Spring 2021

The Twentieth Century Downfall of Professional Midwifery in Britain and its Gendered Connotation

Katherine Epstein
kit.epstein@gmail.com

The Twentieth Century Downfall of Professional Midwifery in Britain and its Gendered Connotation

By Katherine Epstein

Thesis Submitted to Trinity College History Department

Class of 2021

Table of Contents

Acknowledgements

To my advisor Professor Jennifer Regan-Lefebvre for making me fall in love with British History within my first semester at Trinity. Your support, patience, and knowledge throughout my four years in the History department have been immeasurable. You have pushed me to become a greater writer, reader, and critical thinker. Thank you.

To the entire Trinity College History Department for fostering an environment in which students are encouraged to think outside of the box and understand the past in a compassionate, critical way.

To my family for being my greatest support system and for putting up with my late night stress-induced phone calls in the midst of this project. I love you Mom, Dad, Harry, and Maggie.

To my St. Anthony Hall brothers for cheering me on for the past year. GSTDP.

Finally, to my Barcelona crew, thank you for being there since the first week of freshman year. I can't wait to take on life with you girls.

Introduction

To the modern day adult in Britain, the notion of pregnancy and the birthing process in general most likely forges a pictured ideal of a woman laying in a hospital bed, surrounded by beeping machines, adjacent beds, and various birth attendants. The idea of labor, the oldest natural human process, has become an inherently medicalized idea to the Western World. However, the practice of a wholly medicalized childbirth has not been, until recent history, the standard practice in Britain. Until the mid-twentieth century, the large majority of babies were being born at home within the care of a domiciliary midwife. For the most part, the use of a midwife was the standard course of care for all Britons. That is, until, the medical aristocracy and the British Government found political and economic interest in limiting the authority of the female midwife in all aspects of maternity care. Beginning in 1902, the care of the private British midwife has been invalidated and occupied by the medical gentry in an attempt to thrust the General Practitioner into the role of the primary birth attendant.

In this thesis, I will attempt to analyze and investigate the causes of the British midwife's professional demise through a gendered lens. I will examine the inner workings of midwifery legislation of the twentieth century in an effort to truly understand why the interests of the British midwife, after generations of trusted care, were placed on the political back burner. I aim to contribute to the modern discourse of maternity care by tracing the history of the midwife from her earliest recorded days in literature within the seventeenth century through the late twentieth century. I intend to make clear to the reader

how maternity care in Britain has been effectively transformed from that of a sacred place to an interventionist, medicalized process.

In Chapter One, I will provide critical historical context of midwifery to the reader in order to establish the importance of the position. The Biblical significance of the midwife will be discussed to set the stage for the introduction of Britain's first recorded midwife author, Jane Sharp. Jane Sharp's seventeenth century midwifery manual is the original published source advocating for a women-led maternity practice. She was the earliest author to fight for the autonomy and spiritual necessity of the female midwife. I then examine the writings of subsequent male authors of the seventeenth century in an attempt to draw a comparison of the earliest opinions in women leading medical care. Chapter One provides integral context for my analysis of twentieth-century legislation regulating midwifery, setting the stage for a gendered discussion of maternity care.

Chapter Two deals with the earliest legal regulation of midwifery care in 1902 spanning to the Midwives and Maternity Homes Act of 1926. I will analyze the national maternal mortality rate and its relation to midwifery legislation through careful readings of Government reports. I then go on to establish the Government's delusion in placing full blame on female midwives for maternal mortality rates. This Chapter aims to establish the British Government's untethered bias towards its female midwifery population.

In Chapter Three, I examine the causes and effects of the harshest and most regulatory piece of midwifery legislation, the Midwives Act of 1936. The Midwives Act of 1936 instituted a domiciliary service where midwives were directly salaried by the Local Supervising Authorities. This act ultimately placed the midwife's professional autonomy as a private worker into the hands of Government agencies. I will examine various

Parliamentary Records and Ministry of Health Reports to prove the destructive nature of such legislation to the British professional midwife.

Chapter Four deals with the midwife throughout the interwar period and her role under the National Health Service of 1948. This chapter examines how the 1942 Beveridge Report and the subsequent introduction of a universally free healthcare system under the National Health Service ultimately destabilized and displaced the British midwife. The National Health Service's strict midwifery regulation and recommendations for hospital birth were the culmination of five decades of the slowly-encroaching demise of the professional midwife. This chapter also examines how the Royal College of Obstetricians and Gynaecologists influenced Government committees to recommend majority hospital birth following the implementation of the National Health Service. Altogether, Chapter Four aims to substantiate my argument that the professional destruction of the midwifery practice was not only resolute, but politically and economically charged.

I will conclude this thesis by assessing the ever-present effects of twentieth century legislation on the British midwifery practice. Despite the work of organizations like the Association of Radical Midwives, a specialized group that continues to fight for a return to privatized, women-led midwifery, the overall rate of midwifery use in Britain has never fully recovered to its pre-1902 position. British midwives have been grievously written out of the nation's medical history and the canon of standard care.

It is my hope that this thesis will launch a conversation where the reader is inclined to understand and appreciate the position of midwifery in Britain's history of maternity care. It is my belief that midwives deserve the utmost respect for their tireless work as the

primary maternity attendant for generations of women. One can only hope that the next generation of British midwives can rebuild the practice to its strong and sacred role.

Chapter 1: History of Midwifery in Britain

I. History of Midwifery

II. Biblical Significance

To understand the plight of twentieth century British midwives as they watched the status of their profession be diminished by the government through the various Midwives Acts and the implementation of the National Health Service, one must first fully grasp the ancient historical and spiritual importance of midwifery. Without context, legislation regulating midwifery in Britain between 1902 and 1948 might seem modern and medically necessary in nature. However, as the history of midwifery is unveiled, one can see the parallels between the discreet banishment of midwives in the twentieth century from the medical elite and their predecessors three hundred years prior.

It is difficult to note the exact date of the creation of midwifery as a practice, as women have been involved in the birthing process since the dawn of time biblically. Nurse Mary Breckenridge discusses this notion in her 1927 article for the *American Journal of Public Health*, titled "The Nurse-Midwife - A Pioneer".[1] Breckenridge writes,

> "The midwife's calling is so ancient that the medical and nursing professions, in even their earliest traditions, are parvenus beside it. As a calling it is more than primaeval [sic] ; it is primordial. In the continental countries of the Old World where the calling has kept abreast of modern developments, the position of the midwife is dignified and assured, and something of her long descent is kept still in the names by which she is known -- 'wise woman' and 'earth mother'".[2]

---

[1]Mary Breckinridge , Director , Kentucky Committee for Mothers and Babies, Wendover, Ky. "THE NURSE-MIDWIFE—A PIONEER", American Journal of Public Health 17, no. 11 (November 1, 1927): pp. 1147-1151.
[2]Breckinridge, "THE NURSE-MIDWIFE—A PIONEER", 1147.

Breckenridge's assessment of midwifery as primordial is fascinating in that it places the practice ahead of standard doctors and nurses on the medicinal timeline. She asserts the midwife as a spiritual matriarch, the "earth mother".[3] To Breckenridge, the midwife is the original caregiver, and the original patron of life. Beyond her declaration of the midwife as a spiritual matriarch, Breckenridge reminds her reader of the midwife's role as the wise woman in the Old World. This conviction of midwifery as a spiritual, female-led practice can be dated back to the Bible, specifically within the Old Testament.[4]

Within the Old Testament/Hebrew Scriptures, the term midwife (translated from "hameyaledet" in Hebrew), is mentioned only ten times.[5] However, when mentioned, the "hameyaledet" is presented factually and not prefaced.[6] The fact that the "hameyaledet" bore no introduction suggests that the presence of the "hameyaledet" was already a constant during the times of the Old Testament around four thousand years ago.[7] Thus, as historians, we can assume the existence of female midwifery from the earliest points of recorded history. This assumption should come as no surprise logically. Sensibly, one must ask themselves the question: who better to assist in labor than somebody who has the anatomy to experience birth firsthand? The medical profession was dominated by men in the twentieth century, and midwifery is almost exclusively a female-led practice. Thus, the professional role of midwives is and always has been an inherently gendered issue.

---

[3]Breckinridge, "THE NURSE-MIDWIFE—A PIONEER", 1147.
[4]Theology of Work, "Exodus and Work: Bible Commentary," accessed October 29, 2020, https://www.theologyofwork.org/old-testament/exodus-and-work.
[5]Beth Overton, "Midwifery and the Bible Part I: Genesis 35: 16-18," 2001, https://www.ccbirthcenter.com/midwifery-bible-i/?doing_wp_cron=1604345400.9546859264373779296 87
[6]Overton, "Midwifery and the Bible Part I: Genesis 35: 16-18," 2001.
[7]Overton, "Midwifery and the Bible Part I: Genesis 35: 16-18," 2001.

The first explicit reference to midwifery in the Old Testament can be found in Genesis 35:16-17, when Rachel is giving birth to Joseph.[8] The passage reads,

> "And they moved on from Bethel, and there was still a distance of land before they came to Ephrathah. And Rachel began to give birth, and had it hard in her childbearing. And so it was, as she had a very hard time in her childbearing, that the midwife was saying to her, 'Don't be afraid, because this one also is a son for you".[9]

The fact that the Bible's first reference to midwifery is one where a midwife is actively consoling a woman in labor holds great historical significance. In Genesis 35:16-17, one is able to see the most original and raw task of the midwife – taking care of and supporting the mother throughout her labor. Genesis 35:16-17 is the first significant historical passage that shows the importance of the female midwife in birth, followed by Exodus 1:15-17.

Yet, Exodus 1:15-17 most greatly represents the biblical importance of the midwife. The passage reads, "The king of Egypt said to the Hebrew midwives, one of whom was named Shiphrah and the other Puah, 'When you act as midwives to the Hebrew women, and see them on the birthstool, if it is a boy, kill him; but if it is a girl, she shall live'. But the midwives feared God; they did not do as the king of Egypt commanded them, but they let the boys live".[10]

This passage presents midwives as some of the earliest fearful followers of God. The Hebrew midwives' choice to fear God over the king of Egypt shows their commitment to righteousness and the word of God himself. The Hebrew midwives chose to let the Hebrew

---

[8]Overton, "Midwifery and the Bible Part I: Genesis 35: 16-18," 2001.
[9]Gen. 35:16-17
[10]Exod. 1:15-17

population grow, aiding in God's commandment to be fruitful and multiply.[11] Thus, one is shown the primitive importance of the spiritual midwife and her moral duties. The midwife was the original caregiver and gatekeeper of life. In the Christianity-dominated culture of 20th century Britain, midwives were aware and protective of the long and spiritual legacy of their practice.

III. Ancient Society

The important work of the midwife progressed beyond biblical times and into the lives of women in Ancient Greece and Rome. In the fifth century, Hippocrates began a midwife training program in Athens, Greece.[12] Hippocrates' school of midwifery trained women in two groups: the "iatpouaiai", who were responsible for normal births, and emergency midwives.[13] Hippocrates' school of thought taught midwifery as a women-led practice, lending agency to the women within the practice.

Another leader of gynecology in antiquity was Soranus, a physician from Ephesus who practiced medicine in Alexandria and Rome.[14] Soranus published approximately twenty books during his time working in Rome, covering surgery, anatomy, hygiene, and more. However, one of Soranus' most revered works is his book on gynecology, which consists of two essential parts: one on midwifery, and one on the anatomy of obstetrics.[15] Soranus' *Gynaecology* is unique in his commitment to meticulous detail while explaining the midwife. He classified midwives into three categories, as opposed to Hippocrates' two

---

[11]Theology of Work, "Exodus and Work: Bible Commentary,".
[12]Judith Rooks, *Midwifery and Childbirth in America* (Philadelphia: Temple University Press, 1999).
[13]Helen King, *Midwifery, Obstetrics and the Rise of Gynaecology: the Uses of a Sixteenth-Century Compendium* (Place of publication not identified: Routledge, 2017).
[14]G. Tsoucalas, M. Karamanou, and M. Sgantoz, "Midwifery in Ancient Greece, Midwife of Gynaecologist-Obstretrician?," *Journal of Obstetrics and Gynaecology* 34, no. 6 (2014), https://doi.org/https://doi.org/10.3109/01443615.2014.911834.
[15]"Soranus' Gynecology," *Journal of the American Medical Association* 161, no. 1 (May 1956): p. 115, https://doi.org/10.1001/jama.1956.02970010117040.

category classification. [16] Yet, the main difference between Hippocrates and Soranus' views on midwifery is that, quite interestingly, Soranus believed that women could reach ranks in medicine to be considered equal to male physicians.[17]

In *Gynaecology*, Soranus writes that all midwives should be literate, have experience in all facets of medicine and obstetrics, be able to provide comfort and psychological advice, be spiritually healthy, understand pharmacology, and have a great memory.[18] Soranus held midwives in the highest regard, as his expectations for their work were equal to male physicians and required great skill. Soranus' expectations of the midwife made it possible for women in antiquity to be respected in medicine and carry great responsibility throughout the pregnancy process and labor.

At this point in time, it seems as though the practice of midwifery was absent of harsh male critique. Female midwives in ancient society were provided with the means to have agency over birth and labor. The work of men like Hippocrates and Soranus uplifted midwives. Although women were not allowed to become registered physicians amongst men, midwives held an honorable place in classical society that coincided with biblical passages. The respectable midwife status rang true until the eighteenth and nineteenth centuries, with the rise of the man-midwife.[19]

IV. History of Midwifery Manuals

[16]Tsoucalas, Karamanou, Sgantoz, "Midwifery in Ancient Greece, Midwife of Gynaecologist-Obstretrician?,"
[17]Tsoucalas, Karamanou, Sgantoz, "Midwifery in Ancient Greece, Midwife of Gynaecologist-Obstretrician?,"
[18] Tsoucalas, Karamanou, Sgantoz, "Midwifery in Ancient Greece, Midwife of Gynaecologist-Obstretrician?,"
[19]Anne Borsay, Billie Hunter, and Helen King, "Midwifery, 1700-1800: The Man-Midwife as Competitor," in *Nursing and Midwifery in Britain since 1700* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012), pp. 107-127, 108.

Historiographically, historical accounts of midwifery did not progress greatly until the early modern era of the sixteenth and seventeenth centuries.[20] As author and history professor Victoria Glover argues in her dissertation, prior to the sixteenth and seventeenth centuries, most physicians and midwives relied solely on the ancient teachings of Hippocrates, Galen, and Soranus to conduct obstetrics.[21] Knowledge from Galen's medical theories made their way to Britain in the beginning of the eleventh century through various trade routes, and became the canon for physicians to diagnose and treat various ailments until the mid-sixteenth century.[22]

In 1542, Flemish physician and anatomist Andreas Vesalius published *De Humani Corporis Fabrica (On The Structure of the Human Body)*, which became the new and improved standard for medical diagnoses.[23] Vesalius was a proponent of cadaver dissection, a practice that had always been looked down upon by the Roman Catholic church.[24] Vesalius' revolutionary cadaver work was the first of its kind to accurately display the function and location of every human organ, greatly improving medical care across the board. The expertise published by Vesalius made its way into all medical written work of the time, including manuals. Soon thereafter, books known as midwifery manuals began to be printed across Europe.

Originally, early modern era midwifery manuals were printed solely in Latin, limiting the reach of such books to educated, elite physicians.[25] Yet, as the rate of literacy rose across

---

[20]Victoria E. C. Glover, "'To Conceive with Child Is the Earnest Desire If Not of All, Yet of Most Women': the Advancement of Prenatal Care and Childbirth in Early Modern England: 1500-1770" (dissertation, VCU Scholars Compass, 2018), 7.
[21]Victoria E. C. Glover, "'To Conceive with Child Is the Earnest Desire If Not of All, Yet of Most Women': the Advancement of Prenatal Care and Childbirth in Early Modern England: 1500-1770"6.
[22]Glover, 6.
[23]Glover, 6.
[24]Glover, 6.
[25]Glover, 7.

Europe in the sixteenth and seventeenth centuries, so did the publication of midwifery manuals in standard English.[26] Authors of midwifery manuals intended to spread medical knowledge of childbirth and pregnancy to physicians across Europe, thus proliferating and modernizing the standard of medicine. Additionally, the knowledge shared in midwifery manuals was meant to be used to decrease infant mortality rates and repopulate the continent after fourteenth century plagues.[27] Manuals typically included chapters on anatomy, pregnancy, herbal medicine, ailments, and how to conduct labor. Acting a step-by-step guide through labor and childbirth, midwifery manuals quickly became the medical standard in educating midwives and physicians across Europe.

