employment would "deplete the ranks of the best of the midwives. . . . "[86] The independent midwife had a vested interest in developing her own pool of patients, with whose home conditions, health and personal problems she was familiar. The Institute argued that the municipal midwife, as an employee, would lack incentive to cultivate a practice. The midwife employee might be appointed for a short time only, or she might be let go for no fault of her own, or she might become unsatisfied with her position and rather "go from place to place according to the possibilities of advancement."[87] Indeed, the loss of

personal ties to patients from long years of attending them and their families might force her out of midwifery and into other fields.

The Institute understood that all patients who applied for the municipal midwife's services would be investigated and that all but the most destitute would be required to pay something toward the cost. Nevertheless, the leadership believed that even the appointment of a salaried midwife by a public authority sent a clear message that provision for attendance was no longer an individual responsibility. The Institute feared that without the punitive stigma which usually accompanied relief there would be no means of ensuring that the patient's "economic independence should be maintained and encouraged and pauperism discouraged."[88] As the municipal midwife's salary would come out of the taxpayer's pocket it amounted to nothing less than forcing, "charity on the part of the provident for the benefit of the improvident."[89]

The Institute argued that the answer to midwifery's problems lay in guaranteeing that a decent standard of living could be made from private practice.[90] That midwives establish a standard fee for the district in which they worked was of utmost importance. Some reformers had suggested that the Ministry set a minimum fee. Providers would not be allowed to offer their services for less. The Institute opposed this proposal on the grounds that it would violate the midwife's right to set her own fees according to the market. Instead, the leadership urged the Institute's affiliated associations to gather together all of the midwives in the district to determine a scale of fees which would allow each midwife to receive "from each (case) . . . such as will compensate the midwife for the time and services given. . . . "[91] For the strategy to work, however, these guidelines had to be adopted by providers and local governments alike. "Here it need only be said," Nursing Notes asserted, "that such remedies must depend in large measure upon . . . . cooperation among those groups of midwives and those who have the power and the authority to carry out the necessary reforms."[92] It was essential that in a locale, independent midwives agree that "none shall go for a lesser one [fee], except in cases of real necessity."[93] Even in cases of real need, midwives had to agree on a scale of fees "applicable to different degrees of necessity" and not deviate from it. It was equally essential for the Institute and its associations to dissuade the local authority-sponsored services from undercutting independent midwives. The Institute confidently assumed that "the lack of

knowledge and foresight is the cause of any seeming injustices," which might stem from undercutting. By approaching the suspected offenders personally, members of the Institute's associations would find "a half an hour's friendly talk will often lead to amicable adjustment."[94]

Some critics charged that the Institute's proposals would stabilize fees at the expense of midwives' patients. The Institute leadership responded that the majority of people could afford to pay a higher fee. It had been the government which had used "public money to bring down the fee to an uneconomic level."[95] The Institute reported that in one county, for example, "although enquiry was made as to the circumstances of the patients, many of those who could pay more were only charged 25s or 30s" when the suggested fee was almost twice as much.[96] If patients were more carefully screened with an eye to weeding out only those who were "truly necessitous . . . . it is possible for all to pay the fee."[97]

The leadership conceded that cases of genuine destitution did exist. They did not propose that these women be denied trained attendance, but only that they be given help with the cost "after due investigation" into their financial situation. In these cases, the Institute argued, the local authorities would be responsible for paying a subsidy to independent midwives to attend women who could not otherwise afford the standard fee of the district. A patient would choose her midwife, agree upon a fee, and pay the portion of the fee the authority had determined she was capable of paying. The midwife would attend the patient, would notify the authority of any abnormalities or complications, and would receive the remaining portion of the payment from the local authority. If the local authority paid "the balance of the fee which the mother is unable to pay herself, to the midwife of her choice," neither midwifery nor the patient would be pauperized. Because the local authority would ensure that the independent midwife received the standard fee set in the district, independent midwifery was protected from the undercutting of municipal practice. As long as she was not offered the midwife's services without responsibility for some payment, the patient's economic independence was preserved. The local authority could monitor the quality of the work the midwife performed in exchange for the subsidy, but this would be done through the standard procedures of inspection set down by the Central Midwives Board and the Midwives Act, and the authority could never interfere with the patient or the midwife.[98] Under the

system they proposed, the Institute leadership argued, the independent midwife would be as reliable a supporter of the local authority-sponsored services as the municipal midwife would be. "Let them [independent midwives] push the centres, let them fill the clinics with their abnormal (*never* their normal) cases . . . and in the end there will be far greater happiness, goodwill and efficiency."[99]

By 1927, however, the Institute's proposals to counter undercutting had not only not been adopted by local authorities and competing providers, but the problem had become so serious that the Institute appointed a special Committee on Undercutting to gather information from midwives' around the country and to directly intervene on their associations' behalf. In letters sent to those suspected of undercutting, the Committee directed its appeal to the interests of the guilty party. A circular was sent to all the London Hospitals, for example, pointing out that by lowering their fees, "a valuable source of income was by this means lost" to them.[100] Although the Committee received "sympathetic replies in nearly every instance" from these hospitals, most nevertheless declined to change their policies. Letters sent to the superintendents of all the training schools resulted in only nine replies which, "with the exception of one, all manifested sympathy of a practical nature with the requirements of the independent midwife."[101] Yet only three schools had come to agreements with the local independent midwives. Although these returns inspired hope, the Committee had to acknowledge that these, "instances are not typical and that defaulters may predominate among those who failed to reply. [102] Midwives' reports supported this more pessimistic observation. At the 1927 Summer Meeting of Representatives, independent midwives from all over the country testified to the continued and widespread undercutting of their practices. Some midwives' associations were successful in their attempts to resolve pricing disputes, but many others encountered resistance and refusal. Where a hospital cooperated in one area a nursing association might turn a deaf ear. Where a training school might raise its fees, independent midwives not affiliated with the Institute might lower theirs. No matter how patient and logical their arguments , midwives seemed unable to overcome the practical necessity of locally-sponsored services to secure patients, whether for education, philanthropy or as a requirement of the Ministry of Health.[103]

Reorganizing to Meet the Challenge

Simultaneously with their campaign against undercutting, and partially as a result of their failure to stem its use, the Institute leadership took steps to restructure the organization and expand its membership. The affiliated associations represented a potential source of political influence wielded in local areas on behalf of the Institute's goals. Where associations existed, midwives could band together to prevent undercutting among their number. As a corporate body speaking for local midwives, the association could participate in discussions regarding local health and midwifery affairs or seek appointment to the various local government bodies which oversaw the public health and maternity services. While working to improve local conditions, these association members would still be bound by the rules of affiliation to promote Institute strategies for resolving the larger problems facing midwifery. As long as midwives remained unorganized or within non-affiliated associations, or the affiliates were weak, the Institute (or its members, for that matter) would not be able to fulfill the potential of their organization. "There are things that we want," Mrs. Mitchell told the Annual Meeting of the Affiliated Associations, "and if we had thousands of midwives behind us we could say that we must have them."[104]

The recognition of the associations' potential was one thing; however, its application was another. Since the 1910 challenge to the Institute from the British Union of Midwives and the National Association of Midwives, the Representative Committee had been gradually helping to form new associations and recruit new members. In 1922, seventy associations were affiliated with the Institute.[105] By 1925, the number had increased to ninety-five.[106] Although it did not print membership numbers, the Institute acknowledged that the figures were low relative to the number of practicing midwives. The development of the associations themselves was uneven. "Some are gasping for breath", Miss Pearson, the honorary secretary of the Committee of Representatives, told her audience the evening she delivered the Fynes-Clinton Memorial Lecture. "Others are in rude health; all need periodic visiting."[107] Even organizations that were affiliated with the Institute were often beyond the control of the Center. "The most distant associations are those where danger is most likely to insidiously creep in, and endanger our whole life and work," Pearson warned.[108]

Pearson argued that by strengthening central control over those associations already affiliated to the Institute the organization could lay the basis for further expansion. She suggested that the Institute divide the country into districts and appoint a "district secretary" to oversee each one. The district secretary would be responsible for the associations in her area. She would act as the conduit for information between the associations and the Institute, attend local meetings, advise the associations on local problems, and organize new affiliates in her district. Pearson's plan reflected the needs of the Institute, however, more than the needs of the affiliates. The district secretaries were charged with organizing and supervising the affiliates for the Institute. The Associations could nominate their district secretaries, but the appointment would be made at headquarters.

In 1925, Janet Early, the honorary secretary of the Oxfordshire Midwives Association, spoke up for the affiliates. Early wondered "whether the Associations have any real voice" in the election of their representatives.

> In the little book In the Beginning we are told that the 70 Associations "share in the privilege of election the Institute representatives on the Central Midwives Board, through their representative members", and later, that "the three C.M.B. representatives are appointed by the Midwives Council." But it the Associations have no voice on the Representative Committee, how can they help to elect the C.M.B. representative?[109]

Early assured the editor that she had no criticism of those currently in leadership positions on the Committee of Representatives and the Council. She did, however, believe that representatives should be chosen more democratically. Like Pearson, she also proposed that the country be divided into districts, but added that the associations should elect a member from each district to sit on the Committee of Representatives. The district representative would be eligible for a seat on the Council. "In these democratic days", she wrote, "such a right to share in the affairs of the central body would increase the interest of the Associations, weld them together and infuse new life into them, as nothing else can. . . . "[110]

The notion that the central mechanisms of decision-making would be available to the rank and file was one which the Institute leadership had long

resisted. The leadership relied upon the affiliates and members to provide them with information about conditions throughout the country and to support the Institute financially, but they did not consider that the Institute had any obligation to consider their views when decisions were made. In this regard, the absence of any means of membership representation was not surprising. The affiliates were depicted in Institute literature as independent organizations which affiliated with the Institute for the services the Institute could provide. The fact that affiliates had to abide by the Rules set down by the Institute and could neither act nor issue a public announcement without the Council's permission were not considered sufficient basis for representation. As Edith Simpson wrote to Mrs. K-- when she complained of the Institute's lack of responsiveness to her association's problems, "Our Constitution is not that of a Trades Union. We do not require a 'mandate' from our members, but . . . get at their views and opinions and are thus able to watch over their interests and help them where possible."[111] Nonetheless, the Institute leadership recognized that some means had to be found to encourage new members, integrate them into the life of the organization and give them a sense of participation. In its response to Early's proposal to democratize the Institute, Nursing Notes also acknowledged that there had been "considerable thought and discussion lately" as to the future of the affiliates, "more especially as regards their relation to each other and the Midwives' Institute. "[112]

By 1929, the leadership conceded that the membership should have some representation in the life of the organization. As such, the leadership's scheme to reform the internal structure of the organization reflected the contradictory elements of the Institute's exclusivity and the demands for more democratic ways. At the 1929 Annual General Meeting, the Institute announced the reorganization of the associations.

Prior to 1929, local midwife associations had been able to affiliate with the Institute, and in exchange for a fee, receive the services which the Institute provided. Affiliates were allowed one representative (who had to be a member of the Institute) for each twenty-five members. These representatives attended the Affiliated Association meetings and the larger Annual General Meeting where they were each granted one vote. Affiliation had advantages for both parties. Affiliate members received the benefits of the Institute's expertise without having to pay for direct membership in the

Institute. The Institute extended its influence over local midwifery organizations without having to accept them all as members. The disadvantages to the affiliates were that while the Institute demanded that every affiliate submit to the Institute's policies and strategies, the affiliates had virtually no voice in the formulation of those policies. For that matter, neither did direct members.

Under the 1929 scheme, direct membership was to be the basis of midwives' relationship to the Institute. Associations could continue their affiliate status, but greater advantages would be extended to those which adopted the new status of "Branch" of the Institute. To become a Branch, all affiliate members had to become direct members of the Institute. They paid a membership fee of 7s 6d, 3s 6d of which went to the Institute and the remainder to the local organization.[113] Branches were allowed to elect their own regional representatives to the Council, the Institute's policy making body. The branches were organized into five regions, each to be overseen by one regional representative. The branches could nominate candidates for this position and cast their vote for the woman whom they wanted to represent them. The five women elected would attend Council meetings and (as official representatives of the branches) vote on policy matters. Their travel expenses would be paid by the regions.[114] By the end of 1929, eleven Branches had been added to the one hundred affiliated associations.[115] Elections for regional representatives did not take place until two years later at the Annual Meeting of Representatives, and then Mrs. Mitchell was careful to remind the attendees that the "scheme was experimental."[116]

Although the new scheme was not without controversy, the Branch organizations quickly superceded the affiliates. Representation in Institute affairs was costly. Under the pre-1929 terms of affiliation, midwives had been able to pay the relatively small fee of 2s 6d to the association, with the additional fee for their direct representative member pooled among the group. Many midwives objected to the considerable increase in fees required to acquire some voice in the organization, and when the scheme was announced at the 1929 Affiliated Associations Annual Meeting there was "a great deal of discussion on the matter in which the representatives . . . and many others took a lively part."[117] Concern over cost was great enough for the Institute to modify the requirements of Branch status so that "a full membership of the Institute of not less than two-thirds of the Association

members should be deemed sufficient for the formation of a Branch."[118] Branch status increased the representation for midwives and the associations who could afford the additional fees, but the future appeared uncertain for those associations which, for cost reasons or otherwise, chose to retain their affiliate status. Branch status threatened to marginalize those associations who retained affiliate status and make them into second class citizens within the organization. The Institute feared that the increased cost of membership would cause the affiliated members to sever their relationship with the organization. "Though we are anxious to increase our power and unity . . . " Nursing Notes quoted Mrs. Mitchell when she reassured the affiliates, "we do not wish to lose any affiliated associations for their value [is] very great."[119] Apparently, enough affiliates were able to meet the cost of membership, and the number of Branches increased rapidly. By 1933, seventy-four Branches had been formed, with only twenty-six affiliates remaining. In that year alone, 556 new members had joined the Institute bringing the total number who had joined through the Branches to 2, 522.[120] By 1935, the Institute could claim that almost 6,000 midwives were either direct members of, or affiliated with, the Institute.[121]

* * *

The development of the maternity services presented both danger and opportunity to the Institute in its struggle to achieve its professional aspirations. As the primary attendant in the majority of the country's births, the independent midwife occupied a pivotal position in the delivery of maternal care. Recognizing midwives' position, Campbell sought to harness this workforce for the needs of the midwifery service. She had no interest in meddling with private practice, but she wanted midwifery to upgrade the social and educational composition of its recruits so that they could take full advantage of an extended and more sophisticated course of professional training. While Campbell and the Institute leadership did not agree upon every point, there was no dispute on these larger issues. For the Institute, reforms in midwifery training were expected to maximize the profession's claim to the health services market and to raise the social and educational floor of midwifery practitioners. These reforms promised greater status and prestige for midwives. At the same time, however, the maternity services

presented considerable dangers to midwives. The basis of private practice, a free market of services, was increasingly eroded by the growth of government-subsidized providers who could offer midwifery care at a fee below what independent midwives could afford. Without subsidies of some sort, midwives in private practice became increasingly vulnerable to competition from other providers. Nonetheless, during the 1920's, with the economic ground shifting beneath their feet, the Institute leadership clung to a concept of professional identity and aspiration still predicated on private practice. To do otherwise, would have necessitated a transformation in their understanding of themselves as professionals, a transformation which, although germinating, had to wait to be midwifed by the pressure of larger events.

References

1. "Midwifery Under Present Conditions", NM, October 23, 1825, 81; See also: "A Reader's Point of View", NN, October 1920, 107; "Correspondence", NN June 1926, 285.

2. "Why Will Not--or, at Any Rate, Does Not the Well-Educated Woman Who Must Earn Her Living Practice as a Midwife?" NN, August 1927, 108.

3. "Midwifery Under Present Conditions" NM, October 23, 1926, 81; "Midwifery Under Present Conditions", NM, October 2, 1926, 19; "Midwifery Under Present Conditions", NM, October 30, 1926, 101.

4. "A Reader's Point of View", NN, October 1920, 107; See also: "Abnormality and Medical Aid" NM, November 30, 1918, 119, in which the midwife wrote that she threatened the parish doctor with the police if he did not come. "That fetched him."

5. "Midwifery Under Present Conditions", NM, October 2, 1926, 19.