V. Introduction to Jane Sharp

In 1671, Jane Sharp published the first edition of her midwifery manual, *The Midwives Book*. Jane Sharp was the first woman of Britain to publish a midwifery manual, working as a midwife for approximately thirty years before writing her book.[28] Unsurprisingly, Sharp published *The Midwives Book* under a pseudonym, never revealing her true identity throughout her work. Many female writers of the early modern era published their work under a pseudonym to avoid ridicule and unwanted attention from critics.

At the time of *The Midwives Book* publishing in 1671, almost all of British babies were born at home. Midwives like Jane Sharp were responsible not only for the labor and delivery of the baby, but ante and postnatal care including psychological guidance and church practices.[29] Midwives were regularly present at baptisms and church dedications

[26]Glover, 9.
[27]Glover, 8.
[28]Jane Sharp, *The Midwives Book, or, The Whole Art of Midwifry Discovered*, ed. Elaine Hobby (New York, New York: Oxford University Press, 1999), xii.
[29]Jane Sharp, *The Midwives Book, or, The Whole Art of Midwifry Discovered, xiii.*

throughout the sixteenth and seventeenth centuries.[30] In Britain, midwives like Sharp were able to earn a comfortable salary through their work, garnering economic independence and agency over their livelihoods.[31] Yet, to legally practice midwifery in the seventeenth century, women were supposed to obtain a "bishop's license" from the church, costing around two pounds each -- a large sum of money at time.[32]

However, it is estimated that a large portion of working midwives in the seventeenth century performed their duties without a license, as many did not have the means to pursue and obtain a bishop's license.[33] Several midwives simply inherited their jobs from grandmothers, mothers, and other women in their neighborhoods.[34] Midwifery acted as a community builder throughout Britain, a livelihood passed down from generation to generation and taught through hands-on experience at births.[35] Additionally, according to Sharp herself, owning a bishop's license simply was not seen as the most important qualification of midwifery at the time. More important to the midwife was the continued careful care of the mother and baby before, during, and after birth.

And, in contrast to the opinions of several male physicians of the early modern era, the midwives of Sharp's time did just that. It is estimated that eighty five percent of babies in the late seventeenth century survived into early-childhood and that mothers had a less than ten percent risk of dying during labor with a midwife by their side.[36] Although these mortality figures may seem bleak to a modern-day reader, they are quite impressive when one considers the epidemics and general lack of medicine that was plaguing Britain

---

[30]Sharp, *xiii.*
[31]Sharp, *xiii.*
[32]Sharp, *xiii.*
[33]Sharp, *xiv.*
[34]Sharp, *xiii.*
[35]Sharp, *xiv.*
[36]Sharp, *xv.*

throughout the seventeenth century and beyond. Essentially – midwives like Jane Sharp did their jobs and did them well.

Yet, what makes Sharp's writings so revolutionary is the fact that they were the first of their kind to claim that midwifery should be a women-led practice in every way.[37] Sharp argued that communities of female midwives were the figurative glue holding towns together, and should be treated with the utmost respect.

Sharp's publication of *The Midwives Book* is feminist in nature, a notion that becomes quite clear when examining midwifery manuals written in the same time period. Yet, it is important to note that what one describes as feminist in modern did not exist in theory in 1671. I intend to prove that Sharp's message is feminist because she argues for a women-led midwifery practice, not because she labels herself as a feminist.

VI. The Male View

Every other midwifery manual published in the seventeenth century was written by a man. Men like William Sermon and Nicholas Culpeper, who wrote *The Ladies Companion* (1671) and *A Directory for Midwives* (1656), wrote full manuals for midwives -- despite not being midwives themselves.[38] Culpeper's manual doesn't even include a chapter on the birthing process, as he admitted that he had never actually attended one before writing his book.[39]

Although there is scarcely any records of midwifery response to written manuals, one can look at the 1634 petition of Doctor Peter Chamberlen as the prime example of female response towards male infiltration into the practice in the seventeenth century.[40]

---

[37]Sharp, *xiii.*
[38]Sharp, *xvii.*
[39]Sharp, *xviii.*
[40]Peter M Dunn, "The Chamberlen Family (1560-1728) and Obstetric Forceps," *Archives of Disease in Childhood - Fetal and Neonatal Edition* 81, no. 3 (1999), https://doi.org/10.1136/fn.81.3.f232, 233.

Peter Chamberlen, widely known as the son of the inventor of the Chamberlen Forceps, was a leading physician in seventeenth century Britain. Being the son of the man who created birth forceps, Chamberlen saw that it was his right to become the leader of all British midwives. In 1634, Chamberlen petitioned the King to create a Corporation of London Midwives under the guise that he would become the chief president and examiner.[41] A Corporation in the time of 1634 was essentially what one would describe as an organization today.

The petition was denied by the King, seen as so egregious that it garnered a personal response from midwives at the College of Physicians, which stated:

> "Neither can Dr Chamberlane teach the art of midwifery in most births because he hath no experience in itt but by reading and it must bee continuall practise in this kind that will bringe experience, and those women that desire to learn must be present at the deliv'y of many women and see the worke and behaviour of such as be skilfull midwives who will shew and direct them and resolve their doubts".[42]

This statement from the London midwives is one of the only responses to male involvement in midwifery recorded from the seventeenth century, until Sharp's manual in 1671. Clearly, along with the King, the midwives found Chamberlen's appointment of himself as the president of a hypothetical Corporation of London Midwives ridiculous, as he was not a seasoned midwife himself. The protective ethos of this statement is echoed in Sharp's *The Midwives Book.*

To garner another male perspective of midwives at the time, one can look to John Maubray, a practicing physician who published his manual *The Female Physician* in 1724. In

[41]Dunn, "The Chamberlen Family (1560-1728) and Obstetric Forceps," 233.
[42]Dunn, 233.

the introduction to his book, Maubray writes, “She ought not to be too fat or gross, but especially not to have thick or fleshy hands and arms, or large-boned writs; She ought to be patient and pleasant; soft, meek, and mild in her temper”.[43] Although Maubray’s writing is almost laughable to any modern-day historian, the fact that he chose to lead his manual by detailing the looks and nature of his ideal midwife shows just how little he knew of the practice. In reality, a midwife having “fleshy hands and arms” bears no consequence in her ability to safely deliver a baby. If that were the case, male obstetricians with large arms and hands in the twentieth century would have been at a great disadvantage in their catapult to success. That, of course, did not happen. Maubray is certain in his descriptions of a not-too-fat and not-too-gross midwife, projecting the same type of unsolicited confidence as Peter Chamberlen in 1634.

One can also look to James Hobson Aveling’s *English Midwives, Their History and Prospects* (1871) to fully grasp the male opinion of midwifery in early Britain.[44] James Hobson Aveling was an obstetrician and gynecologist operating in the 19th century who largely wrote about the history of seventeenth century male midwifery manuals. Although he was not one of the men who published a midwifery manual without ever attending to a birth, Aveling’s opinions regarding the early midwifery practice represent a continuity between what Sharp was so fiercely attempting to dismantle in her manual. Aveling’s opinion towards females in midwifery can be summed up by his choice of quoting medical journal *Lancet* in his foreword in *English Midwives, Their History and Prospects:*

> “Until a respectable, well-educated class of females are brought up exclusively to midwifery as a profession and in a school for that purpose, undergo an examination

[43]John Maubray, *The Female Physician*, 1724, 1.
[44]British Medical Journal, “British Medical Journal ,” *OBITUARY* 2, no. 1668 (December 17, 1892): pp. 1349-1350, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2421653/?page=1, 1349.

> by a college of professors, receive certificates of their proficiency from that college, and by Act of Parliament are thus permitted to practise, I am decidedly of opinion the employment of women will always be replete with danger both to mother and child".[45]

Aveling's use of this quote, one that prefaces his misogynistic book that repeatedly calls midwifery the "dark ages", sets the stage for his summaries of midwifery up until the late nineteenth century.[46] By using the term "class of females", Aveling is clearly not only arguing for greater training of midwives as a profession, but against classes of women as a whole. He is distinguishing women into their own uneducated class, a notion so classist it is almost unbelievable that it came from the publication of a well-regarded physician. Aveling even goes so far as to claim that "At this period the man - midwife was not employed in ordinary cases, his assistance being only sought when instrumental interference became necessary. A strong and deeply-rooted prejudice existed against the male practitioner in midwifery, and the midwives themselves, although they were glad enough to have his assistance when in difficulties, were, on all other occasions, more violent than any other class in denouncing him".[47]

These little jabs of misogynistic writings are present throughout the whole of Aveling's writings. These types of claims, which essentially allude to the fact that women were violent in denouncing men in a practice that literally translates to "with-woman" are unsurprising, yet still rather disappointing coming from a man of such high regard. Although Aveling is a reputable and educated source in terms of obstetrical knowledge, his

---

[45]James Hobson Aveling, *English Midwives, Their History and Prospects* (London: J. & A. Churchill, New Burlington Street, 1991).
[46]James Hobson Aveling, *English Midwives, Their History and Prospects*.
[47]Aveling, 57.

choice of language and use of quotes is fundamentally chauvinistic. Aveling's writing shows the same level of disconnect from the point midwifery as those written by Maubray and Culpeper.

Unsurprisingly, the writings of seventeenth century male-midwife Percival Willughby show the same level of disdain towards his female counterparts. Yet, Willughby's work differs from that of Aveling or Culpeper in that he was a legitimate midwife. Willughby's unfinished book, *Observations in Midwifery*, is mostly just untethered rage towards women midwives. He calls them ignorant and suggests that they are far too invasive throughout the entire birthing process.[48] That is until, he, perhaps unknowingly, undermines his own characterization of the female midwife in a passage, stating,

> "In my first dayes of ignorance, I thought that it was the best way to suffer midwives to stretch the labia vulvae with their hands and fingers, when the throwes approached. But friendly nature in time shewed mee my mistaking errour. Through the remoteness and the large distance of several places where unto I was called, the women, in the mean time, keeping the labouring woman warm and quiet, and the midwife desisting from using violence, by such usage I found the woman oft happily delivered before my coming".[49]

This revelation from Willughby's *Observations in Midwifery* is fascinating in that, for the first time, he is admitting the skill and care of the female midwife. Not only that, Willughby is admitting his previous thoughtless mistreatment towards the woman in labor, a mistreatment that could only come from a place of unfamiliarity with the extent of pain that the woman could experience. Obviously, Willughby did not know the pain that could be caused from the violent gesture of quickly stretching the labia vulvae during labor, as he

[48]Sharp, *xxiii.*
[49]Sharp, *xxiv.*

did not possess that body part. Thus, he is essentially divulging the fact that male midwives were more likely to be unable to truly conceive the pain and process of a laboring mother, as they could never and will never go through the process themselves. Now, this is not to say that a doctor is inherently incompetent in his inability to treat a patient without being able to firsthand experience the same type of pain. However, Willughbhy's passage reveals an incomprehension and a lack of compassion towards his female patient. The lack of understanding towards female patients presented in *Observations in Midwifery* ultimately reveals a level of neciense towards the female body and medical experience. In this passage, Willughby is unintentionally proving Jane Sharp's assertion that midwifery must be a female-led practice.

In order to fully understand the absurdity of Aveling, Maubry, Culpeper, Willughby, and Chamberlen, one can compare their writing styles to Jane Sharp's, who in 1671, was able to communicate a thoughtful and spiritual argument in making midwifery a female-led practice.

VII. Sharp's Message

Jane Sharp does not employ language that aims to strip women of midwifery down. In fact, she does quite the opposite. In Sharp's introduction, she expresses concern over the untrained midwife. Yet, she does so in a way that is uplifting, writing:

"Sisters, I have often sat down sad in consideration of the many miseries women endure in the hands of unskilful midwives. I have been at great cost in translations for all books, either French, Dutch, or Italia, of the kind. All which I offer with my own experience;

humbly begging Almighty God to aid you in this great work; and am your affectionate friend, Jane Sharp".[50]

Sharp refers to her fellow midwives as sisters, an intentional choice in wording that creates a familial bond between Sharp and her coworkers. She goes on to express her desire to have *The Midwives Book* translated, so that midwives all over Europe can learn from her thirty years of experience. Sharp's subsequent labelling of herself as a friend to all of the midwives reading her book places her in a maternal position of the profession. This warm and maternal language must not go unnoticed. Sharp's language in this passage reveals not only her compassionate nature, but how she views midwifery as a whole. The community of midwives were to be sisters united in a female practice, inspiring and uplifting one another to do better for the mother.

Sharp's manual is not only feminist in its introductory message to other midwives, but in its actual content. Sharp's midwifery manual outwardly champions female sexuality, a rather taboo topic of the time. Unlike her male counterparts manuals, Sharp did not only discuss male anatomy in detail. She does not romanticize the male "yard", but rather explains its function in relation to impregnation.[51]

In her descriptions of female anatomy, Sharp explicitly describes the clitoris in comparison to the penis, writing "this clitoris will stand and fall as the Yard doth, and makes women lustuff and take delight in Copulation, and were it not for this they would have no desire nor delight, nor would they ever conceive".[52] Sharp's decision to not only include a chapter on female sexuality in her manual, but to state that female delight in sex is

[50]Aveling, 48.
[51]Sharp, *28.*
[52]Sharp, *39.*

necessary for conception, is shocking. Although in modern day it is known that female orgasm is not necessary for conception, it says quite a lot about Sharp's feminist plight that she chose to include such instruction. Sharp wanted not only the process of labor to be enjoyable to women, but sex, too.

Beyond her chapters on female anatomy and conception, Sharp devotes ample reporting to instructing midwives in how to deal with actual labor, miscarriages, barrenness, various ailments that arise during pregnancy, antenatal care, and early care of the infant.[53] In chapter five of the manual, Sharp describes how women should be cared for after labor. She writes, "There is great difference in women's constitutions and education; you may kill one with that which will preserve the other; tender women that are bred delicately must not be governed after the same manner that hardy country women must, for one is commonly weak stomached, but the other is strong".[54] Again, the reader can observe a distinct sense of knowledge in Sharp's understanding of the woman. She is purposeful in explaining that antenatal care is not a one-size-fits-all experience. Moreover, one can sense Sharp's devotion to the instruction of proper midwifery care. She not only instructed her peers to attend to a birth with personalized care, but to provide personalized care to the mother in the days and weeks after labor. This notion of personalized care is pinnacle to the practice of midwifery and its feminist roots.

Yet, the crux of Jane Sharp's feminist argument in the writing of her manual is the notion that midwifery should be a women-led practice. In the introduction of *The Midwives Book,* Sharp writes, "Some perhaps may think, that then it is not proper for women to be of this profession, because they cannot attain so rarely to the knowledge of things as men may,

[53]Sharp, *9.*
[54]Sharp, *175.*

who are bred up in Universities, Schools of learning, or service for their Apprenticeships for that end and purpose, weer Anatomy Lectures being frequently read. [...] But that objection is easily answered, by the former example of the Midwives amongst the Israelites, for though we women cannot deny, that men in some things may come to a greater perfection of knowledge than women ordinarily can; yet the holy Scriptures hath recorded Midwives to the perpetual honour of the female sex".[55] Sharp even goes on to say, "I cannot deny the honor due to able physicians and chyrugions, when occasion is: Yet, we find that even amongst the Indians, and all barbarous people, where there is no Men of Learning, the women are sufficient to perform this duty".[56]

What is so fascinating about Sharp's statement in this introduction is that she is speaking from the defense, sharply aware of men's doubts of women in midwifery. She knows that people will doubt a woman's place in the medical world, and chooses to defend it right off the bat in the first few pages of her manual.

When Sharp mentions the fact that men are allowed greater education in universities and apprenticeships, she is essentially naming the injustices that midwives endure. Her choice to list the various academic achievements that most men in the medical field obtain is no accident. Sharp is disguising her call to action as praise for the "Men of Learning".[57] Sharp's disclaimer is clever -- she attempts to suppress the anger of her male counterparts while simultaneously proving that she and other midwives can do their jobs just as well, if not better than the competition.