6. Great Britain, Ministry of Health, Departmental Committee on the Training and Employment of Midwives, 1929, 38.

7. Central Midwives Board, Report on the Work of the Board for the Year Ending March 1919; Interestingly, the table also showed that it was the less prestigious institutions such as the provincial hospitals, maternity homes

and independent trainers which were producing the highest percentages of practicing midwives.

8. Midwives' Institute, Representative Committee, Miss B-- to Miss Eaton, October 22, 1925; E. B-- to E. Simpson, July 1, 1923; Miss F-- to Secretary of the Midwives' Institute, March 10, 1926, courtesy of RCM Archives.

9. For incidences of these cases see: Midwives' Institute, Executive Club and Council, minutes, June 5, 1925; January 1, 1925; Midwives' Institute, Representative Committee, Memo, Southampton and District Midwives Association, November 24, 1926, courtesy RCM Archives; See also: "A Minimum Fee for Midwives", NN, April 1926, 244; "Openings for Midwives", NM, March 11, 1922, 422; "Openings for Midwives", NM, March 18, 1922, 459 for midwives who could not find employment in institutional or municipal posts.

10. Departmental Committee, 1929, 35.

11. Departmental Committee, 1929, 38.

12. Departmental Committee, 1929, 45.

13. Ministry of Health, Memorandum on the Training of Midwives (by Janet Campbell), Public Health and Medical Subjects, HMSO, 1923, 39.

14. Central Midwives Board, Report of the Work of the Central Midwives Board For the Year Ended March, 1920 ;Report of the Work of the Central Midwives Board For the Year Ended March 1925; Report of the Work of the Central Midwives Board For the Year Ended March 1930; Report of the Work of the Central Midwives Board For the Year Ended March 1935.

15. "Midwifery Services in England", NN, October 1923, 12; Typically, London statistics were always lower due to the relatively sophisticated standard of care of the London hospitals and the superior organization and comprehensive nature of midwifery services there.

16. "Conference on the Place of Midwifery", NN, April 1928, 53.

17. Campbell, 1923, 18; Information on the marital status of midwives drawn from Census of England and Wales, Occupation Tables, 1911, 1921, table 4, 1931, table 5; Even though the percentages of married and widowed midwives did decline during this period, they still remained much higher than those for the female workforce as a whole. Between 1911 and 1931, 77% of the female workforce was unmarried, while the percentages of employed married women reached no more than 16%. The percentages of widowed women declined slightly from 9% to 7% during this period. Census of England and

Wales, 1911, Occupation Tables; Census of England and Wales, Occupation Tables, 1921, table 4, 101; Census of England and Wales, Occupation Tables, table 5, 58; For a different interpretation of these statistics, see Jane Lewis, The Politics of Motherhood, Child and Maternal Welfare in England, 1900-1930 (London: Croom Helm, 1980) 145.

18. Central Midwives Board, Rules Framed by the Central Midwives Board, 1927, Rules E. 1, 22. Information for age distribution was drawn from Census of England and Wales, Occupation Tables, 1911, 1921 table 4, 1931 table 5.

19. Campbell, 1923, 8.

20. Campbell, 1923, 8.

21. Midwives' Institute, Teachers' Executive Committee, minutes, July 16, 1920, courtesy of RCM Archives; See also: "The Position of Midwives in 1921" NN, January 1922, 1. None of these women, according to Campbell, were of the "of the type one would choose as being likely to make first rate midwives. . . ." (Campbell, 1923, 18).

22. Campbell, 1923, 39.

23. "How the Midwife Can Help", NT, November 21, 1925, 1117.

24. Edith Doubleday, "Modern Midwifery Service", NN, September 1927, 122; Naturally, the leadership did not include its own membership in this characterization. As Edith Simpson, the Institute's Secretary, explained in her evidence before the 1929 Departmental Committee, "The Midwives' Institute makes a great point of the character of the midwife it admits to its membership; its numbers, therefore, are not as large as might be expected from the number of midwives on the Roll." "Evidence Given Before the Departmental Committee", NN, September 1929, 139.

25. "Theory and Practice", NN, July 1925, 98.

26. "Incorporated Midwives' Institute", NN, April 1931, 48.

27. "Modern Maternity Service", NN, September 1927, 122.

28. "Ante-Natal Care", NN, September 1920, 97.

29. "Future of the Midwifery Service", NN, March 1920, 29.

30. "Maternity Homes", NN, October 1925, 147. The high mortality statistics reported by many institutions was the strongest evidence in behalf of the Institute's argument for domiciliary deliveries. Janet Campbell, for example,

cited several instances of outbreaks of puerperal sepsis in both maternity homes and maternity wards of larger hospitals. In one hospital, Campbell reported that 21% of the women admitted between January 1925 and June 1926 had developed puerperal pyrexia. Although the hospital reported no deaths in 1925, seven women died from puerperal infection in the three months between April and June 1927. See: Great Britain, Ministry of Health, The Protection of Motherhood, (by Janet Campbell), Public Health and Medical Subjects, no. 48, 1927, 20. Campbell argued that the common thread in these mortalities (many of which occurred during normal, uncomplicated labors) was failure to take proper antiseptic precautions. For other examples, see: Campbell, 1927, 21-32. The high mortality rates of many of the small maternity homes which local authorities built and administered created such a scandal in some instances that the Ministry eventually discontinued its support of this means of supplying maternity beds to women in the area.

31. "Theory and Practice", NN, July 1925, 98.

32. See, for example, "Ante-Natal Care", NN, September 1920, 97; Continuous care advocates wrote for other journals as well, see: "Midwives and Ante-Natal Work", NT, June 30, 1928, 818.

33. "Practical Notes: Ante-Natal Care", NN, February 1927, 24; For the most direct discussion, see: "Ante-Natal Care", NN, November 1917, 184; "Current Notes", NN, August 1924, 119-121.

34. "Evidence Given Before the Departmental Committee", NN, September 1929, 143.

35. "The Organisation of the Ante-Natal Work of the Midwife", NT, March 21, 1925, 281; For the rest of this series, see: March 28, 1925, 301-302; April 18, 1925, 385; May 9, 1925, 465-466; See also: "Ante-Natal Work", NT, April 4, 1925, 326.

36. "New Scheme for a National Maternity Service" NN, October 1931, 150.

37. "How the Midwife can Help", NT, November 21, 1925, 1117. For others who supported general training, see "The Making of a Midwife", NT, December 17, 1927, 1521; See also: "The Modern Midwife in Domiciliary Practice", NT, February 8, 1930, 175-176; Not all proponents were necessarily drawn from the elite. See the series of letters entitled "A Midwife's Complaint" in "Everybody's Opinion", NM, November 3, 1928, 107; November 10, 1928, 131; November 17, 1928, 151; December 8, 1928, 223.

38. "New Scheme for a National Maternity Service", NN, October 1931, 150; See also, the article by H.W. Harding Medical Officer of Health for Edmonston, "Advantages of Trained Midwives in the Community", NM,

August 18, 1923, 374 in which he argues that, "every midwife should be a certified nurse of three years training. . . ."

39. "The Practicing Midwife", NN, October 1922, 125.

40. "Ante-Natal Work and the General Practitioner", NN, February 1930, 17; For other examples of this view of the midwife's place in the medical hierarchy, see: Edith Doubleday, "Modern Midwifery Service", NN, September 1927, 122; and her "Maternity Nursing From the Nurses Point of View", NM, September 21, 1929, 531; Constance Taylor's letter, "Correspondence", NN, November 1935, 151; For others see: Olive Hadyn, "The Management of the Lying-In Period", NT, April 19, 1919, 379- 380; and also her "Work of the Midwife" NT, July 19, 1919, 735-736; and the later, "The Penal Cases", NN, January 1936, 5, in which Nursing Notes accused midwives of "occasionally--perhaps rather too often--a tendency to overstep the province of the midwife's duties."

41. "A Midwife's Complaint", NM, October 27, 1928, 87.

42. "Correspondence.", NN, November 1932, 351; See also: John Fairbairn, "Politics of the Midwifery World", NN, June 1931, 85; See also: "The Importance of the Teacher's Work", NN April 1926, 262.

43. "Summary of Replies", NN, September 1927, 125.

44. "Summary of Replies", 125; See also: "Midwifery Under Present Conditions", NM, November 13, 1926, 143 ; "Maternal Mortality", NM, September 30, 1935.

45. "Ante-Natal Care", NN, December 1931, 180.

46. "Midwives or Hospitals", NN, March 1933, 35.

47. "Why Maternal Mortality has not Decreased", NN, June 1927, 82.

48. "Summary of replies", NN, September 1927, 125.

49. "Maternity Cases" NM, May 14, 1934, 115.

50. "Why Does Maternal Mortality Not Decrease?" NN, September 1934, 139; See also: "Maternity Cases", NM, May 4, 1934, 115; "Maternity Cases", NN, May 14, 1934, 115; "Maternity Homes", NN, June 1936, 87; For this same reason some midwives even questioned ante-natal care. See, for example, "Ante-Natal Care", NN, March 1933, 41.

51. "General Lying-In Hospital", NT, May 17, 1930, 641.

52. "Correspondence", NN, May 1935, 71.

53. "Politics in the Midwifery World", NN, June 1931, 85.

54. "Correspondence", NN, August 1925, 122.

55. "A Midwife's Complaint", NM, November 24, 1928, 173; See also "Correspondence", NN, August 1929, 130.

56. "Correspondence, The Midwife of the Future", NN, August 1925, 122.

57. Alice Gregory, "The Midwife", NN, April 1936, 50.

58. "Placenta Praevia: a condition in which the placenta is implanted abnormally in the uterus so that it impinges upon or covers the internal os of the entrance to the cervix. A placenta in this position is highly vulnerable to separation and rupture, resulting in severe hemorrhage." Mosby's Medical and Nursing Dictionary (St Louis: The C.V. Mosby Co., 1983) 851.

59. "A Placenta Praevia case", NM, May 30, 1931, 172; see also: Rhoda Rose, NT, September 27, 1919, 1009; "Life as We Sometimes See It", NT, August 18, 1928, 1012; "Born in the Dark", NM, October 25, 1930, 76.

60. For an excellent exploration of this notion of professional work culture in nursing and the uses of correspondents' letters and stories to understand it, see Barbara Melosh, "The Physician's Hand": Work, Culture and Conflict in American Nursing (Philadelphia: Temple University Press, 1982). Melosh's work was crucial to my study. Her innovative approach to professionalization and her insight into the rank and file allowed me to look at my own research in a new way. Without her contribution, my own would have been greatly diminished.

61. Incorporated Midwives' Institute, Memorandum of the Council of the Report of the Departmental Committee on Training and Employment of Midwives, 1929, 2, courtesy of RCM Archives.

62. Memorandum . . ., 1929, 2; See also, Midwives' Institute, Special Council, minutes, October 15, 1929; See also: Midwives' Institute, Special Council and Advisory Board, minutes, July 26, 1920, RCM Archives; "A National Problem", NN, December 1920, 129; Although the CMB did not require midwives to train first as nurses, the Board's chair Frances Champneys supported general training for midwives. See: "Shortages of Cases: What is the Remedy", NN, July 1920, 74.

63. "Evidence Given Before the Departmental Committee, B.--Suggested Scheme", NN, September 1929, 141. Incorporated Midwives' Institute, Memorandum of the Council on the Report of the Departmental Committee on Training and Employment of Midwives, 1929, 1.

64. Departmental Committee, 1929, 15.

65. "Midwifery Work and Social Health", NN, April 1923, 43.

66. "Midwifery Work and Social Health", NN, April 1923, 43; See also "Maternal Mortality and Disability", NN, January 1925, 4.

67. Midwives' Institute, Teachers' Committee, "The Association of Teachers of Midwifery", (circular), January 1924, courtesy of RCM Archives.

68. Quoted in Egbert Morland, Alice and the Stork, (London: Hodder and Stoughton) 61; For a selection of Gregory's writings, see Alice Gregory, The Midwife: Her Book, (Oxford: Oxford Medical Publications, 1923).

69. "Teachers of Midwifery", NN, February 1920, 16; See also: "The Importance of the Teacher's Work", NN May 1926, 260-262; Many considered midwifery teachers crucial gatekeepers in the struggle to elevate the educational and social status of the profession. See: Olive Hadyn, "The Wider Education of Midwives", NT, May 3, 1919, 443-444; Alec Bourne, "Our Midwifery Service and Women's Health", NT, August 19, 1922, 811; "How the Midwife Can Help", NT, November 21, 1925, 1117; "Teacher's Instruction Course", March 1923, 29; In 1925, the CMB strengthened the teachers' hand in this regard by giving them the right to refuse those candidates who did not meet the teacher's educational criteria. "The New Rules", NN, June 1925, 96.

70. Campbell, 1923, 32.

71. "The Importance of the Teacher's Work", NN, April 1926, 260; See also: "Teacher's Instruction Course", NN, December 1924, 166.

72. "Ideals in the Teaching of Midwifery", NN, August 1918, 109-113; September 1918, 124-126.

73. "Annual General Meeting", NN, February 1919; See also Olive Hadyn, "Teachers of Midwifery", NN, February 1920, 16; "Discussion at Annual Meeting", April 1922, 52.

74. These lectures were also reprinted in Nursing Notes. For examples, see: "Teacher's Instruction Course", NN, January 1921, 2-3; "Teacher's Instruction Course", NN, March 1923, 29; "Midwifery Work and Social Health", NN, April 1923, 43; "Teacher's Instruction Course, Principles of Teaching",

December 1924, 166; "Midwives' Institute Teacher's Instruction Course", NN, May 1926, 260-263.

75. Midwives' Institute, Council, minutes, Report of the Sub-Committee to Consider a Scheme for a Qualification for Teachers of Practical Midwifery, July 17, 1925, courtesy of RCM Archives.

76. Betty Cowell and David Wainwright, Behind the Blue Door (London; Balliere and Tindall, 1981) 51.

77. "Maternity and Child Welfare", NT, November 22, 1929, 1265.

78. "Maternity and Child Welfare", NT, November 22, 1929, 1265.

79. "Maternity and Child Welfare", NT, November 22, 1929, 1265.

80. "Theory and Practice", NN, July 1925, 98.

81. "Recommendations for the More Complete Co-Operation Between Practicing Midwives and Local Health Agencies", NN, March 1919, 22.

82. "Recommendations for the More Complete Co-Operation Between Practicing Midwives and Local Health Agencies", NN, March 1919, 22.

83. "Evidence Given Before the Departmental Committee", NN, September 1929, 142.

84. "Maternal Mortality", NN, January 1931, 4.

85. "Retrospect and Prospect", NN, January 1920, 1.

86. "The Problem of Undercutting", NN, April 1923, 39.

87. "The Problem of Undercutting", NN, April 1923, 39.

88. "Municipal Midwives", NN, June 1917, 95.

89. "Notes: A Guaranteed Minimum Fee", NN, May 1920, 50.

90. "The Position of the Midwife in 1924", NN, January 1924, 3.

91. "A Minimum Fee for Midwives", NN, April 1926, 244-245.

92. "The Difficulties of the Practicing Midwife", NN, February 1926, 215.

93. "A Minimum Fee for Midwives", NN, April 1926, 245.

94. "The Problem of Undercutting", NN, April 1923, 40.

95. "The Problem of Undercutting", NN, April 1923, 40.

96. "Summer Meeting of Representatives of Affiliated Associations, 'Undercutting by Municipal Midwives'", NN, August 1927, 110.

97. "Notes: A Guaranteed Minimum Fee", May 1920, 50.

98. "The Problem of Undercutting", NN, April 1923, 39. To arguments that a system of subsidies did not allow the local authority control, the Institute remarked, "a subsidy *does* give the local authority some control, Nursing Notes argued, "it is always open them to withhold it if they have reason to believe that any a midwife does not carry out her duties fully".

99. "The Problem of Undercutting", NN, April 1923, 39.

100. "Report of the Committee on Undercutting", NN, May 1927, 73; "A Minimum Fee for Midwives", NN, April 1926, 244.

101. "Report of the Committee on Undercutting", NN, May 1927, 73.

102. "Report of the Committee on Undercutting", NN, May 1927, 73.

103. "Summer Meeting of Representatives of Affiliated Associations", NN, August 1927, 109-110; For examples of midwives' local experiences with undercutting, see: Midwives' Institute, Representative Committee, E.C. B- to Miss Simpson, July 1, 1923; Simpson to "sir", rough draft, July 23,1923; A. F-- (?) to "Madame, York Midwives Association", March 10, 1926; H.G. W-- to Miss Pearson, March 11, 1926; H. G. K-- to Miss Simpson, March 11, 1926; Southampton and District Midwives Association, November 24, 1926; Nurse H-- to the Secretary, June 26, 1928; Midwives' Institute, Executive Club and Council, minutes, July 12, 1923; Midwives' Institute, Special Council minutes, May 31, 1927, "Pension Scheme for Midwives", courtesy of RCM Archives.

104. "Affiliated Associations Annual Meeting", NN, March 1929, 46.

105. Report of the Committee of Representatives, March 2, 1922, courtesy of RCM Archives.

106. "Annual Meeting of Representatives", NN, March 1925, 43.

107. "The Organization and Future of the Midwifery Profession", NN, January 1923, 3.

108. "The Organization and Future of the Midwifery Profession", NN, January 1923, 3.

109. "Local Representation", NN, April 1925, 58.

110. "Local Representation", NN, April 1925, 58.

111. Midwives' Institute, Committee of Representatives, E. Simpson to Mrs. K-, December 17, 1927, courtesy of RCM Archives.

112. "The Affiliated Associations: Their Present and Future Development", NN, May 1925, 68.

113. "Affiliated Associations Annual Meeting", NN, March 1929, 16; Midwives' Institute, Executive Club and Council, minutes, April 5, 1928, "Suggestions in Regard to the Formation of Branches of the Midwives' Institute".

114. "Summer Meeting of Representatives of Branches and Affiliated Associations", NN, June 1929, 89.

115. Midwives' Institute, Special Council, minutes, November 15, 1929, "Memorandum of the Council on the Report of the Departmental Committee on Training & Employment of Midwives", courtesy of RCM Archives.

116. "Annual Meeting of Representatives", NN, April 1931, 61.

117. "Affiliated Associations Annual Meeting", NN, March 1929, 16.

118. "Affiliated Associations Annual Meeting", NN, March 1929, 16.

119. "Affiliated Associations Annual Meeting", NN, March 1929, 16.

120. "Annual Meeting of Representatives of the Branches and Affiliated Associations", NN, April 1933, 51.

121. "Fifty-Fourth Annual General Meeting", NN, April 1935, 62; The continued existence of affiliates was, apparently, frowned on by that time. Miss Burnside, who presented the Annual report to the General Meeting that year, complained that "a fairly large proportion of those 5,626 people associated with the Institute were not full members and did not carry their weight."

Chapter 9

The Making of the Midwives Act, 1936

By the early 1930's, it had become clear that the Institute's attempt to resolve the crisis of the 1920's had failed. The private practice of midwifery was increasingly marginalized by subsidized maternity care. High maternal mortality rates continued as well, bringing increased pressure to integrate midwives in private practice within the public maternity services. For the Ministry of Health, the answer to the problem of maternal mortality lay in "an all-round tightening up as well as strengthening of each link in the chain of obstetric supervision . . . rather than in any single arresting or comprehensive remedy."[1] The central government now considered the midwife--independent or salaried--the crucial intermediary between the childbearing woman and the growing system of government sponsored maternity services. But in 1930, local authorities had no means of coordinating the work of private practitioners--the largest pool of practicing midwives--with those in public service. That is, the predominance of "independent" midwives reduced the government's management of public services as a solution to maternal mortality.

The Institute leadership and its supporters increasingly came to recognize that private practice would never be able to compete with the greater efficiency and lower fees of the subsidized providers. Gradually, they came to accept--and ultimately to lobby for-- a salaried service of domiciliary midwives subsidized by the government. The hoped for integration of midwifery practice into the government sponsored maternity services might achieve the financial stability and high professional status which had eluded the Institute in the 1920's.

The Institute and its supporters did not, however, propose that all practicing midwives would be included in this service. By the early 1930's, midwifery reformers began to argue that midwifery's problems stemmed from an oversupply of midwives and that the numbers should be reduced for the profession's own good. The Institute identified a type of midwife that bore significant responsibility for the low fees and case loads which characterized private practice. The Institute sought to eliminate those midwives they had

always considered undesirable in the drive for a significantly reduced midwifery workforce.

The proposal for a salaried service solved the problems which had plagued the Institute since its inception, and also fixed the Ministry's most pressing political problems. A salaried service, by integrating midwives more fully into the public maternity services, would strengthen what the Ministry regarded as the weak link in the chain of supervision over childbearing women. The Ministry, if it could strengthen its solution to maternal mortality, could then counter those who criticized the government's prior ineffectiveness. The Ministry and the Institute and its supporters joined together to pass the legislation which would end private practice and exclude thousands of women from the midwifery practice, the Midwives Act of 1936.

The Demise of Private Practice

The Institute leadership only gradually came to accept that private practice was no longer compatible with their goal to raise the social and educational level of the profession. Although they continued to defend private practice until 1934, evidence mounted that they were fighting a losing battle. The conditions of private practice continued to deteriorate, despite their efforts. Subsidies through the contributory insurance system became increasibly unlikely as the depression strained the already penurious relief system of National Insurance. Finally, a number of influential members of the Institute (salaried midwives themselves) began to endorse salaried practice. These factors combined to persuade the Institute leadership that they had to begin to entertain alternatives to private practice if midwifery was to attain the status they evisioned.

The Departmental Committee on the Training and Employment of Midwives--charged in 1928 to inquire into the state of midwifery and make recommendations for its improvement--confirmed the difficulties that midwifery reformers and midwives had detailed. The Committee's report, published in 1929, collected evidence from providers, local officials, professional associations and pressure groups which concerned themselves with the interests of midwives. What emerged from the evidence was the stark disparity between the life of the privately practicing midwife who "must

of necessity often find the utmost difficulty in eking out a somewhat precarious existence," and midwives employed in the public maternity services.[2] That is, the independent midwife contended with declining case loads, low fees, and a deteriorating standard of living. She had no extra funds to hire qualified assistants. She could not afford sickness insurance. She could not save for her retirement. In contrast, the Committee reported that midwives employed by voluntary agencies, health institutions and municipalities maintained a decent standard of living and enjoyed stable employment. For example, Nursing Association midwives and hospital midwives enjoyed medical insurance under the National Health Insurance and many were under some sort of retirement scheme.[3]

The Committee reported that the difficulties of private practice contributed to the unequal distribution of maternity services. Public or subsidized organizations could provide care in poor areas that could not afford services under a private system. Independent midwives often congregated in urban areas where the market was sufficient "to justify them in embarking upon the practice of their profession."[4] Consequently, nursing associations provided much of the midwifery care in rural areas although there were areas in which trained maternity attendance was unavailable. The Committee determined that, while urban midwives competed for fewer and fewer cases, 20% of the "rural population of England is unprovided with the services of trained midwives."[5] Clearly, the country lacked a system of maternity services that could make efficient use of available personnel.

With the exception of "a Bill hastily introduced and as hastily withdrawn," there were few material results from the Committee's report.[6] The Committee recommended creating a pool of independent midwives who would be reimbursed by a system of expanded payments from national insurance. This scheme supported midwifery reformers' and government officials' goal of preserving private practice, and left responsibility for health and welfare with the individual. The report's greatest significance lay in the way in which it recast independent midwifery's problems. Contrary to what the Institute had maintained, the Committee's evidence established that independent midwifery could not rely solely upon the patient's ability to pay. As such, the Committee maintained that some alternative source of payment had to be forthcoming if independent midwives were to survive within the profession.

The Institute understood that while the Committee had endorsed private practice, the facts they had collected could also lead to the conclusion that a salaried service would serve the country just as well. The Institute attempted to counter any movement in this direction. In her 1931 speech to the Annual General Meeting, Institute President Edith Pye reaffirmed the Institute's commitment to private practice. Midwives might envy the salaried worker's "freedom from responsibility, regular hours, definite salary and favored position. . . . But we have to remember that independence is a privilege in itself. . . . "[7] In the government's own words, she criticized the assumption of social responsibility for individual problems. "Individual and corporate responsibility, individual initiative, exertion and diligence, and above all, personal discipline--these are more valuable to the nation, more constructive and permanent than a too rapid or superficial provision of external facilities for securing social well-being."[8] The Institute joined the call to use National Insurance to reimburse midwives; such funding would prolong the survival of independent midwifery.

In 1932, the Institute published its own "Suggestions for Inclusion in a National Maternity Scheme"; endorsing midwives' reimbursement from a system of expanded National Insurance payments.[9] By the time the Institute made its proposal, though, even this door appeared to be closing. Because it only provided for those who were actually insured, the National Insurance solution had always been limited. By the early 1930's, the National Insurance system was straining under the pressures of mass unemployment. In a letter to Nursing Notes, "an old friend of the Midwives Institute," Henry Lesser, pointed out that National Insurance was incapable of providing the funds needed to cover the cost of maternity care, even to the insured. Many of the Approved Societies making insurance payments were insolvent, and the Government had begun to reduce benefits dispensed to women who were sick or disabled. Lesser echoed what many were beginning to believe: "If there is to be a comprehensive scheme for the whole country," he suggested, "then it should be dealt with on the lines of a public social service quite outside National Insurance altogether, both financially and administratively."[10]

The Institute leadership, faced with the clear evidence that the private practitioner "must starve or get someone else to keep her," gradually conceded that alternatives to private practice (even private practice funded by

National Insurance) were necessary. The leadership had traditionally identified the private delivery of services with professional control and status. In their eyes, freedom to make contracts, set fees, and to conduct the case as the midwife saw fit within her designated authority comprised the essential professional elements in midwifery. In return for the privileges of this control, midwifery pledged itself to altruism and service. When the foundation of private practice crumbled, the Institute had to reconstruct professional control on the basis of a new set of economic relationships--relationships which had formerly been associated with subservience, inferior work and avarice. Nothing less than a new understanding of professionalism was required.

One of the more prestigious members of the Institute, K.V. Coni, the Matron of Hull Maternity Hospital , was instrumental in convincing others in the Institute that municipal employment would strengthen rather than reduce the professional status of midwifery. Coni argued that the midwife's status would result from her integration into an organized system, from her stable employment, and from her release from sweated labor--not from whatever personal freedoms she was able to exercise (increasingly limited the poorer she became as a private practitioner). The municipal midwife, working within an organization based on a clearly administered division of labor, did not need to worry about competition. "She can at once co-operate with her fellow workers," Coni told her audience at the 1928 Midwifery Conference. "There should be little room for professional jealousy when all are members of the same organization, following their specialized jobs."[11] Security of tenure and sustained levels of remuneration would elevate the midwife from "being Cinderella" to a self-supporting colleague in the maternity service. For midwives with appropriate credentials, the public maternity system also offered "plenty of opportunity for advancement."[12] Because the employed midwife would be eligible for National Insurance and for any municipal retirement fund, she no longer needed to scrimp and save to protect herself. Coni did not deny that the midwife surrendered "a certain amount of personal liberty," but in return "she will gain security both professional and financial."[13]

Increasingly, the Institute leadership conceded that salaried employment could not longer be ignored. Indeed, "It is inevitable," remarked Nursing Notes of the trend, "and there is no use in fighting the principle."[14]

The journal tentatively explored the possibility that midwifery could retain its vocational and altruistic quality in which "real disregard of self and willingness to give up some of the things that make life attractive" still informed midwives' motivations for practice.[15] Without improvements midwifery would soon disappear, so standing firm on an outmoded service ethic seemed ultimately counterproductive. "Health, decency, and reasonable freedom from anxiety," Nursing Notes remarked, "are basic necessities without which our work and service can never even approximate to any ideal we may have in mind."[16] Within the context of increased support for some subsidized system for midwives, Nursing Notes tentatively entertained the possibility that midwives would have "perhaps to give up some degree of independence and individuality in order to improve the conditions of our profession as a whole.[17]

A Salaried Service of Midwives

Campbell's reports and those of the Departmental Committees had placed the question of a national maternity service on the Ministry's agenda. It gradually became clear, however, that the government would not consent to a full-scale reorganization of public maternity services because of the cost. As a result, attention focused on piecemeal legislative changes which were expected to integrate independent midwifery into existing government maternity--not out of a desire to improve the condition of private practice, but to strengthen the public services. The concept of a salaried service of midwives established on a fee-for-service basis and subsidized by the government, no longer resisted by the Midwives Institute, moved to center stage.

The Institute and its various allies moved quickly to establish the grounds for debate. The Joint Council of Midwifery (JCM) was formed to give voice to their combined interests. Although Joint Council literature gives January 1934 as the Council's formation date and the National Birthday Trust Fund as the group's sponsor, in her 1930 speech before the Annual General Meeting Edith Pye implied that the JCM was conceived much earlier and was much more a brainchild of the Institute than was later publicized. Immediately after the publication of the 1929 report on the Training and

Employment of Midwives, the Institute called together "those organizations especially interested in midwives and their work to form a joint committee" to consult about matters of common concern. The committee, Pye told her audience, "at once gave its strong support to the midwives' point of view."[18] It is likely that this earlier group which the Institute called together, and "appears . . . would be welcomed in many quarters as a permanent independent body to which questions affecting maternity service can be referred from time to time," constituted either in part or entirety the later group known as the Joint Council of Midwifery. The JCM was to function as a pressure group for the Institute and others with an interest in seeing the midwife question resolved. The JCM included some of the most prestigious names in medical, midwifery and government circles. All of the committee members were known allies of the Institute and all were vocal advocates of the preventive, domiciliary based maternity service which Campbell had outlined in her reports. Of the twenty members of the Midwifery Services Committee (a smaller group charged to propose specific solutions to economic problems) seven were Institute Council members, two were representatives on the Central Midwives Board (CMB), four were medical professionals, and two were Members of Parliament.[19] This group formulated the proposal which would become the blueprint for the Midwives Act of 1936.

The JCM framed its proposals within the politically-charged milieu of criticism of the government over the rising maternal mortality rate on the one hand and the increased number of hospitalized births on the other. For the JCM, as with most of the proponents of the maternity services solution, the failure to reduce (or even arrest) maternal mortality resulted from failure to extend the services far enough, rather than inherent flaws in the service concept itself. The greatest weakness in the system was the failure to integrate practicing midwives with other health services. As the attendant for the majority of births the midwife was the crucial link between the services as they existed and the thousands of women who gave birth every year. As such, she was in a position to influence the women she attended "to take advantage of the all the agencies designed for [their] benefit," in a way that no other representative of the maternity services could.[20] "A well-trained, well-informed and intelligent service of midwives working in cooperation with the medical profession, the Joint Council concluded, "is

therefore of premier importance in any scheme for the reduction of maternal mortality and morbidity."[21]

The JCM echoed past commentators' conclusion that private payment of midwifery services alone was insufficient to maintain the independent midwife in practice. The spread of mass unemployment had stretched the relief apparatus beyond its already penurious limits. Even in less depressed areas, the independent midwife still had to contend with competition by subsidized services charging lower fees. Given the "small fees paid by persons of the insured class and poorer persons, the remuneration is entirely inadequate."[22] Independent midwives suffered, the quality of midwifery care declined.

> There is evidence that the low standard of comfort and cleanliness obtaining in the houses or lodgings occupied by midwives in certain areas today militates against the maintenance of a high standard of professional work, particularly where ante-natal examinations have to be undertaken in unsuitable rooms normally utilized for other purposes, or where sanitary arrangements are inadequate for the midwives' requirements.[23]

The JCM argued that continuing the private payment system of midwifery care would jeopardize the few gains which the midwives had made.