---

[55]Sharp, *12.*
[56]Sharp, *12*.
[57]Sharp, *12*

Additionally, by attributing midwifery as a female-led practice to the Holy Scriptures, Sharp assigns a historically spiritual value to the practice. This attribution is historically accurate, as midwives were routinely asked by the church to baptize the children they delivered beginning as early as the seventh century.[58] Although British midwives ended baptism practices in the seventeenth century, over four thousand years of religious procedures established midwifery as a highly spiritual practice.[59]

Sharp's assertion of midwifery's spiritual history is critical to her feminist ideology. Little did she know, her plight to keep midwifery in the hands of expert women would still be in debate over three hundred years later when legislation to regulate midwifery was first introduced in Britain in 1902. Whether the midwives of the twentieth century were fully aware of it or not, they were embedded in a feminist and anti-establishlment enterprise in their daily work to keep midwifery an internally-run, private practice.

[58]Aveling, 4.
[59]Aveling, 4.

Chapter One Bibliography

Aveling, James Hobson. *English Midwives, Their History and Prospects*. London: J. & A. Churchill, New Burlington Street, 1991.

Breckinridge, Mary. "THE NURSE-MIDWIFE— A PIONEER, American Journal of Public Health." DeepDyve. American Public Health Association, November 1, 1927. https://www.deepdyve.com/lp/american-public-health-association/the-nurse-midwife-a-pioneer-ZRb9UdTJuF.

British Medical Journal. "British Medical Journal ." *OBITUARY* 2, no. 1668 (December 17, 1892): 1349–50. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2421653/?page=1.

Dunn, Peter M. "The Chamberlen Family (1560-1728) and Obstetric Forceps." *Archives of Disease in Childhood - Fetal and Neonatal Edition* 81, no. 3 (1999). https://doi.org/10.1136/fn.81.3.f232.

Glover, Victoria E. C. "'To Conceive with Child Is the Earnest Desire If Not of All, Yet of Most Women': the Advancement of Prenatal Care and Childbirth in Early Modern England: 1500-1770." Dissertation, VCU Scholars Compass, 2018.

Hunter, Billie. *Nursing and Midwifery in Britain since 1700*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012.

King, Helen. *Midwifery, Obstetrics and the Rise of Gynaecology: the Uses of a Sixteenth-Century Compendium*. Place of publication not identified: Routledge, 2017.

Maubray, John. *The Female Physician*, 1724.

Nuttall, Alison. "Midwifery, 1800-1920: The Journey To Registration." Essay. In *Nursing and Midwifery in Britain since 1700*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012

Overton, Beth. "Midwifery and the Bible Part I: Genesis 35: 16-18," 2001. https://www.ccbirthcenter.com/midwifery-bible-i/?doing_wp_cron=1604345400.9546859264373779296875.

Rooks, Judith. *Midwifery and Childbirth in America*. Philadelphia: Temple University Press, 1999.

Sharp, Jane. *The Midwives Book: or the Whole Art of Midwifry Discovered*. Edited by Elaine Hobby. New York: Oxford University Press, 1999.

"Soranus' Gynecology." *Journal of the American Medical Association* 161, no. 1 (1956): 115. https://doi.org/10.1001/jama.1956.029700101170

Theology of Work. "Exodus and Work: Bible Commentary." Accessed October 29, 2020. https://www.theologyofwork.org/old-testament/exodus-and-work.

Tsoucalas, G., M. Karamanou, and M. Sgantoz. "Midwifery in Ancient Greece, Midwife of Gynaecologist-Obstretrician?" *Journal of Obstetrics and Gynaecology* 34, no. 6 (2014). https://doi.org/https://doi.org/10.3109/01443615.2014.911834.

Chapter 2: The Professional Midwife

In the first decade of the twentieth century, the British government embarked on its earliest legal regulation of midwifery. Early legislation that regulated midwifery was encouraged in Parliament by the Midwives Institute, an organization that claimed to operate as the fighting voice for all British midwives. However, the passage of the Midwives Act of 1902 can be traced back to the likeness of the aristocratic medical elite and their interests. In this chapter, the pitfalls of the twentieth century Midwives Acts up until the act of 1936 will be examined, revealing the bureaucratic and misogynistic snowball effect that later became the degradation of the midwife through the 1948 creation of the National Health Service. This chapter will discuss the Midwives Act of 1902, 1918, and 1926.

I. The First Midwives Act

The 1902 Midwives Act was the first piece of British legislation that directly regulated and legally recognized midwifery and those who could participate in the practice. The largest aspect of the 1902 Midwives Act was the creation of the Central Midwives Board, a group that registered, kept track of, and regulated the standard practice of midwives throughout Britain.[60] The Central Midwives Board sought to legitimize the profession of midwifery to the rest of the medical community, attempting to keep the midwives on its roll in good moral character and following the board's "Rules of Practice".[61]

---

[60]"The Midwives Act 1902," Policy Navigator (The Health Foundation), accessed January 18, 2021, https://navigator.health.org.uk/theme/midwives-act-1902#:~:text=The%201902%20Midwives%20Act%20created,the%20regulation%20of%20their%20practice.&text=Records%20of%20the%20Central%20Midwives,The%20National%20Archives%3B%20nd.

[61]Eileen Richardson, "Midwifery in Britain in the Twentieth Century," Midwifery in Britain in the Twentieth Century - Memories of Nursing, 2009, https://memoriesofnursing.uk/articles/midwifery-in-britain-in-the-twentieth-century#:~:text=Midwifery%20became%20legally%20recognised%20in,with%20the%20first%20Midwives%20Act.&text=The%20Midwives%20Act%20allowed%20for,the%20time%20(Heagerty%201997).

Whilst examining the government's actions to monitor midwifery, it is critically important to note that the Central Midwives Board did not see the need for a midwife member until 1920, eighteen years after the creation of the organization.[62]

Following the passage of the 1902 Midwives Act, midwives had to obtain a midwifery certificate from the LOS (London Obstetrical Society) to continue their practice.[63] The London Obstetrical Society was founded in 1858 by Doctor Granville of London, acting as the main predecessor to the Royal College of Obstetricians and Gynaecologists.[64] Granville had attempted to create the LOS thirty years prior, yet had been met with contempt from his fellow physicians in London. Henry Halford, who was the president of the Royal College of Physicians from 1820 to 1844, wrote to Sir Robert Peel at the time of Granville's attempted creation of the LOS stating that "midwifery was an unfit occupation for gentlemen of an academical education".[65] Thus, Granville was truly doing a public service when he decided to finally create the LOS, despite his colleague's blatant misogynistic view of midwifery as a profession. From 1902 onwards, The Central Midwives Board worked alongside the London Obstetrical Society to ensure that all midwives on their roll had obtained a LOS license and were practitioners in good moral standing.

It is important to note that the introduction of the 1902 Midwives Act was influenced largely by the Medical Registration Act of 1858, an act that aimed to oversee registration and standards for physicians throughout Britain.[66] The 1902 Midwives Act mirrored the Medical Registration Act in its expectations for legitimate medical

---

[62]Eileen Richardson, "Midwifery in Britain in the Twentieth Century,".
[63]"The Midwives Act 1902." Policy Navigator.
[64]Humphrey G Arthure, "The London Obstetrical Society," *Proceedings of the Royal Society of Medicine* 62, no. 4 (1969): pp. 363-366, https://doi.org/10.1177/003591576906200428.
[65]Arthure, "The London Obstetrical Society," *Proceedings of the Royal Society of Medicine* 62, no. 4
[66]Alison Nuttall, "Midwifery, 1800-1920: The Journey To Registration," in *Nursing and Midwifery in Britain since 1700* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012), 134.

qualifications for practicing. Yet, in the years leading up to 1902, midwifery, as a practice, was subject to various attacks by the male-dominated medical elite.

According to historian Alison Nuttall, when the revised 1886 Medical Registration Act required that all registered physicians be knowledgeable of basic midwifery practice, medical schools across Britain found themselves at a loss.[67] Medical schools were unable to find enough maternity cases to provide adequate teaching to their students, as the majority of cases were being overseen by registered midwives. Thus, due to the frustration of medical school administrations, the General Medical Council formally withdrew its support for the legal registration of midwifery. In turn, the London Obstetrical Society was forced to change the wording of its training certificate, as the board of the General Medical Council claimed it to be "colourable [sic] imitations of a medical diploma".[68]

General practitioners, following the leadership of their council, became increasingly agitated towards midwives. Nuttall explains that due to general practitioners' anger towards midwives following the 1886 Medical Registration Act, a Select Committee was established to inquire into the need for registration.[69] The Select Committee found that, "a serious amount of suffering and permanent injury to women and children is caused from the inefficiency and want of skill of many of the women practicing [sic] as midwives".[70] Even after this critical report from the select committee, which emphasized the need for highly trained midwives, the Midwives Act of 1902 did not pass in Parliament until five failed attempts later.

---

[67]Nuttall, "Midwifery, 1800-1920: The Journey To Registration," 138.
[68]Nuttall, 138.
[69]Nuttall, 138.
[70]Nuttall, 139.

Thus, what began as an attempt to hold midwifery to a greater standard of modern medical advancements became a gendered debate. When male physicians were expected to study the basics of midwifery in 1868, female midwives were degraded, insulted, and faced mockery for their medical accomplishments. Yet, when those same women attempted to inflict change and hold their profession to the same standards as men after a Select Committee report, legislation failed for over five years. For midwives across Britain in the years leading up to 1902, it seemed as though there was no way to win when it came to professionalization.

After 1902, informally trained midwives were forced to shift their practice. By 1905, every single practicing midwife had to be fully registered by the London Obstetrical Society as a "bona fide" midwife.[71] The "bona fide" midwife was not formally trained, but still regulated by the Central Midwives Board. Additionally, 34 Inspectors of Midwives were quickly appointed by the Central Midwives Board in 1905 to strictly watch midwives in all regions of the UK.

Yet, by 1910, "bona fide" midwives were no longer able to operate legally unless supervised by a LOS-certified midwife or a physician.[72] However, Nuttall claims that several of the handy-women (untrained and uncertified) midwives that became outlawed the 1902 Midwives Act continued to practice in secrecy in rural, poor areas until the early 1930s.[73] Additionally, even as midwifery continued to become tangled in national legislation and Inspectors were sent to rural areas, several certified midwives found themselves continuing

---

[71]Alice Reid, "Birth Attendants and Midwifery Practice in Early Twentieth-Century Derbyshire," *Social History of Medicine* 25, no. 2 (May 2012): pp. 380-399, https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.270.8471&rep=rep1&type=pdf, 380.
[72]Richardson, "Midwifery in Britain in the Twentieth Century,".
[73]Reid, 381.

to practice in the ways they had been taught prior to the legislation.[74] According to the Association of Radical Midwives, Nurse Davies, continued "to practice as she had been taught by her mother to the hour of her death, placing her faith in herbal tonics and strict cleanliness".[75] Traditions of traditional midwifery continued, and the majority of women continued to have their babies delivered by midwives at home until the latter half of the twentieth century.

Although the Midwives Act of 1902 can be credited with an attempt to advance the profession of midwifery through greater regulation by the state, a question must be posed: who was this act truly made for? According to British historian Marjorie Mcintosh, the 1902 Midwives Acts had "'more of an impact on doctors' impressions of midwives than on the way midwifery was actually practiced of the type of women undertaking it'".[76]

In truth, the Midwives Act of 1902 did not aim to represent the midwives of rural UK, and rather the interests of the aristocratic physicians in London. In the first decade of the twentieth century, two new organizations were founded in Britain, the British Union of Midwives and National Association of Midwives. According to Nuttall, the British Union of Midwives and the National Association of Midwives released statements asserting that because midwives were not a part of their own, self-ran association when the Midwives Act of 1902 was passed, "the Institute had 'no moral right to the title which it assumed[d]'".[77] The statement also read that they "'not need to be fussed over and patronized, They [were] tired of 'charity-mongers' – they [were] sick of being 'bossed'".[78]

---

[74]Nuttall, 141.
[75]Nuttall, 141.
[76]Reid, 382.
[77]Nuttall, 141.
[78]Nuttall, 141.

The statements from the British Union of Midwives and the National Association of Midwives mirror the same thought as the work of Jane Sharp. There is a level of continuity between the midwives in the early twentieth century and the seventeenth century midwives like Sharp – a sharp awareness of their profession's vulnerability. The same fear and cognizance of male power in medicine that pushed Sharp to publish *The Midwives Book* and empower her fellow sisters existed in the words of the British Union of Midwives and National Association of Midwives.

Nuttall's inclusion of the words of the British Union of Midwives and National Association of Midwives reveals a historiographical record of midwife resistance towards the bureaucratization process, a record that has been sparsely reported on until the creation of the Association of Radical Midwives in 1976. The Midwives Institute has long been regarded as the fighting force behind the progression of midwifery. Yet, as British Union of Midwives and National Association of Midwives revealed – this was hardly the case. The early professionalization of midwifery was a nuanced development, a process that ultimately kickstarted the decline of midwives in the UK as a whole.

II. Continued Legislation

Following the Midwives Act of 1902, midwifery continued its path towards greater governmental control. Throughout the 1920s and 1930s, midwifery was hard-pressed with criticism, despite the fact that most British babies were still being born at home until the implementation of the National Health Service in 1946. Three additional midwives were passed under the Central Midwives Board post-1902, in 1918, 1926, and 1936.[79] All three of these acts were a culmination of the government's continued support of greater

[79]Nuttall, 152.

supervision of midwifery. Whilst examining the government's actions to monitor midwifery post-1902, it is critically important to note that the Central Midwives Board did not see the need for a midwife member until 1920, eighteen years after the creation of the organization.[80] Thus, the notion that the British medical elite genuinely valued the voice of the midwife is not only debatable, but superfluous.

Nevertheless, according to Reid, when a 1902 government report found that only two out of five Boer War army recruits were suitable to become active soldiers, concern over birth rate and maternal health escalated in Britain.[81] Thus, the 1907 Notification of Birth Act was created. This Act required that all births be reported to the Medical Officer of Health in the designated district where labor occurred within thirty-six hours of the child being born.[82] Medical officers were then required to visit the home of the mother to instruct and advise the family on how to better care for their infant to guarantee higher rates of survival.[83] The data submitted to the Medical Office of Health required the name and registration number of the practicing midwife. By 1915, the Notification of Birth Act was one hundred percent compulsory across England and Wales.[84]

Reid's article specifically examines the work of midwives in Derbyshire between 1917 and 1922, using a data set obtained from birth registers at the time. In terms of historiography, Reid's choice to use Derbyshire as her place of analysis is ideal as a control group. Derbyshire has a strong urban-rural combination, allowing it "to serve as a reasonably representative example of early twentieth-century England".[85] The data set

[80]Nuttall, 140.
[81]Reid, 383.
[82]Reid, 383.
[83]Reid, 383.
[84]Reid, 383.
[85]Reid, 384.

reports that over half of the doctors in Derbyshire delivered less than two babies per year, while 76-79 percent of babies were delivered by midwife.[86] This data is particularly fascinating in that the original Insurance Act was passed in 1911, which, among establishing Britain's modern welfare state, guaranteed thirty shillings of maternity benefit payment to the wives of employed men.[87] Despite the fact that wives of working men in Derbyshire were awarded this additional welfare payment, Reid's data makes it clear that pregnant women still chose midwives as their preferred method of maternal care. It seems as though no amount of government involvement could break the spirit of British midwives in the 1920s, even with literal inspections from the Central Midwives Board.

Despite the overwhelming data citing midwives as the consistent delivery attendant in Derbyshire between 1917 and 1922, incessant inspection from health officials under the Central Midwives Board persisted. According to the same data set from the Medical Office of Health, Derbyshire midwife inspectors made approximately 750-800 inspections of midwives per year between the years of 1916 and 1924.[88] These inspections reveal that midwives, despite their continued role as the main caregiver to laboring women and adherence to higher training requirements from the Central Midwives Board, were met with distrust. The distrust of midwives in early twentieth century Britain, shown in Reid's dataset of Derbyshire, preserves and perpetuates the centuries-long model of the unfit and suspect midwife presented by Aveling and other male practitioners in the seventeenth century.

III. Midwives Acts of 1918

[86]Reid, 388.
[87]Reid, 391.
[88]Reid, 390.

In 1918, a second Midwives Act was passed following the absolute devastation of the First World War. With close to a million British soldiers dead by 1918, the United Kingdom found itself in a state of reconstruction, grief, and disbelief. Although this thesis does not aim to analyze the harrowing effects of World War One, its effect on the general concern for population and subsequent legislation must be noted. More than ever, post-war Britain was anxiously aware of its need to repopulate and create a space where birth was a priority.