The JCM was equally concerned about the effects of reduced private practice on the desirable provision of domiciliary maternity care. Independents only attended home confinements. Unless something was done to bolster domiciliary attendance, many midwifery reformers feared that the independents' demise would spell the end of home confinement and the concept of normal birth. Many obstetricians--smarting under their failure to reduce the maternal mortality rate--began talking about the "failure of ante-natal care" and the need to place increased pressure on the government to shift the emphasis of the maternity service toward institutional care.[24] The Departmental Committee on Maternal Mortality and Morbidity had deliberated in this climate of increased criticism of the apparent failure of the maternity services to stem the rising tide of maternal death. Most of the members were consultants and one, F.J. Browne, began to publicly question the efficacy of ante-natal care.[25] The Committee concluded that ante-natal care

had its place, but urged increasing institutional facilities and services, and expanding the type of cases requiring hospitalization. The Committee argued that women with ante-natal diseases (like pregnancy-related toxemias or general illnesses like tuberculosis and heart disease), where previously under the care of a general practitioner at home, must be sent to the hospital. Any cases "in which labour is likely to be unduly prolonged or difficult" needed to be admitted to the hospital. In cases diagnosed as resulting from abortion, institutional care was required. These conditions were largely defined as cases of disease, or widely recognized as complications. However, the Committee also proposed that a woman who lived in unsuitable housing arrangements, such as an overcrowded house or flat, or who lived with her parents, should be institutionalized during labor even if her pregnancy was normal and no complications were expected. The Committee also recommended that primigravida should be routinely institutionalized "as a precautionary measure" whether difficulties were expected or not. Having expanded the number of situations requiring institutionalization, the Committee urged that facilities for institutional accommodation and their staff be increased, that obstetric work be concentrated in the larger hospitals and that clear lines of authority be delineated within hospitals. The combination of an increased number of institutionalized cases, an increased organization of institutional care, and an increased authority for obstetricians threatened to supercede the influence of the home based maternity service staffed (both privately and salaried) by general practitioners and midwives.

The JCM acknowledged the need to increase the number of maternity beds for ante-natal complications and abnormal labors, but rejected the notion that "a reduction in maternal mortality will . . . be secured merely by increasing the hospital provision for normal cases."[26] The JCM believed that the government should invest its resources in extending the domiciliary-based, salaried midwifery service throughout the country, rather than fund an increase in maternity beds. The JCM's most powerful argument was the dramatically lower mortality statistics of midwives' practice as compared to hospital statistics and the national rate. Significantly, the statistics which they quoted were those collected from salaried domiciliary services operated either through voluntary hospitals or country nursing associations rather than the overall rates for independent midwives. This was partially due to the fact that these organizations were able to collect statistics on a more consistent basis

than local authorities could. Yet, these statistics also provided powerful evidence of what could be accomplished through a domiciliary based service staffed by salaried midwives and operated along the correct lines. The JCM argued that these examples proved that the proposal could work and in fact that "better results can be achieved than under those which appertain to midwives practicing independently."[27] In light of these successes, the JCM concluded that "it is not necessary greatly to increase hospital accommodation for *normal* cases in order to deal with the problem of maternal mortality."[28]

The JCM recommended that local authorities be required to provide adequate domiciliary midwifery services, and that midwives be employed to staff that service, or that local authorities further subsidize voluntary associations which already provided domiciliary care. Under the JCM proposal, the local authority would administer municipal services and, in conjunction with providers in the area, set the appropriate fees. If a woman could not pay the established fee, the authority would investigate her circumstances, and determine how much she would be required to pay. The difference would represent the added "cost to the public of putting the Midwives' Service upon a proper basis. It will not represent the provision of any service at a cheaper rate to the patient than at present," the report assured its readers, "but merely the cost of providing a better service at the present rate. "[29]

The JCM was careful to highlight the advantages of its proposals to the government. The midwifery profession would be assured a steady and adequate living, albeit partially at public expense; the people would receive a more efficient maternity service. If midwives were made employees, the local authorities could improve coordination of existing services. "The patient would be continuously in the care of the same service", the JCM pointed out, "with no risk of the lapses which now occur owing to the detachment of the independent midwife from the official members of the Health Service."[30] One more step would be taken toward securing a "comprehensive scheme coordinating all the agencies, professional and lay, concerned in rendering motherhood safer," thereby strengthening public maternity services and (hopefully) reducing maternal mortality.[31]

A salaried service was expected to improve the quality of midwifery care throughout the country. "One of the principal objects of the proposed scheme" the JCM commented, "is to attract a better type of candidate to the

profession, and eventually ensure a higher degree of proficiency."[32] The security provided by steady and adequate remuneration, set hours of duty, a limited caseload, new opportunities for advancement, health insurance and provision for retirement would attract well-educated women. If such women became the norm among midwifery recruits, it would be possible to raise the training requirements to match this educational preparation. With the incentives of better pay and professional advancement it would be realistic to require women to undergo the extended training period of three years which the JCM recommended.[33] Since the service offered direct subsidies to maternity care providers rather than to the patient, the principle of the individual's responsibility for her own welfare was preserved.

Despite the relatively limited nature of the JCM's proposals, such a salaried service still required increased government expenditure. In order to determine the potential costs of such scheme, the JCM attempted to estimate the number of midwives required for the service. Since the figures were based largely on speculation, they must be regarded with some suspicion. The JCM arrived at their figures with virtually no reference to statistical data on the distribution of midwifery practice and with no method, other than JCM members' impressions, with which they could determine either the immediate or the long range needs of the midwifery service. The only reliable figures which the JCM utilized were the number of midwives who had notified their intention to practice to the Central Midwives Board. Since these figures did not indicate whether a midwife practiced independently, or was salaried through a local authority, hospital or nursing association, the JCM had to estimate how many midwives practiced within each of these categories. Furthermore, since the JCM's calculations were based on the improbable assumption that only independent midwives would be considered for the service (as opposed to hospital midwives for example) it is likely that their final figures seriously underestimated the number of independent midwives who would be displaced by the new scheme.

The JCM estimated that 6, 255 midwives were in salaried practice.[34] Since "separate returns were not available to show what is the proportion employed in hospitals and in domiciliary work, the number of midwives who worked in hospitals was "estimated at 900," with the remainder (5,355) working in district practice. The JCM obtained the 6,255 figure by adding the number of Queen's Nurses (who practiced as midwives) who had notified

(4, 000), the number of those district nurses not affiliated to the Queen's Institute (802) and those who worked in conjunction with independent voluntary associations (400). The JCM then subtracted the estimate of salaried midwives from the total number of midwives who had notified their intention to practice in 1934 (15, 442), yielding another estimate, of 9, 200 independent midwives. To determine how many additional midwives would be needed for a salaried service, the JCM subtracted the number of births attended by the estimated number of existing salaried midwives (267, 699) from the total number of births (583, 812). From the difference (316, 113), the JCM subtracted the estimated 25, 000 births which they believed would be attended by the estimated 750 midwives who would remain in independent practice, leaving 291,113 additional births to be attended by the maternity service. Based on an average of 80 cases per midwife, the JCM calculated that the maternity service would need to absorb an additional 3, 639 midwives. The JCM added 500 more midwives who were "thought . . . to be required to cover holidays, sickness etc." and 200 "additional midwives" who the Queen's Institute "considers . . . required to complete the service in rural areas . . ." and since "it is probable that the Local Authorities will find it necessary to increase their number of midwives in receipt of subsidy in semi-rural districts from the present figure of 168 (also estimated) to, say 300."[35] On the basis of these figures, the JCM estimated that "the number of independent midwives likely to be absorbed by the salaried service is therefore estimated at 4, 500."[36] Assuming that an estimated 750 midwives would stay outside the service and that 616 would drop out due to "normal wastage", (both figures for which the JCM offered no data to support their calculations), the JCM calculated that 3, 321 midwives would find no place in the service. To soften the blow of forced elimination, the JCM suggested a formula for limited compensation. The JCM recommended these women be compensated for a "net value of their practice calculated over a period of five years."[37] The JCM recommended that the older midwives be given no choice and be required to retire.[38]

The JCM's analysis of midwives' problems and their proposed solutions proceeded from the Institute's and the governments's understanding of the needs of the midwifery profession. Throughout the 1920's, the leadership had placed the blame for economic marginalization of independent midwifery at the feet of a publicly subsidized system of services

which offered midwifery attendance at a lower cost to the patient than independents could afford to charge. By the early 1930's, midwifery reformers' had shifted the blame away from the reorganization of the maternity service to an "oversupply" of midwives. From the JCM's perspective, low educational standards and the short duration of training had encouraged an influx of poorly educated women into midwifery without consideration of the availability of work.[39] Within this general glut of midwifery practitioners, the JCM charged, there were midwives, usually married, who, carelessly and with no regard for the profession or the women they attended, drove down the standard of the entire profession. The 1929 Departmental Committee had identified such women as "not solely dependent upon midwifery work for their livelihood . . ." and who chose to work only part-time when the need for extra income arose.[40] The JCM echoed the charge. These midwives engaged in "some other occupation, or [were] . . . mothers of families [who] take cases occasionally to supplement the family income. Such midwives," the JCM asserted, "tend to cut fees below the average for the neighborhood in which they live, and have only a secondary interest in their work."[41] Miss Carter, an Inspector of Midwives for Manchester and an Institute member, warned her audience at the 1932 Annual Nursing Conference sponsored by the Institute, of the "growth of a pin money class of midwife whose existence is a menace to midwifery considered as a profession.[42] Because of these "pin money" midwives, midwives who supported themselves solely from their midwifery work either could not get work, were forced to work part-time, or had to take more cases at a lower fee. These midwives were depicted as hard-working, long-suffering and wholly dedicated to their work, in contrast to Carter's "pin money" midwives who did not care about their work. Dr. Watts Eden, a well-known obstetrician and a JCM member, juxtaposed the two in his speech before the Midwifery Conference.

> Of these private midwives there are two classes; some use midwifery as a sort of side show, they are married women with families and have little time to spare, all in all they average less than 15 cases in a year. There remain about 60% of the 9,000 independent practicing midwives to whom midwifery is the work of their lives and who devote heart and soul to doing their best for the mothers day and night. Their lot is a hard one, they

> work among the industrial classes and those below any industrial scheme, and we believe that their already scanty earnings have been considerable reduced in recent years. . . .[43]

Ideally, a salaried service would incorporate those women who wanted a full-time career in midwifery and eliminate those who chose to work part-time and were not serious about midwifery as a career. "We say that the time has come when the public must step in and place the practice of midwifery by midwives on a secure basis," Eden told his audience, "and give the comfort of security of living to those who practice it."[44]

The JCM's proposals were formulated with the intention of excluding the "pin money class" from practice and to prevent women like them from entering midwifery. In an article for Nursing Notes, JCM secretary Juliet Williams recalled that the members of the committee were by no means in agreement that a salaried service was the best solution to the oversupply of midwives.[45] However, they concluded that potential alternatives were unworkable. They dismissed entrance restrictions to teaching programs (which would reduce the number of midwives allowed to practice) because this solution did not address the problem of the midwife's fee and therefore would not serve "to induce candidates to submit to a lengthened training, and will not attract a higher type to the profession."[46] The committee also rejected a system of higher fees paid either through an expanded maternity benefit program or through subsidies to the local authorities because it would only encourage the "pin money" women and "perpetuate the present system by which the practice of midwifery is carried on largely by women who consider it as an adjunct to family resources rather than a whole-time profession."[47] A salaried service, organized through the local authorities and operated with strict requirements as to credentials, character and expertise of the midwife would allow closer control over the type of woman who practice as a midwife.

The JCM proposals represented the intersection of the interests of the government and the Institute leadership and their supporters. The government would acquire a more efficient and more closely coordinated maternity service and a strengthened provision for domiciliary confinement. The Institute and its supporters were assured a means by which midwifery

could be economically stabilized and, as a result, made more attractive to middle class, educated women. As importantly, the JCM proposals offered the means by which to purge the profession of its more undesirable elements, that is, those midwives who did not fit the Institute's ideal. Since these women were also largely responsible for the profession's poor circumstances, according to the JCM, once they were excluded midwifery would finally achieve the social and professional status of which it had been deprived for so long.

The Debate Within Midwifery

The JCM's proposals set off a debate within the nursing and midwifery journals. Despite the fact that the Institute representatives had joined with their colleagues and voted unanimously for the proposals, the Institute gave its members the impression that the discussion was still open and that members had some influence over the outcome. However, internal Institute documents indicate that while there was some discussion at headquarters, the outcome was determined quite soon after the JCM issued its report. Despite the weakness of aspects of the JCM's argument and the serious reservations on the part of some midwives, the Institute endorsed the JCM's plan in June of 1935, four months after it was first published.

Letters to Nursing Notes reflected a broad spectrum of concerns some of which appeared to be influenced by recent findings and some of which appeared to be a result of midwives' own experience. These concerns touched upon the professional values the Institute had promulgated for the past fifty years, the mother's right to freedom of choice, the midwife's right to freedom from interference, and the alleged superiority of voluntary service over government responsibility for social problems. No correspondent considered midwifery free of problems, but some questioned that salaried employment was the only solution. Most correspondents feared the potential for the local authority meddling in the midwife's work, which the salaried service would entail. "To give of her best", one wrote, "a midwife must be unhampered with petty rules and conditions. . . ."[48] Some midwives believed that salaried employment, because it was based on a cash relationship and not on moral duty, would take the heart out of midwifery. A midwife would become a cog

in an impersonal bureaucratic machine. "The state is too cold and too cumbersome. . . ." one midwife wrote. "Human feelings are negligible to the State, but vital to midwifery."[49] These correspondents also recognized that if the principle of freedom of choice could not be sustained, private practitioners would have the choice of either entering into the salaried service or losing their livelihood. "However popular she may be", wrote "Fair Play", "the independent midwife will be forced to accept State service or retire altogether, for the mother many not be able to afford the midwife of her choice, if she can obtain municipal services for less money."[50] Opponents of the JCM proposal wanted instead to strengthen the financial and professional value of private practice.[51]

Correspondents considered the criteria for acceptance into the service of utmost importance. Some expressed concern over the future of married midwives. "Are they going to be accommodated", one correspondent wrote, " or are married women going to be barred from a service which is essentially a mother's service?"[52] The same correspondent questioned whether the nurse-midwife would be considered over the midwife with midwifery training only. "Midwifery is not sick nursing", she wrote. "This popular idea will have to be exploded and a State-registered general trained nurse should not be considered a superior midwife to her friend who is not general trained."[53] Correspondents were equally alarmed at the JCM's proposal to eliminate thousands of women from practice, particularly without prior government assurances of compensation and when local authorities such as the London County Council were beginning to balk at footing the bill.[54] "What is to become of those not chosen to fill the salaried posts?" Margaret Burnside asked in a July letter to the Daily Telegraph.[55] Burnside's question was echoed by other suspicious members. "It appears", E.A. Weale, a branch member of the Midwives Institute wrote, "that the LCC would sweep the best trained midwives out without compensation or pensions if owing to age or for other reasons, they were not wanted in a Salaried Midwifery Service."[56]

Letters evoked a sense of profound injustice at the prospect of mass exclusion. Were independent midwives to be punished for the mistakes of others? "Two wrongs do not make a right", Miss Regan, the President of the Institute's Liverpool Midwives Association told her audience at the Nursing Conference session debating a salaried service. Midwives had been "trained without limit, [but] to replace them irrespective of their competence is not

British justice. . . ."[57] Even if midwives were compensated for their loss of practice, "F.S.S." doubted that settlements would equal what they would be forced to relinquish. A midwife who had trained "at great personal sacrifice of time, energy and expense" and who had expected to have decades of "lucrative practice before her and may need it desperately" would be "most inadequately compensated by the value of three years' practice."[58] The Branch member from Wales agreed. "Midwives are not likely to forget that they are voters", she warned, "and might take unpleasant reprisals if justice is not done to them and their patients."[59]

The correspondence reflected a depth of feeling which the Institute could not ignore. The letters had raised issues which were central to the Institute's professional ideology, and consequently had to be resolved. Most prominent of these issues were the questions of midwifery's professional independence and the mother's freedom of choice. An internal Institute document acknowledged that a midwife in salaried employment would experience a "lessening of general independence, there might be definite restraint either in the mode of her own life, e.g., if she were required to live in a hostel; or through regulations concerning, for example, the ante-natal care of her patient."[60] The internal document argued, however, that the problems that might occur in the course implementing the JCM proposals would be offset by the considerable advantages of the scheme: an adequate income, an established place in the health service, a pension, off-duty time, refresher courses, and "the certainty of a holiday with pay."[61] The document acknowledged that the mother's freedom of choice would have to be sacrificed in a salaried midwifery service. "It is not possible to give midwives many of the advantages made possible under this scheme," the document explained, "leisure, fixed periods of rest, opportunities of education--and at the same time retain the patient's freedom of choice. One or the other must go."[62] To the extent that the Institute had wanted to help protect the woman's privacy, this was a matter of regret to the leadership. Yet, under a salaried service the principle of freedom of choice was no longer necessary. Where midwives no longer competed for cases, they no longer needed the safeguards to protect their equal access to the patient pool. "I think it is more honest to accept it as inevitable," wrote the author of the internal document, "and as a disadvantage which must be set against the gains of the scheme."[63]

While a salaried service would reward those who were accepted into the scheme with better pay, regular hours, holidays, time off and pensions, the Institute was faced with the reality that thousands of midwives would be forced to give up their livelihood in the midst of a crushing economic depression. The internal document pointed out that the older women, who might have remained in practice because they had no other means of supporting themselves would, with compensation, be able to afford to retire. The others would not be as fortunate. The "able-bodied" who applied but were not accepted would "lose their life work; the compensation given, if adequate, mitigates, but can not wholly do away with the hardship involved."[64] Those who attempted to practice outside the service "may find their practice diminishing and finally vanishing (the association of the municipal midwives with the Centre will tend to draw patients away from those in independent practice)" and if they waited too long, "and may then find no place in the scheme", i.e., receive no compensation.[65] While these hardships were regrettable, the Institute argued, the purge would rid midwifery of its undesirable elements and leave the profession free to rise to the respected and privileged position which it had always been denied. "If [the service] does not succeed in eliminating the least fit," the author of the document warned, "and giving the full-time work for the more-fit, the money [for the service] will have been spent without gain."[66]

The ideas outlined in the Institute internal document appeared in advocates' letters to Nursing Notes, in lectures and speeches at professional conferences and in Nursing Notes editorials and articles. Where critics of the proposals had pointed to the mothers' lack of choice and the midwife's lack of freedom, advocates of the proposals emphasized the gains which midwifery would make as a profession. JCM member and respected midwifery teacher Elsie Hall wrote to Nursing Notes that greater status would be derived "at once if an adequate salary, superannuation or pension were assured . . ." and the best women no longer prevented from entering midwifery.[67] A Nursing Notes editorial agreed. Midwives would no longer be regarded as "poor and perhaps ill-behaved relations [and] when they became servants of the local supervisory authority they would enjoy its fatherly protection."[68] Proponents of a salaried scheme conceded that the mother's freedom of choice would be curtailed and the midwife would give up some of her independence, but this had to be weighed against the greater "security both professional and

financial" that the midwife would gain. Katherine Coni reminded her audience at the April 1935 Nursing and Midwifery Conference that while the salaried service did represent an extension of government responsibility for the individual, the service was not to be given as a right. A midwife taken into the service would have the "satisfaction of knowing that people who can pay will be made to pay, while those who cannot are not deprived of skilled care."[69] Nursing Notes expressed reservations over the potential for interference from local authorities, but argued that as long as any restrictions on personal freedoms and initiative did not "impair the personal trust in the individual midwife that has helped mothers in the past, we must be ready to accept the position."[70] A letter in the same issue from JCM and Institute member, G. B. Carter, sought to discredit the notion that manner of payment had any bearing on the quality of work. "Nothing will ever convince me", she wrote, "that because I happen to get my money paid to me by the Local Authority instead of by the patient, I shall serve her less."[71]

It was more difficult to minimize the outcome of the JCM proposals for those who would not be included in the scheme. Few correspondents attempted to defend this tactic of exclusion, but the Institute could not shrink from its logical conclusion. In keeping with the tone of the internal document, the Institute approached the elimination of so many midwives from the ranks of midwifery as an unfortunate, but unavoidable, outcome of forces over which the leadership had no control. "We know, of course, that some people will, and must, suffer in any large re-organisation . . ." Nursing Notes told its readers. "But our aim should be to secure that as few as possible suffer and in the slightest degree possible. . . ."[72] The leadership sought to minimize the number of midwives who would lose their practice. "A great many of those in practice are of the right type", Nursing Notes speculated, "and many of them would probably be quite ready to come under the scheme."[73] All that the Institute could do for the rest was to defend their right to fair compensation.

> Some midwives, who under present conditions have barely existed, might be grateful for a mere pittance in the way of pension, but those who have managed with hard work and much anxiety to keep a decent home and their independence cannot be expected to accept gratefully proposals for early

> retirement in return for an allowance or a sum of money that represents semi-poverty.[74]

Since little reliable data then existed on the age, marital status and practice size of independent midwives, the Institute undertook a massive sampling of over 7, 000 independent midwives to develop "an estimate of the cost of fair compensation and pension rates. . . ."[75] By fighting for "fair" compensation, the leadership cast itself in the role of the independents' defender while at the same time its own policies and aspirations played a pivotal role in their demise.

Strengthening the Case for Exclusion

At the same time that the Institute officially endorsed the JCM's proposals, the leadership asked the physician and Institute member Lady Forber (the former Janet Lane-Claypon) to determine how many independent midwives might need to be compensated. Forber obtained lists from local authorities of midwives who had notified their intention to practice. Although local authorities "do not as a rule distinguish between salaried and independent midwives", Forber and her assistants were able to glean a cumulative list of 7,565 names of independent midwives from lists which did make the distinction. Because Forber did not include the questionnaire she sent to these women in any of her reports, we have no record of precisely what questions they were asked. However, in her Fynes Clinton Memorial lecture in November 1935, she indicated that the Institute was primarily interested in obtaining information on the number of cases midwives attended, the fees they made from those cases and changes in their financial condition.[76] Independents on her list were also asked to offer their opinions of the current climate for private midwives. Forber's mailing yielded her an impressive return of 3, 447 questionnaires (45% return rate) from independent midwives. Where the JCM's "estimates" were impressionistic, Forber's study, based as it was on such a large sample of statistical data, appeared to offer a more reliable profile upon which to analyze midwives' predicament as well as to make recommendations for compensation. Forber published the results of her study in two stages. In November 1935, she

summarized her preliminary findings in her address for the Insitute's annual Fynes-Clinton Memorial Lecture. The following January, she issued her final report, The Midwife in Independent Practice Today under the auspices of the Midwives Institute.[77]

Forber endorsed the view that an oversupply of midwives lay at the root of the profession's problems, but she placed greater emphasis than the JCM on the role that government's role in creating that oversupply. Government subsidies to hospitals had increased the number of maternity beds and had in turn increased the number of normal births admitted into the hospitals. The absorption of these cases by institutions reduced the number of cases available to the independent midwife. The increase in hospitalization of maternity cases had also contributed to an absolute increase in the number of midwives in practice. As more women were institutionalized, training schools admitted more pupils to midwifery training programs in order to supplement their hospitals staffs while they learned their future profession. Government grants facilitated this process. A proportion of pupils were offered their training free while the hospital was able to use "the pupil-midwives to do the greater part of the maternity nursing of the mothers and employs only a small staff of nurses to train them."[78] By way of illustration, Forber cited the returns she received from Yorkshire, Durham County and Hampshire. In each area, the number of independents had increased between 1929 and 1934. Some increases were dramatic. In the North Riding of Yorkshire, the number increased by 48%; the East Riding, by 44%; in Durham, by 33%. Other areas in her sample, such as the West Riding of Yorkshire, were less dramatic at 14%, but still represented significant growth for a five year period.[79] In all areas, the number of cases per midwife dropped, in one area by 25%. The need for "teaching material" increased as the numbers of midwives in training increased. Hospitals would lower their fees to attract patients, thereby further decreasing the number of cases available to the midwife in private practice. While teaching institutions and maternity homes absorbed some of the graduates, the steady supply of free midwife-pupil labor forced significant numbers of graduates into private practice in a market increasingly monopolized by subsidized providers.

With an increasing number of independent midwives competing for a smaller number of cases, the outcome could be nothing less than catastrophic.

Of Forber's total sample, "scarcely more than 2 midwives out of 5 at all ages under 60, attended as many as 50 cases in 1934."[80] Their fees were necessarily low. At a time when the Institute had estimated £3 3s per case as a reasonable fee for midwifery attendance, most midwives were able to get no more than £2 2s maximum for a primipara and £1 10s maximum for a multipara. Based on the figures from Yorkshire, Durham and Hampshire Forber estimated that, given the low fees and the difficulty in securing cases, 33% of her sample made less than £50 a year and 27% made less than £100 a year. Only one in seven were earning more than £200 a year.[81] Because fees were so low, even these seemingly luckier midwives "in order to earn a livelihood . . . [were] working more than whole-time."[82]

Forber also shared the JCM's concern that steady encroachment by the hospital sector into the former home confinement clientele threatened midwifery. Midwifery's authority extended only to attendance on normal cases. As long as childbearing was considered a physiological process midwives were allowed ample scope for their authority. Home confinement at once represented the belief in the normality of childbearing and allowed a midwife to carry out her work unimpeded by interference from the physician. The demands by some obstetricians to increase the types of cases considered "abnormal" and therefore more appropriately managed in the hospital, threatened home confinement and the philosophical concept upon which it was based. Exhortations to the public that childbearing was dangerous had only created "fear in the mothers of to-day . . . and this is detrimental to their well-being."[83] Most damaging to hospital proponents' case was the fact that, despite a steady increase in subsidies from "the charitable public or by public money in the form of rates and taxes", more maternity beds had failed to reduce maternal mortality. As the actual cost of each patient to the hospital was much higher than it would be for a domiciliary delivery with a midwife in attendance, Forber argued that a system of domiciliary midwives salaried to attend to normal childbearing would offer a far cheaper service and, since midwives consistently had fewer deaths in their practices, much improved maternal mortality statistics.[84]

While the defense of home confinement and normal childbearing strengthened the case for a domiciliary based service, a salaried service would not on its own solve the problem of the oversupply. Some means had to be found which would allow the profession to adjust the "supply" to the

"demand" in ways that maximized professional advantages. Forber argued that the "portal of entrance" had to be defined in such a way as to restrict the numbers of trained midwives. Longer training and a higher standard of preliminary requirements would help to weed out the less educated and less refined, while the exclusion of all but those pupils who sought a career in midwifery would guarantee that training cases would be available where they would do the most good. Forber acknowledged that other health professionals needed "some acquaintance with the general phenomenon of pregnancy and parturition", but disagreed that they needed the full midwifery training that was "necessary for a woman who proposes to devote her life to the work."[85] By keeping expertise scarce the profession would be able to raise its value in the market place for services. "So long as there is an unrestricted influx of certified midwives", Forber told her audience in her Fynes-Clinton Memorial Lecture, "there is no reasonable hope of sufficient improvement in conditions for those midwives who want to make it a whole-time livelihood."[86]

Although the Institute's alternative scale of compensation was no more based on a realistic or even charitable assessment of midwives' needs than either the JCM's or the Ministry's had been, it was, compared to theirs, more "generous". Compensation was not only the means by which the Institute could emerge from the process unscathed, it was crucial to the success of the scheme itself. As the Institute continually pointed out, midwives were licensed by the state to practice midwifery and there appeared to be no legal means to prevent them from doing so. Without some means of encouraging them to relinquish their practices these midwives would continue to work "even if now superfluous. . . ." and the problem of oversupply among the existing rank and file of midwifery would continue.[87] Therefore, when the Ministry issued in December 1935 what the Institute considered inadequate proposals for compensation, the Institute was swift to respond. The Ministry recommended that upon surrender of their certificates, the local authority would pay midwives the "average net annual value" of their practice over the previous three years, "or during the period she has practiced in that area, whichever is less."[88] The JCM had recommended five years. If a midwife had practiced in more than one area her compensation would be based on how much she had earned in each area. The Institute, however, doubted that midwives would consider that the Ministry's plan

would adequately compensate them for their work. "The Midwives Institute notes with utmost concern the recommendations made in the Minister's memorandum", the Institute's official response admonished. "generous and just compensation is an indispensable condition of the success of any scheme."[89] Otherwise, midwives would not find giving up their practices in their interest. "It will not be in the interests of anybody", the Institute's official memorandum on the salaried service pointed out, "to see midwives conducting large midwifery practices in working class areas standing outside the scheme."[90]

The Institute's formula, designed by Lady Forber, was published in her final report. Forber acknowledged that it was impossible to predict how many women would be accepted into the service, but, she wrote, "it seems reasonable to assume that except in a few instances, those over 60 would not be accepted."[91] For this most vulnerable group, and one for which the Institute could be criticized, Forber recommended pensions "without regard to the size of their practice either past or present."[92] She recommended that these women receive "10s per week rising by 1s a week for every additional year of service up to a maximum of 30s per week."[93] To receive this pension, a woman had to have been in practice for ten years or more and have notified her intention to practice in 1936. Pensions along similar lines were recommended for women under 60 who applied to the service, but who were not accepted. For these women, eligibility was more stringent. They had to have been in independent practice for ten or more years and have attended 250 cases in the last five years. Those women who did not fit the requirements for pensions--those under 60 who attended less than 50 cases per year for the past five years--could apply for compensation "at the rate of £2 per birth attended during the past three years, the maximum compensation for any one midwife to be £300.[94] Forber defended the generosity of her proposals as just compensation for women "who having obtained a license from the State have been gradually deprived of their livelihood by the State by indirect means, and are now to be deprived of their right to earn at all through practice of their profession."[95]

Having made the case for "generous" compensation and pensions Forber's study was also intended to provide estimates of the cost to the government of the Institute's scheme. While the JCM had put the total of midwives to be displaced at 3, 321, Forber estimated that only 1, 799 midwives would be made redundant by the scheme. 583 of these would be over 60 and

would be eligible for pensions and the remaining 1, 216 would be eligible for compensation. For those eligible for pensions, Forber predicted that midwives over 60 would receive £1 a week and those under 60, 15 shillings a week, at a total cost to the government of £45,900. The remaining midwives (those who were under 60 and who had been in practice less than 10 years) would receive approximately £120 each for their practices at a total cost to the government of £96, 6000.

Forber's figures were so low, however, because she based them only on incomplete data. She estimated that midwives would have available to them approximately 2/3 of the total number of births and the rest would be allotted to hospital confinements. Using figures for total births in 1934, she estimated that this would have amounted to 231,133 births of the 347, 063. According to her calculations, at 100 births per midwife, the service would need 2, 311 midwives. When Forber estimated how many midwives would be displaced, however, she subtracted the total number of midwives needed, not from the total number of independent midwives known to be in practice (which had already been estimated by the JCM at 9, 200) , but from the smaller number of independents who notified their intention to practice in the County Boroughs, 3, 337. Hence the smaller number of midwives to be displaced. She had no data on midwives who practiced in areas under County Councils in which there "are a number of populous areas," and in which she acknowledged "it is not possible to obtain the number of midwives who practice there."[96] Limitations on data are endemic to any researcher, but Forber merely went on to present her figures without any qualification. Without any qualification, that is, except that even these figures were too high and that few would be eligible even for the compensation which the Institute's plan had offered. "The results," she concluded, "are probably a good deal too high."[97] Given the flaws in her calculations, one can only assume that Forber's figures were meant not to reflect an accurate accounting, but rather to offer reassurances to both midwives anxious that they were to be cleared wholesale from their ability to make a living and to government officials already suspicious about further outlays which required the government to foot the bill for what still was largely regarded as the individual's responsibility.

Too Many Midwives?

With the publication of The Midwife in Independent Practice Today, the Institute leadership helped to consolidate the case for the tactic of exclusion.The Institute's analysis of midwifery's problems was based on a perception of an absolute oversupply of midwives. Midwifery reformers like the members of the JCM and the leadership had been persuaded that midwives could no longer make a living from private practice. The training schools were seen as the ultimate source of this absolute increase, but the primary target was married women. These women were characterized as having received their training for free and, with husbands to support them, had driven down the living to be made from midwifery. The solution was at once simple, yet difficult. Reduce the number of midwives. Their success in promulgating this analysis was evident even in the Parliamentary debates over the Midwives Act which took place in the spring of 1936. As one member of the House of Lords told his colleagues, "One of the main objects of this Bill is to reduce, in their own interests, the number of independent midwives."[98] Similarly, the Ministry's circular instructing local authorities on the terms of the Act referred to it as the means of "reducing the present overcrowding in the ranks of the profession."[99] Even the weight of such venerable opinion, however, can not obscure the serious flaws in the analysis.