The Midwives Act of 1918 was largely created to amend and improve the original 1902 Midwives Act, adding greater specificities and eliminating any ambiguity. The 1918 Act encouraged Local Supervising Authorities, under the guise of the Central Midwives Board, to make greater use of midwife suspension in pending cases and to further raise the standard of care.[89] The act made the Local Supervising Authorities the main authority when dealing with midwives and maternal homes, extending the overarching power of the Central Midwives Board.[90] Essentially, the Midwives Act of 1918 pushed board-controlled local authorities to be even more involved in their region's maternal care in the wake of devastating population loss.

In the wake of the creation of the Ministry of Health in 1919, the role of the Local Supervising Authorities became even stronger.[91] The Ministry of Health gifted grants to Local Supervising Authorities to extend their outreach in communities, increasing numbers of health visitors and encouraging greater registration for a Central Midwives Board certificate for general nurses.[92] Additionally, Local Supervising Authorities were encouraged to create new maternity clinics, nurseries, and provide free cheap food for new

[89]Hester Viney, "The English Midwifery Service, *"The American Journal of Nursing* 30, no. 4 (1930): pp. 408-12, doi:10.2307/3411155, 409.
[90]Viney, 409.
[91]Viney, 410.
[92]Viney, 410.

mothers.[93] Although such changes were not made compulsory through the Midwives Act of 1918, the influence of Local Supervising Authorities on the work of midwives continued to grow.

IV. The Midwives and Maternity Homes Act

In 1926, a third Midwives Act was introduced, titled The Midwives and Maternity Homes Act.[94] Hester Viney claims in his 1930 article, "The English Midwifery Service", published in the *American Journal of Nursing*, that

> "From 1918 onwards, the question of the maternal mortality rate attracted public attention, and its persistently high level in the face of so much effort in the direction of health for mothers and children aroused alarm and criticism. Public attention concentrated upon two aspects of the questions upon the whole practice of midwifery as it concerned the health of the mother and upon the environmental conditions under which the mother lived and in which the confinement often took place. These inquiries led on the one hand to a new Act of Parliament dealing with midwifery and on the other to the Housing Acts and schemes which, it was felt, would relieve some of the hardships inflicted by the war restrictions upon building".[95]

Thus, the Midwives and Maternity Homes Act of 1926 was born, supposedly out of continued concern over the wellbeing of expectant mothers and public welfare. The act stipulated that all maternity homes had to be registered and regularly inspected under the Local Authorities to ensure proper cleanliness and meet construction standards.[96] The

---

[93]Caitríona Beaumont, "Welfare Rights for Women: Maternity Care, Social Welfare Benefits and Family Allowances," in *Housewives and Citizens: Domesticity and the Women's Movement in England, 1928–64* (Manchester University Press, n.d.), pp. 101-134, https://www-jstor-org.ezproxy.trincoll.edu/stable/pdf/j.ctt1mf71x2.9.pdf?ab_segments=0%2Fbasic_SYC-5187_SYC-5188%2F5188&refreqid=fastly-default%3A64c15374d68088670e22c9f4b8baad55, 105.
[94]Viney, 410.
[95]Viney, 410.
[96]Viney, 410.

same standards were extended to nursing homes. Thus, the environmental conditions that were under scrutiny from the Ministry of Health became manageable under the Midwives and Maternity Homes Act of 1926.

However, the terms of the act mainly regulated and restricted midwifery in greater ways. The effects that the Midwives and Maternity Homes Act had on the midwife are explained in a report from the 1926 issue of *Public Health*, written by four male officers from the Ministry of Health.[97] The *Public Health* journal regularly published reports from Ministry of Health officers discussing new and important legislation, allowing analysis from various branches of the ministry to share discourse. This article, spearheaded by Doctor Vincent Thomas Thierens, was produced by the Yorkshire Branch. Doctor Thieriens' explanation of the new legislation can be likened to the words of male practitioners mentioned in Chapter 1, saturated with the internal assumption that women are simply unfit for the medical profession.

In the very first paragraph of the report, Doctor Thierens writes,

> "Legislation for the control of midwives and maternity homes in this country has been slow in development, little or no systematic effort in this direction having been made prior to 1902. Although this Act and that of 1918 which amended it in certain particulars have done much to prevent the irregular practice of midwifery and to protect the public from the well-intentioned, but often septic, ministrations of Sarah Gamp, they contained no provisions for the regulation of maternity homes".[98]

This piece of writing poses a question to the reader of *Public Health* journal– most of whom are presumably other physicians and persons of the medical field: are women to be

---

[97]Vincent Thomas Thierens, R.L. Thornley, H.T. Bates, "The midwives and maternity homes act, 1926," in *Public Health*, Volume 40 (1926): pp. 385-389, https://doi.org/10.1016/S0033-3506(26)80275-6, 385.
[98]Thierens, "The midwives and maternity homes act, 1926," 385.

trusted? In the first sentence, Thierens describes midwives as a person who has to be "controlled" by legislation. Thierens' decision to use the word control, as opposed to regulation or inspection, implies that midwives are unable to think, act, or work without policing. Furthermore, Thierens is quick to claim that there are midwives acting like Sarah Gamp, the stereotype of the drunken, sloppy, and angry nurse produced by Charles Dickens in his novel *Martin Chuzzlewit*.[99] The fact that Thierens cites the supposed lack of legislation to regulate midwifery to that of a harmful and misogynistic caricature of a Victorian-era nurse reveals his lack of respect for the practice, whether purposely or not. Thierens' characterization of midwives reveals something deeper about the men of the Ministry of Health, the men who were actively participating in the regulation of midwifery. More importantly, his words reveal the type of attitude the midwives of Britain were expected to remain hopeful in opposition to.

Thierens' continues his article by explaining the more intricate details of the act, which discuss how a midwife was to react if suspended from practice due to hygienic reasons. Section 1 of the act amended the Midwives Acts of 1902 and 1918, while Section 2 stated that a midwife was entitled to recover funds from the Local Supervising Authorities if she was suspended from a job due to fear of spread of infection.[100] However, this section ultimately safeguards the Local Supervising Authorities, as the board is able to choose the awarded compensation and which cases are even deemed reasonable to petition for.[101] Additionally, such levels of hygienic regulation was not put forward for physicians. So, ultimately, the jurisdiction remained in the hands of the Local Supervising Authorities,

[99]Thierens, 385.
[100]Thierens, 385.
[101]Thierens, 385.

making the lives of midwives that much more difficult compared to their male physician counterparts.

The Central Midwives Board added a new rule as the Midwives Act of 1926 was being passed, which stated that

> "whenever a midwife has been in attendance, whether as a midwife or a nurse, upon a patient, or in contact with a person suffering from puerperal fevers of from any other condition supposed to be infectious, she must at once notify the Local Supervising Authority of the fact, must disinfect herself and all her instruments and other appliances, and have her clothing thoroughly disinfected to the satisfaction of the Local Authority before going to any other maternity patient".[102]

As one could imagine, inflicting such a tedious disinfection process upon busy midwives had the ability to affect her workload and time. As Thierens reports, the only way for the supposedly-infected midwife to relieve herself of such disinfecting duties was to resign the case, opting to give up work and compensation to avoid a cleaning process that would essentially end her ability to adhere to a schedule anyways.[103] For self-employed independent midwives, such an impediment to their time and daily rounds was inexplicably detrimental to her earnings. Once again, the Local Supervising Authority was made the controlling factor in the midwives' ability to complete her work.

Thus, the Midwives and Maternity Homes Act of 1926 was not only responsible for creating stricter guidelines in midwife certification, but for restricting midwifery practice by instituting a tedious, overbearing, and discouraging disinfection routine that forced midwives to resign from such cases. Certification training for midwives under the Central

[102]Thierens, 385.
[103]Thierens, 385.

Midwives Board went from six to twelve months for direct enrollment and four to six months for nurse enrollments.[104] Consequently, the question became, were midwives to blame for the septic cases that sustained maternal death rates? According to the Ministry of Health, the answer to that question is, yes.

In 1929, the Ministry of Health released a report of findings from two departmental committees to investigate the midwifery service and the causes of the average maternal mortality rate, which averaged around five deaths per thousand births.[105] The report begins with a paragraph reading, "The recommendations of this first report aim at improving the education and supervision of the midwife. Many suggestions are made for the improvements of the conditions of her employment and of her remuneration and pension. The report recommends a larger sphere of influence over the midwife by the Ministry of Health".[106] Thus, the standard recommendation of the Ministry of Health was to continue to increase the power of its own organization, while simultaneously increasing supervision of the midwife in order to battle maternal mortality rates. The report goes on to recommend a restriction of power of the Central Midwives Board, and to incorporate the maternal health scheme into that of National Health Insurance and Local Government.[107]

The Ministry of Health's 1929 report laid the official groundwork for the government's continued push of supervising midwives. Not only that, the report suggested a decrease in power of the Central Midwives Board, which, up until that point, was the main source of advocacy for midwives. Even though the Central Midwives Board was problematic

---

[104]Anne Borsay, Billie Hunter, and Helen King, "Midwifery, 1700-1800: The Man-Midwife as Competitor," in *Nursing and Midwifery in Britain since 1700* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012), pp. 107-127, 101.
[105]Beaumont, "Welfare Rights for Women: Maternity Care, Social Welfare Benefits and Family Allowances," 102.
[106]Viney, 411.
[107]Viney, 411.

in its own right, forbidding a midwife majority within its organization and being headed by an obstetrician at all times, it still served as the proverbial leadership organization for midwives. The Ministry of Health's recommendation to abate the Central Midwives Board's leadership power was another illustrative step towards the decimation of the midwifery profession in Britain.

The Ministry of Health's blame of the midwife for the average maternal mortality rate, displayed in their condemnation of the Central Midwives Board, is, at its core, a function of sexism. Marjorie Tew, a historian, professor, and author of *Safer Childbirth?* articulates this concept in the very first chapter of her 1998 book, writing,

> "Doctors might condemn these birth attendants, but they would not have considered replacing them for such low financial rewards. As their interest in childbirth extended, however, doctors soon recognized professional midwives as commercial rivals who undercut the market they wanted by charging lower fees. Doctors were, therefore, only too willing to attribute the high mortality in childbearing to the incompetence of midwives".[108]

As Tew suggests, doctors, many of whom served on the several boards of the Ministry of Health that published the 1929 report, suggested that the steady rate of maternal mortality was due to lack of proper antenatal care – the specialty of the midwife profession. In reality, the main causes of maternal mortality in the mid-20th century were puerperal fever, convulsions, illegal abortion, and hemorrhage.[109] Midwives were not directly responsible for these conditions. Most of these conditions are now widely

[108]Marjorie Tew, *Safer Childbirth?: a Critical History of Maternity Care* (London: Chapman and Hall, 1998), 7.
[109]Geoffrey Chamberlain, "British Maternal Mortality in the 19th and Early 20th Centuries," *Journal of the Royal Society of Medicine* 99, no. 11 (2006): pp. 559-563, https://doi.org/10.1177/014107680609901113.

eradicated due to general medical advancements, like greater use of antibiotics, blood transfusions, and a more intricate knowledge of the female body.[110]

Interestingly, a 1920s study of Leeds in West Yorkshire found that poorer women in working-class neighborhoods displayed lower levels of maternal mortality than wealthier women in middle-class neighborhoods.[111] The poorer women in Leeds, as in every region, were more reliant upon local midwives for labor and delivery, as a midwife was cheaper than hiring a private physician or attending a lying-in hospital. Senior Medical Officer Janet Campbell even found in her 1924 report titled *Maternal Mortality* that the cause of persistent maternal mortality rates from puerperal fever were not due to an unsanitary home that a midwife would visit, but rather the use of forceps and other medical instruments.[112]

Campbell concluded that the use of unsanitary medical equipment, which would be used by a physician or obstetrician, was the main cause of continued puerperal fever. Fascinatingly, Janet Campbell was a leading officer of the Ministry of Health, bringing strong female representation to the organization. Yet, her findings, which supported the midwives' place in the home during labor and the strategy to place responsibility on the mother to adhere to a healthy lifestyle during pregnancy, were left out of the official 1929 Ministry of Health Report. Tew explains that the exhaustive investigative reports into maternal health following Campbell's report "shed only limited light on the causative factors".[113]

Essentially, Campbell's in-depth research into women's health and wellbeing were cherry-picked by her male colleagues to produce a scheme where obstetricians were

[110]Chamberlain, "British Maternal Mortality in the 19th and Early 20th Centuries,".
[111]Beaumont, 103.
[112]Tew, 148.
[113]Tew, 149.

regarded as the saving grace of women. This mentality is exemplified in Sir William Fletcher Shaw's book, titled *Twenty-Five Years, The Story of the Royal College of Obstetricians and Gynaecologists 1929-195*. Shaw, who was the founder of the British College of Obstetricians and Gynaecologists, wrote

> "the main cause [of reduced mortality] has been the improved training and teaching of the medical profession, both pre- and post-graduate, and the general realization that the care of abnormal cases must be left to those who have had special postgraduate training. In bringing about the improvements in teaching and training, the College played a great part".[114]

Shaw's assertion that reduced maternal mortality was a result of abnormal cases being designated to those with special post-graduate training is a prime example of how midwives in Britain were forced into a feminist plight, whether knowingly or not. Shaw's ability to even study maternal mortality rates in detail came from the work of Campbell, a woman whose message dissolved when acquired by the men of the medical world. The founder of one of the most important medical colleges in Britain was proud to assert a falsehood to the public, insinuating that abnormal cases were the central cause of maternal mortality and that men with special training would be best suited to face such cases. This is simply not true.

Thus, the opinions of the 1929 Ministry of Health Report and leading gynecologist William Shaw, ones that denoted the midwife as complicit in maternal mortality, was false. Midwives, as they had been doing for centuries, strived to perform the best standard of pre

[114]William Fletcher Shaw, *Twenty-Five Years; the Story of the Royal College of Obstetricians and Gynaecologists, 1929-1954* (London: Churchill, 1954), 66.

and antenatal care to all patients, despite indifference and disregard from the government and physicians alike.

This is not to say that public and government concern over the welfare of pregnant women was not warranted, because it was. Women in Britain, especially those in working class and poor neighborhoods, were left to suffer in unsanitary environmental conditions complete with poor nutrition, cholera, tuberculosis, and high levels of pollution from increased industrialization. The general standard of living made way for a society in which many women had little to no access to medicine or standardized healthcare to fight off infectious diseases.

Additionally, the 1911 National Health Insurance Act did not grant free healthcare insurance to married women who worked inside the home, leaving millions of women without accessible and affordable healthcare.[115] Between 1931 and 1932, married women in Britain experienced 140 percent more sickness than expected by the government, representing the low standard of care for women at the time.[116] This is most likely due to the fact that the 1918 Midwives Act, which was so widely advertised as legislation that would provide free maternity and healthcare services to women through the Local Supervising Authorities, was not compulsory.

1935 statistics released by the National Council of Women revealed that 33 out of 62 city County Councils and 141 out of 185 County Boroughs supplied less than half of the services advertised by the Local Supervising Authorities in the Midwives Act of 1918.[117] In fact, the Midwives Act of 1918 served more so a restriction to working midwives than as a

[115]Beaumont, 103.
[116]Beaumont, 103.
[117]Beaumont, 105.

general welfare bill. In reality, women's healthcare was a full governmental, environmental, and societal issue – not simply a midwife's issue.

According to Tew, Professor and epidemiologist Tom McKeown examined the slow rise of British public health in 1965, writing that

"We owe the advance in health mainly, not to what happens when we are ill, but to the fact that we do not so often become ill. And we remain well, not because of specific preventative measures, such as vaccination and immunization, but because we enjoy a higher standard of living and live in a healthier environment".[118]

Thus, the slow increase in welfare of women throughout the twentieth century, including the maternal mortality rate, relied heavily on environmental improvements and general immunity.

The Midwives Acts of 1902, 1918, and 1926 all played an equal part in the disenfranchisement of the British midwife. Although seeming like general welfare bills to the public, each one of these pieces of legislation chipped away at the professional regard of midwives, despite the fact that she was still the main caregiver and trusted birth attendant in Britain. The bureaucratic regulation of midwifery snowball began its roll in 1902 and would continue to grow throughout the twentieth century until the midwife's place as a primary pregnancy caregiver seemed like history. To the men of obstetrics and the Ministry of Health, this was a palpable goal to strive for.