While the Institute and its supporters went to great lengths to prove their position, a considerable amount of data which contradicted their position existed either in reports which would have been easily available to them or even in their own evidence. There was no evidence to support the contention that midwifery experienced an absolute increase in the number of midwives. On the contrary, year after year, the Annual Reports of the Central Midwives Board showed that the number of midwives who notified their intention increased very little. In its 1925-1926, the Board reported that 16, 282 midwives notified their intention to practice to the LSAs. Of these, the Board estimated that 14, 281 midwives were in practice. [100] Five years later, the Board reported that 16, 673 had notified their intention to practice and estimated that 14, 516 of these were in practice.[101] In its 1933-1934 report, the Board reported that the number of notifications had increased to 17, 789 (or 1, 116 over the the 1930 figures) and estimated that 15, 442 of these were in practice

(or 926 over the 1930 figure).[102] These numbers reflect an increase of 6%, but it is difficult to imagine that the addition of less than one thousand independent midwives practicing throughout the country would have represented the kind of threat which the Institute claimed. What the evidence does indicate instead is a slight increase coupled with a more marked redistribution to salaried employment. Where the majority of the midwifery workforce once worked privately, 40% now worked in some form of salaried employment.[103]

The Institute and its supporters argued that married women worked part-time out of choice, that their husbands could support them, and that the existence of such part-time workers "subsidized" by spouses was ruining the living of midwives who were self-supporting (and, by implication, "serious" about their work). However, neither Forber nor the JCM presented evidence that married women chose to attend fewer cases. On the contrary, Forber herself concluded that there was no "reason to suppose . . . that they [married women] refuse cases; on the contrary, a large number state they want more cases."[104] Second, none of these reports presented any direct evidence of married women being directly responsible for the downward spiral of midwifery fees. As Forber herself had argued, most married midwives used their midwifery as a source of additional income for the family. "In some cases," she wrote, "there appears to be no other source of income other than the wife's, but that perhaps is rather more frequent in the older age groups."[105] With such a responsibility, it would seem unlikely that the married woman would choose to reduce her fees. Evidence collected for the Institute suggests that midwives dropped their fees in response to the lower fees charged by training schools and nursing associations. Third, it is difficult to see how a woman who took very few cases, married or not, was a source of competition.[106] Again, what Forber's evidence did show was, first, that of all the independents she sampled, the majority were older, married women. Out of a total of 2, 849 midwives who indicated their age, 39% were between 40 and 49 and 43% were between 50 and 59.[107] Forber did not make similar calculations of the percentages of married women in the total sample, but she did find that in her smaller sample of Yorkshire, Durham County and Hampshire, "the total number of married midwives is greatly in excess of either widowed or single."[108] Second, her own figures indicated that due to the falling birth rate, the competition from the subsidized services and the

spread of unemployment among their patients, midwives regardless of age or marital status had experienced an overall decline in case loads.[109]

Why, if the evidence suggests that all midwives experienced the same relative reductions in caseloads due to competition from public service midwives, would the Institute argue that an oversupply existed which must be reduced? The leadership's goal had consistently been to attract middle class, well-educated, professionally superior women into midwifery. Unless the working conditions could be improved and incomes could be considerably augmented, such women would continue to choose forms of employment other than midwifery. Throughout the 1920's, the Institute had sought to protect private practice by keeping midwifery fees up, but this attempt had failed. Although the Institute leadership increasingly acknowledged that the practice environment had changed for all midwives, its recruitment objective remained unaltered. In embracing salaried employment they had merely adapted to new conditions. The financial security, the regular hours, professional allowances, free time and holidays, and pensions were the means by which the "right type of woman" would finally take up the work.

But a salaried service would not "improve" the social and professional calibre of the rank and file already registered as midwives. That the majority of midwives were married and older was disturbing enough. Perhaps Forber was troubled by evidence that such women dominated what was left of independent practice. Of the 2, 849 midwives about whom Forber had collected evidence about years in practice and case loads, midwives over the age of 40 and particularly those between 50 and 60 years of age had the largest practices. This profile meant that the preponderence of independent midwifery was practiced by women who had been trained many years before the current educational standards.[110]

The absolute reduction of the number of midwives in practice would serve two purposes. First, the Institute had argued that the absolute increase in practicing midwives had flooded the supply of midwives beyond the demand for their services. The Institute did not consider the alternative of incorporating all independents within an expanded maternity service. This possibility had been raised in the debate earlier that spring. As the President of the Liverpool Midwives Association had pointed out, "the more midwives there are, the less the distance there is between them, thereby emergencies are

easily served and risks which occur from lack of attention will be less, for time often means danger."[111] The Institute and its supporters, however, clung to a free market analysis of midwifery's problems. By reducing the number of practicing midwives the immediate supply would be readjusted to the existing demand. The scarcity which would result from such readjustment would in turn raise the value of midwifery's professional services. Second, the very process of exclusion promised to rid the profession of many of the women the Institute had felt itself saddled with these many years. The leadership, pivotal in the establishment and promulgation of the notion that the best midwife was unmarried, young and had both midwifery and general nursing training, could not have been oblivious to possibility that local authorities would not accept any midwife into the service who did not fit this criteria. The Institute had demanded that the most experience midwives, "married or single or irrespective of the fact that some of them are old and cannot have more than a few years practice in the future," should be appointed into the service. Yet this was considered only a temporary measure. Once the service got going the Institute was confident that the composition would change.

> It has to be recognized that until schemes can be devised to make recruitment to the midwife service an attractive and permanent profession to young, well-educated women, both by regulation of the number of entrants and the provision of better and longer training, both expediency and justice will be best served by making full use of the most experienced of the present day midwives.[112]

In one broad sweep of legislative action, the liabilities of the profession would finally be removed and the field left clear and open for the midwife who would elevate the profession to the heights to which the leadership had always aspired.

The oversupply thesis also served the interests of the government. By the mid-1930's, the government faced a difficult political situation when it came to public health. The continued rise in maternal mortality was only one of a number of examples which had brought the government's policies into question. Physicians, social reformers, scientists and nutritional experts had

provided study after study to support their contention that maternal mortality could not be reduced without attention to a woman's level of income. These critics argued that medical and midwifery services were necessary, but were alone insufficient to solve the problem. Not only did the maternity services need to be expanded to actually meet the need, but steps had to be taken to raise incomes to a level capable of sustaining health. As we have seen, the government had publicly dismissed its critics claims and had sought to contain its response to maternal mortality within medical and administrative boundaries. To a public made increasingly nervous and outspoken about the failure of the maternity services to reduce maternal mortality, the salaried service represented evidence that the government was taking steps to improve its own solution. "This new Act", the Minister proclaimed in his speech before the Institute's Branch Representatives in November 1936, "will be a powerful instrument . . . in securing an improved midwifery service in this country . . . it will give to every mother, whatever her circumstances, the opportunity of having a qualified midwife at a very critical and important time for her. . . ."[113]

If, as the official representative of trained midwives, the Institute had demanded, for example, an expansion of the services instead of a reduction in the number of midwives the service could have been quite costly. The Institute, however, took the lead in helping the government to reduce costs. The Institute's proposal, based as it was on the notion of oversupply, required that only a fraction of independents be absorbed into the existing services. Compensation plans were quite modest and even for that the Institute counseled its members against expecting too much. An excerpt from a Nursing Notes editorial is worth quoting in full.

> What recompense would be adequate for the annual financial loss?--Adequate--not more, not less. In estimating the possibility of compensation, we must not forget that however good the intentions of the Government are, its resources are not exhaustless, and that a scheme that made demands beyond its financial capacity would not be passed. . . .We should all like to see those midwives who have given the best years of their lives to their arduous calling amply rewarded and retired on a really good pension. But, unhappily, we are living

> in a practical work-a-day world, these miracles do not happen, and we shall be wise to ask for the best terms and conditions that are possible, to insist that they are in every way fair and adequate without indulging in wild and impossible dreams.[114]

It is likely that the government considered the political advantage it gained against its critics to be worth the cost of the limited provision which was ultimately embodied in the Midwives Act of 1936.

The Institute tried to persuade rank and file midwives, many of whom were married and had fallen victim to the marginalization which was underway, of the validity of their analysis. Not all of the midwives targeted for exclusion were persuaded. Yet, it is possible to speculate why some might have been. If the Nursing Notes letters are any indication many midwives were already anxious that they were going to lose their livelihood. There were more private practitioners than there were places for them in the service. Midwives would be competing against each other for these positions. The Institute's and its supporters' analysis helped to foster divisions within midwifery which this general climate of competition engendered by directing attention from the legitimacy of exclusion to a debate over who was to be excluded. As the overwhelming majority of practicing midwives were now trained it was difficult to argue they were technically or professionally deficient without throwing the competence of the entire profession into question. Instead, they depicted one type of midwife as less deserving to practice than another. Their argument turned on the element of choice. Those who were undeserving had not been forced to lower their fees or to work part-time by circumstances, but rather had chosen to do so because they had some alternative means of support, most specifically, marriage. From here, true or not, the Institute arguments exploited widely propagated stereotypes of married women. Married women, especially if they had received their training free, did not need "to take this profession as a career," Forber claimed but merely took up the work "as a means of adding to their husband's income."[115] Protected by that income, these midwives, as one midwife whom Forber quoted declared, "can afford to work cheap."[116] And by working cheap, they took the bread from the mouths of self-supporting midwives. "I may add that I am the only single midwife here," wrote another midwife whom Forber quoted to prove her point. There are " one or two

[midwives who] are married women without the slightest need to take the living of the single woman."[117] That this image did not fit many married midwives may have worked in the Institute favor. Given the conditions married women would have been forced, whether they wanted to or not, to drop their fees or to work part-time. As a result, they may not have seen themselves in the role of the undeserving midwife and therefore might have convinced themselves that they would be able to secure a place in the new service. At the same time, married midwives might also be persuaded that while they did not fit this image others might. In the absence of other facts and in light of deeply rooted prejudices regarding married women's right to work midwives might have been persuaded when an organization as influential and prestigious as the Institute told them that these women existed in great enough numbers to have the effect the leadership claimed. The Institute offered the undeserving midwife as the scapegoat. With her elimination, midwifery's problems would be solved, and by implication, the deserving would be allowed to prosper.

Assessing the Act

The Midwives Act of 1936 has been hailed as a victory for midwives and the women they attended. The Institute and its supporters claimed that the salaried midwifery service created by the Act would provide greater access for women to midwifery attendance, more efficient delivery of that care through greater coordination and the improvement in midwives' living and working conditions. Midwifery histories have helped to establish these mere hopes as fact by uncritically accepting reformers' rhetoric.[118] The Midwives Act of 1936 has been interpreted as another significant milestone in the upward progress of midwifery and its practice.

Like other milestones in the profession's history, this judgement should be subjected to greater scrutiny. The benefits which might have been achieved by greater State responsibility for the organization and delivery of midwifery attendance were often undercut by the preservation of local responsibility for its administration and by the continued requirement that women pay for the services which they received. The Ministry's failure to guarantee any kind of mechanism to establish an adequate methodology to

determine the personnel requirements for the service or to enforce standardized case loads, salary levels and professional allowances undermined the improvements in living and working conditions which midwives might have derived from salaried employment. Moreover, the Act excluded thousands of practicing midwives who were considered unacceptable in the reformed public maternity services. The campaign which justified this exclusion--the attack on one section of midwives in defense of the ideal midwife of the "right type of "--could not help but have a demoralizing effect on the profession itself.

The new Act did not depart from the existing organization and philosophy of government sponsored public maternity provision. As in other matters of this type, local authorities were given the responsibility for organizing, subsidizing and administering a service of salaried midwives "who are available in its area for attendance on women in their own homes as midwives or maternity nurses during childbirth. . . ."[119] The local authorities could employ their own midwives (as many already did), or they could increase their subsidies to organizations such as hospitals, training schools or nursing associations so they would increase their staff of domiciliary midwives. In consultation with other providers in the area, local authorities were to determine the arrangements by which the service would be operated and administered and how many additional midwives would be needed to staff the service. Many authorities simply helped support organizations or institutions already providing midwifery care. As late as 1942, for example, only 45% of those midwives in salaried domiciliary work were in municipal employment. The rest were employed by voluntary associations.[120] As it perpetuated the parochial nature of the maternity services, the Act provided no opportunity to examine the country's long-range needs for midwifery attendance. Without local documents it is difficult to know if local authorities undertook any evaluation of the service in their own jurisdiction or any planning for the future. From preliminary reports on their proposals, however, it appears that some merely adopted the formula of dividing the number of births by the number of cases which a midwife could safely and efficiently attend.[121] The difference between that caseload and the number of midwives currently salaried would be the number of midwives the service would need. By restricting the determination of need to simple numerical calculations, local authorities integrated midwives into the

maternity services without having to question either the quality of the service they offered or to evaluate the work of that service in the fight against maternal mortality.

The Act did not reflect a change in the government's philosophy of relief to the poor. Despite the fact that most supporters understood that a salaried service was necessary because, as the Minister himself stated, "the economic position of a large number of patients prevents them paying adequate fees . . ." women were still expected to pay for the services they received.[122] While fees might have been lower than those required to keep an independent midwife in practice, they might still be higher than women had been used to paying or could afford. In London, for example, the LCC set the fees at "£2 for a primipara and 30s for further confinements or maternity nursing."[123] If a woman was on the standard public assistance of 15 shillings , for example, this fee might have been too high. In other areas, such as where the nursing association charged 15 shilllings for each confinement, the cost might not have been so difficult to meet.[124] While it is difficult to generalize when there was so much local variation, it is probable that working class women, especially the poor, benefitted to a certain degree from the competition among midwifery providers. If a woman was poor she probably could find cheap trained attendance from providers who, because they wanted her "case" or her "business", did not pry unduly into her financial situation. If she was very poor or wanted, for some reason or another, to avoid the voluntary hospitals or philanthropic organizations, she could engage a handywoman. Handywomen charged less than other providers and took care of the children and the home as well.[125]

Under the new service, however, the elimination of competition among providers was crucial if the service was not to go the same way as the independent midwife. To prevent undercutting that would undermine the entire scheme, local authorities worked to have all the providers they subsidized adhere to an agreed-upon scale of fees. Provider agreements to abide by these standardized fees reduced competition among them. Further, the Act made it illegal for a handywoman to attend cases under any circumstances. Once the Minister was satisfied that a viable service had been introduced in a local authority, any handywoman practicing in the area would be arrested and, if proven guilty, fined up to £10.[126] With their options thus narrowed, childbearing women had no other choice but to meet the

standard fee or apply for dispensation from the local authority. But dispensations were only granted by local authorities after a thorough investigation as to the woman's eligibility. If a woman was considered able to pay the fee and could or did not, the authority could recover the fee "summarily as a civil debt."[127] The conditions under which women received maternity care were, therefore, no different than they had been under the Midwives Act of 1918.[128]

Early in local authority planning, it became clear that the new service was going to yield considerable changes in the composition of the midwifery workforce. Forber's figures had shown that older, married midwives made up the majority of women in independent practice. Although she provided no figures for certification, it was estimated that the majority of these women had been trained in midwifery only. In his speech to the Institute Branch representatives, the Minister of Health Sir Kingsley Wood, assured midwives that he had persuaded local authorities to appoint their new employees on the criteria of expertise rather than age, marital status or whether they had the nursing credential.[129] Perhaps the Minister made such claims in all good faith, but unless he wanted to take the rather serious step of withdrawing funds from uncooperative authorities, few (except perhaps rank and file midwives themselves) could have considered his authority in this matter anything other than limited. Although the Act required local authorities to submit their proposals to the Minister of Health, these "Proposals" as the Ministry's circular on the Act indicated did, "not require[d] the Minister's approval."[130] As a result, there was no way of enforcing any assurances which did not themselves appear in the Act.

Authorities appointed whom they wished and generally according to the criteria which had been established by the Institute and its supporters over these many years. Quite early in the planning process local authorities made clear their preference for midwives with general training.[131] This preference was exercised despite the greater experience of midwife applicants in the area who had midwifery training only. One midwife complained to the Institute that even though she had fourteen years experience in private practice she found she always lost out to the nurse.

> We are Not given Priority Positions as District Midwife, but, Have had to stand down Many Years

> for (inserted) the S.C.M. with SRN "why is this". I always thought Midwifery was a class on its own, when I took the Training Years ago I Never thought that the very People who ought to have Known better, should Mix the Work. I Said So, &, I still Maintain A Midwife to do her work, &, a S.R.N. to do hers, &, let us either be one or the other. . . .[132]

Older midwives were also passed over. One woman wrote in 1940 that at 45 she had been considered "too old for a hospital post or domiciliary midwifery."[133] Also as expected, authorities preferred "single women without domestic ties, giving," the Institute commented without surprise, "as might be expected , preference to young well trained midwives who are also State Registered Nurses."[134]

The actual midwifery workforce under the new Act did not change as much, however, as the local authorities, the Institute and its supporters perhaps had wished. Older, married women trained in midwifery only still found a place in the work. The 1949 government appointed Working Party on Midwives found that 33% of domiciliary midwives in their sample who notified their intention to practice in 1944 were between 35 and 44 years of age and 29% were between 45 and 54.[135] In 1947, 44% of domiciliary midwives in their sample were married.[136] The greatest change was probably the increase in the number of nurses who were also trained in midwifery. With the revision of training in 1938, the number of State Registered Nurses who trained for midwifery rapidly increased. By 1949, 96% of all pupils entering midwifery training were SRNs and only 4% were direct entrants.[137] As a result, midwifery increasingly became dominated by general trained nurses.

The Act brought about considerable changes for midwives, although the benefits were decidedly mixed. The Act did require compensation for the thousands of midwives who would be forced from their means of making a living, yet that compensation was by no means generous, or even charitable. If a midwife was not accepted into the service, or if she tried to continue in private practice and could not compete with the municipal service, she could, as long as she applied before 1940, receive compensation for her lost practice. The Institute was unable to convince the government that compensation should take age or years of practice into account. Instead, the government

adopted more restrictive criteria. For voluntary surrender of her certificate, the midwife would receive in exchange "a sum equal to three times the average net annual emoluments derived from her practice as a midwife or maternity nurse . . ." during either the previous three years or the period in which she had practiced as a midwife, "whichever of the following periods is the shorter. . . ."[138] If a midwife was mandatorily retired by the local authority because she was "incapable, by reason of age or infirmity of mind or body, of efficiently performing her duties as a midwife," she would receive five times the average net value of her practice over the preceding three years or for the period which she practiced as a midwife or maternity nurse, again, "whichever of the following periods is the shorter. . . ."[139] As the formula compensated midwives only for their last three years of practice, the years in which their case loads were, in many cases, at the lowest number, there is little doubt that the formula was calculated to keep the cost to the government as low as possible.

The Act provided few safeguards against abuses by local authorities when paying compensation. Under the Act, the government was required to pay only one half of the cost of compensation.[140] Because the other half came out of the local authorities' pockets, the Act encouraged them to skimp. Local authorities had the prerogative, for example, to require older midwives who were "incapable, by reason of age or infirmity of mind or body, of efficiently performing her duties as a midwife", to retire. The Institute reported to the JCM soon after the bill was passed that in an attempt to avoid the payment of this additional compensation some local authorities were not using their power to retire older midwives. "This means," the Institute complained, "that these women have to struggle on in spite of age and infirmity and are not to benefit" from the particular clause which was designed specifically for them.[141] Further, midwives found they had no control over the way in which they received their payment. The Act granted local authorities a choice: either pay midwives in a lump sum or "if the authority decides that it is in the interest of the midwife to do so, purchase an annuity for her which would be "payable to her at such intervals as the authority may determine."[142] The Act did allow for a midwife to appeal her compensation, but the Act made it difficult to do so. Rather than make her appeal to a local body or even the Central Midwives Board, midwives had to send petitions to the (often) distant Minister of Health.[143]

For those who were accepted into salaried employment conditions did not necessarily improve as the government and the Institute had promised. Salaries were less than expected, case loads were excessive and the time-off and holidays were often sacrificed to authorities' or voluntary associations' own skimping. While some authorities had incorporated experience in the determination of salary scales, many of these offered higher salaries to women with nursing training.[144] The Institute found that not only were "salaries creating a problem," but some authorities were reluctant to give midwives adequate reimbursement for their expenses, including laundry, uniforms, travel, and telephone.[145] Midwives reported that their case loads were much too high. During the time the provisions of a salaried service were being debated, the Institute had recommended that salaried midwives be required to attend no more than 100 cases per year. This figure theoretically allowed not only for the time spent with the women during her labor, but for ante-natal and post-natal care. By the time the Act was passed, however, the Central Midwives Board had extended the number of days of post-partum attendance from ten to fourteen. This substantially increased the time required for each case and reduced the number of cases a midwife could safely attend. In its circular, the Ministry had advised that midwives should be expected to attend no more than 70 cases as a midwife and 30 cases as a maternity nurse. According to Institute investigations, however, it appeared that some local authorities required their new employees to shoulder the higher case loads of earlier recommendations. The Liverpool authority, for example, proposed to require its midwives to attend ninety cases per year. Both the Medical Officers of Health from Hull and from Portsmouth calculated that midwives they employed could safely attend eighty cases per year. Despite its support of the service itself, the Institute disapproved. "Such poor conditions," Nursing Notes warned, "will not lay the foundation of a satisfactory service."[146]

Midwives' complaints of the poor conditions in the new service were registered at Institute functions and in the midwifery and nursing press. One midwife complained at the Institute's 1938 Annual General Meeting that there was so much work that neither she nor her partner could keep up.

> One of her colleagues had already attended 80 confinements in 6 months and she herself had

> attended 67. During the last three weeks there had been so many morning and evening visits that they had not been able to do their duty as they would like to, and the ante-natal work had not been able to be done. . . .[147]

Conditions did vary. One midwife reported that a friend who had been appointed as a "municipal midwife has one whole day per week, one week-end every month and three weeks annual leave." She, on the other hand, had only "one half-day per week, one long week-end every three months and only fourteen days annual leave."[148] Midwives employed by district nursing associations complained of similar iniquities. "I was told by my secretary when I returned from my summer fortnights holiday that I was lucky to get a month a year," one midwife wrote to the Institute. "They only gave me two weeks the nurse on the next district gave two of them, & I gave her two, doing double work while. "[149] The sentiment of dissatisfaction was summed up by one midwife who rendered the judgement at the 1938 Annual Meeting: "The Municipal Midwives were on duty 24 hours out of 24; when they were independent they could relax, but now they were on the qui vive the whole time.[150]

These conditions were not merely temporary kinks in a new system. Over the following ten years conditions for many midwives continued to deteriorate. A gradually rising birth rate coupled with changes in the requirements of midwifery work had increased both the number of cases which midwives attended and the time spent on each one. Where in the early 1930's, fewer than half of the women who gave birth ever had any ante-natal care, by the late 1940's a rising standard of care and greater organization had made it routine. "Now these visits," observed the 1949 Working Party on Midwives, "both in the clinics and the patient's home, may amount to a dozen or more in a normal case and take up a great deal of a midwife's time."[151] But an insufficient number of new midwives were entering the profession to take up the additional work. Although an increasing number of women trained and were certified as midwives, that increase did not compensate for the considerable annual losses in numbers of working midwives. The Working Party on Midwives found that out of their sample of 1, 725 midwives who qualified in 1946, only 1, 200 entered midwifery practice and remained in the work for at least a year. At the same time, however, the

committee estimated that 1, 300 midwives left midwifery that year, for a net loss of 100 midwives.[152] Taken together, these factors--an increase in the requirements of the work and the decline in the number of practicing midwives--meant that midwifery suffered from "a problem of absolute shortage. . . ."[153] The result was the now familiar conundrum of midwifery. Midwives in both domiciliary and hospital work were responsible for far too many cases according to the accepted standards for safe attendance. In 1944, at a time when government and professional experts had pronounced 66 cases per midwife in urban areas and 30-40 cases in rural areas, almost 54% of urban domiciliary midwives were assigned between 60 and 100 cases a year and 36% of midwives in country districts had between 40 and 70 cases a year.[154] In a comparison of midwives who qualified in 1944 and in 1946, the Working Party found that both domiciliary and hospital midwives agreed that overwork and finances were the two most important problems which they faced.[155]

It is not only because of its failure to substantially improve the living standards of practicing midwives and the access to care for childbearing women that it is difficult to view the Midwives Act as the victory it has been seen to be by midwifery historians. The Act, with the active assistance of the professional association which was supposed to represent their interests, drove, at minimal estimates, almost three thousand women out of midwifery practice. 1, 201 midwives surrendered their certificates for compensation in the first year and a half of the Act's operation. By the time the eligibility period had expired, 1, 742 more midwives had surrendered their certificates in the next two years.[156] For those who continued in private practice, the struggle became increasingly difficult. "We can, perhaps look forward to the 'Public Assistance', seeing we have, of course, been 'assistants to the public' for the great events of their lives", one midwife wrote to the Nursing Mirror. "Sir Kingsley Wood made great promises to the midwives, and we, the 'independent ones, are anxiously awaiting the fulfillment of his word to us.[157]

There were those who continued to regard the entire process as offensive to their sense of justice and morality. A supporter of the Institute and a contributor to Nursing Notes, the Medical Officer of Health (MOH) from Middlesex wrote in 1939,

> This Act, with a ruthlessness rare in public health legislation of this country, faced the independent midwife with the virtual alternative of obtaining employment with a municipality (if she could get it), or of giving up midwifery. Retirement from her profession might be immediate and sweetened by her acceptance of a payment by way of compensation, or it might be deferred until the remorseless competition of a subsidised municipal service squeezed her out of practice.[158]

The outrage that emerges from such published complaints about conditions and salaries suggest what many midwives might have felt. While members raised their complaints before the Annual Meetings, there were no indications of serious defections. At the same time, perhaps we should not discount the sense of betrayal which some midwives, particularly the targets of the Institute's campaign, might have felt.

> With other members of the Institute I have fought shy of answering further questionaires issued by the Institute sharing a feeling that on our previous questionaires we have been rather badly let down. During the meetings held at the Institute prior to the passing of the Midwives Act after the questionaire had been scrutinised it was stated--widows and even women separated from their husbands could take their midwifery and launch out in practice--Well, I happen to be a woman who has a legal separation from her husband, and my separation was primarily caused by bad midwifery . . . through the culpable neglect of a medical man . . . during the time I was in hospital my husband sold up my home because this same medical man told him I could not possibly recover, and made himself comfortable in a life in which I could have no share. All my own sad experience of personal neglect has, I venture to hope has helped me to become the midwife that I am. I am telling you this because it has been stated that the prestige of the profession has been lowered by the inclusion of women who are widows and such. Personally, I feel it would be a very good thing if everyone could learn the art of living, as also the <u>art</u> as well as science of midwifery. I am sorry if I have bored you,

but this one separated wife from her husband has been made rather bitter.[159]

* * *

It is difficult to leave a discussion of the 1936 Act without some sense of concern and perhaps even disillusionment. The Midwives Institute, the organization which claimed to represent the interests of the rank and file, had manipulated evidence to construct a self-serving analysis of the profession's problems in order to replace rank and file midwives with a new breed. The strategies they employed in their pursuit of the salaried service replicated those of the past. The Institute did not represent the rank and file of midwifery. To the extent that the organization did so, it represented an ideal: women who were educated, who were nurses, who were young and unmarried. For the Institute, the majority of the rank and file were millstones who dragged down the profession and drove the ideal woman away. As a result, the cultivation of division within the ranks of midwifery and the exclusion of the scapegoat was the driving strategy of the Institute since its inception. According to this strategy, even the formally trained, certified midwife was no different from her bona fide counterpart of the pre-war period once the leadership had decided her time had come.

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110. The Midwife in Independent Practice Today, 20; See also, "The Fynes-Clinton Memorial Lecture", 2, where she noted that the responsibilities of family life required women to be"in and out of practice" due to having children of their own, through illness, or because "family difficulties of various kinds" contributed toward "a good deal of movement among practicing midwives, which can hardly contribute toward a stable and large practice."

111. "Conference at the Nursing and Midwifery Exhibition, 'On the Independent Midwife as the Basis of a National Maternity Service'", NN, April 1935, 55.

112. "Our Changing Outlook", NN, December 1935, 163.

113. "The Minister and the Midwives", NN, December 1936, 175.

114. "Our Changing Outlook", NN, December 1935, 163.

115. The Midwife in Independent Practice Today, 13.

116. The Midwife in Independent Practice Today, 17.

117. The Midwife in Independent Practice Today, 19.

118. See, for example, Betty Cowell and David Wainwright, Behind the Blue Door. The History of the Royal College of Midwives, 1881-1981, (London:

Balliere and Tindall, 1981), 59; Jean Donnison, Midwives and Medical Men (New York: Schocken Books, 1977) 191-192; Audrey Wood, "The Development of the Midwifery Service in Great Britain", International Journal of Nursing Studies, 1963, 55, in which she mistakenly asserted that the salaried service provided "every woman having her baby at home could have the services of a qualified midwife free of charge."

119. Great Britain, Laws, Statutes, etc., Midwives Act, 1936, 26 Geo. 5 & 1 Edw.. 8, Ch 40, 1. (1); For further discussion, see: G.B. Carter, "The Midwives Bill", NN, July 1936, 96.

120. "A Stocktaking of the Midwifery Service", NN, October 1942, 84.

121. "Comments on Some of the Schemes Drawn Up By the Local Supervising Authorities Under the Midwives Act, 1936", NN, March 1937, 45.

122. "The Minister and the Midwives", NN, December 1936, 173.

123. "Problems Arising Out of the Midwives Act 1936", NN, October 1939, 162,

124. "Wanted--A Square Deal", NM, August 19, 1940, 714.

125. The Midwives Act, 1926 had made it illegal for anyone who was not a certified midwife to attend women in childbirth without the supervision of a physician. Women's poverty, however, kept the need for the handywomen's services alive.

126. Midwives Act, 1936, Section 6, clauses 1 (a),(b),(c),2,&3.

127. Midwives Act, 1936, Section 3, clauses 1 & 2.

128. See, Great Britain, Laws, Statutes, etc., Midwives Act, 1918, 8 and 9 Geo. 5 CH. 43, 14. (4).

129. "The Minister and the Midwives", NN, December 1936, 173.

130. "Midwives Act 1936", NN, October 1936, 150.

131. See, Midwives Institute, Memorandum to the Joint Council of Midwifery, c. 1936-37, courtesy of RCM Archives; See also: "Letter from the North", NN, January 1937, 8-9, Thomas Aker to Dear Madame, October 7, 1943, Rushcliffe files, RCM Archives in which Aker, the Town Clerk notified Mitchell that the City Council "is of the opinion that modern standards of Midwifery demand the employment of midwives who are general State Registered Nurses."

132. -- to Mrs. Mitchell, July 24, 1943, Rushcliffe files, RCM Archives; SCM referred to State Certified Midwife and SRN to State Registered Nurse.

133. "Wanted--A Square Deal", NM, August 19, 1940, 714; See also: "Comments on Some of the Schemes Drawn up by the LSA Under the Midwives Act, 1936" NN, March 1937, 45.

134. Midwives Institute, Memorandum on Salaries and Service Conditions of Midwives, draft, 1942, 9, courtesy of RCM Archives.

135. Great Britain, Ministry of Health, Report of the Working Party on Midwives, HMSO, 1949, 93; The Working Party on Midwives was appointed by the Ministry of Health, the Department of Health for Scotland and the Ministry of Labour and National Service to investigate the causes for the shortage of midwives. Committee members were Mary Stocks, Jean P. Ferlie, Veronica Shand, Richard Titmus and Albertine L. Winner; The report which they produced is an invaluable source for the demographics of the midwifery workforce, their work conditions, and their training, and for discussions on some of the key problems facing the profession in the nineteen forties.

136. Working Party on Midwives, 91.

137. Working Party on Midwives, 27; In 1938, the CMB training rules were revised. The training was divided into two parts and two different groups of training schools were designated for each part. Part I was designed to train those nurses who wished to acquire midwifery training to enhance their prospects of advancement, but did not want to practice. Part I training which was six months for SRNs and eighteen months for non-SRNs, focused primarily on the theoretical foundations of midwifery work. Part II training, which was conducted in specifically designated training schools, was designed for those women who had completed Part I successfully and wanted to go on to practice as midwives; Great Britain, Central Midwives Board, Suggestions and Instructions regarding the Conduct of the Course of Training of Pupil-Midwives, September 1938).