[118]Tew, 4.

Chapter 2 Bibliography

Arthure, Humphrey G. "The London Obstetrical Society." *Proceedings of the Royal Society of Medicine* 62, no. 4 (1969): 363–66. https://doi.org/10.1177/003591576906200428.

Beaumont, Caitríona. "Welfare Rights for Women: Maternity Care, Social Welfare Benefits and Family Allowances." Essay. In *Housewives and Citizens: Domesticity and the Women's Movement in England, 1928–64*, 101–34. Manchester University Press, n.d. https://www-jstor-org.ezproxy.trincoll.edu/stable/pdf/j.ctt1mf71x2.9.pdf?ab_segments=0%2Fbasic_SYC-5187_SYC-5188%2F5188&refreqid=fastly-default%3A64c15374d68088670e22c9f4b8baad55.

Borsay, Anne, Billie Hunter, and Helen King. *Nursing and Midwifery in Britain since 1700*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012.

Chamberlain, Geoffrey. "British Maternal Mortality in the 19th and Early 20th Centuries." *Journal of the Royal Society of Medicine* 99, no. 11 (2006): 559–63. https://doi.org/10.1177/014107680609901113.

Nuttall, Alison. "Midwifery, 1800-1920: The Journey To Registration." Essay. In *Nursing and Midwifery in Britain since 1700*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012.

Reid, Alice. "Birth Attendants and Midwifery Practice in Early Twentieth-Century Derbyshire." *Social History of Medicine* 25, no. 2 (May 2012): 380–99. https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.270.8471&rep=rep1&type=pdf.

Richardson, Eileen. "Midwifery in Britain in the Twentieth Century." Midwifery in Britain in the Twentieth Century - Memories of Nursing, 2009. https://memoriesofnursing.uk/articles/midwifery-in-britain-in-the-twentieth-century#:~:text=Midwifery%20became%20legally%20recognised%20in,with%20the%20first%20Midwives%20Act.&text=The%20Midwives%20Act%20allowed%20for,the%20time%20(Heagerty%201997).

Shaw, William Fletcher. *Twenty-Five Years; the Story of the Royal College of Obstetricians and Gynaecologists, 1929-1954*. London: Churchill, 1954.

Tew, Marjorie. *Safer Childbirth?: a Critical History of Maternity Care*. London: Chapman and Hall, 1998.

Thierens, Vincent Thomas, R.L. Thornley, and H.T. Bates. "The Midwives and Maternity Homes Act, 1926." *Public Health* 40 (1926): 385–89. https://doi.org/https://doi.org/10.1016/S0033-3506(26)80275-6.

Vincent Thomas Thierens, R.L. Thornley, H.T. Bates,The midwives and maternity homes act, 1926, Public Health, Volume 40,1926, Pages 385-389,ISSN 0033-3506, https://doi.org/10.1016/S0033-3506(26)80275-6, (https://www.sciencedirect.com/science/article/pii/S0033350626802756)

Viney, Hester. "The English Midwifery Service." *The American Journal of Nursing* 30, no. 4 (1930): 408-12. Accessed February 2, 2021. doi:10.2307/3411155.

Chapter 3: The Midwives Act of 1936

In 1936, the fourth and final Midwives Act was passed in Britain. The Midwives Act of 1936 was the product of decades of criticism towards the practice of midwifery and its supposed lack of appropriate regulation. This act revolutionized the operation of midwifery in Britain, placing midwives under direct government rule and regulation. The Midwives Act of 1936 instituted a domiciliary service where midwives were directly salaried by the government. The Act also introduced a Midwife Teachers Diploma and instituted compulsory seven-day "refresher courses" every five years.[119] Thus, independent midwifery practices became a rarity, placing the midwife's professional autonomy in the hands of the government and rival medical professionals. The act was ultimately harmful to the midwives of Britain, as it removed even more freedom in occupation than any of the previous Midwives Acts had.

Doctor Janet Campbell's, senior officer of the Ministry of Health, second report titled *The Training of Midwives* of 1926, deeply influenced the government's creation of the Midwives Act of 1936.[120] As previously discussed in Chapter 2, Campbell's 1924 *Maternal Mortality,* commissioned under the Ministry of Health, was minced apart by leading gynecologists to suggest the ineptitude of midwives. However, Campbell's 1926 report kickstarted a scheme for a National Maternity Service under the Ministry of Health. This scheme was partially led by The National Birthday Trust Fund (For The Extension of Maternity Services), which was founded in 1928.[121]

---

[119]Billie Hunter, "Midwifery, 1920-2000: The Reshaping of a Profession," in *Nursing and Midwifery in Britain since 1700* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012), 155.
[120]Hunter, "Midwifery, 1920-2000: The Reshaping of a Profession," 155.
[121]Hunter, "Midwifery, 1920-2000: The Reshaping of a Profession," 155.

I. The Departmental Committee Report under the Ministry of Health

In September of 1929, the Departmental Committee's Report from the Ministry of Health was published in the *British Medical Journ*al.[122] The Departmental Committee was commissioned by Neville Chamberlain, then Minister of Health, in May 1928. This committee, headed by Sir Robert Bolam, proceeded to conduct an in-depth investigation into British midwifery as a whole, acting "to consider the working of the Midwives Acts, 1902 to 1926, with particular reference to the training of midwives (including its relation to the education of the medical students in midwifery) and the conditions under which midwives are employed".[123] The committee, which included six medical professionals, recommended an establishment of a total national maternal scheme to eliminate the need for local and regional supervising offices.[124]

The recommended national maternity scheme aimed to supposedly improve the training and conditions of midwifery by standardizing fees and assimilating **t**he functions of the Central Midwives Board into that of the General Medical Council. [125] Essentially, The Departmental Committee recommended a transfer of power of midwife education requirements to the Minister of Health in an effort to substantially increase the training requirements necessary to become a certified midwife. Despite the national scheme, the Central Midwives Board remained in function, albeit mainly just in name, until 1983.[126] The committee recommended a new standardized entrance exam, a clinical examination, and a

---

[122]The Departmental Committee, "Training And Employment Of Midwives." *The British Medical Journal* 2, no. 3586 (1929): 592-95. Accessed March 22, 2021. http://www.jstor.org/stable/25333815
[123]The Departmental Committee, "Training And Employment Of Midwives."
[124]The Departmental Committee, Training And Employment Of Midwives."
[125]The Departmental Committee, Training And Employment Of Midwives."
[126]Hunter, "Midwifery, 1920-2000: The Reshaping of a Profession," 166.

three-month period of compulsory post-examination experience.[127] However, even as The Departmental Committee recommended a complete overhaul of midwife training to supposedly increase the standard of care in the profession, the midwife's education still remained second in line to that of men in medical school. The report states that in the assumed event of a shortage of medical training supplies, "students in a medical school area should have preference in the apportionment of material, and that pupil midwives should be allowed to make use of such material only in so far as it is in excess of the needs of medical students".[128] Since midwifery training and medical school were almost entirely segregated by gender, this report, by nature, prioritised resources to men.

There is a distinct irony in this section of The Department Committee's report – an irony that remained present throughout all midwifery legislation. The fact that a government issued report, created by a specialty committee that was created explicitly to advance the status of the midwife, states that midwives should only have access to medical material "in excess" displays a lack of true investment in the profession. How can one possibly trust the recommendations of The Departmental Committee and the Ministry of Health if both parties, both of which are meant to ensure that midwifery training obtains resources, think of midwives as second-class medical practitioners? Needless to say, doctors do go through greater training to reach their physician status. However, when the institutions put in place to protect and advance midwifery deny resources to midwives in the name of protecting doctors, a deeply-rooted bias is revealed. Furthermore, the committee's recommendation to virtually dissolve all powers of the Central Midwives Board raises large concerns.

[127]The Departmental Committee, Training And Employment Of Midwives."
[128]The Departmental Committee, Training And Employment Of Midwives."

Interestingly enough, two members of the Departmental Committee chose to dissent from the rest of the board on this report because they believed that the Committee was clearly overstepping. Doctor Fairbairn and Mrs. Bruce Richmond (whose exact occupation is unnamed) laid out their reservations towards the committee's proposal in a dissenting piece.[129] Fairbairn and Richmond attest their absolute disagreement with the rest of the committee, writing that that the report was "wholly inconsistent" with any ideal towards the betterment of midwifery.[130] Richmond and Fairbairn articulate their disagreement with the committee, stating that,

> "This proposal to break up work that has, in the experience of a generation, been welded into a compact whole, and the distribution of its party between an attenuated Midwives Board and a department of the Ministry of Health, with an Advisory Committee at its back, makes a dual control that is not likely to draw women into a profession already groaning under a weight of official supervision".[131]

Richmond and Fairbairn's assertions are advanced and held up by the history of past Midwifery Acts, and would be borne out in the longer term declining number of midwives. In fact, their assertions acted as a red flag indicative of what was to come in the midwifery profession – a complete decentralization of a midwife-led power, resulting in a lack of desire to join the world of midwifery. At its core, midwifery is based on a strong interpersonal relationship between the mother and the midwife. As Jane Sharp described in the eighteenth century, midwives were more than just a delivery attendant, but a spiritual leader bonding women in a sisterhood. The independence of midwifery was integral to the salience of the profession. Thus, the continued centralization of power that the government

[129]The Departmental Committee, Training And Employment Of Midwives."

[130]The Departmental Committee, Training And Employment Of Midwives."

[131]The Departmental Committee, Training And Employment Of Midwives."

garnered when creating the Midwives Acts was directly harmful to the independence and sacredness of midwifery. The recommendations presented by The Departmental Committee coincided with the work of the Birthday Trust.

The National Birthday Trust Fund is an advocacy group that was founded in 1928, described by the Charity Commission of England and Wales today as a trust meant to

> "1. To assist towards the cost of establishing or maintaining voluntary maternal hospitals and training centres or classes for midwives or maternity nurses and generally improving the professional ability and standing and emoluments of such persons. 2. To promote friendly relations and cooperation between maternity or similar services throughout the British empire for mutual improvement and advancement in constitution, management and aims and for avoiding overlapping in connection with appeals or otherwise. 3. Any other purpose connected with maternity and the welfare of maternity patients and newborn children''.

Essentially, this trust worked as a private sponsorship of the Departmental Committee and the Ministry of Health, using money from various donors to back the claims of such governmental groups. The trust worked to advocate for further legislation alongside the government to improve not only midwifery, but all maternity services across Britain. The National Birthday Trust Fund is still operating today.[132] In the decades before the passage of the 1936 Midwives Act, Britain had clearly moved towards a total push for intense regulation of midwives. The continued pressure put on the Government aided in the eventual creation of the fourth and final piece of midwifery legislation, the 1936 Midwives Act.

---

[132]"THE NATIONAL BIRTHDAY TRUST FUND (FOR THE EXTENSION OF MATERNITY SERVICES) - Charity 239281-1." About the register of charities, 2009. https://register-of-charities.charitycommission.gov.uk/charity-search/-/charity-details/4045112.

II. Parliamentary Records

On July 31st, 1936, the final Midwives Act passed through Parliament, historically altering the course of midwifery in Britain for good. However, before examining the effects of such a bill, one must understand the rhetoric and discourse behind the legislation. In 1935, Parliament's Joint Council of Midwifery released a memorandum on the issue of maternal mortality, bringing attention to the supposed need for further legislation.[133] Although the government had been moving towards further regulation of midwifery for decades, this memorandum into maternal mortality gave a newfound urgency to the matter.

Written records from the Order of The Day for the Second Reading of the bill reveal a level of distrust towards midwives under the guise of the need to abolish maternal mortality. The Second Reading of the bill began on the morning of July 14th, 1936, with Viscount Gage saying, "I think it is important to emphasise the limited scope of the Bill at the very start. There are some very complicated and insistent problems connected with maternal mortality, and a great deal of money is being spent on its prevention every year".[134]

Viscount Gage was correct in his assertion that copious amounts of money were being spent on maternal mortality prevention each year. However, the three million pounds being poured into maternal mortality prevention through clinical research and medical discovery annually was not something that should have been considered to be a midwife's problem. Advocating for higher education standards in any profession is acceptable. In fact,

[133]House of Lords, "MIDWIVES BILL.," MIDWIVES BILL. (Hansard, 14 July 1936), accessed March 26, 2021, https://api.parliament.uk/historic-hansard/lords/1936/jul/14/midwives-bill#S5LV0101P0_19360714_HOL_209.
[134]House of Lords, "MIDWIVES BILL.," MIDWIVES BILL. (Hansard, 14 July 1936), accessed March 26, 2021, https://api.parliament.uk/historic-hansard/lords/1936/jul/14/midwives-bill#S5LV0101P0_19360714_HOL_209.

upholding standards of care through refresher courses and long-term education in the medical world is why western medicine maintains its effectiveness.

However, as discussed in Chapter 2, when blame is inaccurately placed upon a select group of professionals, that group is sure to be affected negatively. In reality, maternal mortality rates were a paltry four out of one thousand births per year.[135] Statistically, that is .4%. The government acting as though that is a statistic that requires such extraordinary intervention, on the supposed behalf of all women in Britain, is almost irrational. The memorandum was truly a scapegoat for the government -- a decision to blame midwives for the poor living standards of the lower class. Instead, the government could have taken action to ensure that all women in Britain, including married women working inside the home, were guaranteed healthcare -- which the 1911 Insurance Act prohibited.

As the proceedings continued on July 14th, 1936, Viscount Gage went on to say,

> "Some are properly qualified nurses who do a certain amount of maternity work, also on a salary basis. Another class have certificates, but work in independent practice. Finally, there is—chiefly in the large centres of population—a class of women with no qualification whatever, who are really not midwives at all, but who do, under the supervision of a doctor, act as midwives and receive remuneration from the patients they attend. There are so many undesirable features attaching to the employment of this unqualified class that the Government have come to the conclusion that the time has come for their abolition".[136]

Once again, the assertion that a large population of women with absolutely no qualifications were regularly delivering babies became a chief argument in the fight to

[135]House of Lords, "MIDWIVES BILL.,"
[136]House of Lords, "MIDWIVES BILL.,"

change the course of midwifery. Unsurprisingly, Viscount Gage, along with the other members of the House of Lords and government who chose to harp on the claim of the 'unqualified class', provided no legitimate evidence to prove such a case.

Viscount Mersey soon joins the conversation and goes as far as to completely undermine the general goal of the Parliament's Joint Council of Midwifery and the 1936 Midwives Act. Mersey says,

> "It is further said that out of 57,000 midwives now on the roll of the Central Midwives Board only 15,000 are practising. At present there are too many midwives trained, thus seriously interfering with the training of medical students, and State registered nurses are given no teaching of this nature in their general training and therefore are quite unfit to act as maternity nurses".[137]

The irony of Viscount Mersey's point cannot be understated. In discussing a piece of legislation that is meant to uphold the standard of midwifery and supposedly increase the standard of the profession, he is saying that midwives are interfering with the training of male medical students. If only fifteen thousand midwives were practicing out of a roll of fifty-seven thousand, Mersey's point should have been to encourage those forty-two thousand non-practicing midwives to rejoin the force, not leave it.