138. Midwives Act, 1936, 5, (1) (a) (b) .

139. Midwives Act, 1936, 5, (2).

140. Midwives Act, 1936, Section 5, (6).

141. Midwives Institute, Memorandum from the Midwives Institute to the Joint Council of Midwifery, c.1936, RCM Archives.

142. Midwives Act, 1936, Section 5, (4), 39; See also: "Summary of Memo. 200/M.C.W.", NN, October 1936, 151.

143. The Institute created a special department to handle their members' compensation and other problems related to the Act. See: "Proposed Scheme for a Temporary Department to Deal with Special Problems Arising From the Midwives Act", February 1927. See also: "To All Midwives", October 1926, 148.

144. "Comments on Some of the Schemes Drawn Up by the Local Supervising Authorities Under the Midwives Act, 1936", NN, March 1937, 46.

145. "Comments on Some of the Schemes Drawn Up by the Local Supervising Authorities Under the Midwives Act, 1936", NN, March 1937, 45.

146. "Comments on Some of the Schemes Drawn Up by the Local Supervising Authorities Under the Midwives Act, 1936", NN, March 1937, 45.

147. "General Meeting", NN, April 1938, 58.

148. Correspondence, NN, January 1939, 7.

149. H.B– to 'Madame', December 10, 1943, Rushcliffe files, RCM Archives; see also, the letter from Mrs. J--to Miss Wakeman, October 13, 1943, "I was forced to relieve the nurse in the neighbor district on all Bank Holidays, including Christmas. I have spent four Christmases here. I always have my Christmas dinner warmed up. . . ." Rushcliffe files, courtesy of RCM Archives.

150. "General Meeting", NN, April 1938, 58; For the conditions of practice in the later 1930's and 1940's, see the collection of letters midwives wrote to the Institute in response to the 1942 Rushcliffe Committee salary proposals. Rushcliffe files, courtesy of RCM Archives..

151. Working Party on Midwives, 6.

152. Working Party on Midwives, 14.

153. Working Party on Midwives, 6.

154. Working Party on Midwives, 17.

155. Working Party on Midwives, 104; see also: Alderman C.W. Key, "Midwifery Today--Stocktaking", NN, November 1945, 171.

156. Central Midwives Board, The Work of the Board for the year Ending, March 1944.

157. "Wanted-A Square deal", NM, August 19, 1940, 714; see also "Letter from the North", NN, January 1937, 8-9; By 1946 the number of independents had been reduced to 1888 or little over 12% of the total midwifery workforce. Central Midwives Board, The Work of the Board for the Year Ending March 1963.

158. H. M. Cameron McCauley, M.D., "Cooperation of the Midwife with Other Public Health Services", NN, July 1939, 108-109.

159. Mrs. K--to Mrs. Mitchell, 1937, courtesy of RCM Archives.

GLOSSARY

GLOSSARY

antisepsis: the prevention of infection.

bona fide midwife: lay midwives who registered under the 1902 Midwives Act. The Act allowed lay midwives who had been in practice for at least one year prior to the passage of the Act and who could produce written testimony of their good character to register under the Act and thereby legally practice midwifery. After 1905, lay midwives were no longer allowed to register under the Act and after 1910, if any woman practiced "habitually and for gain" she was liable to prosecution, a fine of £10 and a possible jail term.

breech presentation: when the infant's feet, knees or buttocks emerge first rather than the head. As the head is usually larger than the infant's body there may be complications with this type of presentation if the cervix is not fully dilated.

Central Midwives Board: regulatory body created under the Midwives Act, 1902. The Board designated and approved training institutions and teachers, set the syllabus and the examinations for the CMB certificate, issues the certificates upon successful completion of training, formulated and codified rules by which midwives' practice was defined and supervised, and in the event of suspected malpractice, the procedures by which midwives would be investigated and disciplined.

cervix: the neck of the uterus.

domiciliary: at home. When applied to childbirth, birth at home; when applied to a midwife, a midwife who attends a woman in childbirth in her home.

eclampsia: the most serious form of the toxemias of pregnancy. It is characterized by convulsions and follows preeclampsia.

handywoman: generally a working class woman who did not register under the Act and who worked as a midwife either alone or in cooperation with a physician. In addition to helping with the birth the handywoman not only looked after the mother and the infant for a number of days but also did the cleaning, cooking and washing for the mother until she was on her feet again. After 1910, these women could not legally practice unless they were under the direct supervision of a physician. After 1936, handywomen were no longer allowed to practice.

lay midwife: a midwife who had been experientially trained in an apprenticeship with another lay midwife.

Local Supervising Authority: for purposes of the supervising midwives'\ practice, county and county borough governments were designated as Local Supervising Authorities. They were charged with ensuring that midwives practicing in their jurisdictions were registered under the Midwives Act and conformed to the Rules of the Central Midwives Board.

Medical Officer of Health: public health physician appointed by a local authority to oversee public health programs, collect public health data and implement the authority's public health policies.

Midwifery inspector: appointed by the local supervising authority to supervise and inspect midwives who had notified their intention to practice in the LSA's jurisdiction.

Midwives' Institute: the organization which sought to make midwifery into a profession for well-educated, middle class women. The organizational structure was as follows: The Midwives' Council--comprised of the elite of nursing, midwifery and medicine--set policy for the organization. The Executive Council (sometimes Club) constituted a steering committee which made the daily decisions and ran the organization. This core group constituted the Institute's leadership, which exercised both formal and informal influence within the organization through their positions on the Council and on the various committees appointed by the Council to investigate and attend to various policy issues.

multigravida: a pregnant woman who has had more than one pregnancy.

multipara: a woman who has given birth to more than one viable infant.

opthalmia neonatorum: any purulent discharge from the infant's eyes within 21 days after birth. Blindness can be the result if the infection is caused by the bacteria gonococcus.

os: the opening of the cervix into the vagina.

parturition: the act of giving birth to a child.

pemphigus: an acute or chronic skin disease which is very infectious and characterized by watery blisters.

perineum: the area around and between the vagina and the anus.

placenta praevia: a condition in which the placenta is implanted abnormally in the uterus so that it impinges upon or covers the internal os of the

entrance to the cervix. A placenta in this position is highly vulnerable to separation and rupture, resulting in severe hemorrhage.

placenta: the afterbirth; the placenta transmits oxygen and nutrients from the maternal blood to the fetus and excretes carbon dioxide and other waste products from the fetus.

post-partum: after giving birth.

preeclampsia: a disease specific to pregnancy which is characterized by elevated levels of albumin (a protein) in the urine, high blood pressure and oedema. Healthy living conditions, including a diet high in protein, calories and essential nutritional elements, and rest and exercise are associated with decreased incidence of preeclampsia. After a hundred years of research, the cause is still unknown. Unchecked, it can lead to eclampsia. Also called toxemia of pregnancy.

primigravida: a woman pregnant for the first time.

primipara: a woman who has given birth to one viable infant.

puerperal mania: a rare mood disorder that sometimes occurs in women after they have given birth, characterized by a severe manic reaction.

puerperal sepsis: a condition associated with systemic bacterial infection and septicemia that occurs following childbirth. The hemolytic streptococci is usually the bacteria responsible for the infection and unsterile hands or instruments are the means of its introduction into the vaginal tract.

puerperium: the six to eight week period following childbirth during which the woman's uterus and other organs return to their pre-pregnancy state.

pyrexia: fever

rank and file midwifery/midwives: Trained and bona fide practicing midwives who were not part of the general elite of midwifery or of the leadership of the Institute.

registered midwife: any midwife--trained or lay--who was registered under the Midwives Act, 1902.

toxemia: the poisoning of the blood by the absorption of toxins, once thought to be responsible for preeclampsia.

trained midwife: a midwife who had undergone formal training either in one of the many hospital programs prior to the Midwives Act, 1902 or under the Central Midwives Board programs established as a result of the 1902 Act.

vertex presentation: the infant emerges with the vertex presenting first. The vertex is the area of the head bounded by the anterior and posterior fontanelles and laterally by the parietal eminences. The vertex presentation is the most common presentation.

APPENDIX

APPENDIX

The Central Midwives Board Penal Files

A random sample of 73 cases (brought against 74 midwives) was drawn from a list of midwives who had been charged by the Central Midwives Board between 1905 and 1919. Every tenth case was chosen.

Like every source, the sample has its weaknesses. First, the 73 case files are a random sample of surviving records and not of all the midwives called before the Board. Approximately 100 penal cases, on the average, were brought each year by the CMB. Therefore, the surviving case files probably represent a little under half of all the estimated 1500 cases brought against midwives between 1905 and 1919. Second, the files did not routinely include the transcripts of the proceedings of the hearings. Because those transcripts that were included were recorded in a now obsolete method of shorthand, it was impossible to decipher them or to find someone who could. Without the transcripts, the Board's attitude toward the midwives brought before it in the specific cases and the reasons for its judgements have to be interpreted through the use of other sources.

The findings in the sample differ in two ways from Nursing Notes, the only other significant source of information on midwives who were called before the Central Midwives Board. First, accounts of specific cases in Nursing Notes included the woman's name, where she was from, the judgement against her, and usually whether she was a bona fide midwife or a trained midwife . The reporters did not, however, have access to the case files and therefore their reporting was shaped by the evidence presented at the hearing. Because of the editorializing tone used in the descriptions of the cases, it was impossible to either discern the primary charge or to formulate an informed, independent opinion of the events surrounding the case from the journals accounts. On the other hand, the reporters' editorializing did help to recreate a sense of the overall texture of the hearings as well as the hearings of some of those midwives who were included in the random sample. Second, Nursing Notes reported significant differences from the random sample in the percentages of bona fide midwives who were called

before the Board. Of the 995 cases which the journal reported on between the years 1905 and 1919, 843 (85%) were listed as having been certified by virtue of bona fide status and 152 (15%) had formal training. In the random sample of 73 cases (74 midwives), 37 (50%) were bona fide and 35 (47%) were formally trained (certification was not designated in two cases). Further, Nursing Notes recorded that a higher percentage of bona fide midwives (76%) were struck off than trained midwives (44%). In the random sample, 58% of the bona fides and 54% of the trained midwives were struck off the Roll. There was no difference in the incidence of guilty verdicts, however. No matter their status, accused midwives were found guilty of the charges against them in 93% of the cases reported by Nursing Notes and 91% of the cases in the random sample.

The Nursing Notes accounts provide useful data regarding the women whose cases they covered and helpful descriptions of the hearings, but the source as a whole is not as statistically reliable as the random sample. Although the journal reported on a higher number of cases than the random sample represents, the cases which they reported still represent only a little over half of all the cases brought before the Board. Almost a third of the cases in the random sample were not reported in the journal, for example. While there might be many explanations for these omissions, the exercise of self-interest cannot be discounted. As the Institute would have had a vested interest in publishing some cases (such as those of the bona fides) and and not others (like the trained midwives), it is entirely possible that the editor purposely selected which cases would be recorded in the journal and which would not. In the case of the missing penal files, it is more likely that they were either lost or inadvertently destroyed. The Central Midwives Board had no motive for skewing the representation of cases. They were there to discipline midwives whether they were trained or bona fide. Further, it likely that the took their function as the official, government body responsible for keeping records on registered midwives very seriously. Therefore, the collection of original penal files from which the random sample was taken is, if not wholly representative of all midwives called before the Board, nevertheless more reliable given the sources available.

The sample

Age

According to the 1911 Census, 84% of the women who gave midwifery as their occupation were over 45 years of age. Of the 23 bona fide midwives in the sample who listed their age, 17 or almost 75% were over 45 years of age and almost half of the total were over 60. A full third, however, were between 36-50, ages which belied the Sairy image of all bona fide midwives as the doddering, dangerous old woman. Compared to the other practitioners in the sample, the CMB midwives were relatively younger women. 44% of them were under 30 years of age. Yet, 56%, more than half, were between 36 and 50. Midwives who held the LOS or had taken hospital training fell between these two extremes, with approximately 50% over and 50% under 50 years of age.

Table 4: Age Distribution of Midwives (CMB Penal Files)

	20-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	+70
Bf	-	-	-	3	3	1	2	3	7	-	4
Cmb	2	2	-	2	1	2	-	-	-	-	-
Los	-	-	-	2	-	3	1	2	2	-	-
Hosp	-	-	-	-	1	-	-	-	1	-	-
	2	2	-	7	4	6	3	5	10	-	4

Marital Status

According to the 1911 Census, 70% of the women who gave midwifery as their occupation were married or widowed. LSA officials recorded marital status for 68 (92%) of the 74 midwives. The majority, 57 (84%) were either married or widowed at the time of their hearing. 94% of the bona fide midwives, 91% of the LOS midwives and all of the midwives trained in hospital were either married or widowed. 7 of the 11 of the unmarried women were CMB midwives. Yet, 8 or 53% of them were not only somewhat younger than the reformer's image implied, but 53% of them were married.

Table 5: Marital Status of Midwives (CMB Penal Files)

	m/w	u/m	total
Bf	34	2	36
Cmb	8	7	15
Los	10	1	11
Hosp	5	0	5
Nc	-	1	1
	57 (84%)	11 (16%)	68 (92%)

Training

Of the 74 midwives in the sample 35 (47%) had received formal training. 16 held the certificate of the Central Midwives Board, 13 had been trained according to the standard of the London Obstetrical Society, and 6 had been certified by virtue of hospital training received prior to 1902. 37 (50%) midwives in the sample were bona fide practitioners. Officials did not list the certification of the remaining 2 (3%)midwives in the sample. Taking the number of years in practice at the time of their trial LOS midwives averaged 17 years and hospital trained midwives average 13 years. For those 15 bona fide midwives who specifically indicated their years in practice the average was 29 years. CMB midwives in the sample had been in practice an average of 4 years, although one had practiced for over a decade.

Typical Charges by Central Midwives Board

Midwives in the sample were brought before the Board on a variety accusations, but "failure to advise and send for a physician" (a/s) constituted the majority of cases brought against a midwife regardless of training. Midwives were generally brought up on one primary charge which was then bolstered by a variety of miscellaneous charges. I have categorized the midwives' offenses by these primary charges. (In addition to the 51 midwives charged with "failure to advise and send for a physician", 14 were called for misconduct and 9 midwives were called on charges too varied to classify except under the category of miscellaneous). 78% of all the bona fide midwives in the sample, 63% of all the CMB certified midwives, 54% of the LOS midwives, and 67% of the hospital midwives were cited on this primary charge.

Table 6: Charges Brought Against All Midwives (CMB Penal Files)

	a/s	misconduct	miscellaneous	total
Bf	29	2	6	37
Cmb	10	5	1	16
Los	7	4	2	13
Hosp	4	2	-	6
Nc	1	1	-	2
	51	14	9	74

To support their case, midwifery reformers cited the high number of women accused of failing to send for a doctor more often than any other charge (except perhaps cleanliness) Precautions against antisepsis and medical aid in the event of complications were principles the positive nature of which few could deny. Cases in which a midwife was charged with the violation of these principles were paraded before the public as evidence of the flagrant disregard of human concern and the challenge to the public welfare that unsupervised midwives represented. The high number of convictions for these violations further justified, reformer's argued, the strict control of midwifery and the extensive authority embodied in the Board's disciplinary role. The sample of actual cases, however, suggest that few of the alleged violations in this category conformed to the image created by midwifery reformers. In 20 (40%) of the 51 cases the cost of the physician's services caused the family to refuse the midwife's recommendation for a physician or the midwife to delay in sending for one. In 9 (18%) cases, the midwife had not failed to call a physician, but rather had been accused of failing to submit notification to the LSA. In 7 of these cases (involving 8 midwives), although the midwives was blamed, it was the physician who was responsible for the poor outcome of

the case. Only the remaining 15 (29%) cases out of the 51 involved questions of the midwife's compliance with the requirement to send for a physician in the event of complications.

Table 7: Failure to Advise and Send for a Physician (CMB Penal Files)

	So	Sc	Cens	Caut	Na	Total
Bf	16	5	-	5	3	29
Cmb	3	2	-	2	3	10
Los	6	-	-	-	1	7
Hosp	1	1	2	-	-	4
Nc	1	-	-	-	-	1
	27	8	2	7	7	51

Key: SO=struck off; SC=severely censured; Cens=Censured; Caut=cautioned; NA=no action.

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