Unsurprisingly, only one man throughout the Second Reading of the bill chose to question the real cause of the maternal mortality rate; albeit insulting midwifery in the same breath. The Earl of Listowel states that

[137]House of Lords, "MIDWIVES BILL.,"

> "Besides the inadequate midwifery service at present in existence, under-nourishment, which is due to poverty. It stands to reason that a perfect state of physical health is necessary for the mother if she is to be able to stand the strain of childbirth, and that under-nourishment both diminishes her powers of resistance and produces certain minor ailments which in the case of the mother are peculiarly dangerous. That, of course, is a factor in maternal mortality which the Government have not dealt with and which is naturally not touched upon in the present Bill".[138]

In his statement, The Earl of Listowel is essentially calling out the government for their choice to handpick which aspects of maternal mortality are worth investigating. Undernourishment in low-class neighborhoods became a topic of elevated national debate in the 1920s and 1930s, causing the British government to employ a national scheme researching poverty and the low-income population. The MRC (Medical Research Council) was founded in 1920 following the end of the First World War to fund and research the effects of vitamins and fiber on gestational health.[139] The MRC worked alongside the New Health Society to launch the 1927 "Wholemeal Manifesto", a campaign published in the *Daily Mail* to push Britons to cut white bread out of their diets and replace it with whole grain carbohydrates to provide sufficient vitamin B and ease the "White Man's Burden" of chronic constipation.[140] The "Wholemeal Manifesto" was based upon clinical studies performed by Sir Robert McCarison in the 1920s, a physician in the Indian Medical Service.[141] McCarison conducted several rat experiments, where he fed some rodents the typical diet of a poor person in Britain and the other rodents the Sikh diet of wholemeal

[138]House of Lords, "MIDWIVES BILL.,"
[139]Ina Zweiniger-Bargielowska, ""Not a Complete Food for Man": The Controversy about White versus Wholemeal Bread in Interwar Britain." In *Setting Nutritional Standards: Theory, Policies, Practices,* ed. by Neswald Elizabeth, Smith David F., and Thoms Ulrike (Woodbridge, Suffolk, UK, Boydell & Brewer, 2017), 142-64, 142.
[140]Zweiniger-Bargielowska, ""Not a Complete Food for Man": The Controversy about White versus Wholemeal Bread in Interwar Britain", 148.
[141]Zweiniger-Bargielowska, 148.

flour, vegetables, and minimal meat.[142] McCarison's study found that the rats who were fed the typical British diet of copious amounts of white bread, margarine, and tinned meat were "stunted", "badly proportioned" and "began to kill and eat the weaker ones amongst them".[143] The rats who were fed the healthy Sikh diet had shiny coats, flourished health-wise, and "lived happily together".[144] McCarison's findings substantiated the beliefs of the MRC and the New Health Society that the diet of the lower classes in Britain were significantly flawed, and were ultimately causing extreme illness amongst the population.

Findings in studies like those of McCarison's helped the MRC and the New Health Society to publish various modes of advocacy for a wholemeal, well-rounded diet. The New Health Society commissioned a film titled *Health Is Wealth* in 1929.[145] *Health Is Wealth* showcases healthcare provisions while providing ways for Britons to avoid "preventable wastage of life, health, efficiency, happiness, and money" through poor nutrition.[146] The film was shown at the 1929 New Health Exhibition, an event that aimed to confound the government's newfound focus and devotion to higher health standards.[147] The push for an abandonment of white bread was continued throughout the 1930s and into wartime as American fiber breakfast cereals were subject to "vigorous promotion" in British media.[148] By 1938, breakfast cereal made up for ten percent of all British advertisement, making whole-grain cereals like Grape-Nuts and Shredded Wheat a standard aspect of the British diet.[149]

---

[142]Zweiniger-Bargielowska, 149.
[143]Zweiniger-Bargielowska, 149.
[144]Zweiniger-Bargielowska, 149.
[145]Zweiniger-Bargielowska, 155.
[146]Zweiniger-Bargielowska, 155.
[147]Zweiniger-Bargielowska, 155.
[148]Zweiniger-Bargielowska, 155.
[149]Zweiniger-Bargielowska, 155.

Thus, The Earl of Listowel's decision to challenge the government's decision to obviously avoid the gross national issue of malnourishment and lack of fiber in the debate of the 1936 Midwives Act was perfectly warranted. British women were sick and sometimes dying in childbirth due to their malnourished lives living in poverty, not because of midwives.

II. Effects of the Act

Following the passage of the Midwives Act of 1936, midwives were paid a regulated salary through their Local Supervising Authority. The standardization of payment from the government helped to compensate midwives who worked for poor families who had trouble completing full payment directly, holding patients accountable in a greater way. However, such standardization also acted as a dividing factor between midwives. In an oral account from a middle-aged British midwife named Mary, she reports that

> "The 1936 Act said that the local authorities had to provide midwives for the people in its area. Well, the posts were advertised and we all applied. In fact, it helped the local authority weed out the ones they didn't want. It gave them more control over us. Some midwives didn't get jobs and it caused a lot of hard feelings. The reorganization caused a lot of friction".[150]

Besides creating a salaried domiciliary, the Midwives Act of 1936 also pushed for a complete overhaul of antenatal care. Antenatal care is how a mother is cared for after she gives birth, whether that be at home or at an antenatal clinic. In 1936, the Central Midwives Board increased its suggested post-natal care attendance to fourteen days.[151] In these

---

[150]Nicky Leap and Billie Hunter, *The Midwife's Tale: An Oral History From Handywoman to Professional Midwife* (Barnsley: Pen and Sword, 2013), 94.
[151] John J Buchan, "The Midwives Act, 1936, and Its Operation," *Public Health* 50 (1936): pp. 420-436, https://doi.org/10.1016/s0033-3506(36)80034-1, 421.

fourteen days, the midwife was expected to perform daily checks on the mother to ensure her continued safety and wellbeing. The new standard of antenatal care, coupled with the Ministry of Health's recommendation for a midwife to take on seventy cases a year plus thirty cases as a maternity nurse, were cause for concern to many.[152]

In Doctor John Buchan's 1936 report titled *The Midwives Act, 1936, and its Operation,* he examines the Act's effects on the expectations of practicing midwives. John Buchan was the leading Medical Officer of Health in Bradford, a city in West Yorkshire. He was a proponent of the 1936 Act in general, yet he held reservations about the legislation's effect on the goodwill of the midwife. Buchan writes,

> "If a midwife attends seventy cases as a midwife and thirty cases as a maternity nurse, she will usually have put in some three thousand hours of work. Much of this will be done at irregular hours and during the night. Even in populous districts, it hardly seems safe, therefore, to assume that more than eighty cases, including those attended as a midwife and those as a maternity nurse, can be expected to be undertaken by one midwife in the course of a year". [153]

Buchan's concern for the wellbeing of the midwife if she is expected to work three thousand hours per year is precisely why the extreme standards of the Midwives Act of 1936 were so hard on practicing midwives. Three thousand hours of work per year averages to a standard twelve-hour workday. Even after a twelve-hour workday, midwives under the 1936 Act were usually only granted one-half day off a week under their Local Supervising Authority. How can anyone, let alone a person working in such a precarious profession, be expected to uphold a high standard of care for twelve hours straight?

---

[152]Buchan, "The Midwives Act, 1936, and Its Operation," 421.
[153]Buchan, 422.

In *The Midwife's Tale: An Oral History From Handywoman to Professional Midwife*, a midwife named Esther S. describes just how incredibly hard British midwives were expected to work – and just how dangerous that predicament was. Esther writes,

> "One weekend I had seven babies single-handed and that's when I had that big baby (twelve and a half pounds!). That was the only time I've been so desperate. I was 'drunk' – I never understood the saying 'drunk with tiredness' until then. I was high as a kite! I never went to my bed for four nights and four days. I was fed in the houses with bits of toast but I went for my meals at all. From one to another – sterilizing bowls in the houses as I went around. And when I got home on the last day, my legs were so swollen I could not put them on bed".[154]

Stories like that of Esther's are not uncommon. In fact, *The Midwife's Tale: An Oral History From Handywoman to Professional Midwife* is chock-full of them. Full of anecdotes from midwives who were constantly working hard, delivering babies day in and day out to serve their local communities.

Buchan also points to the Departmental Committee for Training and Employment of Midwives report in his analysis and predictions of the quick effects of the 1936 Midwives Act. He writes that

> "Most authorities will prefer that these midwives should have the training of a general nurse, in addition to training and sufficient experience in the practice of midwifery. The supply of such women is quite definitely limited, despite the fact that there are some fifty-four thousand midwives on the Roll. The report of the Departmental Committee on the Training and Employment of Midwives, recorded as their opinion that so long as the midwifery profession held out such poor rewards,

[154]Nicky Leap and Billie Hunter, *The Midwife's Tale: An Oral History From Handywoman to Professional Midwife,* 102.

> so long would it tend to be regarded as a natural calling only for women whose standard of efficiency was too often lamentably low".[155]

It is clear, from the words of Buchan, that midwives were being systematically set up to fail by the government by the Midwives Act of 1936. British midwives, as evidenced in Esther's anecdote, never stopped working dutifully and diligently. Contrary to the opinion of the Ministry of Health, midwifery is not and was not a profession for women with low standards. Had the government actually spoken to local midwives, who were devoting their lives to making laboring mothers comfortable and safe, maybe the legislation of 1936 would have been devoid of such ridiculous work standards and competition.

Unfortunately, the Midwives Act of 1936 would not be the last piece of legislation to delegitimize the work of midwives. Following Britain's devastating involvement in World War II, the government founded a program under the new welfare state, titled the National Health Service. The National Health Service was critical to rebuilding Britain, but it destabilized midwifery on the way. Chapter Four will discuss the National Health Service and its role in ending midwifery as anyone knew it.

[155]Buchan, 424.

Chapter Three Bibliography

Buchan, John J. “The Midwives Act, 1936, and Its Operation.” *Public Health* 50 (1936): 420–36. https://doi.org/10.1016/s0033-3506(36)80034-1.

House of Lords. “MIDWIVES BILL.” MIDWIVES BILL. (Hansard, 14 July 1936). Accessed March 26, 2021. https://api.parliament.uk/historic-hansard/lords/1936/jul/14/midwives-bill#S5LV0101P0_19360714_HOL_209.

Hunter, Billie. *Nursing and Midwifery in Britain since 1700*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012.

Leap, Nicky, and Billie Hunter. *The Midwife's Tale: An Oral History From Handywoman to Professional Midwife*. Barnsley: Pen and Sword, 2013.

“THE NATIONAL BIRTHDAY TRUST FUND (FOR THE EXTENSION OF MATERNITY SERVICES) - Charity 239281-1.” About the register of charities, 2009. https://register-of-charities.charitycommission.gov.uk/charity-search/-/charity-details/4045112.

"Training And Employment Of Midwives." *The British Medical Journa*l 2, no. 3586 (1929): 592-95. Accessed March 22, 2021. http://www.jstor.org/stable/25333815.

Zweiniger-Bargielowska, Ina. "“Not a Complete Food for Man”: The Controversy about White versus Wholemeal Bread in Interwar Britain." In *Setting Nutritional Standards: Theory, Policies, Practices*, edited by Neswald Elizabeth, Smith David F., and Thoms Ulrike, 142-64. Woodbridge, Suffolk, UK: Boydell & Brewer, 2017. Accessed April 17, 2021. http://www.jstor.org/stable/10.7722/j.ctt2111fb9.10.

Chapter 4: The National Health Service and Midwifery

On July 5th, 1948, the National Health Service (NHS) was implemented in Britain, acting as a taxed universal healthcare system for all citizens and free at the time of need. On that very day, the National Health Service gained control of 480,000 hospital beds in England and Wales, changing the course of British healthcare forever.[156] The National Health Service was first brought before Parliament in 1946 and ended up becoming the crowning accomplishment of Clement Atlee's post-war Labour government.[157] The NHS was the defining factor and essence of the new welfare state following the absolute devastation of World War II.

The creation of the National Health Service was largely influenced by the 1942 report titled *Social Insurance and Allied Services* by the renowned British social economist William Beveridge.[158] In 1939, Beveridge was commissioned by Whitehall (British civil service) to research and report on the current social welfare programs in Britain.[159] Beveridge's findings constituted his philosophy to rebuild post-war Britain, which included fighting against the five major giants of society: idleness, ignorance, disease, squalor, and want.[160] Beveridge concluded that the only way to beat the five giants of society was to create a universal welfare system. This system, which is now known as the National Health Service, is what Clement Atlee's cabinet used in their reconstruction of British healthcare.

---

[156]Louise Tweddell, "The Birth of the NHS – July 5th 1948," Nursing Times, August 2, 2019, https://www.nursingtimes.net/archive/the-birth-of-the-nhs-july-5th-1948-08-01-2008/.
[157]Tweddell, "The Birth of the NHS – July 5th 1948,"
[158]"1942 Beveridge Report," UK Parliament (UK Parliament, 2021), https://www.parliament.uk/about/living-heritage/transformingsociety/livinglearning/coll-9-health1/coll-9-health/.
[159]"1942 Beveridge Report," UK Parliament.
[160]"1942 Beveridge Report," UK Parliament.

The National Health Service made all healthcare free, including maternity care. Unfortunately, this same service is the reason why midwifery continued to decline in status and numbers throughout the twentieth century. When the National Health Service was implemented, pregnant women were encouraged by the State to have their babies in hospitals using an NHS General Practitioner. Ultimately, the culmination of the regulation of previous Midwifery Acts combined with the NHS regulations making midwives second in line to General Practitioners in labor is what caused the slow downfall of midwifery as a profession in Britain. Finally, in 1948, the medical elite and bureaucracy finally achieved their sexist goal of destabilizing and displacing midwives in Britain with the creation of the National Health Service.

This chapter will examine the causes, reactions, and residual effects of the National Health Service on midwives in Britain. To be quite clear, this chapter and thesis in its entirety is not meant to discredit the National Health Service in itself. The NHS has granted millions with medical expertise that they would not have been able to pay for without a universal healthcare system. However, in the process of creating a welfare state, the Government also succeeded in pushing midwives out of their seat at the table.

I. The Wartime Midwife

By the time that Britain entered into World War II in 1939, around seventy percent of British women were still giving birth at home with a midwife.[161] Midwive**s** were still, despite the government's continuously intensive regulation of the profession, the most important aide in the lives of pregnant women. The long hours and intense workload described in midwife interviews in Chapter 3 only intensified during wartime. Suddenly,

[161]Billie Hunter, "Midwifery, 1920-2000: The Reshaping of a Profession," in *Nursing and Midwifery in Britain since 1700* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012), 153.

midwives bore even greater responsibility than before. The Ministry of Health found that there was a substantial shortage of midwives and nurses heading into the war. The Ministry became so desperate for midwifery help throughout the war that notices were sent out asking for retired and non-working midwives to come back to the practice as a designated wartime civil service.[162] Additionally, according to British Medical Historian Carly-Emma Leachman, the birth rate, which had been in steady decline since 1918, also began to grow at the start of World War II.[163] Thus, the pressure was on for midwives in Britain in 1939. The presence of wartime evacuations from London for at-risk populations did not dissipate such stress.

Wartime evacuation of pregnant women was the Ministry of Health's safety scheme in maintaining a healthy, growing population of Britons. On September 2nd, 1939, twelve thousand pregnant women were shipped out of urban areas to Emergency Maternity Homes in rural Britain to escape air raids while waiting to go into labor.[164] In 1940 alone, 10,500 babies were delivered in an Emergency Maternity Home in the countryside.[165] This delivery rate almost tripled in 1941.[166]

Midwives were heroic during wartime. To ensure that Britain's pregnant women remained safe during frightening air raids, hundreds were forced to leave their homes for sometimes months on end to deliver babies in speciality hospitals. Delivering a baby during normal conditions is a feat in itself. Now, midwives were required to deliver babies in a

---

[162]Hunter, "Midwifery, 1920-2000: The Reshaping of a Profession," 156.
[163]Carly-Emma Leachman, "Most Women Give Birth in Hospital – but It's Got More to Do with World War II than Health," The Conversation (Nottingham Trent University, February 20, 2020), https://theconversation.com/most-women-give-birth-in-hospital-but-its-got-more-to-do-with-world-war-ii-than-health-110647.
[164]Leachman, "Most Women Give Birth in Hospital – but It's Got More to Do with World War II than Health,".
[165]Leachman, "Most Women Give Birth in Hospital – but It's Got More to Do with World War II than Health,".
[166]Leachman, "Most Women Give Birth in Hospital – but It's Got More to Do with World War II than Health,".

crowded Emergency Maternity Home in an unfamiliar area during a bombing raid. The bedside manner of devoted midwives never faulted. One mother from Benson, Oxfordshire described her experience with a midwife whilst having her baby in 1942. Enid wrote,

> "My biggest worry was that it wouldn't come, that it wouldn't happen [laughing]. Yeah, no you didn't know anything really, nothing at all, no. And of course you had no gas and air, nothing to ease the pain, nothing at all. But the only thing was that when the midwife came she never left you. If you were all day and all night she was there with you all day and all night. So you weren't left on your own like you hear they are, put in a room, can be a bit frightening I should think".[167]

Enid's firsthand account of her experience at an Emergency Maternity Home shows the unwavering support from Britain's midwives, and the personal support that midwifery creates. As Jane Sharp asserted in the seventeenth century, the emotional bond between a mother and a midwife is a sacred relationship that cannot be replicated. The tenacity of midwives during wartime is further exemplified in Billie Hunter and Nicky Leap's 1985 interviews for their book, *The Midwife's Tale: An Oral History from Handywoman to Professional Midwife.* Esther Silverton of Portsmouth, a newly-trained midwife, performed her first ever delivery in an Anderson bomb shelter in the early 1940s.[168] One evening, she was called to a home several blocks away. Due to the air raids, Esther was forced to bike to the home in absolute pitch black. As she was biking to the home of the expectant mother, Esther heard the "swish" of planes and bombs dropping -- forcing her to jump off of her

[167]Angela Davis, "Wartime Women Giving Birth: Narratives of Pregnancy and Childbirth, Britain c. 1939–1960,".
[168]RCOG Heritage Collections Blog, ed., "Esther Silverton: The Midwife's Tale Oral History Collection," Midwives Chronicle: The Heritage Blog of the Royal College of Midwives, February 10, 2017, https://rcmheritage.wordpress.com/2016/05/09/esther-silverton-the-midwifes-tale-oral-history-collection/.

bike and lay on the wet ground for several minutes at a time.[169] Once Esther arrived at the home and met the father of the child, she said that,

> "Anyway he got to give me this water and just as he was about to give it to me, the doodlebug had stopped and it was coming down and we could hear it swishing, any minute it was going to drop. I mean you don't know it could only drop the-, further away you see, shatter a road, two roads from you. And so what did he do? He was so frightened he fell and he tipped eight pints of cold water over me. Head to foot. I was absolutely drenched. Right, course he cried, he was in such a state coz there was I dripping wet, from head to foot. So I just laughed, what could we do and it was all mud underneath because it was earth you see, it made it into a slop".[170]

To fully grasp the gravity of Esther's situation, one should place him or herself in the shoes of this young woman. One must conceptualize the mere idea delivering a child for the first time in your career in a bomb shelter, hearing bombs being dropped around you, with a father who was so nervous of his environment that he accidentally spilled eight pints of water on top of you. Then, place oneself in the shoes of a midwife like Esther, being so able and committed to the cause of safely delivering a child that you are able to laugh at the situation and simply get on with it. This anecdote is a stark reminder of the concerns in William Beveridge's report, which detailed the widespread poverty and general working conditions of the 1940s that midwives and other laborers were forced to endure. Esther's story should compel one to believe that midwives not only needed, but deserved the highest degree of recognition following Britain's involvement in World War II. This was not the case.

---

[169]RCOG Heritage Collections Blog, ed., "Esther Silverton: The Midwife's Tale Oral History Collection,".
[170]RCOG Heritage Collections Blog, ed., "Esther Silverton: The Midwife's Tale Oral History Collection,".

II. The Reports

Following the publishing of William Beveridge's Report in 1942, many in the government were forced to consider the future of the medical profession and its position in a future universal healthcare system. In July of 1943, the Rushcliffe Committee of Parliament published a report detailing the wartime status of midwives and nurses including salary and conditions. The Rushcliffe Report praised midwives for their civil service and ability to deal with highly complicated births while most General Practitioners were tending to wounded soldiers.[171] The Report also drew attention to the shortages present in the field, causing concern for the government.Following the Rushcliffe Report, the Ministry of Health took action in September of that same year, making it compulsory for midwives to remain in their current posts for nine months.[172]

The Rushcliffe Report was, in theory, a positive force in recognizing the commitment of midwives during wartime. Yet, in reality, the Report served as a way for the Ministry of Health to keep midwives loyal to the cause -- despite brutally long hours and tough working conditions. Medical Sociologist Robert Dingwall of Nottingham Trent University articulates this in his book, *An Introduction To The Social History Of Nursing.* Dingwall writes,

> "The Rushcliffe Committee's work was conducted against a background of attempts by the Ministry of Health to keep midwives at work by persuasion, flattery, and cajolery. When its report emphasized the independence of the midwife then, it may be more plausible to read this less as a reversal of the trend towards emphasizing her nursing background and auxiliary status than as part of the campaign to preserve the staffing of maternity services by voluntary means".[173]

---

[171]Robert Dingwall, Anne Marie Rafferty, and Charles Webster, *An Introduction To The Social History Of Nursing* (London: Routledge, 2016), 167.
[172]Dingwall, *An Introduction To The Social History Of Nursing, 167.*
[173]Dingwall, *168.*

One must understand just how slyly the Ministry of Health went about its operation to keep midwives in their back pocket. Every Midwife Act and government report prior to the Rushcliffe Committee's Report in 1943 ultimately advocated for greater regulation, surveillance, and governmental control of midwives. This begs the question: why, suddenly, was the Government and Ministry of Health proud to report to the nation on the need to appreciate and grant independence to midwives? In that moment, in 1943, the Ministry of Health needed loyalty from the midwife population that they had been pushing away since The Midwives Act of 1902 passed. The Rushcliffe Report and the following 1945 midwife recruitment scheme put in place by the Ministry of Health was no coincidence. It was manipulation of a hardworking population of women that they would abandon completely just three years later.

Just one year later, in 1944, the Royal College of Obstetricians and Gynaecologists (RCOG) released a report calling for a 70 percent hospital birth rate in Britain.[174] What is so profound regarding the Royal College of Obstetricians and Gynaecologists' report is the subject in which they were reporting on. The 1944 report reported on the "National Maternity Service", not midwives.[175] The college's word choice in titling their report was no mistake. Although the Labour party did not come into power until 1945, William Beveridge had published his report calling for a universal healthcare system in 1943. The Beveridge Report was already proving to be influential in the fact that the Royal College chose to abandon the term midwifery in their title and essentially advocate for total obstetric power in its universal maternity scheme. The Royal College was, in their word choice, reiterating

[174]Hunter, "Midwifery, 1920-2000: The Reshaping of a Profession," 157.
[175]Hunter, "Midwifery, 1920-2000: The Reshaping of a Profession," 157.

Beveridge's opinion that all maternity care should fall under one mass power. When all is said and done, advocating for 70 percent hospital birth at a time where 70 percent of babies were being delivered at home is a direct message and warning to midwifery as a profession.

In 1946, the Royal College of Obstetricians and Gynaecologists, in collaboration with the Population Investigation Committee, released a second report calling for a slow demise of home births with midwives. The Population Investigation Committee is a social research group that was founded by the British Eugenics Society in 1936. One can assume an inherent bias in the Population Investigation Committee's findings as they were backed and funded by an immoral eugenics society that believed poor hereditary was the central cause of Britain's poverty. Seeing as the poor people of Britain were still largely having their children at home, it comes as no surprise that the British Eugenics Society and the Population Investigation Committee were vehemently against the continuation of a domiciliary midwifery service. At this point in time, Clement Atlee and the Labour party became the Government and were planning on their institution of the National Health Service from such findings. The Population Investigation Committee was determined to obtain base-line information for the Ministry of Health for the imminent reorganization of the healthcare system.

As renowned British Historian Marjorie Tew points out in her book *Safer Childbirth?,* one must consider the context in which the Royal College of Obstetricians and Gynaecologists were writing this report. Tew writes, "The joint report bears the imprint of the obstetricians' influence, [...] the relevant recommendations made were those on which obstetricians were thereafter to rely in pursuing their campaign to medicalize childbirth".[176]

[176]Marjorie Tew, *Safer Childbirth?: A Critical History of Maternity Care* (London: Chapman and Hall, 1998), 151.

Essentially, obstetricians identified an opportunity in Atlee's Labour Government to capitalize on their own opinions of who should be leading childbirth. Although only five percent of home births ended up in a transfer to hospital for an emergency complication, the report stated that, "until the incidence of such emergencies can be reduced, there is a good case for the encouragement of institutional delivery. If a sufficiency of maternity beds is provided in suitable institutions… there is little doubt that in England, as in America, the institutional habit would be established for the large majority of confinements".[177]

In this statement, the RCOG is grasping at straws for reasoning to recommend full institutional birth. The fact that American obstetricians had been shifting towards full hospital birth is not reason enough to follow suit. To claim taking influence from America, while simultaneously crafting a free and universal healthcare system that is at its core anti-capitalist American is nonsensical. Even more ironic in the Royal College's desire to follow the US is the fact that America's shift to greater hospitalization births was not working in the favor of mothers and babies. In 1932, The New York Academy of Medicine investigated the nation's shift to almost 75 percent hospital births by 1930.[178] The report found that the maternal mortality rate was 4.4 per thousand in a doctors care, and only 2.9 per thousand in a midwife's care at home.[179] Additionally, The New York Academy of Medicine report explicitly stated that two-thirds of all infant deaths could be avoided without the "incompetence" of the standard obstetrician and general practitioner.[180] Ergo, the RCOG's recommendation to follow the early hospitalization of America was simply not an informed choice in itself.

---

[177]Tew, 151.
[178]Tew, 62.
[179]Tew, 62.
[180]Tew, 62.

Additionally, the Royal College of Obstetricians and Gynaecologists 1946 report stated that there was absolutely no increase in mortality in home births versus institutional births, just as Dr. Janet Campbell had stated in her 1924 report.[181] For the RCOG to lay claim that safety was the main concern for recommended full institutional birth, as opposed to a desire to boost the obstetricians status, is simply untrue. Tew articulates the gall of obstetricians in post-war Britain in the first ten pages of her book, stating that "the policy of the increasing hospitalization of birth advocated by doctors, allegedly to improve the welfare of mothers and babies, was in fact a very effective means of gaining competitive advantage by reducing the power and status of midwives''.[182]

Thus, it comes as no surprise that just two years later, the passing of the National Health Service Act made the midwife permanently subordinate to any male general practitioner, gynaecologist, or obstetrician. Her work as the primary caregiver to pregnant women for centuries was brought to a calculated and adamant halt.

III. The Terms of the NHS

The National Health Service officially made pregnancy, birth, and antenatal care free for all British citizens. To an outsider looking in, the introduction of such a service may seem entirely positive. However, the actual provisions within the National Health Service Act prove to be far more complicated in terms of a midwife's autonomy. First of all, for a pregnant woman to find a midwife in the National Health Service, she had to contact a General Practitioner directly first. Then, the General Practitioner would refer her to an

[181]Tew, 151.
[182]Tew, 6.

appropriate midwife.[183] The insertion of a third party in matching an expectant mother and midwife immediately complicates, slows down, and taints the sacred relationship that the two individuals are meant to naturally form.

The practice of referral introduced by the National Health Service not only diminished the power of the midwife in a professional manner, but even more so diminished her power as the first reference and safety net for a pregnant woman. As previously discussed in this Chapter, midwives had just completed their work as the primary caregivers to pregnant women during World War II. Wartime midwifery proved to be especially stressful for the midwife -- yet she still upheld her responsibility of making the expectant mother feel safe and comfortable. The midwife was the caregiver biking through air raids to a home miles away to deliver a baby in a bomb shelter -- not the General Practitioner. Thus, the NHS placing a General Practitioner in the middle of that relationship is a direct besiege of midwifery's role as the primary caregiver to pregnant women.

Furthermore, the Act explicitly states that if a General Practitioner and a midwife are present together at a birth, the GP is to have precedence and the midwife is to be defined as a "maternity nurse".[184] Now, there is no intent to belittle the incredible work of nurses in this body of work. Nurses, and maternity nurses, are formally trained and do gratifying work. However, a midwife is not a maternity nurse. She is not an assistant to birth. She is trained, capable, and willing to lead labor from start to finish. Thus, the National Health Service's choice to place the midwife in subordinate position to a general practitioner in

---

[183]Eileen Richardson, "Midwifery in Britain in the Twentieth Century," Midwifery in Britain in the Twentieth Century - Memories of Nursing, 2009, https://memoriesofnursing.uk/articles/midwifery-in-britain-in-the-twentieth-century#:~:text=Midwifery%20became%20legally%20recognised%20in,with%20the%20first%20Midwives%20Act.&text=The%20Midwives%20Act%20allowed%20for,the%20time%20(Heagerty%201997).

[184]Dingwall, *An Introduction To The Social History Of Nursing,* 168.

labor is not only fraught with sexist undertones, but quite frankly, a safety hazard. If a General Practitioner straight out of medical school is placed in a higher position than a midwife who has, for example, led fifty women through birth -- the logical person of precedence in that situation is the midwife. The board-certified, trained, and experienced midwife is not a maternity nurse. She is just as, if not more qualified than the General Practitioner to be leading a laboring mother through birth.

Finally, The National Health Service made a provision stating that the General Practitioner did not even have to attend the physical birth of a laboring mother to receive their pay.[185] That means that a midwife who has never met the woman in labor may be asked to deliver her child in a day's notice because the General Practitioner on call knows that they do not have to do the work of delivering the baby to receive compensation from the State. This provision is not only economically unfair, but unfair to the midwife, too. To expect a midwife to step in at the drop of a hat without ever meeting the mother and understanding her situation is ludicrous. Yet, the National Health Service is just fine with crediting General Practitioners financially, even if they are not at the actual birth. Once again, a nonsensical provision of the NHS that inherently hurts midwifery is present.

In 2012, heavily-published British Historian Nick Hayes of Nottingham Trent University published a scathing article in *The English Historical Review* titled *Did We Really Want a National Health Service? Hospitals, Patients and Public Opinions before 1948*.[186] Hayes wrote his piece in the wake of 2011 modernizing health reforms proposed by the Conservative-led government at the time, when he began to question why the National

[185]Eileen Richardson, "Midwifery in Britain in the Twentieth Century,"
[186]N. Hayes, "Did We Really Want a National Health Service? Hospitals, Patients and Public Opinions before 1948," *The English Historical Review* CXXVII, no. 526 (2012): pp. 625-661, https://doi.org/10.1093/ehr/ces072.

Health Service is widely regarded as well-received by popular opinion.[187] In this piece, Hayes focuses heavily on midwifery as he explains that while the introduction of The National Health may have been suitable for several medical subsections, it greatly jeopardized what makes midwifery unique -- a close relationship between mother and caregiver. Fear of poor or impersonal care is only amplified whilst dealing with a pregnant woman, as she is in a uniquely vulnerable state. This vulnerability is precisely why the bond between midwife and mother is so important.

Britain's most widely-known public opinion research polling organization, Mass-Observation, conducted several mass surveys following the introduction of the National Health Service in 1948. The Mass-Observation polling that Hayes studied from the London area found that working-class women suffered from the largest disparities of maternity care in state-run hospitals.[188] Several working-class women found the new hospital birthing experience to be impersonal and quite cold.

One woman, the wife of a dock-labourer, described her experience of labor at the hospital as "awful. They just leave you in a room to get on with it. At home at least you can have someone with you".[189] This dock-labourer's wife never had a child in a hospital again, as she had firsthand experience of the indifference of hospitals in making women feel at their most comfortable. But, then again, is there any place more comfortable to go through a vulnerable and spiritual experience than in one's own home? Another woman described her discomfort in the sheer lack of privacy that hospital birth created. She told Mass-Observation that,

---

[187]N. Hayes, "Did We Really Want a National Health Service? Hospitals, Patients and Public Opinions before 1948," 625.
[188]Hayes, 654.
[189]Hayes, 654.

> "I was in a poor state of health and very nervous. We used to go for examination at various periods. We had to strip and wait about in the presence of a score of others and then a doctor or matron ward probationer examined us in turn as we lay on a hard bed".[190]

Although these observations are purely anecdotal, one must assume that if one pregnant mother was very uncomfortable in her state-recommended hospital birth experience, others must have been too. A third mother expressed her dissatisfaction with hospital birth, as she suggested "to have mothers in labour in a soundproof room, as the noise some of them make is very upsetting to the rest waiting to have their babies".[191]

One can only imagine the difference in experience for a woman having her second or third child in a hospital when she had previously labored at home. While these anecdotes are not to suggest that all hospital births are uncomfortable or bad, they are meant to suggest that the terms of the NHS deeply shifted the role of the midwife in her relationship to a laboring mother. The midwife knows how to navigate one's personal home -- she would be putting the kettle on, preparing home cooked meals for mom, getting to know the rest of the family, and making sure the birthing room is warm and comfortable. The comfort of a midwife is not something that can be easily replicated in a hospital setting -- and it was not. Yet, midwives were still pushed out of their role by the RCOG's 1946 Royal Charter and their subsequent influence over the NHS. The lasting effects of the National Health Service on midwifery are staggering, and were quickly examined by the Central Midwives Board and the Working Party on Midwives in 1949.

---

[190]Hayes, 654.
[191]Hayes, 655.

IV. The Effects

In April of 1947, the creation of a Working Party on Midwives was commissioned by the Ministry of Health.[192] The Working Party on Midwives was tasked with investigating the national post-war midwifery shortage before the National Health Service was to be implemented in July of 1948. In 1948, once the National Health Service was implemented, the Working Party sent out various questionnaires to the 17,819 midwives on the Central Midwives Board roll to inquire about their current satisfaction within their profession.[193] The following report of the Working Party on Midwives, which was officially published in January of 1949 using statistics provided from the Central Midwives Board, exemplifies the first public instance of concern for midwifery's longevity in the British healthcare system.[194] The Party quickly issued a memorandum to the Minister of Health within the report, pleading for greater and continued support of domiciliary midwifery training.

The Party cited four causes in the lack of available training for future midwives, pointing to,

> "***(a)***a decrease in the birth rate, without a relative ~ decrease in the number of institutional confinements, ***(b)*** the incursion of the general practitioner into normal midwifery under the provisions of the National Health Service (Maternity Medical Services), ***(c)*** the economic pressure forcing the mother to choose institutional confinement owing to the provision of **an** entirely free hospital service, while in the case of a domiciliary confinement she was not relieved of the cost of food and had to provide domestic help or make a contribution towards the Home

[192]Dingwall, 168.
[193]The Central Midwives Board, "Report of the Work of the Board for the Year ended March 31st, 1949," *The British Journal of Nursing*, November 1949, pp. 124-125, https://rcnarchive.rcn.org.uk/data/VOLUME097-1949/page125-volume97-november1949.pdf.
[194]The Working Party on Midwives, "Report of the Working Party on Midwives," *The British Journal of Nursing*, November 1949, pp. 124-125, https://rcnarchive.rcn.org.uk/data/VOLUME097-1949/page125-volume97-november1949.pdf.

> Help provided by the local health authority, ***(d)*** housing shortage, which made domiciliary confinement unsuitable in many cases. This last, however, was short-term and should be rectified in due course".[195]

Seeing as just one year after the National Health Service was implemented, a government-commissioned Working Party sent a fervent memorandum to the Minister of Health citing the intrusion of the General Practitioner as a factor in the low enrollment in midwifery training is self-evident of a major gendered issue. Not only that, the Working Party on Midwives' was successful in calling out the terms of the National Health Service for its economic inequities and manipulation of the pregnant mother. The Party recognized that it is a no-brainer for somebody to take advantage of a free health service -- but that begs the question, why were at-home births not covered in the plan, too? This memorandum displays the consequences of the Government's decision to listen only to the men leading the Royal College of Obstetricians and Gynaecologists, and not even consider the consequences to the midwives that had been so loyal to their cause.

Two months later in March of 1949, The Central Midwives Board released a report furthering the investigation into the status of midwifery under the National Health Service.[196] The CMB report found a large discrepancy in the number of Pupil Midwives choosing to enter training institutions, revealing a rapidly decreasing interest rate in entering the profession. A shocking 486 less pupils chose to enroll in a midwifery training institution in 1948 than in 1947.[197] Additionally, the total number of pupil's First Examination failures in 1948 was 138 more than in 1947, a 3.6 percent increase in overall

---

[195]The Working Party on Midwives, "Report of the Working Party on Midwives," 125.
[196]The Central Midwives Board, "Report of the Work of the Board for the Year ended March 31st, 1949," 124.
[197]The Central Midwives Board, 124.

failure rate.[198] The Central Midwives Board report offers stark contrast to these failure rates, stating, "It will be remembered that in the previous report these figures [passes] were recorded as increases of 35.2 percent [...] respectively over the year before".[199] Finally, the report states that Part One of the Midwife Teachers Diploma Examination (the first examination in entrance to midwifery) that was held in both June and November of 1948 received only 176 entries, 53 of which passed.[200]

Unfortunately, despite the publishing of both the Central Midwives Board Report and the Working Party on Midwives Report in 1949, the status of midwifery continued to decline. No action was taken by the Government to solve the issues presented following the publishing of both reports. As both of the reports described and cautioned towards, enrollment rates in midwifery training continued to decline throughout the following decade and the Ministry of Health's recommendation for institutionalized birth intensified. The Ministry of Health not only chose to ignore the report and memorandum from the Working Party on Midwives, but to act on exactly what they had warned. Again, the methodological disenfranchisement of British midwives continued, indiscreetly and unapologetically.

When the National Health Service began to encounter intense financial insecurities in 1959, The Guillebaud Committee of Enquiry was created to investigate such issues. Yet, The Guillebaud Committee did not find itself entirely qualified to pass judgement upon maternity and obstetric issues in the budget, so a second committee was commissioned to investigate maternity services.[201] This second committee, titled The Cranbrook Committee,

[198]The Central Midwives Board, 124.
[199]The Central Midwives Board, 124.
[200]The Central Midwives Board, 124.
[201]Tew, 153.

garnered its evidence from the very people who were most economically incentivized to increase hospital births -- hospital specialists and providers.[202] Seeing as the Cranbrook Committee collected opinions from the literal medical elite, it is no surprise that its report came as no help to midwifery.

The 1959 Cranbrook Committee, listening to the medically unsubstantiated claims of the Royal College of Obstetricians and Gynaecologists, reported that hospital confinement for a laboring mother provided the most safety.[203] The Report recommended a 70% hospital birth rate for all mothers and estimated that only 20-25% of these births would require impatient antenatal care.[204] Unsurprisingly, the 70 percent hospital birth rate recommended by the Cranbrook Committee in 1959 was the exact same rate proposed by the Royal College of Obstetricians and Gynaecologists Report of 1944. Evidently, the political scheming of the medical elite in the RCOG was reason enough for the Cranbrook Committee to relay the College's recommendations.

The Cranbrook Committee Report went on to recommend that "a general practitioner obstetrician should, whenever possible, attend all domiciliary confinements, to safeguard the mother and baby against unforeseen emergencies".[205] Although this may seem like a harmless medical recommendation, it is not. The midwife had been successfully and safely delivering babies in patient's homes for hundreds of years. She did not require a "safeguard" against her maternity work, contrary to the opinion of this Report. This recommendation is a direct clause to diminish the small amount of medical authority and sacred position the midwife had left by 1959. The entire idea that is midwifery, the strong

[202]Tew, 153.
[203]Tew, 153.
[204]Tew, 153.
[205]Tew, 154.

and personal relationship between mother and midwife in the patient's home, was now facing a recommendation to be completely overseen. Yet, the true insult within the Cranbrook Committee Report was the intentional exclusion of midwives from proposed "clinical meetings which could bring together for discussion of clinical cases all those persons responsible in a particular area for carrying out maternity care".[206] Thus, midwives were not only excluded from their role as a primary caregiver, but excluded from the table of medical legitimacy entirely.

Only to be expected, the recommendations of the Cranbrook Committee Report of 1959 worked with ease. By 1965, hospital birth rates in Britain rose to the anticipated 70 percent.[207] Just three years later in 1968, the hospital birth rate reached 79 percent.[208] Shortly later in 1970, the Ministry of Health's newly-commissioned maternal investigative committee, The Peel Committee, issued a report calling for 100 percent hospital delivery.[209] Thus, within the twenty-two years of the National Health Service's introduction, the medical role and influence of the domiciliary midwife had essentially been reduced to zero by the interests of the medical elite. The destruction of midwifery as a popular practice was personal, purposeful, and politically charged by posh men running in the same professional, social, and political circles in Britain. The profession never fully recovered to its initial position as the primary maternity caregiver.

[206]Tew, 154.
[207]Tew, 154.
[208]Tew, 154.
[209]Tew, 154.

Chapter Four Bibliography

Dingwall, Robert, Anne Marie Rafferty, and Charles Webster. *An Introduction To The Social History Of Nursing*. London: Routledge, 2016.

Davis, Angela. "Wartime Women Giving Birth: Narratives of Pregnancy and Childbirth, Britain c. 1939–1960." *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences* 47 (September 2014): 257–66. https://doi.org/10.1016/j.shpsc.2013.11.007.

HAYES, NICK. "Did We Really Want a National Health Service? Hospitals, Patients and Public Opinions before 1948." *The English Historical Review* 127, no. 526 (2012): 625-61. Accessed April 19, 2021. http://www.jstor.org/stable/41474092.

Hunter, Billie. *Nursing and Midwifery in Britain since 1700*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012.

Leachman, Carly-Emma. "Most Women Give Birth in Hospital – but It's Got More to Do with World War II than Health." The Conversation. Nottingham Trent University, February 20, 2020. https://theconversation.com/most-women-give-birth-in-hospital-but-its-got-more-to-do-with-world-war-ii-than-health-110647.

RCOG Heritage Collections Blog, ed. "Esther Silverton: The Midwife's Tale Oral History Collection." Midwives Chronicle: The Heritage Blog of the Royal College of Midwives, February 10, 2017. https://rcmheritage.wordpress.com/2016/05/09/esther-silverton-the-midwifes-tale-oral-history-collection/.

The Central Midwives Board. "Report of the Work of the Board for the Year ended March 31st, 1949" *The British Journal of Nursing*, November 1949, 124–25. https://rcnarchive.rcn.org.uk/data/VOLUME097-1949/page125-volume97-november1949.pdf.

The Working Party on Midwives. "Report of the Working Party on Midwives" *The British Journal of Nursing*, November 1949, 124–25. https://rcnarchive.rcn.org.uk/data/VOLUME097-1949/page125-volume97-november1949.pdf.

Tweddell, Louise. "The Birth of the NHS – July 5th 1948." Nursing Times, August 2, 2019. https://www.nursingtimes.net/archive/the-birth-of-the-nhs-july-5th-1948-08-01-2008/.

"1942 Beveridge Report." UK Parliament. UK Parliament, 2021. https://www.parliament.uk/about/living-heritage/transformingsociety/livinglearning/coll-9-health1/coll-9-health/.

Conclusion

"Unfortunately, the role of obstetrics has never been to help women give birth. There is a big difference between the medical discipline we call "obstetrics" and something completely different, the art of midwifery. If we want to find safe alternatives to obstetrics, we must rediscover midwifery. To rediscover midwifery is the same as giving back child- birth to women. And imagine the future if surgical teams were at the service of the midwives and the women instead of controlling them".[210]

- *Doctor Michael Odent, 1986, Director of The Primal Health Institute, London*.

The art of midwifery and its professional status in Britain never fully recovered following the introduction of the National Health Service in 1948 and subsequent legislation. Following the Report of The Peel Committee in 1970, the standard recommendation for childbirth from the Ministry of Health remained at one hundred percent in hospital. Labor was no longer considered a natural process that required medical intervention in the case of an emergency. Instead, labor became a process of medical intervention from the start. According to the Institute of Research at the University of London, the rate of hospital births rose from 68.2% to 91.4% between 1963 and 1972.[211] From 1975 to present day, the rate of hospital births has not dipped below 95 percent.[212] Midwives have been effectively shunned from their position of expertise and authority within the birthing process, replaced by General Practitioners and sterile hospital rooms.

Nevertheless, midwives persisted. In 1976, a small group of training midwives across Britain formed the Association of Radical Midwives, an organization that sought to

---

[210]Suzanne Hope Suarez, "Midwifery Is Not The Practice Of Medicine," *Yale Journal of Law and Feminism* 5 (1993), https://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1080&context=yjlf.
[211]Angela Davis, "Choice, Policy and Practice in Maternity Care since 1948," Policy Papers (Institute of Historical Research, Senate House, London, May 30, 2013), https://www.historyandpolicy.org/policy-papers/papers/choice-policy-and-practice-in-maternity-care-since-1948.
[212] Davis, "Choice, Policy and Practice in Maternity Care since 1948,".

challenge the increasing banishment of midwives from their area of expertise.[213] The Association of Radical Midwives argues for a return to midwifery pre-1936 Midwives Act, a time when midwives had autonomy, privacy, and were held in high regard. The Association of Radical Midwives was quickly recognized as a political action group fighting for a feminist reclamation of the practice.[214] Throughout the 1970s and 1980s, the group regularly hosted support groups, meetings, and assemblies where they penned several documents to politicians explaining their cause. When the Central Midwives Board was formally disbanded in 1982 and absorbed into the all-encompassing United Kingdom Central Council for Nursing, Midwifery, and Health Visiting, the radical midwives found themselves in an even more vulnerable position to fight for professional autonomy. The Association of Radical Midwives is still active today, releasing a quarterly journal titled *Midwifery Matters*. There are currently thirteen active chapters of the Association of Radical Midwives all across England and Scotland.

The Association of Radical Midwives' continuous pressure on the Government to review its maternity recommendations came to fruition in the 1992 Winterton Report.[215] The Winterton Committee was created and commissioned by the House of Commons Committee of Health to conduct an investigation into Britain's maternity recommendations.[216] The Winterton Committee's report stated, in direct contrast to the previous reports from the Ministry of Health, that there is no medical evidence supporting a recommendation of one hundred percent hospital birth.[217] This finding, as expected,

[213]Billie Hunter, "Midwifery, 1920-2000: The Reshaping of a Profession," in *Nursing and Midwifery in Britain since 1700* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012), 164.
[214]Hunter, 164.
[215]Hunter, 165.
[216]Hunter, 166.
[217]Hunter, 166.

created rather a large stir amongst Sir John Major's Conservative Government. In response, House of Lords Baroness Cumberlege was assigned to chair an Expert Maternity Group to investigate the findings of The Winterton Committee.[218] The Expert Maternity Group proceeded to publish a report titled *Changing Childbirth*, which recommended a return to individualized and personal care for each and every mother in Britain.[219] The report stated that women should ultimately have a choice and be encouraged to feel confident in wherever they chose to give birth, whether that be in a hospital or at home. *Changing Childbirth* of the Expert Maternity Group ultimately confirmed the findings of the Winterton Committee, yet made its work less controversial by choosing to focus on the aspect of choice in its record. The decision to focus on a woman's choice to decide her place of birth, instead of outright discrediting the Ministry of Health's medical recommendation of one hundred percent birth in hospital, made the Expert Maternity Group's *Changing Childbirth* far more digestible to all. Finally, the Government was beginning to grasp the fact that a woman bearing a child at home was just as safe as in a hospital, and far cheaper, too. Seeing as the Government of 1992 was a Conservative leadership that harped on the notion of consumer choice, it is no surprise that *Changing Childbirth* advocated for a cost-effective and less demanding approach to midwifery.

Ultimately, the recommendations stemming from *Changing Childbirth* failed to produce any noticeable change in the stagnantly poor rate of home births in Britain. Yet, for midwives, *Changing Childbirth* was a testament to the power of their feminist voice in the Association of Radical Midwives. Midwives had finally gained enough political traction to at least influence the reigning agenda of the Government. Additionally, *Changing Childbirth*

[218]Hunter, 166.
[219]Hunter, 166.

was the first time that the Government publicly admitted to inaccuracies in previous recommendations that hospital births with a General Practitioner were safer than a home birth with a midwife. Jane Sharp, the original advocate for British midwives, would have been proud to see how the women of the Association of Radical Midwives fought for those around them to consider the beauty that is a women-led, women-represented midwifery practice.

Since 1902, British midwives have been faced with gruelling working conditions, harsh regulation, unfair oversight, and lack of representation. They have been forcibly removed from their position of authority in childbirth by the aristocratic male medical elite within the Government, the Ministry of Health, and the Royal College of Obstetricians & Gynaecologists. And yet, the solution to the diminished role of the midwife in maternity is not to continue to place blame on its twentieth-century medicalization. Instead, it is to move forwards with dignity and a sense of hope. Midwives, and women in general, deserve recognition for their contribution to the medical field. We should, as a society, be more eager to honor the millions of midwives who have brought life into this world since the Biblical age. Labor should be guided by gentle, loving hands. I pray that one day birth is placed back into the hands of the spiritual midwife.

Conclusion Bibliography

Hunter, Billie. *Nursing and Midwifery in Britain since 1700*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2012.

Davis, Angela. "Choice, Policy and Practice in Maternity Care since 1948." Policy Papers. Institute of Historical Research, Senate House, London, May 30, 2013. https://www.historyandpolicy.org/policy-papers/papers/choice-policy-and-practice-in-maternity-care-since-1948

Suarez, Suzanne Hope. "Midwifery Is Not The Practice Of Medicine." *Yale Journal of Law and Feminism* 5 (1993). https://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1080&context=yjlf.